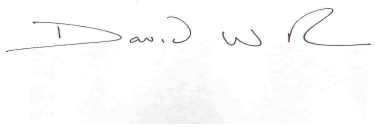
Public Document Pack

Health Policy and Performance Board

Tuesday, 7 January 2014 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
Vacancy	Co-optee

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, 4 March 2014

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.

REPORT TO: Health Policy & Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Strategic Director, Policy & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Health Policy and Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

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

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 18 September 2013 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Polhill (Chairman) Morley and Wright and S. Banks, P. Cook, J. Cooper, M. Creed, M. Grady, D. Hebden, T. Holyhead, D. Lyon, E. O'Meara, C. Myring, D Nolan, M. Pickup, C. Samosa, N. Sharpe, I. Stewardson, C. Richards, N. Rowe, P. McWade, A. Williamson and S. Yeoman.

Apologies for Absence: Councillors Philbin and S. Boycott, D. Johnson, A. McIntyre, D. Parr, D. Sweeney and J. Wilson.

Absence declared on Council business: None

Also in Attendance: One Member of the public.

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB23 MINUTES OF LAST MEETING

The minutes of the meeting held on 17th July 2013 were taken as read and signed as a correct record.

HWB24 NHS A CALL TO ACTION - PRESENTATION

The Board received a presentation from Simon Banks, Chief Officer, NHS Halton Clinical Commissioning Group, on the publication of the *NHS belongs to the people: a call to action*, which called for the public, NHS staff and politicians to engage in an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of patients. This was set against a backdrop of flat funding which, if services continued to be delivered in the same way as now, would result in a national funding gap which could be £30bn between 2013/14 and 2020/21.

The NHS belongs to the people: a call to action set out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remained flat and rising expectations of the quality of care. The document stated that the NHS must

change to meet these demands and make the most of new medicines and technology and that it should not contemplate reducing or charging for core services.

It was noted that NHS Halton CCG had already facilitated an event on 26th June 2013 at which themes similar to those raised by *The NHS belongs to the people: a call to action* were discussed with Halton Borough Council and NHS England colleagues. NHS Halton CCG, working with NHS England and Halton Borough Council, proposed to utilise the outcomes of this event, which was to be discussed later on the agenda, to continue a dialogue with local people about the future shape of the NHS.

RESOLVED: That.

(1) the report and the publication of *The NHS belongs to the people: a call to action* be noted;

(2) the work already facilitated by NHS Halton CCG in partnership with Halton Borough Council to commence a public narrative about the future of health in Halton be noted; and

(3) the continuation of this public narrative with local people, NHS staff and politicians be supported.

HWB25 NHS ENGLAND - MERSEYSIDE UPDATE - PRESENTATION

The Board received a presentation from Michelle Creed, Deputy Director of Nursing – Patient Experience, on behalf of NHS England (Merseyside), which provided:

- an update on the revised structures of the NHS and their relationships;
- an outline of the different NHS organisations within the Merseyside area;
- the financial allocations for each CCG within Merseyside for 2013/14; and
- details of each Directorate within NHS England (Merseyside) including key ambitions.

RESOLVED: That the presentation be received.

HWB26 FUTURE OF HEALTH IN HALTON - PRESENTATION

The Board received a presentation from Simon Banks, Chief Officer, NHS Halton Clinical Commissioning Group, which provided details on the Future of Health in

Halton Seminar which was held on 26th June 2013. The seminar discussed how health could look like in the future in Halton including:

- ageing population;
- improving but still low life expectancy;
- unhealthy lifestyles;
- high rates of hospitalisation, demands on unplanned/urgent care;
- scarce resources; and
- the need to do things differently;

It was noted that the following points were raised:

- demographic changes, their impact on all services for the local population, not just hospitals;
- do plans take account of the changes ahead? Do we need to be more ambitious and aim for a radical step change; and
- focus should be on frail, vulnerable people – not just older people.

The seminar also discussed the next steps which included, checking the five key themes, developing metrics, defining the key themes in an accessible manner, how to work with local people and using social marketing approaches.

RESOLVED: That the presentation be noted.

HWB27 JOINT PROTOCOL BETWEEN HALTON CHILDREN'S TRUST, HALTON SAFEGUARDING CHILDREN BOARD AND HALTON HEALTH & WELLBEING BOARD

The Board received a report of the Strategic Director, Children and Enterprise, which outlined the draft protocol/memorandum of understanding that had been developed to define the role of the Board and relationship with Halton Children's Trust and Halton Safeguarding Children Board.

It was proposed that the joint protocol would be updated in light of the new Working Together to Safeguard Children 2013 Guidance. The Guidance placed a duty on the Director of Public Health to ensure that the needs of vulnerable children were a key part of the Joint Strategic Needs Assessment that was being developed by the Board.

Members considered a copy of the revised protocol which set out the expectations of the relationship and

working arrangements between Halton Children's Trust, Halton Safeguarding Children Board and Halton Health and Wellbeing Board. It covered the respective roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny, and performance management. The arrangements set out in the Protocol would be subject to review annually as a minimum to reflect recent developments or immediately following legislative change.

RESOLVED: That

(1) the report be noted;

(2) the Board agrees to sign up to the Protocol (attached to the report); and — Chief Executive

(3) six monthly meetings of the Chief Executive of Halton Borough Council and respective Board Chairs as described in Paragraph 36 of the Protocol be approved.

HWB28 END OF LIFE SERVICES

The Board considered a report which provided an overview of current End of Life services available in Halton, which included an outline of future priorities. Members considered a current Model of Clinical Support at End of Life in Halton which consisted of a range of services and systems to ensure the requirements of the patient pathway were met along with the support networks within the community.

With regard to future priorities the following were proposed:

- a two year strategy had been put in place to deliver End of Life tools training to all care homes in Halton;
- by 2015 all care homes within Halton would have been part of the six steps training programme;
- key champions had been identified within Social Care teams and these would be integrated into the existing Key Champions' Network established across care homes;
- the implementation of an electronic palliative care co-ordination system as recommended "Dying Well at Home – The Case for Integrated Working" was a

priority for 2013/14;

- a key priority was to ensure that Liverpool Care Pathway was replaced with a care plan that was reflective of individual patient circumstances in the last few days of their life; and

- Halton Haven Hospice had been successful in securing funding to build a new Family Support Centre with men's shared facility incorporated in 2013.

RESOLVED: That the report be noted.

HWB29 JSNA REFRESH

The Board considered an update report on the Joint Strategic Needs Assessment (JSNA). Since the transfer of the public health responsibility and team to the local authority, a public health page had been set up on the Halton Borough Council website and all JSNA chapters, data updates and other products were now located there.

Members considered a summary document which presented a number of in-depth health needs assessments that had been completed February 2012 to March 2013. It was noted that during 2013-14 major refresh elements of the JSNA were proposed as follows:

- Children: Following discussions with the Children's Trust Executive and Commissioning partnerships, a refresh of all elements of the children's JSNA using a life course approach had begun. This also included vulnerable children and young people such as Looked After Children and those with disabilities.

- Disabilities: Following requests for information to support the annual Self-Assessment Framework submission, Liverpool Public Health Observatory were commissioned to undertake a detailed needs assessment for Learning Disabilities and Autism. This covered children and adults;

- Environmental Health: Work would start on developing this during quarter 2;

- An in-depth needs assessment had been jointly commissioned from Liverpool Public Health Observatory on the health needs of homeless people. This would be led by Liverpool Public Health with

input from Halton staff;

- Halton was also participating in a research project on the impacts of fixed point gambling terminals. This was scheduled to report April 2014.

The Board was advised that despite the continuing challenges that the Borough faced, many of the health indicators showed year on year improvements. Therefore, whilst the Borough continued to be generally worse, in certain areas, than the England average, these improvements showed that the Borough was moving in the right direction, people were able to engage with services, making the most of them to bring about positive changes for themselves, their families their communities. The report detailed areas of improvements within the health indicators and also areas which had remained difficult to improve since the previous reporting period.

RESOLVED: That the report be noted.

HWB30 NHS HEALTH CHECKS

The Board considered a report of the Director of Public Health, on the NHS Health Check Programme and which sought to make recommendations on how health checks should be implemented in Halton.

From 1st April 2013 local authorities took over responsibility for the NHS Health Check Programme (The Programme). The Programme was a Public Health Programme for people aged 40 – 74 and aimed to keep people well for longer. It also aimed to reduce levels of alcohol related harm and raise awareness of the signs of dementia.

The Board was advised that commissioning of the risk assessment element of the programme was a mandatory public health function, to be funded from the public health budget. Details of the arrangements which local authorities must make were provided in the report. In addition, the report also contained information on the risk assessment tests and measures which were to be carried out.

At present, the Council had an agreement with GP practices to deliver Health Checks Plus to local residents as a local enhanced service. Health Checks Plus included most of the minimum requirements of the NHS Health Checks, in addition to some locally developed questions around

housing and fuel poverty and some medical questions. Following feedback from GP practices, it was reported that the Health Checks Plus assessment took on average around 45 minutes per patient, far longer than the 20 minutes expected. It was therefore proposed that Health Checks would be streamlined so that they included only the required information to carry out the mandatory risk assessments and included the new areas of alcohol screening and dementia awareness for patients aged 65 to 74.

It was also proposed that Health Checks would continue to be delivered by GP practices under existing contractual arrangements and a community-based provision would be identified that was also cost effective. A copy of the new Service Legal Agreement which had been drafted for GP practices setting out the requirements of the revised NHS Health Checks was circulated to Members.

RESOLVED: That

(1) the report be noted; and

(2) the proposals for delivery NHS Health Checks in Halton be noted.

HWB31 TROUBLED FAMILIES / INSPIRING FAMILIES UPDATE

The Board considered a report of the Strategic Director, Children and Enterprise, which gave members an update on the development of Inspiring Families Programme.

It was noted that in the first year 145 families were identified and details of their status in relation to Payment by Results (PBR) claims in January 2013 and those estimated for January 2014, with the percentage of those families achieving targets was outlined in the report. It was anticipated that approximately 70% (102 out of 145) of all families from year 1 were likely to achieve targets and a claim made for PBR to the Department for Communities Local Government by the end of July 2013.

It was also noted that from the 29 families where PBR had been claimed:

- 12 adults were on the work programme;
- there was a 75% reduction in calls to the police;
- 139 less service calls over a 6 month period; and
- 11 young people had successfully completed their Youth Offending Team order and had not reoffended

over a 6 month period.

In addition, it was noted whilst the development of the Inspiring Families cost savings tool continued, work was taking place collating local costs incurred in relation to staffing the process.

With regard to year 2/3 allocation, following a review in April 2013, practitioners and lead managers raised concerns at the number of families allocated at one time. They suggested that instead, the Inspiring Families Team should "drip feed" families on a smaller scale. This would enable teams to manage the workload/demands more effectively. At present, 109 out of 195 families had been allocated with the remaining families to follow during October and November.

RESOLVED: That

(1) the Inspiring Families approach in Halton be supported; — Strategic Director Children and Young People

(2) where viable, partners adopt a "Think Family" approach in the planning and implementation of their service delivery;

(3) the development of family assessment that could be used across all organisations be progressed;

(4) partners consult with the Troubled Families Co-ordinator when commissioning services for children, young people and families; and

(5) the options of reinvesting cost savings to add investment to areas of agreed work be explored with partners.

HWB32 AUTISM SELF ASSESSMENT FRAMEWORK

The Board considered a report of the Strategic Director, Communities, which provided Members with an update on the Autism Self-Assessment Framework.

The Board was advised that in December 2010, statutory guidance was published, 'Fulfilling and Rewarding Lives'. As part of this the Department of Health issued a local self-assessment for adults with autism for Local Authorties and Clinical Commissioning Groups to aid commissioners to plan how they were going to respond to statutory guidance. The purpose of the self-assessment

framework was to:

- assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;

- assess progress since the baseline survey, as at February 2012;

- provide evidence of examples of good progress made that can be shared and of remaining challenges.

It was noted that the Autism Self-Assessment Framework would be submitted on 30th September 2013 as part of the validation process. The submission would also be presented to the Autism Strategy Group on the 23rd September 2013 and the Learning Disability Partnership Board. A copy of the Autism Self-Assessment Framework which was jointly owned by both the Local Authority and the Clinical Commissioning Group had been previously circulated to Members of the Board.

RESOLVED: That the report be noted.

HWB33 SCHOOL NURSING

The Board considered a report of the Director of Public Health, which provided an update on the progress of the procurement of School Nursing Service for Halton. From April 2013, Local Authorities assumed the accountability for the commissioning of School Nursing Services. This had provided an opportunity to review the existing commissioning arrangements to shape and design future provision with input from stakeholder engagement, in line with on-going review of all public health contracts. It was noted that the contract for the existing School Nursing Service had been extended to March 2014, with the option to extend for a further one year period. Due to the financial value of the contract and in line with Council policy, the service would need to go through an open procurement process.

A new specification was being developed as part of a collaborative piece of work with commissioners across the Cheshire and Merseyside footprint and the core elements of the proposed service were detailed in the report.

In order to ensure that all stakeholders could inform and influence the development of the service, it was intended a period of engagement would begin in September

for two months. During this time, head teachers, school staff, School Nurses, youth workers and other partners would be encouraged to provide their opinions on how the service could be improved to better meet the needs of children, young people and their families. In addition, children and young people would also be encouraged to feedback on the service and identify ways in which it could be improved. Further, Elected Members, The Children's Trust, Health and Wellbeing Board and the Local Healthwatch and other interested partners would also inform the final specification before it was subjected to procurement.

It was intended that the procurement process would commence in early 2014 with a view to ensuring that the successful provider was appointed no later than September 2014, in line with the beginning of the new school year.

RESOLVED: That

(1) the contents of the report and the appendices be noted;

(2) any comments be fed back to the Director of Public Health; and — Director of Public Health

(3) the recommendation to commence with consultation on the procurement of a service to be in place no later than September 2014 be supported.

HWB34 NATIONAL ENERGY ACTION (NEA) PUBLIC HEALTH WORK PROGRAMME

The Board considered a report which sought approval in principle of an application for free assistance from National Energy Action (NEA) to support the achievement of fuel poverty public health outcomes. NEA was a national charity which aimed to eradicate fuel poverty and campaigned for greater investment in energy efficiency for vulnerable people.

Members were advised that the support offered would take up 12 days of officer time for development activities in 8 localities across England, which must be utilised by the 14th March 2014. Applications for assistance must be submitted by Friday 20th September 2013 by either a Director of Public Health or the Chair of the Health and Wellbeing Board. A copy of the completed draft application to be submitted to NEA was circulated to Members of the Board.

RESOLVED: That the Board support in principle the application for free NEA support.

HWB35 ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST - PROPOSED 5 YEAR CLINICAL AND FINANCIAL PLAN

The Board considered a report of the Strategic Director, Communities, which provided an initial assessment of St. Helens and Knowsley (STH&K) Teaching Hospitals NHS Trust proposed 5 year Clinical and Financial Plan and outlined areas that required close scrutiny.

On 2nd August 2013, Ann Marr, Chief Executive of STH&K Teaching Hospitals NHS Trust wrote to the Chief Officers of Halton, Knowsley and St. Helens Clinical Commissioning Groups (CCGs) outlining details of the Trust's draft 5 year Clinical and Financial Plan. The bulk of the Trust's income came from contracts with English CCGs, NHS England and Local Authorities. A table was detailed in the report outlining the breakdown of this funding.

Following a review of the Plan, a number of points were highlighted in the following areas:-

- Support to the whole of the Urgent Care Pathway;
- Accident and Emergency Department Attendances and Non-Elective Admissions;
- Social and Intermediate Care Activity and 7/7 working ;
- Estate Costs;
- Nurse Staffing Levels; and
- Medium Term Growth.

Members of the Board were advised that it had recently been announced that Accident and Emergency Units would benefit from an additional £500m over the next two years to ensure they were fully prepared for Winter. However, it was anticipated that the new funding would go to areas that were identified as being the most under pressure which may exclude both STH&K and Warrrington and Halton Hospital FoundationTrust (WHHFT) who both achieved their 4 hour A&E targets.

It was noted that when the announcement for winter pressure funding was made, reference was also made to the £3.8b pooled health and social care funding for integration to be held by Local Authorities. There would be an expectation that this fund was also used to support pressures across the

urgent care system.

Arising from the discussion, the Board referred to STH&K proposal that contracted levels for non-elective activity should be rebased, releasing 70% tariff for investment with the Trust to maintain safety, patient experience and levels of performance. It was acknowledged that should this funding be released then the funding should also be released to WHHFT and they should be given an opportunity to submit a proposal. It was recognised that STH&K funding proposal needed to be considered as a whole, which included WHHFT; and Halton CCG would meet in October to consider the five year plan and to make a response.

RESOLVED: That the contents of the report and associated appendixes be noted.

Meeting ended at 3.50 p.m.

REPORT TO: Health Policy and Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Quality in Healthcare

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report provides the Board with :-

- an overview of health reports including Keogh Reviews, Cavendish Review, and the government response to the Francis Inquiry 'Hard Truths, The Journey to putting patient's first';
- an overview of the findings from 'Putting Patients Back in the Picture', the final report by Ann Clwyd PM and Professor Tricia Hart, the review of NHS Complaints systems;
- a further update on progress made in relation to Quality in Health care through the commissioning process in response to the findings of the Francis Inquiry and other reports; and
- aims to provide assurance to the Board on the quality of service provided to the population of Halton and the actions being taken to ensure improvements in quality.

2.0 RECOMMENDATION: That the Board:

i) Note the contents of the report; and

ii) Notes the progress made in monitoring and improving the quality of health care delivered locally.

3.0 SUPPORTING INFORMATION

The Cavendish Review

3.1 The Cavendish Review was published during July 2013 following an independent review into Healthcare assistants (HCA) and Support Workers in the NHS and Social Care settings, the review was led by Camilla Cavendish, health reporter for the Times. The report notes that 1.3 million of the front line care staff across health and social care are not registered with any professional body but they now deliver the bulk of care. The review was completed in just 14 weeks during which time the author spent the bulk of her time with front line staff.

The production of the report is based on two principals; to try to reduce the complexity and bureaucracy and to go with the grain of what the best employers are already doing. The report clearly outlines the silo working of the NHS and notes that 'social care is seen as a distant land occupied by a different tribe.'

The HCA workforce makes up about one third of the NHS workforce, which spends more time at the bedside than qualified nurses. These staff must therefore be seen as a critical resource for ensuring patient care, these staff report feeling undervalued and overlooked. There is no compulsory or consistent training and a profusion of titles, many of the staff are now delivering roles once the preserve of nurses and doctors. The other major issue for the NHS is that HCAs and the nurses who supervise them are viewed as separate workforces. The report clearly outlines recommendations for Trust Boards, Directors of Nursing and the NHS to ensure that HCAs are able to deliver safe and effective care.

The HCA workforce in social care dwarfs that of the NHS and had a high turnover rate up to 19% in care homes and 30% in domiciliary care. As in the NHS care workers in social care are increasingly taking on more complex and challenging tasks. The evidence is that in some places the training provided to these staff in minimal (in some areas staff reported being shown a DVD as their training and where then sent out to care for vulnerable people).

Another key finding of the review was the inescapable fact that people needed time to deliver care, it is impossible to build sustainable, caring, integrated health and social care system unless local authorities commission for outcomes rather than by the minute.

The simple approach taken by the review is to try to identify what is common, to then enable a reduction in complexity and duplication thereby giving the user a better service. The review therefore proposes a new common set of standards across health and social care (based on the processes currently used by the best employers) called a Certificate in Fundamental Care and asks the Care Quality Commission to require all workers to achieve this before working unsupervised. This certificate would link healthcare assistant training to nurse training for the first time. .

The review identifies recommendations in four key areas:

Recruitment, training and education

- Development of a certificate in fundamental care
- Higher certificate in fundamental care (more advanced skills)
- CQC should require staff to hold the base certificate
- NMC should advise how to draw the practical elements of nursing degree into the certificate.
- Develop rigorous system of quality assurance for training
- Employers should test values, attitudes and aptitude at recruitment stage

Making caring a career

- Developing bridging programmes into pre-registration nursing
- Clear plan to widen participation in recruitment to NHS funded courses
- Caring experience a prerequisite to entry into nursing degrees
- Development of robust career development framework for health and social care

Getting the best out of people : leadership, supervision and support

- HCAs to use Nursing Assistant as title on completion of certificate in fundamental care.
- Regulators, commissioners and employers define a single common dataset and commit to its use
- Directors of Nursing to take a greater Board level responsibility for recruitment, training

and management of HCAs.
- Improve processes through professional standards and other processes to enable the dismissal of unsatisfactory staff.
- Code of conduct for staff (Skills for Health) and progress the social care compact, or substitute a formal code of conduct for employers if not in place by June 2014.

Time to care

- DH to explore with social care how to move to commissioning for outcomes and eliminate commissioning based on activity by 2017
- NHSE include the perspectives of HCAs in its review of impact of 12 hour shifts
- Statutory guidance should include payment of travel time as contract conditions for home care providers.

The NHS Halton Clinical Commissioning Group (CCG) will be utilising the recommendations to ensure all health care providers in the contractual process for 2014/15 to ensure HCA training and competency is part of developmental and quality improvement programmes.

3.2 **Keogh Reviews**

During July 2013, NHS England published the Review into the Quality of Care and treatment provided in 14 hospital trusts in England: overview report.

Each of the 14 trusts where identified as having persistently higher than average mortality ratios, this measure was used for the review as it had been recognised that Mid Staffordshire NHS Trust has high mortality levels and these were associated with failures of all dimensions quality, clinical effectiveness, safety and patient experience.

SMRs or Standardised Mortality Ratios are measured by dividing the number of deaths in a time period by expected number of deaths. Expected deaths has a specific meaning in the context of SMR, the term provides an indication of how likely a patient is to die of the symptoms they had when they came into hospital. Currently three different methodologies are used:

- Summary Hospital Level Mortality Indictors (SHMI) published by NHS Information Centre;
- Hospital Standardised Mortality Ratio (HMSR) developed by Dr Foster Intelligence; or
- Risk Adjusted Mortality Index (RAMI) developed and published by CHKS.

The process for the reviews was labour intensive which commenced with a data gathering exercise and detailed analysis of the data, followed by a multi-disciplinary review with planned and unannounced site visits, the teams 15 to 20 strong consisted of patients, lay representatives, senior clinicians, junior doctors, student nurses and senior managers. During the visits the teams listened to staff and patients to gain insight into the services delivered as well as to CCGs, local politicians and those who represented local people. Common themes were identified across all 14 hospitals and the overview report provides eight ambitions for improvement and for each ambition areas of action are outlined.

The ambitions outlined are:

1. We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

2. The Boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They along with patients and the public will have rapid access to accurate, insightful and easy to use data about quality at service line level.

3. Patients, carers and members of the public will increasingly feel like they are being as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their care and the care of others.

4. Patients and clinicians will have the confidence in the quality assessments made by the Care Quality Commission, not least because they will be active participants on inspections.

5. No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

6. Nurse staffing levels and skill mix will appropriately reflect the caseload and severity of illness of the patients they are caring for and be transparently reported by trust boards.

7. Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but the clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

8. All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates and will be making this a key part of the quality improvement strategy.

For each of the 14 hospital reviewed individual reports were published via the Care Quality Commission's (CQC) website and were appropriate an improvement plan was developed. The CCG is using the Keogh ambitions to define quality markers for the 2014/15 contractual year. The CQC have now developed an inspection programme based on the Keogh reviews which will commence shortly with the next fourteen reviews to commence and will include follow ups of the initial reviews.

3.3 During November 2013 the Department of Health published '**Hard Truths, the journey to putting patients first**' which consists of two volumes plus a guide to nursing, midwifery and care staffing capacity and capability (How to ensure the right people, with the right skills, are in the right place at the right time), and a Concordat from the National Quality Board (Human Factors in Healthcare).

Hard Truths commences with a **statement of common purpose** which outlines the government commitment to the improvements to quality and safety in healthcare. The commitment outlines the values expected from the NHS (respect and dignity, commitment to quality, compassion, everyone counts, putting patient first, working together to do it better).

Areas of improvement and delivery are:

- Expert inspections of hospitals
- Independence for CQC
- Failure regime
- New system of ratings
- Involving patients and relatives

- Fundamental standards
- Publication of clinical outcomes
- New nursing and midwifery leadership programmes
- Senior leaders will spend time on front line
- Transparent reporting of staffing levels
- Clear processes to raise concerns or complain
- Will full neglect legislation
- Fit and proper person test
- Minimise burden of bureaucracy on trusts
- Criminal offence to supply or publicise false or misleading information
- Culture of making care safer through new patient safety collaborative
- Named consultant and nurse
- CQC, NHSE and monitor to safety data available
- Publication of safety thermometer data (Local trusts doing this as of November 13 WHHFT and STHKHT)
- Publication of never events data
- Re-launch safety alerts system
- Openness and candour – strengthened duty of candour, professional advice and conduct guidance, NHS litigation
- Listening to patients F&FTs, NHS Constitution. Support for patients to participate in decision regarding their care, CQC involving patients in inspections,
- Safe staffing guidance and publication (all local trusts now reporting to trust boards from April 14 will need to be published monthly, staffing levels will be reviewed by CQC, toolkit to engage and support staff and development of values based recruitment processes.
- Detecting problems early- expert inspection teams, inspector of hospitals, rating from outstanding to inadequate, by end of 2015 all hospitals will have been reviewed. CQC will develop fundamental standards, and ask five key questions is a service safe, effective, caring, responsive and well led?
- Guide for boards to ensure working effectively to improve patient care.
- Commissioners will focus on putting clinicians at the heart of commissioning with an explicit focus on improving health outcomes.
- Ensuring staff are trained and competent revalidation for nurses, older persons nurse post graduate qualification,
- Releasing staff from unnecessary work to enable more time for care

The recommendations will be used within the 2014/15 contractual round to drive clinical quality improvement for the population of Halton.

3.4 **Putting Patients Back in the Picture** is the final report of the review into the NHS complaints procedure; the review was completed by the Right Honourable Ann Clwyd MP and Professor Tricia Hart following the painful experience suffered by Ann Clwyd when her husband died in a hospital in Wales.

The inquiry was set up by the then Prime Minister to consider the handling of concerns and complaints. 20 individuals and 38 organisations were involved in the review. The reviewers asked to receive by post and email accounts of experiences on the complaints system with suggestions for improvements. Letters from patients, relatives and friends received before the review were also included in the process. More than 2500 letters and emails were received. The team also carried out seven public engagement events to take oral evidence from the public, alongside eight individual meetings with people considered to have particular expertise. Supported by patient representatives nine hospitals and one hospice were visited

were patients fronts line staff and board members were interviewed.

The report notes that complaints procedures had been reviewed by other inquiries, Dame Janet Smith as part of the Fifth Report of the Shipman Inquiry, the Health Select Committee and the Francis Report all outlined concerns of a similar nature regarding the management of complaints within the NHS. The Francis Inquiry in particular outlined his support for the Patient Association's standards for good complaints handling developed as part of the Health Foundation funded 'Speaking Up' project.

The report clearly outlines the **key points which lead to complaints**:

- Lack of information
- Failures of compassion
- Dignity and care
- Staff attitudes
- Resources

And the **key points raised about what it feels like to complain**:

- Information and accessibility
- Freedom from fear
- Sensitivity
- Responsiveness
- Prompt and clear processes
- Seamless service
- Support
- Effectiveness
- Independence

Organisations involved in managing complaints outlined key issues from their perspective:

- Complexity
- Advocacy
- Leadership and governance
- Skills and attitudes
- Toxic cocktail (people reluctant to complain and staff being defensive)
- Independence
- NHS reforms
- Whistle-blowing and Duty of Candour
- Lack of compliance

The report makes **recommendations in four areas**:

- Improving the quality of care 10 recommendations spread across staff and boards
- Improvements in the way complaints are handled- 19 recommendations across Regulators, Commissioners and providers.
- Greater perceived and actual independence in the complaints process five recommendations for trusts
- Whistle-blowing five recommendations for trusts, DH and CQC

The report also outlines **an approach to implementation and the pledges to act made by:**

- Nursing and Midwifery Council
- Royal College of Nursing
- NHS Trust Development Authority
- Health Education England
- Local Government Association
- NHS confederation
- NHS Employers
- General Medical Council
- Monitor
- Care Quality Commission
- NHS England
- The Parliamentary and Health Service Ombudsman

As part of the commissioning process for the 2014/15 contractual year the CCG will aim to include a requirement on all providers to improve complaints management and learning from complaints as a quality measure reported via the contractual performance processes.

3.5 **Delivery of quality improvement and assurance in line with the recommendations of the Francis Inquiry**

Following the last update to the Board it was agreed that this update would include an overview of some of the improvements areas delivered in the 2013/14 contract performance year as an outcome of implementation of Francis Inquiry recommendations.

All providers have in this year delivered:

- Development and implementation of quality and nursing strategies including action on safer staffing and HCA training, for acute providers all are publishing safety thermometer data through the open and honest care programme. Community and mental health providers are to follow.
- Development of clinical leadership programmes which include percentage of time by senior staff working with front line staff and development of leadership skills in clinical staff.
- Evidence of implementation of a culture of openness and transparency through duty of candour statements in complaint, incident and concerns reports and responses.
- All providers signed up to health economy wide working in relation to safer care and Health care acquired infection.
- All providers are now presenting at contracts quality meetings: incident reporting outcomes, full complaints reports, compliance with NICE guidance and alerts.

The CCG and LA as commissioners are working closely together to ensure quality is monitored and reported across all provision health and social care, this being delivered through the development of joint reporting processes and integrated working. .

As part of the commissioning process for 14/15 the CCG is aiming to commence the use of quality outcomes based commissioning processes to ensure quality measures deliver real patient outcomes and do not just count widgets.

4.0 **POLICY IMPLICATIONS**

4.1 The LA and CCG need to ensure that policies for local service delivery and development ensure a focus on care provision with the patient or user at the centre and deliver outcomes

for patients and their families.

4.2 The CCG must now develop its five year strategy for commissioning the strategy must be developed in an integrated way with the local authority and must focus on delivery of care that is high quality and safe. All areas within the strategy must focus on outcomes for patients and delivery of the health improvements as defined with the Joint Strategic Needs Assessment.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The CCG needs to ensure the continuous improvement of quality in all services, the financial challenge for the NHS remains

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The delivery of high quality health care is essential to support the achievement of the potential of children and young people.

6.2 **Employment, Learning & Skills in Halton**
Good health is essential to enabling local people to achieve their potential through education and into employment.

6.3 **A Healthy Halton**
Quality of health care is essential in supporting the delivery of improved health to the population of Halton.

6.4 **A Safer Halton**
Health care services support the delivery of safety in Halton through support to local people.

6.5 **Halton's Urban Renewal**
The CCG is aiming to ensure Halton pound is spent within Halton and through this supporting the urban development and renewal for Halton.

7.0 RISK ANALYSIS

7.1 Key strategic objectives and key functions for the CCG are to commissioning health care to improve the Health of the local population and to drive continuous quality improvement in the service it commissions

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 All health service provision is delivered in line with the requirements of equality and diversity law.

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

9.1 None under the meaning of the Act.

REPORT TO: Health Policy & Performance Board

DATE: 7th January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Urgent Care Consultation - NHS Halton Clinical Commissioning Group

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update Members of the Health Policy & Performance Board (PPB) on the results from the information received from the different methods of the urgent care consultation carried out in the Summer 2013.

2.0 **RECOMMENDATION**

i) That Members of the Health PPB note the report, the summary results (Appendix 1) and the briefing note (Appendix 2).

3.0 **SUPPORTING INFORMATION**

3.1 The attached report provides a summary of the information received following the consultation undertaken in Summer 2013 with residents and key stakeholders.

3.2 Also attached is a briefing on the re-design of urgent care and the proposed changes.

4.0 **POLICY IMPLICATIONS**

4.1 None

5.0 **FINANCIAL IMPLICATIONS**

5.1 None

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**

None identified.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 A risk assessment will be completed as part of the implementation/business planning stage

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 A equality impact assessment will be completed as part of the implementation/business planning stage

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

None under the meaning of the Act.

Urgent Care Health Provision in Halton:

Summary results

During summer 2013, residents and key stakeholders were given the opportunity to respond to a consultation regarding urgent care health services in Halton. The two areas of urgent health care that were being consulted on were the proposal for urgent care centres in both Widnes and Runcorn and the proposal for a CDU (Clinical Decision Unit) based at the Halton Hospital Site.

There were a number of opportunities for residents and key stakeholders to take part in the consultation. These were:

- Healthwatch Halton Meetings
- Two Public events held at Select Stadium Halton and Runcorn Town Hall
- GP and Practice Feedback Questionnaire
- Young Persons Questionnaire via Catch-22 and Halton Speak Out
- Online / Paper questionnaire available for the public to complete via http://www.haltonccg.nhs.uk/urgentcare and also distributed via local community groups and advertised in 'Inside Halton' - a quarterly magazine that is distributed to every household in the borough.

The overwhelming majority of attendees at the meetings, as well as those who responded to the GP and practice feedback questionnaire and those who responded to the questionnaires are in favour of the proposals. There was also opportunity for people to make further comments and a number of questions and suggestions were made.

The following report provides a summary of the information received from the different methods of consultation listed above.

Methodology

For the purpose of the urgent care proposal consultation, the best approach was to gauge as many different views and opinions from members of the public as possible. Therefore it was decided that the best technique to use to achieve this was the 'snowball sample' technique.

A 'snowball sample' is a non-probability sampling technique where respondents are recruited through existing networks (for example, hard to reach groups), allowing research to include these residents as well as the general population.

Consequently, we were able to consult with not only the wider public via an online and paper questionnaire advertised in 'Inside Halton' (a magazine that is distributed to every household in Halton) but also to target individual service user groups and young people through those who work in the community in the voluntary and third sector.

As the sample of responses built up i.e. like a snowball, enough data was gathered to build a picture of opinion. Over 350 residents took part in the consultation overall.

Key Findings from all consultation methods

The feedback from the varied methods of consultation was overall in favour of the urgent care proposals. Those who responded believe that the new facilities would be of great advantage to the residents of Halton and in terms of health and wellbeing it will be of comfort to residents that they would have immediate access to urgent care facilities. Not having to worry about public transport, not having to travel to Warrington A&E and lessoning the burden on A&E were also factors as to why the proposals are a good idea. It was also discussed that having a Walk-in Centre based in Runcorn would also help residents of other surrounding areas such as Frodsham.

Over 800 comments, concerns and questions about the proposals were also gathered from the consultations and from these; four overarching themes can be identified.

Customer Care and Quality

Comments focused on the need for good customer experience when using the facilities. Signage should be easy to understand in the buildings and thought should be given to the layout of waiting areas, as well as facilities being made available for those using the urgent care facilities and their carers. Easy access to the building and easy read signs and leaflets should be available for those with learning difficulties or other disabilities. It is also important that staff (both medical and non-medical) are knowledgeable, approachable and willing to explain / advise if people have questions or are worried.

Opening hours and transport issues were also discussed. The general opinion is that the service should be open late night – if not all night – and that the pharmacy should also be available during the full opening hours of the service. If the service is not open all night then information should be provided on what services can be used.

Travel over the Silver Jubilee Bridge and parking availability / fees were also discussed. Currently you have to pay at Halton Hospital to park, however the Walk-in Centre at Widnes is free? This should be clarified at the new Walk-in Centre. People should be directed to alternative facilities if there are road works / blockages on the Silver Jubilee Bridge rather than travel to Runcorn.

Education and Publicity for the Public

Although respondents are in favour of the proposals, it would add another strand of urgent care for residents which may cause confusion over which service should be used. Therefore, any advertising campaign for the public should be clear, concise and informative. This applies not only to advertising the service but also educating the public as to what service is available, what each service provides and when it is appropriate to use a particular service.

It was also discussed that residents should be informed of the reasons why the new services are being proposed / developed and how this will benefit them in terms of costs and A&E admissions.

Education / Training and Publicity for Professionals

It was felt that alongside education and advertising for the public, it is also important to inform all health professionals in the same manner. GP's and health centre staff should be trained on what services are available and when it is best to refer or direct a patient. Some comments also suggested that the referral process to A&E should change to reflect the new service provision.

Service Provision

There are concerns that the new facilities will become overstretched as people will use these instead of going to their GP. It is important that the level of care within the two walk in centres will be of the same high standard and that there will not be competition between the centres.

The level of qualified staff was also discussed, as the level of qualification determines the type of treatment / prescription facility that can be provided. Staff numbers should also be considered and service providers should work together to help ensure that the facility does not become overstretched.

Comments were also made concerning other services that could be provided within the buildings, such as a full x-ray service and mental health services.

Demographic Profile of Halton

Produced by the Customer Intelligence Unit
E-mail: research@halton.gov.uk
Webpage: www.halton.gov.uk/research

Ten things you need to know about Halton...

- In the long term, the older people age group (65+) are projected to grow by 33% from 18,800 in 2011 to 24,700 in 2021.
- Halton has a largely White population (around 97.5% of population).
- Unemployment and worklessness are key challenges in Halton, with variation at small area level – around 1 in 3 adults in Windmill Hill ward are claiming an out-of-work benefit.
- Residents in Halton have a lower average wage than people working in Halton.
- GCSE attainment[12] in Halton is slightly lower than the national average and ranges from 33% in Riverside to 86% in Farnworth.
- House prices in Halton are low; this does mean that Halton is a relatively affordable place to live, with house prices around 4 times average earnings.
- Around a quarter of Halton's population rent from Registered Social Landlords (RSL's), this is around twice as much as regional and national figures.
- Deprivation is a major issue in Halton, 21 of the 79 'Super Output Areas' fall in the 10% most deprived areas in England. Over a quarter of children – 7,800 – live in poverty.
- Life expectancy in Halton is low – Halton's female life expectancy is the 4th lowest in the country.
- Halton has been identified as the 96th worst local authority area in England for alcohol related crime and the 67th worst area for binge drinking (2013 LAPE).

How does Halton compare with other places in England?

Key: England worst | England average | England best | Halton value

Domain		Indicator	Halton	England average	England worst	England range (out of 326 local authorities)	England best
Population	1	Population Growth 2001-12	6.3%	8.9%	-5.0%		34.1%
	2	0-15 age group	19.8%	18.9%	9.2%		26.5%
	3	16-64 age group	64.6%	64.1%	53.8%		76.3%
	4	65+ age group	15.6%	16.9%	6.1%		30.6%
Economy	5	Jobs in public admin, education & health	30.4%	29.6%	16.7%		49.3%
	6	Average weekly earnings (£)	£462	£513	£330		£803
	7	Unemployment (JSA claimants)	4.5%	3.3%	7.8%		0.2%
	8	Youth unemployment (JSA claimants aged 18-24)	12.6%	5.9%	16.0%		0.0%
	9	Worklessness (claiming out-of-work benefits)	16.6%	11.3%	21.6%		3.1%
	10	No qualifications	12.1%	9.5%	21.9%		1.4%
	11	Qualified to NVQ3 and above	45.7%	54.9%	33.3%		80.5%
	12	GCSE attainment	59.0%	59.4%	40.9%		86.4%
Housing	13	House prices (£000)	134	254	97		659
	14	Long-term vacant dwellings (%)	1.2%	1.2%	4.4%		0.0%
	15	Earnings to house price ratio	4.2	6.7	27.8		2.8
Quality of life	16	Happiness Index	7.4	7.4	7.1		7.9
	17	Proportion of Children in Poverty	26.5%	20.6%	48.6%		2.4%
	18	Deprivation (IMD score)	32.5	19.2	43.4		4.5
	19	Crime (per 1,000 residents)	42.8	38.0	151.8		13.0
Health	20	Life expectancy - females (years)	79.6	82.6	79.1		89.8
	21	Life expectancy - males (years)	75.5	78.6	73.6		85.1
	22	Obese Children (Year 6)	23.8%	19.0%	26.5%		9.8%
	23	Alcohol-specific hospital stays (Under 18)	153.9	61.8	154.9		12.5
	24	Admission episodes for alcohol-attributable conditions	2833.7	1895.2	3275.8		909.9
	25	Early deaths by cancer	159.1	110.1	159.1		77.9

Notes for chart:

1 % total population growth from 2001 Census to 2012 mid-year population estimates. 2-4 given as % of total population, 2012 mid-year population estimates. 5 given as % of all in employment, ONS Annual Population Survey, Apr-12 to Mar-13. 6 Average (median) gross weekly earnings of residents, ONS Annual Survey of Hours and Earnings 2012 7 % of 16-64 year olds claiming JobSeekers Allowance, NOMIS, Aug-13 8 % of 18-24 year olds claiming JobSeekers Allowance, NOMIS, Aug-13 9 % of 16-64 year olds claiming out-of-work-benefits, NOMIS, Feb-13 10 % of 16-64 year olds who have no qualifications, ONS Annual Population Survey, Jan-12 to Dec-12 11 % of 16-64 year olds qualified to NVQ3 or above, ONS Annual Population Survey, Jan-12 to Dec-12 12 % pupils achieving 5+ GCSE's A*-C inc. English and Maths, Department For Education, 2011/12 13 Average house price based on Land Registry data, CLG housing - live tables (table 581), Q3 2012 (London boroughs removed as significantly higher than other authorities) 14 % unoccupied or substantially unfurnished for over 6 months (given as % of total households from 2011 Census), CLG housing - live tables (table 615), 2012 15 Ratio of median house price to median earnings, workplace based gross earnings of employees from ASHE and median house price based on Land Registry data, CLG housing - live tables (table 577), 2012 16 Response to the question 'Overall, how satisfied are you with your life nowadays?' Where 0 is 'not at all satisfied' and 10 is 'completely satisfied, ONS Annual Population Survey, Apr-11 to Mar-12 (only county and unitary authorities) 17 % children (under 16) in families receiving means-tested benefits & low income, 2010 18 Overall Deprivation Score, Index of Multiple Deprivation 2010 (the higher the score, the more deprived the area is) 19 Crimes per 1,000 population, ONS, 2011/12 (based on the Recorded crime CSEW comparator, which is a subset of recorded crimes. The following crimes are included in the recorded crime/CSEW comparator measure: Theft of a vehicle, theft from a vehicle, vehicle interference and tampering, domestic burglary, theft of a pedal cycle, theft from a person, criminal damage, common assault, wounding and robbery (of personal property not business property. This set of crimes covers about 60% of all recorded crimes) 20-21 Life expectancy at birth, Department of Health, 2008-10 22 % obese school children in Year 6 (age 10-11), 2010/11 23 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 24 All ages, Directly age standardised rate per 100,000 population, 2010/11 25 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 (All health indicators from DoH local authority health profiles and local alcohol profiles for England)

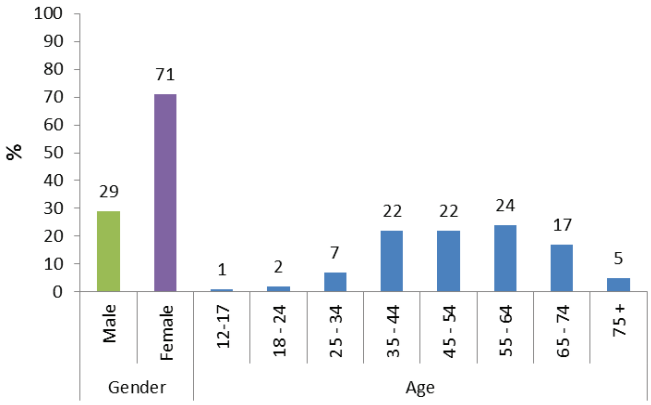
Online / Paper Questionnaire Summary Results

Who responded?

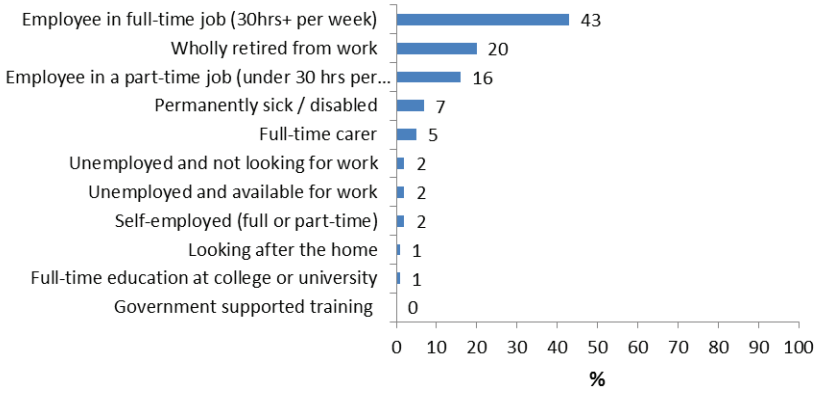
297 responses were received in total and the demographic of the respondent is illustrated below.

97% of respondents stated that they are White British. 35% stated that they have parenting responsibilities. 30% stated that they regularly provide unpaid support to care for somebody. 45 respondents stated that they class themselves as having a disability. The two most frequent type of disability selected were mobility (26) and physical (21).

Gender and Age



Employee Status

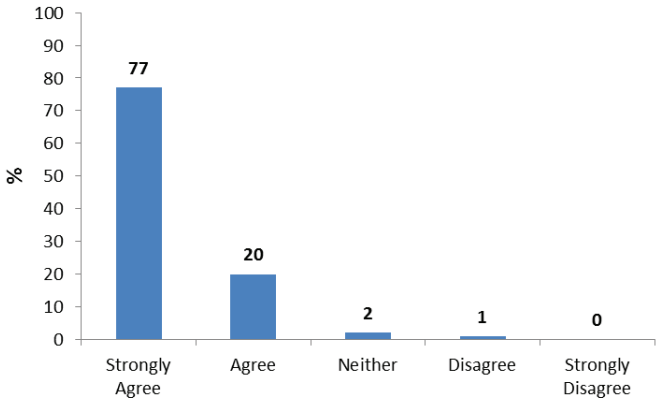


What did they tell us?

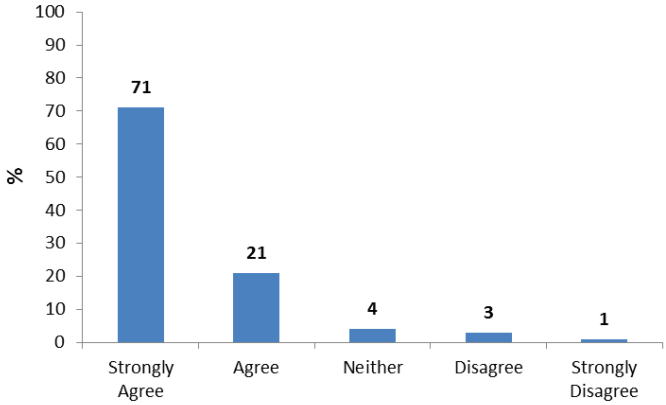
The online / paper questionnaire not only provided an opportunity for respondents to tell us if they agree or disagree with the proposals but also to give comments about the proposals.

An overwhelming majority of respondents, (94%) either 'Strongly agree' or 'Agree' to the proposals suggested.

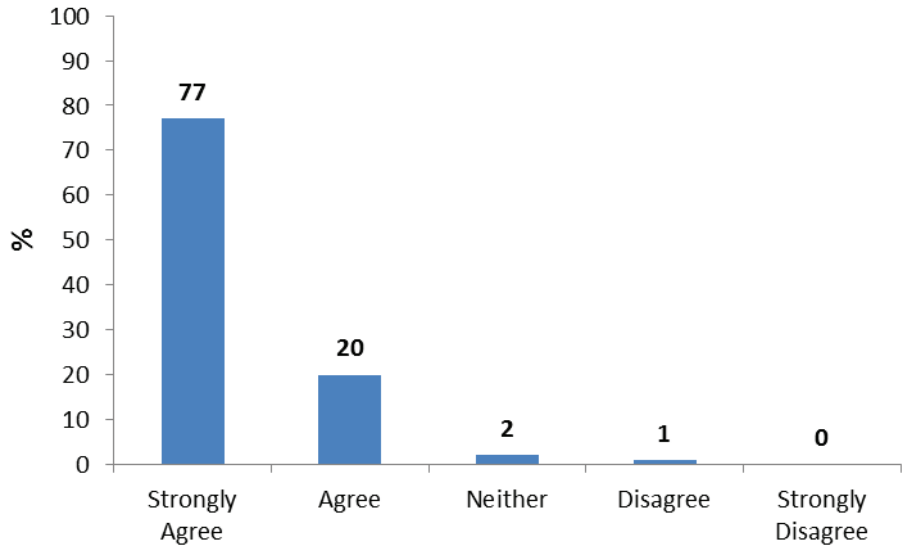
Walk in Centre



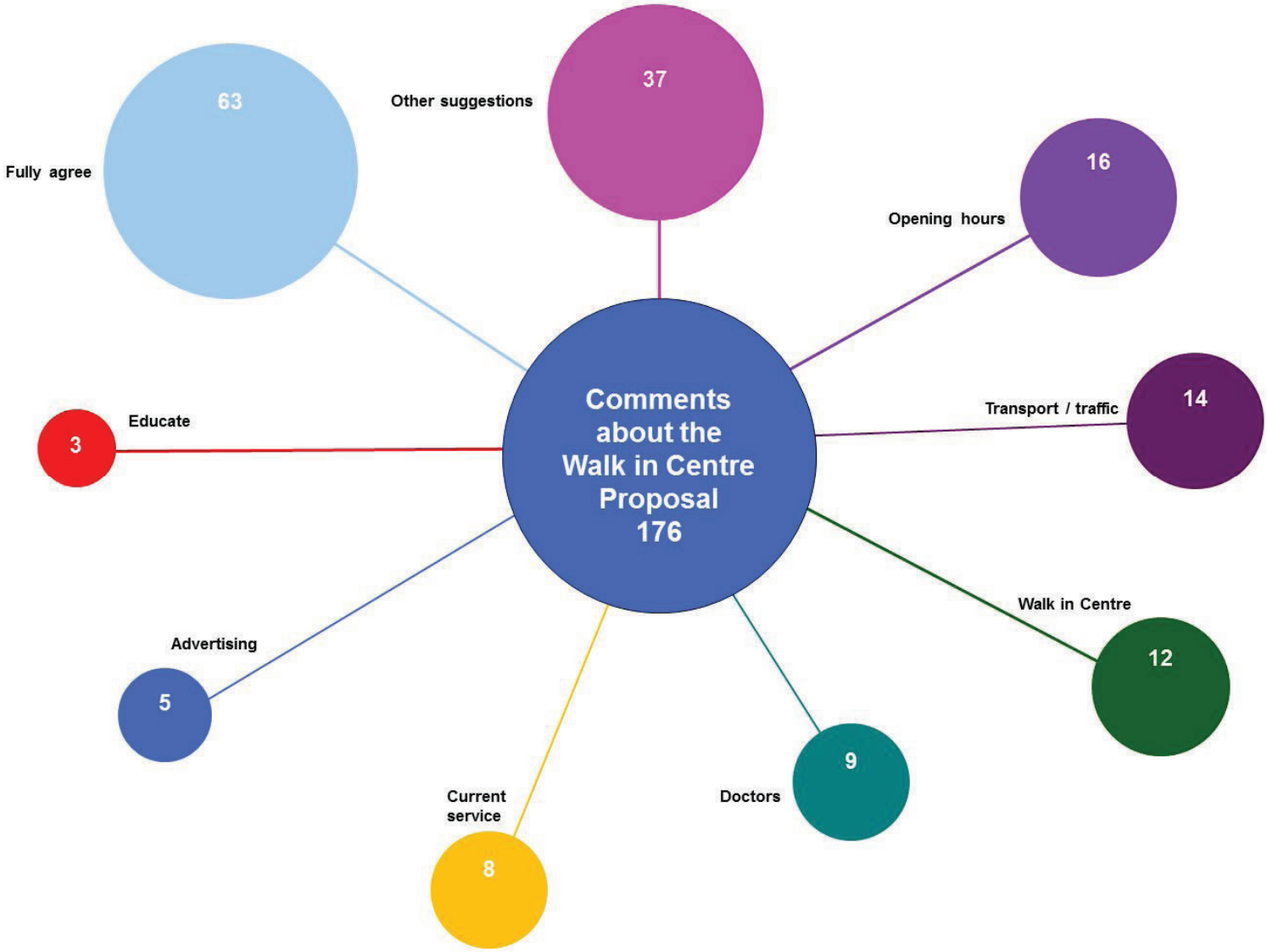
Clinical Decision Unit



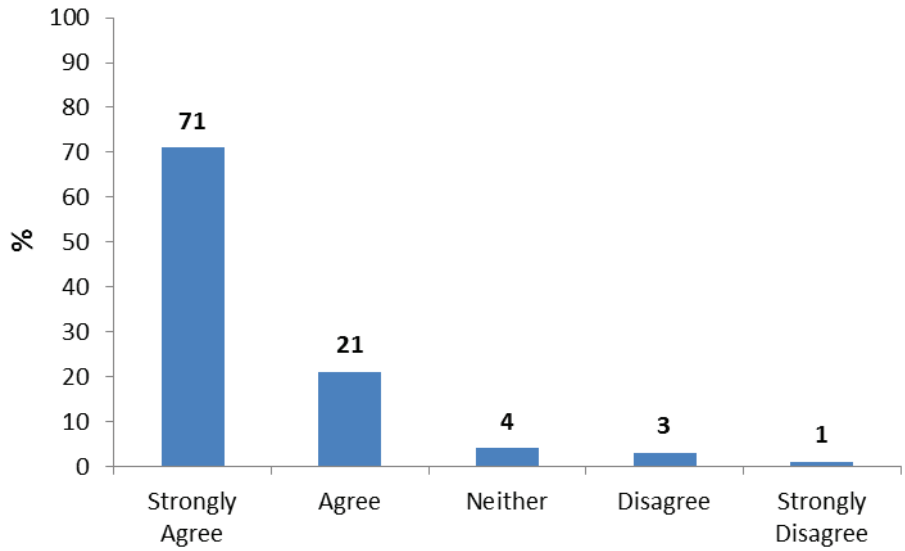
Walk-in Centre Proposal



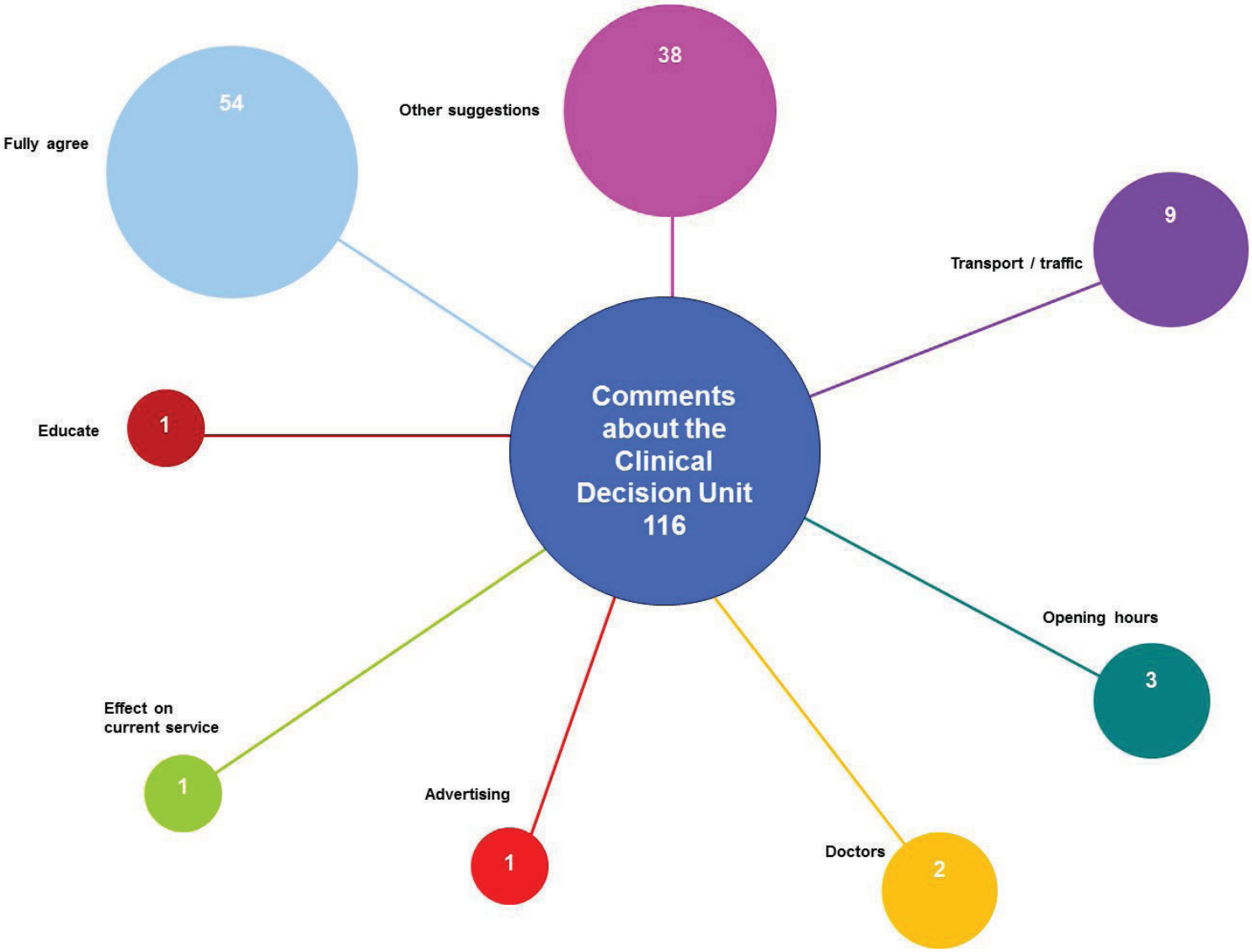
Walk-in Centre Proposal Grouped Comments



Clinical Decision Unit Proposal



Clinical Decision Unit Proposal Grouped Comments



Walk-in Centre Proposal *Summary of Grouped Comments
(*all comments will be considered on an individual basis)

Fully Agree: 63 Comments
The walk-in centre proposal is an excellent idea for the residents of Halton.

Other Suggestions / questions for service provision: 37 Comments
Where should people go if they have broken bones and also where should those with heart conditions or chest pains travel to? The x-ray department / ultrasound and CT Scanner should be in use at Halton Hospital. Halton Hospital should be a full working hospital.

Opening Hours: 16 Comments
Out of hours services should be available. Opening hours should be extended in Walk-in Centres. What will the opening hours be? Should be a seven day service.

Transport and Traffic: 14 Comments
Parking issues – not enough spaces. Charging for parking at Walk-in Centres is wrong as in an emergency you may not have any cash readily available. Good idea as it can be difficult for people to get to Whiston or Warrington if you don't have a car. Good for when we have to pay to cross the bridge.

Walk in Centre: 12 Comments
Halton Minor Injuries provides a better service than Widnes Walk-in Centre – would not want to see this service lost. Walk-in Centre service should guarantee highly qualified staff at all times, not just at certain times of the day and should be fully staffed. Service should be prompt. Walk-in Centre both sides of the river should be provided. More nurses should be able to prescribe at the Walk-in centres and should be staffed later. High pay of receptionists at weekend needs to be looked at. Walk-in Centre has lack of communication with the GP. Has been a lack of accurate diagnosis at the Walk-in Centre.

Doctors: 9 Comments
Being able to visit the Walk-in Centre when your GP is not available or you cannot get an appointment. The Walk-in Centre will take pressure off GP's. Any treatment given should be forwarded on to your usual GP. GP surgeries tell you to go to the Walk-in centre so the new service will become overstretched.

Effect on Current Service: 8 Comments
There are concerns that the qualities of the current service will be lost and that residents will use the facility as their first choice to see a see doctor rather than go to their GP. Nurse led facilities are highly efficient so why do we need a doctor at the Walk-in Centre? Also concerns that provision elsewhere e.g. A&E may be affected due to the running of the new service; sufficient staff numbers are required across all health provision.

Advertising: 5 Comments
Easy read leaflets, emphasis on a large publicity campaign.

Educate about New Services: 3 Comments
Both staff (community staff and staff in GP practices and other health professionals) and the public should be educated as to the new services and also as to what is currently available.

Clinical Decision Unit Proposal *Summary of Grouped Comments
(*all comments will be considered on an individual basis)

Fully Agree: 54 Comments
The Clinical Decision Unit proposal is an excellent idea for the residents of Halton.

Other Suggestions for service provision: 38 Comments
If people have chest pains where should they go? Minor injuries should stay as a full working department alongside a Walk-in Centre. The facilities should be a full triage unit. Halton Hospital should be a full working hospital.

