Public Document Pack

Health and Wellbeing Board

Wednesday, 17 July 2013 2.00 p.m.
Karalius Suite, Stobart Stadium, Widnes

Chief Executive

Please contact Gill Ferguson on 0151 5118059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 18 September 2013

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

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HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 22 May 2013 at Karalius Suite, Stobart Stadium, Widnes

Present: S. Banks, D. Johnson, A. McIntyre, E. O'Meara, Cllr Philbin, Cllr Polhill (Chairman), N. Sharpe, Cllr Wright, A Jones, J Bucknall, G Hales, A McNamara, S Wallace Bonner, S Yeoman, J Stephens, A Marr, M Cleworth, M Treharne, J Wilson and D Lyon.

Apologies for Absence: Cllr Gerrard, D. Parr, D. Sweeney, A. Williamson, Nick Rowe and K Fallon

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB1 MINUTES OF LAST MEETING

The Minutes of the meeting held on 13 March 2013 were taken as read and signed as a correct record subject to noting that Sally Yeoman and Gaynor Hales had submitted their apologies in advance of the meeting.

HWB2 TEENAGE PREGNANCY PRESENTATION

The Board received a presentation from John Bucknall, Integrated Commissioning Manager, on teenage pregnancy in Halton.

It was suggested that young women in Halton felt they had limited prospects in life and that the best option for them was to become pregnant. Further it was suggested that the use of drugs and alcohol amongst young people left them vulnerable in certain situations. He commented that statistics showed that families in Halton had children earlier than the national average and the pattern tended to be followed across generations.

The Board was advised that The National Support Team Visit back in October 2008 gave the following priority actions and recommendations for Halton:

- To improve and extend provision and access to a full range and choice of sexual health information, advice and services;
- The Joint commissioning Plan needed to identify additional contraception funding already in the PCT general allocation for 2008/09 and forthcoming for 2009/10;
- There needed to be a designated young people's services with an emphasis on positive sexual health and wellbeing;
- Universal advertising aimed at young people, families/carers and professionals was required, around the availability of sexual health services;
- It was important that positive partnerships existed to encourage meaningful partnership working.

In response to the recommendations, it was reported that Halton had established a Teenage Pregnancy Group as a means to share good practice and learning to identify opportunities for collaboration. Further, Halton had increased the number of young people focused sexual health clinics and made them more accessible by changing opening times and venues. Also, media tools had been implemented to promote positive relationships and sexual health to young people, for example the website www.getiton.

Halton had also increased the number of holistic health sessions in schools, facilitated by youth workers and increased the number of targeted programmes in schools, such as *Teens and Toddlers, Skills for Change* and *Healthitude*. Further, the VRMZ outreach bus had been commissioned which provided a mobile and street based service, engaging with young people in 'hotspot' areas.

John provided the current picture of Teenage Pregnancy, in that it had fallen in 2012 and was predicted to fall in 2013. The advised that the challenges for the future would include:

- Continuing to ensure meaningful partnership working through the Targeted Youth Support Strategy Group;
- Encouraging all partners to become involved in the delivery of Teens and Toddler and other programmes in schools;
- Continuing to encourage all schools to take up the offer of targeting programmes in schools;
- Increasing the number of targeted campaigns aimed at promoting positive relationships and young people's sexual health clinics;

- Continuing to deliver sexual health provision in hotspot areas, through the VRMZ outreach bus and street based teams and to ensure sustainability of such provision;
- To monitor numbers accessing young people's sexual health clinics and review types of interventions requested;
- Continued training to all frontline staff on talking to young people about sexual health and relationships; and
- Increasing the number of male registrations on to the C-Card condom scheme.

Following the presentation the following comments were noted:

- Not all schools had engaged in the holistic health programmes, such as Catholic schools. It was noted however the programmes could be customised to suit them;
- The development of the School Nurses would help to back up the above programmes;
- It was possible to associate the drop in teenage pregnancies with the increase in GCSE achievements and reduction in NEETs;
- Pregnancy as a 'lifestyle' choice was now more difficult due to austerity measures.

RESOLVED: That the presentation and comments made be noted.

HWB3 FALLS STRATEGY 2013 - 2018

The Board was advised that falls had been identified as a particular risk in Halton due to higher levels of falls in older people as well as higher levels of hospital admissions due to falls. Consequently, a Falls Strategy for 2013 – 2018 had been developed which set out the importance of understanding the complexities of both the causes and effects of falls. In particular, the strategy highlighted the high risk of social isolation that falls could lead to.

In addition, the Strategy aimed to identify areas that needed to improve in Halton, and it also recommended the following outcomes that formed the basis for the action plan and the implementation of the strategy:

- Develop current workforce training;
- Develop a plan for awareness raising with both the public and professionals;

- Improve partnership working;
- Set and deliver specific targets to reduce falls;
- Develop a prevention of falls pathway;
- Identify gaps in funding of the pathway; and
- Improve Governance arrangements to support falls.

Members noted that it was anticipated that the strategy would be launched in June during *Falls Awareness Week*; a joint public and professional week taking place on 17th to 21st June. It was also noted that the Strategy implementation would be through the multi-disciplinary Falls Steering Group and this Group would report to the Urgent Care Board. It was proposed that performance would be reported to the Health and Wellbeing Board on a quarterly basis.

RESOLVED: That

1. the Falls Strategy 2013 - 2018 be supported and approved; and

2. the Board agrees to receive quarterly reports on performance against the strategy action plan.

HWB4 FRANCIS INQUIRY

The Board considered a report which provided an overview of the key findings and recommendations of the second Francis Inquiry and the actions to be delivered locally to ensure the quality and safety of health care provision for the population of Halton.

The Francis 2 High Level Enquiry (following on from the first one published in 2009) outlined the appalling suffering of many patients at the Mid Staffordshire Hospital. This was caused by a serious failure on the part of the Provider Trust Board who did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.

Following on from the Inquiry, all NHS Provider Trusts were now required to review this high level enquiry and assess and have an action plan in place for monitoring by the Governance Committee on behalf of the Board of Directors. This was a requirement within the Quality Contract for 2013/14 for submission to the Commissioners during early 2013.

Members were advised that the Government had produced its response to the second Francis Inquiry in March 2013 – *Patients First and Foremost*, in which it stated that the NHS was there to serve patients and must therefore put the needs, the voice, and the choice of patients ahead of all other considerations. The response outlined actions in five key areas:

- Preventing problems;
- Detecting problems quickly;
- Taking action promptly;
- Ensuring robust accountability; and
- Ensuring staff were trained and motivated.

In order to ensure the full implementation of all areas of the inquiry recommendations, NHS Halton Clinical Commissioning Group had/would:

- Included within the contract requirements the submissions of review and action plan for the Francis inquiry report including a commitment to the Duty of Candour;
- Included within the contract quality metric in relation to time to care, nursing/care assistant training, clinical leadership and organisational culture;
- Receive and review outcomes including delivery of actions required of internal reviews and respond appropriately;
- Develop and maintain a process to ensure cost improvement programmes within providers were reviewed and impact assessed for any potential impact on quality and safety;
- Develop and maintain processes for GPs and others including members of the public to raise concerns regarding the quality of care and ensure these were investigated and acted upon;
- Develop and maintain a robust early warning system for care quality across all providers and ensure any issues were acted upon effectively;
- Be an active member of the *Quality Surveillance Group*;
- Work with providers in a supportive way to support continuous improvements and developments in quality whilst ensuring any issues were monitored and managed effectively; and
- Ensure open, regular and robust reporting of performance of providers locally and ensure local people are engaged in these processes for reporting.