Transport and Traffic: 9 Comments
Will cut down on travelling time e.g. to Warrington. Good for those who live outside of Halton e.g. Norley. Improve access for those who do not have transport. Will there be help for transport costs if you live in an area where there are no buses at certain times of the day?

Opening Hours: 3 Comments
24 hour opening should be available. Opening hours should be the same as the Walk-in Centres.

Doctors: 2 Comments
Will help with those who cannot get an appointment at their GP surgery.

Advertising: 1 Comment
Will need wide publicity and waiting times should be published.

Educate about New Services: 1 Comment
People need to know when it is appropriate to use a specific service.

Effect on Current Service: 1 Comment
Good idea, but there should be a direct service into hospital if required.

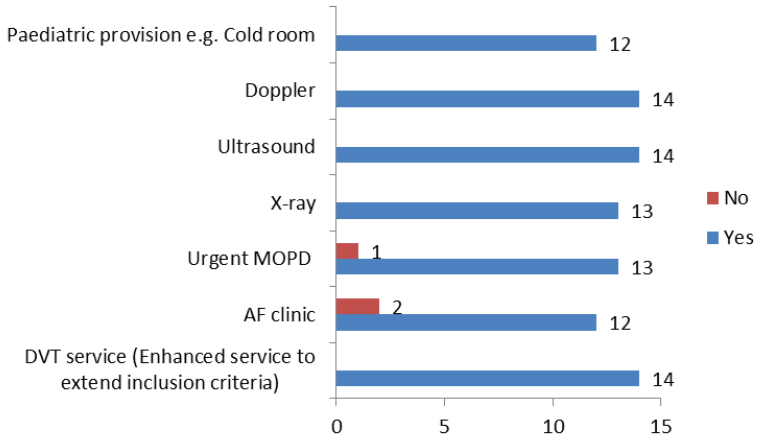
GP and Practice Feedback Questionnaire

Who responded?

An Urgent Care Services questionnaire was distributed at a Halton Members Event in June 2013 to collate views from General Practice on the Urgent Care proposals.14 responses were received.

What did they tell us?

Would you use the following services that could be offered within the CDU/ Walk-in centre?



Would you feel confident in using the CDU rather than GPAU (GP Assessment Unit)?

11 respondents stated that they would feel confident in using the CDU:

- Provided you can ensure the quality of care provision.
- Patients would welcome going to Runcorn as lots of patients currently going to Warrington.
- Yes – depending on staffing quality and experience. 'Register level' - would this mean staff grades unable to gain training posts in specialities?

Does the CDU being attached to the intermediate care ward make you feel more confident in referring sub-acutely ill patients into the intermediate care ward?

11 respondents stated that they would feel more confident in referring sub-acutely ill patients into the intermediate care ward.

- This is the most appropriate setting
- Could be
- Probably

If your acute visits were done for you, could your Practice provide a Walk-in clinic in return?

2 respondents stated Yes, 6 respondents stated No and 5 respondents stated that they were unsure

- Urgent care trialled in practice – demand high, 40 daily.

Would your practice be interested in supporting an NWAS (Northwest Ambulance Service) acute visiting scheme (post 999 call), where a patient needs to be seen and reviewed within 2 hours, by a GP?

5 respondents stated Yes 2 respondents stated No and 5 respondents stated that they were unsure

- Difficult to provide service

Have you any views on intermediate care developing into a step up-step down model?

- Makes sense in principle
- Good idea
- Best approach
- Need more experience of the model before comment – but can see how it would work well

How can you as a member practice support the CCG in engaging with your PPGs (Patient Participation Groups) in the Urgent Care Consultation?

- Develop existing structure rather than new systems.
- Practice still in the process of PPG.
- Making it a specific agenda for discussion – especially changes which affect Runcorn as patients seem to geographically isolate themselves off.
- Hold a meeting for Runcorn PPGs and Widnes PPGs, or email agenda items and key topics to be taken to PPGs
- More support for individual practices who wish to develop services in-house.

How can you as a member practice support the CCG in engaging with your Practice population in the Urgent Care Consultation?

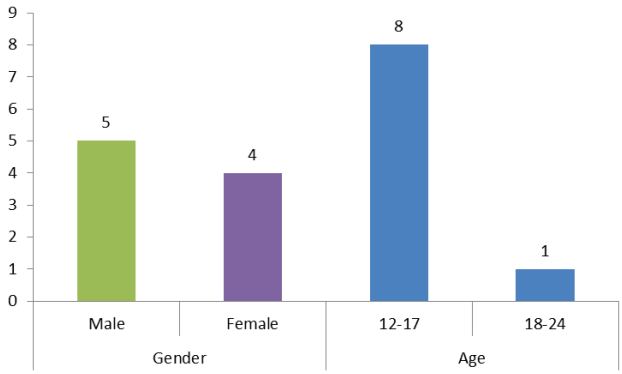
- Materials/ leaflets in waiting rooms (3)
- Go to practices and health centres with the questionnaire and talk to patients.
- Public meeting

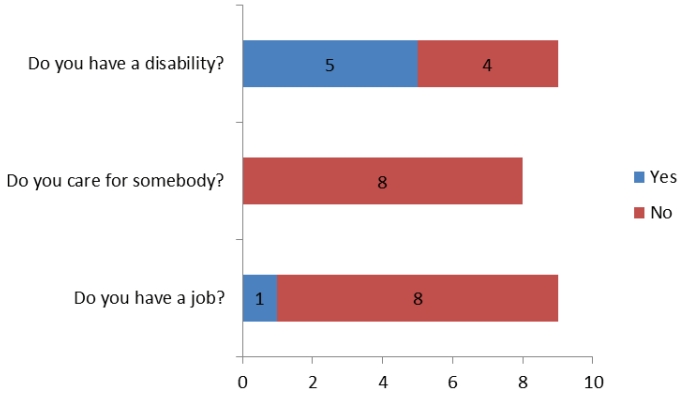
Do you think after reviewing the consultation plan that any opportunities for engaging have been missed?

- Educating the population – available services and how best to use
- Improve self-care and management by patient population to treat minor illnesses. Improve health education

Young Peoples Urgent Care Questionnaire

Who responded?





What did they tell us?

Do you think it would be good to have a Walk-in Centre in both Widnes and Runcorn?

All 9 respondents stated that it would be good to have a Walk-in Centre both in Widnes and Runcorn.

- If someone needed an x-ray but they didn't understand would there be someone there to help them? Or if they needed other treatment?
- Will this effect staff numbers in the area?
- Would both Walk-in centres have the same facilities?

Do you think it would be good to have a Clinical Decision Unit in Halton?

All 9 respondents stated that it would be good to have a Clinical Decision Unit in Halton.

- How will it be publicised?

Public Events Summary Results

Halton People's Health Forum Steering Group

The proposals were discussed and the following concerns / questions were raised

Big concerns with crossing the new toll bridge when Urgent Centres were in place. Suggestions made that could help to alleviate any problems were:

- Patients to be given pre-paid ticket
- Token
- Taxi contract
- Discounts for local residents and workers
- Free bus service/Bus passes
- Appointment to be made at an appropriate time to fit in with transport services

Other comments discussed were:

- Halton Hospital to advertise changes to appointments.
- CCG to include in the contract for WHHFT.
- Important for ambulance service to be involved.
- Signs for Urgent Care Centres to be made visible on roads.
- Speak to Commissioners about future problems with toll bridge.
- Question – will Halton fit plaster casts after an X-ray?
- Concerns with paying to park at Halton Hospital Halton - Disability badge holders do not have to pay.

Select Stadium and Runcorn Town Hall Public Event

Who responded?

Two events were held, one at Select Security Stadium and the second at Runcorn Town Hall. Members of the public were invited to attend the events to discuss the urgent care proposals. Attendees were split into groups to discuss the proposals and to raise any questions that they had about the proposals.

What did they tell us?

86 comments / opinions were recorded during the two events and can be split into three categories

- Education, Publicity and Training
- Day to Day running of the Service
- Structure and Service Delivery

Education Publicity and Training

31 comments were made and can be split into the following 3 groups

- Education / publicity for the public = 17
- Education / training for professional staff = 11
- Educate about costs = 3

The public should be able to easily understand the different service provision and when it is appropriate to use each type of provision. Promotion of the services should be borough wide. GP's and other GP staff should be educated / trained on appropriate referral. Should referral rules for A&E also change? The public and staff should be educated about the costs / 'frequent flyers' of A&E against the costs of the new service.

Day to Day Running of the Service

29 comments were made and can be split into the following 3 groups

- Customer care and quality = 13 comments
- Opening hours = 10 comments
- Transport = 6 comments

A quick and quality service is needed, and thought to be given to carers / families of patients in terms of waiting room and facilities available e.g. drinks, disabled access. Clear signage and information within the building should be provided, with knowledgeable staff to help. It should be a service that fits demand.

Structure and Service Delivery

26 comments were made and could be split into the following 4 groups

- Medical Staff and Structure = 13 comments
- Service Delivery = 5 comments
- Other services and Facilities = 6 comments
- IT Systems = 2 comments

Discussion of GP and Nurse grade in the Walk-in Centre, responsibility for intermediate care or should a sub-acute unit be considered instead? Sharing of capacity for extending the services and to cope with demand. Are the proposals duplicating GP services? Do we have a model of best practice for Walk-in Centres? Walk-in Centre should have x-ray services and is there capacity to have other services in the building as well?; For example mental health and social care services Will IT systems be compatible so that patient records can be transferred?

Healthwatch Halton workshop with adults with a learning disability

Who responded?

Healthwatch Halton, through their experience of facilitating consultations and engagement opportunities, recognised the difficulties that some vulnerable adults (including adults diagnosed with learning disabilities), experience in these processes. Because of this, a workshop was arranged with a voluntary sector organisation that supports adults with a learning disability to look at the proposed changes to urgent care service delivery. This was held on Friday 26th July 2013, with 31 attendees. Additional views from 13 individuals unable to attend the workshop have been taken into account in this response.

What did they tell us?

Participants welcomed the opportunity to have their say and believed that Halton CCG appears to be committed to achieving better services for local people.

During the workshop, participants used the Halton CCG easy read consultation document, which led to discussions and debate. The proposed changes were welcomed, especially the additional Walk-in Centre based at the Halton Hospital site in Runcorn. This was clearly reflected in the responses, as everyone agreed with the newly proposed facility and the proposed Clinical Decision Unit was also unanimously approved. Whilst the overall consensus of the respondents was in agreement with the proposed changes as a way of streamlining services by agencies, people hoped that the services would be delivered in a way that reflected the needs of users, including individuals diagnosed with a Learning Disability.

The workshop promoted a very open and productive discussion and comments were collated using the themed summary of the responses listed below.

Communication and Information

During the workshop there was a discussion around communication and information which highlighted some of the difficulties that respondents had with both written and verbal communication. This led to participants saying that they often became upset and struggled to understand a health professional's explanations of their diagnosis, treatment and procedures.

One participant highlighted their own personal anxiety and confusion experienced when they needed urgent medical treatment. They suggested the need for more easy read documents to lessen their distress. Comments included "*I would like easy read documents to explain what treatment I am having. This is important to me and to my friends who also have a learning disability as I sometimes get very upset when I have to go to the doctors or hospital."* This viewpoint was re-enforced by another participant who disclosed "*I sometimes do not understand everything the doctors and nurses tell me and I get upset."*

One participant put forward a suggestion for *"easy to read leaflets with pictures to explain the different treatments and illnesses"* Discussions also highlighted difficulties with signage at both the Walk-in centre and hospital with one participant who said "*I would like signs in the Walk-in centre and hospital to be easy read also, because sometimes signs confuse me and I don't know where to go."*

Transport

Although the general consensus that the proposal for an additional Walk-in centre to be located in Runcorn was welcomed, discussions highlighted the difficulties that some residents experience with the current transport system in Halton, which they suggested are often exacerbated at weekends.

This was especially significant for participants living in Runcorn as underlined by one participant who commented "*I think it is essential to have a Walk-in centre in Runcorn. It is not easy to get to Widnes due to lack of transport at weekends etc.* and *not having to go over the bridge to get to the Walk-in centre will be good for people in Runcorn."*

During this discussion one participant was keen to point out that transport at a weekend was especially difficult saying "*The bus service from Runcorn to Widnes is not good from some areas and is worse on a Sunday."* The benefit of having a Walk-in centre in the area where participants lived was highlighted by the comment *'I would be lost without Widnes Drop-in Centre. I live in Widnes; it is a very useful service, but the distance to travel maybe prohibitive to those living in Runcorn."*

Walk-in Centre / Clinical Decision Unit

During the discussions, participants highlighted the positive impact that the proposals would have on the demand for accident and emergency services. A comment "*The proposals for increase in services would be really useful and save unnecessary trips to A&E"* summarised this viewpoint.

Participants regarded the additional services, treatment and equipment as a helpful way of reducing the anxiety experienced by some people attending hospital and using accident and emergency services.

This was reflected in the following comments: "The *new things at each Walk-in centre will be good and the Clinical Decision Unit will be good, as you might not have to go all the way to Warrington only if it is an emergency"* and "*It is good that they will have more things at the Walk-in centre as it will save you going to hospital. I get scared if I have to go to hospital."*

At the workshop we took note of the current publicity campaign and media coverage both locally and nationally and one participant commented, "'*Accident and Emergency has been in the news as some people are going there with small things wrong with them, they shouldn't go."*

However during discussions a concern was raised that the proposed Walk-in centre and Clinical Decision Unit may be used as an alternative by medical professionals to avoid sending patients to Accident and Emergency when that is what the person really needs. This was reflected in a *comment, "I believe there should be a Walk-in centre in Runcorn, but if it is a real emergency and it is life threatening they should go to A & E."*

Employment

One participant regarded the proposals for urgent care as a useful way to increase employment in Runcorn maintaining that the proposed changes to urgent care service delivery could "*Create jobs in Runcorn."*

Additional Services / Suggestions

During discussions suggestions were put forward for additional preventative services in the Walk-in Centres, including a drop-in smoking cessation clinic; weight loss clinic or support group to reduce obesity and give the opportunity to promote healthy diets, through healthy food recipes and a service for individuals experiencing mental health issues and learning difficulties.

GP Appointments

A number of participants mentioned the difficulty in accessing their GP which they said could inadvertently impact on the demand for urgent care services. Comments included "*Getting a GP appointment is hard sometimes" and "I cannot get an appointment with my GP they always say they have not got any."*

Staff Attitude

The attitude of staff towards individuals with Learning Disabilities when accessing GP services was also highlighted by some participants. Comments included, "*The receptionist at the doctors asks 'what is wrong with you?... they should not know what is wrong with you"; "Some receptionists are not very nice" and "My friend goes to the walk in centre for dressings and he told me one nurse is very nice and the other one is horrible to him."*

Conclusion

The people attending the workshop welcomed the chance to 'have their say' on these proposals and they hope that the services will be delivered in a timely, equitable and accessible way to all residents in Halton.

As the Wanless Report points out it is the wider determinants of health that impact on people's lives and empowering the individual to have more control of his/her own service needs will ultimately be both cost effective and life enhancing and will help to reduce health inequalities.

Halton Clinical Commissioning Group

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22nd November 2013

Final Version

Briefing – Urgent Care Redesign

Part of NHS Halton Clinical Commissioning Group's commissioning intentions 13/14 included a review of the current urgent care facilities across the borough, development of a preferred model of care and completion of a formal three month public consultation. The new model of care has been designed to reduce pressures on capacity with Accident and Emergency departments and also provide innovate ways of working with partner organisations such as North West Ambulance Service, Acute Hospitals and community NHS trusts. Below is an outline of the proposed changes.

NHS Halton Clinical Commissioning Group completed the public consultation on 31st August 2013 and is in the process of developing the operational model in partnership with Warrington and Halton Hospital NHS Foundation Trust, ,Urgent Care-24 (GP Out Of Hours), NHS property services, St Helens and Knowsley Teaching Hospitals and Bridgewater Community NHS Trust this will include the development of a business case. The implementation phase is planned for completion in September 2014, taking into account any contingency plans that may need to be actioned.

Interim Winter Arrangements
In the Winter of 2013 NHS Halton Clinical Commissioning Group will work with partners to extend current provision to improve outcomes for Patients until the preferred model can be implemented during 2014 the interim arrangements will not affect the final model, the Winter arrangements will include redesigning the Widnes Walk In Centre building space to accommodate an x-ray, paediatric cold room and ultra sound facility. Access to CT, MRI, planned investigations and step up beds within Halton Hospital has also been extended, together with additional emergency access clinics staffed by AED senior clinicians and the development of an Acute Visiting Scheme supported by North West Ambulance Service and Urgent care 24 (GP-out of Hours provider)

Proposal Summary of Halton Urgent Care Centres

- Maintain the current Widnes Walk-in Centre and provide extra facilities

A nurse-led primary care facility that deals with illnesses and injuries - including infections and rashes, lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains - without the need to register or make an appointment. It is not designed for treating long-term conditions or life threatening conditions. Current opening times- 7am- 10pm Monday to Sunday

- Create a new Walk-in Centre in place of the Minor Injuries Unit at Halton Hospital, and provide extra facilities

Currently the service is open 9am to 10pm 7 days per week, the unit provides treatment for less severe injuries such as sprains, broken bones, cuts and grazes, infected wounds, eyes problems, emergency contraception and skin infections. As above the unit is not designed for treating long term conditions or life threatening conditions.

The extra facilities proposed for both Walk-in-centres are:

X-ray: which is a test that is often used to produce pictures of dense tissues inside the body such as bones

Ultrasound: which is a painless test that uses sound waves to create pictures of organs and structures within the body

Paediatric specialist nursing provision / Paediatric cold room

Proposal Summary of Clinical Decision Unit

Extend services at the Halton Hospital Runcorn Site to include a Clinical Decision Unit

A clinical decision unit is a unit designed to manage urgent medical problems that cannot be dealt with in the community by your own GP. The unit is headed by doctors, who have access to urgent blood tests, x-rays and other tests.

Once you have been assessed and a diagnosis made, you may be discharged with treatment and/or other support or referred onto a specialist doctor for more expert opinion or admitted into a hospital bed (depending on your condition).

Patients attending the clinical decisions unit would normally be referred by their own GP, the doctor at the Urgent Care Centre or by the Ambulance Service.

Types of conditions include:

Chest pains

Abdominal pain

Breathing difficulties

Dehydration

Fits (seizures)

Additionally a number of new outpatients clinics have started being provided out of Widnes Health Care Resource Centre which includes Vascular Services

For further inquiries or questions please do not hesitate to contact NHS Halton CCG.

With thanks and regards,

Signature

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e: simon.banks@haltonccg.nhs.uk

REPORT TO:	Health Policy & Performance Board
DATE:	7 January 2014
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Health Policy & Performance Board Priority Based Report : Quarter 2 2013/14
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to health in Quarter 2 of 2013-14. This includes a description of factors which are affecting the service.

2.0 **RECOMMENDATION: That the Policy and Performance Board:**

i) Receive the Quarter 2 Priority Based report

ii) Consider the progress and performance information and raise any questions or points for clarification

iii) Highlight any areas of interest or concern for reporting at future meetings of the Board

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. In line with the Council's performance framework, therefore, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 2 2013 – 14.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this Report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this Report.

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

6.1 **Children & Young People in Halton**

There are no implications for Children and Young People arising from this Report.

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

There are no implications for Employment, Learning and Skills arising from this Report.

6.3 **A Healthy Halton**

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.4 **A Safer Halton**

There are no implications for a Safer Halton arising from this Report.

6.5 **Halton's Urban Renewal**

There are no implications for Urban Renewal arising from this Report.

7.0 **RISK ANALYSIS**

7.1 Not applicable.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no Equality and Diversity issues relating to 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 & Performance Board Priority Based Report

Directorate: Communities Directorate

Reporting Period: Quarter 2: 1st July 2013 – 30th September 2013

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the second quarter of 2013/14; for service areas within the remit of the Health Policy and Performance Board.

2.0 Key Developments

There have been a number of developments within the second Quarter which include:-

COMMISSIONING AND COMPLEX CARE SERVICES

Housing
News was received late September of additional funding awarded by the Homes and Communities Agency to Halton Housing Trust for the development of 218 dwellings across 8 sites. This together with the recent success in securing the extra care housing scheme at Pingot means investment of around £30m for the borough.

Following the Government announcement in the June spending review of £3.3 billion for the next phase of the Affordable Homes Programme (2015/16 to 2017/18), the Homes and Communities Agency has provided details of the bidding timetable. Guidance is to be released in December 2013 with bidding deadline of the end of March 2014. Funding decisions will be announced in June 2014.

The Council will liaise with and support Housing Associations in developing proposals in order to maximise investment in Halton and meet the needs identified in the Housing Strategy.

Domiciliary Care Tender
A new service specification has been developed to deliver the provision of domiciliary and personal care services in Halton. The Tender will be three years initially with an option to extend for an additional year on top. The Council intend that the new contracts will be flexible enough to cater for innovation and the wish of the authority to move towards a model of provision that demonstrably delivers positive outcomes for its citizens. They will be accompanied by a quality monitoring framework that acknowledges the importance of the workforce capacity and capability as well as the systems and processes that go together to ensure that people get what they need and when they need it.

Alcohol
Night Time Economy Scrutiny Topic Group
The scrutiny review concluded in July. The review has provided an opportunity to review our local night time economy and identify what works well and what could be improved to provide a safe, accessible, well managed night time economy that meets the needs of residents and businesses and attracts visitors to the borough.

As a result of the review it has been recognised that there is much good practice happening in Halton and our town centres are well managed through the excellent working relationships between the council and our partners, businesses and the public. The review has identified a series of recommendations for further improvement which have been drawn into an action plan.

Mental Health Services
Section 136 Mental Health Act 1983: this is a legal provision which allows police officers to take to a place of safety any adult who they believe to be mentally disordered and who may pose a risk to themselves or other people. This requires close co-operation between the police, social services and the health services. All areas are required to have an agreed multi-agency policy and procedure which clearly identifies roles and responsibilities of each agency, and also clearly identifies the designated places of safety. A draft policy has been developed, which can be agreed by both the police and the Borough Council, and work is taking place with colleagues in the 5Boroughs to finalise the policy.

At the last Quarterly Monitoring Report, it was reported that a Mental Health Strategy for Halton was to be presented to the Health Policy and Performance Board in September 2013. This has now been deferred to later in the year, to allow more time for consultation.

A pilot scheme has been developed by the Mental Health Outreach Team to provide support to people known only to primary care services. The intention of this is to offer structured support at an earlier stage in people's lives, to prevent them from deteriorating and needing greater levels of support. All GP surgeries were given information about the pilot and a number have expressed interest in this. This is being taken forward in this quarter.

PREVENTION AND ASSESSMENT SERVICES

Care Management and Assessment Services
The Care Management Teams are participating in the development of community Multi-Disciplinary Teams already consisting of social workers and occupational therapists, that will be locality based, and aligned to GP practices across Widnes and Runcorn. The teams are realigning their work to match against General Practices and staff have begun attending the surgeries in Widnes (as they do in Runcorn) to move the forward. There is on-going work with Halton Clinical Commissioning Group, General Practices, Bridgewater Community Healthcare Trust in developing an integrated approach to delivering care for people with high level needs based around their GP practice. We are currently moving forward on gaining some Clinical Facilitator time to support practices in implementing their models.

Care and Support for You Portal
There is on-going development of an online, "Care and Support for You" portal. This is a website where you can easily find lots of information about Adult Social Care Support and Services to help you get on with your life and keep your independence. 'Care and Support for You' delivers information and advice, signposting citizens to the relevant information, and towards enabling self-assessment and self-directed support. The portal has now gone LIVE with over 3,000 organisations now available in the public domain. 'Care and Support for You' is also being used by our care management teams to signpost citizens to the relevant information required. System Administration access has been given to a number of providers for them to amend and change information on their own service

page; this enables the information on the website to beup to date. http://halton.olminfoserve.co.uk/home/defaultalt2.aspx

Learning Disability Nurses
The team continue to work proactively with individuals, their family, carers and professionals such as GPs, allied Health professionals etc.

Progress:

- The women's health and relationships group has finished with an increase in understanding and knowledge
- The Friendships and Relationships training via the Learning Disability Training Alliance has been requested for another year due to the feedback being excellent
- The friendships and relationships walks in the park are continuing. The number has increased to 11 people in attendance regularly.
- Those individuals who have been admitted to inpatient services, have been monitored throughout their stay via face to face contact with the nursing team, and supported to be discharged with positive prevention plans to reduce the risk of further admissions.
- The team and the Health Improvement Team have collaborated to make the FreshStart programme (a healthy eating and exercise programme) accessible for people with a learning disability. The pilot was held in August and was a great success. The full 6 week course commences in Widnes an October. A Runcorn session will begin in the New Year.
- A team member attended a Saturday health check morning at Brookvale to support the surgery to carry out the annual health LD checks. 13 people attended.
- The team supported the successful Big Health Day for people with a learning disability. This enabled people with a learning disability to talk and think about health checks and supporting them to be empowered around their health needs.
- The links into the GP surgeries are being consolidated, with support from the CCG's clinical lead for Learning Disabilities. The surgeries are being encouraged to plan the completion of the health checks until the end of the financial year.
- The team were inspected by CQC and received an extremely positive inspection report.
- The next men's group will start on 11th October 2013.
- Peer development meetings have commenced to reflect on cases, research and articles

End of Life Care
Training was held for staff across care management and assessment services with the aim of increasing knowledge of end of life care issues. The two day course was run in conjunction with Halton Haven Hospice and Halton Borough Council Learning & Development Division, The learning outcome was to enable staff to identify and relate end of life care to client assessment. The course has started to equip staff with knowledge and confidence to use end of life care tools and advance care planning during assessment. We had a follow up event in June 2013 to develop fourteen staff as dedicated champions of end of life care.

These champions now attend a Multi-Agency End of Life Champions Forum. Work is underway to develop electronic systems in regard to service users preferred place of care, to ensure all agencies are aware and support this. Halton Haven have now recruited new staff and work will commence for the champions to spend dedicated time with staff at

Halton Haven who will operated a buddying approach for staff, with the opportunity to shadow more experienced staff to enhance staff confidence, learning and development.

PUBLIC HEALTH

Public health responsibility, under the Director of Public Health and their team became the responsibility of the Local Authority on 1st April following implementation of the Health and Social Care Act 2012. The Environmental Health and Public Protection team has now also become part of the Public Health team. The Public Health Team have led the development of a Joint Health & Wellbeing Strategy which has cancer, alcohol, falls, mental health and child development as key priorities. The implementation of Action Plans to address these priorities will impact positively on the milestones and performance indicators outlined. This is the first quarter monitoring report since the development of that strategy.

3.0 Emerging Issues

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

COMMISSIONING AND COMPLEX CARE SERVICES

Development of an Older People's Vision
Commissioning in partnership with the Clinical Commissioning Group and Older People have begun the process of developing an Older People's Vision for Halton. Titled "Halton – a good place to grow older in" it focuses on some of the softer outcomes that help people to enjoy a better quality of life and clearly compliments some of the disease specific work delivered in the Borough. It is anticipated that the draft will be completed in Quarter 3 and the vision signed off in Quarter 4.

Mental Health Services
Inspection of 5Boroughs Partnership: it has been announced that the Care Quality Commission will be carrying out an inspection of the mental health services provided by the 5BoroughsPartnership in November 2013. The main focus of the inspection will be on the assessment and management of compulsory admissions to hospital under the 1983 Mental Health Act, which is a process which centrally involves the Council's Approved Mental Health Professionals. The Council is working closely with the 5Boroughs to deliver a positive outcome for this inspection

PREVENTION AND ASSESSMENT SERVICES

Mobile Working
In care management we are developing mobile working solutions for staff. With the introduction of electronic assessment forms in CareFirst 6, Social Care Practitioners could potentially use a range of devises, i.e. I pads or laptops, whilst visiting people in their own homes. A pilot will be implemented to test some of these systems, an evaluation and recommendations will be developed.

Making Safeguarding Personal
"Making Safeguarding Personal 2013-14" is a sector-led improvement project supported by funding from the Association of Directors of Social Services (ADASS) and the Local Government Association (LGA) Safeguarding Adults Programme.

Halton have been invited to participate in this improvement project. This work aims to facilitate a shift in emphasis from processes to a commitment to improve outcomes for people at risk of harm. The purpose of this work is to enable staff to use their skills, knowledge and judgement to work with people to *Make Safeguarding Personal* and to improve and capture outcomes with them, rather than to feel they are only there to follow a process.

PUBLIC HEALTH

Transfer and access to some required data sets, particularly relating to NHS data for which Public Health, now within the Local Authority, have accountability for reporting is problematic. This is a national issue and solutions are being sought both locally and nationally. Some data sets may not therefore be as current as possible and provision data may not yet be verified as a result of this situation.

The Trading Standard Contract with Warrington comes to an end in November 2013. We are currently identifying options to retender service, which may include returning the service to within the Environmental and Public Health team.

Currently options are being identified to retender for the stray dog kennelling contract in cooperation with other Merseyside Authorities including Liverpool, Knowsley and Sefton.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. During the development of the 2013/14 Business Plan , the service was required to undertake a risk assessment of all key service objectives with high risks included in the Directorate Risk Register.

As a result, monitoring of all relevant 'high' risks is undertaken during Quarter 2 and Quarter 4.

Progress on the Risk Control Measures for the second quarter for Commissioning and Complex Care is detailed below. No Risk Control Measures are identified for Prevention and Assessment.

COMMISSIONING AND COMPLEX CARE SERVICES

Ref	Risk Identified	Q2 Progress
CCC1 (1)	Not implementing the Local whole system Dementia Strategy	✓
CCC1 (2)	Failure to implement 5 Boroughs NHS Foundation Trust proposals to redesign pathways for people with acute Mental Health problems and services for Older People with Mental Health problems.	✓

SUPPORTING COMMENTARY

CCC1 (1)

The Dementia Strategy has recently been reviewed and updated. Further progress will be made during 2013/14.

CCC1 (2)

The changes within the 5Boroughs are monitored by the Mental Health Strategic Commissioning Board and CQC are conducting a brief inspection of Assessment and Admissions in November 2013. The outcome will be subsequently be reported

PUBLIC HEALTH

Ref	Risk Identified	Q2 Progress
PH LI 09 (SCS HH7	Mortality from all cancers at ages under 75 is not decreasing at a fast enough rate.	✓
PH LI 10 (SCS HH8)	16+ current smoking rate prevalence – rate of quitters per 100,000 population Not increasing enough to meet the target.	✓

SUPPORTING COMMENTARY

PH LI09

To ensure progress in this area the new Cancer Action Plan focusses on early identification of cancers by the public and GPs. An integrated Council/CCG Cancer strategy is being launched. An audit of GP Practice progress with cancer is included.

PH LI 10

Stop smoking rates across England have been impacted upon by the advent of e-cigarettes. NICE has recently advocated that these cigarettes should be licensed as medicines, this will mean they can only be sold in chemists. This should reduce the number of people smoking them instead of quitting, although this is not likely to be imminent.

5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

6.0 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.

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q2 Progress
CCC1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2014.** (AOF 4) **KEY**	✓
CCC1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2014.** (AOF 4) **KEY**	✓
CCC1	Continue to implement 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2014** (AOF 4) **KEY**	✓
CCC1	Develop a Homelessness strategy for 3-year period 2013-2016 in line with Homelessness Act 2002. March 2014. (AOF 4, AOF 18) **KEY (NEW)**	✓
CCC2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2014** (AOF 21) **KEY**	✓

SUPPORTING COMMENTARY

Services for children and adults with Autistic Spectrum Disorder
The Autistic Spectrum Conditions Strategic Group continues to monitor progress and the recently submitted Autism Self-Assessment showed good progress across a wide range of activity.

Implementation of Dementia Strategy
Services linked to the clinical pathway are now in place and are being evaluated during November. Low-level services including Dementia Care Advisors and Dementia Café's are being reviewed in line with the requirements of the Dementia Strategy

Implementation of service redesign within 5Boroughs Partnership
The Acute Care Pathway for adults (18-64) with complex mental health problems has now been fully developed and is in place. There is a new assessment team, based in Warrington but covering both Halton and Warrington, a Home Treatment team to support people in crisis in their own homes, and a Recovery Team (which has full social services input) to support people on a longer term basis. The Later Life and Memory Service is also now largely in place and is delivering the requirements of the local dementia strategy; this again has social work input to the people with the most complex needs.

Development of Homelessness Strategy
Extensive consultation with local people, key stakeholders and elected members on the cause and effect of homelessness in Halton has been collated to inform the development of a strategy. The draft strategy will be completed by December 2013.

Ensure Healthwatch is established and consider working in partnership with other Councils to deliver
Halton Healthwatch established with all Executive Board posts filled and operational. The service is now working on a range of consultations to deliver against agreed targets and outcomes. In relation to the Independent Complaints Advocacy Service (ICAS) this service is delivered in partnership with eight other authorities and provides quarterly data on the number of people from Halton who access the service.

Key Performance Indicators

Ref	Measure	12/13 Actual	13/14 Target	Q2	Current Progress	Direction of travel
CCC 4	Adults with mental health problems helped to live at home per 1,000 population	3.23	3.97	2.88	✓	↓
CCC 5	Total number of clients with dementia receiving services during the year provided or commissioned by the Council as a percentage of the total number of clients receiving services during the year, by age group. (Previously CCC 8)	4.0%	5%	3.9%	✓	↓
CCC 6	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 8).	0	[1.2]	0	✓	↑
CCC 7	Number of households living in Temporary Accommodation (Previously NI 156, CCC 10).	6	[12]	4	✓	↑
CCC 8	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in	5.42	[4.4]	8.7	✓	↑

	the Borough) (Previously CCC 11).					
CCC 11	Carers receiving Assessment or Review and a specific Carer's Service, or advice and information (Previously NI 135, CCC 14).	18.87 %	25%	7.24 %		

SUPPORTING COMMENTARY

CCC4
There has been a reduction in the absolute numbers of people with mental health problems who receive services to help them to live independently, and when combined with an overall increase in the general population, this has reduced the overall proportion of people who are being helped. This is maybe due to the new acute pathway for severe mental illness, which means that services are being targeted more at people with the greatest need and risk. This means that new protocols are being addressed to manage people with less significant needs being managed through shared care. The redesign of the Outreach Service which will support these individuals is now agreed. A number of schemes to further increase awareness and self-management have been put into place.

CCC5
There has been an increase in the number of people supported by the 5 Boroughs Partnership and Alzheimer's Society. This is alongside a significant increase in Primary Care dementia diagnosis. This rise will meet our end of year target of 62%, which also puts Halton high in the North West rankings. However, this increase is not reflected in this indicator as it only reports on clients recorded on Carefirst, with a primary need of dementia. Work is underway to more accurately report all clients in receipt of a service.

CCC6
The Authority forms part of the Merseyside Sub Regional, No Second Night Out scheme which is proven to be a successful resource and fully utilised across the Merseyside Authorities. . The service provides an outreach service for rough sleepers and has a close working partnership with Halton to identify and assist this vulnerable client group. The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district.

CCC7
Established prevention measures are in place and the Housing Solutions team continue to promote the services and options available to clients. There has also been a change in the Temporary Accommodation process and amended accommodation provider contracts. The emphasis is focused on early intervention and further promotes independent living. The improved process has developed stronger partnership working and contributed towards an effective move on process for clients. The Authority will strive to sustain the reduced Temporary Accommodation provision.

CCC8
The Housing Solutions Team promotes a community focused service. During the last 2 years there has been an increase in prevention activity, as officers now have a

range of resources and options to offer clients threatened with homelessness. Due to the proactive approach, the officers have continued to successfully reduce homelessness within the district

CCC11
Good progress is being made on carers assessments but will need to be kept constantly under review in light of increased demand.

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q 2 Progress
PA1	Implement and monitor the pooled budget with NHS partners for complex care services for adults (community care, continuing health care, mental health services, intermediate care and joint equipment services). **Apr 2014.** (**AOF 21 & 25**) **KEY (NEW)**	✓
PA1	Engage with new partners e.g. CCG, Health LINks, through the Health and Wellbeing Partnership to ensure key priorities, objectives and targets are shared, implementing early intervention and prevention services. **Mar 2014.** (*AOF1, 3 & 21*) **KEY (*NEW*)**	✓
PA1	Review the integration and operation of Community Multidisciplinary Teams. **Mar 2014.** (*AOF 2, 4, & 21*). **(*NEW*) KEY**	✓
PA1	Develop working practice in Care Management teams as advised by the Integrated Safeguarding Unit. **Mar 2014** (AOF 10) **(*NEW*) KEY**	✓
PA1	Embed and review practice in care management teams following the reconfiguration of services in 2012/13 to ensure the objectives of the review have been achieved. **Mar 2014** (AOF 2, 4). ***(NEW)*** **KEY**	✓
PA1	Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets. **Mar 2014** (AOF 2, AOF 3 & AOF 4) **KEY**	✓

SUPPORTING COMMENTARY

Implementation of pooled budget
Pooled budget fully implemented. Executive Commissioning Board and Partnership Board in place to monitor impact, performance and spend.

Engagement with partners to ensure delivery of early intervention and prevention services

Health and well-being partnership group in pace, to lead on the future development and monitor performance against key priorities. Update report to Health and Well-Being Board by January 2014.

Community Multidisciplinary Teams
We are currently moving forward on gaining some Clinical Facilitator time to support practices in implementing their models using risk stratification. Social care teams are realigning their work to match against General Practices and staff have begun attending the surgeries in Widnes (as they do in Runcorn) to take this work forward.

Develop working practice within care management teams which is advised by the Integrated Safeguarding Unit
Working practices are continuing to be progressed within the new structure including a focus on prevention and quality.

Continue to embed and review practice within care management teams
Work is progressing well, with the recent establishment of a practitioner groups to ensure ownership of the recent changes.

Continue to ensure the delivery of personalised quality services through self-directed support and personal budgets
A review of systems to ensure effectiveness has taken place. A new range of streamlined self- directed support documents and processes have been developed. A pilot is underway to look at safeguarding and personalisation.

Key Performance Indicators

Ref	Measure	12/13 Actual	13/14 Target	Q2	Current Progress	Direction of travel
PA 2	Numbers of people receiving Intermediate Care per 1,000 population (65+) (Previously EN 1)	84.35	99	38.16	?	
PA 3	Percentage of VAA Assessments completed within 28 days (Previously PCS15) (Previously PA5 [12/13], PA8 [11/12])	86.73%	82%	89.8%	✓	
PA 7	Percentage of items of equipment and adaptations delivered within 7 working days (Previously PA11 [12/13], PA14 [11/12], CCS 5)	94%	97%	90.3%	✓	

SUPPORTING COMMENTARY

PA2
Figures are cumulative and are generally higher in Q3 and Q4.

PA3
We have exceeded the target to date.

PA7
On-going Issues with Helena contract- this will be addressed through regular performance meetings

APPENDIX 1 – Financial Statements

COMMISSIONING & COMPLEX CARE DEPARTMENT

Revenue Budget as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,081	3,260	3,240	20
Premises	223	118	114	4
Supplies & Services	1,996	1,158	1,167	(9)
Emergency Duty Team	103	26	24	2
Carers Breaks	471	57	54	3
Transport	170	85	85	0
Contracts & SLAs	199	88	46	42
Payments To Providers	3,839	1,620	1,617	3
Other Agency Costs	734	376	387	(11)
Total Expenditure	**14,816**	**6,788**	**6,734**	**54**
Income				
Sales & Rents Income	-162	-110	-109	(1)
Fees & Charges	-169	-40	-30	(10)
CCG Contribution To Service	-846	-378	-374	(4)
Reimbursements & Grant Income	-870	-304	-315	11
Transfer From Reserves	-245	0	0	0
Total Income	**-2,292**	**-832**	**-828**	**(4)**
Net Operational Expenditure	**12,524**	**5,956**	**5,906**	**50**
Recharges				
Premises Support	304	152	152	0
Central Support Services	1,958	887	887	0
Transport Services	440	218	218	0
Asset Charges	82	3	3	0
Internal Recharge Income	-1,747	0	0	0
Net Total Recharges	**1,037**	**1,260**	**1,260**	**0**
Net Departmental Total	**13,561**	**7,216**	**7,166**	**50**

Comments on the above figures:

Net operational expenditure is £50,000 below budget profile at the end of the second quarter of the financial year.

Employee costs are currently £20,000 below budget profile. This results from savings made on vacant posts, specifically in relation to Day Services and the Supported Housing Network. The majority of these posts were appointed to in September, and it is not anticipated that the current level of underspend will increase.

Expenditure on Contracts and Service Level Agreements is projected to be £75,000 below budget at the year-end. This relates to savings in respect of payments to bed & breakfast providers for homelessness support, and savings made on the Bredon Respite Care contract. There has historically been significant variations in demand for the bed and breakfast service, although current expenditure patterns are stable, and the projected underspend seems realistic.

At this stage, it is anticipated that expenditure will balance to overall budget by the end of the financial year. Whilst expenditure is currently £50,000 below the budget profile,
It is anticipated that this trend will continue for the final two quarters of the year, and a balanced budget overall will be achieved.

Capital Projects as at 30th September 2013

	2012/13 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Disabled Facilities Grant	584	150	150	434
Stairlifts	250	125	112	138
Energy Promotion	6	0	0	6
RSL Adaptations	350	70	69	281
Choice Based Lettings	7	5	5	2
Bredon Respite Unit	13	13	13	0
Bungalows At Halton Lodge	400	0	0	400
Grangeway Court Refurbishment	347	0	0	347
Contingency	29	0	0	29
Total Spending	**1,986**	**363**	**349**	**1,637**

PREVENTION & ASSESSMENT DEPARTMENT

Revenue Budget as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (underspend) £'000
Expenditure				
Employees	6,921	3,199	3,136	63
Other Premises	68	22	19	3
Supplies & Services	472	247	244	3
Aids & Adaptations	113	20	20	0
Transport	5	3	3	0
Food Provision	18	9	13	(4)
Other Agency	68	24	25	(1)
	14	7	7	0
Capital Finance	18,164	5,923	5,892	31
Contribution to Complex Care Pool				
Total Expenditure	**25,843**	**9,454**	**9,359**	**95**
Income				
Other Fees & Charges	-222	-111	-116	5
Reimbursements & Grant Income	-662	-396	-397	1
Transfer from Reserves	-451	0	0	0
Capital Salaries	-84	0	0	0
Government Grant Income	-40	-13	-11	(2)
CCG Contribution to Service	-187	-314	-314	0
Total Income	**-1,646**	**-834**	**-838**	**4**
Net Operational Expenditure	**24,197**	**8,620**	**8,521**	**99**
Recharges				
Premises Support	373	195	195	0
Asset Charges	294	0	0	0
Central Support Services	2,447	1,175	1,176	(1)
Internal Recharge Income	-419	-204	-204	0
Transport Recharges	58	26	28	(2)
Net Total Recharges	**2,753**	**1,192**	**1,195**	**(3)**
Net Departmental Total	**26,950**	**9,812**	**9,716**	**96**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the second Quarter of the financial year is £65,000 under budget profile excluding the Complex Care Pool.

Employee costs are currently showing £63,000 under budget profile. This is due to savings being made on vacancies within the Department. Some of these vacancies are yet to be filled. The annual staff savings target for the Department (excluding the Complex Care Pool) is £227,000 and will be achieved by the end of the financial year.

Income has for the second quarter running marginally over achieved by £4,000 and income targets in the main are expected to be achieved in full this financial year.

The anticipated year end position for the Department is expected to be circa £130,000 under budget. However, this is based on current information and variations are very much dependant on other pressures within the Directorate.

A detailed analysis of the Complex Care Pool is shown below:

COMPLEX CARE POOL

Revenue Budget as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000
Expenditure				
Employees	3,276	1,070	1,056	14
Contracts& SLA's	1,846	905	892	13
Transport	5	3	1	2
Joint Equipment Store	518	0	0	0
Adult Care:				
Residential & Nursing Care	18,421	7,036	6,916	120
Domiciliary & Supported Living	10,389	4,312	4,326	(14)
Direct Payments	2,518	1,490	1,632	(142)
Block Contracts	181	0	0	0
Day Care	404	171	166	5
Total Expenditure	37,558	14,987	14,989	(2)
Income				
Residential & Nursing Income	-4,294	-2,078	-2,093	15
Community Care Income	-1,451	-583	-597	14
Direct Payments Income	-128	-84	-90	6
CCG Contribution to Pool	-12,877	-6,306	-6,306	0
Reablement & Section 256 Grant	-1,273	-378	-378	0
Transfer from Reserves	-100	0	0	0
Other Contributions to Care	-114	-57	-57	0
Total Income	-20,237	-9,486	-9,521	35
Net Operational Expenditure	17,321	5,501	5,468	33
Recharges				
Central Support Services	313	156	156	0
Premises Support	115	58	58	0
Internal Recharge	409	205	205	0
Transport Support	6	3	5	(2)

Net Total Recharges	843	422	424	(2)
Net Departmental Total	18,164	5,923	5,892	31

Comments on the above figures:

From 1st April 2013 Halton Borough Council (HBC) and the Clinical Commissioning Group (CCG) have agreed to pool their resources due to the increasing challenges for the Health and Social Care economy in Halton. This will result in the alignment of systems, improve effective and efficient joint working, but more importantly improve the pathways, speed up discharge processes, transform patient/care satisfaction and set the scene for the future sustainability of meeting the current and future needs of people with complex needs.

The figures above include the income and expenditure relating to Adult Care for both Halton Borough Council and Halton Clinical Commissioning Group. Adult Care includes expenditure on clients with Learning Disabilities, Physical & Sensory Disabilities, Mental Health and Older People for services such as residential and nursing care, domiciliary and supported living, day care and direct payments.

In overall terms the Net Operational Expenditure for Quarter 2 is £31,000 under budget profile. Expenditure on employee costs is currently showing £14,000 under budget profile. This is due to savings being made on vacancies within the Department, which are yet to be filled. Contract's & SLA's spend is £13,000 under budget profile mainly due to a reduction in the contract price for the Sub Acute Unit.

The net expenditure for Adult Care for Quarter 2 is currently showing £31,000 over budget profile. Direct payments has noticeably increased in the first half of the year compared to this point last year and expenditure is £142,000 over budget profile at the mid-point of the year. A separate working group has been established to evaluate the additional expenditure across Adult Care, to date a third of the increase in direct payment expenditure is due to new clients to Halton and two thirds is due to increases in direct payments or a client moving from domiciliary care to direct payments.

Domiciliary & supported living are also showing an over budget profile of £14,000 at this point in the year. Residential & nursing care are showing an under budget profile of £120,000 however caution is being taken due to a 4.5% increase in the count of clients, from April to August, going into permanent care. All areas of Adult Care spend will be monitored closely during the next quarter and budgets will continue to be realigned to reflect the spending patterns of health and social care.

Due to expenditure by nature, being volatile and fluctuating throughout the year depending on the number and value of new packages being approved and existing packages ceasing. Trends of expenditure and income will be scrutinised in detail throughout the third quarter of the year to ensure a balanced budget is achieved at year-end and in order to identify pressures that may affect the budget in the medium term.

PUBLIC HEALTH DEPARTMENT

Revenue Budget as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (underspend) £'000
Expenditure				
Employees	1,433	663	653	10
Supplies & Services	48	17	15	2
Consumer Protection Contract	393	219	231	(12)
Other Agency	20	20	17	3
	5,971	2,371	2,347	24
Contracts & SLA's				
Transfer to Reserves	207	0	0	0
Total Expenditure	**8,072**	**3,290**	**3,263**	**27**
Income				
Other Fees & Charges	-68	-34	-21	(13)
Sales Income	-26	-26	-24	(2)
Reimbursements & Grant Income	-7	-7	0	(7)
Government Grant	-8,510	-2,127	-2,128	1
Total Income	**-8,611**	**-2,194**	**-2,173**	**(21)**
Net Operational Expenditure	**-539**	**1,096**	**1,090**	**6**
Recharges				
Premises Support	47	23	23	0
Central Support Services	2,014	145	145	0
Transport Recharges	27	10	10	0
Net Total Recharges	**2,088**	**178**	**178**	**0**
Net Departmental Total	**1,549**	**1,274**	**1,268**	**6**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the first two quarters of the financial year is £6,000 under budget profile.

Employee costs are currently showing £10,000 under budget profile. Of this, almost £8,000 relates to a reduction in hours from 37 to 29.6 for one employee in the Environmental Health Division.

The Consumer Protection Contract is currently £12,000 over budget profile. This is due to the increase in the Warrington Borough Council Trading Standards contract for the combined service they provide, which will be £23,000 over the budget profile by the end of the financial year.

Other fees and charges income is currently showing £13,000 below budget profile, this is due to domestic pest control fees income underachieving. The income target had previously been reduced due to a unachievable income target. This will be reviewed again during the budget setting process.

Reimbursements & Grant Income is currently showing £7,000 below budget profile, this is again due to pest control, with sewerage agency works income underachieving.

The Public Health Division came under the control of Halton Borough Council in April this year. Therefore, after two quarters, and with no historical information available, it is too early to comment further. However, the budget will be monitored and scrutinised closely as we move through the year.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

Green		*Indicates that* **performance is better** *as compared to the same period last year.*

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

REPORT TO: Health Policy & Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: A Mental Health and Wellbeing Commissioning Strategy for Halton

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present to Health Policy and Performance Board, Halton's draft integrated Mental Health and Wellbeing Commissioning Strategy 2013-2018 and supporting evidence paper.

2.0 **RECOMMENDATION: That:**

i) The Board note and comment on the content of the Halton Mental Health and Wellbeing Commissioning Strategy 2013-2018 and evidence paper.

3.0 **SUPPORTING INFORMATION**

3.1 National policy relating to mental health is set out in No Health without Mental Health – DH 2011 (NHWMH) which emphasise that mental health is everybody's business and sets 6 high level objectives with an emphasis on prevention and early intervention:

- more people will have good mental health
- more people with mental health problems will recover
- more people with mental health problems will have good physical health
- more people will have a positive experience of care and support
- fewer people will suffer avoidable harm
- fewer people will experience stigma and discrimination

3.2 Mental health problems are the single largest cause of ill health and disability in the Borough. Halton's Health and Wellbeing Board has recognised this by including "Prevention and early detection of mental health conditions" as one of its 5 priorities. The Boards Health and Wellbeing Strategy 2013-16 includes actions to begin addressing this.

3.3 The six objectives of NHWMH have been incorporated in the Mental Health and Wellbeing Commissioning Strategy as the framework to address the challenge of improving mental health and wellbeing in the Borough. The strategy adopts a life course approach which recognises that the foundations for lifelong wellbeing are already being laid down before birth, and that there is much that can be done to protect and promote wellbeing and resilience through early years, into adulthood and then on into a healthy old age. Only a sustained approach across the lifecourse will equip Halton to meet the social economic and environmental challenges it faces and deliver the short and long term benefits needed.

3.4 This is Halton's first integrated strategy for Mental Health and Wellbeing in the Borough bringing together commissioning intentions of Public Health, the Clinical Commissioning Group, Children's Services and Adult Social Care. It is complementary to the Health and Wellbeing Strategy and has been informed by feedback at public engagement events hosted by the CCG and open consultation with the public and key stakeholders through a recent survey.

3.5 The overarching aims of the strategy are to:

- Improve the mental health and wellbeing of Halton people through prevention and early intervention.
- Increase the early detection of mental health problems leading to improved mental wellbeing for people with mental health problems and their families.
- Improve the outcomes for people with mental health problems through high quality accessible services.
- Optimise value for money by developing quality services which achieve positive outcomes for people within existing resources
- Broaden the approach taken to tackle the wider social determinants and consequences of mental health problems.

3.6 In Halton, Commissioners have adopted a stepped care service model which promotes recovery. In this model the recommended treatment/intervention is the least restrictive of those available but still likely to provide significant health gain. This approach encourages individuals to take responsibility for regaining their own wellbeing and ensures effective use of scarce resources with the ultimate aim of improving the quality of life for individual residents and strengthening communities in Halton.

3.7 The overview of progress in implementing the strategy action plan will be through the Mental Health Strategic Commissioning Board which reports to the Health and Wellbeing Board.

4.0 POLICY IMPLICATIONS

4.1 This strategy will support progress in local delivery of the three national outcomes frameworks for the NHS, Adult Social Care and Public Health.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The action plan within the strategy contains a summary of resources required. These are primarily investment of staff time to effect the change or redirection of current investment to achieve service redesign. This is deliverable within existing staffing structures and funding levels; however the need to make efficiency savings across the system may impact on successful delivery of the strategy.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The strategy takes a whole life course approach and thus promotes the health and wellbeing of children and young people from birth.

6.2 **Employment, Learning & Skills in Halton**
Employment is a key determinant of health and wellbeing. The recovery model referred to above encourages individuals to think about work and if appropriate set this as a goal to work towards.

Work may be needed with Local employers to breakdown preconceptions of the ability of those with mental health problems to retain employment.

6.3 **A Healthy Halton**

Delivery of the Mental Health and Wellbeing Strategy will have a positive impact on the health of Halton citizens.

6.4 **A Safer Halton**

A number of priorities in the strategy promote safety of individuals and address stigma associated with mental ill health which will contribute to building stronger communities.

6.5 **Halton's Urban Renewal**

None identified

7.0 RISK ANALYSIS

7.1 The Mental Health and Wellbeing Commissioning Strategy supports progress in delivering the strategic priorities of the Council for a Healthy Halton and the Health and Wellbeing Board "Prevention and early detection of mental health conditions"

As described in 5.1 the Strategy is capable of delivering within

existing resources, however a reduction in budget or staffing levels will impact on service delivery.

Any reductions in mental health funding allocations in the financial years that the Strategy covers could have an impact in delivering on key aims

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The strategy specifically aims to meet the needs of vulnerable people experiencing mental health problems irrespective of their protected group and will therefore have positive impacts for all groups.

An equality impact assessment (EIA) has been completed.

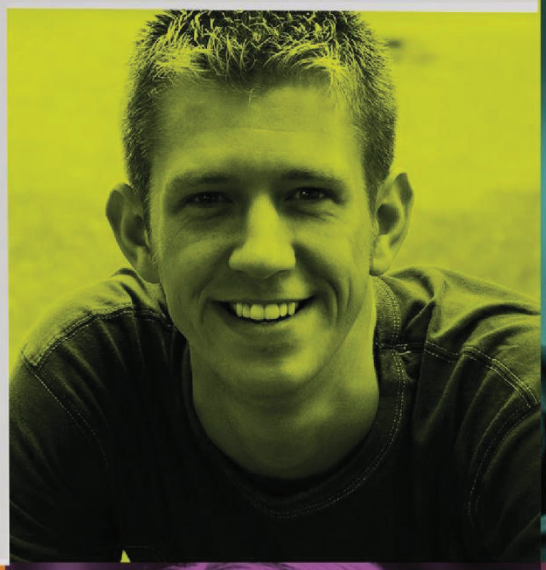
9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
No Health without Mental Health	Runcorn Town Hall (Second Floor)	Liz Gladwyn
NHS Mandate	Runcorn Town Hall (First Floor)	Dave Sweeney

A Mental Health and Wellbeing Commissioning Strategy for Halton

2013 to 2018

myhalton
living life well



NHS
Halton Clinical Commissioning Group

HALTON
BOROUGH COUNCIL

Contents

Foreword

Poor mental health is one of the biggest social issues in the UK today representing up to 23% of the total burden of ill health and is the largest single cause of disability. The North West has a higher prevalence of mental illness, dementia and depression than the national average, with Halton recording the highest rate of depression in the North West. Mental health problems are the single largest cause of ill health and disability in the Borough.

At least one in four people will experience a mental health problem at some point in their life, and around half of people with lifetime mental health problems experience their first symptoms by the age of 14. By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does.

Deprivation is linked to poor mental health and 26% of Halton’s population reside within the top 10% most deprived Super Output Areas. Poor mental health can be distressing to individuals, their families, friends and carers. It affects local communities and has a significant impact on national prosperity and wellbeing. It is inextricably linked to causes and consequences of many major public

policy issues including poverty, social exclusion, unemployment, chronic illness, low educational attainment, anti-social behaviour, crime and lack of social cohesion.

The challenges are enormous but the rewards of meeting them are great. Halton's Health and Wellbeing Board has set the "Prevention and early detection of mental health conditions" as one of five priority areas to address to achieve its vision for the Borough. To progress this, Halton Clinical Commissioning Group and Halton Borough Council have developed this joint health, public health and social care strategy which sets key objectives and priorities to improve mental health in the Borough.

Only a sustained approach across all ages and all agencies, organisations and the wider public will equip us to meet the social, economic and environmental challenges we face and deliver the short and long-term benefits we need to promote and improve the overall health and wellbeing of the residents of Halton.

Why do we need a mental health strategy?

Mental health problems have been identified as the highest single cause of ill health in the borough and can impact on a person's ability to lead a full and rewarding life.

In Halton:

- **One in four people attending GP surgeries seek advice on mental health**
- **The number of people suffering from depression is 12,471(12.4% of the GP population who are aged 18 and over)**
- **Deaths from suicides & undetermined injuries have reduced but remain higher than national averages (Rate 8.2 per 100,000 population compared to England (7.2), and the North West (9.07) (2008-10)).**
- **The rate of hospital admissions due to self- harm for under 18s is high.**
- **Halton has an estimated prevalence of 1143 people aged 65+ with dementia compared to 690 people identified on the GP register in 2011-12.**
- **More than 1 in 5 of Halton's population live with a limiting long term condition (2011 Census).**
- **Research has shown that mental illness and harmful/dependent alcohol consumption are very closely linked and over a quarter of all alcohol-related admissions are those conditions caused by mental and behavioural disorders due to alcohol (dual diagnosis). Halton's admission rate is significantly higher than both England and North West averages**.

Halton has previously implemented "The Primary Care Mental Health Strategy 2009-2012" which has been reviewed and refreshed to inform and influence the development of this strategy. The Mental Health Strategic Commissioning Group has been established with a remit to develop and oversee the implementation of this strategy and action plan. The group is responsible for developing actions that will feed into the Health and Wellbeing Board who will, in turn, co-ordinate commissioning activity to address identified needs.

Halton Council and Halton Clinical Commissioning Group (CCG) have worked in partnership and established joint commissioning agreements for specific services areas. Aspects of integrated commissioning structures are developed with both formal and informal arrangements in place for Halton. It comprises of experienced commissioners across health and social care services who have delivered improved outcomes for service users.

The partnerships as a whole have delivered on a number of key ambitions, aided by having forward thinking commissioners working in an integrated manner, and the aim of this joint approach is to co-ordinate needs assessments, strategy development, service specification and procurement, monitoring and evaluation and to further develop the integrated commissioning landscape for Halton.

The promotion of positive mental health and wellbeing, prevention activity and the early diagnosis and provision of appropriate information and support can mean that a good quality of life is possible. While the costs associated with responding to the challenges of mental health and wellbeing are expected to rise in coming years because of growing numbers of people affected, there is significant scope for spending money more efficiently and effectively and for changing how we respond to local need.

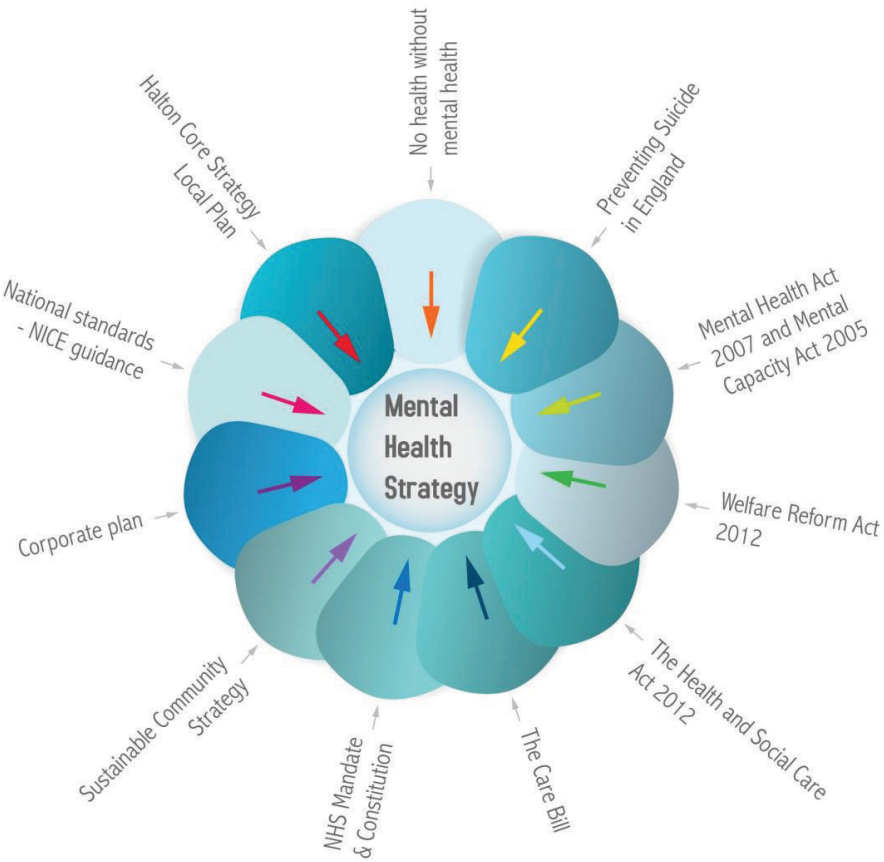
By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does. Only a sustained approach across the life course will equip Halton to meet the social, economic and environmental challenges it faces and deliver the short- and long-term benefits needed.