It was commented that the Quality Surveillance Groups would meet locally and regionally to provide leadership for quality improvement. They had proved useful for people to exchange information and share ideas in an open and honest way. It was noted that the local Healthwatch group were represented on the Quality Surveillance Group.

This agenda item would also be taken to the next meeting of the Safeguarding Adults Board.

RESOLVED: That

1. the contents of the report and the findings of the Inquiry be noted; and

2. the actions planned locally be noted.

HWB5 EARLY HELP STRATEGY

The Board considered a report of the Strategic Director, Children and Enterprise, on Halton Children's Trust first Early Help Strategy.

The Board was advised that Early Help had been a priority for over two years. The Early Help and Support Strategic Sub-Group (EHaS) of the Children's Trust regularly reported to the Executive Board highlighting progress of Halton's model of "Team Around the Family" (TAF).

It was reported that in 2012, the next step was for the development of an early help strategy and local offer, with the emphasis on early intervention in order to have a positive impact on families. The strategy would need to focus primarily on pre-birth to five year old children and their families. The draft Strategy attached to the report, comprised the main Strategy, four cross cutting themes that spanned across the Children's Trust, a joint action plan and an appendix that highlighted Halton's local offer.

RESOLVED: That

1. the Early Help Strategy, Local Offer and action plan be endorsed; and

2. the Early Help Strategy be implemented in conjunction with the 0 – 5 year old Development Action Plan, a priority of the Health and Wellbeing Board.

HWB6 NATIONAL CHILD MEASUREMENT PROGRAMME (NCMP) OUTCOMES

The Board received a report from the Director of Public Health, which provided an update of levels of childhood obesity in Halton, as recorded through the National Child Measurement Programme (NCMP). The NCMP involved school nurses measuring the height and weight of all children in reception (aged 4 – 5) and year 6 (aged 10 – 11) annually. Using these figures the child's body mass index was calculated and this provided a measure of the proportion of children who were overweight or obese in these individual year groups. Paragraph 3.4 of the report highlighted that the NCMP would report the percentage of children who were of 'excess weight', incorporating both the number of children who were overweight and the number who were obese, this would simplify the interpretation of results.

It was reported that in Halton there had been an extensive programme working with both schools and early year settings to reduce the levels of childhood obesity. This included the school Fit4Life Programme which tackled overweight and had impacted on year 6 obesity rates. The Fit4Life programme targeted schools with the highest obesity rates. It offered education for teachers and children and their parents in cooking, healthy eating and the importance of exercise. Data from the programme indicated that for participating schools the Fit4life programme reduced the level of excess weight by approximately a third. In addition, the following programmes were also offered in Halton:

- Healthitude which linked the personal, social and health education curriculum and had a healthy eating component to it;
- Healthy Early Years Programme (Fit4life) for children aged up to five and their families;
- Children's Centres and Early Years Providers continued to work to meet the Healthy Early Years standards;
- The development of an Infant Feeding Team and weaning services; and
- The national programme to increase the number of Health Visitors.

Members were advised that the data gathered for 2011/12 indicated reductions in the levels of excess weight in both reception and year 6 children when compared to 2010/11 figures. The rates of children who were obese and overweight in reception and year 6 had reduced in 2011/12 in all measures with the exception of the number of year 6 children who were overweight. However, evidence from staff running the Fit4life Programme in schools suggested that one of the reasons for the increase in the number of children in year 6 who were overweight, was as a result of obese children successfully losing weight and moving to the overweight category. It was noted that for the first time since NCMP had started, Halton had rates of obesity that were similar to the England average for all measures and ages. For a more detailed analysis, the Board was referred to the full NCMP report which was attached at Appendix one.

RESOLVED: That the Board

1. noted progress in reducing levels of excess weight (overweight and obese) in children in Halton from 28.4% in 2010/11 to 23.1% in 2011/12 for children in reception and from 37.5% in 2010/11 to 34.5% in 2011/12 in year 6 children;

2. note that children in Halton were now at the same weight as the England average;

3. note the impact of the Halton Healthy Early Years Standards and schools “Fit4life” Programme; and

4. note that in the future, performance reporting against this outcome would change to a measure of “excess weight” (which included both children who are overweight and children who are obese).

HWB7 CHIMAT – CHILD HEALTH PROFILE

The Board received a report on the Child Health Profile (CHIMAT) which was released each year by the Public Health Observatory and provided a summary of the health and wellbeing of children and young people in Halton. Data that was included was available at a national level and enabled Halton to benchmark their health outcomes against the England average values.

It was noted that Health outcomes were very closely related to levels of deprivation, the more deprived an area the poorer health outcomes that would be expected. Overall

the health and wellbeing of children in Halton was generally worse than the England average, as with levels of child poverty. Currently Halton was the 27th most deprived borough in England out of 326 boroughs and, as such, would be expected to have lower than average health outcomes. It was noted that the infant and child mortality rates were similar to the England average.

Members were advised that there were 26 out of the 32 health and wellbeing indicators included in the CHIMAT report which were applicable to Halton. In the 2013 report, there was an improvement in 19 areas, equal performance in five and reductions in performance in two outcomes (which had recently improved: young people not in education, employment or training; and teenage conception). Six new indicators were new in 2013, therefore could not be compared to the 2012 report. The report detailed the areas where Halton had successfully improved rates, those where it had maintained and those areas where performance in Halton remained lower than the England average.

It was noted that whilst child health remained a challenge for Halton, there was a need to continue to drive to improve outcomes for children and young people. Whilst improvements had been seen in 2011/12, work to maintain these improvements would continue, in order to reduce the gap between Halton's outcomes and the England average. The Board was asked to support work in those areas where performance remained below the England average and also where progress had been made programmes in these areas be continued to be supported. The main areas identified in CHIMAT where further improvements were needed included:

- Children and young people who were not in education, employment or training and youth justice;
- Hospital admissions (all causes);
- Breast feeding rates and smoking at the time of delivery;
- Child poverty; and
- Child development.

RESOLVED: That

1. the contents of the 2013 Child Health Profile and the progress that had been made against a challenging baseline be noted. Out of the 26 areas 19 had improved (Green Arrow), 5 had stayed the same (=) and 3 were worse (red arrow). The new data for

teenage conceptions showed dramatic improvements; and

2. any comments be reported back to the Director of Public Health.

HWB8 NATIONAL CONSULTATION – SUSTAINABLE DEVELOPMENT STRATEGY FOR THE HEALTH, PUBLIC HEALTH AND SOCIAL CARE SYSTEM

The Board was advised that the Sustainable Development Unit was working in partnership across NHS England and Public Health England with the desire to engage with all agencies responsible for delivering and commissioning health within the new Health and Social Care structures. In January 2013 a new strategy for sustainable development in the health, public health and social care system was launched for consultation. The closing date for consultation was 31st May 2013 and it was suggested within the consultation document that all elected members, staff, members of the Health and Wellbeing Board and local community be consulted in order to formulate a considered response.

It was noted that the strategy consultation document would like consideration to be given to two key aspects of the next strategy:-

- Should the scope of the strategy be widened beyond the NHS to the wider social care and public health system? and

- Should the approach of the strategy be widened beyond carbon reduction to include other areas of sustainable development?

Members of the Health and Wellbeing Board were requested to comment directly to the Public Health Team by 27 May 2013 to enable collation and completion of the final consultation response by 31 May 2013.

RESOLVED: That

1. the Health and Wellbeing Board consider the proposed response to the consultation and agree the mechanism of response on behalf of Halton Borough Council; and

2. Members of the Board share the document with appropriate staff and members to generate any

additional comments and suggestions and report back to Public Health Team no later than 27th May to enable completion of the consultation process.

Meeting ended at 3.30 p.m.

Agenda Item 3

REPORT TO:	Health and Wellbeing Board
DATE:	17th July 2013
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Adults
SUBJECT:	Longer Lives
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Health and Wellbeing Board with a presentation and overview of the new website *Longer Lives,* launched in June by Public Health England.

RECOMMENDATION: That the contents of the presentation and report be noted.

3.0 SUPPORTING INFORMATION

3.1 It has been specifically designed to provide local authorities and the NHS with an insight into the top causes of avoidable early death in their areas such as heart disease, stroke and cancer, and how they compare to other areas with a similar socioeconomic profile. Halton's profile can be found here: Longer Lives - Halton

Agenda Item 5

REPORT TO:	Health and Wellbeing Board
DATE:	17th July 2013
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Adults
SUBJECT:	Widnes Vikings - Health and Wellbeing Presentation
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Health and Wellbeing Board with a presentation from Widnes Vikings who are commissioned by Public Health to work on Health and Wellbeing as part of their contract.

RECOMMENDATION: That the Board note the contents of the presentation.

Agenda Item 6

REPORT TO:	Health and Wellbeing Board
DATE:	17 July 2013
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Adults
SUBJECT:	Support for patients identified with Impaired Glucose Regulation (IGR)
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform members of the Health and Wellbeing Board of a proposed Merseyside wide project to support patients identified as having IGR and thereby prevent or delay the progression to type 2 diabetes.

2.0 **RECOMMENDATION: That the report be noted and the Health and Wellbeing Board comment on the proposed pathway.**

3.0 SUPPORTING INFORMATION

3.1 Impaired Glucose Regulation (IGR, also known as non-diabetic hyperglycaemia or pre-diabetes) refers to blood glucose levels that are above the normal range but are not high enough for the diagnoses of Type 2 diabetes.

3.2 Type 2 diabetes is a chronic costly condition which in the majority of cases is preventable. Local prevalence of Type 2 diabetes is increasing. Before people develop Type 2 diabetes they almost always have IGR and over a third of IGR patients will go on to develop Type 2 diabetes within 6 years. However, there is evidence to suggest that the onset of Type 2 diabetes can be delayed for an average of 8 years through intensive lifestyle intervention (primarily weight management), avoiding substantial future costs. In particular, evidence shows that:

- Modest lifestyle changes can significantly postpone the onset of diabetes for high risk individuals;
- A weight reduction of 3.7 - 6.8kg in overweight people aged 30-50 equates to a 33% reduction in the risk of developing Type 2 diabetes;
- Lifestyle intervention is more effective than the drug treatment Metformin in reducing the incidence of Type 2 diabetes in IGR patients.

3.3 An audit of patient records across 148 GP practices in Merseyside (including Halton) undertaken in September 2012 revealed that:

- The known incidence (number of new cases diagnosed per year) of IGR has roughly doubled since 2006 rising from 644 new cases in 2006-07 to 1,203 new cases in 2010-11;
- The current known adult prevalence (total number of cases in a population) of IGR across Merseyside is 0.8%, ranging from 0.5% in Liverpool to 1.6% in Halton and St Helens;
- This equates to 1,998 patients known to have IGR in Halton. Using NHS Health Check modelling it is estimated that a further 874 Halton residents are potentially undiagnosed;
- 34.5% of known IGR patients are overweight (BMI between 25 and 30) and 47.3% are obese (BMI over 30);
- Only 0.2% of overweight and 1.2% of obese IGR patients were recorded has having been referred to a weight management intervention by their GP (note that in Halton patients can self refer to weight management interventions so there may be a level of under recording of IGR patients accessing weight management services);
- 65.7% of those diagnosed with IGR in 2009-10 were not offered a follow up blood test in the following 12 months.

4.0 **Proposed IGR pathway**

In September 2012 a QIPP business case (attached as Appendix A) was developed for a standardised diabetes prevention pathway to identify and manage patients with IGR across the Mersey Cluster. The proposed pathway (Appendix B) is based around a five step process which is described below.

4.1 Step 1 - Identification of high risk patients

It is proposed that high risk patients will be identified through searches of GP practice registers, via NHS Health Checks and opportunistically. NICE Guidelines recommend stratifying the whole population using real and estimated data and then offering blood tests to those identified as high risk, however, the steering group deemed it more appropriate to manage patients already identified as having IGR before expanding the identification process.

4.2 Step 2 – Offer blood test

High risk patients would be tested by GPs for IGR using the HbA1c blood test. An HbA1c of between 42 to 47mmol/mol indicates that the patient has IGR. It is proposed that patients diagnosed with IGR would be placed on an IGR register and would be referred or encouraged to self refer to lifestyle interventions (primarily weight management) .

4.3 Step 3 – Patient invited for clinical/lifestyle review

This step would be undertaken by the Health Improvement Team currently located in Bridgewater NHS Trust. The team already undertake reviews of clients prior to registration onto the Fresh Start weight management programme to assess their suitability for the programme and where appropriate make referrals to the Dietetic service offered by Warrington and Halton Hospital Trust.

4.4 Step 4 – Patient offered IGR education and lifestyle intervention

The precise model for patient education is currently under consideration by the IGR steering group but will include education around risk of cardiovascular disease, diabetes and how to reduce risk. Although the Merseyside business case proposes that patient education is delivered separately from weight management intervention it is likely that in Halton the patient education element will be integral to the Fresh Start weight management programme. This is currently a 10 week course but there are proposals to increase this to 20 weeks which will easily accommodate the IGR patient education element. Halton has an advantage over other areas within the Mersey Cluster due to the well established weight management programmes on offer which are run by staff who are highly experienced in delivering behavioural change training for clients.

4.5 There will, however, be a need to provide IGR specific training for approximately 20 staff from the Health Improvement Team (predominantely Lifestyle Advisors and Health Trainers). It is proposed that training is delivered on a Merseyside wide level to ensure consistency across the sub region and deliver economies of scale. The various options for this are currently being considered but Directors of Public Health have been requested to set aside £20,000 each to contribute to the training.

4.5 Step 5 – Patients thereafter invited for annual review

Participants of Halton's Fresh Start programme already have their progress monitored regularly in terms of weight and BMI for the duration of the course. However, it is anticipated that the annual review will be undertaken by the patient's GP and will include an HbA1c test. The annual review also ensures that patients who do progress to diabetes are identified at an early stage and managed by the practice.

4.6 It is proposed that a range of IGR educational material be developed for those patients who choose not to participate in a lifestyle intervention but who wish to manage their condition themselves and to support those that do participate in interventions. Funding for this element has been provided through the Quality, Innovation,

Productivity and Prevention (QIPP) Programme.

4.7 Halton's CCG Governing Body confirmed its support for the pathway at its meeting of 20th September 2012 and agreed to fund annual reviews for patients known to have IGR and those identified as having IGR through Health Checks. It is anticipated that, subject to delivery of the training element, the pathway will be formally launched and rolled out to GP practices in September 2013. Directors of Public Health from all local authorities involved have also given their in principle support for the new pathway.

5.0 POLICY IMPLICATIONS

Obesity is a contributory factor in a number of the priorities contained in Halton's Health and Wellbeing Strategy including increased risk of various forms of cancer, mental health and wellbeing, child development and has been associated with an increased risk of falls due to impaired balance.

6.0 OTHER/FINANCIAL IMPLICATIONS

GPs have indicated through the CCG Commissioning Body that they consider the IGR pathway to be part of their core contract, therefore, there is no additional cost arising from the need to take HbA1c readings and undertake annual reviews.