This strategy promotes recovery[1] so that individuals will be empowered to define the outcomes they desire based on their own experiences and aspirations and be supported to achieve their own recovery and gain a meaningful life.

This strategy also adopts a life course approach that recognises that the foundations for lifelong wellbeing are already being laid down before birth, and that there is much that can be done to protect and promote wellbeing and resilience through early years, into adulthood and then on into a healthy old age.

Only a sustained approach across the life course will equip Halton to meet the social, economic and environmental challenges it faces and deliver the short- and long-term benefits needed.

This strategy has been developed within the context of a range of national, regional and local policies, strategies and plans as summarised in the diagram below. Further details of how these influence the strategy can be found in the supporting evidence paper.



[1] [1] "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life" - No Health Without Mental Health (2011)

This strategy is for people of all ages – children and young people and older people, as well as working age adults. It underlines the importance of providing equal access to age appropriate services for everyone. It applies to the full range of services, from public mental health promotion through to suicide prevention, forensic mental health services, services for people with personality disorders, severe and enduring mental illness, people with learning disabilities and people detained under the Mental Health Act or subject to the Mental Capacity Act.

The strategy and associated action plan complements other work programmes, including the local Dementia Strategy and the Suicide Prevention, Loneliness and Child & Adolescent Mental Health (CAMHS) Strategies which are currently in development, and should be read in conjunction with these pieces of work.

In demonstrating the importance of mental health outcomes, it is the intention of this document to explicitly recognise the importance of putting mental health on a par with physical health.

Halton is committed to a focus on individual people, their health and wellbeing and supporting the communities in which they live. The major local concerns relating to mental health and wellbeing which have influenced this Strategy are examined in detail in the Mental Health and Wellbeing 2013-2018 Strategy Evidence Paper and are summarised under three themes as illustrated below.

Consultation

In developing this strategy the views of Halton residents and other interested parties were sought to help shape local mental health and wellbeing services over the next five years. 132 people responded to an online survey while Healthwatch co-ordinated a response on behalf of the 80 attendees at their 'Fact or Fiction' workshop. The key themes from open comments received are:

- **Education:** Of the general public, in schools, colleges and the workplace. Health professionals trained to give the correct advice. Everyone should understand that mental health can affect anybody.

- **Consistency:** of messages to the public about mental health to increase understanding and in service provision/aftercare.

- **Provision of service:** Out of hour's provision**,** support for families and carers. More service provision for children and young people. Early intervention services are important.

- **Access to services:** Better access to services, the waiting lists is too long. Clear information about service provision should be provided.

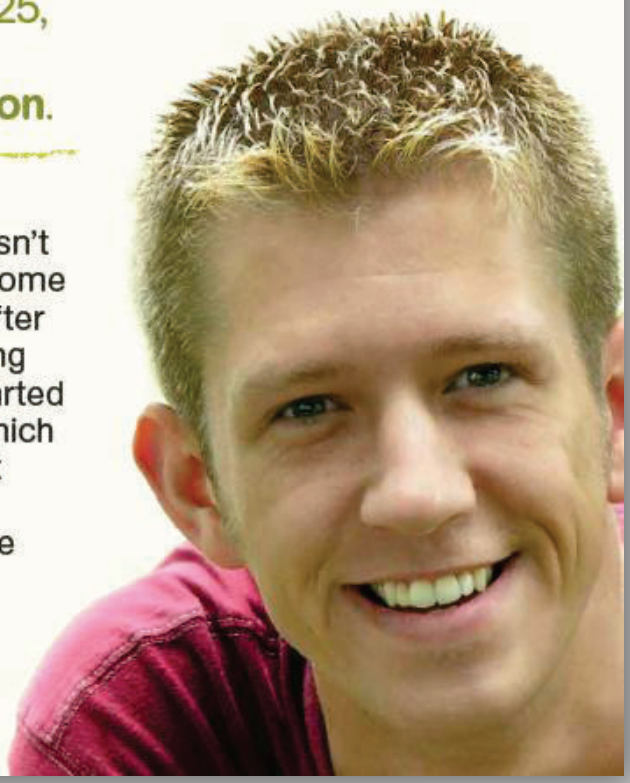
- **Promotion:** Of a healthy lifestyle, healthy eating, leisure and activities to reduce isolation, loneliness and stigma.

A full analysis of the consultation can be found as an Appendix to the Evidence Paper.

Like Minds
For better mental health in Halton

"My name is James, I'm 25, from Runcorn and I've suffered from **depression**.

I knew I needed help when I split up with my girlfriend, wasn't able to see my son, lost my home and had to stay in a hostel. After talking to my Uncle and getting help from a local service I started doing things that I enjoyed which kept me busy! I have now got myself a house, see my son and have made sure that I see people regularly."



Local Concerns

People

- Mental health is the single highest cause of ill health in the Borough
- Number of people suffering with depression slightly higher than national rates
- Deaths from suicides and undetermined injuries higher than national rates
- Hospital admissions rates due to self-harm for under 18's is high
- Mental wellbeing of children who have been in care tends to be worse than children who have not been in care
- Estimates of people aged 65+ with dementia are significantly higher than those identified with a diagnosis on GP registers

Health & Well-being

- One in four people attending GP surgeries seek advice on mental health
- Mental health is the single highest cause of ill health in the Borough
- Mental and emotional wellbeing has a high impact on a persons ability to lead a full and rewarding life
- Current economic climate and welfare reforms likely to increase levels of people suffering from mental illness
- Amenable to change through a range of evidence-based interventions to promote mental and emotional wellbeing

Communities

- Local people have identified mental health as a local priority
- People with mental health problems have the lowest employment rate of any disability group
- Support to access independent or supported housing
- Access to employment opportunities
- Utilisation of parks and green spaces to promote health and wellbeing
- Impact of stigma on the ability of those with mental ill health to contribute to their community

Our vision, objectives and priorities

Our vision for improved mental health in Halton is:

People of all ages living in Halton will have a high level of self-reported wellbeing, having happy and fulfilling lives, being able to contribute economically and socially to their own networks and the community as a whole.

Those who do experience mental ill health will not feel any stigma attached to the condition and be able to easily and quickly access appropriate levels of professional support to help them recover.

To help achieve this vision this joint strategy is based upon the national mental health strategy, "No health without mental health - A cross-government mental health outcomes" (HM Government, 2011)[2]

Through the work of this strategy, Halton aims to ensure the **objectives** outlined in the national strategy and those identified in the Halton Health and Wellbeing Strategy 2013-2016, and the Halton Clinical Commissioning Group Strategic Plan are realised for local people.

(i) More people will have good mental health

More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well. We will improve the mental health and wellbeing of Halton people through prevention and early intervention. We will increase the early detection of mental health problems which will lead to improved mental wellbeing for people with mental health problems and their families

(ii) More people with mental health problems will recover

We will improve outcomes for people with mental health problems through high quality accessible services. More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

(iii) More people with mental health problems will have good physical health

Fewer people with mental health problems will die prematurely and more people with physical ill health will have better mental health.

(iv) More people will have a positive experience of care and support

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

(v) Fewer people will suffer avoidable harm

People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

(vi) Fewer people will experience stigma and discrimination

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

This strategy identifies five **priority** areas for work to meet the needs of local people.

The number of people suffering with depression in Halton is slightly higher than the national rates

Priority 1 - Improve the mental health and wellbeing of Halton people through prevention and early intervention

Priority 2 – Increase the early detection of mental health problems which will lead to improved mental wellbeing for people with mental health problems and their families

Priority 3 - Improve outcomes for people with identified mental health problems through high quality, accessible services

Priority 4 - Broaden the approach taken to tackle the wider social determinants and consequences of mental health problems

Priority 5 - Optimise value for money by developing quality services which achieve positive outcomes for people within existing resources

This strategy aspires to meet the needs of the whole population and by using the best evidence of what works to increase the effectiveness and value for money of mental health services.

This will be achieved by:

- **Improving the quality and efficiency of current services;**
- **Radically changing the way that current services are delivered so as to improve quality and reduce costs;**
- **Shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and**
- **Broadening the approach taken to tackle the wider social determinants and consequences of mental health problems**

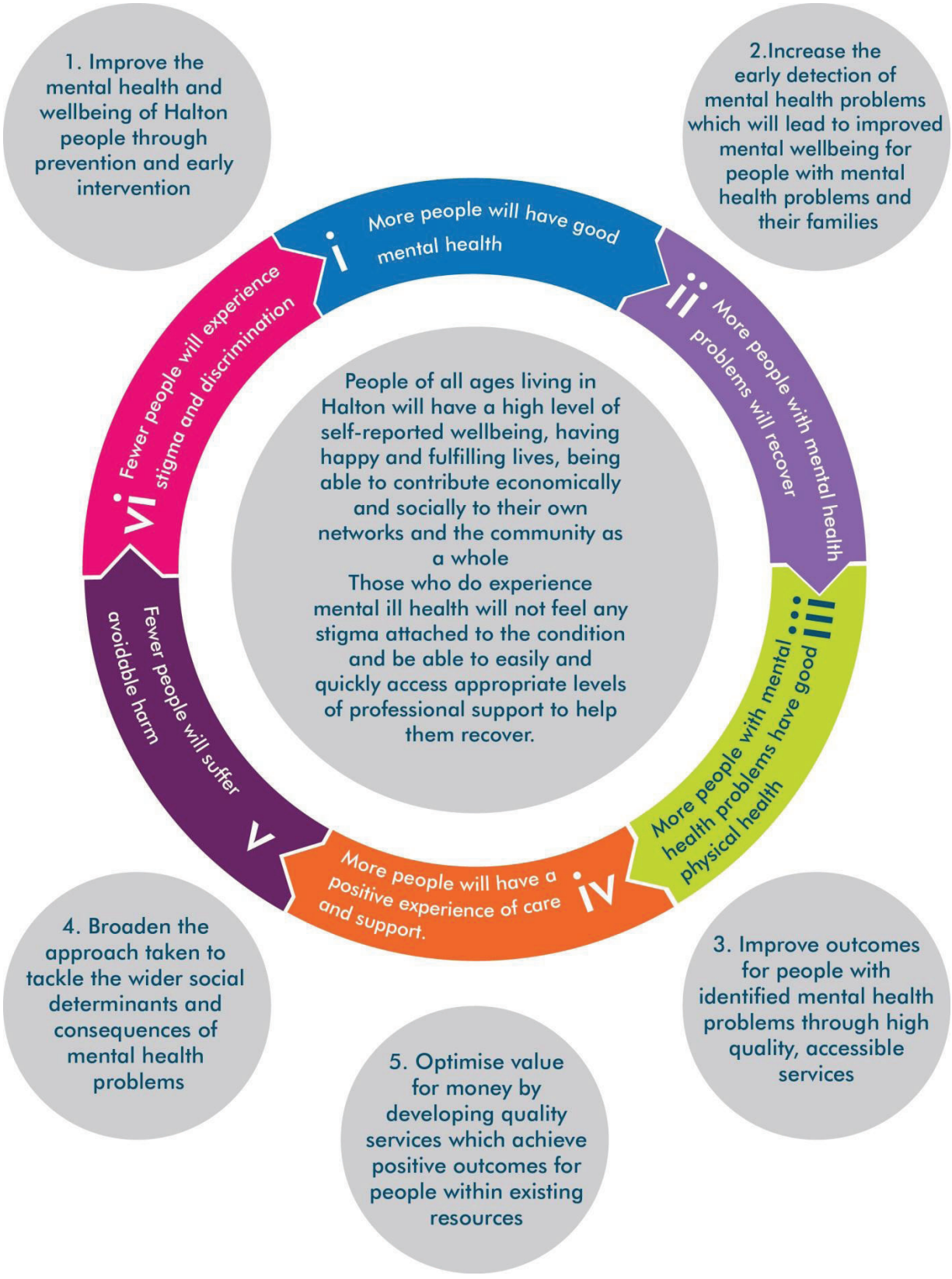
The accompanying evidence paper shows that current investment in mental health services is primarily focussed on long term support and acute care. This is not sustainable against a backdrop of treatment costs expected to double in the next twenty years and the current economic climate.

This strategy places an emphasis on whole population mental health promotion and prevention alongside early intervention to prevent mental illness developing and mitigating its effects when it does.

By clearly defining prevention and early intervention in this way we can begin to consider how through addressing people's low-level needs and wants we can begin to shift service provision from high cost complex care to more cost effective low-level support.

Mental health and wellbeing services along with preventative support and earlier interventions are essential in meeting Halton's priorities. Whilst this strategy covers a five year period it is organic and will evolve in response to changes in national and local drivers and emerging issues.

Our vision, priorities and objectives



Implementing our priorities

At a time of financial and demographic pressure, improving quality while increasing productivity and effectiveness is vital for any improvements in care. The national strategy advocates local areas to consider the importance of mental health services and the resources that are allocated to provide them.

It suggests that each local area should focus upon three work streams when considering the development of local strategies:

The **acute care pathway** – avoiding hospital admissions through effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided (for example, by action to tackle delayed discharges);

out of area care – getting better quality and better value through ensuring that appropriate in-area care is available where this is a better solution and commissioning effectively so that care is managed well, in terms of both care pathways and unit costs; and

physical and mental health co-morbidity – getting better diagnosis and treatment of mental health problems for those with long-term physical conditions, and getting identification and treatment of anxiety or depression for those with medically unexplained symptoms.

As the Government's policy of deficit reduction continues, the impact on the public sector is significant and with the public sector having to make unprecedented decisions about the services that it continues to deliver, this ultimately impacts on service delivery and residents expectations.

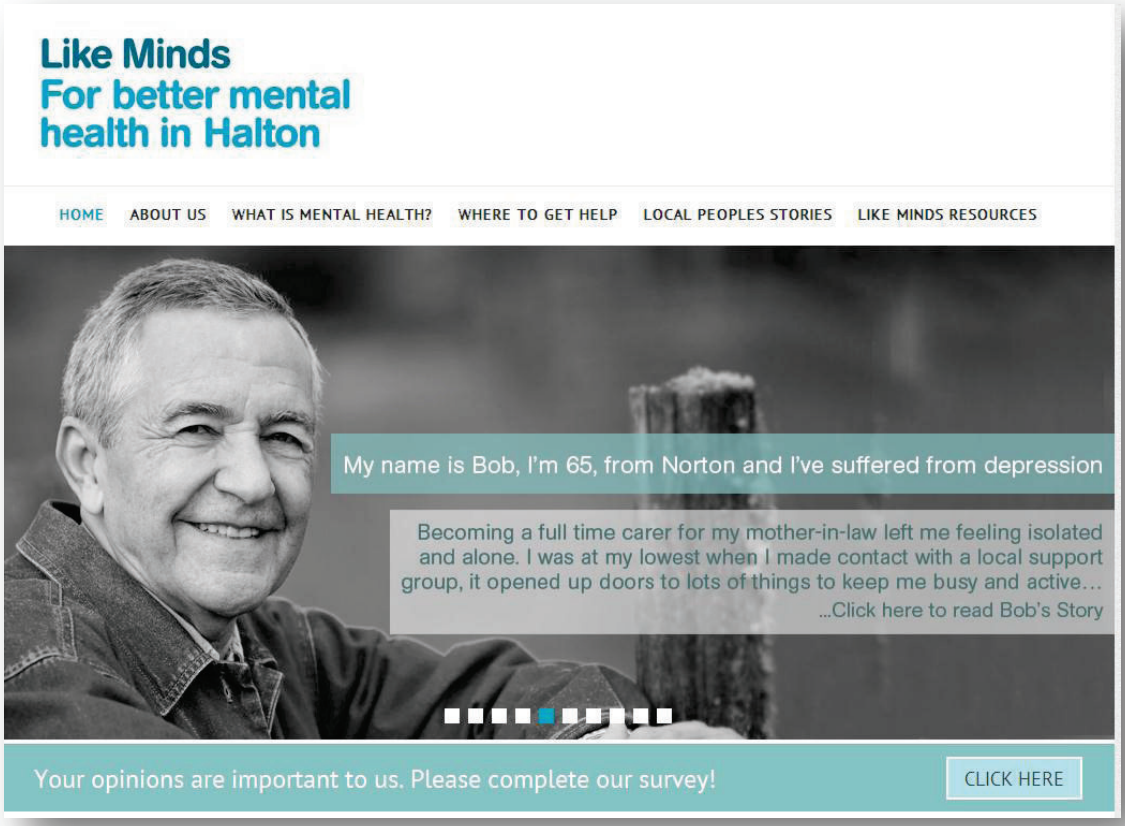
The success of the Strategy will depend upon partnership working in its broadest sense, if we are to achieve the best possible outcomes for everyone who lives or works in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in the delivery of the health and wellbeing agenda. This is even more imperative given the challenges brought about by the current economic climate.

The successful implementation of the strategy may mean staff working in new ways and all partners will need to ensure that the local workforce is trained and enabled to do this. In addition, the Health and Wellbeing Board in partnership with Halton Borough Council, has developed the concept of

Wellbeing Areas based on the existing seven Area Forum boundaries. This is in recognition of the fact that, whilst there are common issues across the borough, there are different needs across communities and one approach does not necessarily meet the needs of all.

The aim of Wellbeing Areas therefore is to work alongside local communities to address specific issues and wherever possible, tailor services to meet the needs of that particular community. This approach will move away from the traditional approach of delivering health and wellbeing services and instead will focus upon a 'grass roots' community development approach.

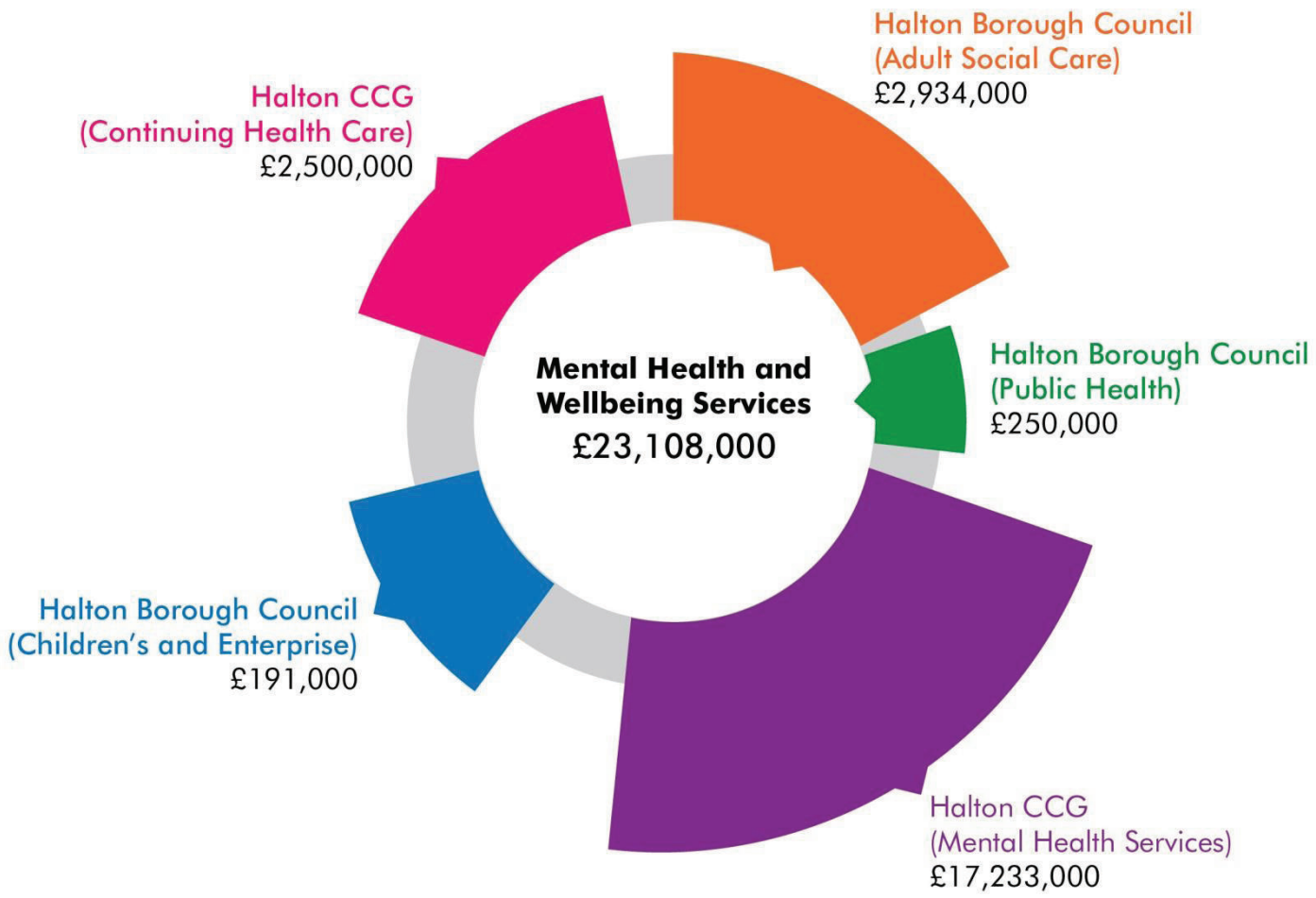
This approach is complemented by the development of the Well Being Practice model by NHS Halton CCG and their commissioning intentions to focus provision around local communities. GP Practices working as part of the Health and Wellbeing Practice approach will seek to deliver a culture change by enabling their patients to improve their health by accessing local services and facilities, using self-help tools, accessing training and participating in the local community.



How will it be paid for?

The following financial breakdown is based upon current direct expenditure in mental health and wellbeing services and does not reflect all of the wider universal and targeted activity that is commissioned locally. Such expenditure, on areas such as Primary Care (GPs, etc), general health promotion, weight management, or voluntary and community sector activity, all have a direct impact upon the mental health and wellbeing of local communities, but does not fall within the direct influence of the mental health and wellbeing strategy and action plan.

Further financial analysis across the range of activities and interventions can be found in the evidence paper.



How will we know if we have been successful?

When we have achieved our aims there will be a high level of self-reported wellbeing, with people having happy and fulfilling lives, being able to contribute economically and socially to their own networks and the community as a whole.

Those who do experience mental ill health would not feel any stigma attached to the condition and be able to easily and quickly access appropriate levels of professional support to help them recover.
Those who do and have experienced mental illness would be able to contribute fully to the community, have good levels of employment in fulfilling jobs.

Hospital admissions and deaths due to mental ill health and emotional distress would be much rarer than they are now.

People with dementia would have good levels of support.

People would live in healthy homes and communities that do not result in them experiencing mental ill health.

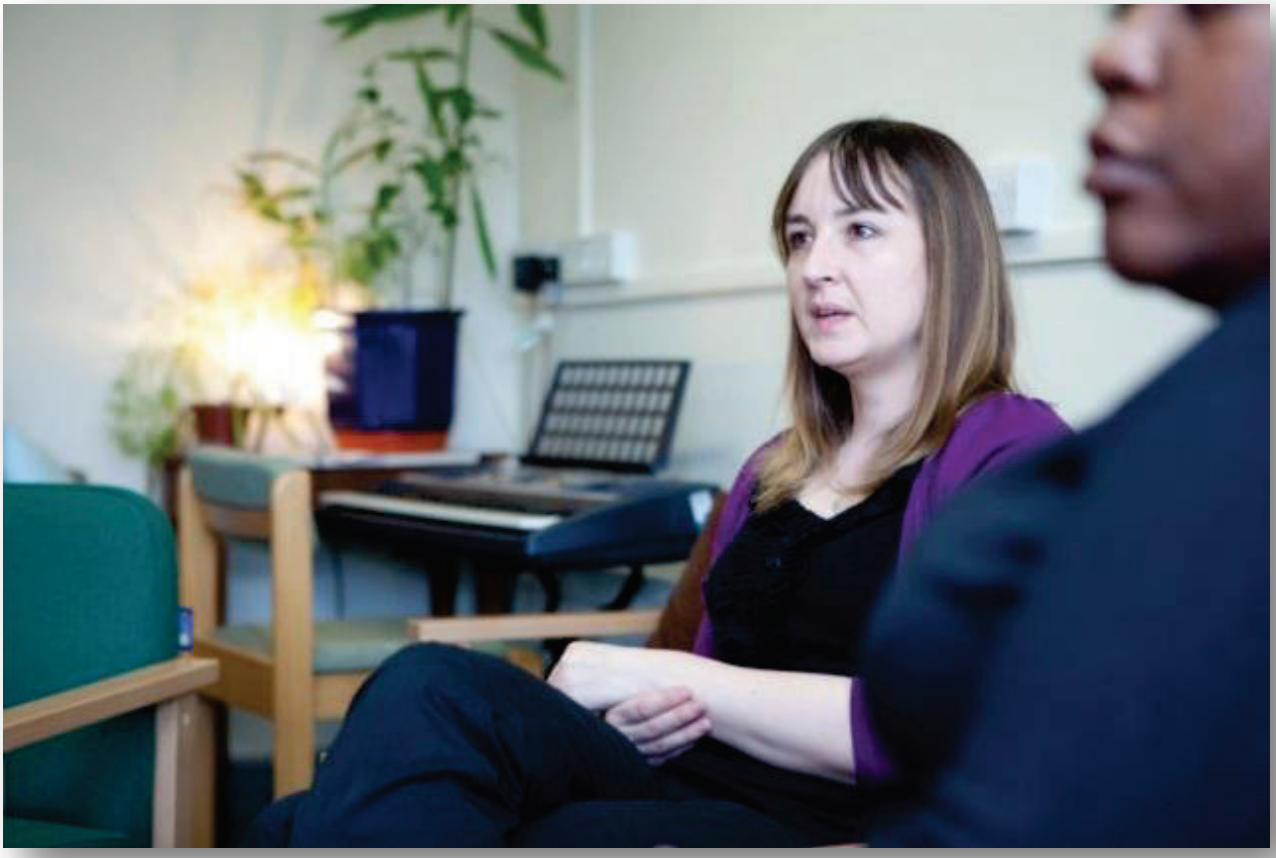
The Overarching Outcome for the Strategy is to improve the health and wellbeing of Halton people so they live longer, healthier and happier lives. This will be achieved by focussing efforts on delivering against the priorities and achieving the five priorities.

It is important to make sure that real health and wellbeing improvements are delivered through the implementation of this strategy. The best way to achieve this is to use recognised measures to monitor the benefits arising from agreed priority actions and five high level targets have been set as a measure of success:

	Priority	Target to measure success
1	Improve the mental health and wellbeing of Halton people through prevention and early intervention	**Increase of 1% in self-reported wellbeing (Feeling Worthwhile) (Baseline 2012 = 17.6%)**
2	Increased early detection of mental health problems leading to improved mental wellbeing for people with mental health problems and their families	**Improved access to Psychological Therapies – 10.5% of people with depression or anxiety disorders will receive psychological therapies.**
3	Improve outcomes for people with identified mental health problems through high quality, accessible services	**100% of commissioned services working towards compliance with NICE guidelines for "Patient Experience of Mental Health".**
4	Broaden the approach taken to tackle the wider social determinants and consequences of mental health problems	**100% of commissioned services taking up anti-stigma / mental health awareness training.**
5	Optimise value for money by developing quality services which achieve positive outcomes for people within existing resources.	**Improved outcomes relative to spend – shift in Spend and Outcomes Tool (SPOT) from Lower spend, Worse outcomes to Lower spend, Better outcomes.**

An ‘Outcomes Framework’ provides a template of how measures can be used to monitor different priority areas. There are currently a number of recognised outcomes frameworks covering the NHS, Adult Social Care and Public Health. We will use these to inform our overall outcome measures and our performance indicators. As we achieve our desired outcomes we will review our priorities and change them if appropriate. More detail on these indicators can be found in the evidence paper.

It is also important that the quality of what we are delivering is monitored to make sure people have a positive experience. On-going customer feedback as well as activities such as local surveys and focus groups will be used to monitor current services and see where any improvements need to be made. The discussions that have taken place during the development of this framework should continue throughout the lifetime of the Strategy and to help in the development of the next JSNA and Strategy.



PRIORITY 1: Improve the mental health and wellbeing of Halton people through prevention and early intervention

Increase of 1% in self-reported wellbeing (Feeling Worthwhile) (Baseline 2012 – 17.6%)

Why is this priority?

As life expectancy increases, it is critical that healthy life expectancy also increases. Higher than England averages of Halton's population are exposed to adverse social, economic and environmental conditions that influence the health of individuals and of populations.

The prevention and early detection of mental health conditions is a key area for development in Halton.

We know more about which interventions and factors work to improve mental wellbeing and prevent problems developing. By focusing on the prevention of mental health problems and the promotion of mental wellbeing, we can significantly improve outcomes for individuals and increase the resilience of the population, while at the same time reducing costs.

What do we want to achieve?

More people will have good mental health

- Improved social and emotional health of the population across all ages.
- Improved support for families in dealing positively with toddlers
- Improved mental well-being of school-aged children
- Improved information and support available to help young people maintain positive mental health
- Improve the social and other determinants of mental ill health across all ages and reduce the inequalities that can both cause and be the result of mental health problems including for example, social isolation
- Improved integration of services and support for people with dementia

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Determine if current maternal depression and Post Natal Depression pathways are in line with national evidence and guidelines for detecting depression	Detection and treatment of maternal depression - 100% of women to be offered screening antenatally at 36 weeks Detection and management of Post Natal Depression to improve attachment - 90% of eligible women screened at 6-8 weeks	March 2014 March 2014	Midwifery Service Health Visitors
Borough-wide availability of specific activities and programmes of support in dealing positively with toddlers in Children's Centres	Terrific Two's and Positive Play available in all Children's Centres	Sept 2014	CYP Services
Training for staff in Nurturing-based approaches to support parenting skills and confidence in achieving positive behaviour management and emotionally healthy relationships	Getting it Right with Families training delivered to first cohort of 16 practitioners	March 2014	CYP Services
Implement recommendations from the health needs assessment of young offenders Implement recommendations from the Health Needs Assessment on adult mental health and wellbeing Implement recommendations from the Health Needs Assessment of ex-armed forces personnel Implement recommendations of the health impact of the economic downturn report from Liverpool Public Health Observatory	Reduce number of first time entrants into the Youth Justice System (PHOF) Baseline: TBC Increase in self-reported wellbeing (PHOF) Baseline: TBC Reduce unemployment, including youth unemployment and long-term unemployment Baseline: TBC Reduction in admissions due to alcohol and drugs, including reduced inequalities Baseline: TBC	Ongoing	Integrated CYP Commissioners Public Health CCG Adults and Communities
Review current 'State of Mind Review' service provision to identify any gaps and develop business case to improve performance and maintain quality.	Review undertaken and new business case developed	March 2015	Integrated Commissioning 5BP NHS FT
Re-establish the Mental Health Carers' group as a sub group of the Mental Health Strategic Commissioning board to inform and influence service development.	Mental Health Carers Group established	December 2013	Integrated Commissioning Team

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Early identification and support for children who are potentially more vulnerable to developing mental health problems	Train 10 school nurses in how to identify children and young children at risk of developing mental health conditions and offer low level counselling and support with referral to specialist services, e.g. Ad Action, GP, CAMHS	March 2014	Primary Care Mental Health Team
Reduce levels of sexual exploitation and improve self-esteem and confidence	Run four workshops per annum to train teaching staff in how to communicate with children on social and emotional issues using evidence based interventions, e.g. SEAL	March 2014	Primary Care Mental Health Team
	Develop resources and packs for teachers on gender, identity, confidence and aspirations	March 2014	CAMHS team
Reduce levels of cyber bullying	4 sessions per annum on anti-cyber bullying training and materials for front line staff, teachers and school nurses.	March 2014	Health Improvement Team
Improve healthy eating and reduce levels of obesity	Enrol all schools on Healthitude programme which covers healthy eating, drinking, tobacco and drugs.	June 2014	Health Improvement Team
Increased promotion and use of materials within schools about the importance of emotional health and well being	Review school nurse provision and develop new school nurse specification to include social and emotional health outcomes.	June 2014	Public Health
	Develop information packs and resources on the impact of change on social and emotional health of children for front line staff	March 2014	Health Improvement Team
	Refresh CAYP EWB Strategy and Implementation plan Implement recommendation of HNA of children & young people's emotional wellbeing	March 2014	Integrated CYP Commissioners
	Agree final recommendations from the Looked After Children's needs assessment and implement.	Ongoing	Integrated CYP Commissioners
	Expansion of Healthitude Programme in schools which includes: • Drug and alcohol • Relationships • Peer Pressure • Sexual Health • Exam Stress	Ongoing	Health Improvement Team
Develop a series of messages for young adults and ensure that they are disseminated through variety of mediums. Mental health and wellbeing issues will be considered alongside other issues important to young people	Insight work carried out.	September 2013	Health Improvement Team
	Messages developed and disseminated.	October 2013	
	Information distributed throughout the borough	Ongoing	
Rollout of the Community Wellbeing Practice Initiative	GP Practices support patients to access local services and facilities, use self-help tools, access training and participate in the local community	Rollout from April 2013	Halton CCG/ Wellbeing Initiative/ evaluation support from Public Health
GPs and primary care staff will be encouraged to use non-medical initiatives where appropriate for those with mild mental health issues e.g. social prescribing	50% of practice staff participating in the initiative will undertake brief intervention training re: wellbeing		
Expansion of social prescribing services e.g. access to CAB, books on prescription, access to self-help website.	Increased referral of 20% into community based services	March 2014	Health Improvement Team
Training for GP Primary Care staff on how to recognise mental health conditions and early non-medical treatment.	An agreed % of the practice population of those practices involved will report improved wellbeing levels using SWEMWBS before and after interventions	Ongoing	CCG / HIT

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Implement the Health and Wellbeing Steering Group Loneliness action plan to identify people within the Borough at risk of, or suffering from loneliness, and develop a strategic plan which demonstrates a partnership approach to combating loneliness. Review Halton's approach to active ageing including support with health and wellbeing and access to appropriate housing, transport, leisure and opportunities for community engagement.	Reduction in the number of lonely older people. Reduction in the number of older people with low to moderate mental health conditions in Care Homes and for those that receive domiciliary care. Implementation of Guidelines in How to Identify Treat and Refer Older People with Low to Moderate Depression in Care Homes and for those that receives domiciliary care.	December 2014 December 2014	Health and Wellbeing Steering Group Health and Wellbeing Service Older people's Team

PRIORITY 2: Increase the early detection of mental health problems which will lead to improved mental wellbeing for people with mental health problems and their families

Improved access to Psychological Therapies – 10.5% of people with depression or anxiety disorders will receive psychological therapies.

Why is this priority?	What do we want to achieve?
Evidence shows that earlier identification and intervention can prevent mental health problems becoming more serious and long lasting. Different approaches are required across the lifecourse and for those with more complex multiple needs. The principles of the recovery approach have been shown to be effective across all age groups.	More people will have good mental health More people with mental health problems will recover • Detection and treatment of maternal depression • Detection and management of Post Natal Depression to improve attachment • Improved mental wellbeing of school aged children • Improved support for children and young people experiencing mental health problems • Improve lifetime health and wellbeing of vulnerable children and young people so their life opportunities enable them to thrive physically and emotionally. • Early identification of those with mild to moderate mental health problems • Improved range and use of self-help and other non-medical interventions to improve levels of self-reported wellbeing. • More people will have good mental health • More people of all ages and backgrounds will have better health and wellbeing. • Improved integration of services and support for people with dementia

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Review the emotional health and wellbeing pathway across the Tiers (1-3) of CAMHS provision. Reinstate transition meetings and invite CAMHS to consider the needs of those age 17+ who potentially will need adult mental health services or whose lifestyle choices place them at risk.	Improved support for children and young people experiencing mental health problems New Children and Young People pathway developed and implemented Transition meetings established and regularly meeting to review needs of young people.	July 2014 September 2014 March 2014	Integrated CYP Commissioners
Establish a Children and Young People emotional health and wellbeing board to design and configure new integrated service based on evidenced based approaches such as IAPT	Board established	September 2013	Integrated CYP Commissioners
Review current skin camouflage service provision to identify any gaps and develop business case to improve performance and maintain quality.	Skin camouflage service reviewed and business case developed.	December 2014	CCG
Continue to implement the Dementia Strategy and review impact.	Ongoing review and monitoring of implementation of the dementia strategy.	On-going	Integrated Commissioning
Redesign current IAPT service to include increased access and recovery targets for depression or anxiety disorder as part of the commitment to full rollout by 2014/15 through a procurement process Promote increased access of services by black and minority ethnic groups and by older people, and increased availability of psychological therapies for people with severe mental illness and long term health problems.	IAPT Programme: Services provided to at least 15% of disorder prevalence Recovery rate of at least 50% in fully established services. Improved access for BME and older people Increased availability of psychological therapies for people with severe mental illness and long-term health problems Pre and post treatment outcome data (PHQ9 & GAD7)on over 90% of all patients who start treatment.	March 2014 Monthly contractual reporting of current contract will happen in tandem with tender exercise	CCG

PRIORITY 3: Improve outcomes for people with identified mental health problems through high quality, accessible services

100% of commissioned services working towards compliance with NICE guidelines for "Patient Experience of Mental Health".

Why is this priority?

Halton has above average levels of people living with long term conditions and evidence shows those with chronic physical health problems are more likely to experience mental health problems and need access to need access to health services.

People with mental health problems are twice as likely as the general population to experience a long term illness or disability leading to poor quality of life.

Having a mental health problem increases the risk of excess mortality by 50% for those suffering depression while those with schizophrenia or bipolar disorder die on average 15-25 years sooner than the general population. Increased smoking is responsible for most of this amongst those with severe mental health problems.

The pathway for those detained under S3 of the MHA often leads to hospital or specialist out of area placement with a focus on containment which delivers poor outcomes.

The impact of a person taking their own life is devastating on family, friends and many others offering support. Whilst the number of suicides is low there are key groups who present as high risk and are more likely to become suicidal if they have a mental health condition.

What do we want to achieve?

More people with mental health problems will recover
More people with mental health problems will have good physical health
More people will have a positive experience of care
Fewer people will suffer avoidable harm

- Improve the social and other determinants of mental ill health across all ages and reduce the inequalities that can both cause and be the result of mental health problems including for example , social isolation
- Improved access and availability of psychological therapies
- Improved integration of services and support for people with dementia
- Vulnerable people with high rates of mental health problems (including those who are homeless, sex workers, gypsies/travellers) have access to primary healthcare and community based services to prevent the need for acute services.
- Reduce number of suicides over the lifespan of this strategy.
- Reduction in the number of hospital admissions for self-harm.
- Redesign current IAPT service to improve access to psychological therapies as part of the commitment to full rollout by 2014/15.
- Promote increased access of services by black and minority ethnic groups and by older people, and increased availability of psychological therapies for people with severe mental illness and long term health problems.
- Increase access to personal health budgets in line with the Cheshire and Merseyside pilot.
- Review Carers Strategy and information and support available to both young and adult carers of a person with mental health needs.
- Evaluate benefits of ICT Applications to highlight where mental health and wellbeing services can be accessed or as part of wrap around support, avoiding need for visit to GP or attendance at A&E,
- Re-procurement of IAPT to include increased access and recovery targets for depression or anxiety disorder
- All people accessing mental health services will have access to support to address their physical health and wellbeing.
- Increase numbers of people with severe mental health problems accessing smoking cessation support.

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Work with local independent and voluntary sector providers to develop condition specific workforce skills (e.g. Asperger's, personality disorder) and ensure linked in to local health and other professional support.	Enhanced focus on the needs of vulnerable members of the community in partnership with the independent and voluntary sector.	On-going	Divisional Manger Mental Health Integrated Commissioning
Work with statutory, voluntary and independent sector to review access to health and wellbeing support for ex-offenders and offenders managed in the community in line with evidenced best practice	Enhanced focus on the needs of vulnerable members of the community in partnership with the independent and voluntary sector.	March 2014	Divisional Manger Mental Health Integrated Commissioning
Review access to respite provision and current response to social crises against recognised best practice.	Review of access to respite provision. Recommendations presented to Mental Health Commissioning Board.	March 2014	5 Boroughs Partnership NHS FT

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Review current Asperger's service provision to identify any gaps and develop business case to improve performance and maintain quality.	Review of access to Asperger's Service provision. Recommendations and business case presented to Mental Health Commissioning Board.	March 2015	CCG 5 Boroughs Partnership NHS FT
Ensure advice for media reporting on suicide is still current and widely disseminated.	Review of current advice Meeting / training with local media representatives Improved public reporting on suicide	March 2014	Health Improvement Team
Refresh Suicide Prevention Strategy to ensure promotes best practice.	New suicide Prevention strategy developed and implemented Closer partnership working in relation to suicide prevention	March 2014	Public Health Commissioners
Increased information sharing across services regarding incidence of self-harm or risk laden lifestyle choices. Ensure self-harm referrals to commissioned 'Hear4u' Service are prioritised and audited, with revised assessment process in place to deliver most appropriate response for individual children and young people	Development of improved information sharing protocols and closer working between partners Reduction in hospital admissions due to self-harm <18 years of age Two Training Sessions per year for GP, A & E nurses, social workers and teachers on how to communicate and treat self-harming children and young people using evidence based material and programmes	Ongoing June 2013 June 2013	All Partners Integrated CYP Commissioners Integrated Commissioners
Raise awareness of organisations that offer support to people considering suicide by disseminating information through engaging with at least 20 staff and community forums per year Review the current contract with organisations that offer support to people considering suicide – this is a Mersey wide funded service. Halton is an associate commissioner Training for Primary Care staff on how to recognise and help people at risk of suicide.	Ensure Halton suicide rates are in line with those reported nationally (PHOF)	Through the year until review (below) is complete Review complete by Mar 2014 Ongoing	Health Improvement Team Public Health Health Improvement Team
Increase access to personal health budgets in line with the Cheshire and Merseyside pilot.	Increased take-up of Personal Health Budgets.	Ongoing	Complex Care Board
Review Carers Strategy and information and support available to both young and adult carers of a person with mental health needs.	Review of Carers strategy and recommendations presented to Mental Health Commissioning Board. Report on benefits of ICT Apps presented to Mental Health Commissioning Boards.	March 2014 On-going	Commissioning Managers across CCG/Adult Social care and Children's Services Carers Centre Commissioning Managers across CCG/Adult Social care ICT/Communications
Increase the number of individuals with severe mental health problems accessing health screening and improvement programs.	Increased number of individuals with an identified severe mental health problem accessing screening programmes and health improvement programmes.	Ongoing	Public Health Commissioners
Develop care pathway to support patients with enduing mental health problems to access physical health checks on an annual basis.	Health check programme pathway developed and implemented	March 2014	CCG

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Work with Halton Military Veterans to scope out needs and make recommendations for service improvement.	Report to Mental Health Commissioning Board on needs of Military Veterans. Procure military vets specialist IAPT service	September 2014	CCG
Improve access to psychological support for people with long term conditions across Cheshire and Merseyside Clinical Networks (CMCN) through better integrated services provision between physical and mental health.	Increased access to IAPT services.	On-going	CCG
Develop a local response to severe mental health problems which keeps individuals close to home and works towards agreed goals	Review of all out of Borough placements and action plans developed to focus upon a local response to need.	On-going	CCG 5 Boroughs Partnership NHS FT
Develop Recovery Team care pathway to support discharge of patients in recovery from 5 Boroughs to Primary Care.	Recovery Team Care Pathway developed and implemented.	March 2014	CCG 5 Boroughs Partnership NHS FT
Review current Out of Area Treatment Services/Psychiatric intensive care unit service provision to identify any gaps and develop business case to improve performance and maintain quality.	Review of current Out of Area Treatment Services with recommendations as to how to address any identified service gaps.	March 2014	CCG 5 Boroughs Partnership NHS FT

PRIORITY 4: Broaden the approach taken to tackle the wider social determinants and consequences of mental health problems

100% of commissioned services taking up anti-stigma / mental health awareness training.

Why is this priority?

By building care and support around individual outcomes recovery can be promoted to help individuals to readjust to living in the community. Resilience can be developed which reduces the risk of relapse and the need for crisis interventions or on-going support and improves quality of life for the individual and their family.

Mental health problems may be many and interrelated – for example, a third of families with multiple problems have at least one family member who has a mental health problem. A whole-family approach that addresses mental health together with other issues, such as domestic violence or alcohol misuse, has been shown to reduce the risks associated with mental health problems.

People with mental health problems have worse life chances than other people partly due to the effect of their condition but stigma and discrimination are key contributors. Addressing this will progress one of Halton Strategic Partnership's five priorities:

A Safer Halton
To ensure pleasant safe and secure neighborhood environments, with attractive, safe surroundings, good quality local amenities, and the ability of people to enjoy life where they live.

What do we want to achieve?

More people will have good mental health
More people with mental health problems will recover
More people with mental health problems will have good physical health
Fewer people will suffer avoidable harm
Fewer people will experience stigma and discrimination

- Outcomes focussed pathways where the person is a partner in their own care and the emphasis is on working towards recovery and being able to gain/maintain employment.
- People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.
- Proportion of adults in contact with secondary mental health services in paid employment.
- Proportion of adults in contact with secondary mental health services living independently, with or without support.
- More parents with common mental health problems are supported by mental health services through greater engagement with the Team Around the Family and Inspiring Families programmes.
- Fewer people will suffer from stigma and discrimination because of their mental health problems.

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Improve housing pathways for people of all ages with mental health problems who are ready to move on from short term accommodation and for those aged 55+ access to extra care housing. Promote the inclusion of Lifetime Homes and wheelchair standard dwellings in all new housing developments	Development of Housing Pathway	March 2015	Divisional Manger Mental Health Integrated Commissioning
	Monitor impact on individuals and provide recommendations to Mental Health Commissioning Board. An increase in the proportion of adults in contact with secondary mental health services living independently, with or without support	March 2015 March 2014	Divisional Manger Mental Health Integrated Commissioning
Review barriers to private rental e.g. impact of recent housing benefit changes, and identify solutions.	Monitor impact on individuals and provide recommendations to Mental Health Commissioning Board	September 2015	Divisional Manger Mental Health Integrated Commissioning
Continue joint working across children's and adults services and establish follow through support in adult services to maintain placement stability whilst promoting greater independence.	Monitor impact on individuals and provide recommendations to Mental Health Commissioning Board	March 2014	Divisional Manger Mental Health GP Practices
Acknowledge that for some people low level support is all they will accept but have in place strategies to manage risk and respond when mental state escalates.	Monitor impact on individuals and provide recommendations to Mental Health Commissioning Board.	On-going	Employment Learning and Skills Division Community Services Division Integrated Commissioning
Pilot current Mental health Outreach Team provision within Primary Care to establish capacity, demand and develop robust outcomes/outputs.	Pilot Mental Health Outreach Team in place.	September 2014	Mental Health Integrated Commissioning

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Identify opportunities to further develop support available to those with mental health problems to gain and retain employment or maximise their potential to work.	Recommendations to Mental Health Commissioning Board on development of employment and work related activities for those with mental health problems An increase in the proportion of adults in contact with secondary mental health services in paid employment.	March 2014	Operational Director Complex care Divisional Manager Community Services
Develop specific adult social services input into the Team Around Family service.	Recommendations to Mental Health Commissioning Board as to how adult social services can contribute to Team Around the Family (TAF).	March 2014	Integrated Commissioning
Review local implementation of Ofsted recommendations relating to children of parents/carers with mental health and/or drug or alcohol issues.	Recommendations to Mental Health Commissioning Board on how joint working across adult and children services can be enhanced.	September 2014	Integrated Commissioning Divisional Manger Mental Health
Develop a domestic violence perpetrator programme in line with RESPECT	Development and implementation of domestic violence perpetrator programme.	December 2013	Integrated Commissioning HIT
Develop an anti-stigma campaign, in partnership with elected members	Like Minds Campaign to be developed	October 2013	HIT, Elected Members

PRIORITY 5: Optimise value for money by developing quality services which achieve positive outcomes for people within existing resources

Improved outcomes relative to spend – shift in SPOT from Lower spend, Worse outcomes to Lower spend , Better outcomes.

Why is this priority?	What do we want to achieve?
Halton is committed to promoting the recovery model and empowering individuals to take responsibility for and control over the decisions made regarding their mental health. Mental Health Services have a key role in protecting vulnerable adults and children from harm and to provide support to alleviate the effects of harm so individuals and families can recover and thrive.	More people will have good mental health More people with mental health problems will recover More people with mental health problems will have good physical health Fewer people will suffer avoidable harm More people will have a positive experience of care Fewer people will experience stigma and discrimination • Care and support should be age appropriate with services designed around the individual enabling them as far as possible to control and manage their own support to match their needs. • When treatment is delivered under the Mental Health Act without consent, the principle of least restriction will be applied. • A reduction in numbers of people with severe mental health problems having to move away from Halton to receive treatment and support. • Fewer people suffer avoidable harm • People with mental health needs access services that protect them as far as possible from avoidable deaths, disease and injury allowing them to feel safe and where adherence to human rights is enshrined within all care and treatment settings.

ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Introduce Payment by Results (PbR)	Payment by Results introduced to all relevant service specifications in line with national timetable	In line with national timetable	CCG
Support recovery and enable those who no longer require specialist help to self-manage their mental health with appropriate community based support	Increased access to enhanced recovery focused community services.	On-going	Integrated Commissioning
Develop business case across Mid Mersey to implement AED Rapid Assessment interface and Discharge(RAID) liaison	Business case presented to Mental Health Commissioning Board.	March 2014	CCG
Dementia screening in Care Homes/Primary Care	Increased number of dementia screenings recorded in care homes / primary care.	September 2014	Integrated Commissioning
Develop business case for Alzheimers admiral nurse community service	Business case developed and considered by Mental Health Commissioning Board.	March 2014	Integrated Commissioning
Implement redesign and roll out of Later life and Memory Service as agreed at Dementia Board.	Later Life and Memory Service reviewed and new ways of working implemented.	March 2014	Integrated Commissioning
Implement shared care for those identified for transfer back to GP care with support from 5 Boroughs.	Increase in the number of service users under the shared care system.	March 2014	Integrated Commissioning
Review and update local Section 136 Place of Safety policy and provision to reflect best practice.	Updated policy agreed by all partners and presented to Mental health Commissioning Board	September 2014	Whole system approach across Cheshire and Merseyside
Develop transitional provider care pathway between children and young people and adult services.	Transitional Care Pathway presented to Mental Health Commissioning Board.	December 2013	CCG
Ensure that safeguarding procedures are applied to people with lower level needs who may be eligible for support from adult social care services	Success measures and outcomes	On-going	Divisional Manager Mental Health Integrated safeguarding unit

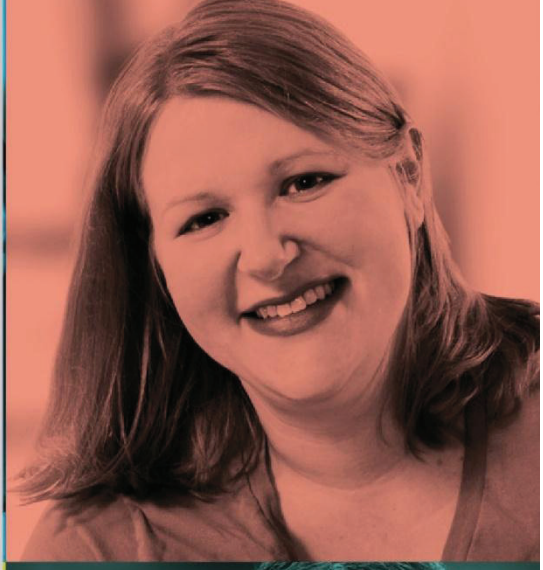
ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESPONSIBILITY
Ensure commissioned services implement good practice in safeguarding and demonstrate compliance with agreed Halton policies and procedures.	Review current eating disorder service provision to identify any gaps and develop business case to improve performance and maintain quality.	On-going	Integrated Commissioning Quality Assurance team
Review current eating disorder service provision to identify any gaps and develop business case to improve performance and maintain quality.	Review of Eating Disorder Service with recommendations presented to Mental health Commissioning Board.	March 2014	CCG

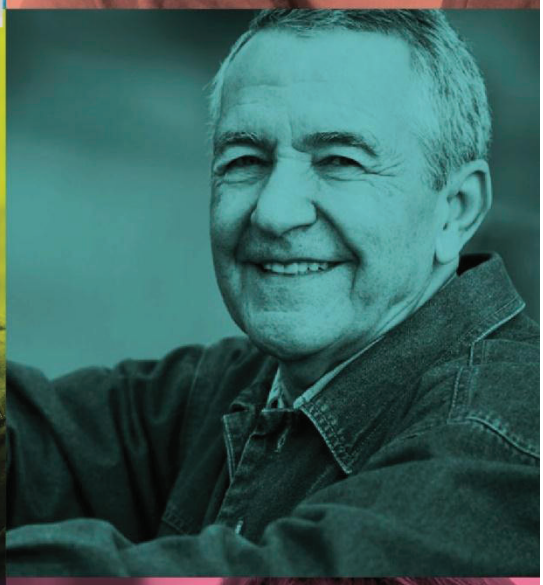
A Mental Health and Wellbeing Commissioning Strategy for Halton

2013 to 2018

Evidence Paper

myhalton
living life well







NHS
Halton Clinical Commissioning Group

HALTON
BOROUGH COUNCIL

Contents

Glossary

ACP	Acute Care Pathway
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CMD	Common mental disorders
COF	NHS Commissioning Outcomes Framework
CURT	CAMHS Urgent Response Team
DOLS	The Deprivation of Liberty Safeguards was introduced by the Mental Capacity Act 2007 to protect individuals from the unlawful deprivation of their liberty. The concepts of restraint, restriction and deprivation of liberty are best understood as existing on the same 'spectrum of control', with deprivation of liberty involving a higher degree or intensity of control over that individual. Ultimately, the concept is one to be interpreted in view of the specific circumstances of that individual.
Dual diagnosis	Dual diagnosis is the term used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use
HWBB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
IMCA	Independent mental capacity advocate
IMHA	Independent mental health advocate
LAT	Local Area Team
NICE	National Institute for health and Care Excellence
Open Mind	Single point of access for primary and secondary care mental health services.
PBR	Payment by results
Stigma	A negative association attached to some activity or condition. A cause of shame or embarrassment.

Foreword

The Halton Mental Health Strategic Commissioning Board has been established with a remit to develop a Mental Health Strategy and action plan. This plan has been based on national best practice as outlined in The national Mental Health Strategy 'No Health without Mental Health' (2011)which takes a life course approach and prioritises action to enhance wellbeing and increase the early detection and treatment of mental health problems at all ages.

It also promotes robust and comprehensive services for people with severe and enduring mental health problems. The strategy promotes independence and choice for people and recognises that good mental wellbeing brings much wider social and economic benefit for the population.

Mental health problems cost individuals, their families and the economy an enormous amount. There is a growing body of evidence that some approaches to addressing mental health issues can produce better outcomes while achieving significant reductions in costs. This is of particular relevance at a time of economic constraint. Although the NHS is as a whole was protected from cuts in the government spending Review, rising demand means that the NHS has to find up to £20 billion in efficiency savings by 2014. As nearly 11% of England's annual secondary care health budget is allocated to mental health care, the mental health sector cannot be exempt from having to make savings. There are many interdependencies between physical and mental health, so any efficiencies in mental health services need to be carefully thought through so that false economies and greater costs elsewhere in the health and social care system are avoided.

This document provides an overview of the national policies that have influenced the Mental Health and Wellbeing Strategy, and gives in more detail the local context through a range of resources and information as well as key statistical information to demonstrate the work that has taken place within Halton by all partners. It is intended to provide the evidence base that supports Halton's Mental Health and Wellbeing Strategy 2013-2018 which describes the strategic approach to tackle mental health and wellbeing within the Borough of Halton. The findings of the evidence paper will also enable partners, stakeholders and the wider community to understand the impact that mental ill health has within the Borough.

This document is intended to provide evidence to support the strategy, and uses the same definitions and priorities. It is for people of all ages – children and young people and older people, as well as working age adults. It underlines the importance of providing equal access to age appropriate services for everyone. It applies to the full range of services, from public mental health promotion through to suicide prevention, forensic mental health services, services for people with personality disorders, severe and enduring mental illness, people with learning disabilities and people detained under the Mental Health Act or subject to the Mental Capacity Act. The strategy and associated action plan compliments other work programmes, including the local Dementia Strategy, the new Suicide Prevention Strategy and Child & Adolescent Mental Health (CAMHS) Strategies which are currently in development, and should be read in conjunction with these pieces of work. In demonstrating the importance of mental health outcomes, it is the intention of this document to explicitly recognise the importance of putting mental health on a par with physical health.

For further information on this paper and the Mental Health and Wellbeing Strategy 2013 -18 please contact Liz Gladwyn, Halton Borough Council, on 0151 511 8120 or email liz.gladwyn@halton.gov.uk

Part One – What are mental health and mental wellbeing?

- **Mental health problems may be more or less common, may be acute or longer lasting and may vary in severity and may manifest themselves in different ways at different ages.**
- **At least one in four people will experience a mental health problem at some point in their life and one in six adults will have a mental health problem at any one time.**
- **One in 10 new mothers experience postnatal depression.**
- **One in 10 children aged between five and 16 years of age has a mental health problem, and many continue to have mental health problems into adulthood.**
- **Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters before their mid-20s.**
- **Self-harming in young people is not uncommon – an estimated one in ten 15 to 16-year olds has self-harmed.**
- **Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood**
- **Young people in prison are 18 times more likely to take their own lives than others of the same age**
- **About one in 100 people has a severe mental health problem.**
- **The cost to the economy of mental health problems is over £100bn.**
- **Nearly nine out of 10 people who experience mental health problems say they face stigma and discrimination as a result.**

Mental health is central to our quality of life, central to our economic success and interdependent with our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse, to drug use and crime.

Mental health encompasses mental wellbeing, good mental functioning and the absence of problems in relation to thinking, feelings or behaviour. The World Health Organization (WHO) defines mental health as:

"a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Mental illness encompasses a broad range of mental health problems ranging from common mental disorders (CMDs) such as anxiety and depression to severe forms such as psychosis. Results from the 2007 Adult Psychiatric Morbidity in England Survey showed that at least 1 in 4 people will experience a mental health problem, while 1 in 6 (17.6%) were diagnosed with a common mental disorder.

The two continua model of mental illness and mental health holds that both are related, but distinct dimensions: one continuum indicates the presence or absence of mental health, the other the presence or absence of mental illness. Therefore the presence of a mental illness does not imply poor mental health: a person with a mental illness may experience high levels of mental health while a person with poor mental health may not suffer from a mental illness[1]. This continuum is best represented diagrammatically – page 8.