Directors of Public Health across the Mersey cluster have been requested to set aside £20,000 to support the commissioning of an IGR training package.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children and Young People in Halton

The pathway is aimed at adults, however, it has the potential to bring about positive benefits for the children of participating adults resulting from their parents improved knowledge about the risks associated with unhealthy eating and lack of exercise and reducing potential caring responsibilities for children if the parent were to go on to develop Type II diabetes.

7.2 Employment, Learning & Skills in Halton

The pathway includes a training element for Lifestyle Advisors and Health Trainers around IGR.

The pathway could also help to increase the self confidence of overweight and obese participants which in turn can increase their chances of finding employment.

7.3 A Healthy Halton

The symptoms of type 2 diabetes can lead to a range of health complications including angina, heart attacks, stroke, kidney damage, eye and foot problems. A study carried out in 2012 by the

York Health Economic Consortium estimated that by 2035 type 2 diabetes could cost the NHS £16.9 billion (up from £9.8bn in 2012).

7.4 A Safer Halton

None directly

7.5 Halton's Urban Renewal

None directly

8.0 RISK ANALYSIS

The QIPP business case identified a number of risks and mitigating actions as outlined in section 5 of the original Business Case attached as Appendix A.

9.0 EQUALITY & DIVERSITY ISSUES

None identified

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

None under the meaning of the Act

Business Case Merseyside Health Economy

Business Case for:
Diabetes Prevention Pathway
Identification and management of patients with Impaired Glucose Regulation (IGR) across the Mersey Cluster

Executive Sponsor/ Owner	**Dr Gary Francis (Aintree Univesity Hospital)**
Lead Manager	**Sarah McNulty / Jackie Rooney**
Project Team	**Ruth du Plessis (NHS Sefton)** **David Conrad (NHS Knowsley)** **Lyndsey Abercromby (Halton CCG)** **Annette James / Kerry Lloyd (NHS Liverpool)** **Helen Cartwright (CHaMPS)**
Date	**September 2012**
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Revision History

Revision Date	Brief Summary of Changes
Version 2: May 2012	Format of business case, changes to sections: 2,3,5,6, and 7. Changes to appendix
Version 3: June 2012	Changes to sections 1, 4,5, 6,7 and section 8
Version 4: July 2012	Changes to sections 2, 3, 4,6 and 7
Version 5: September 2012	Changes to all sections following consultation period

Approvals

This document requires the following approvals.

Name	Title	Date of Issue	Version
Dr Gary Francis	CEO LCH (Executive Sponsor)		Version 1, 3 and 5
Clare Duggan	QIPP/Cluster lead		Version 1
Diabetes QIPP Board/ Diabetes Network	Initial Governance		Version 1 & 3 and 5
Clinical Redesign Board			Version 1

Distribution

Title	Date of Issue	Version
Merseyside Diabetes Network	November 2011, July 2012	Version 1and 4
Communications	July 2012	Version 4

Primary Authors

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Ruth du Plessis	Public Health Development Manager, NHS Sefton

Lead reviewer

Name	Title
Sarah McNulty	Assistant Director of Public Health Quality and Health Protection, NHS Knowsley

Previous Steering group members

Name	Title
Nicky Speakman	Public Health, NHS Sefton
Lee Panter	Public Health, NHS Knowsley
Kerry Lloyd	Public Health, NHS Liverpool

Executive Summary

Introduction

1. Impaired glucose regulation (IGR) (or non-diabetic hyperglycaemia) refers to blood glucose levels that are above the normal range but are not high enough for the diagnosis of Type 2 diabetes. The risk factors for IGR are the same as those for Type 2 diabetes – the greatest single risk factor being obesity. Before people develop Type 2 diabetes, they almost always have IGR. The identification of IGR provides a substantial opportunity for preventing or delaying the future burden of Type 2 diabetes on the NHS, as well as on patients and their families.

Case for Change

2. Alongside the need to reduce the burden of diabetes on the population, there are a number of drivers for improving the identification and management of IGR patients including: the views of local patients; the spiralling costs of diabetes; national and European guidance on IGR (including newly published NICE guidance); the development of Pre-diabetes Education programmes; and the rolling out of the NHS Health Checks, which are expected to increase the numbers of IGR and diabetes cases being diagnosed in primary care. A primary care survey and audit of current practice in identifying and managing IGR patients in Merseyside have both recently highlighted significant inconsistencies between practices and demonstrated the need for a common standardised pathway.

3. The current registered adult prevalence (17 yrs +) of IGR on Merseyside is 0.8% (9265 people), this is likely to be a significantly lower than the true prevalence. The Department of Health's NHS Health Checks modelling assumes an IGR prevalence amongst adults aged 40-74 years of 2.3% and estimates that with the introduction of NHS Health Checks 1,153 people will be diagnosed with IGR annually in Merseyside.

4. Once diagnosed, over a third of IGR patients will go on to develop Type 2 diabetes within 6 years if no intervention is made; however, evidence shows that the onset of Type 2 diabetes can be delayed for an average of 8 years through intensive lifestyle intervention, avoiding substantial costs. Offering patients with IGR an annual review will also enable early identification of diabetes which is likely to have clinical benefits and lead to further cost savings.

Identifying the way forward

5. It is proposed that a shared pathway is put in place across the Merseyside Cluster for the identification and management of IGR patients. A number of options are presented, covering diagnostics (including initial tests and annual follow up tests where appropriate); primary care provision of annual reviews for IGR patients; and the provision of patient education and weight management services. It is likely that individual Clinical Commissioning Groups (CCGs) will wish to implement the pathway to fit local circumstances. This paper spells out the options and recommendations available.

6. Cost-effectiveness of the proposed pathway has been calculated on the basis of cost-avoidance through the delay in onset of diabetes estimated to be achieved against costs of diagnosing and appropriately managing IGR patients.

7. This modelling has estimated that diagnosing and appropriately managing those who have been previously identified as having IGR or with previous blood tests results that meet the threshold for IGR, and those diagnosed with IGR as a result of an NHS Health Check, would deliver an annual cost saving across Merseyside of £2,068,553 in Years 1 & 2 and an annual cost saving of £549,872 in Year 3 onwards.

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1. Strategic Context and Drivers

1.1 Background

The driver for this business case is the increasing prevalence of Type 2 diabetes, a chronic costly condition, which is preventable in the majority of cases.

It is possible to identify those who are 'borderline' for diabetes and offer interventions to prevent or slow the progression to diabetes and/or detect diabetes earlier before complications have set in. This 'borderline' state is termed Impaired Glucose Regulation (IGR) – sometimes referred to by the lay term 'pre-diabetes'.

The prevention of diabetes has been a priority of the Merseyside Patient Group (North Mersey Diabetes Action Group) for some time, while Liverpool PCT had a patient and professional group with a remit to work together to prevent diabetes. It was also a priority identified by the Diabetes Health Needs Assessment for Halton, St Helens and Warrington (November 2007) and the North Mersey-wide Diabetes Health Needs Assessment (April 2010).

When the Diabetes QIPP work stream came into being in the summer of 2010, public health were given the opportunity to present two briefing papers on strategies for preventing diabetes as prevention is one of the Ps of QIPP. The first paper made the case for a broad approach of targeting interventions to those with risk factors for diabetes (such as obesity). The second paper focused on those at highest risk – those with IGR. The decision was made by the Diabetes QIPP board members to prioritise this group of patients.

A steering group was formed with public health representatives from across Merseyside and from the Diabetes Network to progress the IGR business case. At each stage of the IGR pathway development, meetings were held with local primary care clinicians and weight management specialists to determine the specific requirements. Each key decision was then discussed at the Diabetes QIPP board meetings.

Until recently there were no national guidelines for the management of IGR and no reliable information about the number of people with IGR in Merseyside. Therefore, before the business case could be progressed, work began on identifying current practice, and the number and demographics of patients who are already known to have IGR. Thus in spring 2011 an electronic questionnaire was sent out to all general practices in Knowsley, Liverpool and Sefton to ascertain current management and views on producing a local pathway. This was followed by a clinical audit of IGR patients in September 2011 to provide the necessary baseline data.

A number of options were considered during the development of the IGR Pathway by the diabetes leads in primary care and weight management specialists and preferred options chosen in February 2012. In May 2012 the pathway was agreed by the Diabetes QIPP / Merseyside Diabetes Network and the options were discussed with patient representatives.

The delivery model proposed involves: identifying the patients at risk of IGR and those already diagnosed by running searches in GP clinical systems, offering blood tests to those identified, then offering the patients an initial review and an annual review thereafter, providing a package of patient education and offering patients with IGR access to an appropriate weight management intervention with defined follow-up and evaluation.

1.2 Introduction

1.2.1 What is Impaired Glucose Regulation?

Impaired glucose regulation (IGR) (or non-diabetic hyperglycaemia) refers to blood glucose levels that are above the normal range but are not high enough for the diagnosis of Type 2 diabetes. IGR is used to describe the presence of impaired fasting glucose (IFG) and/or impaired glucose tolerance (IGT), (and/or HbA1c of HbA1c of 42 to 47mmol/mol) which are intermediate states of abnormal glucose regulation that exist between normal blood glucose levels and Type 2 diabetes[1]. IGR is asymptomatic and can often go undiagnosed for many years[2]. IGR is also sometimes referred to as 'pre-diabetes' – a term recommended by Diabetes UK for communicating the concept of IGR to the public.

1.2.2 IGR risk factors

The risk factors for IGR are the same as those for Type 2 diabetes – the greatest single risk factor being obesity. IGR itself is a risk factor for Type 2 diabetes. Women with a history of gestational diabetes are also at greater risk of developing IGR and diabetes.

1.2.3 Diagnosing IGR

The Department of Health's diagnostic criteria for IGR for the purpose of the NHS Health Checks are based on a single fasting plasma glucose (FPG) test followed by an oral glucose tolerance test (OGTT) for those who cannot be diagnosed as diabetic or within a normal range (normoglycaemia) based on the single test.

In 2011, the WHO made a recommendation that HbA1c can be used as a diagnostic test for diabetes.[2] This recommendation was endorsed by a UK expert group[3], although there remained some debate on whether HbA1c was appropriate for diagnosing IGR. Following discussion with local clinical leads and the endorsement of HbA1c for this purpose in the NICE guidance *Preventing Type 2 diabetes: Risk identification and interventions for individuals at high risk* (published in July 2012), it was decided that HbA1c should be the preferred diagnostic test for IGR in Merseyside, with a HbA1c of 42 to 47mmol/mol indicating IGR. (See also section 3.1). Evidence shows that using HbA1c will result in an additional 10% of patients being diagnosed with IGR compared with using FPG and OGTT tests in the same patients.[4]

1.2.4 Prevalence of IGR

Estimating the prevalence of IGR is not straightforward due to the range of diagnostic criteria being employed in clinical practice and in research studies. A number of epidemiological studies in North America, Europe and Asia have

estimated that approximately 15% of adults have IGR based on a single FPG test result to diagnose IFG and a single FPG followed by an OGTT to diagnose IGT.

The NHS Health Check modelling assumes an IGR prevalence of 2.3% among those who attend a Health Check. However, whereas those with a raised FPG result (but not diabetic) who went on to have a normal OGTT result would be classed as having IFG (and therefore IGR) in most research studies, in an NHS Health Check these patients would only have been diagnosed with IGR if they had a raised (but not diabetic) OGTT result. In other words, only patients diagnosed with IGT are included in the NHS Health Check definition of IGR.

1.2.4 What is the purpose of identifying and managing IGR patients?

Before people develop Type 2 diabetes, they almost always have IGR[5]. The identification of IGR provides a substantial opportunity for preventing or delaying the future burden of Type 2 diabetes on the NHS, as well as on patients and their families. In the absence of intervention the majority of individuals with IGR are likely to develop Type 2 diabetes within 5-10 years.[1] However, there is good evidence to suggest that Type 2 diabetes can be prevented or delayed in people with IGR. Although inherited factors predispose to Type 2 diabetes, environmental and lifestyle factors leading to over-nutrition and insufficient physical activity are mainly responsible for the increasing prevalence of the disease over the past decades.[6] Type 2 diabetes could be prevented in many people, or certainly postponed, if weight could be kept within the healthy BMI range of 20-25kg/m^2.[7]

Evidence shows that:
- modest lifestyle changes can significantly postpone the onset of diabetes in high risk individuals;[8,9]
- a weight reduction of 3.7–6.8 kg in overweight people aged 30–50 equates to a 33% reduction in the risk of developing Type 2 diabetes;[10]
- lifestyle intervention is more effective than the drug treatment Metformin in reducing the incidence of Type 2 diabetes in IGR patients;[5]

There have been two major studies evaluating the effectiveness of lifestyle intervention based diabetes prevention programmes in IGR patients – the Finnish Diabetes Prevention Study and the Diabetes Prevention Program in the US. In the Finnish study, the five year Number Needed to Treat (NNT) was five; i.e. for every 5 IGR patients who went through the programme, one case of Type 2 Diabetes would have been prevented as a result in 5 years' time. In the US study, the three year NNT was 6.9.

Since Type 2 diabetes is associated with an increase in CVD, preventing or delaying the onset of Type 2 diabetes may also reduce the risk of CVD.[1, 2,11,12,13] It is known that lifestyle-based intervention to prevent Type 2 diabetes also improves cardiovascular risk factors.[14,15] Because CVD accounts for much of the morbidity and mortality associated with Type 2 diabetes, even small reductions in cardiovascular risk would be clinically significant.[16]

The process of identifying IGR patients will also pick up cases of undiagnosed Type 2 diabetes. It is thought that many people with Type 2 diabetes may have had the

condition for 9-12 years before diagnosis[17] and half of those who are diagnosed with Type 2 diabetes present with advanced complications.[18]

The benefits of actively identifying and managing IGR patients therefore include the delay or prevention of Type 2 diabetes in IGR cases and the delay or prevention of complications in previously undiagnosed Type 2 diabetes cases, with a possible reduction in morbidity and mortality from CVD.

1.3 Drivers for Change

1.3.1 National Drivers

The importance of reducing the incidence of diabetes is recognised at a national level. NHS Diabetes and Kidney Care have taken a strong interest in the development of the Merseyside Cluster IGR pathway & QIPP business case and have provided support in its development.

Standards 1 and 2 of the Diabetes National Service Framework (NSF) relate specifically to identifying and managing IGR patients:

- Standard 1 - Prevention of Type 2 diabetes
- Standard 2 - Identification of people with diabetes

The NSF illustrative targets for local priorities for these standards include implementing a protocol to identify IGR patients, provision of weight management counselling and support, offering patients with IGR a test for diabetes, flagging patients with IGR on a register for regular recall and offering repeat testing and support on lifestyle change.[19]

1.3.2 Spiralling Costs of Diabetes

The Wanless Report (2004)[20] noted that there is scope for significant cost-savings through prevention of diabetes, earlier diagnosis and better management. A report from the NHS Information Centre showed that prescriptions for diabetes now account for 8.4% of the entire NHS net bill for primary care drugs in England, with a 41.1% increase in the cost of prescribing from £513 million in 2005/06 to £725 million in 2010/11. Over the same period, the number of items dispensed to treat diabetes rose by 41.2%, from 27.1 million to 38.3 million.[21]
Diabetes UK, the national diabetes charity, has estimated that diabetes currently costs the NHS £1million an hour: [22]

- 10% of people in hospital have diabetes and 60% of inpatients with diabetes have been admitted as emergencies.
- People with diabetes are twice as likely to be admitted to hospital.
- Diabetes UK estimates that people with diabetes spend 1.1 million days in hospital a year.
- The hospital stay for a person with diabetes is likely to be up to twice that of a person without diabetes: the hospital stay for a person with diabetes is an average of 11 days.
- 20% of people with diabetes in hospital have already been hospitalised in the previous year.