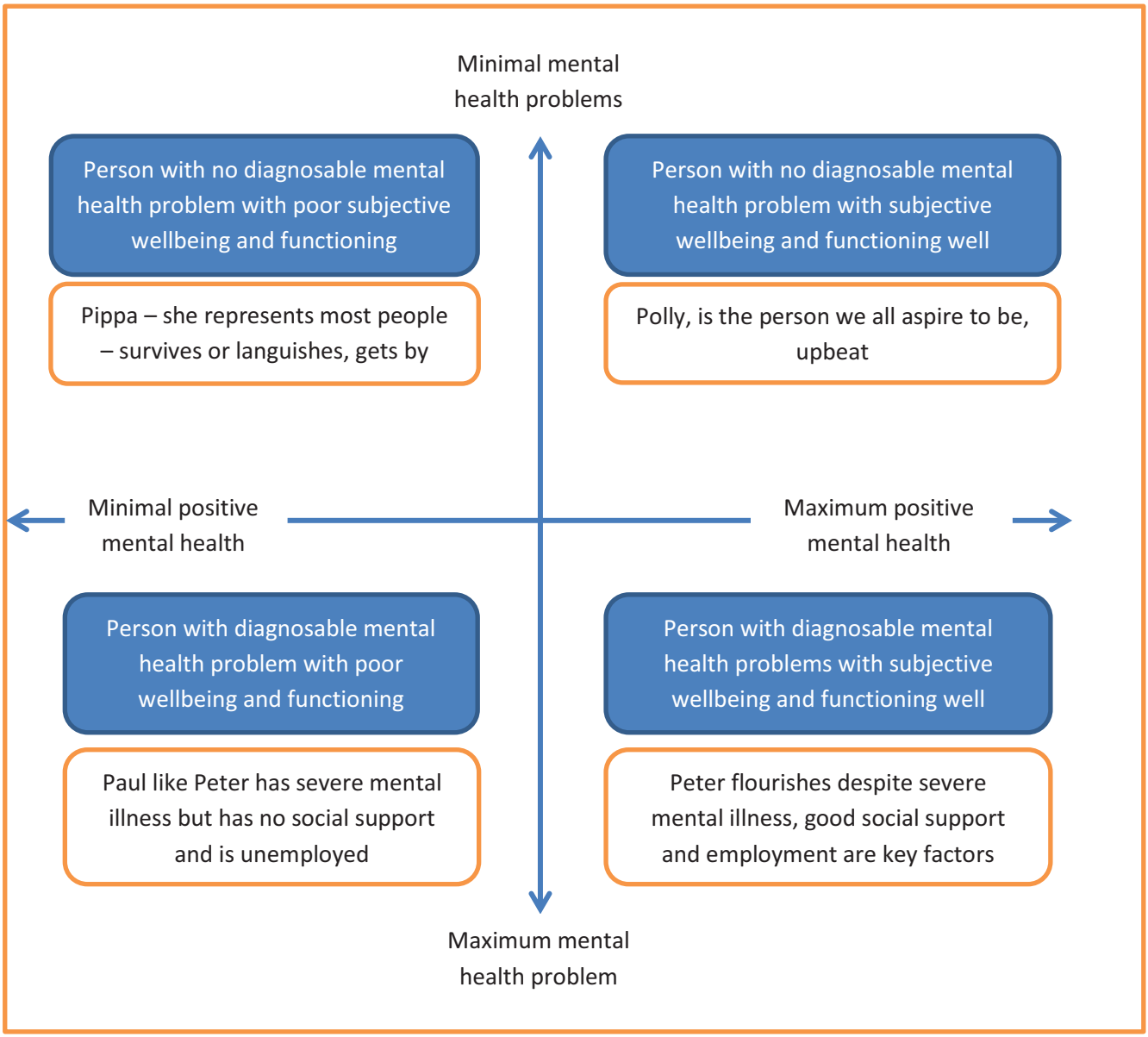
Mental illness is common and is associated with significant individual, social and economic costs. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes. This means that in 2012 across Cheshire and Merseyside around a quarter of a million adults suffered from a common mental disorder and just fewer than 6,000 people had a psychotic disorder. Among people under 65, nearly half of all ill health is due to mental illness. Mental illness represents the single largest cost to the NHS.

Only a sustained approach across the life course will equip Halton to meet the social, economic and environmental challenges it faces and deliver the short- and long-term benefits needed.

[1] Keyes, C.L.M. (2002) The mental health continuum: from languishing to flourishing in life. J Health Soc Res 43:207---22: http://tinyurl.com/8ox38p5

The Mental Health 2 Continua

(Adapted from The Mental Health Continuum: From Languishing to Flourishing in Life, Corey L. M. Keyes 2002)



The concept of well-being comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life. Equally important for well-being is our functioning in the world.

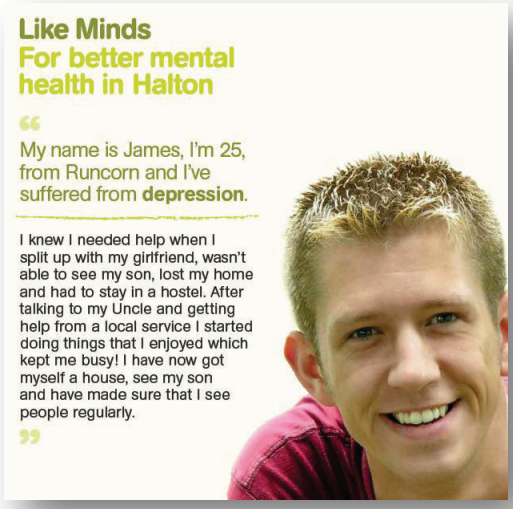
Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.[2]

There are five simple and practical steps that can be taken to improve wellbeing, called the 'five ways to wellbeing' they are:

- **Connect – connect with the people around you**
- **Be active – physical activity is good for the mind and the body**
- **Take notice – become aware of the world around you**
- **Keep learning – learn new skills and set yourself challenges**
- **Give – be a good citizen and help others**

In contrast to the negative focus of mental illness, mental health and wellbeing focus on positive aspects of a person's attitude and situation that can promote human flourishing (i.e. being happy, healthy and prosperous). Mental wellbeing is not the absence of negative emotions (e.g. disappointment, failure, grief) but the ability to manage these emotions.

The Local Authority, Health and Wellbeing Board, Clinical Commissioning Group, providers of health and social care, education, employment and housing are ideally placed to take a strategic role and support effective partnership working to promote positive mental health and wellbeing and to reduce the burden of mental illness within Halton.



[2] www.fivewaystowellbeing.org

Part Two – No Health without Mental Health - The National Policy Context

In 2010 the Health and Social Care Act brought about a major reorganisation of the National Health Service, so that from April 2013, upper tier local authorities assumed lead responsibility for improving public health, coordinating local efforts to protect the public's health and wellbeing, for ensuring health services effectively promote population health and for addressing health inequalities. At a local level these issues are overseen by Health and Wellbeing Boards (HWBBs), whilst the national lead comes from Public Health England. Directors of Public Health, employed by local authorities and members of Health and Wellbeing Boards, are responsible for delivering public health outcomes, of which mental health and wellbeing is one.

Clinical Commissioning Groups (CCGs) are the body responsible for the design and commissioning of local health services such as acute hospital services and mental health services. CCGs are comprised of local GPs and in addition to being statutory members of HWBBs, are required by law to consult with HWBBs over their plans. Mental health is now near the top of the national policy agenda. This section sets out the key national policies which are shaping priorities and activity within this area.

The Mental Capacity Act (MCA) came into force on 1 October 2007 and created a framework to provide protection for people who cannot make decisions for themselves. The Act contains provision for assessing whether people have the mental capacity to make decisions, and procedures for making decisions on behalf of those people who lack mental capacity, as well as measures to ensure that vulnerable people are safeguarded. It applies to anyone whose mental capacity to make decisions is affected by what the MCA refers to as "an impairment of, or a disturbance in the functioning of, the mind or brain" which may be long or short term. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. The MCA is supported by a Code of Practice and has been further enhanced through the Mental Health Act 2007 to include the duty of access to Independent Mental Health Advocates and Deprivation of Liberty Standards. (DOLS) In 2010 the Marmot Review of Health Inequalities "Fair Society, Healthy Lives" proposed a new way to reduce health inequalities by action across all the social determinants of health including education, employment, housing transport and community. It stated that this could be achieved through two overarching policy goals:

1. **Create an enabling society maximising individual and community potential**
2. **Ensure social justice, health and sustainability is at the heart of all policies.**

Local Authorities have a key role in shaping the wider determinants of good health and supporting individuals, carers and communities. The public health white paper *Healthy lives, healthy people*[3] provided a comprehensive definition of public health, as aiming to improve public mental health and well-being alongside of physical health.

No health without mental health[4] is a cross-government mental health strategy that sets out the ambition to mainstream mental health, and establish parity of esteem between services for people with a mental and physical illness. The strategy is underpinned by two aims - Firstly, to improve the mental health and wellbeing of the population and to keep people well; Secondly, to improve outcomes for people with a mental illness through high quality services which are equally accessible to all.

In order to achieve these aims the strategy sets six overarching objectives:

--- More people will have good mental health
--- More people with mental health problems will recover
--- More people with mental health problems will have good physical health
--- More people will have a positive experience of care and support
--- Fewer people will suffer avoidable harm
--- Fewer people will experience stigma and discrimination

Alongside *No health without mental health* the government also published supporting documents; No health without mental health: Delivering better mental health outcomes for people of all ages[5] which explains in detail each objective and outlines effective interventions; and the No health without mental health: implementation framework[6] which aims to ensure that the commitment to parity of esteem between physical and mental health becomes a reality at a local level. The framework sets out what a range of organisations (including local public health teams, Public Health England, clinical commissioning groups, mental health providers, local authorities, and health and wellbeing boards) can do to implement the No health without mental health strategy**.**

[3] Department of Health (2010) Healthy Lives, healthy people. Available from: https://www.gov.uk/government/publications/healthy---lives---healthy---people---our---strategy---for---public---health---in---england

[4] Department of Health (2011) No health without mental health A Cross---Government Mental Health Outcomes Strategy for People of All Ages. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

[5] Department of Health (2011) No health without mental health: Delivering better mental health outcomes for people of all ages. Available from: https://www.gov.uk/government/publications/delivering---better---mental---health---outcomes---for---people---of---all---ages

[6] Department of Health (2012) No health without mental health: implementation framework. Available from: https://www.gov.uk/government/publications/national---framework---to---improve---mental---health---and---wellbeing

At a time of financial and demographic pressure, improving quality while increasing productivity and effectiveness is vital for any improvements in care. The national strategy advocates local areas to consider the importance of mental health services and the resources that are allocated to provide them. It suggests that each local area should focus upon three work streams when considering the development of local strategies:

- **The acute care pathway** – avoiding hospital admissions through effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided (for example, by action to tackle delayed discharges)
- **out of area care** – getting better quality and better value through ensuring that appropriate in-area care is available where this is a better solution and commissioning effectively so that care is managed well, in terms of both care pathways and unit costs;
- and **physical and mental health co-morbidity** – getting better diagnosis and treatment of mental health problems for those with long-term physical conditions, and getting identification and treatment of anxiety or depression for those with medically unexplained symptoms.

The recent vision for adult social care also emphasised that the delivery of adult social care must be accompanied by re-design of services to deliver efficiencies. This could include:

- better joint working with the NHS;
- helping people to stay independent for longer, with a focus on re-ablement services, and more crisis or rapid response services;
- more streamlined assessment;
- reduce spend on residential care and increase community-based provision.

In addition, a new cross-government strategy *Preventing suicide in England*[7] highlights that local responsibility for coordinating and implementing work on suicide prevention has become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement. This focus on suicide prevention is reflected within the Public Health Outcomes Framework which includes the suicide rate as an indicator and aims to reduce suicide rates in the general population in England and better support for those bereaved or affected by suicide.

The Welfare Reform Act 2012 and resilience to the economic downturn

The Welfare Reform Act received Royal Assent on 8th March 2012. The Act has been described as the biggest shake up of the benefits system in 60 years. It aims to simplify the system and create the right incentives to get people into work by ensuring that no individual is better off by not working. Key features of the Act that will have the most significant impact on Halton's residents are:

[7] Department of Health (2012). Preventing suicide in England: A cross---government outcomes strategy

- Introduction of Universal Credit. The level of Universal Credit is to be capped at £26,000. While it is estimated that only a small number of Halton residents will see their income reduce as a result of the cap, some will be significantly affected. In addition, Housing Benefit is to be included in Universal Credit and will consequently be paid directly to tenants of social housing.
- Replacement of Disability Living Allowance with a Personal Independent Payment (PIP) for those of working age. Halton, which has been selected as a pilot area for the scheme, has a disproportionate amount of disabled residents and the change to PIP will involve a reduction in the numbers of those receiving financial assistance.
- Changes to Housing Benefit including the introduction of an under occupancy penalty for households whose homes are deemed to be too large for their needs. Described as the "Bedroom Tax", this change will have a very significant impact in Halton residents.

It is too early to assess the impact of other reforms such as the ongoing reassessment of Incapacity Benefit claimants against the stricter criteria of the Employment Support Allowance, changes to Community Care Grants and Crisis Loans and recent reforms to Council Tax benefit which will include a 10% cut in scheme funding and "localised" benefit schemes.

Studies[8] show coping with the impact of the current recession and rising costs of living creates a stressful burden by having to economise on food, heating and travel. Such effects occur disproportionately among people with disabilities, ethnic minorities, the poor, some women and single mothers (and their children), young unemployed and older people.

Cuts in public spending are affecting services that promote long-term health and wellbeing (such as: adult social care, libraries, community centres) and their reduction or closure could threaten the health of the vulnerable and the elderly. There is also substantial evidence that poverty is both a determinant and a consequence of mental health problems.

It is estimated that 50-60% of disabled people live in poverty and are particularly vulnerable to cuts in public sector services and any changes in levels of entitlement or support can have life changing implications. People suffering from financial strain are particularly at risk of mental health problems.

These impacts are long term and will continue beyond entering financial recovery. The report suggests consideration should be given to:

[8] Assessing the impact of the economic downturn on health and wellbeing - Liverpool Public Health Observatoryhttp://www.liv.ac.uk/PublicHealth/obs/publications/report/88_Assessing_the_Impact_of_the_Economic_Downturn_on_Health_and_Wellbeing_final.pdf

- Health and social care professionals being trained to recognise debt triggers and sources of help for money problems
- Base debt/welfare benefit advisors in GP surgeries and hospital clinics
- Review access to welfare benefit/debt advice services and Credit Union.
- Continue programs of integration of care, health and potentially housing and leisure to minimise back office costs, maintain front line services and improve outcomes through seamless and jointly commissioned support.
- Develop a strategy of progression – 'Just Enough Support' so there is less reliance on formal services and more community based support (Prevention and Early Intervention Strategy)

A Vision for Social Care: Capable Communities and Active Citizens DH 2010 / Caring for our future: reforming care and support - White Paper 2012

This document sets out the overarching principles for adult social care and gives context for future reform. It sets the vision of services being more personalised, more preventative and more focussed on delivering best outcomes for those who use them. It also reaffirms the Government's commitment to devolving power from central government to communities and individuals.

Capable Communities aims to deliver the transformation of adult social care. This strategy is one element of a much wider programme designed to introduce a new system of care and support that gives communities, and the voluntary sector, a bigger role in maintaining the independence of vulnerable people. This system links strongly into and is supported by policies relating to the Big Society.

Capable Communities promotes independence, choice, well-being and dignity to enable people to live their lives as they wish. Commissioners are challenged to ensure there is personalised support for people with multiple and complex needs, for people to maintain their independence and for people with emerging needs. In doing so commissioners must recognise the impact of services outside social care such as advocacy, housing, education and leisure.

Part Three – Mental Health and Wellbeing in Halton

Halton's Vision

"Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and a safer, stronger and more attractive neighbourhood." (Sustainable Community Strategy 2011-2026)[9]

Halton Core Strategy Local Plan

The Core Strategy[10] provides the overarching strategy for the future development of the Borough, setting out why change is needed; what the scale of change is; and where, when and how it will be delivered. It does this through identifying the current issues and opportunities in the Borough, how we want to achieve change and stating the future vision for Halton to 2028. To deliver this vision the Core Strategy sets out a spatial strategy stating the extent of change needed and the core policies for delivering this future change.

The Core Strategy will help to shape the future of Halton, including its natural and built environments, its communities and ultimately peoples' quality of life. The Core Strategy therefore joins up a range of different issues such as housing, employment, retail, transport and health. This is known as 'spatial planning'.

[9] (http://www3.halton.gov.uk/lgnl/pages/86821/86827/174277/Sustainable_Comunity_Strategy_2011__final_Nov_11_.pdf)

[10] http://www3.halton.gov.uk/lgnl/policyandresources/policyplanningtransportation/289056/289063/314552/1c)_Final_Core_Strategy_18.04.13.pdf

Halton Priorities

Halton's Strategic Partnership has set out five strategic priorities for the Borough, in its Sustainable Community Strategy 2011-2026, which will help to build a better future for Halton:

- A Healthy Halton
- Employment learning and skills in Halton
- A Safer Halton
- Children and Young people in Halton
- Environment and Regeneration in Halton

Corporate Plan

The Corporate Plan[11] presents the councils response to how it will implement the Community Strategy. This is achieved through a framework consisting of a hierarchy of Directorate, Division and Team Service Plans known as 'the Golden Thread' this ensure that all strategic priorities are cascaded down through the organisation through outcome focused targets. The Five strategic priorities discussed above are mirrored in the makeup of the Councils Policy and Performance Boards which together with the Executive Board provide political leadership of the Council.

Health and Wellbeing Board and Strategy

From a Halton perspective, the local Health and Wellbeing Board has developed a vision that aims "To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives".

The Board has developed a strategy which has been informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, and has identified five key priorities for action.

- Prevention and early detection of cancer
- Improved child development
- Reduction in the number of falls in adults
- Reduction in the harm from alcohol
- Prevention and early detection of mental health conditions

The Joint Health and Wellbeing Strategy set the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. It does

[18] http://councillors.halton.gov.uk/documents/s14868/ExecB%2022Sept11%20DftCorpPlanAppend.doc.pdf

not replace existing strategies, commissioning plans and programmes, but influences them. For example, NHS Halton Clinical Commissioning Group (CCG) has adopted the Strategy as a key document that will shape their commissioning plans and the Local Children's Trust has responded to the priorities identified in the formulation of its Children and Young Peoples strategic plan. Within Halton there is an increasing shift to improving the prevention and early intervention services in the Borough, including public health improvement/promotion services. There is evidence from the evaluation of the Partnerships for Older People (POPP) programme that the funding of more prevention and early intervention services has a positive impact on acute services. The development of preventative services with higher emphasis on mental health and wellbeing will continue to shift the focus from being reactive to proactive reducing the demand for more acute interventions.

A set of Action Plans have been developed to meet the key priorities with ultimate responsibility for the monitoring of the implementation of the Strategy and Action Plans against set outcomes and key performance indicators with the Health and Wellbeing Board who are accountable to the public.

There is also a Mental Health Strategic Commissioning Board established with a remit to develop and oversee the implementation of a Mental Health and Wellbeing Strategy and action plan. This plan has been based on national best practice as outlined in Section 1 including The National Mental Health Strategy 2011 "No Health without Mental Health".

This strategy takes a life course approach and prioritises action to increase prevention, early detection and treatment of mental health problems at all ages, as well as robust and comprehensive services for people with severe and enduring mental health problems.

Underpinning this strategy is a philosophy of personalisation which maximises independence and control by encouraging an individual to take responsibility for their own support on the road to recovery. The strategy also recognises that good mental wellbeing brings much wider social and economic benefit for the population.

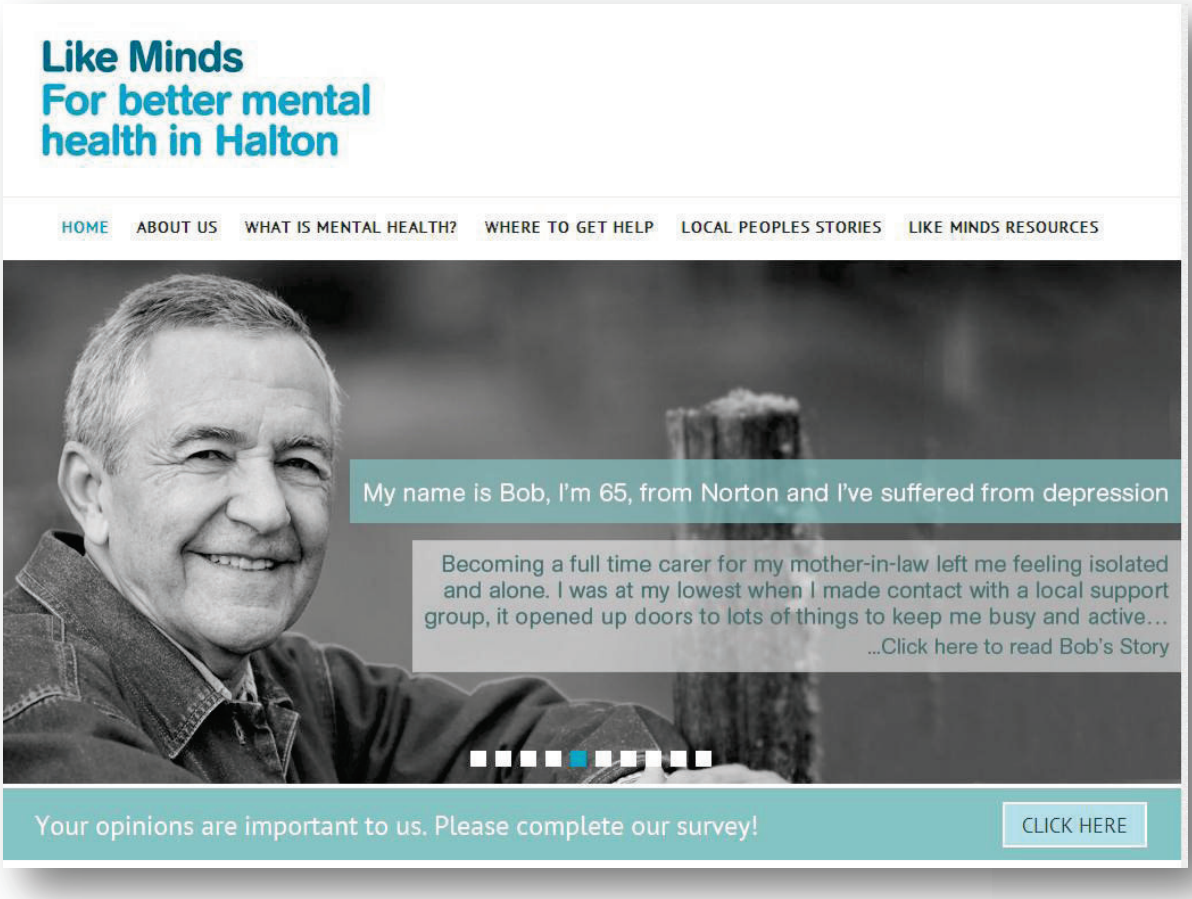
Integrated working

As national reforms continue to take shape, work has already taken place locally to look more strategically at improving models for integrated working and this vision has been captured within the **Framework for Integrated Commissioning in Halton (2012).** The Framework outlines the current strategic landscape of commissioning across Halton and explores national good practice translating this into an action plan.

In support of the implementation of the Framework, work is currently progressing in respect of the development of a Section 75 Partnership Agreement between Halton CCG and HBC which will provide robust arrangements within which Partners will be able to facilitate maximum levels of integration in respect of the commissioning of Health and Social Care services in order to address the causes of ill health as well as the consequences. Part of this Agreement will focus on the commissioning of Mental Health services.

Halton has identified further integration to support its the strategic approach with all partners working together to deliver:

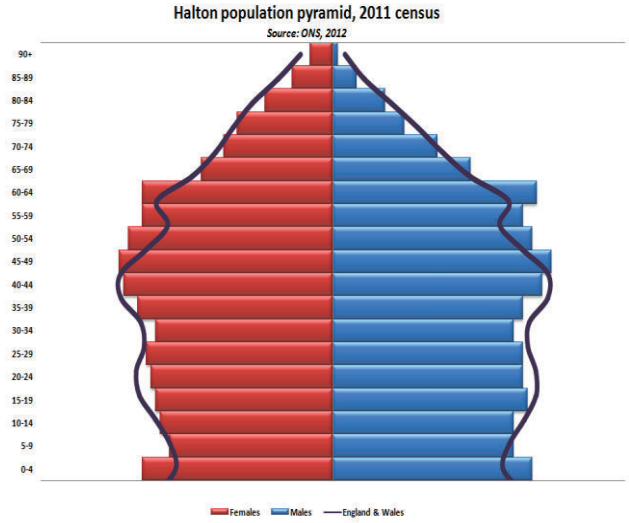
- joint commissioning
- culture change through community development
- training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work

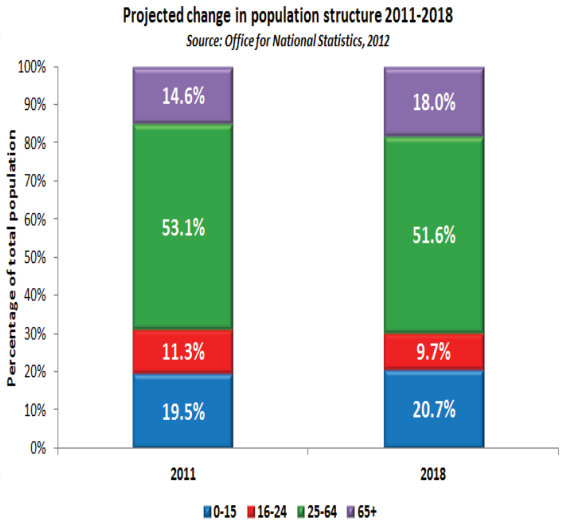


Halton's Demographic Information

Population

Halton is a largely urban area of 125,700 (2011 Census) people. Its two biggest settlements are Widnes and Runcorn. The population is predominantly white (98.6%) with relatively little variation between wards.





Halton's population structure is slightly 'younger' than that seen across England as a whole. However, in line with the national trend, the proportion of the population in the working age bands i.e. 16-24 years and 25-64 years is projected to fall with the younger age band i.e. 0-15 years, projected to rise slightly. The most significant shift is the proportion of the population in the older age band.

Deprivation

Deprivation is a major determinant of health. Lower income levels often lead to poor levels of nutrition, poor housing conditions, and inequitable access to healthcare and other services. Deprivation, measured using the English index of Multiple Deprivation (IMD) 2010, ranks Halton as ranked 27th most deprived out of 326 local authorities (a ranking of 1 indicates the area is the most deprived).

The 2010 IMD shows that deprivation in Halton is widespread with 60,336 people (48% of the population) in Halton living in 'Lower Super Output Areas' (LSOA's) that are ranked within the most deprived 20% of areas in England.

In terms of Health and Disability, the IMD identifies 53 SOA's (Super Output Areas) that fall within the top 20% most health deprived nationally and that approximately 40,000 people in Halton (33% of the

population) live in the top 4% most health deprived areas in England. At ward level, Windmill Hill is the most deprived area in terms of health. However, health deprivation is highest in a LSOA within Halton Castle, ranked 32nd most deprived nationally.

Health is also a key determinant of achieving a good quality of life and the first priority of Halton's Sustainable Community Strategy. This states that 'statistics show that health standards in Halton are amongst the worst in the country and single it out as the aspect of life in the Borough in most urgent need of improvement'.

In Halton, one in four people attending GP surgeries seek advice on mental health, and the number of people suffering from depression is 11,924 (11.94% of the GP population who are aged 18+). Whilst the prevalence of mental health problems is comparable with regional and national rates, deaths from suicides and undetermined injuries have reduced but remain higher than national averages (Rate 8.2 per 100,000 population during 2008-10 compared to England (7.2), and the North West (9.07)) and the rate of hospital admissions due to self- harm for under 18s is high.

Halton has also seen an estimated prevalence of 1,082 people aged 65+ with dementia compared to 634 people identified on GP registers in 2010-11.

More than 1 in 5 of Halton's population live with a limiting long term condition (20011 Census). Those living with long term physical conditions are the most frequent users or health and care services and commonly experience mental health problems such as depression and anxiety and in older people dementia.

The Halton Joint Strategic Needs Assessment and the North East Public Health Observatory Community Mental Health Profile and The Mental State of the North West (AQuA Observatory Dec 2012) contain more detailed analysis of local need.[12]

The headline messages conveyed from these analyses are:

- Halton experiences significantly higher rates of adults (18+) with depression than England or the North West region
- There will be a 60% increase in numbers of older people (age 65+) suffering with depression and 65% increase in those with severe depression
- Research has shown that mental illness and harmful/dependent alcohol consumption are very closely linked and over a quarter of all alcohol-related admissions are those conditions caused

[12] Halton Community Mental health Profiles 2013 can be found at: http://www.nepho.org.uk/cmhp

by mental and behavioural disorders due to alcohol (dual diagnosis). Halton's admission rate is significantly higher than both England and North West averages.

Employment for people with mental illness is important in promoting recovery and social inclusion and can have a positive effect on mental health, although benefits depend on the nature and quality of work. However having a mental illness is associated with an increased risk of unemployment; having a common mental disorder is associated with a three-fold increased risk of unemployment while only one in five specialist mental health service users are either in paid work or full-time education[13].

The economic cost of mental illness to the English economy was estimated at £105 billion in 2010. Mental illness is the largest area of NHS spending; spending on mental health services accounts for £11.9 billion (11 per cent) of the NHS secondary health care budget, more than spending on either cardiovascular disease or cancer services[14].

As well as being common mental illness also leads to a reduced quality of life. Mental illness is the single largest source of burden of disease in the UK. In 2004, 22.8% of the total burden of disease in the UK was attributable to mental illness, this compares to 16.2% for cardiovascular disease and 15.9% for cancer, as measured by disability adjusted life years (DALYs)[15].

Unlike other health problems such as cardiovascular disease or many cancers mental illness begins early in life and persists over the life course. Half of those suffering from a lifetime mental illness first experience symptoms by age fourteen and three quarters by before their mid-twenties[16].

Morbidity due to mental illness peaks at age 15 to 29 and remains higher than or equal to morbidity due to physical illness until age 45 to 59. This means that among people under 65, nearly half of all ill health is due to mental illness.

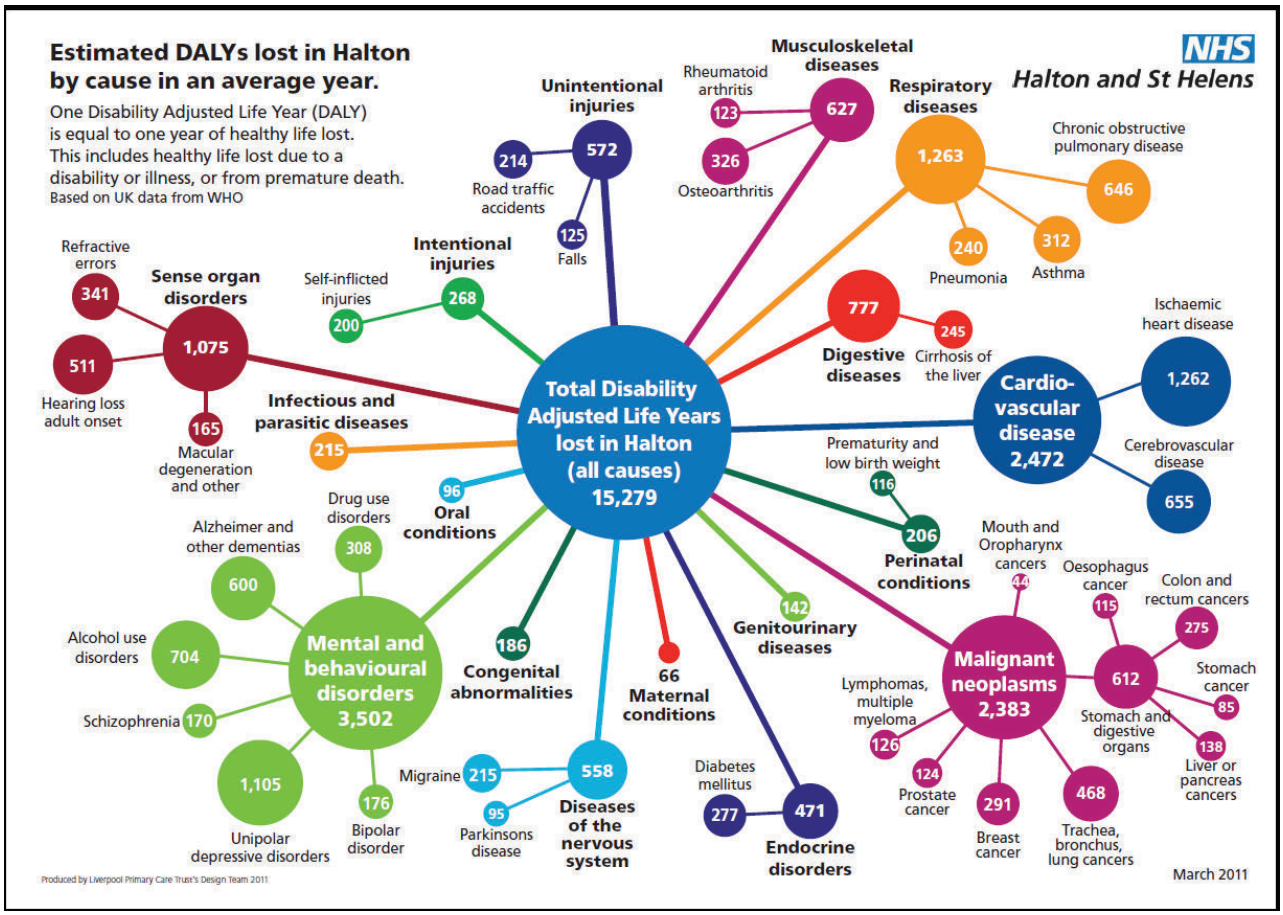
[13] Royal college of psychiatrists (2010) No health without public mental health http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

[14] Department of Health (2011) National expenditure data 2003---04 to 2010---11. Available from: https://www.gov.uk/government/publications/2003---04---to---2010---11---programme---budgeting---data

[15] A disability adjusted life year (DALY) is a time---based measure that combines years of life lost due to premature Mortality and years of life lost due to time lived in states of less than full health. Further information on the Global burden of disease study is available from: http://www.who.int/healthinfo/global_burden_disease/en/index.html

[16] Kim---Cohen J, Capsi T, Moffitt E et al (2003). Prior juvenile diagnosis in adults with a mental disorder: Developmental follow---back of a prospective---longitudinal cohort. Archives in General Psychiatry 60: 709---717. Available from: http://archpsyc.jamanetwork.com/article.aspx?articleid=207619

Fig – Estimated DALYs lost in Halton by cause in an average year



The prevalence of mental illness

Mental illness is common. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes.

The Quality Outcome Framework (QOF) depression register for Halton in 2011/12 is 12,471 persons aged 18+ (prevalence 12.4%) whilst the QOF mental health register for people with schizophrenia, bipolar disorder and other psychoses for 2011/12 shows 959 people, 0.7% prevalence. Psychoses are defined as disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder.

Recent research has shown that having a mental health problem increases the chances of a person's developing substance misuse problems, independently of adverse childhood impacts[17].

Research by Green et al[18] showed that 7.7% of 5-10 year olds and 11.4% of 11-16 year olds were likely to have experienced a mental health disorder. As well as age differences, there were gender differences, with prevalence being greater amongst boys (11.4%) than girls (7.8%). Applying prevalence rates for the different mental health disorders to the 2013 population estimates for Halton residents aged 5 to 19, the numbers likely to have mental health disorders and been estimated. Numbers for all types and each type do not add us as some children will have more than one disorder.

Estimated number of children with mental health disorders, by age group and gender, 2013

			Mental Health Disorder		Conduct Disorder		Emotional Disorder		Hyperkinetic Disorder		Less Common Disorders		Totals
Gender	Age group	Population	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	
females	5 to 10	4,586	5.1%	234	2.8%	129	2.5%	115	0.4%	18	0.4%	18	514
	11 to 16	4,485	10.3%	462	5.1%	229	6.1%	274	0.4%	18	1.1%	49	1032
	17 to 19	2,170	10.3%	224	5.1%	111	6.1%	132	0.4%	7	1.1%	24	498
males	5 to 10	4,784	10.2%	488	6.9%	330	2.2%	105	2.7%	129	2.2%	105	1117
	11 to 16	4,476	12.6%	564	8.1%	363	4.0%	179	2.4%	107	1.6%	72	1285
	17 to 19	2,387	12.6%	301	8.1%	193	4.0%	96	2.4%	57	1.6%	38	685
persons	5 to 10	9,370	7.7%	722	4.9%	459	2.4%	225	1.6%	150	1.3%	122	1556
	11 to 16	8,961	11.5%	1031	6.6%	591	5.0%	448	1.4%	125	1.4%	125	2320
	17 to 19	4,557	11.5%	524	6.6%	301	5.0%	228	1.4%	64	1.4%	64	1181
total all ages		22,888		2277		1351		901		339		311	5179

Source: Green 2005 & ONS 2012

The numbers for 17-19 year olds may be underestimates as mental health problems are more prevalent in 18 year olds than 15 year olds as studies in New Zealand[19] and the USA[20] have shown. Other studies confirm the finding that the late teens and early twenties are periods of especially high risk of mental disorder– possibly the highest of any stage in the life course[21]. Young people over the

[17] Harrington M,Robinson J, Bolton SL, *et al.*A longitudinal study of risk factors for incident drug use in adults: findings from a representative sample of the US population. *Can J Psychiatry* 2011;**56**:686–95.

[18] Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) *Mental health of children and young people in Great Britain*, Office for National Statistics

[19] Fergusson D M and Horwood J (2001) The Christchurch Health and development Study: Review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry* **35,**287-296

[20] Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, &Swendsen J (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49* (10), 980-9

[21] Newman D L, Moffit T E, Caspi A, Magdol L, Silva PA and Stanton WR (1996) Psychiatric disorder in a birth cohort of young adults: Prevalence, co-morbidity, clinical significance and new case incidence from ages 11-21. *Journal of Consulting and Clinical Psychology.**64*** 552-562

age of 16 were included in the Adult Psychiatric Morbidity Survey in England 2007[22]. The mental disorders classified in the adult's survey are different to children's disorders. The adult mental disorders are:

- Depressive episodes
- Obsessive compulsive disorders
- Psychotic disorders

The Adult Psychiatric Morbidity Survey (APMS) was a point prevalence survey of UK residents aged between 16 and 75 years old. Prevalence estimates for young people aged 16 to 24 are presented in Table 3 and applied to the estimated Halton population of 16-19 year olds at 2013 and projected population for 2021 (the population aged 16-19 is projected to fall from 6090 in 2013 to 5455). These estimates assume no change in prevalence over this time.

Estimated number of children aged 16-19 with neurotic disorders

	Men			Women			Persons		
		Estimated Numbers			Estimated Numbers			Estimated Numbers	
	%	2013	2021	%	2013	2021	%	2013	2021
mixed anxiety and depressive disorder	8.2%	257	221	12.3%	364	340	10.2%	621	556
Generalised anxiety disorder	1.9%	60	51	5.3%	157	146	3.6%	219	196
Depressive episode	1.5%	47	40	2.9%	86	80	2.2%	134	120
All phobias	0.3%	9	8	2.7%	80	75	1.5%	91	82
Obsessive compulsive disorder	1.6%	50	43	3.0%	89	83	2.3%	140	126
Panic disorder	1.4%	44	38	0.8%	24	22	1.1%	67	60
Any Common Mental Health Disorder	13.0%	407	350	22.2%	656	613	17.5%	1066	955

Source: McManus et al 2009 and ONS 2012

Children's emotional and mental health and wellbeing

9.6% of all children and young people aged 16 and under will have some form of mental disorder (ONS 2005). This equates to 2500 Halton children aged 0-15 with a diagnosable emotional and mental health condition. There is wide spread evidence suggesting that vulnerable groups are more at risk of developing mental health problems:

Children with disabilities

Research suggests that almost 1 in 4 children with a disability have an emotional disorder. In Halton there are more SEN children as a proportion of all children than the national average.

[22] McManus S., Meltzer H., Brugha T., Bebbington P. & Jenkins R. (2009) *Adult psychiatric morbidity in England, 2007: Results of a household survey* The Health & Social Care Information Centre

Young people who smoke and drink

Of 11-15 year-olds who smoke regularly, 41% have a mental disorder, as well as 24% of those who drink alcohol at least once a week, and 49% of those who use cannabis at least once a month (MHF, 2007). In Merseyside, levels of those under 18s admitted to hospital with alcohol specific conditions are more than twice as high as the national rate of 55.8 per 100,000. Local Alcohol Profiles for England demonstrate that there has been significant reduction in Under 18's admitted to Hospital with Alcohol Specific Conditions within Halton.

Halton Under 18s admitted to hospital with alcohol specific conditions
Published data from LAPE (Local Alcohol Profiles for England) Persons, crude rate per 100000 population

04/05 to 06/07	05/06 to 07/08	06/07 to 08/09	07/08 to 09/10	08/09 to 10/11	09/10 to 11/12*
161.1	182.6	180.9	153.9	122.9	110.00

* local data

Not in education, employment, or training (NEET)

Being in education, employment and training between the ages of 16-18 increases a young person's resilience (ChiMat, 2012). In 2011 10.3% of Halton young people were 'NEET' and this is significantly higher than the average of 6.2%. The latest information from Halton indicates that at the end of 2012 the NEET figure was 9% of the cohort.

Pregnant teenagers

Although early parenthood can be a positive experience for some young people, low levels of emotional health and wellbeing can often be regarded as both a cause and a consequence of teenage pregnancy. Halton has been able to reduce the numbers of pregnant teenagers locally, although Halton still remains above the regional and national average with the (ONS 2011) confirming that Halton has 40 per 10000 15-17 year old girls conceiving.

Asylum Seekers, Refugees and Immigrants

Mental health problems in some migrant groups are higher than in the general population, for example migrant groups and their children are at two to eight times greater risk of psychosis (DH, 2011a).

Gypsy, Roma and Traveller children

Gypsy, Roma and Traveller children have the worst educational outcomes of any ethnic group in the UK and high rates of school exclusion. Currently in January 2013, there are five gypsy and traveller sites across Halton.

Young carers

There is unfortunately a strong relationship between poor mental health and caring. There are 296 known young carers as of November 2012 within Halton, although it is widely recognised that many young carers are not known to service provision.

There are also risk factors associated with increased prevalence of mental ill health such as single parent households, poverty and lack of educational attainment. These can be countered by development of resilience factors such as improved appropriate relationships and opportunities for improved self-esteem and confidence.

Children with a parent/carer experiencing mental ill health

A thematic inspection by Ofsted and the Care Quality Commission [23] explored how well adult mental health services and drug and alcohol services considered the impact on children (up to age 18) when their parents or carers had mental ill health and/or drug and alcohol problems; and how effectively adult and children's services worked together to ensure that children affected by their parents' or carers' difficulties were supported and safe.

Data is not collected nationally about how many of the adults receiving specialised mental health services are parents or carers, but it is estimated that 30% of adults with mental ill health have dependent children.[24]

Key findings from the inspection highlighted considerable variations in the extent to which adult and children's services worked effectively together to assess concerns and support and challenge parents and carers. Overall, the quality of joint working was much stronger between children's social care and drug and alcohol services than between children's social care and adult mental health services.

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[23] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems (Ofsted 2013)

[24] D Meltzer, *Inequalities in mental health: a systematic review*, The research findings register, Summary No.1063, Department of Health; www.dh.gov.uk/health/category/publications/.

Thinking about the impact of parents' or carers' difficulties on children was more strongly embedded in drug and alcohol services than in adult mental health services. This stronger focus on children by drug and alcohol services has been driven by the requirement for local areas to gather information on the number of adults with children and report on this to the National Treatment Agency for Substance Abuse. Within adult mental health services, while it is expected that the care programme approach considers safeguarding of children, there are no national requirements to gather information and report on the number of parents or carers who have serious mental health difficulties. Therefore, in the absence of any national drivers there is limited scrutiny of this issue within mental health services generally.

The inspectors make a number of recommendations across government and agencies including Local Safeguarding Children's Boards, mental health service providers, commissioners and local authorities.

Self-harm

Self-harm is a public health issue, particularly among children and young people. It is difficult to measure the extent of the issue in the population, but evidence suggests that self-harm affects at least one in 15 young people and is one of the top five causes of acute hospital admission for people of all ages in the UK. Within Cheshire and Merseyside, rates of emergency hospital admissions for self-harm vary substantially with eight out of nine local authorities having rates that are significantly higher than the England average.

Published national statistics show that Halton has a significantly higher rate of emergency hospital admissions resulting from people across all ages self-harming. The rate for age 0-17 shows a substantial reduction in numbers though remains significantly higher than national average.[25]

Halton Rate per 100,000 population

	2009/10		2010/11		2011/12	
	Number	Rate	Number	Rate	Number	Rate
All ages	400	349.9	453	399.8	*	415
Age 0-17	Data not provided		90	329.6	59	208.7

Analysis of referrals to CAHMS Urgent Response Team Data (CURT)[26] from April 2012 to March 2103 provides greater intelligence on the local perspective for children and young people:

[25] Data from Halton Public Health Evidence and Intelligence Team

Total number of referrals to CURT	119
Referrals from hospital	115
Referrals already open to CAMHS	52
Referrals from females	79
Referrals from males	40
Age at referral: Under 13 13-15 16+	 24 52 43

Suicide

Each year, an audit is performed with the aim of learning lessons from local suicides to try to identify ways of preventing future deaths. Each year in the UK, there are approximately 6000 suicides, every single one having a great impact on those involved and representing a large number of years of life lost. This number has not changed dramatically over the years but the age-standardised rate of suicide per 100,000 population has decreased since 1981 (from 14.9 per 100,000 population to 11.8 per 100,000 population in 2011).

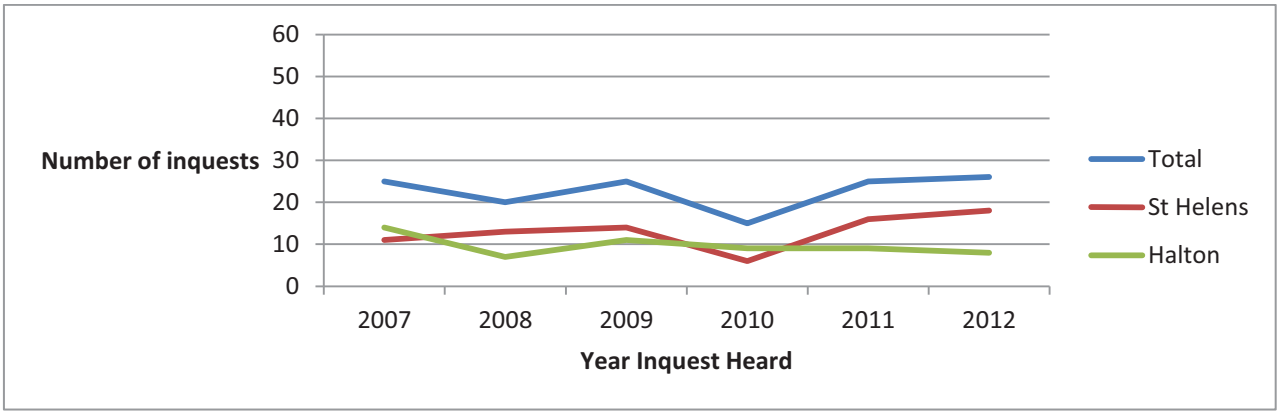
It is known that the circumstances surrounding suicides are complex; however, there are important recurring features. Most people who complete suicide are male (18.2 per 100,000 population vs. 5.6 per 100,000 population), they live alone and often have or have had mental health problems.

In 2012, there were 26 suicide inquests heard for the St Helens and Halton area, 18 for St Helens and 8 for Halton, and 24 were suicide verdicts, and 2 open verdicts (both Halton). The data does not show any significant differences from the national trends.

The graph below shows the number of suicide inquests heard over the past 6 year in St Helens and Halton. This graph does not represent the annual figures of suicides as this audit is completed by date inquest heard, not date of death. Annual suicide rates per local authority can be found on the NHS Indicator Portal website.

[26] Data from 5BP NHS FT CURT Team

Table - Suicide trends over past 6 years in St Helens and Halton[27]



Some key trends in suicides in the St Helens and Halton area are:

1. Men continue to have a higher rate of suicide than women (92% overall, 100% St Helens, 75% in Halton).
2. Hanging at home was the single most common method of suicide (13/26, 50%)
3. The majority of the deceased were living alone at the time of death (54%)
4. The most common marital status at time of death was single (39%)
5. There was evidence of personal problems in the majority of cases (85%), most were relationship problems (50%)
6. Nearly 25% of the deceased had been in contact with mental health services within the 6 months prior to death, with a total of 19 people (73%) having had a diagnosis of mental health problems at some point in their life.
7. Substance misuse was present in nearly a third of cases.

These findings appear to follow national trends and there does not appear to be any specific areas of concerns (i.e. methods of suicide) that are particular to the area with the main groups of concern being middle-aged men, those living alone and single people.

A new 'Suicide Prevention Strategy' is under development and the work of the strategy will compliment further activity to tackle this area of focus to ensure that local teams can deliver effective care utilising local resources for the benefit of those at highest risk of suicide.

Dual diagnosis

Dual diagnosis is the term used to describe people with mental illness and problematic drug and/or alcohol use. Historically the term has been used for those with "severe and enduring mental illnesses" such as psychotic/ mood disorders. More recently there has been an acceptance that personality disorder may also co-exist with psychiatric illness and/or substance misuse. The relationship between both conditions is complex. Concurrent mental health problems and substance misuse increases potential risks to the individual and is associated with; increased likelihood of suicide; more severe mental health problems; increased risk of violence;

[27] Data taken from the NHS Indicator Portal https://indicators.ic.nhs.uk/webview/

increased risk of victimisation; more contact with the criminal justice system; family problems; more likely to slip through services; less likely to adhere to medication or engage with other services; and more likely to lose accommodation and be at risk of homelessness.

With regards to prevalence; about half of patients in drug and alcohol services have a mental health problem, most commonly depression or personality disorder; about a third to a half of those with severe mental health problems will also have substance misuse problems; and alcohol misuse is the most common type of substance misuse and, where drug misuse occurs, it tends also to coexist with alcohol misuse.

In Halton, adult mental health services are delivered by the 5 Boroughs Partnership NHS Foundation Trust and the Council's mental health social care team. Following a recent configuration, the social care team are co-located with the Trust's Recovery Team. A recent audit of individuals in these mental health services identified 51% (n=198) individuals as having previous or current substance misuse.

In 2012, NHS Mersey led on a review of the response to Dual Diagnosis involving substance misuse in Liverpool, St Helens, Knowsley, Sefton and Halton. Two of the aims of the review were to 'highlight opportunities for change which could benefit all areas, and to identify gaps in provision'. The key issues that arose from the review and discussions with key stakeholders were;

- Transitions between services are problematic and are the points at which some individuals drop out of treatment.
- Clarification of the roles and responsibilities of the service and staff working within them in relation to dual diagnosis.
- Creating a network between the medical professionals working in substance misuse, mainstream mental health services and primary care.

- Both substance misuse and mental health services are increasingly 'recovery driven' and subject to 'payment by results', presenting opportunities for shared learning and development between the two sectors.
- Service users and their carers need to be involved at every stage in service improvement and development.

Drug use amongst people with mental health problems

Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms or syndromes. Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction). The most common associations for substance misuse are with depression, anxiety and schizophrenia, post-traumatic stress, attention deficit, hyperactivity and memory disorders also occur[28].

For young people, emotional and behavioural disorders are associated with an increased risk of experimentation, misuse and dependence[29]. Recent research showed that pupils with a wellbeing score less than 10 (considered to be relatively low level of wellbeing) were more likely than pupils whose wellbeing scores were higher to have taken drugs in the last year (odds ratio=1.55)[30].

Research suggests 21.4% of people in contact with community mental health services also have a problem with drugs[31]. Other studies suggest the prevalence of dual diagnosis is between 30% and 50% of psychiatric caseloads, with some mental health conditions being more often associated with substance misuse than others e.g. Schizophrenia, Psychosis, Severe Depression: and Personality Disorder[32]. Indeed, a study using data from the Scottish Drug Misuse Database, April 2001 and March 2002, revealed that over 40% of individuals who sought

[28] Crome I., Chambers P., Frisher M., Bloor R. & Roberts D. (2009) The relationship between dual diagnosis: substance misuse and dealing with mental health issues London: Social Care Institute for Excellence

[29] Green H, McGinnity A, Meltzer H et al (2005). Mental Health of Children and Young People in Great Britain 2004. Office for National Statistics

[30] Fuller E., Henderson H. Nass L., Payne C., Phelps A. & Ryley A. (2013) *Smoking, drinking and drug use among young people in England in 2012* London: Health and Social Care Information Centre

[31] Weaver, T., et al (2003) Co-morbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry,* **183**, 304-313.

[32] Banerjee, J., Clancy, C., Crome, I. (2002). *Co-existing problems of mental disorder and substance misuse (dual diagnosis): an information manual 2002*. London: The Royal College of Psychiatrists Research Unit.

treatment for problem drug use (3,236 out of a total of 10,798 individuals) reported that their mental health was one of the issues which led them to seek treatment[33].

With an estimated 2277 young people under age 16 (Table 3), 1066 young adults aged 16-19 years (Table 4), 12,583 adults aged 18-64 years estimated to have common mental health disorders and 5,606 two or more psychiatric disorders in Halton a significant proportion of these are also likely to have substance misuse issues. Even applying the lowest estimated prevalence rate of 21.4% identified in the research to the number of adults estimated to have common mental health problems and two or more psychiatric disorders would suggest **3,813** people in Halton with mental health problems also use drugs.

People aged 18-64 predicted to have a mental health problem, projected to 2020

	2012	2013	2014	2015	2016	2018	2020
Common Mental Disorder	12,608	12,583	12,499	12,442	12,365	12,269	110.00
Borderline Personality Disorder	353	353	350	349	347	344	341
Antisocial Personality Disorder	270	268	267	265	263	261	256
Psychotic Disorder	313	313	311	309	307	305	303
Two or more Psychiatric Disorder	5,620	5,606	5,570	5,542	5,506	5,463	5,420

Source: PANSI,2013

Mental illness and physical ill health

There is a strong interconnection between a person's mental and physical health. 30% of people with long-term conditions have a mental health problem, whilst 46% of people with mental health problems have a long term condition.[34]

People with a mental illness have higher rates of physical illness and die earlier than the general population, largely from treatable conditions associated with modifiable risk factors such as smoking, obesity, substance abuse, and inadequate medical care. Having depression is associated with a 50% increase in mortality. While in the UK people with schizophrenia die an average of 16 to 20 years earlier than the general population largely due to physical health problems. Smoking is twice as common among people with a mental illness and is a significant cause of morbidity and mortality among those with a mental illness. Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco in England.

[33] Scottish Advisory Committee on Drug Misuse (SACDM) & Scottish Advisory Committee on Alcohol Misuse (SACAM) (2003) *Mind the Gaps: meeting the needs of people with co-occurring substance misuse and mental health problems* Edinburgh: The Scottish Executive

[34] Data source: http://www.champspublichealth.com/sites/default/files/media_library/files/Reducing%20the%20burden%20of%20mental%20illness%20-%20Report@1.pdf

Learning Disabilities and Mental Health

There are estimated to be 1.14m people with learning disability in England[35] and estimates of prevalence of mental health problems vary from 25-40%, depending on the population sampled and the definitions used.

'No health without mental health' notes the increased risk of mental health problems faced by people with learning disabilities and sets two aims for improvement:

- inclusivity of mainstream mental health services for people with learning disabilities who have mental health problems
- development of appropriate skills and provision of adjustments to meet the individual needs of people with learning disabilities and autism.

Prevalence of anxiety and depression in people with learning disabilities is the same as the general population, yet for children and young people with a learning disability, the prevalence rate of a diagnosable psychiatric disorder is 36%, compared with 8% of those who do not have a learning disability. These young people were also 33 times more likely to be on the autistic spectrum and were much more likely than others to have emotional and conduct disorders.

Children and young people with learning disabilities are much more likely than others to live in poverty, to have few friends and to have additional long term health problems and disabilities such as epilepsy and sensory impairments. All these factors are positively associated with mental health problems.

Key highlights of research evidence on the Health of People with Learning [Intellectual] Disabilities[36] offers the following summary relating to mental health:

- People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities
- The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (21.6% vs 5.7% aged 65+)
- People with Down's syndrome are at particularly high risk of developing dementia, with an age of onset 30-40 years younger than the general population
- Prevalence rates for schizophrenia in people with learning disabilities are approximately three times greater than for the general population (3% vs 1%)
- Reported prevalence rates for anxiety and depression amongst people with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population and higher amongst people with Down's syndrome

[35] People with learning disabilities in England 2012 IHAL
[36] http://www.learningdisabilities.org.uk/help-information/Learning-Disability-Statistics-/187699/

- Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49

The Mental Health Foundation have highlighted the following areas to be addressed to improve the mental health of people with learning disabilities

- There is little attention to promoting mental health amongst people with learning disabilities, their families and frontline staff.
- There is insufficient attention to identifying early warning signs of common mental health problems.
- A minority of people with learning disabilities get an annual health check in primary care; of those who do, it is not known how well mental health issues are covered. If people with learning disabilities, their families and staff are not alert to mental health problems, this may affect the detection rate via health checks.
- 'Boundary' problems between secondary mental health and learning disability services persist.

Autistic Spectrum Disorder

People with Autistic Spectrum Disorder (ASD) may experience a range of mental health issues relating to their ASD symptoms or from the social isolation it generates. People with autism or Asperger syndrome are particularly vulnerable to mental health problems such as anxiety and depression, especially in late adolescence and early adult life37. Ghaziuddin et al (1998) found that 65 per cent of their sample of patients with Asperger syndrome presented with symptoms of psychiatric disorder. Whilst the National Autistic Society has evidence that as many as 71% of children with autism have mental health problems, such as anxiety disorders, depression, and obsessive compulsive disorder (OCD), and 40% have two or more[38].

People with ASD may experience higher rates of:

- Low self esteem
- Depression
  Anxiety
- Obsessive Compulsive Disorders
- Attention Deficit Hyperactivity Disorder
- Self-Harm- People with autism will often engage in self-harming behaviours as a response to stress, anxiety or depression.
- Dual Diagnosis - when an intellectual disability is present with a mental health condition such as schizophrenia

[37] Tantam & Prestwood, 1999
[38] You Need to Know Campaign – National Autistic Society

It is very important people with ASD seek appropriate supports when suffering depression, anxiety or other mental health issues. It can be very difficult to distinguish mental health problems in those with severe autism and poor verbal skills as mental health diagnosis often is dependent on the ability of the person to describe their symptoms or on a skilled clinician to be able to observe symptoms and distinguish them from autism related behaviour. This can mean that it is not until the mental illness is well developed that it is recognised, with possible consequences such as total withdrawal; increased obsessional behaviour; refusal to leave the home, go to work or college etc.; and threatened, attempted or actual suicide.

Mental health and Wellbeing in Older People

As life expectancy increases healthy life expectancy also needs to increase. Healthy ageing is a concept promoted by the World Health Organisation that considers the ability of people of all ages to live a healthy, safe and socially inclusive lifestyle. It recognises the factors beyond health and social care that have a major effect on health and well-being, and the contribution that must be made by all sectors with an influence on the determinants of health. It also embraces a life course approach to health that recognises the impact that early life experiences have on the way in which population groups' age[39].

Healthy ageing may be considered as the promotion of healthy living and the prevention and management of illness and disability associated with ageing. There is an appreciation that the locus of responsibility for the prevention and management of many chronic diseases lies with the individual through their behaviour and the recognition that a range of factors – socio-economic, environmental and cultural – influences this behaviour.

This points to one of the key challenges for the preventive approach – it is not just about providing good information and services. Crucially, it is about persuading people of the healthy ageing argument to change their behaviour[40] By adopting a more pro-active approach to ageing through the 'five ways to wellbeing' highlighted earlier (page 9) the onset of loneliness, social isolation or depression can be avoided or delayed and a sense of wellbeing maintained.

In Halton's older population, levels of depression and dementia are significant. However it is recognised that loneliness and social isolation impact on the wellbeing of older people.

[39] http://www.ageuk.org.uk/documents/en-gb/for-professionals/health-and-wellbeing/evidence%20review%20healthy%20ageing.pdf?dtrk=true

[40] The Case for Healthy Ageing: Why it needs to be made, P. Holmes and P. Rossall, Help the Aged, 2008

Loneliness and Social Isolation

Whilst 'social isolation' and 'loneliness' are often used interchangeably, people attach distinct meanings to each concept[41]. 'Loneliness' is reported as being a subjective, negative feeling associated with loss (e.g. loss of a partner or children relocating), while 'social isolation' is described as imposed isolation from normal social networks caused by loss of mobility or deteriorating health. Although the terms might have slightly different meanings, the experience of both is generally negative and the resulting impacts are undesirable at the individual, community and societal levels.