- An average daily bed stay costs the NHS around £215.
- Emergency ambulance attendance costs around £220 and minor Accident and Emergency attendance costs around £55.
- Recent estimates are that 10% of NHS spending goes on diabetes. This equates to £9 billion a year.
- Local cost estimates of diabetes spend during 2011/12 across the Mersey Cluster equate to £514 per patient with diabetes, at a total of £30,778,297 (this is likely to be an underestimate as due to current coding for diabetes some spend could not be attributed).

1.3.3 National and European Guidance

In the absence of UK specific guidance, Diabetes UK published a position statement in 2009 on the management of IGR patients, developed in consultation with experts, to provide consensus-based recommendations for healthcare professionals managing people with IGR.[23] Similarly, the IMAGE project (Development and Implementation of a European Guideline and Training Standards for Diabetes Prevention), funded by the European Commission, produced comprehensive evidence-based guidelines for the prevention of Type 2 diabetes which were published in 2010.[24] This includes guidance on identifying at risk patients, appropriate diagnostic tests and effective interventions. Both these sets of guidelines have informed the development of the IGR pathway which forms the basis of this business case.

NICE guidance on preventing the progression from IGR to Type 2 Diabetes was published in July 2012 following the draft published on 9 November 2011 which went out for consultation until the 9 January 2012. The NICE guidance presents a large amount of evidence, including a cost effectiveness analysis, to support the recommendations of implementing risk assessment and IGR testing, an IGR register, and intensive lifestyle-change programmes and advice, followed up by annual assessment, for those diagnosed with IGR.[25] The core recommendations broadly reflect the preferred options put forward in this business case, with some variation in the detail. The publication of the NICE guidance will essentially place an expectation on commissioners to ensure that processes are in place for the effective identification and management of IGR patients; implementing this business case will ensure that the Merseyside Cluster is equipped to meet this expectation without delay.

1.3.4 NHS Health Checks

The NHS Health Checks programme is being implemented across Merseyside, offering a health check to every adult aged 40-74, without known cardiovascular disease, every five years as part of an ongoing rolling programme. As a result it is expected that many new cases of both IGR and Type 2 diabetes will be identified. This represents a vital opportunity to prevent future cases of diabetes; however, without a clear pathway and services in place to ensure that new IGR patients receive the necessary intervention, this opportunity will be missed.

1.3.5 Local Objectives

Effectively identifying and managing IGR patients fits with key local objectives of; A) reducing obesity, B) reducing health inequalities, and C) cost saving:

A) Reducing overweight and obesity, which forms the backbone of IGR intervention, is highlighted as an objective in the Cluster PCTs' Strategic Commissioning Plans. The Strategic Commissioning Plan for Halton & St Helens includes an explicit goal that *"By 2013 people with risk factors for diabetes will be identified to reduce their risk of developing the disease. People with diabetes will have improved, easily accessible, preventative treatments in place to support them in managing the disease and stop it or delay it progressing into other debilitating conditions".*

B) The prevention of diabetes has an important role to play in reducing health inequalities. Diabetes is more common among deprived populations and the prevalence of IGR varies among the population depending on ethnic background.[13, 10] There is UK evidence that South Asians progress to diabetes at three times the rate of White Europeans.[26]

C) The cost of diabetes to the health system in terms of care and prescribing are substantial and growing. Current registered adult prevalence of diabetes is 5.8%. It is predicted that by 2030, 10% of the population will have diabetes.[27] Unless effective action is taken to reduce the incidence of diabetes, this will directly result in a dramatic increase in cost burden on Clinical Commissioning Groups (CCGs) in the future. The financial modelling section of this business case includes further detail of the estimated financial implications of implementing the proposed IGR pathway compared with taking no action.

1.3.6 Local delivery

Strong interest in this area among GPs in Sefton has already enabled a Locally Enhanced Service Agreement (LES) to be put in place, where practices receive a time limited payment for actively identifying and offering patients with IGR an annual review. This was designed to serve as a 'stop gap' in Sefton until the Merseyside Cluster IGR pathway can be implemented.

In the current LES practices are paid for; administration of call and recall, for taking the blood for HbA1c and for reviewing patients fact-to-face. **For an example LES see Appendix 2**

1.3.7 Patient views

The North Mersey Diabetes Action Group, which includes cluster wide diabetes service user representation, has requested that prevention of Type 2 diabetes be made a key priority for the Mersey Diabetes Network.

2. Health Needs Assessment

2.1 Prevalence of Diabetes

The best estimate of true diabetes prevalence available at PCT level is provided by the Association of Public Health Observatories' (APHO) Diabetes Prevalence Model[28]. Based on this model, the number of people in the Merseyside Cluster estimated to have diabetes is 70,541, or 7.6% of the population. Comparing clinically diagnosed levels of diabetes to these estimates reveals disparity, suggesting a potential figure for undiagnosed diabetes cases of 12,937 across the Merseyside Cluster (Table 1).

Table 1: Estimated vs. recorded prevalence of diabetes in the Merseyside Cluster

Area	APHO estimated Prevalence (%)	2009-10 QOF Prevalence	Estimated prevalence minus known prevalence
Liverpool	25,937 (7.4)	20,640	5,297
Sefton	17,741 (7.9)	12,684	5,057
Knowsley	9,027 (7.5)	7,644	1,383
Halton & St Helens	17,836 (7.5)	16,636	1,200
Merseyside Cluster	**70,541 (7.6)**	**57,604**	**12,937**

2.2 Prevalence of Obesity

Obesity is the major risk factor for IGR and Type 2 diabetes. Data on current levels of obesity in Merseyside is limited, although it is increasing, see table 2.

Table 2: Local obesity data

Area	Obesity prevalence	Source	Notes
Liverpool	10%	GP practice records	GP recorded BMI data covers only 29% of the population, of whom a third are obese. Overall recorded levels of obesity are below the expected prevalence, reflecting this under recording of BMI.
Sefton	19%	2010 Sefton Lifestyle Survey	BMI is based on self-reporting of height and weight.
Knowsley	20%	2006 Knowsley Adult Health and Lifestyle Survey	BMI is based on self-reporting of height and weight.
Halton & St Helens	12%	GP practice records	Recorded rates varied from 5-28%. Practices recording the lowest rates of measuring BMI also reported the lowest rates of obesity and vice versa.

2.3 Prevalence of IGR

The NHS Health Check modelling assumes an IGR prevalence of 2.3% among adults. It has been estimated that 5-12% of those with IGR go on to develop Type 2 diabetes annually, however this is based on a definition of IGR which includes those with a single raised FPG result and normal OGTT result who would not be classed as having IGR under the Health Check criteria. As the criteria for an IGR diagnosis are stricter in the Health Check pathway, it is likely that the higher estimate will be more applicable to this cohort or possibly that even the higher figure is an under-estimation. Table 3 shows how these estimates apply to the Merseyside population, with a total estimated number of 26,636 IGR cases currently, of whom between 1,332 and 3,196 will go on to develop diabetes annually.

Table 3: Estimated prevalence of IGR in the Merseyside Cluster

Area	Adult Population	Expected Numbers with IGR	IGR patients expected to develop diabetes annually
Liverpool	434,900	10,003	500 – 1,200
Southport and Formby	115,542	2,657	133 – 319
South Sefton	159,558	3,670	183 – 440
Knowsley	150,800	3,468	173 – 416
Halton	124,866	2,872	144 – 345
St Helens	172,434	3,966	198 – 476
Merseyside	1,158,100	26,636	1,331 – 3,196

2.4 Current practice in identification and management of IGR patients in Merseyside

In order to establish current practice in identification and management of patients with IGR in GP practices in Spring 2011 (prior to the current formation of the Mersey Cluster), a short questionnaire with a combination of closed and open questions was devised in collaboration with the diabetes lead GPs for Knowsley, Liverpool and Sefton. Overall, the results showed major inconsistencies in management of IGR patients between GPs across the three PCTs (see **Appendix 3**). Key findings included:

- Overall response rate was 39%.
- 67% of respondents kept an impaired glucose patient register.
- 42.9% of practices with an IGR register reported reviewing patients on an annual basis.
- 91.5% of respondents stated that the intervention they were most likely to offer during the review was lifestyle advice.
- Blood pressure monitoring (BP) was included in 84.5% of reviews.
- 31% of reviews included an oral glucose tolerance test (OGTT).

Some key themes emerged from the responses to the open questions, with several respondents commenting on the need for treatment to focus on lifestyle interventions and the need for improvements to current lifestyle services. Other comments

included the need for more funding and better access, along with wider involvement from other health professionals and members of the primary care team. Several respondents stated their support for a common pathway with clear protocols and guidance. Some acknowledged current failures in managing IGR patients, and a recognition that improvements are needed. Concern was also raised regarding current and potential non-compliance of IGR patients with treatment and review.

Whilst there were some limitations from the survey in relation to potential non-response bias, overall the findings strongly support the case for a systematic approach to the management of patients with IGR in Merseyside.

2.5 Current prevalence and management of known IGR patients in Merseyside

In order to establish a baseline of the current numbers of IGR patients recorded in GP practices across Merseyside, and the current management of those patients, an audit of 758,780 patient records at 148 GP practices was undertaken in September 2012 across Merseyside (including Halton and St Helens). The results of this audit show that across Merseyside:

- the known incidence of IGR has roughly doubled since 2006, rising from 644 new cases in 2006-07 to 1,203 new cases in 2010-11;
- the current known adult prevalence of IGR is 0.8%, ranging from 0.5% in Liverpool to 1.6% in Halton & St Helens;
- at an individual GP practice level, current prevalence ranged from 0.0% to 4.6%;
- 34.5% of known IGR patients had a recorded BMI of ≥ 25 and <30 (overweight) and 47.3% had a recorded BMI of ≥ 30 (obese);
- only 0.2% of overweight and 1.2% of obese IGR patients were recorded as having been referred to a weight management intervention (in Knowsley no IGR patients were recorded as having been referred to a weight management intervention);
- 65.7% of those diagnosed with IGR in 2009-10 were not recorded as having had an FPG test in the following 12 months (in Liverpool this figure was 90.1%) suggesting that in the majority of cases, blood tests were not being repeated annually

The 0.8% registered percentage of patients with a diagnosis of IGR in Merseyside was significantly lower than the 2.3% prevalence suggested by the NHS Health Check Modelling, suggesting there could be around 17,370 people with undiagnosed IGR (see Table 4).

Table 4: Summary of registered IGR prevalence compared to NHS Health Checks modelling

	Halton	Knowsley	Liverpool	Southport and Formby	St Helens	South Sefton	Merseyside
Population 17+	124,866	150,800	434,900	115,542	172,434	159,558	1,158,100
Registered prevalence	1998 (1.6%)*	1508 (1%)	2175 (0.5%)	1155 (1%*)	2759 (1.6%*)	1596 (1%*)	9265 (0.8%)
NHS Health Check Modelling	2872	3468	10,003	2657	3966	3670	26,636
Potentially undiagnosed	874	1960	7828	1502	1207	2074	17,371
**based on original data for Sefton and Halton and St Helens*							

Whilst acknowledging that referrals to weight management will be affected by the willingness of patients to be referred and that inadequacies in recording may inaccurately imply inadequacies in practice, these results support the findings of the practice survey regarding the need for much improved management of IGR patients and a consistent approach to identification, recording and follow up of IGR patients across Merseyside. This is essential in order to ensure that appropriate efforts are being too made to prevent people with IGR going on to develop Type 2 diabetes.

3. Models of delivery

There are a number of proposed or existing models of delivery for the management of IGR documented in the UK. The proposed Merseyside model comprises of five steps, and has been compared to four other models, see summary Table 5 below. **See also Appendix 4 for a more detailed comparison of the UK models and the proposed pathway for Merseyside.**

Table 5: Summary of similarities between the proposed Merseyside IGR pathway and alternative models

Merseyside IGR service model	NICE	Diabetes UK	NHS Salford	Let's Prevent
Step 1a: Search practice registers for high risk using known risk factors as opposed to risk stratify population	No	Not specified	Yes	Yes
Step 1b: Follow-up patients identified by NHS health checks	Yes	Yes		
Step 2: Offer blood test	Yes	Yes	Yes	
Step 3: Offer initial review		Yes		Yes
Step 4a: Patient education to include CVD risk, diabetes risk and how to reduce risk		Yes	Not known	Yes,
Step 4b: Lifestyle intervention (weight management), 16 hours in total [includes patient education]	Yes	Time not specified	No	Time not specified
Step 5: Annual review for patient with IGR	Yes	Yes	Yes	

NICE guidelines recommend the method of identifying patients by risk stratifying the whole population using real and estimated data and then offering blood tests to those identified as high risk. The proposed Merseyside pathway uses a more targeted approach, as it recommends managing those already identified through a prior blood test as having IGR and following-up those who will be identified as having IGR through the NHS Health Check. The steering group deemed it more appropriate to manage the patients already identified as having IGR before expanding the identification process, although this could be a future consideration.

There are also differences in the way patients are referred for patient education, as the proposed Merseyside model relies on GP referral whereas Salford use clinical searches to identify the high risk and invite the patients directly. However, it was felt more effective to offer IGR patients an annual review where the patient has a clinical assessment and encouraged to attend patient education and lifestyle service. The annual review also ensures that patients who do progress to diabetes are identified at an early stage and managed by the practice.

NICE guidelines also do not separate out the patient education and lifestyle intervention; however, these are separated out in the proposed Merseyside pathway, as IGR specific patient education is not currently provided across providers.

3.1 Summary of proposed model for Merseyside

In the proposed model for Merseyside, primary care would manage patients with IGR, offering them initial review and thereafter annual review **(see also Appendix 1, primary care pathway).** All patients are offered the opportunity to attend a programme of patient education and those with a BMI of 28kg/m^2 or more are also offered weight management.

The implementation of the proposed model is dependent on securing additional funding. However, funding has been obtained for the cost minimal option which will include:

- Providing practices with searches to identify patients with IGR.
- Providing the pathway and clinical guidelines for management of IGR.
- Launching the pathway in primary care.
- Developing local patient education materials for use by primary care with patients.
- IGR included as a co-morbidity to facilitate access to current weight management services.
- An audit which has been designed to run annually in primary care to assess progress made.

However, should additional funding be agreed as per preferred options, the service delivery model will be as summarised below. The model of service delivery has five steps:

1. Identification of patients at high risk of diabetes using practice registers, NHS Health Checks or opportunistically.
2. Testing for IGR using HbA1c and once diagnosed, placed on IGR register.
3. Patient invited for clinical and lifestyle review.
4. Patient offered education and follow-up:
    a. additional capacity to train staff to deliver IGR specific patient education;
    b. and weight management for those with a BMI of 28 or more;
    c. follow-up telephone support every three months for 18 months – 2 years.
5. Patients thereafter invited for annual review.