Estimates of prevalence of loneliness tend to concentrate on the older population and they vary widely, with reputable research coming up with figures varying between 6 and 13 per cent of the UK population being described as often or always lonely[42.] There is growing recognition that loneliness is a formidable problem which impacts on an individual's health and quality of life and even on community resilience. There is increasing evidence that people who are lonely are more likely to use health and social care services and a developing confirmation, through personal stories, of the emotional costs and misery that loneliness can cause. Those with less than three close relatives or friends are more likely to experience mental health problems.[43]

Loneliness has a very negative impact on health and this impact has been estimated as equivalent to smoking fifteen cigarettes each day, of greater severity than not exercising and twice as harmful as obesity[44]. The lonelier a person is, the more likely they are to experience increased depressive symptoms. Loneliness has been linked to hypertension and high blood pressure and in developing cardiovascular disease. Lonely individuals have double the risk of contracting Alzheimer's disease while having a dementia increases our chance of feeling lonely. Lonely people also have an increased chance of being admitted to care homes and hospitals.

[41] **http://www.scie.org.uk/publications/briefings/files/briefing39.pdf**

[42] **http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true**

[43] http://s.bsd.net/nefoundation/default/page/-/files/Five_Ways_to_Wellbeing.pdf

[44] Holt-Lundstad 2010

National statistics about loneliness:

- **6 - 13% of older people say they feel very or always lonely**
- **6% of older people leave their house once a week or less**
- **17% of older people are in contact with family, friends and neighbours less than once a week, and 11% are in contact less than once a month**
- **Over half (51%) of all people aged 75 and over live alone**
- **Almost 5 million older people say that the television is their main form of company**
- **ELSA estimates 1 in 6 adults aged over 50 are socially isolated (Campaign to End Loneliness)**

Depression

Depression though common is not an inevitable part of aging. Early signs of depression need to be acted on to improve wellbeing and maintain quality of life. Failure to respond can increase risk of further illnesses developing.

Data analysis by the National Mental Health Development Unit[45] tells us that one in four older people in the community have symptoms of depression. The risk of depression increases with age so that 40% of those over 85 are affected. Major depression is a chronic disorder with the majority of older patients having a recurrence within three years.

Some groups are at higher risk of depression: Care home residents (where up to 40% may be depressed) and 20 - 25% of people with dementia also have symptoms of depression. Co-morbidities are the norm in later life. Thus, mental and physical health problems of older people are entwined and manifested in complex co-morbidity.

Physical illness is associated with increased risk of depression:

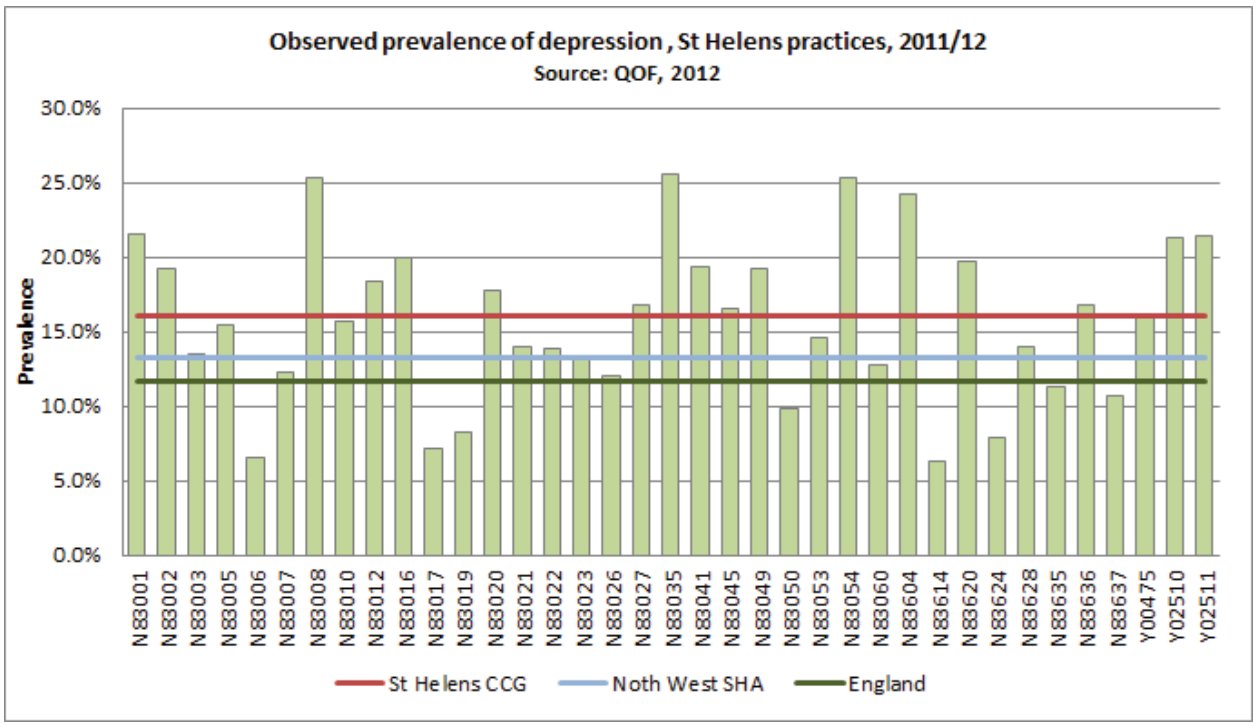
• Depression is three times as common in people with end-stage renal failure, chronic obstructive pulmonary disease and cardiovascular disease as in people who are in good physical health.

[45] http://www.nmhdu.org.uk/silo/files/management-of-depression-in-older-people.pdf

• Depression is more than seven times more common in those with two or more chronic physical conditions.

Locally the GP depression registers for 2011/12 shows that 12,471 persons aged 18+ had a diagnosis of depression. Prevalence at a practice level varied substantially from 1.6% to 22.1%, with an average of 12.4%. This is an increase from 2010/11 figures (11,924 or 11.94%). This may be as much due to a combination of active case finding as well as the potential increase in numbers of people experiencing depression and their willingness to discuss it with their GP.

Observed prevalence of depression, Halton GP practices, 2011/12



Depression is also associated with increased mortality and risk of physical illness.

- Increased mortality: a diagnosis of depression in those aged over 65, increased subsequent mortality by 70%. Depression is associated with 50% increased mortality after controlling for confounders, which is comparable with the effects of smoking.
- Increased risk of coronary heart disease: depression almost doubles risk of later development of coronary heart disease after adjustment for confounding variables.
- Increased risk of stroke: increased psychological distress is associated with 11% increased risk of stroke.

Identified risk factors for depression in older people include:

- Recent (less than 3 months) major physical illness or hospital admission
- Chronic illness
- In receipt of high levels of home care, including residential care
- Recent bereavement
- Social isolation and loneliness
- Excessive alcohol use
- Fuel poverty
- Persistent sleep problems
- Living in a care home
- Dementia
- Some ethnic groups are at higher risk

Dementia

Dementia can affect adults of working age, but is most common in older people. One in six people aged over 80 and one in 14 people aged over 65 have a form of dementia.

In Halton the number of people with dementia is set to rise by 62% by 2030, largely due to the projected increase in the older population. 690 people registered with a Halton GP have a diagnosis of dementia. It is projected that there are 1,143 people aged 65+ living in Halton who have some form of dementia and by 2030 this figure is estimated to be as high as 2,050. In addition the borough currently has 33 working age adults aged 30-64 who have a formal diagnosis of dementia.

Hospital admissions for people living in Halton for Alzheimer's and other related dementia are the highest in the country[46] (2009/10 to 2011/12). It is uncertain whether this results from a higher prevalence of dementia locally or from higher rates of diagnosis. However Halton's ratio of recorded to expected prevalence of dementia is significantly higher than England suggesting that earlier diagnosis is the explanation. Further detail of the prevalence and severity of dementia in the Borough can be found in the Halton Dementia Strategy Refresh 2013

Dementia is characterised by a collection of symptoms, including a decline in memory, reasoning and communication skills needed to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which complicate care and can occur at any stage of the illness. Family carers of people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life. Dementia is a terminal condition but people can live with it for 7–12 years after diagnosis.

There is evidence that early provision of support at home can decrease institutionalisation by 22% and even in complex cases, case management can reduce admission to care homes by 6%. Older people's mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care.

In response to the National Dementia Strategy 2009 local support has been commissioned through a partnership with Alzheimer's Society and Age UK Mid Mersey who have developed Dementia Care Advisors and Dementia Cafés.

Evaluation of the redesign of the later Life and Memory Service (LLAMS) pathway being piloted in Wigan demonstrates that the changes introduced delivered a positive impact upon service

[46] www.nepho.org.uk/cmhp Halton Community Mental health Profile 2013

efficiencies and the timeliness of response to referrals. That contributed to a positive experience of the new service for Service Users and Carers. Similarly, there is evidence to show that collaborative working between staff and the integration of teams improved the speed with which diagnoses were arrived at, the availability of support for the management of memory problems and an increase in the levels of support provided within community settings. A LLAMS for Halton has now been implemented and its impact will be kept under review.

Ex-Armed Forces Personnel and their families

Liverpool Public Health Observatory published a Health needs assessment for ex-armed forces personnel aged under 65, and their families Cheshire and Merseyside (2013)[47]

Extrapolation of estimates within this report for Halton CCG footprint indicate a veteran population under age 65 of 3,700 which is predominantly male. These figures are likely to be an underestimate due to recent redundancies in military personnel.

Overall rates of common mental health problems and Post Traumatic Stress Disorder remain low. Alcohol misuse on return home is an issue for Regulars whilst Reservists are more likely to experience psychological impact of deployment.

There is limited research on the impact of deployment on children and families. One study found 30% of children with a currently deployed or recently returned parent showed clinical level of anxiety which persisted for up to a year after the parents return. A separate health needs assessment has just been commissioned to look at the health needs of Ex-armed forces personnel in Halton.

[47] http://www.liv.ac.uk/PublicHealth/obs/publications/report/93%20Health%20needs%20assessment%20for%20ex-Armed%20Forces%20personnel.pdf

Armed Forces Personnel – Community Covenant

This agreement has been developed across Cheshire, Halton and Warrington to help veterans of the armed forces "live at ease". The initiative provides wrap around support to issues impacting on the mental health and wellbeing of veterans including debt advice, addiction support, counselling etc. In Halton as there is no garrison veterans are integrated into the community and work is on-going to identify the potential level of need.

Mental Health and the Criminal Justice System

Offenders, ex-offenders and those at risk of offending experience significant health inequalities compared to the general population. They experience higher rates of mortality and suicide; drug and alcohol misuse; mental and physical health problems; homelessness, literacy and numeracy difficulties, and unemployment; and poor access to and uptake of health and care services.

Since there is an identifiable link between health inequalities and offending behaviour, improving their health outcomes can markedly reduce re-offending rates. In turn, a reduction in re-offending is likely to bring health and wellbeing benefits to a wider local population as a result of improved community safety.

Liverpool Public Health Observatory published "Health needs assessment of young offenders in the youth justice system on Merseyside" (2013)[48] which evidences mental health needs of the prison population in the region:

	Female %	Male %
Suffer 2 or more mental disorders	70	72
Psychotic disorder	14	7
Drug use in previous year	55	65
Hazardous drinking	39	63

[48] Liverpool Public Health Observatory published "Health needs assessment of adult offenders across the criminal justice system on Merseyside" (2012) http://www.liv.ac.uk/PublicHealth/obs/publications/report/87_Health%20needs%20assessment%20of%20adult%20offenders_210612.pdf

From April 2013 responsibility for prison healthcare has transferred to the NHS England whilst CCG'S have responsibility for offenders managed in the community or released from custody. This will require development of strong links between the NHS England and CCG to deliver the core recommendations within the report. NICE is currently developing guidance on prisoner physical and mental health.

Young Offenders

The age of criminal responsibility in England and Wales is 10 years. The youth justice system (YJS) was set up under the Crime and Disorder Act 1998, to prevent young people offending or reoffending. The formal youth justice system begins once a child aged 10 and over has committed an offence and receives restorative solutions and cautions, or is charged to appear in court. Ministry of Justice figures show the child custodial population has reduced by 44% over the 4 years to 2012. Typically almost 80% of young people sentenced to custody are reconvicted within 2 years.

Amongst children and young people in custody over 30 per cent have a diagnosed mental health problem. Evidence also suggests there is considerable overlap between looked after children and those in the Youth Justice System.

Youth Offending Services

The Crime and Disorder Act requires local authorities, the police, probation, and Clinical Commissioning Groups, to set up Youth Offending Services (YOSs) to work with children and young people offending or at risk of offending. YOSs must include representatives from the police, probation, health, education and children's services. YOSs continue to have responsibility for children and young people sentenced or remanded to custody.

Youth justice liaison and diversion schemes

The cross-government Health and Criminal Justice Liaison and Diversion programme, led by the DOH, includes a major national programme of pilot youth justice liaison and diversion (YJLD) schemes for children and young people with mental health, learning or communication difficulties, or other vulnerabilities affecting their physical and emotional well-being. The purpose of the programme is to identify all health and social care needs at whatever point children and young

people enter the YJS, with a view to securing more systematic access to services and enabling the police and courts to make informed decisions about charging and sentencing.

In Halton there is a CAMHS worker attached to the YOS working 2 days YOS and 3 days with the Divert programme. The Divert programme aims to intervene at the point of arrest and divert young people with mental health issues away from the Criminal Justice System. There is one full-time substance misuse worker covering both Halton and Warrington and all case managers and support staff are trained in the basics of substance misuse.

In October 2012 Halton and Warrington YOS managed 40 young offenders from Halton, 38 male and 2 female. 95% were White British and 27 were in the age range 15-17.

Section 136 – Mental Health Act 1983 – Place of safety

This legislation allows police officers to remove a person they think is mentally disordered and "in need of care and control" from a public place to a place of safety in the interests of that person or for the protection of others. The person can then be examined by a medical practitioner and interviewed by an approved mental health professional (AMHP) to arrange any treatment or care. In such circumstances a person can be taken into police custody under section 136 of the Mental Health Act 1983. Under this power police custody is viewed as a 'place of safety', where a person can be held without harm until the examinations/interview can take place. Police custody is widely viewed as not being a suitable environment for people with mental disorder as it has the effect of criminalising people for what is essentially a health need and the environment may exacerbate their mental state and, in the most tragic cases, can lead to deaths in custody[49]

In February 2013 a multi-agency Mental Health Act group chaired by the Royal College of Psychiatrists published Guidance for commissioners[50]:
The report made a number of recommendations:

1. The custody suite should be used in exceptional circumstances only.
2. A vehicle supplied by the ambulance provider should be able to attend promptly so that it is used for conveyance unless the person is too disturbed.
3. The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3 hours in all cases where there are not good clinical grounds to delay assessment.
4. The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act.

[49] **Police Custody as a "Place of Safety":** Examining the Use of Section 136 of the Mental Health Act 1983 http://www.ipcc.gov.uk/sites/default/files/Documents/guidelines_reports/section_136.pdf
[50] Guidance for commissioners: Service provision for Section 136 of the Mental Health Act 1983

5. A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases.
6. Commissioners should ensure that there is a multi-agency group meeting to develop, implement and quality assure the agreed policy. This group should review the monitoring data. It should also consider how the need for use of Section 136 might be reduced

The place of safety is generally a designated NHS resource in the area if the person does not have any additional injury or illness requiring treatment at an Emergency Department. Alternatives include a domestic address - the persons own home or friend a relative's home.

It has been nationally reported that the use of Section 136 has been increasing, placing additional demands on Police, Health and Social Services resources. To gain a greater understanding of how the use of Section 136 was impacting upon resources within the Cheshire Police area an analysis of data from Section 136 assessments completed in 2012 has been undertaken:

Profile of 2012 Section 136 detentions in Halton

- 92 S136 assessments completed
- 61% of detainees were male
- Average age of detainees is 35
- 5 detainees were aged under 18 no detainees were aged 65+
- 62% were classed as unemployed

Place of Safety following detention

	Brooker Centre	Hollins Park	Runcorn Custody Suite	Warrington General Hospital	Other	Unknown
Number	26	7	39	13	5	2
Percentage	28%	8%	42%	14%	6%	2%

In Halton a revised S136 is being drafted. Within the current protocol attendance as described in recommendation 3 above is two hours rather than three. The local designated place of safety was the Brooker Unit at Halton Hospital. Recent redesign of the Acute Care Pathway has centred support at Hollins Park in Warrington leading to more local options being considered. These alternatives are often not the most appropriate and a review of local provision is needed.

Psychiatric Liaison Service - Warrington and Halton Hospitals Foundation Trust and St Helens and Knowsley

Accident and Emergency (A&E) Services are involved with the assessment and treatment of acute illness and injury suffered by patients of all ages including patients with an acute change in mental status. It also addresses the needs of people who have presented themselves to the A&E department rather than seeking help from their GP or directly from local mental health services.

For patients with mental health problems, this might include those who have suffered self-inflicted injuries, or management of patients presenting with acute mental health problems.

A&E Departments have a short stay ward which has the facilities for the temporary observation of patients who have taken minor toxic overdoses, where more thorough mental health evaluation can be carried out following recovery.

Across the Mid Mersey footprint 5BP liaison teams carry out the assessment and management of care of identified patient within AED. The service aims and Objectives are:

- To ensure that people attending the A&E Department who have mental health needs have them addressed and receive the psychiatric care or social support required or arranged to improve their physical and psychological wellbeing.
- Improve the quality of care provided by A&E staff to mental health service users by improving their knowledge and skills regarding common psychiatric conditions.
- Conduct Risk Assessments for self harm and harm to others.
- Provide brief interventions and advice to people who present with self harming behaviour and arrange for referral to primary care or specialist mental health services depending on risk and severity.
- To provide specific advice to people with depression, anxiety or other mild to moderate mental health problems.
- Provide signposting to appropriate mental health services following discharge from A&E.
- Provide support and advice to the acute general hospital staff for people with physical health problems caused by alcohol or substance misuse that are not linked into appropriate services for these conditions.
- Support people with complex behaviour patterns requiring interventions under the Mental Health Act 2007 and Mental Capacity Act 2005.
- Conduct Mental Health Act and Mental Capacity Act Assessments.
- Provide expert advice regarding capacity to consent for medical treatment in complex presentations.

Physical Health Care

- Physical health needs other than the reason for A&E attendance should be assessed at the same time where possible and action and/or advice given if indicated. Assessing and addressing the physical health needs of the service user should be given a high priority particularly those people on anti-psychotic medication.

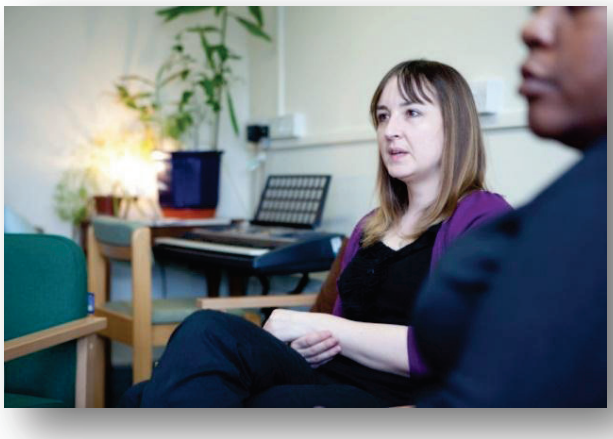
- Opportunity taken to address physical health promotion such as improving lifestyle where the presenting problem is likely to affect the patient's physical health. E.G. diet, smoking, alcohol consumption, breast, bowel and cervical screening.

- Activities should be recommended to improve diet, nutrition; substance misuse, sexual health, smoking cessation, and exercise will be facilitated and encouraged. This service should also encourage access to dental and optical examinations and flu vaccinations where appropriate.

- Where the patient's mental state allows, the assessment/ liaison service will also address the adequacy of housing needs and where appropriate service users employment and accommodation status should be assessed and action taken to signpost to appropriate agencies for assistance. This information will be shared with other mental health services when signposting to them.

Future redesign should include:

- Development of arrangements for Section 136 including liaison suite and wet rooms
- Review and manager of Section 12 (mental health act trained) doctors
- Continued review of both Psychiatric liaison service and its impact and potential redesign to meet local need
- Review of assessment team activity and links to Acute Care Pathway
- Mental health capacity assessments
- Ward liaison



Personality disorder

Personality disorder typically occurs in adolescence, though it may start in childhood, and continues into adulthood. It is a condition in which an individual differs significantly from an average person in terms of how they think, perceive, feel or relate to others. These changes in feelings and distorted beliefs can lead to odd behaviour which can be distressing and upsetting to others. Those experiencing personality disorder are known to encounter significant social exclusion which impacts on demand for health, social care and other public services.

It is estimated that 1 in 20 people have a personality disorder. For many this is mild and they may only require help at time of stress e.g. bereavement. Nationally hospital admissions 2009-10 suggest 70% of inpatient personality disorder cases are diagnosed in females. Borderline and Histrionic Personality Disorder are more common among females whilst Antisocial and Obsessive Compulsive Personality Disorder are more commonly diagnosed among males.

With help many people can lead a normal and fulfilling life and for those with mild to moderate personality disorder access to psychological (talking) therapies can be an effective alternative to medication. Research[51] suggests that progress in recovery is a continuum of co-existing support drawing on crisis support, therapy services and social inclusion development with an emphasis on human interaction rather than drug treatment. Working in groups alongside people with similar problems can be very helpful. Therapeutic Communities have traditionally been residential settings but alternative service user-led networks are developing using web-based messaging as well as face-to-face meetings.

Carers

Carers are key partners in the service user's journey through mental health services. The Triangle of Care: Carers Included: A Guide to Best Practice in Mental Health Care (Carers Trust 2013) sets 6 standards to engage with carers creating an inclusive attitude where they are listened to and consulted more closely. Commissioners will ensure local service provision adopts these standards for engagement within working practices.

In the North West it is estimated that 17% of the adult population over age 16 are carers while only 7% are known to services. Carers themselves are at increased risk of developing mental health problems particularly anxiety and depression. Halton Carers Action Plan June 2013 is owned by the Halton Carers Strategy Group and sets four key objectives for offering support to those in a caring role to alleviate some of the pressures experienced and enable carers to maintain their own health and emotional wellbeing:

[51] A Recovery Journey for People with Personality Disorder (May 2013, The Institute Journal of Psychiatry)

- Supporting those with caring responsibilities to identify themselves as carers at an early stage
- Recognising the value of Carers contributions and involving them from the outset both in designing local care provision and in planning individual care packages
- Enabling those with caring responsibilities to fulfil their educational and employment potential
- Personalised support both for carers and those they support enabling them to have a family and community life
- Supporting carers to stay healthy and well

Promoting Equality and Reducing Inequality

No health without mental health and the Marmot Review place emphasis on tackling health inequalities and promoting equality. Marmot showed that, among other factors, poor childhood, housing and employment (and also unemployment) increase the likelihood that people will experience mental health problems and that the course of any subsequent recovery will be affected. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

Aspects of people's identity and experiences of inequality interact with each other, for example people from black and minority ethnic (BME) groups are more likely to live in deprived areas and have negative experiences, both as a result of their ethnic identity and because of their socio-economic status and living environment.

It is important to work with local communities when developing services, facilities and resources to ensure that they promote equality through the inclusion and equitable treatment whilst eliminating discrimination, advancing equality of opportunity and fostering good relations within communities without disadvantaging people as a result of any of the nine protected characteristics under the Equality Act 2010[52]

People with some of these characteristics for example disabilities, Lesbian, Gay Bisexual and Transgender people and those from BME groups, may already face significant challenges to their resilience and wellbeing as a result of stigma, discrimination and other issues. It is therefore all the more important that they are able to access appropriate services, leisure facilities and other activities to promote wellbeing and resilience.[53]

[52] These can be found at: https://www.gov.uk/discrimination-your-rights/types-of-discrimination

[53] Building Resilient Communities: Making every contact count for public health (August 2013 Mind, Mental Health Foundation)

- People from Black and minority ethnic groups are nearly three times more likely to attempt suicide
- The risk of suffering from depression and anxiety disorders is about twice as high for lesbian, gay and bisexual people.
- Rates of depression among those with two or more long term physical conditions are almost seven times higher than in the rest of the population.

No heath without mental health identifies three aspects to reducing mental health inequality:

i. tackling the inequalities that lead to poor mental health;

ii. tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and

iii. tackling the inequalities in service provision – in access, experience and outcomes.

Whilst tackling inequalities in service provision is addressed through delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers, so that they have more control over the support they receive.

Stigma and Discrimination

People with mental health problems say that the social stigma attached to mental ill health and the discrimination they experience can make their difficulties worse and make it harder to recover. [54]

Mental illness is common as already evidenced it affects thousands of people in the UK, and their friends, families, work colleagues and society in general.

Most people who experience mental health problems recover fully, or are able to live with and manage them, especially if they get help early on. But even though so many people are affected, there is a strong social stigma attached to mental ill health, and people with mental health problems can experience discrimination in all aspects of their lives.

Many people's problems are made worse by the stigma and discrimination they experience – from society, but also from families, friends and employers.

[54] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stigma-discrimination/

Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives.

We know that people with mental health problems are amongst the least likely of any group with a long-term health condition or disability to:

- find work
- be in a steady, long-term relationship
- live in decent housing
- be socially included in mainstream society.

This is because society in general has stereotyped views about mental illness and how it affects people. Many people believe that people with mental ill health are violent and dangerous, when in fact they are more at risk of being attacked or harming themselves than harming other people.

Stigma and discrimination can also worsen someone's mental health problems, and delay or impede their getting help and treatment, and their recovery. Social isolation, poor housing, unemployment and poverty are all linked to mental ill health. So stigma and discrimination can trap people in a cycle of illness.

The situation is exacerbated by the media. Media reports often link mental illness with violence, or portray people with mental health problems as dangerous, criminal, evil, or very disabled and unable to live normal, fulfilled lives.

Research shows that the best way to challenge these stereotypes is through first-hand contact with people with experience of mental health problems. A number of national and local campaigns are trying to change public attitudes to mental illness. These include the national voluntary sector campaign Time to Change and Halton's social marketing campaign Like Minds.

The Equality Act 2010 makes it illegal to discriminate directly or indirectly against people with mental health problems in public services and functions, access to premises, work, education, associations and transport.

Part Four – Outcomes Frameworks

Outcomes Frameworks 2013/14

Outcome measures provide a description of what a good mental health system should aim to achieve, as well as a method of checking progress against achieving these aims. All three of the Outcome Frameworks – Public Health[55], NHS[56], and Adult Social Care[57] contain objectives related to mental illness, with several of the outcomes being shared across outcome frameworks. This close alignment reflects that in order to improve the wellbeing of communities and to improve outcomes for individuals with a mental illness all three sectors must play an effective role.

The 3 outcomes frameworks 2013/14

Public Health Outcomes Framework	NHS Outcomes Framework	Adult Social Care Outcomes Framework
1. Improving the wider determinants of health		
2. Health improvement		
3. Health protection		
4. Healthcare public health and preventing premature mortality	1. Preventing people from dying prematurely	
	2. Enhancing quality of life for people with long term conditions	1. Enhancing the quality of life for people with care and support needs
		2. Delaying and reducing the need for care and support
	3. NHS Outcomes Framework	
	4. NHS Outcomes Framework	3. Ensuring that people have a positive experience of care and support
	5. NHS Outcomes Framework	4. Safeguarding adults who are vulnerable and protecting them from avoidable harm

The detailed indicators relating to Mental Health and Wellbeing are summarised below along with the outcomes they contribute to:

[55] Available from: http://www.phoutcomes.info/
[56] Available from: https://www.gov.uk/government/publications/nhs---outcomes---framework---2013---to---2014
[57] Available from: https://www.gov.uk/government/publications/the---adult---social---care---outcomes---framework---2013---to---2014

Mental Health and Wellbeing Indicators and outcomes framework domain

Indicators in italics are placeholders pending development or identification

National Indicators	NHS	Public Health	Adult Social Care
Excess under 75 mortality rate in adults with serious mental illness	1.5	4.9	
Proportion of people feeling supported to manage their condition	2.1		$
Health related quality of life for carers	2.4		1D
Employment of people with mental illness	2.5	1.8	1F
Estimated diagnosis rate for people with dementia	2.6i	4.16	
A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	2.6ii		2F
Total health gain as assessed by patients for elective procedures – Psychological therapies	3.1v		
Patient experience of community mental health services	4.7		
Adults with a learning disability in contact with secondary mental health services who live in stable and appropriate accommodation		1.6	1G 1H
People in prison who have a mental illness or significant mental illness		1.7	
Employment for those with long-term health conditions including adults with a learning disability or who are in contact with a secondary mental health services	2.2 2.5	1.8	1E 1F
Hospital admissions caused by unintentional and deliberate injuries in under 18s		2.7	
Suicide Rate		4.10	
Proportion of people who use services and who reported they had as much social contact as they would like			1I

$ Indicator complementary with Adult Social Care Outcomes Framework

NHS England (supported by NICE) has developed a Commissioning Outcomes Framework (COF)[58], which builds upon the NHS Outcome Framework and measures the health outcomes and quality of care provided by Clinical commissioning Groups (CCGs).

COF indicators related to mental illness include:

- 1.30: People with severe mental illness who have received a list of physical checks
- 2.79: People on Care Programme Approach (CPA) followed-up within 7 days of discharge from psychiatric inpatient stay
- 3.26i: Recovery following talking therapies for people of all ages
- 3.26ii: Recovery following talking therapies for people older than 65
- 4.20: Access to community mental health services by people from black and minority ethnic groups
- 4.21: Access to psychological therapies services by people from black and minority ethnic groups

Children's Outcome Framework

The Children and Young People's Health Outcomes Forum was asked by the Secretary of State to look at how best the health outcomes of children in Britain could be improved. The forum included a Mental Health Sub Group which made recommendations related to promoting mental health and improving outcomes for children with a mental illness[59]. In view of the paucity of data on the scale and nature of poor mental health among children and young people, the Forum recommended a new survey to support measurement of outcomes for children with mental health problems. The Department of Health has recently published its response to the Children and Young People's Health Outcomes Forum's recommendations outlining actions the government and partners will take to improve the health of children and young people.[60]

[58] Available from: http://www.nice.org.uk/aboutnice/ccgois/CCGOIS.jsp

[59] Report of the children and young people's health forum – mental health sub group. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156063/CYP---Mental---Health.pdf

[60] Department of Health (2013). Improving Children and Young People's Health Outcomes. Available from: http://tinyurl.com/cq43yhg

Part Five – Evidence based interventions

National Standards

NICE quality standards are for use by the NHS in England and do not currently have formal status in the social care sector. However, the NHS will not be able to provide a comprehensive service for all without working with social care communities. Social care commissioners and providers are encouraged to use the standards, both to improve the quality of their services and support their colleagues in the NHS.

Quality standards are also expected to contribute to the following overarching outcomes from the Public Health Outcomes Framework; improving the wider determinants of health; health improvement; health protection; and preventing premature mortality.

The quality standards outline the level of service that people using the NHS mental health services should expect to receive. High-quality care should be clinically effective, safe and be provided in a way that ensures the service user has the best possible experience of care. The standards require that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. An integrated approach to the provision of services is fundamental to the delivery of high quality care to service users.

Quality standards describe markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for service users in the following ways:

- enhancing quality of life for people with long-term conditions.
- ensuring that people have a positive experience of care.
- treating and caring for people in a safe environment and protecting them from avoidable harm.

These overarching outcomes are from the NHS Outcomes Framework 2013/14

The quality standards are also expected to contribute to the following overarching indicators from the 2013/14 Adult Social Care Framework; enhancing quality of life for people with care and support needs; ensuring that people have a positive experience of care and support; safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

Community, in-patient and residential mental health services, where the service employs a doctor, nurse or social worker, are required to be registered with the Care Quality Commission (CQC). It is expected that CQC will align any future work it does with the NICE Quality Standards. More information on the NICE quality standards applicable to mental health services can be found on the NICE website.[61]

The No Health without Mental Health Strategy (DOH 2011) recognises the importance of early intervention to prevent serious mental health issues developing amongst children and young people. The comprehensive Children and Adolescent Mental Health Services (CAMHS) agenda has been well documented since the development of Every Child Matters (DFE 2004) and supports the tiered response to levels of need as demonstrated below.

Tiered Response to Levels of Need all children

Tier 1: Universal Provision, working with all children

This involves the adoption of a range of services designed to create the best developmental and emotional start for all children and which are sustained through to adulthood. They include family/infant mental health and emotional wellbeing approaches.

Tier 2: Early intervention/targeted provision

This involves early detection and provision of preventative support to children and families in need. At this step structured self-help approaches, behavioural, and/or family support are provided to reduce the impact of mental health and emotional problems and prevent their escalation to greater/more significant difficulties.

Tier 3: Specialist provision for those with complex needs

This involves specialist diagnostic assessment and the provision of psychological, systematic and/or pharmacology therapy. Intervention at this step is provided to children and young people who are experiencing moderate mental health and emotional difficulties which are having a significant impact on daily psychological/social/educational functioning. Intervention at this level is normally provided through specialist/specific multi-disciplinary teams.

Tier 4 Highly specialised provision.

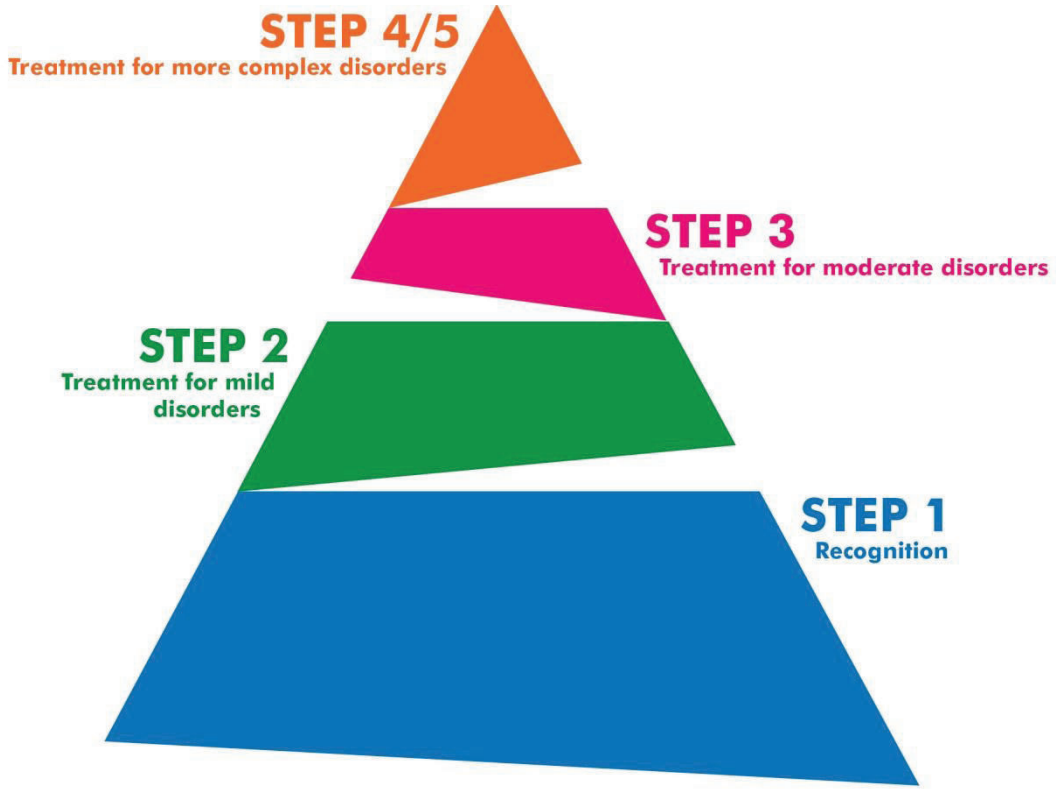
This involves provision of crisis resolution and intensive home/residential/or day care services designed to reduce and/or manage those children and young people who are at immediate risk or who need intensive therapeutic care.

[61] http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

Stepped Care Model

Halton operates a stepped model of mental health and wellbeing services where people can step up or down according to their need. Stepped care is an evidence based model of healthcare delivery with 2 fundamental features:

i. The recommended treatment/intervention should be the least restrictive of those available but still likely to provide significant health gain.
ii. The stepped care model is self-correcting through systematic monitoring and changes made (stepped up) if current treatments are not achieving significant health gains[62]



Halton's Stepped Care Model (based on Kaiser Permanente risk stratification model)

Halton is committed to providing quality evidence based, cost effective and efficient services that meet the varying needs of local people.

[62] Bower & Billbody, The British Journal of Psychiatry 2005

Part Six – Paying for local services

As the Government's policy of deficit reduction continues, the impact on the public sector is significant and with the public sector having to make unprecedented decisions about the services that it continues to deliver, this ultimately has an impact on service delivery and residents expectations. The current investment into mental health and wellbeing services within Halton will be explored within this part of the document.

It is for local commissioners to ensure that when services are commissioned, the needs of the whole population and the best evidence of what works are taken into account there are four main ways of increasing value for money in mental health services:

- improving the quality and efficiencyof current services;
- radically changing the way that current services are delivered so as to improve quality and reduce costs;
- shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and
- broadening the approach taken to tackle the wider social determinants and consequences of mental health problems.

Future costs of mental ill health are forecast to double in real terms over the next 20 years (No health without mental health: the economic case for improving efficiency and quality in mental health). Some of this cost could be reduced by greater focus on whole population mental health promotion and prevention, alongside early diagnosis and intervention. Early detection services for people with earlier symptoms of psychosis (at-risk mental state) have also been estimated to deliver savings–in this case around £23,000 per person over 10 years (about 25% of these costs were incurred in the NHS).

Intervening early for children with mental health problems has been shown not only to reduce health costs but also to realise even larger savings from improved educational outcomes and reduced unemployment and crime. These approaches not only benefit the individual child during their childhood and adulthood but also improve their capacity to parent. They can therefore break cycles of inequality running through generations of families. Conduct disorder is the most common childhood mental disorder, for which parenting support interventions are recommended as first-line treatment. A number of

studies have shown that effective parenting interventions and school-based programmes can result in significant lifetime savings.

By broadening the approach taken to tackle the wider social determinants and consequences of mental health problems, another example of this approach is providing face-to-face debt advice. Evidence suggests that this can be cost-beneficial within five years. The upfront cost of debt advice is more than offset by savings to the NHS, savings in legal aid, and gains in terms of employment productivity, even before taking into account savings for creditors.

Other areas for potential intervention identified in the document along with evidence of deliverable savings include:

1. Addressing the social determinants and consequences of mental health problems;

- Debt advice
- Befriending for older people
- Reducing stigma and discrimination
- Targeted employment support for those recovering from mental health problems
- Housing support services
- Warm housing

2. The promotion of positive mental health and prevention of mental health problems in childhood and adolescence;

- Health visitor interventions to reduce postnatal depression
- Prevention of conduct disorder through social and emotional learning programmes
- School-based violence prevention programmes

3. The promotion of positive mental health and prevention of mental health problems in adults;

- Time banks and community navigators
- Work-based mental health promotion
- Suicide prevention

4. Early identification and intervention as soon as mental health problems emerge;

- Conduct disorder - parenting interventions for families
- Early intervention for psychosis
- Early detection of psychosis
- Screening and brief intervention in primary care for alcohol misuse
- Early diagnosis and treatment of depression at work

5. Improving the quality and efficiency of current services.

- Improvements to the acute care pathway
- Managing ‘out of area’ placements in acute and secure services more efficiently
- Reducing unplanned ‘out of area’ placements
- Reducing Out of Area placements in medium secure services
- Reducing physical and mental co-morbidity
- Early detection and treatment of depression in diabetes
- Medically unexplained symptoms - CBT approach

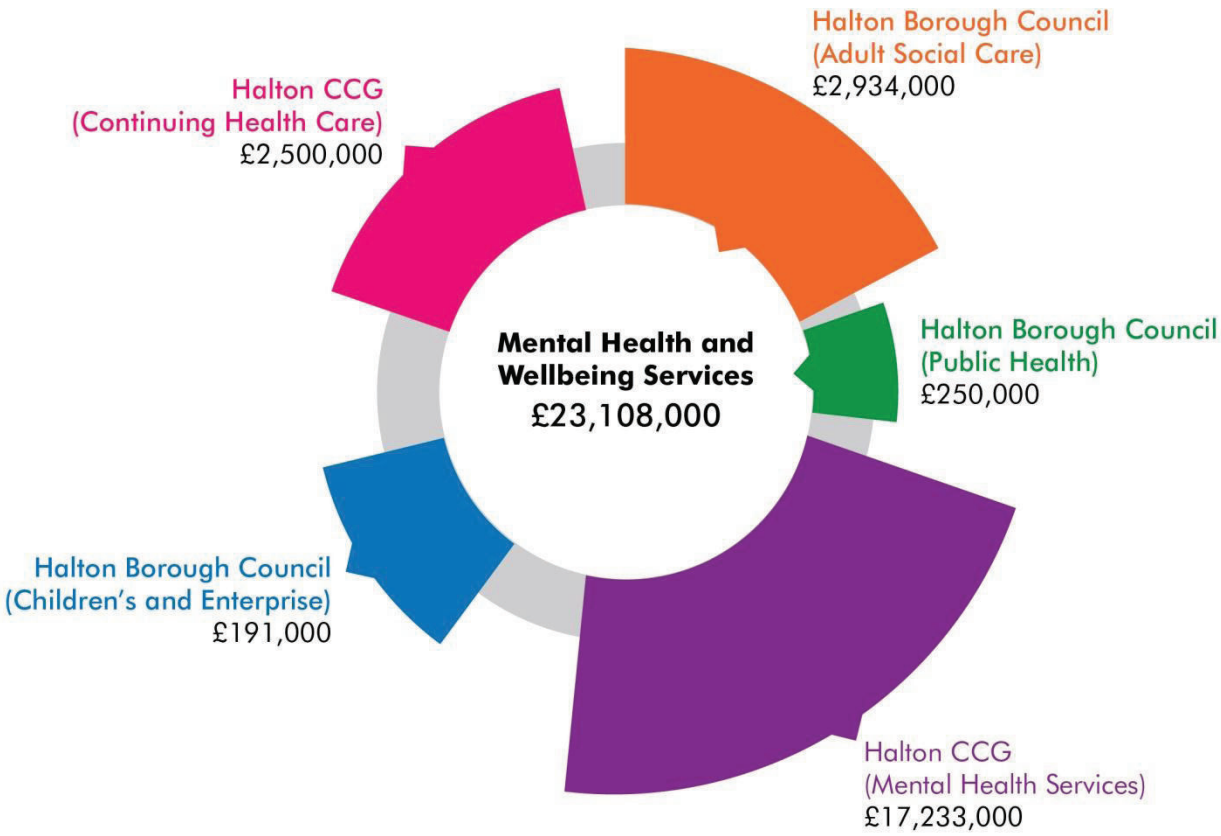
Many of these interventions are already being progressed in Halton. The commissioning intentions set out in the Mental Health and Wellbeing Strategy continues to promote action in these areas.

Current expenditure

The following financial breakdown is based upon current direct expenditure in mental health and wellbeing services and does not reflect the wider universal and targeted activity that is commissioned locally. Such expenditure, on areas as diverse as weight management, Primary Care, or voluntary and community sector activity, can have a direct impact upon the mental health and wellbeing of local communities, but does not fall within the direct influence of the mental health and wellbeing strategy and action plan.

Paying for Mental Health and Wellbeing Services 2013/14

The following is a breakdown of how resources have been allocated for the financial year 2013/14.



Budget received for 2013/14 for Mental Health Services

	£000
Halton Clinical Commissioning Group	17,223
Halton Borough Council - Adult social Care	2,934
Halton Clinical Commissioning Group – Continuing Health Care (Mental Health)	2,500
Halton Borough Council - Public Health	250
Halton Borough Council - Children's and Enterprise	191
TOTAL	**23,108**

How the budget was allocated 2013/14

Halton Clinical Commissioning Group	**£000**
5 Boroughs Partnership NHS FT	13,508
5 Boroughs Partnership ADHD Clinic	35
5 Boroughs Partnership Asperger's Pilot	23
5 Boroughs Partnership State of Mind	4
5 Boroughs Partnership ADOS (CAMHS)	8
Cheshire & Wirral Partnership	44
Manchester Mental Health & Social Care	6
MerseyCare	64
CAB Halton	116
Making Space	22
Women Supporting Women	20
MIND	20
Halton Service User Forum	10
SHAP	22
Bereavement Service	1
Youth Offending Team	8
IAPT (Including Open mind and Well Being Nurses)	986
MH Access	737

PICU - Vancouver House	150
PICU - Other	50
MH Capacity	77
Dementia Nurses and Care Advisors	200
WHHFT (A&E Liaison)	35
StHKHFT (A&E Liaison)	85
Primary CAMHS	492
High Cost Mental Health Funding	500
Continuing Health Care	2,500
Adult Social Care	
Older people community mental health team	147
Mental Health Support (Outreach)	194
Mental Health Resource Centre	117
Mental Health Recovery Team and Community Care	2,366
Emergency Duty Team	103
Women's Centre	7
Public Health	
Campaign against living miserably (CALM)	10
Health Improvement Team & Weight Management Service – Bridgewater	240
Children's and Enterprise	
Children in Care Service	59
Hear 4 U	132

Value for Money

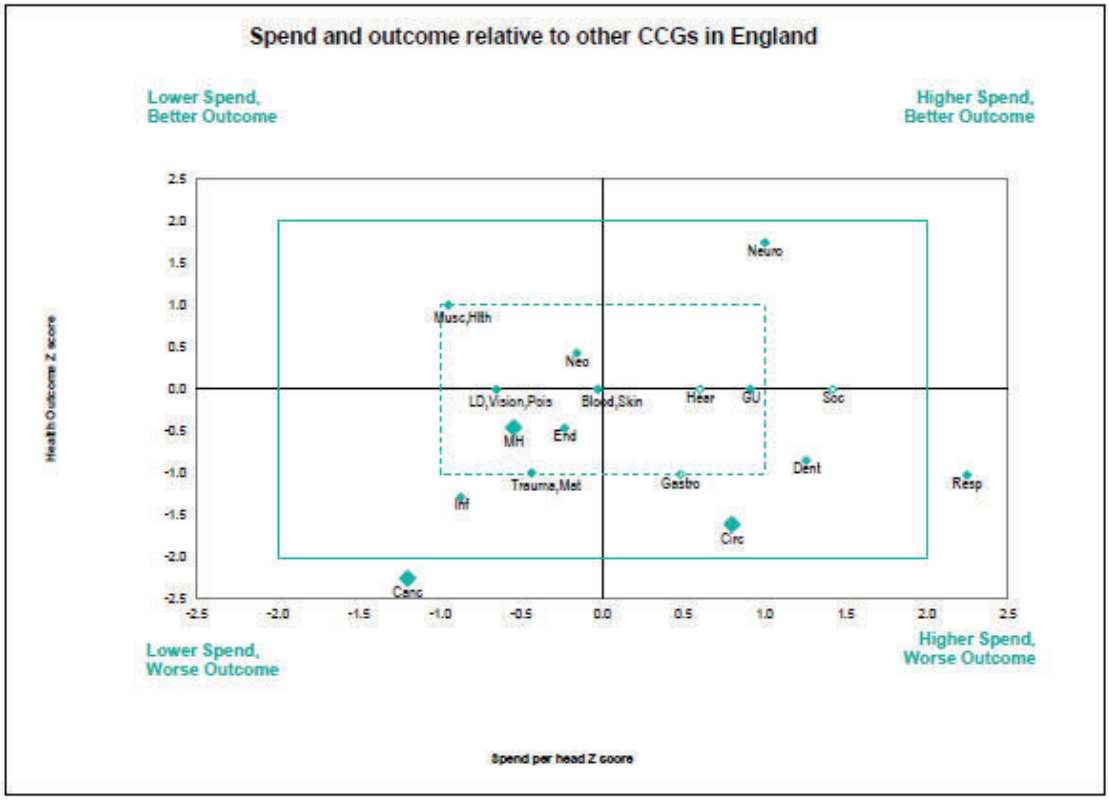
Halton Unit Costs of Adult Social Care - Mental Health

Service	2011/12 Unit Cost	2011/12 England Average	2012/13 Cost	% Change 12/13 v 11/12
Nursing	512	736	423	-17.47
Residential	873	732	878	0.61
Home Care	68	140	106	54.49
Direct payments	99	106	110	11.34
Day Care per person	50	93	59	17.64
Day Care per person per week	56	123	60	8.74

Source: PSSEX1

In general the costs of Adult Social Care appear to be below average costs for England. The exception is residential care which spiked higher than average costs in 2011/12. Whilst unit costs are a useful benchmark they are not representative as a value for money indicator as they do not consider qualitative data and outcomes achieved.

Halton Clinical Commissioning Group Spend per head (excluding Primary Care)[63]



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

This diagram represents an overview of spend and outcomes for Halton Clinical commissioning Group categorised into 4 quadrants in terms of spend and outcomes to allow easy identification of those areas that require priority attention by the CCG . The data is based on that submitted by the former Halton and St Helens PCT.

One of the highest areas of expenditure for Halton CCG is mental health at £185 per head per year. This is considerably lower than England average (£212). However outcomes being achieved are also lower suggesting that review is needed to move into the lower costs better outcomes quadrant.

[63] Source: www.yhpho.org.uk/quad/Default.aspx

Payment by Results

Payment by Results (PBR) is a system introduced in England under which commissioners pay health care providers for each patient seen or treated taking into account the complexity of patient need. The theory is that resources follow the patient rather than the traditional block contract approach.

Currencies are the unit of healthcare for which a payment is made and tariffs are the set prices paid for each currency. Tariffs are currently set locally but will be moving to national tariffs in future.

Appendix A- Local Services - 2013

Current Tiered CAMHS Provision across Halton

Tier 1: Universal Provision, working with all children

Midwifes, health visitors, school teachers, school nurses and youth workers supporting all children and young people in their development.

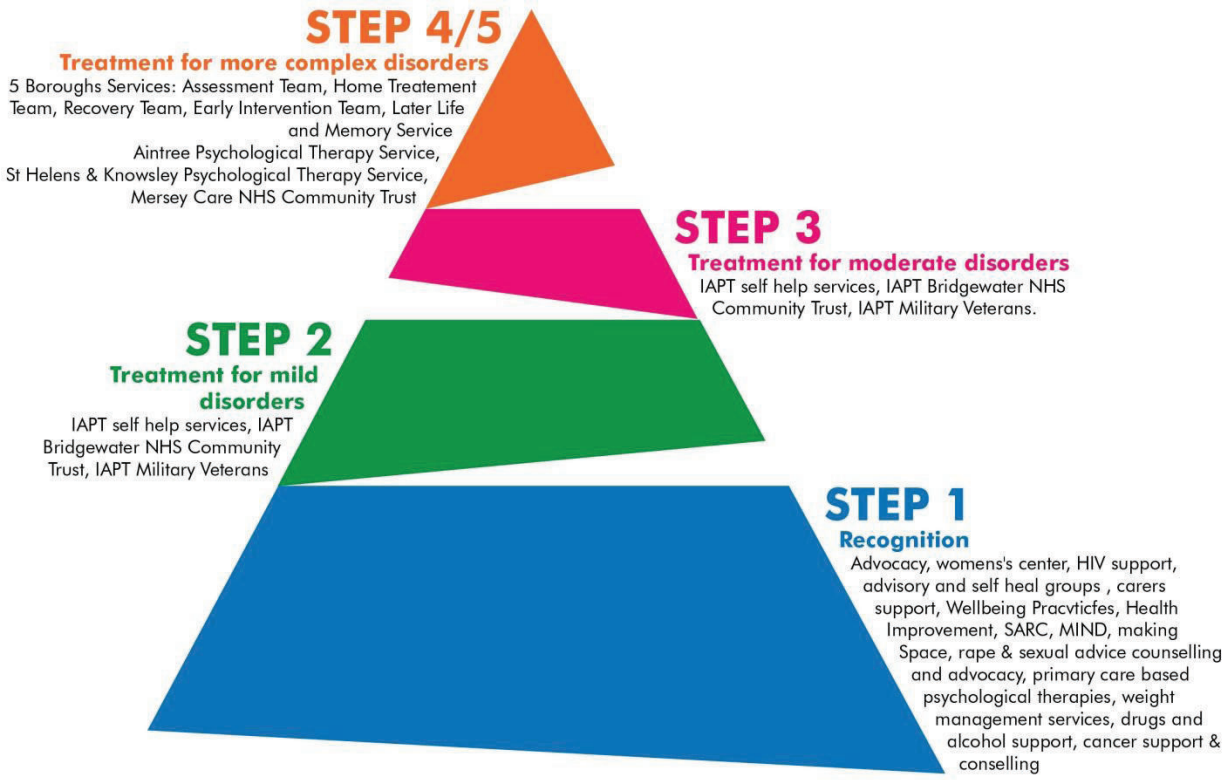
Tier 2:

- Barnardo's Hear for U provision. This service provides interventions such as individual counselling and solution focussed interventions to young people up to the age of 19.
- Barnardo's Go Forward Service (Children in Care). This service provides specialist mental health assessment, advice and support to Children in Care and their carers.
- Bridgewater Community NHS Trust Provider – This service provides consultation, training and interventions to children and young people. This includes preventing mental ill health developing and targeting vulnerable children and young people.
- Paediatric Liaison St Helens Service A+E. This service provides swift emotional and mental health support to children and young people who access A+E.
- YOS CAMHS Service. This service is specifically for children and young people who are young offenders.

Tier 3:

- 5 Boroughs Partnership CAMHS. The tier 3 specialist CAMH service is provided for the most severe, complex and persistent of child mental health problems/disorders and risk factors which have multi-factorial causation, psychological and social outcomes and which require interventions across the same domains to be delivered on a multi-agency basis. The service will deliver specialist services, including assessment, triage, consultation, diagnosis, formulation and treatment in a range of settings, including community and locality settings which meet children and young people's needs for timely and efficient service delivery.
- 5 Boroughs Partnership CURT Service. This urgent response team provide urgent assessment and service to young people up to their 18th birthday within 24 hours.

Tier 4 Highly specialised provision


STEP 4/5
Treatment for more complex disorders
5 Boroughs Services: Assessment Team, Home Treatement Team, Recovery Team, Early Intervention Team, Later Life and Memory Service
Aintree Psychological Therapy Service,
St Helens & Knowsley Psychological Therapy Service,
Mersey Care NHS Community Trust
STEP 3
Treatment for moderate disorders
IAPT self help services, IAPT Bridgewater NHS Community Trust, IAPT Military Veterans.
STEP 2
Treatment for mild disorders
IAPT self help services, IAPT Bridgewater NHS Community Trust, IAPT Military Veterans
STEP 1
Recognition
Advocacy, womens's center, HIV support, advisory and self heal groups , carers support, Wellbeing Pracvticfes, Health Improvement, SARC, MIND, making Space, rape & sexual advice counselling and advocacy, primary care based psychological therapies, weight management services, drugs and alcohol support, cancer support & conselling

Existing Mental Health Services (As at September 2013)

General mental health promotion.	Programmes related to infants and pre-school children within high-risk groups.	Programmes related to school aged children or young people within high-risk groups.	Programmes related to adults or older people within high-risk groups.	Programmes related to individuals or groups with an early or less disabling mental health or behaviour problem, or their carers.	Programmes related to individuals or groups with an identified severe mental health or behavioural problem or a diagnosed mental illness, or their carers.
Live Life Well Directory	Inspiring Families Programme	Inspiring Families Programme	Ashley House	Supported Housing	Suicide prevention section on the live life well website as an online link for suicide prevention support. **http://www.live-lifewell.net/** and click on the blue box called –thoughts of suicide
Wellbeing Areas	Inspiring Families Programme	CAMHS	Halton Employment Programme / HPIJ	The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	Carer's Assessments
Leaflets at GPs & HCRC	Team Around the Family	Team Around the Family	Community Midwives	H&STH Community Mental Health Directory Self Help guides	Social Services Mental Health Outreach Workers

The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	Children's Centres	Social care Transition Services	Halton Domestic Abuse Service	Halton Employment Programme / HPIJ	Halton Carers Centre
H&STH Community Mental Health Directory Self Help guides	Integrated Working Support Team	Children's Centres	HBC Housing Solutions	The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	MIND Halton
Sure Start to Later Life	Antenatal Groups/Community Midwives	5 Borough Partnership CAMHS Website	Extra Care Housing	H&STH Community Mental Health Directory Self Help guides	Open Mind
Carer's Assessments	Halton Family Voice	Young Addaction	Bridge Builders	Social Services Mental Health Outreach Workers	SHAP Mental health Advocacy
Help 4 Me website	Halton Health Visiting Service	Integrated Working Support Team	Suicide prevention section on the live life well website as an online link for suicide prevention support.	Halton Carers Centre	Assessment team
HealthWatch	Early Help Family Work Service	Young Carers	SHAP Mental health Advocacy	MIND Halton	Home Treatment Team
Community Wellbeing Practices	Intensive Family Work Service (IFWS)	Halton Short Break Service	British Pregnancy Advisory Service / Post Termination Support	Open Mind	Recovery Team

Health Improvement Team		Early Help Family Work Service	C.I.C Alcohol Community Link	SHAP Mental Health Advocacy	Psychological Therapy Service
Welfare Rights		Intensive Family Work Service (IFWS)	Merseyside Sexual Assault Referral Centres	Assessment Team	Merseycare NHS Community Trust
Wellbeing Enterprises		Halton School Nursing programme	Rape and Sexual Abuse Relationship Centre Independent Sexual Violence Advocates	Later Life and Memory Services	
Halton Women's Centre		Integrated Behaviour Support Team	Military Veterans IAPT Service		
Halton Citizens Advice Bureau		British Pregnancy Advisory Service / Post Termination Support	Early Intervention Team 5 Borough's Partnership		
Community Weight Management Service (Fresh Start)		Merseyside Sexual Assault Referral Centres	Merseyside Sexual Assault Referral Centres / Crisis Service		
Cancer Support Centre		Rape and Sexual Abuse Relationship Centre ISVA	Military Veterans Improved Access to Psychological Therapies Service		
IAPT Self Help Services		Merseyside Sexual Assault Referral Centres / Crisis Service			

Appendix B

Mental Health Commissioning Strategy Consultation: September 2013

Background

The World Health Organisation defines Mental Health as:
"A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community"

At least one in four people will experience a mental health problem at some point in their life and around half of people with lifetime mental health problems experience their first symptoms by the age of 14.

Halton Borough Council and the NHS Clinical Commissioning Group (CCG) are committed to involving Halton residents in shaping local services. Their views are very important and will help to inform the strategy for developing mental health and wellbeing services over the next five years.

Results

The online survey received 132 responses during September and October 2013.

In addition to this, on Oct 10th 2013 a 'Fact or Fiction' workshop was held with over 80 Healthwatch Halton members and the structure of the consultation was used in the agenda for the day – with voting buttons used to collect responses on the closed questions and discussions used to collect responses on the open questions.

The overall response from both methods of consultation is shown in this report.

Summary Findings – *key themes that are mentioned throughout (from the open comments received)*

Education: Of the general public, in schools, colleges and the workplace. Health professionals should be trained to give the correct advice. Everyone should understand that mental health can affect anybody.

Consistent: Continued service provision / after care. Clear messages to the public about mental health - the more consistent the messages are the more understanding there will be.

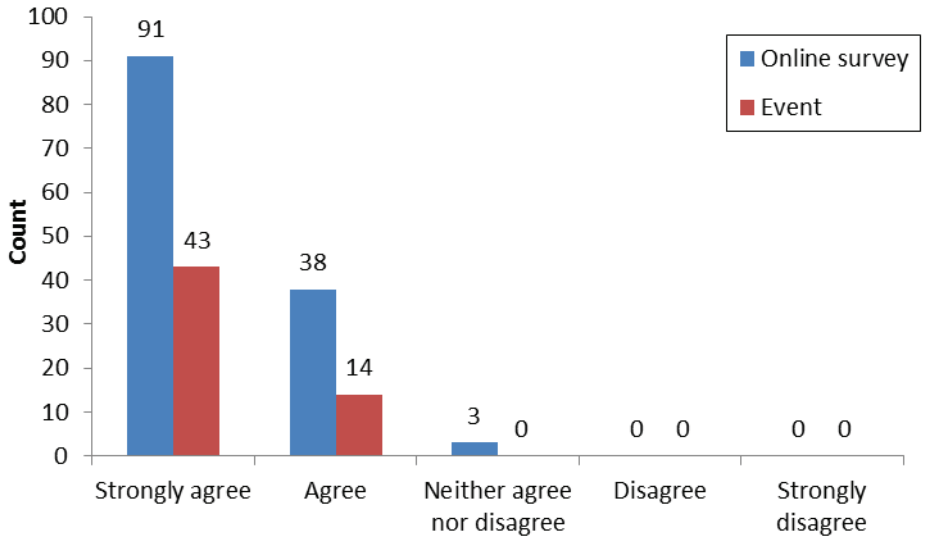
Provision of service: Out of hour's provision, support for families and carers. More service provision for children and young people. Early intervention services are important.

Local Concerns to be addressed

Through talking to local people we know you think that mental health is a priority and we know that:

- *Halton has high numbers of people suffering with depression*
- *Hospital admission rate due to self-harm in under 18's is high*
- *Current economic climate and welfare reforms are likely to increase numbers of people suffering from mental ill health*
- *Those with mental health problems have the lowest employment rate of any disability group*
- *There remains a stigma in the wider community relating to mental ill health*

How much do you agree or disagree that these concerns need to be addressed? (responses received: 132 online survey, 57 event)



Are there any other local concerns relating to mental health and wellbeing in Halton which you feel need to be addressed?

Access to service / information	11
Continued / service provision for children and young people	10
Support and advice for carers / families	8
Correct advice / experts in the field	7
Joined support for homeless and addiction	5
Isolation	4
Continued support - not just in a crisis	3
Support services	2
Support for those who are no longer a carer	1
Professionals working more closely together	1
Attitudes	1
Other	3

Main themes from comments received:

***Access**:*
Access to out of hour's services and early intervention services is a problem as is access to services such as 'Open Mind'. There should also be quicker access into current services.

***Continued / service provision for children and young people**:*
Improve services that are tailored for children and young people. Schools should be key to not only learning about mental health but also identifying people who may have issues.

***Support and advice for carers / families**:*
Information and provision for carers should be given as they provide the main support for those who have problems. Information about support groups etc. should be freely available.

***Correct advice / experts in the field**:*
Medical staff should be fully trained in Mental Health issues if they are giving advice / diagnosing problems that are mental health related. Patients should be able to gain access to staff who specialise in the field rather than a general practitioner or nurse.

***Joined support for homeless and addiction**:*
Services should be joined up e.g. drugs and alcohol, homelessness

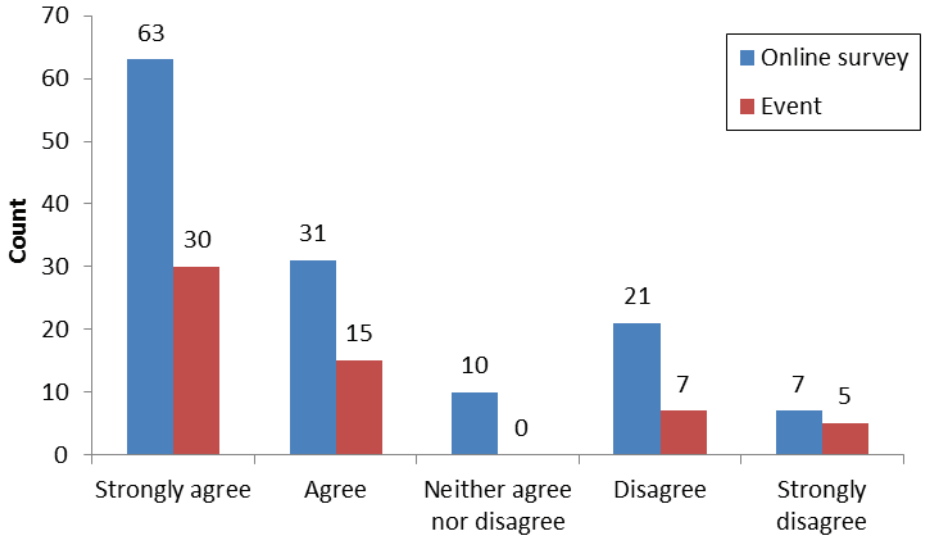
***Other**:*
Other comments focussed on continued support – not just when a person has hit crisis stage. Isolation and support for those who are no longer a carer were also mentioned.

What is our vision of improved mental health and wellbeing in Halton?

"People of all ages living in Halton will have a high level of self-reported wellbeing, having happy and fulfilling lives, being able to contribute economically and socially to their own networks and the community as a whole"

"Those who do experience mental ill health will not feel any stigma attached to the condition and be able to easily and quickly access appropriate levels of professional support to help them recover"

How much do you agree or disagree with this vision of mental health and wellbeing in Halton? (responses received: 132, 57)



Do you think there is anything which has been overlooked in this vision of mental health and wellbeing in Halton?

Rights / stigma for people with Mental Health	11
Loneliness / isolation	7
Access / Information	7
Happiness Statement	4
Resource	2
Monitoring	1
Other	11

Main themes from comments received:

***Rights / stigma for people with Mental Health**:*
Respondents feel that the statement “Those who do experience mental ill health will not feel any stigma..." is incorrect and will not work as it is not just about helping those with an illness to feel there is no stigma attached, but also about reducing the stigma that other people put on the illness.

***Access / Information**:*
Access to and knowledge of services is very important.

***Happiness Statement**:*
Happiness is very subjective and just because a person may feel unhappy for a certain period does not mean that they do not have good wellbeing. Feeling unhappy or sad is a natural part of life and does not mean that you automatically have mental health problems if you are experiencing it.

***Loneliness / isolation**:*
Loneliness / isolation should be tackled either through volunteers or drop in sessions, peer groups or respite for carers / families.

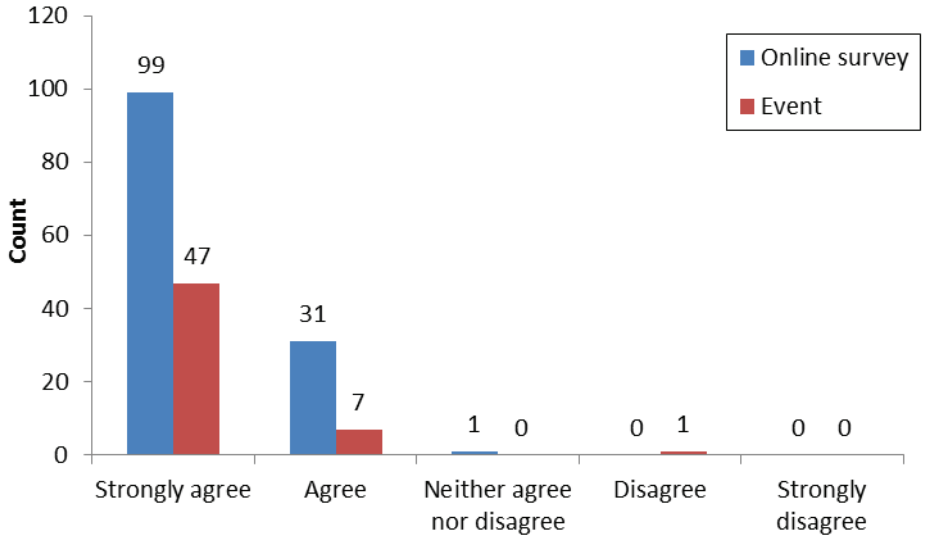
***Other**:*
Other comments related to resource and monitoring.

Our Priorities for Change

Prevention and Early Intervention

To improve mental health and wellbeing for the people of Halton we think when possible we need to prevent problems affecting mental health and when they do happen offer an early response to avoid people developing more serious problems later.

How much do you agree or disagree that prevention and early intervention is a priority? (responses received: 131, 55)



Is there anything you would like to say about the priority area of prevention and early intervention?

Early Intervention	15
Access / provision of information	12
Carers	2
Service provision	9
Support	5
Related Issues	5
Other	3

Main themes from comments received:

***Early Intervention**:*
Early intervention is key to service provision for the person needing treatment and help but also for the costs involved when a mental health problem is diagnosed at a later stage in life. Gaps in provision should also be part of this.

***Access / provision of information**:*
Information about and access to services is important but also that the provision of service is continuous. People being able to recognise the signs of somebody who has mental health issues is also important.

***Service provision**:*
Mental health leads in GP surgeries, mentors, key staff in schools and the work place.

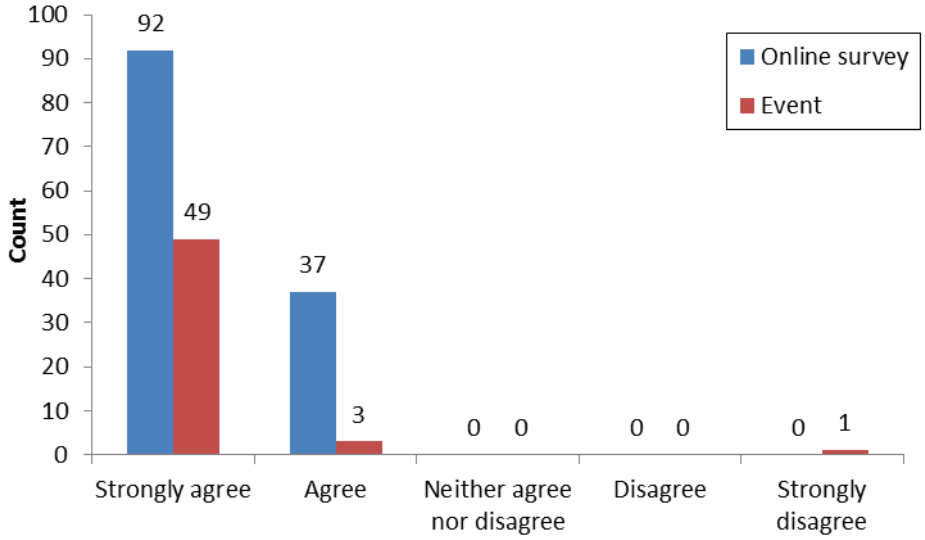
***Support**:*
Support should be available in terms of people having someone to talk to and looking at other issues in a person's life.

***Related Issues**:*
Need to look at alcohol, stress and homelessness.

Early Detection

We think that by increasing early detection of mental health problems we can improve mental wellbeing for both the person experiencing mental health problems and their families.

How much do you agree or disagree that earlier detection of mental health problems is a priority? (responses received: 129, 53)



Is there anything you would like to say about the priority area of earlier detection of mental health problems?

Education / training for professionals	16
Support / information for carers and patients	11
Education / Campaign	9
Resource	2
Other	5

Main themes from comments received:

***Education / training for professionals**:*
Professionals should be more aware of symptoms and how to refer and treat.

***Support / information for carers and patients**:*
Support should be holistic for the whole family / carers. Information should be provided to carers and services should listen to carers.

***Education / Campaign**:*
Information and advice to the public as to what symptoms, signs etc. to look out for.

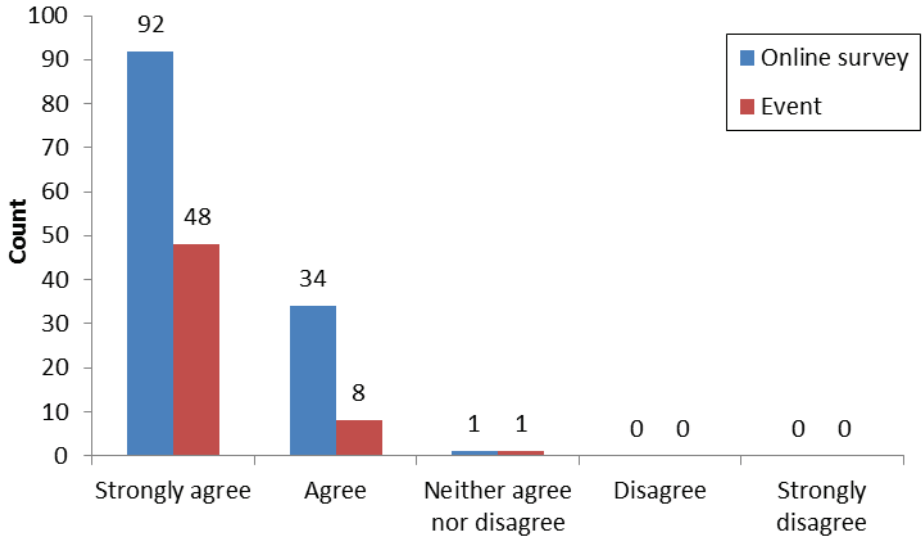
Resource
Is the resource there to be able to meet these objectives?

Other
Concern that early detection means over-diagnosis and one persons 'urgent' is not another persons 'urgent' so who makes the decision?

Better Outcomes and Quality Services

We think that those experiencing mental health problems want better outcomes from local, accessible, high quality services.

How much do you agree or disagree that better outcomes and quality services are a priority? (responses received: 127, 57)



Is there anything you would like to say about the priority area of better outcomes and quality services?

Service Provision e.g. waiting lists / opening times / specialists	13
Service Provision e.g. training / support services / whole family and carer approach	10
Not one approach	3
Other	4

Main themes from comments received:

Service Provision:

Waiting lists to receive treatment / access services are too long. Opening times of services should be looked into, people don't just have problems during the day. Also location of out of hours services should be looked at as people don't want to be taken to Warrington. More specialist staff required within services.

Service Provision e.g. training / support services / whole family and carer approach:

Aftercare is very important as is having a single point of contact. Support / information for the carer and patient, training for professional staff in how to explain what is happening.

Not one approach:

Service should be more flexible around the patient as every person is different.

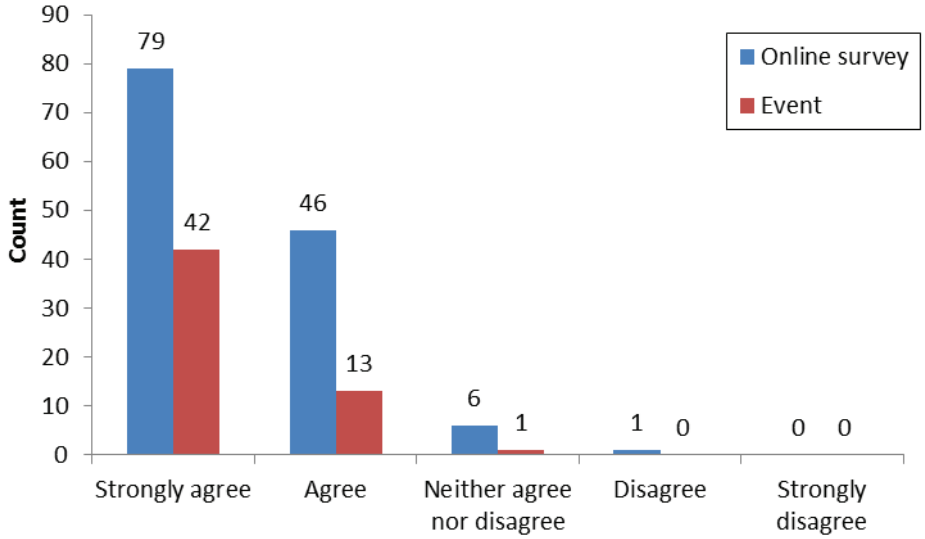
Other

Service should be measured on outcomes not the number of contacts, also the services that are more cost effective in the long term are always the first to be cut. Be honest as to what can be afforded don't make promises that can't be delivered.

Social Determinants

As the Government's policy of deficit reduction continues, both the CCG and Council must ensure value for money across all services. As well as the areas highlighted earlier we think a broader approach to tackle the wider social determinants of mental health is needed. This would place a focus on suitable housing, education, employment, local communities and the local environment.

How much do you agree or disagree that tackling the social determinants of mental health is a priority? (responses received: 132, 56)

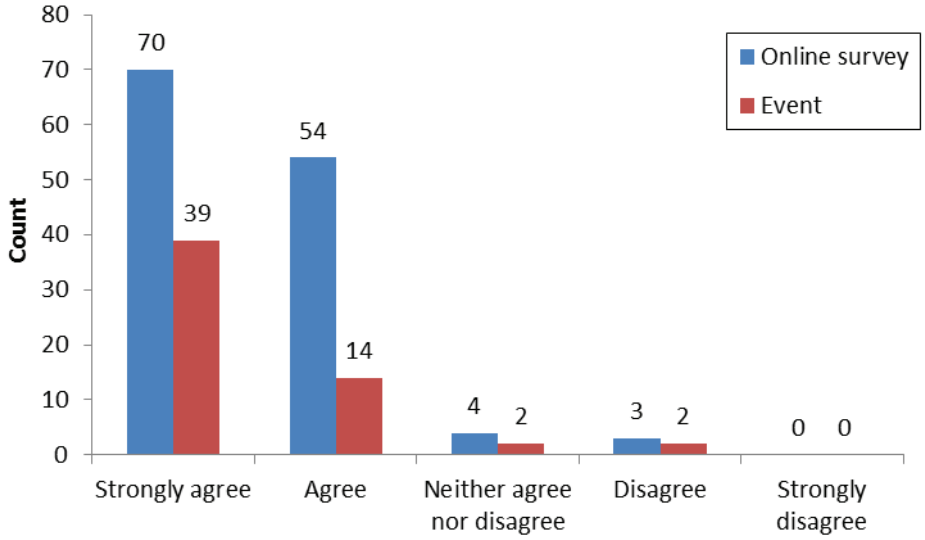


Is there anything you would like to say about the priority area of tackling the social determinants of mental health?
41 comments were received in total to this question. The comments provided were broad in nature and therefore no defined categories could be created from these comments.

The full list of open comments received from this question (and all questions in the survey) will be forwarded to the relevant team for further analysis.

Other Mental Health Related Issues

How much do you agree or disagree that there is a stigma attached to mental illness? (responses received: 131, 57)



What do you think can be done to increase the public understanding of mental illness?

Awareness / Campaigns	24
Understanding of mental health	22
Education: schools	22
Open days / Talks / fact sheets / high profile	21
Education: General	13
Other	6

Main themes from comments received:

***Awareness / Campaigns**:*
Awareness campaigns, media campaigns, clear messages about the signs and problems, clear publication of information / support available. Places to advertise, GP practice, work place, school.

***Understanding of mental health**:*
More understanding of mental health, that it can affect anybody. Mental health as a state of mind rather than an illness to be ignored.

***Education: schools**:*
Better education in schools from an early age. Mental health should be addressed along with other topics. Example of how mental health can affect people, have children help to mentor other children who may have problems.

***Open days / Talks / fact sheets / high profile**:*
Local events / open days / social media / local people who are affected / famous people who are affected / fact sheets

***Education: General**:*
Educate the general public about the signs and symptoms of mental health.

Tell us what you think?

If you could do one thing to improve general mental health in Halton what would it be? (open comment question)

Social / Economic	23
Information / support e.g. helplines, drop in	22
Access / more service provision	22
Training Professionals	17
Education / Awareness	11
Children / Young People	11

Main themes from comments received:

***Social / Economic**:*
Social and economic deprivation / community projects / jobs / lower costs for leisure activities / use current assets e.g. schools, community centre / tackle isolation

***Information / support e.g. helplines, drop in**:*
Helplines / clear information / one stops shops in GP or hospital / support for families.

***Access / more service provision**:*
Easier and quicker access to current service provision to help earlier detection. More provision or trained staff in GP practices

Training Professionals:
More understanding and more awareness from professionals / awareness training / better communication / changing attitudes and approaches

Education / Awareness
Better education and awareness, that mental health can effect anybody.

Children / Young People
More work with children and young people, especially in schools. Also provide a children drop in where children and young people can go and talk to someone. Encourage children and young people, particularly boys, to talk about any worries they may have.

How do you feel we can raise more awareness of the importance of good mental health? (open comment question)

Advertising e.g. Open days / talks / social media / raising funds	31
Schools / college	21
Advertising e.g. leaflets / posters / articles	16
Campaign the same for other illnesses / consistent / on-going / local	12
Investment	11
Other determinants	7
Isolation / Stigma	4

Main themes from comments received:

***Advertising e.g. Open days / talks / social media / raising funds**:*
Open days / awareness days / coffee and tea mornings / open days or events at schools, work place, local groups / positive stories and information via social media, press, TV.

***Schools / college**:*
Go into schools / college with DVD, drop in, chats, information

***Advertising e.g. leaflets / posters / articles**:*
Articles in paper / flyers / posters.

***Campaign the same for other illnesses / consistent / on-going / local Investment**:*
More investment in services / link with carers and families, especially at a local level.

Investment:
Investment should be made with continuous service provision, also investment should be made to work with carers, the carers centre, and those who provide services.

Other Determinants:
Promotion of healthy lifestyles e.g. healthy eating, exercise, laughter and sports.

Isolation / Stigma:
Help to reduce stigma and isolation with good role models and encourage residents to attend activities.

How do you feel we can educate younger people on the importance of good mental well-being? (open comment question)

Sessions / posters / talks	39
Curriculum / lessons	36
Other determinants / normalise / community	25
TV, Radio, Social Media	7

Main themes from comments received:

***Sessions / posters / talks**:*
Go and talk to schools, use examples that students can relate to. Train those who work with children and young people. Advisor or professionals going to schools, encouraging the students to talk about their feelings or issues they may be having.

***Curriculum / lessons**:*
Mental health should be included in lessons / curriculum / activities - including debates and leaflets. Start early in schools.

***Other determinants / normalise / community**:*
Give an understanding of what mental health is, talking about it makes it normal. Teach what good mental health is and encourage good mental health. Integration and working with those who may have mental health problems. Community activity with children and young people around mental health. Local mental health ambassadors.

***TV, Radio, Social Media**:*
Facebook, Twitter, Youtube. Local people and famous people should be highlighted in promotion. Promote eating healthy and exercise.

REPORT TO: Health Policy & Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Halton's Dementia Strategy

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present Halton's Dementia Strategy to Members of the Health Policy & Performance Board.

2.0 RECOMMENDATION: That: Members of the Board note and comment on Halton's Dementia Strategy;

3.0 SUPPORTING INFORMATION

3.1 The local dementia strategy was completed in February 2010 and was a direct response to the National Dementia Strategy – Living Well with Dementia (Department of Health, Feb 2009). The local strategy adopted the national targets as well as developing a specific implementation plan to deliver a range of improvements for people diagnosed with dementia and their carers.

3.2 There can be no doubt about the current and the future challenge posed by dementia. There are an estimated 24.3 million people with dementia worldwide, while in the UK, best estimates suggest that the number is currently 700,000, of whom approximately 570,000 live in England. Dementia costs the UK economy £17 billion a year, and in the next 30 years the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

3.3 The table below outlines the current level of people diagnosed with dementia in Halton, the projected number for 2025 and the estimated costs to the local economy.

	2012	Cost to economy in millions	2025	Cost to economy in millions
Halton	1,143	£25.7*	1613	£39.2**

**calculations based on projected cost to the UK economy divided by number of people in the UK with dementia, multiplied by number of people diagnosed in Halton.*

*** calculations based on projected cost to the UK economy divided by number of people in the UK with dementia, multiplied by number of people estimated to have dementia in 2025 diagnosed in Halton.*

This cost is based on a national calculation and relates to a number of different elements including, primary care visits, secondary care, costs associated to specialist services, mental health services, cost to other services for example Police, voluntary sector. In addition to this the anticipated cost of informal carers in giving support to their families.

3.4 The revised local dementia strategy, 'Living well with dementia in Halton' (Appendix 1), and the associated 'needs' paper (Appendix 2) looks at the progress that has been made since the original strategy publication, as well as identifying some key actions that need to be completed over the next 5 years.

3.5 Key achievements made since the original strategy:

- A project Manager was appointed and employed by the 5 Borough Partnerships. Supported by a multi-agency steering group the project manager completed a mapping exercise of all of the existing pathways, referral processes and service delivery for people diagnosed with dementia. This work initially concentrated on the service delivered within Health, Social Care and 5 Boroughs, but was extended to incorporate voluntary and community services and has informed the recent development of the local dementia pathway.
- Implementation of the Later Life and Memory Service and associated pathway with the aim of a reduction in assessment waiting times.
- Dementia Care Advisors have been commissioned.
- Three Dementia Cafés have been established and more are being planned.
- Improved information provided on diagnosis from the Alzheimer's Society.
- Workforce development training commissioned to deliver basic awareness training, practitioner training and work based vocational training.

3.6 Priorities for 2013-2018 focus on the following areas:

- Prevention and raising awareness
- Early diagnosis, information and advice
- Living well in the community
- End of Life
- Workforce development
- Links to other workstreams

3.7 The 2013-2015 Strategy implementation plan outlines the key actions for future development in improving the outcomes for people with a dementia diagnosis, their families and carers. The implementation plan can be found within the 'Living well with dementia in Halton' Strategy document.

Research and Consultation

3.8 The strategy was developed taking into account findings from large scale national and international research and consultation, along with the local findings of the 2009/10 Halton Borough Council and Alzheimer's Society consultation and research project, 'Dementia Journey Halton'. HealthWatch Halton and the dementia support group 'Lunch Bunch' also provided feedback on the strategy objectives.

4.0 POLICY IMPLICATIONS

4.1 National Policy is directing the future of dementia treatment and support. The launch of the Prime Ministers Challenge on Dementia and the Care Bill places the focus on early diagnosis and person centred support, highlighting the role that families and carers play and the support that must be offered to them. These principals are reflected in the Living well with Dementia in Halton Strategy.

5.0 FINANCIAL IMPLICATIONS

5.1 All financial and commissioning decisions will be managed through the Dementia Partnership Board in accordance with Standing Orders and financial regulations of both the Local Authority and the Clinical Commissioning Group.

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 strategy has a direct impact on the health outcomes of people with a dementia diagnosis, and their families and carers.

6.4 A Safer Halton

The strategy has an impact on people with a dementia diagnosis in living well and living safely within our community.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 A risk log will be completed and managed through the Dementia Partnership Board.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Policies and procedures that are developed or amended as a result of this strategy will be subject to an Equality Impact Assessment.

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

None identified under the meaning of the Act.

HALTON BOROUGH COUNCIL

Living Well With Dementia in Halton

Halton Dementia Strategy and Implementation Plan

2013-2018

CONTENTS

Foreword

As people live longer, Dementia is an increasing problem across the country and this picture is mirrored in Halton. It is a complex condition with widespread effects on the individual, the family and the health and social care system.

Current estimates show that about half the numbers expected in Halton have been diagnosed. Often, the first time the problem is recognised is when a crisis occurs, causing a great deal of distress to all concerned.

There seem to be two main reasons why there is a reluctance to diagnose dementia early; a fear of stigma and a belief that nothing much can be done. Yet, there is no reason why people with dementia cannot live full, happy lives. It is important for health and social care services to work with the public in order to ensure that those with dementia are identified early and are fully supported to enjoy life.

Nationally and locally it is clear that dementia is one of the biggest challenges facing the health and social care economy. Although dementia can affect adults at any age, it is most common in older people becoming more prevalent with increasing age, but this does not mean it is a natural part of the ageing process or inevitable for all older people - a message we need to communicate more widely.

This strategy aims to encourage early, accurate diagnosis and to ensure health and social services are positively organised so that those with dementia receive all the care they need.

Our Vision

Our vision is clear: It is for all people with dementia and their carers to continue to 'live well'. To do this we will create an environment where people feel empowered to seek help early, know where to go for help and what services to expect, have access to the care and support that they would benefit from, and are confident that this care is of high quality, where the public and professionals are well informed and where fear and stigma associated with dementia has decreased.

Councillor Marie Wright.
Halton Borough Council Portfolio Holder for Health and Wellbeing

Dr David Lyon. GP, Clinical Lead for Dementia and Community Services. Halton Clinical Commissioning Group Governing Body Member

Introduction

The 'Living well with dementia in Halton' strategy is coordinated by the Halton Dementia Partnership Board and is based on the requirements identified within 'Living well with dementia in Halton Needs Paper'. The action plan that accompanies this strategy is to be implemented over 5 years, with an update on progress to be published annually.

Whilst there is still much to do, there has been a number of positive national and local developments relating to dementia since 2009. From the national 'Prime Minister's Challenge on Dementia' to the introduction of the 'Halton Later Life and Memory Pathway', living well with dementia is a priority for

all. Seventy five percent of the objectives within the 2009 Dementia Strategy Action plan have been implemented, for example:

- Improving awareness and understanding of dementia through a range of literature and the Dementia Care Advisor service.
- Good quality early diagnosis and intervention through the Later Life and Memory pathway
- Improved intermediate care for people with dementia through professional and vocational training

The 2009 action plan and progress is available on request.

This strategy and associated implementation plan includes the remaining objectives from the 2009 action plan along with new, stretching objectives. The strategy complements other work programmes including the local Halton Sustainable Communities Strategy, Mental Health Strategy, the Halton Health and Wellbeing Strategy, Carer's Strategy Action Plan, Falls Strategy and Loneliness Strategy, and should be read in conjunction with these pieces of work.

This strategy provides plans for the future against the four themed objectives of the national strategy:

1. **Raising Awareness**
2. **Early Diagnosis and Support**
3. **Living Well with Dementia**
4. **Delivering the Dementia Strategy.**

Why do we need a dementia strategy?

The population of Halton is aging. That is, a larger proportion of the total population will be found in the 60-plus age bands by 2031 compared to 2006. This section of the population will increase by 61% to 36,300 by 2031.

- The number of people with dementia is set to rise by 62% by 2030, largely due to the projected increase in the older population. It is projected that there are 1180 people aged 65+ living in Halton who have some form of dementia in 2012 and by 2020 this figure is estimated to be as high as 1518. In addition it is estimated that there are currently about 34 people aged between 30-64 who early onset dementia
- Our current diagnosis rate is **63.3%,** with an aspiration of taking this to over 66% during 2014/15
- Based on National Audit Office research it is estimated that of the people with some form of dementia 788 will live in the community and 392 in a care home. This will rise to 1367 living in the community and 683 requiring care home places by 2030.

With prevention, an early diagnosis and appropriate information and support, a good quality of life is possible. While the costs of dementia are expected to rise in coming years because of growing numbers of people affected, there is significant scope for spending money more efficiently and effectively. A local dementia strategy, over 5 years, will provide the focus and direction of actions to be taken to achive better outcomes for people with a dementia diagnosis.

What would success look like?

Through consultation and research undertaken by Health Watch Halton[i] and Halton Borough Council and Alzheimer's Society [ii] we have been able to understand what success for people with a dementia diagnosis, their family and carers would look like in Halton.

Raising Awareness and Understanding

"*Need to ensure that health and social care professionals have an awareness of dementia"* "Need *to raise awareness across Halton of how to prevent dementia"*
"Need to raise awareness of care staff in residential and community settings."
"young people need to understand Dementia."
This led to an overall agreement and discussion that dementia *'does have an impact on children and grandchildren.'*

Early Diagnosis and Support

"I think there has been improvement in dementia care but it appears to be sporadic, it is not right across the board"
"*Health Passport to improve communication between staff and between staff and patients"*

Theme 3 - Living well with Dementia

"Dignity needs to be included in the training and All health staff need training but it needs to be done properly."
"there *should be an awareness of telecare products and services to help people remain independent."*

Raising Awareness
A sustainable and skilled workforce in the care of people with dementia, their family and carers. Our communities are supported to adapt to become dementia friendly to tackle the fear and stigma of dementia. "First of all is getting my wife to accept there's something wrong"
Early Diagnosis and Support
Early assessment and diagnosis, so that appropriate treatment and support can be put in place as soon as possible to help maintain a good quality of life. "We want quality time with somebody who knows"
Living well with dementia
"I had so many questions"

People with a dementia diagnosis, their family and carers have access to appropriate information at the right time, help to understand information and are supported through treatment and support.
Delivering the strategy
Seamless, wrap around support commissioned through integration of Public Health, Halton Clinical Commissioning Group and Adult Social Care "The quality of our lives has changed so much"

Halton Dementia Pledges

Complementing the person centred ouctomes devised by the National Dementia Partnership [iii] through consultation with people with a dementia diagnosis, their family and carers, a set of local dementia pledges have been developed and are to be adopted in Halton.

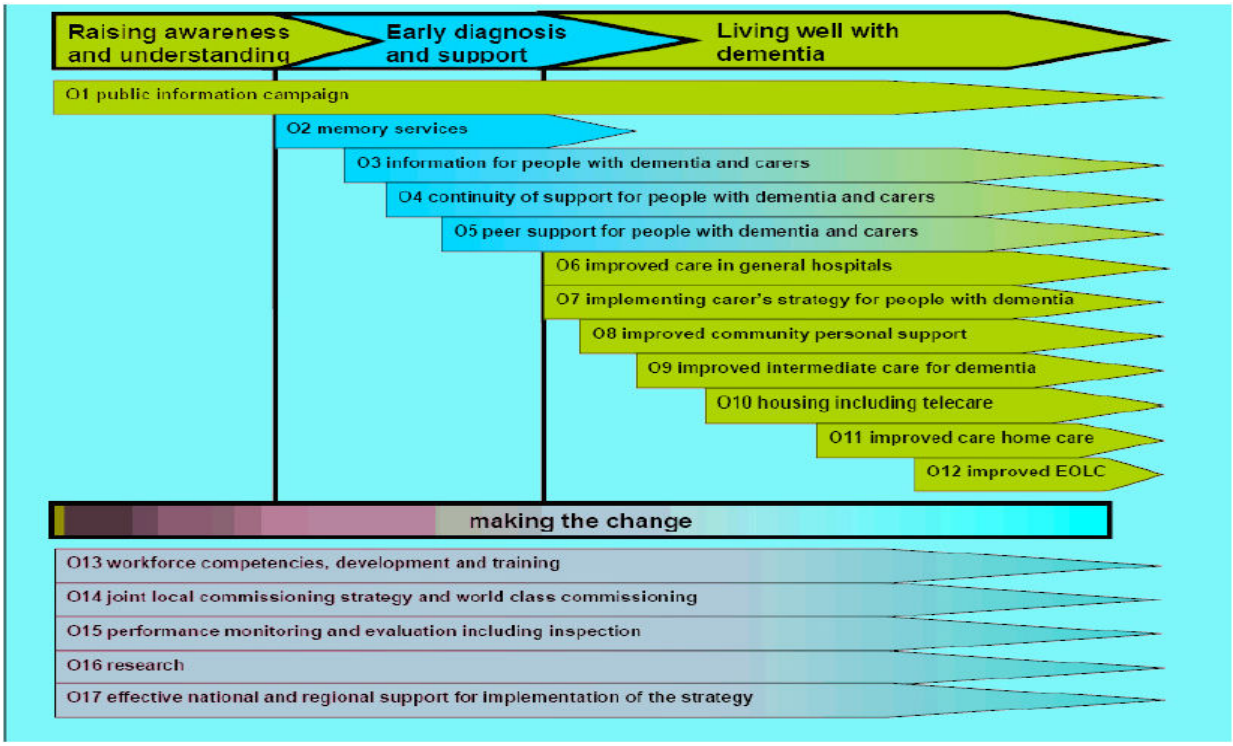
Our pledges are:

1. You will be diagnosed early
2. You will be supported to understand information so that you can make good decisions and you know what you can do to help yourself and who else can help you
3. You will get the treatment and support which are best for your dementia and your life
4. Those around you and looking after you are well supported
5. You will be treated with dignity and respect
6. You will be supported so that you can enjoy life
7. You will be supported to feel part of a community and be inspired to give something back
8. You will be supported to ensure that your end of life wishes will be respected.

The pledges not only demonstate commitment to developing and providing excellent services for people with a dementia diagnosis, their families and carers, but define the quality of those services. The pledges set the bar for expectations, and against which patient, family and carer experiences can be measured and outcomes improved for them over the lifecourse of this strategy.

Realising the vision

The National Dementia Strategy 2009-2014, in its development, was clear that Local Authorities and Primary Care Trust's (at the time) should take a radical approach to whole system transformation to meet the twin aims of better outcomes at lower cost, with outcomes defined within the care pathway, as illustrated below:



When translating the national objectives to local action, a number of priority areas are highlighted for action.

Priorities for 2013-2018

1) Prevention and raising awareness

Actions within this theme are focussed on better public information about dementia, reducing stigma, informing the public what services are available, informing staff how to signpost and support people with dementia and their carers. To achieve this we will work with a wide range of colleagues, including those in Public Health, Housing, Social Care, Police, Fire, Health and voluntary sector to improve the way we provide information.

2) Early diagnosis, information and advice

The first step is to encourage people to visit their GP for an assessment, as soon as they become aware of a problem with their memory. In this way people with dementia and their carers are identified and part of the system. From then on they can be pro-actively offered information and support and helped to access services appropriate to their needs. To achieve this we will link up primary and secondary care services via the simple but effective, multidisciplinary Later Life and Memory Service care pathway, enhance the dementia adviser's service, offer more and varied peer support opportunities, provide training to GP-practices, increase Quality Outcome Framework (QOF) registrations, have

screening in place for people with learning disabilities and for people at risk of vascular dementia and ensure capacity in secondary care memory clinic.

3) Living well in the community

More people with dementia are living well for longer in their community. Key factors are keeping physically and socially active, getting the right encouragement and support, knowing the right coping strategies and supporting carers. Providing a variety of peer support networks across the borough is crucial in achieving this. Also, current housing, health and social care services need to be more joined-up and able to offer greater flexibility and continuity. Mainstream services in particular need to be dementia-friendly and provided by well-trained staff. Furthermore, GP-practices need to offer service users a regular health check and dementia advisers need to be in regular contact with service users and carers so they can signpost them to the right services at the right time to avoid a crisis developing. (Such services may include extra care housing / supported housing, telecare, carers support, well-check, peer support, and home care support). Clear pathways for different groups of people with dementia are being designed ensuring appropriate services are joined up and service provision is commensurate with the changing needs of service users and their carers as the disease progresses. Aiming to advance equality of opportunity for dementia patients , carers and wider communities, in line with The Equality Act 2010, by empowering people with a dementia diagnosis to have high aspirations and feel confident to continue to partake in activities within the community, achievable by Halton becoming a dementia friendly community.

4) End of Life

End of life care has to be considered early when the person with dementia still has capacity to express their future preferences regarding their preferred place to die. To achieve good end of life care we are ensuring that all staff and providers within dementia care utilise the principals of the Gold Standards Framework for end of life care and are trained and competent in the use of end of life tools and policies so that decisions and preferences for care at the end of life can be communicated and documented effectively.

In addition, the dementia end of life pathway will be supported by a robust clinical support network, including GP's, District Nurses, Consultants in Palliative Care, Speciality Doctors, Macmillan Nurses and Social Care teams operating within an Integrated Care Network. The service provision in Halton is designed to take a whole system approach to delivering end of life care, which includes an End of Life Social Service, Palliative Care Sitting Service, 7 day access to Macmillan Nurses, Family support and bereavement services, Palliative Care advice services along with access to Specialist Palliative care teams within in the community, hospice and hospital environments.

5) Workforce development

Developing dementia friendly services requires a whole system approach. Mainstream staff from Older People's and Adult Services are often in contact with people with dementia. It is therefore important that all staff are able to signpost people to the right services, that they can encourage people to visit their GP when they have concerns about their memory and know in general how best to approach and actively support people with dementia. Work with 'Skills for Care' (an organisation that provides work force development resources for Adult Social Care employers in England) is already underway in Halton, with funding secured to implement dementia awareness training and life story work. Reminiscence work and House of Memories[iv] are already in place in nursing homes across the borough.

6) Links to other workstreams

The dementia strategy doesn't stand alone. In order to improve dementia care links are identified with other strategies including End of Life Care, Telecare, Housing and Carers Strategies, and to other workstreams including Personalisation and Dignity in Care.

Underlying principles in developing dementia treatment and support services

- regularly consult people with dementia and their carers to ensure we take account of their needs;
- support equality in access and service provision;
- commission quality and state of the art services and regularly monitor actual provision against agreed outcomes;
- encourage best use of available resources across the borough;
- facilitate working in partnership between providers of dementia care;
- consistency with priorities of the Health and Well-being Partnership Board and Halton Dementia Partnership Board
- Facilitate training and awareness raising for dementia.
- Safeguarding is a priority for all

Resource

Budget received for 2013/14 for Mental Health Services (as a whole)

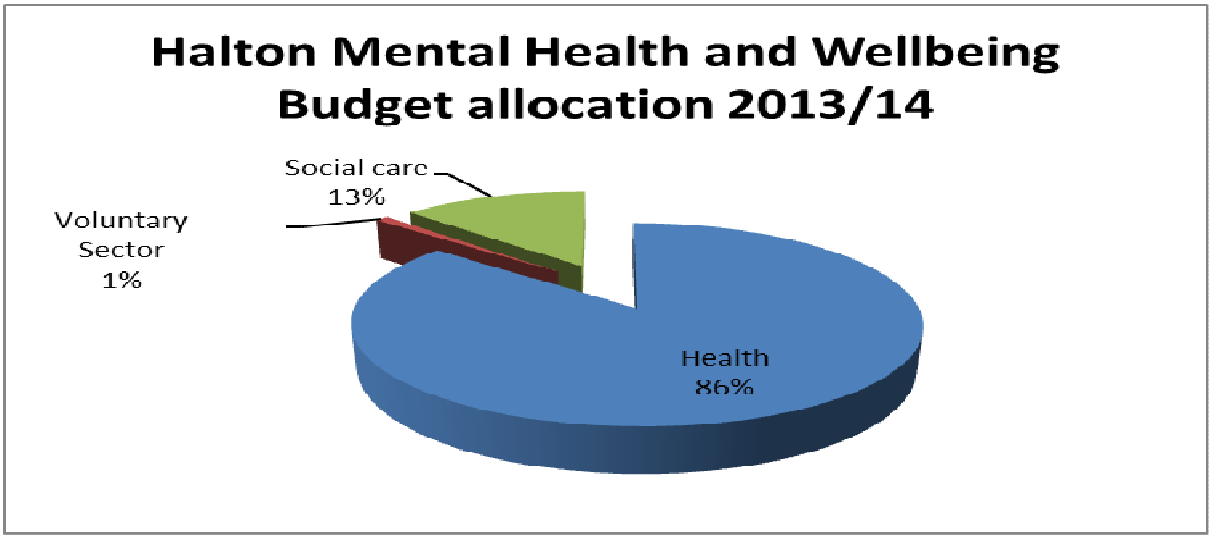
	£000m
Halton Clinical Commissioning Group	17,223
Halton Borough Council Adult social Care	2,934
Halton Clinical Commissioning Group – Continuing Health Care (Mental Health)	2,500
Halton Borough Council Public Health	47
Halton Borough Council Children's and Enterprise	191
TOTAL	**22,895**

It is important to understand the complexities of the existing budget and the challenges in ensuring that people are diagnosed and supported in an appropriate way. The budget above and the chart below is for the total mental health allocation in Halton, however it is not always straight-forward to align a particular expenditure against dementia. For example there is a wide range of generic activity that goes on relation to awareness raising and prevention, that may not necessarily be capture specifically as dementia expenditure.

The chart below does begin to demonstrate the challenge facing commissioners in the next five years. Shifting the budget allocation away from high end health interventions to earlier voluntary sector and

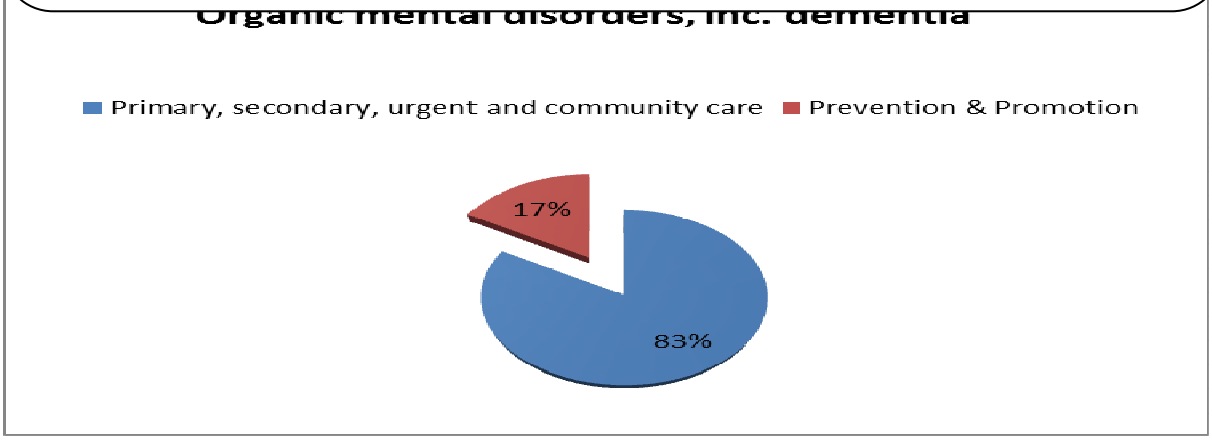
prevention measure is a key priority. This in turn will help to support the improving early diagnosis rate in Halton.

How the budget was allocated between health, social care and voluntary sectors 2013/14



The above pie chart illustrates how the £22.9 million budget for mental health (as a whole) has been invested. It is clear that the majority of resource is currently invested in health treatment and services. In the future the focus for mental health disorders, as whole, will be on supporting people within the community to improve person centred outcomes for individuals and their carers.- The CCG are currently working with 5 Boroughs Partnership to scope out and pilot Payment By Results (PBR) Cluster packages for adult mental health and Children and Adolescent Mental Health Services (CAMHS) and Later life and memory services. In the future this will mean a more robust costing structure based on diagnosis and care pathways.

The pie chart below illustrates that 17% of the £5.7 million health budget for organic mental disorders (including dementia) is spent on prevention and promotion. It is well documented that promotion can increase awareness and therefore early diagnosis, enabling people to access lower level treatment and support at an earlier stage to slow the progression of the disease. We intend to rework our reconfiguration of this allocation and focus on prevention and promotion investment. This will be governed by the Dementia Partnership Board.



Given the complex nature of funding arrangements within the council, it is difficult to determine the precise amount of funding available and used for people with dementia. This is primarily because of the difficulties in diagnosing someone with dementia and the fact that the expertise to meet individual needs are based within older people mental health teams. Whilst the prevalence of dementia continues to grow and will become a significant factor in future years, it is not economically viable to separate out the needs of people with dementia from other older people with mental health issues, such as depression.

There are a variety of different factors that will 'push and/or pull' the funding for services, for example; residential care – price inflation and demographics will push the price but at the same time improvements in Public Health, Telecare and Prevention, will all pull expenditure on residential care down. For each type of expenditure there are all these factors pushing and pulling. We will shift resources from the point of crisis to prevention and early intervention.

How are we going to achieve the priorities?

The implementation plan below details what actions will take place over the life course of the strategy to achieve the vision of living well with dementia in Halton

Implementation Plan 2013-2018

1. Prevention & Raising Awareness

Action	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager/Officer	When
1.1 **Establish a Halton Dementia Training and Information Alliance**	250 health and social care staff dementia awareness trained. 17 GP practices to attend dementia awareness training within Protected Learning Time.	Phase 1: Dementia awareness raising and training delivered to front line social care, primary care and secondary care staff Phase 2: Dementia awareness raising and training to other service areas within the Local Authority, Fire Service, Police Service, Housing providers Utilise Dementia Friends awareness raising sessions Training to include advice on reducing risks of developing dementia e.g. advise around healthy lifestyle and referral to support services as appropriate Awareness raising sessions delivered throughout each year to GPs via Practice Learning Time Events delivered by CCG and Learning Disability Clinical Lead. Dementia Clinical Lead to champion raising awareness within practices through general duties as a CCG clinical	**You will be treated with dignity and respect.** **You will have access to a skilled workforce** **Your GP will be more able to diagnose you earlier**	Dave Sweeney, Halton NHS CCG	Brian Hilton Linda Birtles-Smith Dr David Lyon	October 2014

		lead				
1.2 **Develop Dementia Ambassadors within teams/organisations to maintain awareness raising and promote dementia friendly service**	Minimum of 1 Dementia Ambassador within each member organisation of the Dementia Partnership Board.	Each Dementia Ambassador to undertake Alzheimer's Society Dementia Friends awareness raising session and Dementia Champions Training	**You will be treated with dignity and respect.** **Halton will adopt a consistent approach to your care**	Dementia Partnership Board member from each partner organisation		August 2014
1.3 **Ensure dementia is defined in the delivery of the NHS Healthchecks programme in Halton**	7667 people will be invited to attend an NHS Healthcheck 75% (5750) of people invited will receive an NHS Healthcheck Baseline of 850 people aged 65-74 are eligible to receive the dementia component of the Healthcheck, of which 76% (650) will be given information on the signs of dementia	Over a five year rolling period, everyone aged between 40 and 74 (who hasn't already been diagnosed with one of a series of specific conditions) will be invited for an NHS Health Check at their GP surgery. The check will include personal and family history, a range of physical checks and the provision of information and advice. For those aged 65 and over the check will also include the provision of general information about dementia.	**You will be diagnosed early.** **You will receive care and support at the earliest possible point**	Dr Ifeoma Onyia, Halton Borough Council Public Health	Joanne Sutton and Commissioned Practices	2013-2018

2 Early Diagnosis

Action	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager/Officer	When
2.1 **Delivery of Direct Enhanced Service for Dementia (DES) within general practice, to increase awareness and screening for dementia.**	CCG Quality Premium target is a 62.1% (807 people) diagnosis rate based on a prevalence of 1300 people with dementia.	DES payment data via NHS England Primary Care Team (annually). Dementia Board will request exception reporting from NHS England relating to delivery outcomes	**You will be diagnosed early.**	NHS England contractual arrangements Dave Sweeney, Dementia Board Dr David Lyon, Halton NHS CCG	Jo O'Brien, Primary Care Commissioning Manager	2013-2014
2.2 **Dementia Preliminary Screening Pilot** Develop and evaluate a dementia case finding pilot with non-clinical community based workers.	Output figures to be determined as the pilot is developed. Anticipated outcomes are increased awareness amongst community based staff about dementia Increased awareness of dementia risk factors and symptoms amongst those most vulnerable within the	The pilot will be delivered in partnership with Liverpool Housing Trust, Riverside Housing and Halton Housing Trust, Halton Borough Council Bridge Building Team, Sure Start to Later Life team and Community Development Workers. Working with the CCG Clinical Lead for Dementia to develop referral, information sharing and data protection protocols and evaluation methods. Non clinical Community based staff	**You will be diagnosed early.**	Dave Sweeney, Halton Borough Council Dr David Lyon, Halton NHS CCG	Emma Bragger, Policy Officer Communities Directorate	Evaluation of pilot completed by October 2014

	community Increased attendance at GP with screened cognition concerns, seeking further investigation from GP. Increased referrals to Later Life and Memory Service Pathway Increase in diagnosis rate	already supporting people who may have expressed concern, or display symptoms of cognitive impairment, to be offered the 6CIT screening test and referred to GP for further investigation where indicated.				
2.3 **Develop a business case around the evidence of the effectiveness of the Rapid, Assessment, Interface and Discharge (RAID) programme for people with dementia that could be applied within local hospitals.**	**Recommendations to be made to the Dementia Partnership Board**	The business case will identify potential improvements/risks relating to • satisfaction for dementia patients • experience for staff • choice for the acute trust • better health outcomes for the patient with dementia • value for our economy.	**You will be diagnosed early.**	**Commissioning Managers**	**Mark Holt**	**March 2015**

3. Living well with dementia

Action	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager/Officer	When
3.1 **Improve quality of residential and domiciliary care for people with a dementia diagnosis.**	Pooling of health and social care budgets to commission an integrated model of clinical, social and dementia care across all residential care, not just dementia nursing homes. NICE Care Audit Tool for people with Dementia (due for publication during 2014) is implemented across domiciliary and residential care	The Dementia Partnership Board to contribute to the evaluation of the 5 Boroughs Partnership Care Home Pilot and the Halton Borough Council care Home Model. Implementation of the NICE Care Audit Tool to be included as a contractual requirement in future service specifications. Provide specialist training and support to social workers, residential and domiciliary care staff to support individual and carers in making end of life plans. Consider the results of the evaluation of the 5 Boroughs Partnership Care Home Liaison Project and the existing Halton Borough Council Care Home model and make commissioning recommendations.	**You will get the treatment and support which are best for your dementia and your life.** **You will receive a better level of care in your own home** **You will be confident of the standards of care being delivered in residential care**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Damien Nolan, Divisional Manage, Halton Borough Council	Summer 2014
3.2 **Provision of appropriate information to people**	100 % of people accessing Dementia Care Advisor or Support Worker service to have	Requirement to provide Dementia Guide and IAPT information to be included in future service specification of Dementia	**You will get the treatment and support which**	Dave Sweeney, Operational Director for	Mark Holt, Commissioning manager, Halton	**October 2014**

with a dementia diagnosis, and their carers, at the appropriate time	access to the dementia guide 100% of the Dementia Training and Information Alliance (to be formed) members to receive a copy of the Dementia Guide. 100% of carers of people accessing the Dementia Care Advisor and Support Worker service to be informed of the services available through IAPT	Care Advisor and Support Worker Dementia Care Advisors and Support Workers to provide the Alzheimer's Society resource 'The Dementia Guide. Living well after diagnosis'. Promote to carers of individuals with a dementia diagnosis the availability of psychological therapies through the Improved Access to Psychological Therapies (IAPT) investment programme	**are best for your dementia and your life.** **Those around you and looking after you are well supported**	Integrated Care, Halton Borough Council	Borough Council	
3.3 **Development of a Carer's on line forum to enable carers to get direct access to clinicians for information and advice on the condition.**	Measure – standardised tool of wellbeing to be used	Evaluation of the on line Carer's Forum pilot, with analysis considered in development of future commissioning intentions.	**Those around you and looking after you are well supported** **You will have direct access to key professionals**	**Dementia Partnership Board** **Carers Board**	**Steve Eastwood**	**March 2015**
3.4 **Delivery of community based care and support**	50% increase in the number of people diagnosed with dementia who have access to a Dementia Care Advisor/Support Worker or equivalent trained staff in the voluntary sector	Develop a business case for the Dementia Care Advisor/Support worker service and the potential to skill the voluntary sector and make commissioning recommendations. Evaluate current Dementia Care Advisor and Dementia Care Support Worker	**You will be supported to understand information so that you can make good decisions and know what you**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon,	Mark Holt, Commissioning manager, Halton Borough Council	**2014/15**

		Service, including,– capacity and outcomes and impact of any change in service (increase/decrease in capacity) on other services. Evaluate the use of voluntary sector organisations in supporting the dementia agenda. Including skilling of volunteers who are already providing support to people in their own homes .	**can do to help yourself and those who can help you.** **Those around you and looking after you are well supported.**	Halton NHS CCG		
3.5 **Halton to become a recognised Dementia Friendly Community**	Measures for the Safe in Town scheme to be determined. Anticipated outcomes include: • Improved social inclusion for person with dementia diagnosis • Improved independence for person with a dementia diagnosis • Increased awareness of dementia amongst retailers and service providers Awarded the Alzheimer's Society 'Dementia Friendly Communities' recognition	Use the Alzheimer's Society Dementia Friendly Society web resources and support to achieve dementia friendly status. Expansion of the 'Safe in Town' pilot to include people with dementia. Work towards achieving the Alzheimer's Society Dementia Friendly Community Award.	**You will be supported to feel part of a community and be inspired to give something back.** **You will be supported so that you can enjoy life.**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council	Safe In Town Steering group	May 2014

	award.					
3.6 **Coordinated approach to assistive technology for people with a dementia diagnosis.**	Increase in number of people who are prescribed specialist equipment.	Base line of use of assistive technology amongst people with a dementia diagnosis to be established. Scope the use of alternative technologies to improve outcomes for people with a dementia diagnosis and their carers by participating in the Innovate Dementia programme Needs analysis to be undertaken Recommendations to be considered in commissioning intentions.	**You will be supported so that you can enjoy life.** **You will be able to access equipment that will improve your quality of life**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Steve Eastwood, Commissioning Manager, Halton Borough Council	2014/15
3.7 **Provide specialist input to Care Management and Care Planning teams to improve the quality of end of life care plans for people with dementia.**	Increase in the number of people supported to complete an end of life plan.	End of life tools training delivered by Advanced Care Planning Team	**You will be supported to ensure that your end of life wishes will be respected.**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Jenny Owen/Emma Alcock, Commissioning Manager, Halton NHS CCG	On going
3.8 **Improve access to out of hours service for end of life patients**	Increase in number of completed Special Patient Notes for diagnosed dementia	Cleansing and auditing of current Special Patient Notes to provide baseline.	**You will be supported to ensure that**	Dave Sweeney, Operational Director for	Jenny Owen/Emma Alcock,	Ongoing

	patients within Halton	Training to be provided to GP practices as part of Gold Standard Framework of care by Advanced Care Planning Team Utilising the red flag system for end of life dementia patients – to highlight as emergency to be seen within 1 hour.	**your end of life wishes will be respected.**	Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Commissioning Manager, Halton NHS CCG	

4 Delivering the strategy

Action	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager/Officer	When
4.1 **Development of a performance dashboard**	Qualitative and quantitative evidence of improved outcomes for people with a dementia diagnosis and their carers	Dashboard to be devised around Halton's 8 dementia pledges Development of patient/carers group to enable their qualitative contribution to performance management.	**You will be confident that decisions are being made based on the most up to data information available**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Mike Shaw, Performance Officer, Halton NHS CCG	Quarter 1 2014/15

[i] Halton HealthWatch consultation with 'Lunch Bunch' group for carers of people with a dementia diagnosis. Sept 2013

[ii] 'The Dementia Journey Halton 2009/10'

[iii] Transforming models of care for people living with dementia - Improving experiences and outcomes for people with dementia and their carers and families Report 2012

[iv] House of Memories is a training and delivery programme built around the objects, archives and stories held within the Museum of Liverpool. It aims to provide social and health care staff (in domicile and residential settings) with new skills and resources to share with people living with dementia, and to promote and enhance their wellbeing and quality of life, as a potential alternative to medication

HALTON BOROUGH COUNCIL

Living Well With Dementia in Halton

Halton Dementia Strategy Needs Paper

2013-2018

CONTENTS

Introduction

This strategy needs paper highlights the national policy drivers and local needs analysis. It sets out current initiatives designed to improve the lives of people with dementia, their carers and families, enabling them to have a more fulfilled life and is the culmination of work led by the Dementia Partnership Board. The associated strategy paper and implementation plan shows how these drivers will be translated into action, and the outcomes. It is anticipated that the commissioning process will take five years in total to deliver and is a whole system transformation supported by collaboration of all agencies working to improve both the experience and outcomes of people with dementia and their families.

National Context

'Living Well with Dementia: A National Dementia Strategy' aims to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. Since its launch in 2009 the strategy has provided a catalyst for change at a local level with the vision of positive transformation of dementia services. Click here to see the national strategy.

The Prime Minsters Challenge on Dementia

Since the publication of the Joint Halton Dementia Strategy in 2009, the Coalition Government have set The Prime Minster's Challenge on Dementia (March 2012), to deliver major improvements in dementia care and research by 2015. The Prime Minister's Challenge on Dementia builds on the National Dementia Strategy to provide a framework which directs action. The goal is to make a real and positive difference to the lives of people affected by dementia. The ambition is to ensure that people with dementia and their carers receive high quality, compassionate care whether they are at home, in hospital or in a care home. The person with dementia, and their family and carer, are to be at the heart of everything health and social care providers do, with their wellbeing and quality of life to be first and foremost in the minds of those commissioning and providing services for them. click here to see the Annual Report on Progress.

The Care Bill

The Care Bill was announced in the Queen's Speech in May 2013 and aims to modernise adult social care law, in order to clarify the issues of eligibility and service delivery. It is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. To promote individual wellbeing, their needs, views, feelings and wishes should be considered in all aspects of their wellbeing from physical and mental health, through dignity and respect to control over their daily needs, access to employment, education, social and domestic needs and the suitability of their accommodation.

Whilst the Bill incorporates care and support across the board, when thinking about how dementia services are developed in the future, the Local Authority and health care partners will need to consider the following:

- access to services that help prevent their care needs from becoming more serious
- access to good information to help them make informed choices about their care and support
- have a range of good care providers to choose from
- the public know how to access independent financial advice
- the public know how to raise concerns over the safety or welling being of someone with care needs

Locally, it will require the integration of care and support with the local authority, health and housing services and other service providers to ensure the best outcomes are achieved for the individual. For example, care services will need to consider the strengths and interests of older people and to connect them to local clubs and social groups. This will strengthen communities themselves and helps to keep people safe and reduce, delay or prevent needs for acute care.

House Of Lords Committee on Public Service and Demographic Change report 'Ready For Ageing?'

The report published in March 2013 contained 10 principal conclusions and recommendations for action across Government. In particular the committee emphasised the need for Government to respond to the impact of our ageing population on public service provision. Dementia features heavily in the report, focusing on more ambitious targets for dementia diagnosis rates – to increase to two-thirds by 2015. Click here to see the report

NHS Operating Framework

The NHS Operating Framework 2012/2013 includes requirements for a renewed push on implementation of the national dementia strategy and increased support for carers. One of the key themes is putting patients at the centre of decision making and improving dignity and service to patients. The care of older people and dementia services are given priority within the framework and the move towards an outcomes focused approach provides incentives to improve services for older people. Local implementation of the proposed dementia Quality Outcome Framework indicators for 2014/14 places emphasis on the recognition and support of carers. Click here to see the NHS Operating Framework 2012/2013

National Outcome Frameworks

The Government's outcome frameworks provide accountability that focuses on how well services are improving outcomes for people. Locally this translates into monitoring how services are providing quality support that meets the needs of those with a dementia diagnosis, their family and carers.

The Prime Minister's Dementia Challenge has put the spotlight on improving diagnosis rates, research and the creation of dementia friendly communities. The NHS placeholder indicator 'Enhancing the quality of life for people with dementia' has been updated and extended. Accordingly, the 2013/14 NHS framework includes the two-part indicator, which measures diagnosis rate for people with dementia (there being evidence that receiving early diagnosis is important for people living with dementia, enabling them to cope better with their condition). A second complementary measure i.e. concerning the effectiveness of post-diagnosis care in sustaining independence and improving quality of life, is being developed. This indicator also appears in the Adult Social Care Outcomes Framework.

Data relating to the Public Health Outcomes Framework can be found at the Public Health Outcomes Framework data tool. As at September 2013 the baseline was still being established so there is no data available at this time. Click here to see the latest data for the outcome framework.

Public Health Outcomes Framework	Adult Social Care Outcomes Framework	NHS Outcomes Framework

4.16 Estimated diagnosis rate for people with dementia	Baseline Baseline data not yet published (baseline is not yet available as at Sept 2013)	1B. The proportion of people who use services who have control over their daily life	Performance 79.4% as at June 2013 (AQuA Benchmarking from Adult Social Care Survey)	1.5 Excess under 75 mortality rate in adults with serious mental illness	Baseline 850.7 (period: 2010/11)
		1D. Carer-reported quality of life	Performance 8.2 as at June 2013 (AQuA Benchmarking Carer's Survey)	2.1 Proportion of people feeling supported to manage their condition	Baseline Baseline Data not yet published
		2F Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life (Placeholder)	Baseline Placeholder	2.4 Health-related quality of life for carers	Baseline Baseline data not yet published
		3C. The proportion of carers who report that they have been included or consulted in discussion about the person they care for	Performance 76.7% as at June 2013 (AQuA Benchmarking Carer's Survey)		
		3D. The proportion of people who use services and carers who find it easy to find information about services	Performance 75.8% as at June 2013 AQuA Benchmarking (Adult Social Care Survey/Carers Survey)		

Indicates Halton's performance is within the top 6 Authorities in the region

Indicates that Halton's performance is within 7-12 place within the region

Potential new indicators for the 2014/15 Quality and Outcomes Framework (QOF)

As part of a consultation that was undertaken in early 2013, there are 14 potential new QOF indicators being considered, 4 of which related to Dementia.

1. The percentage of patients with dementia with the contact details of a named carer on their record.
2. The practice has a register of patients who are carers of a person with dementia.
3. The percentage of carers (of a person with dementia) who have had an assessment of their health and support needs in the preceding 12 months.
4. The percentage of patients with a new diagnosis of dementia (after 1 October 2012) who have attended a memory assessment service up to 12 months before the date of diagnosis.

As part of the final menu of QOF indicators for 2014/15, GPs could be encouraged to record the percentage of patients with dementia who have attended a memory assessment service.

A new dementia indicator will encourage practices to record the name and contact details of the carers of each patient with dementia. This is to help improve communication between practices and other teams, such as out of hours care.

Practices could also be encouraged to measure the percentage of patients with a new diagnosis of dementia, with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded.

Comments received during the consultation were considered by the independent Primary Care QOF Indicator Advisory Committee in June 2013, along with the results of the piloting of these indicators across a representative sample of general practices. The Committee will then recommend which of these indicators should be considered for inclusion on the NICE menu for consideration for the 2014/15 QOF in September 2013. For the latest on QOF indicators please click here

Should the proposed QOF indicators be authorised , consideration will need to be given locally by practices on how they could impliment this guideline with the potential for poor access to this group of people. General Practices will need to follow best practise in making contact and arranging the tests, bearing in mind factors such as means of making contact and transport issues.

Local Context

The 'Living well with dementia in Halton ' strategy and implementation plan that accompanies this needs paper compliments other work programmes including the Halton Sustainable Communities Strategy, Mental Health Strategy, the Halton Health and Wellbeing Strategy, Carer's Strategy Action Plan, Falls Strategy and Loneliness Strategy, and should be read in conjunction with these pieces of work.

Halton Health and Wellbeing Board have prioritised Mental Health in their related strategy. The Halton Clinical Commissioning Group (CCG) also supports this priority.

The Halton Joint Strategic Needs Assessment identifies, as a priority, that the early detection and treatment of mental health issues should be improved as this will lead to a quicker recovery and reduce the negative impact on a person's quality of life.

The commissioning of initiatives that promote increased understanding of the needs for people with Long Term Conditions and mental health needs and develop integrated care pathways as a priority, as identified in the Halton Joint Strategic Needs Assessment.

Substantial impact on levels of ill health and costs to health and care budgets, as well as wider economy, can be achieved through integrated commissioning of services that meet the person centred outcomes as evidenced by NICE Dementia Quality Standards. Click here for the NICE Dementia Quality Standards

Performance

Diagnosis

Halton Clinical Commissioning Group Target

	Number of people diagnosed	Prevalence of dementia	% diagnosis rate	Current diagnosis rate (May 2013)
2013/14	**807**	**1300**	**62.1%**	**63.3% as at Nov 2013**
2014/15	**873**	**1323**	**66.0%**	

When comparing at estimated numbers, including those with early onset dementia, in practice-by-practice analysis, with 2012/13 QOF data released from the Health & Social Care Information Centre (The QOF register is all ages and may well include some with early onset dementia) the 63.3% CCG average diagnosis rate stands, with a range of 34.2% to 100%.

Later Life and Memory Service

LLAMS		Actual Activity							Agreed Plan 13-14		
	Service	Total Referrals Received	No. of Appropriate Referrals Received	First Contacts Seen	Total Contacts Seen	Total Contact DNA's	% Total DNA's	Total Discharges from Service	Full Year Total Contacts	Total Contacts	% Variance
Community	ECT				2				-	-	-
	LLAMS Assessment				68				1,242	104	-34.32%
	LLAMS CMHT				182				4,206	350	-48.07%
	LLAMS Liaison				49				820	68	-28.28%
	LLAMS Consultants				58				949	79	-26.68%
	LLAMS Memory				507				5,083	424	19.69%
	SALT				14				400	33	-58.00%
	LLAMS CH Liaison				110				-	-	-
	Total LLAMS Community	0	0	0	990	0	0.0%	0	5,483	457	116.67%

Social Care Support

Halton Borough Council (as at July 2013)

HBC Indicator	Description of Quarterly Monitoring Report Indicator	Actual 2011/12	Target 2012/13	Quarter 4
CCC 7 (Previously CCC 8)	Total number of clients with dementia receiving services during the year provided or commissioned by the Council as a percentage of the total number of clients receiving services during the year, by age	3.4%	5%	4.0%

	group.			

The Council target for providing social service support to people with dementia has not met, however performance is better than performance reported in the previous year (3.4%). It is clear that there are issues on how dementia is recorded within the councils customer management system, Carefirst. This is particularly challenging as people diagnosed with dementia may well have dual diagnosis and this may affect how they are categorised on Carefirst.

Number of People supported via the Dementia Care Advisor Service

	People that have been supported by the service
2012/13	359 people
Year to date 2013/14	189 people (up to end Sept 2013)

These are made up of new referrals to the service, therefore they will have been seen by a Dementia Adviser and some will be supported on an on going basis by the Dementia Support Worker (they have only been counted once). Of 2013/14 figures, 47 are people that just attend one of the activity groups.

Provision of informal information to people at events and over the phone are not included in the above figures.

Halton Dementia Profile

The term 'dementia' describes a set of symptoms that include loss of memory, mood changes, and problems with communication and reasoning. There are many types of dementia. The most common are Alzheimer's disease and vascular dementia. Dementia is progressive and diagnosing dementia is often difficult, particularly in the early stages. The risk of developing dementia increases with age, and the condition usually occurs in people over the age of 65.

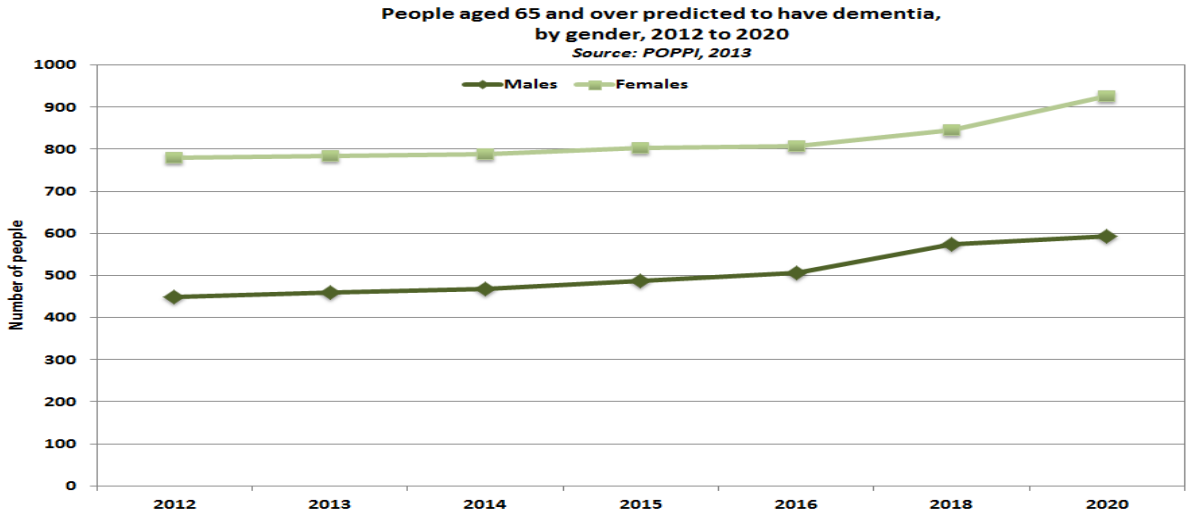
The population of Halton is aging. That is, a larger proportion of the total population will be found in the 60-plus age bands by 2031 compared to 2006. This section of the population will increase by 61% to 36,300 by 2031. This will then constitute 28% of the Halton population.

Dementia diagnosis and estimated prevalence

The number of people with dementia is set to rise by 62% by 2030, largely due to the projected increase in the older population. It is projected that there are 1,229 people aged 65+ living in Halton who have some form of dementia in 2012[1] and by 2020 this figure is estimated to be as high as 1518. In addition it is estimated that there are currently about 34 people aged between 30-64 who early onset dementia[i].

i Estimates from PANSI: Projecting Adult Needs & Service Information System: It is managed by the Institute of Public Care http://www.pansi.org.uk/

The graph below shows the estimated numbers of dementia patients by gender for Halton. There are predicted to be more females than male patients, and the greatest increases are in the 85+ age group. These projections, developed by POPPI[ii] and based on national research applied to Office of National Statistics population projections, estimate that the number of males aged 65+ diagnosed with dementia is set to rise from 449 in 2012 to 593 by 2020 and for females that rise is 780 to 925.



Diagnosing dementia in General Practice

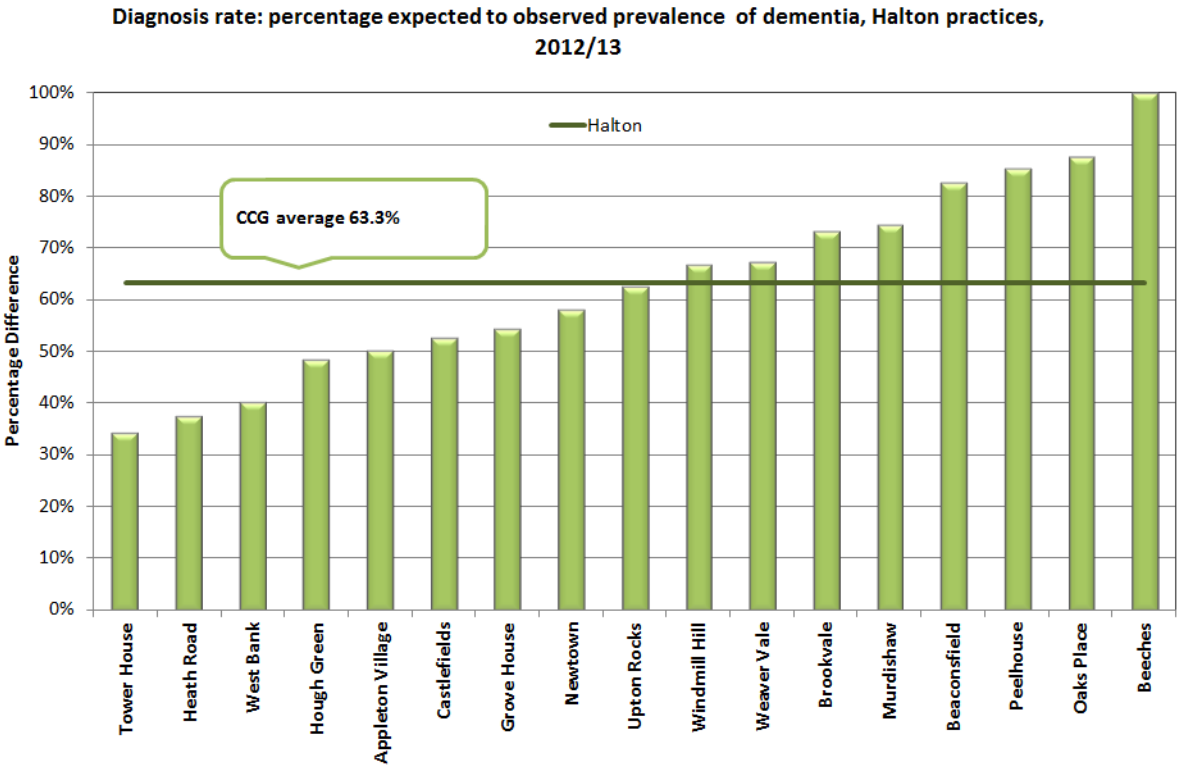
The GP contract includes the requirement for practices to establish a disease register for people with dementia. The diagnosis of dementia may be from correspondence with secondary care or via the GPs own diagnosis.

Quality Outcome Framework (QOF) data for 2012/13 indicates 747 patients registered at Halton GP practices as having dementia, an increase on the 2011/12 figure of 689 patients and 634 in 2010/11. Using the same age-specific prevalence rates utilised by POPPI (Projecting Older People's Population Information) and PANSI (for early onset dementia) and applying these to GP registered population gives an overall estimate for 2012/13 of 1,180 patients with dementia.

This method thus enables practice level estimates to be made which can then be compared to the dementia register numbers. This enables a diagnosis rate to be calculated (percentage of people diagnosed compared to expected/predicted numbers). Practice rates vary considerably from 34.2% to 100%. The CCG average rate was **63.3%.**

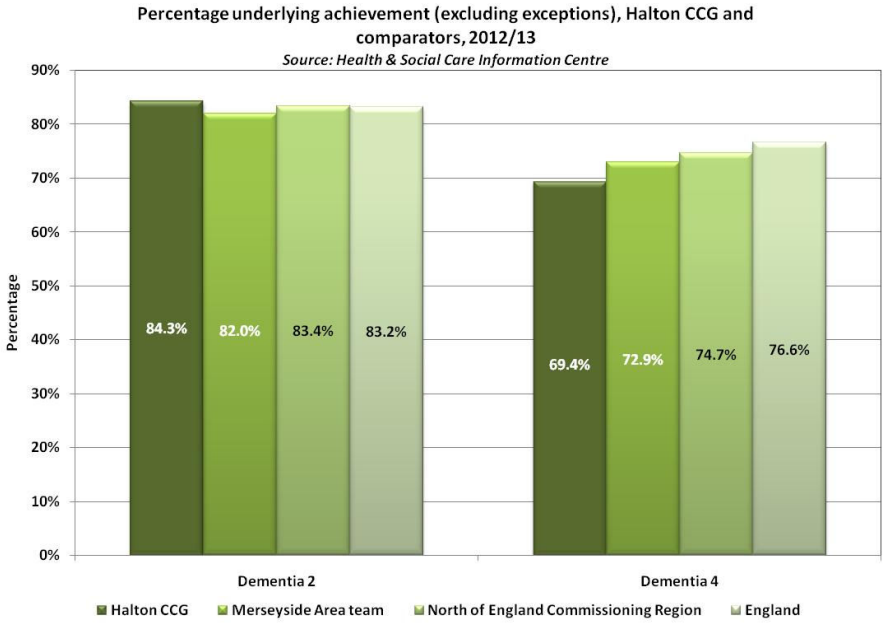
Whilst there has been an improvement there are still considerable levels of under diagnosis. Using this method suggests there are still 433 people with undiagnosed dementia in the CCG catchment.

ii POPPI = Projecting Older People Population Information System. It is managed by the Institute of Public Care http://www.poppi.org.uk/



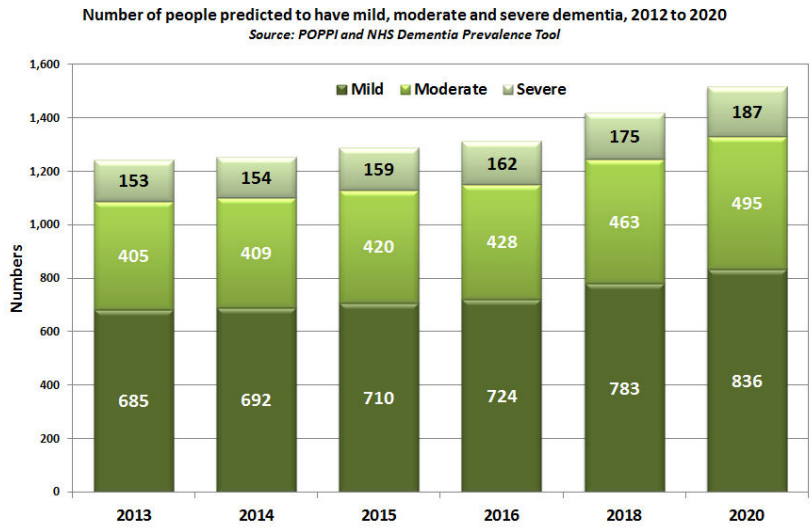
GP: Care Assessments

A further requirement of the GP contract is that patients on the dementia register should have had a care assessment within the previous 15 months. For 2012/13 Halton Clinical Commissioning Group (CCG) performance was 79.5%. This was above comparators (chart Dementia 2 indicator). For patients with a new diagnosis of dementia, practices are also required to record the percentage who have had FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register (between the preceding 1 April to 31 March). For this indicator the CCG achievement was slightly lower than comparators (chart Dementia 4 indicator). There was wide variation across practices. For Dementia 2 indicator this ranged from 70%-100% with three out of the 17 practices achieving 100%. For Dementia 4 indicator the range was much wider 0%-100% (five practices achieved 100%). However, it should be noted that numbers per practice were very small for some practices. The total number of newly diagnosed patients for 2012/13 was 238 of which 180 were eligible for the tests and 125 received them. There were 58 exceptions, ranging from 0-8 per practice.



Different Levels of Severity

The Dementia UK 2007 report estimated that 55.4% of people with dementia have mild dementia, 32.1% moderate and 12.5% severe dementia. It also noted that these proportions change with increasing age with the percentage of those with severe dementia increasing and those with mild dementia decreasing. For example only 6.3% of dementia cases in the 65-69 age band are estimated to be severe rising to 23.3% in the 95+ age group. Using the NHS Dementia Prevalence Calculator tool, we can forecast numbers of dementia by severity in Halton.



Early onset of dementia

Dementia is rare before the age of 65, however, there will be a small number of people who develop the condition before this age. It is estimated that at age 30-34, 8.9 per 100,000 men and 9.5 per 100,000 women will develop dementia. This rate rises with each 5-year age band and equates to 33 people for Halton.

Although the numbers for early onset of dementia are low in Halton, these people are faced with a different set of challenges that include:

- Health care professionals generally don't look for the disease in younger patients and it can therefore be months or years before the right diagnosis is made and proper treatment can begin.
- Many people with early onset Alzheimer's and other dementia are still working when their symptoms emerge. Due to the nature of the condition, changes in their job performance or behaviour may not be understood or addressed. In addition the workplace can become a difficult environment.
- Those who leave their jobs before diagnosis may be denied certain Government assistance that would otherwise be provided to individuals with disabilities.
- Many individuals with early onset Alzheimer's and other dementia have low incomes and are in need of assistance, but have a difficult time getting it.
- Existing healthcare, home care or community service provision may not be appropriate for early onset individuals

Family members and other carers often lack the information and support they need to provide care to the person they support.

Dementia beds

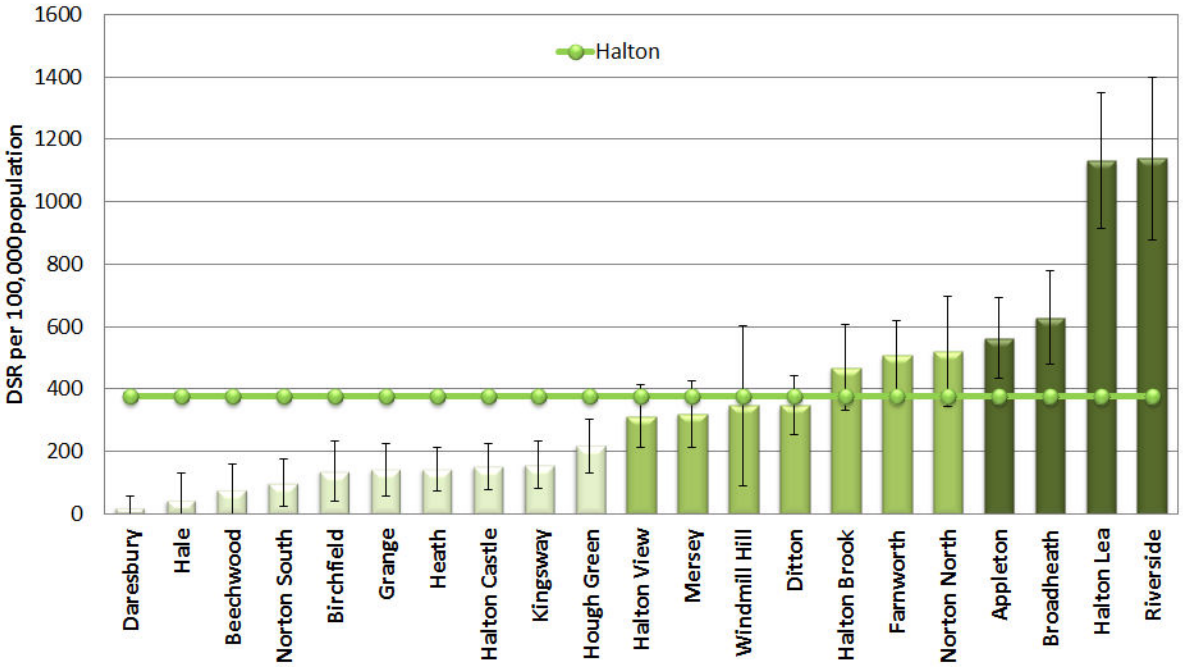
Halton has a 244 registered dementia beds in residential and nursing homes, 82 of these are dual registered. There are also 249 nursing beds available of which 196 are registered as EMI Nursing. It is not clear how many of the residents in residential care have dementia, national research from the Alzheimer's Society suggests that underreporting could lead to 80 % of people in residential care actually have some form of dementia, if we compare this to figures based on National Audit Office research, they estimate that of the 1,180 residents thought to have dementia in Halton 788 will live in the community and 392 in a care home. It is estimated that by 2030 1,367 people diagnosed with dementia will be living in the community and 683 will be requiring care home places.

Work is required to fully assess the current registration levels of care homes in Halton.

Hospital admissions due to dementia

Few people are admitted to hospital primarily due to dementia. In total 747 people across Halton who were admitted to Hospital during 2012/13 had some form of dementia (only 76 had dementia as the primary reason for the admission). This is an increase on the 2011/12 figure of 563, with the figure for 2010/11 being 705. This figure for 2012/13 included 39 admissions for people under the age of 65. Some of these may be one individual who is admitted multiple times throughout the year.

Rate of hospital admissions (DSR: Directly Age Standardised Rate, per 100,000 population, all ages) for Dementia (primary and secondary diagnosis codes 1-5), 2012/13
Source: SUS data, 2013



In Halton during 2012/13, 76 people were admitted to hospital with a primary diagnosis of dementia. However many older people with dementia will have more than one health problem. As such some people admitted for another health reason will also have dementia. This is likely to have implications for the support they need both whilst in hospital and how to manage / level of care needed once they leave hospital.

Social Care

Key findings from the National Audit Office's 2007 *Improving Services and Support for people* with dementia indicate that almost two thirds of patients live in the community and one third are in care homes. If we apply this to Halton data it would suggest that there are 793 people living in the community and 427 in a care home. However, if we consider data from carefirst there are only 308 people identified with dementia. 113 are supported in the community and 195 are in residential care.

The above data collection issues may well be the main reason for the reduction in the number of clients with dementia who have received a review. Although year on year there has been a slight increase the trend has been downwards for a period of six years.

It is clear that there are significant differences in the estimated to the actual figures. At first reading it might be pertinent to suggest that there is some significant under delivery within the system, however, this may attribute for a small amount, but the bigger issue is the quality of the data collection and inputting at source.

clients receiving nursing care has fallen from 32% in 2005/06 to nearly 18% in 2011/12; this represents a decrease in both percentage totals and number of people with dementia.

Of the clients receiving community based care nearly half received home care during 2011/12, just under a quarter received day care, meals and professional support and just under half received some other form of service for example, wardens, equipment etc.

A1: Number of clients with whom a review was completed during the period, by age group

	2005/06				2006/07				2007/08				2008/09				2009/10				2010/11				2011/12			
	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total
Dementia	5	30	140	180	10	35	140	185	15	25	110	145	15	15	100	130	15	10	95	115	10	15	95	120	10	20	95	125
Mental Health Total	260	80	275	615	270	75	255	600	380	80	215	680	310	60	180	550	330	55	150	535	325	65	155	545	325	60	150	535

It's important to note that the number of clients receiving various services does not add up to the total number in receipt of services as many clients will receive more than one service.

click here to see the full Halton Dementia Profile produced by Public Health

Cost of Dementia

Dementia UK found that the total costs of dementia in 2007 amounted to £17.03 billion per annum. Since 2007 the total cost of dementia has continued to rise: updated figures for 2012, published with the Society's Dementia 2012 report, put the cost at £23 billion with 800,000 people living with the condition, with an average cost of £29,746.

The Dementia UK report [2]estimated that the total annual cost per person with dementia in different settings in 2007 was as follows:

People in the community with mild dementia - £14,540

People in the community with moderate dementia - £20,355

People in the community with severe dementia - £28,527

People in care homes - £31,263.

Over a third of the total cost (36%) was due to informal care inputs by family members and other unpaid carers. Not included in this amount is the estimated £690 million in lost income for those carers who have to give up employment or cut back their work hours. This lost employment means a loss of £123 million in taxes paid to the Exchequer. Accommodation accounted for 41% of the total cost.

The greatest proportion of direct costs of dementia care is associated with institutional support in care homes. This is often provided at a crisis point, is always costly and often precipitated by a lack of effective support.

Data collection within the local authority is such that it is difficult to assess the exact number of people with dementia in receipt of a personal budget. However, a national study identified that uptake of personal budgets among people with dementia still lags behind most other client groups. Three in five people with dementia assessed as eligible for a care package were not even offered a personal budget, while 15% declined an offer of one, found a study by Alzheimer's Society [3]. The perceived risk of financial abuse; issues of capacity; lack of information and support for families and carers, and the fact that many people with

dementia only access social care at crisis point – when setting up a personal budget is more complicated – have all been put forward as causes.

A report by the Mental Health Foundation[4] has shown that individualised, tailored support and care that a personal budget can facilitate can have enormous benefits to a person with dementia.

Considerations when assessing a person with a dementia diagnosis for a personal budget should include:

- Training for social work staff specifically on personal budgets and how they can work for people with dementia
- Support social workers, individuals and carers to really understand what support is available in the marketplace so that they can ensure outcomes really match individuals' wishes.

The costs of delivering personal budgets to people with dementia are higher than some other care groups. With uncertainty regarding the social care budget in the context of cuts across the whole of the public sector, personal budgets for people with dementia will need to be introduced with great care and within the realistic context that resources are limited. The additional costs of brokerage and managing the money need to be considered by the local authority.

Prevention

The strength of evidence around dementia prevention is currently not very strong. However, the evidence that is available suggests that the most promising approach to reducing the prevalence of all forms of dementia is a more general promotion of healthy lifestyles, particularly for those in mid-life. It has been estimated that by promoting and adopting healthy lifestyles in middle age, an individual's risk of developing dementia could be reduced by approximately 20%[5]. Other research suggests that decreasing the prevalence of risk factors including midlife hypertension, poor educational attainment and depression, could have a positive effect on the prevalence of Alzheimer's. American researchers[6] analysed the strength of the association between these factors and Alzheimer's and showed that cutting down these risk factors by 25 per cent could reduce Alzheimer's cases by 3 million worldwide.

While it is not possible to prevent all cases of dementia, there are some measures that can help prevent vascular dementia, where problems with blood circulation result in parts of the brain not receiving enough blood and oxygen. According to a World Health Organisation report in 2012 [7], research identifying modifiable risk factors of dementia is in its infancy, but prevention should focus on countering risk factors including diabetes, midlife hypertension, midlife obesity, smoking, and physical inactivity.

Evidence also highlights the value of early intervention and diagnosis, as up to two thirds of people and their families are living with dementia unaware of its existence[8]. Early intervention, both pharmacological and non-pharmacological, can help to slow the progress of dementia and its symptoms. It can also help to better prepare individuals and their families for the future of living with the condition.

Any interventions that could reduce the burden of the condition by preventing or delaying the onset of dementia could not only provide health and well-being benefits to the person with dementia, but to society in terms of reduced carer responsibility and improved productivity, and also the public purse in terms of reduced health and social care costs. This is especially pertinent with regards to an increasing population of older people projected for Halton.

There are a number of local actions being implemented as part of Halton's Sustainable Community, Health and Wellbeing, Mental Health and Loneliness Strategies that are key to tackling both the

Developing dementia friendly communities

Evidence from the Alzheimer's Society report '**Dementia-friendly Communities:** A priority for everyone' [9]suggests that many people with dementia do not feel supported and a part of their local area. Findings from a recent Alzheimer's Society and YouGov Poll suggest that:

• Less than half of the respondents to the Dementia Friendly Communities survey think their area is geared up to help them live well with dementia (42%).
• Less than half feel a part of the community (47%). Results become considerably lower the more advanced the person's dementia is.
• People from seldom heard communities expressed complex issues around feeling part of their community. Stigma was particularly highlighted by people with dementia and carers.
• More than half of UK adults surveyed in the YouGov poll feel that the inclusion of people with dementia in the community is fairly bad or very bad (59%).
• Nearly three quarters (73%) of UK adults surveyed in the YouGov poll do not think that society is geared up to deal with dementia.

During the life course of the strategy that accompanies this needs paper, Halton will be working towards becoming a dementia friendly community. That is, a community that shows a high level of public awareness and understanding so that people with dementia and their carers are encouraged to seek help and are supported by their community. Such communities are more inclusive of people with dementia, and improve their ability to remain independent and have choice and control over their lives, contributing to better outcomes for people with a dementia diagnosis, their families and carers.

Raising Awareness

The Alzheimer's Society has developed a range of literature to support a local public information programme drawing on, and aligned with the national campaign and will includes awareness of the risks of developing dementia at a younger age.

The Bridgewater Community Health Care Trust's Live Life Well website is being promoted as a central source of health and wellbeing self help resources, information and links services. There are resources and information relating to dementia contained in the Mental Health Directory on the site.

Consultation tells us that self-help resources, information and links to services will enable individuals, their family and carers to access information at the appropriate time and understand what services are available to them. This may go some way to addressing the sometimes common misconception that there are no, or limited, services to support people with dementia once a diagnosis has been made.

Like Minds Campaign

Halton Borough Council and Halton Clinical Commissioning Group have lead on the development of a local intergenerational anti stigma campaign, 'Like Minds', which was launched on World Mental Health Day 2013. The campaign aims to tackle perceptions of mental health generally, and has a call to action of encouraging people who may be suffering with the early signs of mental health problems to talk (to anyone, not just their GP) to share their concerns, thoughts and feelings and seek help.

The campaign will offer information about where support can be sought and direct people to the information, services and self help resources available from the livelifewell website, managed by NHS Bridgewater Community Health Care.

This campaign targets carers (including carers of people with a dementia diagnosis) and people hwo may be vulnerable to a dementia related illness, who may be at a greater risk of anxiety and depression related mental illness.

Dementia Training

Halton Broough Council has been successful in a recent funding application to deliver bespoke training in dementia via Skills for Care. This project will focus on:

1. Raising awareness of dementia across the whole community, by bringing local people and professionals together in two planned events;

2. Using the Family Carers Matters and People with Dementia Matter courses, life story training will be provided to individuals with dementia and their carers.

3. Sessions will be held with Housing Providers that will include managers and front line staff, one at the beginning (September 2013) and one in March 2014 with a view to establishing a commitment from providers to develop a coherent housing response to the local dementia strategy;

4. Working with local tenants, using the Volunteers Matter course, training will be provided to support them in recognising the needs of people with dementia and enabling them to provide additional support;

5. Develop the skills and confidence of GPs, managers and staff in the Well Being Practices (CCG);

6. Aligning this with our work on re-commissioning domiciliary care, we are offering training, using the Your Story Matters approach, on the value and impact of life story work to underpin a person centred approach to care.

The training will be developed from August 2013 until March 2014.

This training may contribute to the reduction in use of antipsychotic medication (through life story work) and equip professionals and the public with the skills to provide support to people with a dementia

Early Diagnosis and Support

NHS Health Check

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. From April 2013, as part of the NHS Health Check programme, people aged 65-74 are given information about dementia at the time of risk assessment to raise their awareness of dementia and the availability of memory services.

The intention is to raise awareness of memory assessment clinics for those attending an NHS Health Check.

5 Boroughs Partnership Later Life and Memory Service

In June 2013 the redesigned Later Life and Memory Service (LLAMS) pathway was implemented in Halton. Initially a pilot was agreed and this was run in the Wigan Borough until mid-September 2012. The pilot involved re-configuring existing teams and services to deliver the new model for community focussed dementia care.

Preliminary analysis of the Wigan pilot's findings demonstrated that the changes introduced delivered a positive impact upon service efficiencies and the timeliness of response to referrals. That contributed to a positive experience of the new service for Service Users and Carers. Similarly, there is evidence to show that collaborative working between staff and the integration of teams improved the speed with which diagnoses were arrived at, the availability of support for the management of memory problems and an increase in the levels of support provided within community settings. Further detailed analysis will be needed however before firm conclusions can be drawn about the long-term impact of the new model of care and care pathway upon the likely demand for in-patient care. During the pilot period however, there was a reduction in the need for in-patient care, although those requiring it exhibited more complex needs. Similarly, the pilot appears to support the new service model's assertion that increasing the availability of community-based support and the therapeutic approaches of in-patient teams will result in shorter lengths of stay for service users within in-patient care.

The following specific key findings were observed:

The service received between 100-120 referrals each month (in-line with same period in 2011)

96% of referrals were non urgent

80% of referrals were seen within the 10 working day target (typically, where the 10 day target was not met this was because of a Service User request for a later appointment)

35% of Service Users were referred onwards to the memory function

30% of Service Users had more complex needs and were referred onwards to the Community Mental Health Team function

35% of the Service Users referred benefitted from the service's short term interventions and were then discharged back to primary care

Of the 60% of face-to-face contacts for which the time of contact was recorded, only 4.5% took place during extended opening hours

In-patient units within the pilot area experienced:

Occupancy levels well below capacity (67.5% on average during the pilot's first 3 months)

a reduction in length of stay per episode (this fell by 8 days to 44.6 over the pilot's first 3 months)

Service Users' self-reported experiences of the service were positive

There were increased levels of collaborative working between Trust teams, and Trust teams & external agencies (local authority and acute Trust teams for example). It appears that increased collaborative working directly contributed to the perceptions of service quality (on the part of Service Users and Carers), and staff satisfaction (by Trust staff)

A Primary Care pathway has been developed and is now being used. The pathway can be found in appendix 1

The enhanced service has been designed by the NHS Commissioning Board to support practices in contributing to system wide improvements by supporting timely diagnosis, supporting individuals and their carers an integrated working with health and social care partners.

The assessment for dementia offered to consenting at-risk patients shall be undertaken following initial questioning using the 6CIT (Cognitive Impairment Test) to establish whether there are any concerns about the attending patient's memory.

For the purposes of this enhanced service, 'at-risk' patients are:

- Patients aged 60 or over with cardiovascular disease, stroke, peripheral vascular disease or diabetes
- Patients aged 40 or over with Down's syndrome
- Other patients aged 50 or over with learning disabilities
- Patients with long-term neurological conditions which have a known neurodegenerative element, for example Parkinson's disease.

This enhanced service will be reviewed for 2014/15 in light of possible changes to the Quality and Outcomes Framework (QOF) for 2014/15.

The aims of this enhanced service in 2013/14 are to encourage GP practices to:

1. Identify patients at clinical risk of dementia;
2. Offer an assessment to detect for possible signs of dementia in those at risk;
3. Offer a referral for diagnosis where dementia is suspected; and,
4. Support the health and wellbeing of carers for patients diagnosed with dementia.

In Halton, 16 out of 17 GP practices have signed up to the scheme.

Community Dementia Care Advisors

A key development since the launch of the dementia strategy is the successful commissioning and implementation of the local Dementia Care Advisors and Dementia Cafés.

The service is delivered in partnership by the Alzheimer's Society and Age UK Mid Mersey, drawing on the learning from the Department of Health National Dementia Advisor pilots to deliver positive outcomes for people living with dementia and their carers. Following consultation days people with dementia and their carers highlighted what they wanted from the service; which included the following

- Provide timely information and advice for the carer and cared for
- Provide individualised and timely practical and emotional support for the carer and cared for
- Improve communication between professionals/services in order to reduce unnecessary service duplication and enhance partnership working

The service has been developed to ensure that individuals are kept informed of their choices throughout the dementia journey so that they do not fall through the net and out of the system which will then prevent them going into crisis.

The service offers a pre diagnosis advice service and post diagnosis support including information, awareness and advice, signposting to services and supports, continued consultation, planning and involvement, as well as supporting the development of peer support, group sessions, self-help/ expert patient approaches, the development of user and carer led services and educational programmes.

In addition the service provides a highly responsive information and signposting support service to people with dementia as the first priority, and to those who support and care for them. The role of Dementia Care Advisor is the key person who is responsible for coordinating all the services available to the service user ensuring that agencies and professionals communicate with each other over the delivery of their services.

The service currently has a capacity of 1,200 face-to-face contacts with service users in Halton per annum. Of these some only require initial support and signposting but others need more comprehensive on-going support and case management and the Dementia Advisor ensures that the service user is navigated through the system to ensure that the whole service available is coordinated with all relevant agencies.

The Dementia Care Advisor service works in partnership with key stakeholders and partner services including primary health care services, primary mental health care, adult mental health, older persons social care services and third sector services. The Dementia Care Advisors although based within Alzheimer's Society and Age UK offices also have a presence within the Later Life and Memory Service locations (currently the Norton Day Unit in Halton).

In June 2013 the Halton Dementia Support service and Dementia Adviser service evaluation questionnaire was sent out to a random selection of 100 service users who have within the current contract engaged with services.

The questionnaire was designed to gain an understanding of how both carers and people living with dementia feel about the service that the society provides to them in relation to both the Dementia Support Service and the Dementia Adviser Service. There was a 52% response rate.

Overall it seems that from questionnaire responses, people who are accessing services from Alzheimer's Society in Halton are happy with the service they receive. It's clear that people feel that they are listened to

and treated with respect and dignity. In addition to this people feel that they have received clear and easy to understand information which is useful.

It seems that service users appreciate the different roles that the Dementia Adviser and the Dementia Support Worker offer as some people enjoy the weekly emotional support which the activity groups offer whilst others want the more practical or written information which the Dementia Adviser is able to provide.

It is also clear that the information which is provided upon diagnosis by the Dementia Adviser is more comprehensive than information given by the health service and this information is a lot easier to understand.

"I found that the Dementia Adviser offered more information than any other service we have come into contact with"

"I have enjoyed meeting new people every Friday"

"The Dementia Adviser who visited me was easy to speak to and didn't use jargon"

"The Dementia Adviser involved my mum in all aspects of our meeting. Myself as a carer learned more in the 1.5 hours spent with the Dementia Adviser than I have in the countless meetings with other

"More equipment at activity groups to stimulate those with dementia"

"Social outings for carers and people with dementia"

"I would like to attend a course to learn more about my condition"

"I would like half an hour sing-along incorporated into the activity groups"

Needs analysis and business cases are being undertaken during quarter 2 of 2013/14 for further development of the Dementia Care Advisor service, along with Reader Groups and the requirements for a late night dementia respite provision. This will identify where resources could be targeted to ensure the needs of people with a dementia diagnosis and their carers are more fully met.

Advancing Quality Alliance (AQuA)

Halton has committed to be an active partner in the AQuA Living Well with Dementia Programme for 2013/2014 and are working with leaders in the field to develop needs analysis and business cases for dementia provision locally.

This work will contribute to addressing fear and perceptions associated with receiving a diagnosis of dementia by aiding the development of appropriate, seamless services to meet the real needs of people with a dementia diagnosis.

Research has been undertaken to identify exactly what the key points of intervention for carers are and what types of information, advice and support they require at these junctures [10].

The evidence has highlighted a number of critical points when carers' needs for information, advice and help are particularly acute – and these are also points at which they are likely to encounter professionals and service providers. This means that all professionals and service providers will need to check that carers have the information and advice appropriate for the challenges they are currently experiencing and that they know where to go for further information and advice when future difficulties arise. Failure to recognise carers' needs at these points risks the breakdown of care-giving and the carer's health and other costs for carers and wider society. What is clear from the report is that integration of health and social care information, services and follow up is key to providing a holistic service for the carer. Information provided at the right time, with detail of who to contact for more information is key.

Work undertaken by the Council's Customer Intelligence Unit (Carer's Discussion Groups) highlights the needs of Halton carers generally, in relation to provision of information and support. Often carers of a person with a dementia diagnosis report of receiving too much information in one go, much of which may not be relevant to them or their loved one at the time, or not receiving the much information at all. The role of the Halton Dementia Care Advisor will be key to supporting access to information and assistance in interpreting that information.

Findings from the Carer's discussion groups include:

- Make sure that information about 'Formal' carers groups provided to carers directly and via networks is timely and consistent.
- How can we use current networks and carers to communicate and engage with hidden carers, young carers or those carers who do want / cannot attend meetings?
- Perception of a lack of trustworthy knowledge about specialist conditions / or who to ask for the information
- Listening to carer opinion when discussing health treatment – What about an 'official carer' card – so that professionals can share information with the carer.
- Too much information given / no support / expected to remember everything that was discussed.
- Assessment: lots of agencies and professionals visiting - becomes stressful not knowing who you are talking to person they care for.

C ol
where by carers can ask questions about and provide feedback on their care to health and social care professionals. It is anticipated that the results of the first round of questions and the usefulness of the tool will be available towards the end of 2013.

Carers will be encouraged to use the forum, accessing timely professional advice and the opportunity to provide feedback, on which services can further develop to meet the needs of those who utilise them.

Carers Assessments

Work is currently being undertaken to streamline the process through which carers are assessed and access direct payments to fund a break away from caring. Once in place the revised arrangements will have a significant positive effect on those individuals who care for people with dementia.

Current Council data shows that 4.9% of carers on the Carefirst system receiving a Direct Payment are caring for a person with a dementia diagnosis.

Dementia Support Service (part of the Positive Behaviour Support Service)

'Active Support' is one approach to increasing engagement, and increasing independence that has received much attention with learning disability populations. This is a system that relies on structured daily activity planning, and graduated levels of support and assistance based on the individual's needs to increase activity. A recent research project in Halton Borough Council's Oak Meadow day service conducted by members of the Positive Behaviour Support Service [11] found the Active Support approach to be equally as effective with people with dementia. They found significant increases in social interaction, and in domestic, personal care and leisure activities of the service users. Although the greatest statistical gains were found with the most able (most recent onset) service user, more socially significant effects were evident for the person in the latter stages of the illness.

The 'Living Well with Dementia' national strategy objectives identify goals for improving dementia services such as home care, carer support, intermediate care, residential care and end of life care. The work of a Behaviour Analyst has the potential to enhance support in the community and in care settings.

Care at hospital

During 2013 Warrington Hospital was successful in their bid for Dementia Care Scheme funding. The total value of the funding is £1,053,322, which will be used to transform the care environment for patients with dementia in the hospital. Plans for the funding include a redesign of an existing ward at Warrington Hospital and a new garden area to promote relaxation, stimulation and a calmer environment for patients with dementia.

Funding comes from a £50 million fund from the Department of Health for projects that demonstrated how practical changes to the environment within which people with dementia are treated in will make a tangible improvement to their condition.

The projects will form part of the first national pilot to showcase the best examples of dementia friendly environments across England, to build evidence around the type of physical changes that have the most benefit for dementia patients.

Role of the Fire and Police Services

Older people are significantly more at risk from fire and account for higher representation in the numbers of fire deaths than any other group.

- Within the over 80 age group risk increases significantly, particularly for those living alone.
- Males living alone are at greater risk than same age females and therefore at ages below 80.
- The risk of fire related incidents increases with bereavement
- Fire risk will increase as other vulnerabilities and risks affecting independence start to emerge, including those associated with a dementia diagnosis.

Extensive work has been undertaken locally by Cheshire Fire Service in developing their partnership working with Age UK . Briefing and referral information has will be continue to be widely distributed to professionals, landlords and the public detailing fire related advice available for older people, and those with a dementia diagnosis. The Fire Service also provided fire related advice and support to all Care Quality Commission registered providers in the past 12 months.

Cheshire Fire Service currently joint fund two dementia advisors, one in Cheshire East and one in Cheshire West and Chester. These are co-funded with CCG's and Age UK Cheshire but could potentially replicated with a number partners, including Halton.

Working with the Fire Service will form an important part of developing dementia friendly communities

Cheshire Fire Service are exploring 'dementia friends' training for their advocate teams to better meet the needs of people with a dementia service accessing Fire Services.

Cheshire Fire Service are exploring a transition from hospital to home pilot in Macclesfield, and the support that can be offered by the Fire Service to vulnerable older people, including those with a dementia diagnosis. This may provide a learning opportunity for Halton to review how the Fire Service can further support vulnerable people in Halton.

Delivering the Dementia Strategy

Development of a performance dashboard

There are few national and local indicators that expressly measure the impact on people with a dementia diagnosis or carers of people with a dementia diagnosis. Whilst inferences can be made, links are not explicit. In addition, much of the data in the national indicator set is captured annually, and therefore will not make suitable indicators for a 'real time' dashboard.

A performance dashboard is currently being developed by the Halton Dementia Partnership Board to assess progress and improve outcomes for people with a dementia diagnosis and their carers against the 8 Halton Dementia Pledges. Two sources of information will be used to inform progress against improved outcomes. These are:

- Metrics, for example, the diagnosis level in relation to prevalence;
- Qualiative information on the experience of people with dementia, their family and carers

Gap Anaylysis

Providers have told us[12] that they are increasingly seeing individuals presenting with very complex needs. It has been suggested that there is increasing demand for a number of placements/beds for people that do not require hospital or a specialist placement but need more than the usual residential/nursing care and at times one-to-one care. As the number of older people with increasing complex needs is set to increase, there is some urgency to identifying current and future local need and developing the local market to meet increasingly complex needs. Further exploration between Commissioners and Providers is required.

Work has already been undertaken as part of the Halton's Joint Strategic Needs Assessment that identified the following key issues and gaps in relation to Dementia;

Improving public and professional awareness and understanding of dementia

Gaps include the quantity, quality and frequency of information that is available. There are also possible gaps within information that would support early diagnosis and access to improved community services. In

relation to community services there is a gap in specialist knowledge that often leads to people with dementia being unable to access some generic community services and facilities.

Good-quality early diagnosis and intervention for all

There are no designated teams specifically designed to address early diagnosis and intervention. However, this is being addressed through the development of the Assessment, Care and Treatment Service.

Good-quality information for those with diagnosed dementia and their carers

Information is available; however it needs to be consistent, timely and widely available for people with dementia and their Carers.

Development of structured peer support and learning networks

Capacity for the Dementia Peer Support Network will need to be monitored to ensure that there are appropriate levels of service provision.

Implementing the Carers' Strategy

The specific needs of carers of people diagnosed with dementia are addressed in the Carers Commissioning Strategy. However, the additional support needs of carers of younger adults with dementia require further consideration.

Improved quality of care for people with dementia in general hospitals

Plans are being developed to identify a specific lead for dementia in general hospitals**.**

Living well with dementia in care homes

Improved professional training relating to dementia is required.

Improved end of life care for people with dementia

There needs to be greater clarity around direction of service provision and multi-agency working.

Recommendations are already being acted upon through the Dementia Partnership Board Group. This multi-agency group is tasked with implementation of the dementia strategy and is specifically targeting the following areas:

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

Keeping up the momentum

The 'Living well with dementia in Halton Strategy and Implementation Plan' that accompanies this paper outlines key actions to be undertaken during 2013-2018.

Appendix 1 Later Life and Memory Service Pathway

Halton Later Life and Memory Service Pathway for Professionals. September 2013

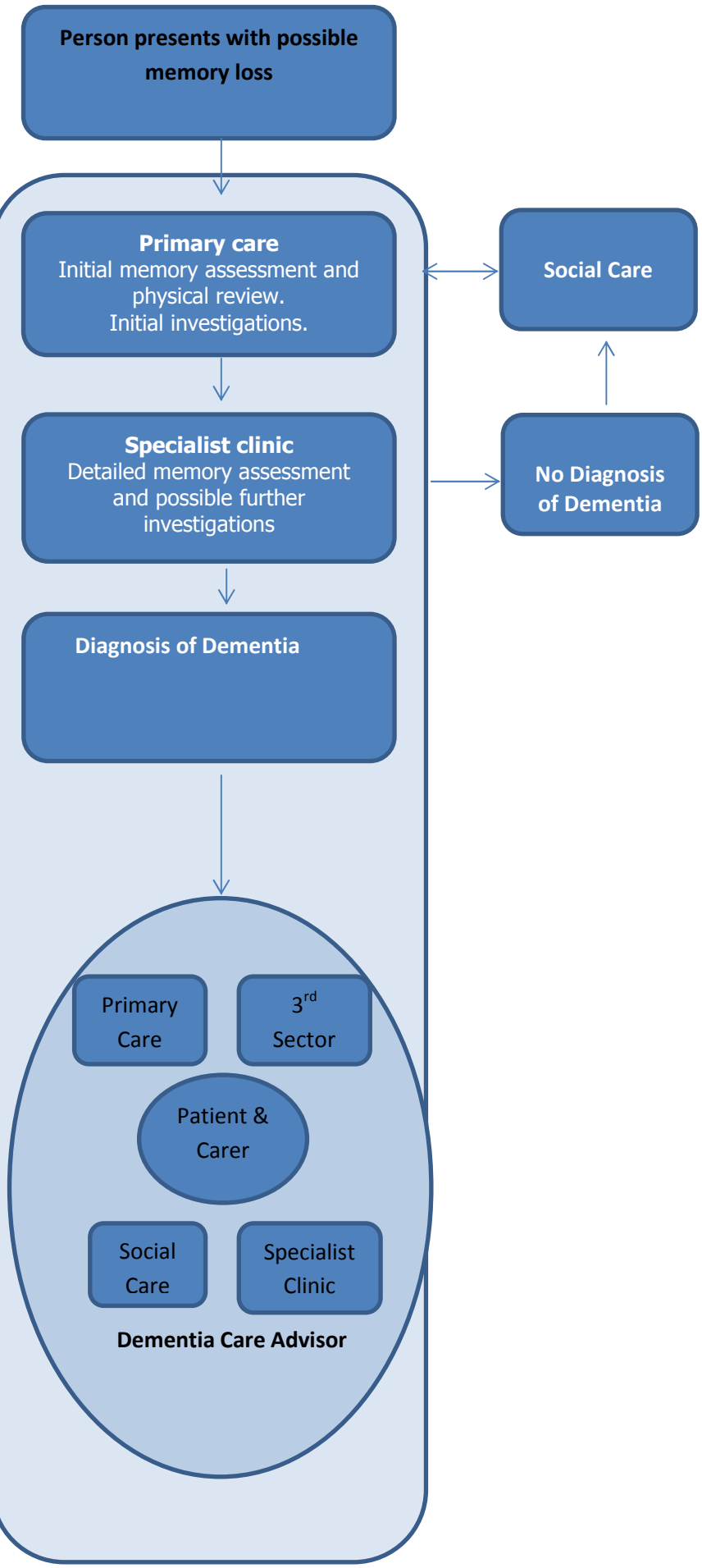
Click here for NICE Pathway for Dementia Diagnosis and Assessment

Patient undertakes '6 CIT' Test (or other). Link to '6 CIT' questions and scoring:http://www.patient.co.uk/doctor/six-item-cognitive-impairment-test-6cit

Routine bloods and ECGPrimary Care Referral to Dementia Care Advisors

Click here for NICE Pathway for Dementia Specialist Assessment

Click here for NICE Pathway for Dementia Diagnosis and Assessment



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Claire Goodchild October 2011

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REPORT TO: Health Policy & Performance Board

DATE: 7th January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Health and Adult Social Care Settlement 2015/16

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to present the Health Policy & Performance Board with a summary of the Government's Health and Adult Social Care Settlement 2015/16 and to highlight how the Health and Well Being Board in Halton have been addressing the issues to ensure the conditions attached to funding and integration are progressed.

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

3.0 **SUPPORTING INFORMATION**

3.1 In June 2013 the Government announced the results of the latest spending round 2015/16 for Adult Social Care and provided information about the settlement for 2015/16 including £3.8 billion of pooled health and social care funding for integration (the Integration Transformation Fund) to be held by Local Authorities. Alongside this, NHS Halton Clinical Commissioning Group (HCCG) received a similar announcement from NHS England (Merseyside) setting out the Health Settlement for 2015/16 and the implications for CCGs.

3.2 The settlement states that "access to the pooled budgets will be conditional on agreeing plans with local health and wellbeing boards to protect access and drive integration of services, to improve quality and prevent people staying in hospital unnecessarily". The plans will be required to satisfy nationally prescribed conditions including:

- Protection for social care services (rather than spending) with the definition determined locally;
- Seven day working in social care to support patients being discharged and prevent unnecessary admissions at weekends;
- Better data sharing between health and social care based on the

NHS number;

- Risk sharing principles and contingency plans for if/when targets are not being met;
- Provision of integrated support to carers so that they don't feel they are struggling to cope alone and can take a break from their caring responsibilities; and
- Agreement on consequential impacts of changes in the acute sector.
- Intervening early so that older and disabled people can stay healthy and independent at home avoiding unnecessary A&E attendances and emergency admissions;

3.3 On 10th October a letter was published from NHS England (Sir David Nicholson) on "Planning for a sustainable NHS: responding to the 'call to action'" (Appendix 1). This was followed by a letter on 17th October from NHS England and the Local Government Association (Bill McCarthy and Carolyn Downs) on "the next steps on implementing the Integrated Transformation Fund" (Appendix 2), along with a spread sheet template for the "Plan" (Appendix 3). The "Plan" has to be completed and signed off by the NHS HCCG, the Borough Council and the Health and Wellbeing Board by 15th February 2014.

3.4 To ensure that we have the necessary plans in place and comply with the integration, the Board established a short, time-limited Task and Finish Group, chaired by the Strategic Director for Communities, to develop the plan in conjunction with guidance from the Department of Health and Department for Communities and Local Government.

3.5 A plan is currently being drafted and the Health & Wellbeing Board have arranged a workshop to discuss the draft in January 2014. It is then proposed that it is submitted to the Council's Executive Board and through the appropriate CCG governance channels.

4.0 POLICY IMPLICATIONS

4.1 Nationally, the Public Health White Paper and the Health and Social Care Act 2012 both emphasise more preventative services that are focussed on delivering the best outcomes for local people. Locally, the Integrated Commissioning Framework sets out formally the joint arrangements for Commissioning. The joint Health and Wellbeing Strategy includes shared priorities based on the Joint Strategic Needs Assessment and local consultation.

5.0 FINANCIAL IMPLICATIONS

5.1 Undertaking the recommendations within this report will ensure that the new pooled budget funding is accessible so that outcomes for people living within Halton can be improved further.

5.2 The Department of Health have announced significant funding to be made available to implement the plan. However, at this stage it is not clear about the levels of finance and this will be determined at a later date.

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

Developing integration further between HBC and HCCG will have a direct impact on improving the health of people living in Halton. The plan that is developed will be linked to the priorities identified in Integrated Commissioning Framework.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 HBC and HCCG may be at risk of losing funding if certain criteria/conditions described in this report are not met. To avoid this, it is vital that HBC and HCCG work together to produce the "plan" in line with the guidance that has been issued.

7.2 The timeframe for the production of the plan is incredibly tight and this means that partners need to work together to agree a plan as soon as possible.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None under the meaning of the Act.

Publications Gateway Reference No: 00542

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To: NHS Commissioners: CCG leaders and NHS England Area Directors

CC: Chief Executives of NHS providers
Chief Executives of upper tier Local Authorities
Chair and Chief Executive of LGA
ALB Chief Executives
Permanent Secretary, Department of Health
NHS England National and Regional Directors

10 October 2013

Dear Colleague

Planning for a sustainable NHS: responding to the 'call to action'

Earlier this year, we published a landmark document: *The NHS belongs to the people – a call to action.* This document sets out the challenges facing the NHS and makes the case for developing bold and ambitious plans for the future. Commissioners have embraced the *call to action* and are leading discussions locally about how the NHS needs to change. Commissioners now face the task of crystallising the conclusions of these discussions into comprehensive plans.

We heard from the NHS Commissioning Assembly last month about the importance of giving early advice to commissioners, so I am writing to set out my assessment of the challenges facing us as commissioners and the key actions that need to be taken. We will be issuing planning guidance later in the year, but I thought it would be helpful to highlight ten key points at this stage:

1. **Improving outcomes** - commissioners need to place improving outcomes for patients at the heart of their work. For that reason, commissioners should prioritise an approach to planning which combines transparency with detailed patient and public participation**.** We need to construct, from the bottom up, quantifiable ambitions for each domain of the NHS Outcomes Framework. We will, therefore, be asking CCGs and NHS England Area Teams to work together to determine local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators that place our duty to tackle health inequalities front and centre stage. This will ensure that we can clearly articulate the improvements we are aiming to deliver for patients across seven key areas:

- Reducing the number of years of life lost by the people of England from treatable conditions (e.g. including cancer, stroke, heart disease, respiratory disease, liver disease);
- Improving the health related quality of life of the 15 million+ people with one or more long-term conditions;
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital;
- Increasing the proportion of older people living independently at home following discharge from hospital;
- Reducing the proportion of people reporting a very poor experience of inpatient care;
- Reducing the proportion of people reporting a very poor experience of primary care;
- Making significant progress towards eliminating avoidable deaths in our hospitals.

2. **Strategic and operational plans** – given the scale of the challenges we are facing, we are asking commissioners (CCGs and NHS England commissioners) to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five year perspective is crucial, as commissioners need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time. It will be essential for commissioners to work closely with providers and social care partners as they develop these plans, and we are in dialogue with the relevant national bodies to define fully aligned planning processes to facilitate this.

3. **Allocations for CCGs**– we want to provide certainty to commissioners. To this end, we intend to notify CCGs of their financial allocations for both 14/15 and 15/16 to help them plan more effectively. We are currently working with a subgroup of the Commissioning Assembly to finalise proposals for future allocation formulae for CCGs and direct commissioning, but stability is a key consideration and the pace of change is likely to be slow, given that we are operating with very limited financial growth overall.

4. **The tariff** – we recognise the importance of stability of tariff as well as its accuracy and responsiveness to the needs of patients. Together with Monitor, we intend to minimise changes to the structure of the tariff for 14/15. By December we plan to jointly publish our priorities for tariff in 15/16, giving commissioners and providers the maximum amount of time to assess any impact on the financial position of their services and respond systematically to tariff signals.

5. **The integration transformation fund** – the financial settlement for 15/16 includes the creation of an integration transformation fund (ITF). This will see the establishment of a pooled budget of £3.8bn, which will be committed at local level with the agreement of Health & Wellbeing Boards. (Locally, CCGs can decide to place additional resources into the ITF if they wish). The ITF is a 'game changer': it creates a substantial ring-fenced budget for investment in out-of-hospital care. However, it will also require us to make savings of over £2bn in existing spending on acute care. This implies an extra productivity gain of 2-3% across the NHS as a whole in 15/16. We will work with Monitor

to determine how this is reflected in the expectations placed on commissioners (in the form of QIPP savings from demand management, pathway change, etc) and providers (in the form of the efficiency deflator incorporated in tariff). We are currently exploring the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial 'cliff edge' in 15/16.

6. **Developing integration plans** – the NHS will only be sustainable in 15/16 if we put the ITF to the best possible use and reduce significantly the demand for hospital services. It is my view that investment should be targeted at a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge - taking advantage, for example, of new collaborative technologies to give patients more control of their care and transform the cost effectiveness of local services. This will require investment in social care and other Local Authority services, primary care services and community health services. We are currently exploring how an accountable clinician can be identified to coordinate the out-of-hospital care of vulnerable older people and the ITF might be used to accelerate this initiative. We will write to you over the next few days (jointly with the Local Government Association) with more details on the process for developing integration plans.

7. **Working together** – a critical ingredient of success for the transformation fund will be the quality of partnership working at local level. Health & Wellbeing Boards will need to have strong governance arrangements for making transparent and evidence-based decisions about the use of the ITF. The Chief Executive of NHS England will remain the accounting officer for the ITF, accountable to parliament for its use, and in that context I am asking NHS England Area Directors to take a close interest in the effectiveness of local arrangements for governance and implementation.

8. **Competition** – there has been considerable discussion about the impact of competition rules on commissioners over recent months. The key requirement for commissioners is to determine how to improve services for patients including how to use integrated care, competition and choice. Commissioners should adopt transparent decision making processes which use competition as a tool for improving quality, rather than as an end in itself. NHS England and Monitor will support commissioners who adopt this approach to competition.

9. **Local innovation** – while we will set a national framework for planning we want to encourage local innovation and don't want to be overly prescriptive. Within the scope of the new tariff rules for 14/15 agreed with Monitor, we will welcome innovative local approaches that enable change to happen on the ground. For example, commissioners could add additional resources to the transformation fund or they could agree local variations to the national tariff in line with the recently published 14/15 national tariff system rules, where they can demonstrate that it is in the interests of patients to do so. Commissioners could explore new contracting models, such as giving acute providers responsibility for patients 30-100 days following discharge from hospital and introducing prime contractor arrangements for integrated care.

10. **Immediate actions** – I would encourage commissioners to focus on three immediate tasks. First, you should progress the development of five year plans and engage local people in this work. Second, you should strengthen your local partnership arrangements so that you are well placed to make decisions about the use of the ITF. Third, you should identify the things that will make the greatest difference to patients locally and maintain a relentless focus on putting them into action at pace.

Over the coming months we will be publishing further material to help commissioners navigate their way through the planning process. This will include detailed planning guidance, financial allocations and 'commissioning for value' packs for CCGs which will help each CCG to identify where there is the greatest opportunity.

We are committed to working in partnership with CCGs, and I would encourage feedback from CCGs via the Commissioning Assembly planning and finance working group chaired by Paul Baumann, NHS England's Chief Financial Officer. More immediately, however, I advise you to press ahead with development of your plans, and I hope the points I have highlighted in this letter will help you make early progress. The challenges facing both commissioners and providers are significant, and it is essential we start to address them without delay.

Yours faithfully

Sir David Nicholson
Chief Executive

17 October 2013

To: CCG Clinical Leads
Health and Wellbeing Board Chairs
Chief Executives of upper tier Local Authorities
Directors of Adult Social Services

cc: CCG Accountable Officers
NHS England Regional and Area Directors

Dear Colleagues

Next Steps on implementing the Integration Transformation Fund

We wrote to you on 8 August 2013 setting out the opportunities presented by the integration transformation fund (ITF) announced in the spending review at the end of June. While a number of policy decisions are still being finalised with ministers, we know that you want early advice on the next steps. This letter therefore gives the best information available at this stage as you plan for the next two years.

Why the fund really matters

Residents and patients need Councils and Clinical Commissioning Groups (CCGs) to deliver on the aims and requirements of the ITF. It is a genuine catalyst to improve services and value for money .The alternative would be indefensible reductions in service volume and quality.

There is a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.

Changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. Accordingly the NHS planning framework will invite CCGs to agree five year strategies, including a two year operational plan that covers the ITF through their Health and Wellbeing Board.

A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. There is excellent practice in some areas that needs to be replicated everywhere. The ingredients are the same across England; the recipe for success differs locality by locality.

Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches. We are collaborating with all the national partners to support accelerated adoption of integrated approaches, and will be launching support programmes and tools later in 2013.

Where does the money come from?

The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Working with providers

It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Supporting localities to deliver

We are acutely aware that time is pressing, and that Councils and CCGs need as much certainty as possible about how the detail of the fund will be implemented. Some elements of the ITF are matters of Government policy on which Ministers will make decisions. These will be communicated by Government in the normal way. The Local Government Association and NHS England are working closely together, and collaborating with government officials, to arrive at arrangements that support all localities to make the best possible use of the fund, for the benefit of their residents and patients. In that spirit we have set out in the attached annex our best advice on how the Fund will work and how Councils and CCGs should prepare for it.

The Government has made clear that part of the fund will be linked to performance. We know that there is a lot of interest amongst CCGs and Local Authorities in how this “pay-for-performance” element will work. Ministers have yet to make decisions on this. The types of performance metrics we can use (at least initially) are likely to be largely determined by data that is already available. However, it is important that local discussions are not constrained by what we can measure. The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated

care will improve outcomes for local people and using it to build commitment among local partners for accelerated change.

Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

This annex to this letter sets out further information on:

- How the pooled fund will be distributed;
- How councils and CCGs will set goals and be rewarded for achieving them;
- Possible changes in the statutory framework to underpin the fund;
- The format of the plans for integrated care and a template to assist localities with drawing up plans that meet the criteria agreed for the fund;
- Definitions of the national conditions that have to be met in order to draw on the polled fund in any locality; and
- Further information on how local authorities, CCGs, NHS England and government departments will be assured on the effective delivery of integrated care using the pooled fund.

Leads from the NHS and Local Government will be identified to assist us to work with Councils and CCGs to support implementation. More details on this can be found in the annex. We will issue a monthly bulletin to Councils and CCGs with updates on the Integration Transformation Fund.

Yours faithfully

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

NHS England Publications Gateway Ref. No.00535

Annex

Advice on the Integration Transformation Fund

What is included in the ITF and what does it cover?

Details of the ITF Fund

The June 2013 SR set out the following:	
2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:
£1.9bn NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

1. The Integration Transformation Fund will be £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In 2014/15 an additional £200m transfer from the NHS to social care in addition to the £900m transfer already planned will enable localities to prepare for the full ITF in 2015/16.

2. In 2014/15 use of pooled budgets remains consistent with the guidance[1] from the Department of Health to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

3. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

4. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

5. *In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

6. *NHS England is also making it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

7. In 2015/16 The fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities. A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

How will the ITF be distributed?

8. Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014/15 and 2015/16 to enable planning.

9. In 2014/15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

10. The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.

11. In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014/15 and 2015/6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How will Councils and CCGs be rewarded for meeting goals?

12. The Spending Review agreed that £1bn of the £3.8bn would be linked to achieving outcomes.

13. In summary 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that

meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. We are still agreeing the detail of how this will work, including for any locally agreed measures.

14. In practice there is a very limited choice of national measures that can be used in 2015/6 because it must be possible to baseline them in 2014/5 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:

    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.

15. In future we would hope to have better indicators that focus on outcomes for individuals and we are working with Government to develop such measures. These can be introduced after 2016/7 as the approach develops and subject to the usual consultation and testing.

16. When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Does the fund require a change in statutory framework?

17. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the fund?

18. Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs. The specific priorities and performance goals are clearly a matter for each locality but it will be valuable to be able to:

    - Aggregate the ambitions set for the fund across all Health and Wellbeing Boards;

- Assure that the national conditions have been achieved; and

- Understand the performance goals and payment regimes have been agreed in each area.

19. To assist Health and Wellbeing Boards we have developed a draft template which we expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.

20. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

21. Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example if emergency admissions increase or nursing home admissions increase.

What are the National Conditions?

22. The Spending Review established six national conditions:

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 2 to 6,

National Condition	Definition
	above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

23. Ministers will wish to be assured that the ITF is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

24. To maximise our collective capacity to achieve these outcomes and deliver sustainable services we will have a shared approach to supporting local areas and assuring plans. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.

25. We will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.

26. Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. We will have a first review of readiness in early November 2013.

27. We will ask Health and Well Being Boards to return the completed planning template (draft attached) by 15 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

Integration Transformation Fund

Draft Plan Submission Template

Local Authority	<Name of Local Authority>
Clinical Commissioning Groups	<CCG Name/s> <CCG Name/s> <CCG Name/s> <CCG Name/s> <CCG Name/s>
Boundary Differences	<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>
Date agreed at Health and Well-Being Board:	<dd/mm/yyyy>
Date submitted:	<dd/mm/yyyy>
Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

Authorisation and Sign Off

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Clinical Commissioning Group	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Local Authority	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Health & Wellbeing Board	
By Chair of the HWB:	<Name of Signatory>
Position	<Job Title>
date	<date>

Service provider engagement

Please describe how health and social care providers have been involved in the development of this pla, and the extent to which they are party to it

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19.
- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Integration Aims & Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the integration transformation fund will secure improved outcomes in health and care in your area. Suggested points to cover:
• What are the aims and objectives of your integrated system?
• How will you measure these aims and objectives?
• What measures of health gain will you apply to your population?

Description of Planned Changes

Please provide an overview of the scemes and changes covered by your joint work programme, including:
1. The key success factors including an outline of processes, end points and time frames for delivery
2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

National Conditions

1 Protecting social care services

Please outline your agreed local definition of protecting social care services.

Please explain how local social care services will be protected within your plans.

2 7-day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)
Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

3 Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are commited to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are commited to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements , professional clinical practise and in particular requirements set out in Caldicott2.

4 Joint-assessments and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Outcome measures- Examples only	Current Baseline (as at....)	14/15 Projected delivery (full year?)	15/16 Projected delivery (full year?)
Delayed transfers of care			
Emergency admissions			
Effectiveness of reablement			
Admissions to residential and nursing care			
Patient and service-user experience			
<Local measure>			
<Local measure>			
<Local measure>			

Finance

Please summarize the total health and care spend for each commissioner in your area. Please

Organisation	2013/14 spend	2013/14 benefits	2014/15 spend	2014/15 benefits	2015/16 spend	
Local Authority Social Services						
CCG						
Primary Care						
Specialised commissioning						
Local Authority Public Health						
Total						

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total ITF allocation

ITF Investment	2014/15 spend	2014/15 benefits	2015/16 spend	2015/16 benefits
Scheme 1				
Scheme 2				
Scheme 3				
Scheme 4				
Scheme 5				
Total				

Approximately 25% of the ITF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully		
	Maximum support needed for other		
Outcome 2	Planned savings (if targets fully		
	Maximum support needed for other		

Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Risk 1		
Risk 2		
Risk 3		
Risk4		

REPORT TO: Health Policy & Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing; Community Safety

SUBJECT: Safeguarding Adults Update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on key issues and the progression of the agenda for safeguarding 'vulnerable adults' (i.e. adults at risk of abuse) in Halton.

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

3.0 **SUPPORTING INFORMATION**

3.1 An internal peer challenge review was undertaken during June 2013 – August 2013 based on the 'Standards for Adult Safeguarding Peer Reviews'. A Peer Challenge Team was formed along with a number of Lead Officers identified to take forward the review. As part of the review, Lead Officers undertook a self-assessment against the Adult Safeguarding Standards and produced a report for the Challenge Team. A outcome report was presented to the Safeguarding Adults Board on 7th November 2013.

3.2 The recommendations from the report have been converted into an action plan which will be worked on throughout 2014 and its progress monitored by Halton Safeguarding Adult Board.

3.3 In November 2013 Halton were invited to participate in the Making Safeguarding Personal Programme.

3.4 This work aims to provide a commitment to improve outcomes for people at risk of harm. The key focus is on developing a real understanding of what people wish to achieve, recording their desired outcomes and then seeing how effectively these have been met.

3.5 Halton will be using two different methods to:

- Establish what outcomes the person want at the outset and then

a review of the extent to which they have been realised, and
- Gather feedback from people who use services on their experience of the safeguarding adult process.

A briefing paper outlining the initial findings will be available by the end of February 2014

3.6 With an increasing focus on preventing abuse of older people in residential and nursing homes the Integrated Adult Safeguarding Unit has built upon national research and developed a local model – Early Indicators of Concern – which uses a range of indicators across a range of themes which identify risks and act as an indicator of potentially failing resources.

3.7 This is currently being trialled with two local nursing homes where services were perceived to be failing and where increased complaints were being voiced by families and visiting practitioners. A full detailed report will be available by February 2014.

3.8 The Health and Social Care Information Centre has published figures that reflect an increase in alleged abuse allegations across 151 Councils nationally. This trend has been reflected locally with an increase in the safeguarding referrals to the Council for quarters 1 and 2 by 73% and to the Integrated Safeguarding Unit of 40% as compared to the same quarters for 12/13.

3.9 The data also identifies:

- A higher incidence of abuse alerts in respect of females 64% (61% nationally) as opposed to males.
- Nationally and locally adults aged 75 and above still account for the highest number of alerts and emphasises the increased vulnerability of older people.
- Nationally and locally people with physical disabilities continue to be the client group most prevalent with safeguarding investigations continuing to reflect that this is the largest client group within adult services.

4.0 POLICY IMPLICATIONS

4.1 A review of existing policies and procedures will be completed in light of the Social Care Bill.

5.0 FINANCIAL IMPLICATIONS

5.1 The Integrated Safeguarding Unit is co-funded through the Council and the Clinical Commissioning Group.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

Safeguarding Adults Board (SAB) membership includes a Manager from the Children and Enterprise Directorate, as a link to the Local Safeguarding Children Board. Halton Safeguarding Children Board membership includes adult social care representation. Joint protocols exist between Council services for adults and children.
The SAB chair and sub-group chairs ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

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 adultswhose circumstances make them vulnerable to abuse.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 Failure to address a range of Safeguarding issues could expose individuals to abuse and leave the Council vulnerable to complaint, criticism and potential litigation.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 It is essential that the Council addresses issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its safeguarding policies and plans. Policies and procedures relating to Safeguarding Adults are impact assessed with regard to equality.

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

None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Strategic Director – Communities

PORTFOLIO: Health & Wellbeing
Children, Young People and Families

SUBJECT: Mental Health Awareness Promoted in Schools (MHAPS) Pilot

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide Members of the Policy & Performance Board (PPB) with information on the forthcoming MHAPS pilot to be delivered in Warrington.

2.0 **RECOMMENDATION: That:**

i) Members of the PPB note the report
ii) Comments from the PPB be made to the Pilot Coordinator

3.0 **SUPPORTING INFORMATION**

3.1 As a result of a visit made by the Joint Health and Children, Young People and Families PPB Mental Health Scrutiny Topic Group to Thorn Road CAMHS in October 2013 the group met an ex CAMHS service user, Hannah, who is now employed by 5 Borough's Partnership to run a Mental Health Awareness Promoted in Schools pilot.

3.2 The scrutiny group were particularly interested in this pilot, as it comes at a time where young people are increasingly vulnerable to social pressures and at risk of developing poor mental health. Although the pilot is being undertaken in Warrington, it is anticipated that it will be rolled out across the rest of the 5 Boroughs footprint during the second half of 2014.

3.3 The pilot's foundations come from a general lack of awareness about mental health issues amongst secondary school aged pupils, the perceived stigma that is associated with mental illness, lack of understanding about what services are available and how pupils can seek support. This has become apparent through high profile cases where a small number of pupils have reached crisis point and in a case of one, resulted in suicide.

3.4 The delivery of a pilot in schools to address stigma and raise awareness was also emphasised by the short film 'You're not alone', based around the day in the life of a young person with Mental Health problems, produced by Investing in Children Group from Halton Children and Adolescent Mental Health Services (CAMHS).

3.5 The film was designed to reflect young people's experiences of coming along to services and meeting other young people with similar experiences. Other young people's experience of Mental Health and their lack of knowledge of who to talk to in their schools about asking for help was also a driving factor in the development of the MHAPS pilot.

3.6 The pilot coordinator is able to lend some personal experience to delivering the pilot from the perspective of recalling her own experience of not understanding Mental Health or the difficulties she was going through , and also not knowing how to access Mental Health Services.

3.7 Thomas Boteler High School in Warrington has been selected for the initial pilot. The reason for this school being chosen was that CAMHS have an established link with this school through a well-being worker at the school who would be able to offer support to the pilot.

The Pilot

3.8 The Pilot will be trialled across Year 9 pupils and consist of each pupil attending at least 1 dedicated lesson within the Health, Physical and Social Education curriculum which will address mental health stigma and awareness raising.

3.9 Within the pilot there will be information to direct the pupils to the right people if they feel that they need to talk to somebody within school, including peer support.

3.10 The lesson will be supplemented by a teacher's resource pack and materials for the pupils to take away. At this stage much of the resources are under development.

3.11 The pilot coordinator, being an ex CAMHS service user herself, is able to provide a valuable insight into the benefits of accessing services and also resonate with the pupil cohort by being able to provide a real life story of addressing mental health and delivering a message of hope and optimism.

3.12 It is anticipated that the pilot will be undertaken between February 2014 - May2014.The pilot will be evaluated by pre and post session questionnaires, and is overseen by CAMHS clinical and operational management.

4.0 **POLICY IMPLICATIONS**

4.1 The success and findings of the pilot will affect how the programme is rolled out across the rest of the 5 Boroughs Partnership footprint. There will be implications for both Health and Children, Young People and Families in Halton, which will be explored in due course.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Financial analysis will form part of the pilot evaluation and will be available in due course.

5.2 Consideration should be given by the pilot as to the impact on other services CAMHS services, and other services such as the school nursing programme.

5.3 Before implementing in Halton, consideration should be given by the Mental Health Promotion Sub Group (of the Mental Health Board and the CAMHS Board) to the impact on any existing provision of mental health awareness raising currently happening in schools, for example, coordinating with the Bridgewater NHS Trust Health Improvement Team delivery of the 'Healthyttude' programme in schools. This will ensure a complimentary and coordinated approach and reduce duplication.

5.4 There is opportunity for coordination between the Halton 'Like Minds' campaign and any future MHAPS work in Halton.

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

6.1 **Children & Young People in Halton**
Emotional and mental health and wellbeing is a critical factor in supporting children and young people's social development, behaviour and resilience, educational attainment and achievement and life chances. This area of work also supports Halton's focus on Early Health and Support and the priorities within Halton's Children and Young People's Plan.

6.2 **Employment, Learning & Skills in Halton**
Good emotional and mental health and wellbeing is a vital factor in children and young peoples and adults accessing learning and future employment opportunities.

6.3 **A Healthy Halton**
Emotional and mental health services impact directly upon the health and wellbeing of children and young people with an identified need or who are at risk of developing a need.

6.4 **A Safer Halton**

Those who do not experience good emotional and mental health and wellbeing are more likely to be subject to a range of risk factors that can impact negatively on community safety issues.

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

7.0 **RISK ANALYSIS**

7.1 National and local evidence demonstrates that failure to ensure that appropriate services to support emotional and mental health and wellbeing of children and young people is likely to impact negatively on their outcomes and life chances. Failure to provide effective mental health prevention and promotion services across the life course could also result in an increase in the need for specialist services thus leading to potentially increased costs to the Council.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

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

9.1 None identified under the meaning of the Act

REPORT TO: Health Policy and Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Health Profile 2013

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Policy and Performance Board with information relating to Halton's Health Profile 2013 and provide analysis regarding the findings from a local perspective.

RECOMMENDATION: That

(i) **The Board note the contents of the report and note programmes to address areas of concern; and**

(ii) **Feedback comments to the Director of Public Health**

2.0 SUPPORTING INFORMATION

2.1 Every year the Department of Health releases a health profile of Halton which compares it to the England average. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

2.2 The Halton Health Profile 2013 shows that half of all local residents live in the most deprived areas in England. Given the direct relationship between poverty and poor health it is unsurprising that Halton's health statistics are worse than the national average. Using a traffic-light rating system, the profile ranks those better than the England average as green, those similar to the England average as amber and those performing worse than the England average as red.

2.3 Halton's profile can be seen in the Appendix which shows that although Halton is not better than the England average in the majority of indicators it has improved against the previous year's figures in 21 out of 28 indicators, remained static for 5 and worsened in 6.

Halton progress and challenges.

2.4 The data for Halton shows that if we compare the 2012 profile with the 2013 profile we have made very good progress with GCSE results, reduction in

child obesity, reducing higher risk drinking, reducing infant deaths and reducing road traffic injuries and accidents. Halton is classified as green for homelessness but the latest data since the profile was released shows we now have an increase in homeless people.

2.5 Halton has also improved in terms of reducing violent crime, smoking in pregnancy, increasing the number of mothers who breastfeed, reducing the number of under 18s in alcohol treatment, reducing teen pregnancy, reducing drug misuse, reducing the number of TB cases, reducing the number of people who die in winter, increasing male and female lives, reducing the number of smoking related deaths and reducing the number of people who die from heart disease.

2.6 In common with the rest of England Halton has not made progress this year against reducing levels of deprivation, lowering the number of children in poverty, reducing long term unemployment and lowering the numbers of hip fractures. The number of people diagnosed with diabetes has increased but given there is national under diagnosis of this disease this could be considered a good thing.

Programmes to address areas of concern.

2.7 Halton has a wide range of programmes that address deprivation, worklessness, child mental health, diabetes and falls in older people:

- Child Poverty Programme: Halton has a Child Poverty Strategy and Action Plan and is part of the City Region Child Poverty Commission. There is a wide range of work underway to address this area including Children's Centres Programmes, healthy eating, working with food banks, increasing breastfeeding, increasing free school meal uptake, plain packaging for cigarettes, smoking prevention, work with mums and tots, support for the New Shoots Food Coop, Credit Crunch Cooking, work with Housing Trusts around welfare reforms, Healthy Homes/ Warm Homes initiatives, work with the CAB and Supporting Residents at Risk of Home Repossession project.

- Back to work Programmes: Halton works with local residents to enable them to find work through Halton People into Jobs, an apprenticeship scheme, Welfare Rights Programme, Halton Housing Trust financial inclusion, Healthy and back to Work project.

- Child Social and Emotional Health Programmes: Halton has Prevention of Mental Health Conditions as a Health and Wellbeing Board priority. A new Mental Health Strategy and comprehensive Action Plan has recently been developed. There is a review of the CAHMS service underway, Adaction is employed to work with youngsters with addictions, teachers are trained to work with youngsters on developing confidence and self-esteem and counteracting bullying, an anti-cyber bullying project is in development, midwives are working with mothers to avoid post natal depression and

parenting programmes for families in how to bond with babies and deal with toddlers.

- Diabetes Programme: Impaired Glucose Regulation project that picks up people at risk of developing diabetes and provides them with education, diet and exercise advice so they can avoid developing the condition. Diabetes Education Programme for patients with the condition to help them manage it, Expert Patient Programme so people become experts on their condition, Healthy Weight Fresh Start Programme enables people to lose weight and therefore be less at risk of developing diabetes, Healthy Weight in Pregnancy Programme works with overweight pregnant women who are at risk of developing gestational diabetes.

- Reducing Harmful Levels of Drinking Programme: Reduction in the levels of harmful alcohol consumption is a priority for Halton's Health and Wellbeing Board. It has an Action Plan which includes: training for all frontline staff in dealing with alcohol related issues from birth to old age, treatment services for adults and children, awareness raising via campaigns, alcohol prevention programmes for all schools, mystery shopping via trading standards for underage sales, regulation of counterfeit alcohol, alcohol liaison nurse at hospitals A&E and advocacy on minimum unit pricing.

- Falls Programme: Falls is a priority for the Health and Wellbeing Board and a new Falls Strategy and Action Plan has recently been implemented which includes: exercise for older people to improve balance, training on falls prevention for frontline staff, development of new falls pathway.

3.0 POLICY IMPLICATIONS

The Halton Health Profile 2013 highlights a number of key health issues for Halton. The Health and Wellbeing Strategy together with a number of related strategies is already addressing many of the issues highlighted.

4.0 OTHER/FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications as a result of this report. Actions identified within the Health and Wellbeing Strategy and associated strategies however, may have implications that will be reported to the relevant boards as they arise.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

Improving the Health of Children and Young People is a key priority in Halton and will continue to be addressed through the Health and Wellbeing Strategy

whilst taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication

5.2 **Employment, Learning and Skills in Halton**
The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

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

5.4 **A Safer Halton**
Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health.

There are also close links between partnerships on areas such as alcohol and domestic violence.

5.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and should therefore, be a key consideration when developing strategies that examine the wider determinants of health and wellbeing.

6.0 RISK ANALYSIS

Developing strategies to address the issues outlined by Halton Health Profile 2013 in itself does not present a risk. However, there may be risks associated with the recommended actions. These will be assessed as appropriate. There are no financial risks associated directly with this report. The recommendations are not so significant that they require a full risk assessment.

7.0 EQUALITY AND DIVERSITY ISSUES

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

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

Document	Place of Inspection	Contact Officer
Halton Health Profile 2013	Council Website	Diane Lloyd

Health Profile summary for Halton 2013

Please use this summary in conjunction with the Health Profile spine chart.
Please note that although the profile is released in 2013, the data contained within it will relate to various other periods of time (see Indicator Notes on profile).

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

Domain	Indicator	Halton compared to England: 2013 profile	Halton improved or worsened since 2012 profile.	Comments on data
Our communities	**1** Deprivation	🔴	↑	Across England this figure has become worse.
	2 Children in poverty	🔴	↑	Across England this figure has become worse.
	3 Statutory homelessness	🟢	↕	2012/13 published data shows number and rate have gone up to 86 people (1.7 per 1,000), from 64 and 1.3 per 1,000 in 2011/12.
	4 GCSE achieved (5A*-C inc. Eng & Maths)	🟡	↑	No updated data available.
	5 Violent crime	🔴	↓	No updated data available.
	6 Long term unemployment	🔴	↑	England average also worsened.
Children & young people's health	**7** Smoking in pregnancy	🔴	↓	-2012/13 published data shows has reduced from 21.2% in 2011/12 to 18.9%.
	8 Starting breast feeding	🔴	↕	-2012/13 published data shows has increased from 51.3% in 2011/12 to 52.3%.
	9 Obese children (Year 6)	🟡	↕	
	10 Alcohol-specific hospital stays (under 18)	🔴	↓	*Provisional* local data for 2010/11-2012/13 shows rate has decreased to 72.3 (compared to 153.9 for 2007/08-2009/10 quoted on 2013 profile).
	11 Teenage pregnancy (under 18)	🔴	↓	No updated data available.
Adults' health & lifestyle	**12** Adults smoking	🔴	↓	No updated data available.
	13 Increasing & higher risk drinking	🟡	↓	No updated data available.
	14 Healthy eating adults	🔴	/	Based on modelled estimates (no update in 2013 profile).
	15 Physically active adults	🔴	/	Indicator criteria changed so cannot compare. No updated data available since 2013 profile.
	16 Obese adults	🟡	/	Based on modelled estimates (no update in 2013 profile).
Disease and poor health	**17** Incidence of malignant melanoma (skin cancer)	🟡	/	No updated data available. Increasing incidence of malignant melanoma means that more people are being identified with melanoma which if it is recognized and treated early, it is almost always curable, but if it is not, the cancer can advance and spread to other parts of the body, where it becomes hard to treat and can be fatal.

	18 Hospital stays for self harm			- England average worsened. - 2012/13 *provisional* local data shows rate has decreased to 359 (from 416 in 2011/12).
	19 Hospital stays for alcohol related harm			-England average also worsened. -2011/12 published data & provisional 2012/13 data shows no change from 2010/11 for Halton.
	20 Drug misuse			Based on modelled estimates 2010/11. No updated data available.
	21 People diagnosed with diabetes			-England average also worsened.
	22 New cases of tuberculosis			Only 1-2 cases per year. No updated data available.
	23 Acute sexually transmitted infections		/	Indicator not included on previous profiles. No updated data available.
	24 Hip fracture in over-65s			2012/13 p*rovisional* local data shows rate has decreased to 501 (from 600 in 2011/12).
Life expectancy and causes of death	**25** Excess winter deaths			No updated data available.
	26 Life expectancy – male			2010-12 *provisional* local data shows male life expectancy has increased to 77.3 from 76.5 in 2009-11.
	27 Life expectancy – female			2010-12 *provisional* local data shows female life expectancy was 80.6; this is no change from 2009-11.
	28 Infant deaths			2010-12 *provisional* local data shows rate has decrease to 4.1 from 4.6 in 2009-11.
	29 Smoking related deaths			No updated data available
	30 Early deaths: heart disease & stroke			2010-12 *provisional* local data shows the <75 circulatory mortality rate was 82.9; this is no change from 82.4 in 2009-11.
	31 Early deaths: cancer			-Average number of deaths remained same since 2011 profile data; rate decreased (due to population increase). -2010-12 *provisional* local data shows rate has decreased to 137.3; this is slight reduction from 142.7 in 2009-11.
	32 Road injuries and deaths			2010-12 published shows average number of road deaths was 40 per year; this has not changed since 2009-11.

REPORT TO:	Health Policy & Performance Board
DATE:	7 January 2014
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Care Quality Commission's Inspection of Mental Health Hospitals and Community Services.
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with a brief overview of the Care Quality Commission's (CQC) new inspection regime for mental health hospitals and community services and as part of this process seek feedback from the Board in relation to Bridgewater Community Healthcare NHS Trust.

2.0 RECOMMENDATION: That the Board:

i) Note the contents of the report; and
ii) Provide feedback on the services etc. provided by Bridgewater Community Healthcare NHS Trust as part of the CQC inspection process.

3.0 SUPPORTING INFORMATION

3.1 CQC is currently undertaking a radical review of how they inspect mental health hospital and community services. The new inspections will involve significantly larger inspection teams which will include clinical and other experts, and trained members of the public. The teams will spend longer inspecting hospitals and community locations that deliver mental health services.

3.2 The teams will examine key service areas and others if necessary, for example: acute admission wards; psychiatric intensive care units and health based places of safety; long stay, forensic and secure services; in patient and community services; child and adolescent mental health services (CAMHS); services for older people; in inpatient and community settings; in patient services for people with learning disabilities and health related community learning disabilities services; adult community based services; eating disorder and community based crisis services.

3.3 CQC will make better use of information and evidence, using new surveillance indicators and information from partners to guide their teams on where and what to inspect.

CQC's new approach will aim to answer five key questions about an organisation:

- Is it safe?
- Is it effective?

- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Each inspection will provide the public with a clear picture of the quality of care, exposing poor and mediocre care and highlighting good care; hospitals will be rated as outstanding; good; require improvement; or inadequate.

3.4 A crucial part of development on the new inspection regime is the first wave of inspections CQC will be undertaking between January and March 2014 to test their new approach in Mental Health and Community NHS Trusts. Nine trusts have been chosen in this first wave, including Bridgewater Community Healthcare NHS Trust.

3.5 CQC have requested feedback about Bridgewater in advance of their inspection. Bridgewater's inspection is due to commence on 3 February 2014.

3.6 CQC have asked for feedback which is relevant to the quality of care provided at Bridgewater and any of the services it provides. This includes evidence of high-quality care as well as concerns identified. CQC would like to receive evidence that is held which relates to:

- the systems, environment or services in these trusts;
- feedback from people who use services in any form, including complaints information;
- any scrutiny activity you have completed or plan in these trusts; and
- your experiences of working with these trusts.

3.7 In the period before the inspection, the inspection team will make contact with the local scrutiny committees covering Bridgewater to discuss any information that is held.

3.8 The feedback provided will be considered before the inspection to help identify any current issues or concerns, and any additional services which CQC may look at during their inspection of the trust. They will not publish the information that is sent unless they discuss it with the Board first.

3.9 After each inspection is complete, the Chair of the inspection team will hold a quality summit with the trust and local partners to share the inspection findings and to focus on next steps where action is needed.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this stage.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified at this stage.

6.2 **Employment, Learning & Skills in Halton**
None identified at this stage.

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 at this stage.

6.5 **Halton's Urban Renewal**
None identified at this stage.

7.0 **RISK ANALYSIS**

7.1 None identified at this stage.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

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

9.1 None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 7 January 2014

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Joint Health Scrutiny

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with a draft protocol for the establishment of Joint Health Scrutiny arrangements across Cheshire and Merseyside.

2.0 RECOMMENDATION: That the Board:

i) Note the contents of the report and associated appendices; and
ii) Review and comment on the draft protocol attached at Appendix 2.

3.0 SUPPORTING INFORMATION

3.1 A joint Health Scrutiny Officer's meeting took place in September 2013 which focused on the requirements under the new Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (summary attached at ***Appendix 1***), to form joint scrutiny committees where there is a substantial development/variation proposal which is to impact on more than one Local Authority area and how as a Cheshire and Merseyside region we should respond to this requirement.

3.2 Discussions at the meeting centred on the feasibility of developing a Cheshire and Merseyside regional protocol for dealing with joint scrutiny committees. Issues initially raised included Local Authorities experiences of previous joint scrutiny committees e.g. Vascular Services, communication issues, who would lead and support on joint scrutiny arrangements, potential barriers such as appropriate number of representatives, level of commitment from Local Authorities, option for Local Authorities to 'opt out' of a joint scrutiny if they decided that a proposal was not a substantial development/variation etc.

3.3 Besides the issues outlined above, generally officers present were receptive to the concept of having a workable region wide protocol.

3.4 Taking the learning from recent joint scrutiny committees and information from example protocols already available, Knowsley agreed to take the lead/facilitate on the development of the protocol.

3.5 The draft protocol was sent through to each of the 9 Local Authorities that this arrangement would cover at the end of October for comments back by 22nd November.

3.6 The Chair and Vice Chair of the Health Policy & Performance Board meet with a small group of officers to review the draft protocol with a view to returning comments.

Comments made included :-

- Page 3 – Footnote; The NHS Commissioning Board no longer exists, it should be NHS England.

- Page 6 – Membership; Members chose **OPTION 1** with the following amendments:-

  - Only 1 nominated elected member or nominated substitute from each participating authority, whether it be 2 or 9 local authorities.; and
  - Include the quorate in the protocol;

- Page 5 – Paragraph 6.5.2 – to include 'officer support'. It was highlighted that after the experience of a joint committee to look at vascular support, it was felt that the Authority would like officer support at the meetings. Due to the complexity of the issue and there being numerous authorities involved, there was a considerable delay in receiving the minutes etc. and it made it very difficult to keep everyone up to date on the progress. This would enable Health Board's and Members to be updated quickly and on a regular basis.

3.7 At the time of writing this report, we are awaiting feedback from Knowsley as to comments returned by the other Local Authorities and how potentially the draft will change as a result and timescales for this; further information may be available at the Board meeting and if so will be shared.

4.0 POLICY IMPLICATIONS

4.1 The aim of the joint protocol is that it would be used for all future joint scrutiny committees and would help support a more structured approach to joint scrutiny being undertaken.

4.2 Each Local Authority has been asked to consider the draft protocol via their appropriate political channels/structure with a view to developing it further and getting it formally agreed across the Cheshire and Merseyside region.

4.3 It is hoped that the protocol can be agreed in advance of when there will be a requirement to establish another joint scrutiny committee. In terms of the current regional context this is likely to be when the cancer services proposals are made available and there will be a need for formal consultation to take place.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this stage.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified at this stage.

6.2 **Employment, Learning & Skills in Halton**
None identified at this stage.

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 at this stage.

6.5 **Halton's Urban Renewal**
None identified at this stage.

7.0 **RISK ANALYSIS**

7.1 Not having a joint protocol agreed could lead to a disjointed approach to joint scrutiny committees being undertaken in the future.

7.2 Whilst each Local Authority must decide individually whether a proposal represents a substantial development/variation, it is only the **statutory joint health scrutiny committee** which can formally comment on the proposals if more than one authority agrees that the proposed change is "substantial". Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal and exercise other powers, such as the power to refer to the Secretary of State.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

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

Document	**Place of Inspection**	**Contact Officer**
The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013	Municipal Buildings	Lynn Derbyshire Lynn.Derbyshire@halton.gov.uk

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

The new regulations build upon the existing statutory provisions by strengthening the process for consultation and the requirement for making referrals to the Secretary of State. They also provide clarity in relation to the circumstances where joint health scrutiny arrangements are obliged to be formed between 2 or more authorities.

1. General Powers – review and scrutiny

Regulations 21 and 22 make general provisions for local authority health scrutiny functions to:

- review and scrutinise any matter relating to the planning, provision and operation of the health service in its area, and;
- make reports and recommendations on any matter it has reviewed or scrutinised.

These regulations require the local authority to invite interested parties to comment on any matter it has under consideration and take account of information provided, which includes referrals from a local Healthwatch organisation. They also make it a requirement for reports to include:

- an explanation of why the matter was reviewed or scrutinised
- a summary of the evidence considered
- a list of the participants involved in the review or scrutiny
- an explanation of any recommendations on the matter reviewed or scrutinised

The legislation states that if a response to a report is requested from an organisation/ body, the organisation/ body must respond in writing within 28 days.

2. General Powers – provision of information

Regulations 26 and 27 obliges health service commissioners/providers to provide the local authority with information about the planning, provision and operation of health services in the area and to attend before the authority to answer questions.

The health service commissioner/provider is not required to provide information (either as written evidence or evidence provided by a member or employee) if it:

- relates to a living individual unless the information can be provided without disclosing such information
- cannot be disclosed under law
- relates to a trust special administrator's report
- relates to recommendations by a special administrator.

3. Substantial developments/variations – requirements to consult

Regulation 23 makes requirements for a relevant NHS body or relevant health service commissioner/provider to consult the local authority where it has a proposal for a 'substantial development' or 'substantial variation' of the health service in the local authority area.

For example, in the case where a proposal relates to services which a commissioner (such as the Council, Public Health and NHS England) is responsible for arranging, it is the commissioner which must discharge the responsibilities as set out in the regulations.

The regulations do not define a 'substantial variation or development'. Guidance suggests that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients. Guidance also suggests that in considering whether a proposal is substantial NHS bodies, committees and stakeholders should consider:

1. Are there proposed changes in the accessibility of services?
2. What is the impact on the wider community and other services – e.g. is there an economic impact?
3. How many patients are affected by the proposed change? (If it affects a small group of patients it may still be 'substantial' especially if patients need to continue to access that service for many years)
4. What are the methods of service delivery? E.g. is a particular service moving from an acute hospital setting into a community setting?

Following the new regulations, it is expected that there will be new Department of Health guidance published at the end of May 2013 to reflect the changes.

On consulting the local authority, the responsible commissioner/ provider must:

- provide the proposed date by which it intends to make a final decision as to whether to implement the proposal
- provide the proposed date by which it requires the authority to comment
- publish the dates
- inform the local authority if the dates change

4. Substantial developments/variations – exemptions

Regulation 24 provides clarity on situations where NHS bodies or relevant health service commissioners/ providers are not required to consult. This includes where:

- a decision has been taken because of a risk to safety or welfare of patients and staff - in this case the NHS body must notify the authority of the decision taken and the reason why no consultation has taken place;
- a proposal to establish or dissolve an NHS trust or clinical commissioning group (or to vary their constitutions) has been made;
- there are proposals contained in a special administrator's report or recommendations by a health special administrator on the action which should be taken in relation to a company subject to a health special administration order

5. Substantial developments/variations - requirements to respond

In response to any NHS consultation, the regulations give powers to local authorities to:

- Make comments and recommendations on the proposals by the date indicated by the NHS body.
- Report to the Secretary of State in writing if it:

  (a) is not satisfied that the consultation on the proposal has been adequate; or,
  (b) is not satisfied that reasons for an 'emergency' decision are adequate
  (c) does not consider the proposal would be in the interests of the health service in its area

Where either a local authority does not use its power to make comments or recommendations to the NHS body or it has used its power but its comments did not include a recommendation, it is obliged to provide an indication to the NHS body of its intention to refer the proposal to the Secretary of State for Health or the date by which it intends to make a decision as to whether to refer the proposal or not.

6. Making comments and recommendations on proposals

The regulations make provisions for the authority to make comments on the proposal consulted on by the date or changed date provided by the NHS commissioner/provider.

In circumstances where the authority has provided comment and made a recommendation on the proposals and the NHS body does not agree with the recommendation, the following actions must occur:

- the NHS body must notify the local authority of the disagreement

- the NHS body and local authority (and provider where appropriate) must work together to reach agreement on the subject of the recommendation

If the steps above have been taken, but agreement has not been reached in relation to the subject of a recommendation within a reasonable period of time, the authority may exercise its power to report to the Secretary of State in writing on the proposal. This is dependent on the authority having complied with its obligations to notify the NHS body of the date by which it either intended to refer or make its decision on referral.

7. Reports to the Secretary of State

Reports to the Secretary of State must include:

- an explanation of the proposal to which the report relates
- the reasons why the authority is referring the issue (in line with the possible options set out)
- If the reason is that the proposal is not in the interests of the health service, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the authority.
- An explanation of any steps the authority has taken to try and reach agreement in relation to the proposal
- Evidence to demonstrate that the authority has complied with the requirements to attempt to reach agreement in relation to the recommendation
- Any explanation of the reasons for making the report
- Any evidence in support of those reasons

8. Action taken by the Secretary of State

Regulation 25 sets out the powers of the Secretary of State in relation to a decision on a proposal where a local authority has reported to the Secretary of State. In this regard, the Secretary of State may:

- Make a decision on the subject matter of the referral if the local authority has referred the matter either because the consultation has been inadequate or the reasons for the 'emergency' decision have been deemed inadequate and give directions to the commissioner (through NHS England) or provider to:

    - consult with the authority in relation to the proposal
    - determine the matter in a particular way
    - take other steps in relation to the matter

- Make a decision on the final proposal if the local authority has referred the matter because it does not consider the proposal would be in the interests of the health service in its area.

9. Joint Committees

Paragraph 30 provides a general power for two or more authorities to appoint a joint committee and arrange for relevant health scrutiny functions to be exercisable by a joint committee.

However, where a substantial development/ variation proposal impacts on more than one local authority, those local authorities **are required to** appoint a joint overview and scrutiny committee for the purposes of the consultation and only that joint overview and scrutiny committee may:

- make comments on the proposal
- require the provision of information
- require an officer/member to attend before it

A joint overview and scrutiny committee may not discharge any functions other than the relevant functions in accordance with the regulation.

10. Miscellaneous

The regulations make general provisions for county councils to co-opt members of district councils onto their overview and scrutiny committees. It also cites previous regulations which are revoked including the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (a).

PROTOCOL FOR ESTABLISHMENT OF JOINT HEALTH SCRUTINY ARRANGEMENTS FOR CHESHIRE AND MERSEYSIDE

1. INTRODUCTION

1.1 This protocol has been developed as a framework for the operation of joint health scrutiny arrangements across the local authorities of Cheshire and Merseyside. It allows for:

- scrutiny of 'substantial developments and variations' of the health service; and,
- discretionary scrutiny of local health services

1.2 The protocol provides a framework for health scrutiny arrangements which operate on a joint basis only. Each constituent local authority should have its own local arrangements in place for carrying out health scrutiny activity individually.

2. BACKGROUND

2.1 The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 came into effect on 1 April 2013 revising existing legislation regarding health scrutiny.

2.2 In summary, the revised statutory framework authorises local authorities to:

- Review and scrutinise any matter relating to the planning, provision and operation of the health service
- Consider consultations by a relevant NHS body or provider of NHS-funded services on any proposal for a 'substantial development or variation' to the health service in the local authority's area.

2.3 Ultimately the regulations place a requirement on relevant scrutiny arrangements to reach a view on whether they are satisfied that any proposal that is deemed to be a 'substantial development or variation' is in the interests of the health service in that area, or instead, that the proposal should be referred to the Secretary of State for Health. In instances where a proposal impacts on the residents of one local authority area exclusively, this responsibility lays with that authority's health scrutiny arrangements alone.

2.4 Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a "substantial development or variation" or not. The regulations place a requirement on those local authorities that agree that a proposal is "substantial" to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. This protocol deals with the

proposed operation of such arrangements for the local authorities of Cheshire and Merseyside.

3. PURPOSE OF THE PROTOCOL

3.1 This protocol sets out the framework for the operation of joint scrutiny arrangements where:

a) an NHS body or health service provider consults with more than one local authority on any proposal it has under consideration, for a substantial development/variation of the health service;

b) joint scrutiny activity is being carried out on a discretionary basis into the planning, provision and operation of the health service

3.2 The protocol covers the local authorities of Cheshire and Merseyside including:

- Cheshire East Council
- Cheshire West and Chester Council
- Halton Borough Council
- Knowsley Council
- Liverpool City Council
- St. Helens Metropolitan Borough Council
- Sefton Council
- Warrington Borough Council
- Wirral Borough Council

3.3 Whilst this protocol deals with arrangements within the boundaries of Cheshire and Merseyside, it is recognised that there may be occasions when consultations/discretionary activity may affect adjoining regions/ areas. Arrangements to deal with such circumstances would have to be determined and agreed separately, as and when appropriate.

4. PRINCIPLES FOR JOINT HEALTH SCRUTINY

4.1 The fundamental principle underpinning joint health scrutiny will be co-operation and partnership with a mutual understanding of the following aims:

- To improve the health of local people and to tackle health inequalities;

- To represent the views of local people and ensure that these views are identified and integrated into local health service plans, services and commissioning;

- To scrutinise whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community; and

- To work with NHS bodies and local health providers to ensure that their health services are planned and provided in the best interests of the communities they serve.

5. SUBSTANTIAL DEVELOPMENT/VARIATION TO SERVICES

5.1 Requirements to consult

5.1.1 All relevant NHS bodies and provider of NHS-funded services[1] are required to consult local authorities when they have a proposal for a substantial development or substantial variation to the health service.

5.1.2 A substantial development or variation is not defined in legislation. Previous guidance has suggested that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients.

5.1.3 Where a substantial development or variation impacts on the residents within one local authority area boundary, only the relevant local authority health scrutiny function shall be consulted on the proposal.

5.1.4 Where a proposal impacts on residents across more than one local authority boundary, the NHS body/health service provider is obliged to consult all those authorities whose residents are affected by the proposals in order to determine whether the proposal represents a substantial development or variation.

5.1.5 Those authorities that agree that any such proposal does constitute a substantial development or variation are obliged to form a joint health overview and scrutiny committee for the purpose of formal consultation by the proposer of the development or variation.

5.1.6 Whilst each local authority must decide individually whether a proposal represents a substantial development/variation, it is only the statutory joint health scrutiny committee which can formally comment on the proposals if more than one authority agrees that the proposed change is “substantial”.

5.1.7 Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal and exercise other powers, such as the power to refer to the Secretary of State. Once such decisions are made, the ongoing obligation on the proposer to consult formally on a proposal relates only to those authorities

[1] This includes the NHS Commissioning Board, any Clinical Commissioning Group providing services to the residents of Cheshire and Merseyside, an NHS Trust, an NHS Foundation Trust and any other relevant provider of NHS funded services which provides health services to those residents, including public health.

that have deemed the proposed change to be "substantial" and this must be done through the vehicle of the joint committee.

5.2 Process for considering proposals for a substantial development/variation

5.2.1 Where an NHS body or provider of NHS-funded services has a proposal for a substantial development or variation to its services, it must consult each local authority to determine whether the change is considered substantial.

5.2.2 In consulting with the local authority in the first instance, the NHS body/ provider of NHS-funded service is required to:

- Provide the proposed date by which it intends to make a final decision as to whether to implement the proposal
- Provide the proposed date by which it requires comments on the proposals
- Publish the dates specified above
- Inform the local authority if the dates change[2]

5.2.3 NHS bodies and local health service providers are not required to consult with local authorities where certain 'emergency' decisions have been taken. All exemptions to consult are set out within regulations.[3]

5.2.4 In considering whether a proposal is substantial, all local authorities are encouraged to consider the following criteria:

- *Changes in accessibility of services:* any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location.

- *Impact on the wider community and other services:* This could include economic impact, transport, regeneration

- *Patients affected:* changes may affect the whole population, or a small group. If changes affect a small group, the proposal may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.

- *Methods of service delivery:* altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.

- *Potential level if public interest:* proposals that are likely to generate a significant level of public interest in view of their likely impact.

[2] Section 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[3] Section 24 *ibid*

- *Changes to governance:* which affect NHS bodies' relationships with the public or local authority OSCs

5.2.5. This criteria will assist in ensuring that there is a consistent approach applied by each authority in making their respective decisions on whether a proposal is "substantial" or not.

6. OPERATION OF A STATUTORY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

6.1 A joint health overview and scrutiny committee will be made up of each of the constituent local authorities that deem a proposal to be a substantial development or variation. This joint committee will be formally consulted on the proposal and have the opportunity to comment. It will also be able to refer to the Secretary of State for Health if any such proposal is not considered to be in the interests of the health service.

6.2 Powers

6.2.1 In dealing with substantial development/variations, any statutory joint health overview and scrutiny committee that is established can:

- make comments on the subject proposal
- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions
- make reports and recommendations to relevant NHS bodies/local health providers
- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations
- report to the Secretary of State in writing where it:
    - is not satisfied that consultation with the relevant health scrutiny arrangements on any proposal has been adequate
    - is not satisfied that reasons for an 'emergency' decision that removes the need for formal consultation with health scrutiny are adequate
    - does not consider that the proposal would be in the interests of the health service in its area

6.2.2 A committee may also report to the Secretary of State if the NHS body or local service provider does not agree with a recommendation made by the committee and agreement has not be reached on the subject of the recommendation within a reasonable timeframe.

6.2.3 Where local authorities have agreed that the proposals represent substantial developments or variations to services, it is only the joint health overview and scrutiny committee which may exercise these powers.

6.2.4 A statutory joint health overview and scrutiny committee established under the terms of this protocol may only exercise the powers set out in 6.2.1 to 6.2.3 above in relation to the statutory consultation for which it was originally established. Its existence is time-limited to the course of the specified consultation it may not otherwise carry out any other activity .

6.3 Membership – Option 1

6.3.1 Each participating local authority should ensure that those Councillors it nominates to a joint health overview and scrutiny committee reflect its own political balance.[4] However, overall political balance requirements may be waived with the agreement of all participating local authorities.

6.3.2 A joint committee will be composed of Councillors from each of the participating authorities within Cheshire and Merseyside in the following ways:

- where 8 or more local authorities deem the proposed change to be substantial – the joint health overview and scrutiny committee will consist of a nominated elected member from each participating authority

- where between 4 and 7 local authorities deem the proposed change to be substantial, each authority will nominate 2 elected members

- where 3 or less local authorities deem the proposed change to be substantial, then each participating authority will nominate 3 elected members.

  (Note: In making their nominations, each participating authority will be asked to ensure that their representatives have the experience and expertise to contribute effectively to a health scrutiny process)

6.3.3 Each local authority will be obliged to nominate elected members through their own relevant internal processes and provide notification of those members to the lead local administrative authority at the earliest opportunity.

6.3.4 To avoid inordinate delays in the establishment of a relevant joint committee it is suggested that constituent authorities arrange for delegated decision making arrangements to be put in place to deal with such nominations at the earliest opportunity.

6.4 Membership – option 2

6.4.1 Each participating local authority should ensure that those Councillors it nominates reflect its own political balance.[5]Efforts will also be made to ensure a joint committee is both proportionately representative of the populations of the local authorities that are participating in the joint scrutiny arrangement and

[4] Localism Act 2011, Schedule 2 9FA, 6 (b)
[5] Localism Act 2011, Schedule 2 9FA, 6 (b)

reflects the overall. This will mean that the following criteria will be applied to determine the full composition of each joint committee:

- Each local authority which recognises the change as substantial will nominate one elected member ("core membership").

- Additional representation will be allocated taking into account both:

  - the respective populations of each of the participating authorities; and

  - the internal political balance of each participating authority and the overall aggregate political balance of the participating authorities as a whole ("additional membership").

6.4.2 The following sizes are proposed for each committee:

No. of participating authorities.	**Proposed size of committee**	**Core Membership**	**Additional Membership**
9	12	9	3
8	12	8	4
7	10	7	3
6	10	6	4
5	8	5	3
4	8	4	4
3	6	3	3
2	6	2	4

6.4.3 In those instances where additional membership needs to be allocated, the places on the Committee will be allocated in the first instance on a proportional basis based on the populations of the participating authorities. In considering their nominations to fill the additional membership places, each participating authority will be expected to take into account their own internal political balance and the aggregate political balance of the participating authorities as a whole. An example of how this might operate is set out in Appendix A to this document. In the event of a dispute over the allocation of places on a joint committee, the Monitoring Officer of the lead local authority (see section 6.5 below) will be obliged to broker an agreement in consultation with his/ her colleagues in the other participating authorities.

6.4.4 Each local authority will need to nominate elected members through their own relevant internal processes and provide notification of those members to the lead local administrative authority at the earliest opportunity.

6.4.5 To avoid inordinate delays in the establishment of a relevant joint committee it is suggested that constituent authorities arrange for delegated decision making arrangements to be put in place.

6.5 Identifying a lead local authority

6.5.1 A lead local authority should be identified from one of the participating authorities to take the lead in terms of administering and organising a joint committee in relation to a specific proposal.

6.5.2 Selection of a lead authority should, where possible, be chosen by mutual agreement by the participating authorities and take into account both capacity to service a joint health scrutiny committee and available resources. The following criteria should guide determination of the lead authority:

- The local authority within whose area the service being changed is based; or
- The local authority within whose area the lead commissioner or provider leading the consultation is based.

6.6 Nomination of Chair/ Vice-Chair

The chair/ vice-chair of a joint health overview and scrutiny committee will be nominated and agreed at the committee's first meeting. It might be expected that consideration would be given to the chair being nominated from the representative(s) from the lead authority.

6.7 Meetings of a Joint Committee

6.7.1 At the first meeting of any joint committee established to consider a proposal for a substantial development or variation, the committee will also consider and agree:

- The joint committee's terms of reference;
- The procedural rules for the operation of the joint committee;
- The process/ timeline for dealing formally with the consultation, including:
    - the number of sessions required to consider the proposal; and,
    - the date by which the joint committee will make a decision as to whether to refer the proposal to the Secretary of State for Health – which should be in advance of the proposed date by which the NHS body/service provider intends to make the decision.

6.7.2 All other meetings of the joint committee will be determined in line with the proposed approach for dealing with the consultation. Different approaches may be taken for each consultation and could include gathering evidence from:

- NHS bodies and local service providers;
- patients and the public;
- voluntary sector and community organisations; and
- NHS regulatory bodies.

6.8 Reports of a Joint Committee

6.8.1 A joint committee is entitled to produce a written report which may include recommendations. As a minimum, the report will include:

- An explanation of why the matter was reviewed or scrutinised
- A summary of the evidence considered
- A list of the participants involved in the review
- An explanation of any recommendations on the matter reviewed or scrutinised

6.8.2 Reports shall be agreed by the majority of members of a joint committee and submitted to the relevant NHS body/health service provider or the Secretary of State as applicable.

6.8.3 Where a member of a joint health scrutiny committee does not agree with the content of the committee's report, they may produce a report setting out their findings and recommendations which will be attached as an appendix to the joint health scrutiny committee's main report.

7. DISCRETIONARY HEALTH SCRUTINY

7.1 More generally, the Health and Social Care Act 2012 and the 2013 Health Scrutiny Regulations provide for local authority health scrutiny arrangements to scrutinise the planning, provision and operation of health services.

7.2 In this respect, two or more local authorities may appoint a joint committee for the purposes of scrutinising the planning, provision and operation of health services which impact on a wider footprint than that of an individual authority's area.

7.3 Any such committee will have the power to:

- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions
- make reports and recommendations to relevant NHS bodies/local health providers
- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations

7.4 A discretionary joint committee will not have the power to refer an issue to the Secretary of State for Health.

7.5 In establishing a joint committee for the purposes of discretionary joint scrutiny activity, the constituent local authorities should determine the committee's role and remit. This should include consideration as to whether the committee operates a standing arrangement for the purposes of

considering all of the planning, provision and operation of health services within a particular area or whether it is operational for the purposes of considering the operation of one particular health service. In the case of the latter, the committee must disband once its scrutiny activity is complete.

7.6 In administering any such committee, the proposed approach identified in sections 6.3 – 6.8 of this protocol should be followed, as appropriate.

8. CONCLUSION

8.1 The local authorities of Cheshire and Merseyside have adopted this protocol as a means of governing the operation of joint health scrutiny arrangements both mandatory and discretionary. The protocol is intended to support effective consultation with NHS bodies or local health service providers on any proposal for a substantial development of or variation in health services. The protocol also supports the establishment of a joint health overview and scrutiny committee where discretionary health scrutiny activity is deemed appropriate.

8.2 The protocol will be reviewed regularly, and at least on an annual basis to ensure that it complies with all current legislation and any guidance published by the Department of Health.

APPENDIX A

Example of Allocation of Places on the Joint Committee

For example, in the following scenario there are four participating authorities, - A, B, C and D. The allocation of additional membership places would be worked out as follows:

Authority	**Population**	**%**	**Allocated Additional Places**	**Total Places**
A	450,000	45	2 (1.8)	3
B	300,000	30	1 (1.2)	2
C	150,000	15	1 (0.6)	2
D	100,000	10	0 (0.4)	1

The political balance of the four participating authorities is as follows:

	Parties				
Authority	**Maroon**	**Lilac**	**Turquoise**	**Other**	**Total**
A	68		17	5	90
B	28	40	5	3	76
C	36	9	3		48
D	42	5	9		56
Total	174	54	34	8	270
% Total	64%	20%	13 %	3%	100%

The allocation of the 8 places on the joint committee to reflect overall political balance should therefore be as follows:

	Places by Party				
	Maroon	**Lilac**	**Turquoise**	**Other**	**Total**
	5.2	1.6	1.0	0.2	8
Rounded	5	2	1	0	8

Taking into account that each authority is likely to nominate a member from its largest party as its core membership representative, the core membership would comprise the following elements per authority and per party

APPENDIX A

	Core Membership Places by Party and Authority				
Authority	**Maroon**	**Lilac**	**Turquoise**	**Other**	**Total**
A	1				1
B		1			1
C	1				1
D	1				1
Total	3	1	0	0	4

Taking into account overall political balance and internal political balances as far as possible, the following allocation of the 4 additional membership places could be suggested:

	Additional Membership Places by Party and Authority				
Authority	**Maroon**	**Lilac**	**Turquoise**	**Other**	**Total**
A	1		1		2
B	1				1
C		1			1
D					1
Total	2	1	1	0	4

This would leave an overall allocation as follows:

	Total Membership Places by Party and Authority (Option 1)				
Authority	**Maroon**	**Lilac**	**Turquoise**	**Other**	**Total**
A	2		1		3
B	1	1			2
C	1	1			2
D	1				1
Total	5	2	1	0	8

An alternative option would be for a deal to be brokered between authorities B and C which would allow the Lilac Party in authority B to appoint its authority's two representatives and the Maroon Party in authority C to appoint its authority's two representatives as follows:

APPENDIX A

	Total Membership Places by Party and Authority (Option 2)				
Authority	**Maroon**	**Lilac**	**Turquoise**	**Other**	**Total**
A	2		1		3
B		2			2
C	2				2
D	1				1
Total	5	2	1	0	8