In addition, performance management criteria to be agreed for patient education, lifestyle intervention and follow-up. Funding will be sought for a detailed review/evaluation of the pathway once fully implemented.

The detail of the steps for clinicians to follow is outlined in Appendix 5

4. Identifying the Way Forward

4.1 Proposed Service Provision

The proposed Merseyside Pathway has been developed in consultation with local, regional and national stakeholders. This pathway highlights the patient flow, though the way it will be delivered is dependent on the outcome of the options appraisal and local decision making (**please see Appendix 1**).

4.2 Options Appraisal

There were a number of ways the proposed model could be delivered and a range of delivery options were appraised. The proposed model of delivery involves three components: primary care (identification and annual review), patient education (IGR/CVD specific) and weight management referral for those who are eligible. The options appraisal is for these three components with four or five options within each. In total, 16 options were considered with the steering group tasked with selecting one preferred option from each of the three sections.

The preferred options were selected at a consultation event which took place in February 2012 with representation from primary care and weight management services (commissioners and providers) across Merseyside as well as public health. Patients were also asked to give a view on their preferred option at the Merseyside Diabetes Action Group which took place on the 17th of May 2012.

Costs quoted are those of diagnosing and appropriately managing all of the people estimated by the Department of Health's NHS Health Check modelling to be diagnosed with IGR within one year through the NHS Health Checks in Merseyside (see Section 7 for further detail of costing).

Some of the costs will already be accounted for by budgets set aside for the NHS Health Checks and existing capacity of weight management services). See section 7 for further detail of costing and cost effectiveness analysis.

Tables 6-8 outline the preferred options chosen by professionals.

See also appendix 6, for more detail on the 16 options that were appraised.

4.3 Preferred Option

The preferred options selected at the consultation event in February 2012 were as follows. Although these are the recommended options, these are subject to agreement from budget holders and thus may change dependant on the finance made available.

The preferred options are:

- A Cluster wide service level agreement in primary care for the identification and management of IGR.
- Weight management services to provide both patient education and weight management intervention.
- Localised patient information to be produced.

Table 6: Primary Care Preferred Option

Primary Care				
Options		Pros	Cons	Costs
4.	Develop a (Merseyside-wide) Local Enhanced Service (LES) / Service Level Agreement (SLA) for the identification and management of patients with IGR.	▪ Provides finance to support the increase in capacity required in primary care. ▪ Would support the creation of an IGR register and implementation plan. ▪ The impact on reducing variation within primary care is likely to be high. ▪ Performance management would be in place to monitor quality and outcomes. ▪ The impact on health outcomes is likely to be high.	▪ Sustainability of funding and performance post LES/SLA. ▪ There is no guarantee that all practices will sign up to the LES/SLA. ▪ Will require financial governance arrangements. ▪ It could be seen as incentivising primary care to provide a service that should be a part of their core contract (although not part of it at present). ▪ This option will be high cost.	£10,000 for production of guidelines / educational events plus cost of LES/SLA.

Table 7: Adult Healthy Weight Options Appraisal

Healthy Weight				
Options		Pros	Cons	Costs
4.	Add IGR as a co-morbidity within the weight management pathway and build capacity within lifestyle services to deliver both patient education and weight management	▪ Enables wider provision (i.e. outside of primary care) of evidence based education through locality teams that already deliver similar services and have the knowledge of local population groups. ▪ Patients less likely to be lost to follow-up as patient education and lifestyle inventions delivered by the same team. ▪ High impact on outcome. ▪ Performance management would be in place to monitor quality and outcomes;	▪ Sustainability of funding (need to ensure recurrent funding). ▪ Negotiation in contract variations could be problematic as different contracts in place across the borough and different methods of data collection. ▪ Staff may not have the clinical background to be able to advise patients about the aetiology of IGR and diabetes.	Costs of additional capacity and patient education provision will vary locally depending on current contracts.

Table 8: Patient Education Options Appraisal

Patient Education				
Options		Pros	Cons	Costs
2.	**Develop IGR specific patient education material (e.g. information leaflets) and disseminate to GP practices and lifestyle services across the Cluster.**	▪ **Increased knowledge and awareness in primary care clinicians around education.** ▪ **Patients will receive basic information;** ▪ **Locally designed patient information will raise awareness in the community and may improve local knowledge and uptake to services**	▪ **Variations in primary care with regards to quality and delivery of patient education.** ▪ **No evidence base for this approach.** ▪ **NICE state that a formal intensive education programme is required.** **NB: these cons can be overcome if patient education delivered in addition to providing information alone.**	**plus:** **£20,000**

Primary Care: preferred option is 4, Merseyside-wide LES

1. Do nothing – this option was rejected as future predicted costs of diabetes means that to do nothing is not an option.

2. Disseminate pathway – this option was rejected as information alone can be misinterpreted and competing pressures combined with a lack of additional capacity in general practice may mean it would not be implemented.

3. Make IGR core business – this option rejected due to variations in the contracting process across the patch.

4. CCG LES/SLA/Contract – acknowledged that a LES/SLA would have to be well written as some LES' have failed in the past (reviewing local LES' could enable money to be re-directed to IGR LES/SLA). This model is working in Sefton where 90% of practices have signed up to a CCG funded IGR LES. A LES/SLA/Contract would help to build the capacity to deliver the pathway and the support to performance mange it.

5. Primary care deliver the whole service – this option was rejected because it is not feasible in terms of the relatively small number of patients and capacity to deliver a quality assured programme of patient education, even if practices were to federate.

Adult healthy weight: preferred option is 4, build capacity to deliver patient education and weight management

1. Do nothing – this option was rejected as future predicted costs of diabetes means that to do nothing is not an option.

2. Add IGR as co-morbidity – this option was rejected as this does not build capacity to cope with additional demand, other patients may end up waiting longer if IGR is prioritised.

3. Add IGR as co-morbidity and increase capacity – this option could be developed but would not include IGR education as this is different from current practice.

4. Add IGR as a co-morbidity and build addittional capacity for staff to deliver patient education as well as weight management – this is the preferred option as one joined up service means that patients are less likely to be lost to follow-up (as they might be if education separated from lifestyle intervention), and would have added value for lifestyle services as would include holistic approach for all CVD risk factors.

It is important to note that members of the patient group did not wholly agree with this as the option for patient education. One concern expressed was that not all patients would require or want a weight management intervention. Also, that they felt patient education should not be delivered at a gym setting, as this might put some people off from attending. The patients suggested they would prefer patient education to be delivered at the GP practice or another community or health venue.

In addition the patients recommended that the education be opened out to include a key family member or carer.

Patient education: preferred option is 2, IGR specific patient education materials

1. Do nothing – this option was rejected as future predicted costs of diabetes means that to do nothing is not an option.
2. Develop local IGR patient education materials (this is additional to patient education provided by lifestyle services) – preferred option, primary care can use the materials to have the initial discussion with patients to promote the service, as locally developed the process will raise awareness and support community 'buy-in'.
3. Contract variation to provide patient education – this option rejected as felt having patient education separate from lifestyle may mean patients are lost to follow-up.
4. Set up Cluster wide patient education and weight management – this was felt to be expensive to set up and may duplicate some aspects of current provision.

The patients also said they would be willing to attend a patient education session as they wanted to tell other people about what it was like to live with diabetes and that it can happen to anyone (this could also be done by recording a DVD).

5. Strategic Risks

It is proposed that the risks associated with the implementation of this proposal, once approved, will be managed with the support of the Merseyside Commissioning Support Unit, and associated risk management structures.

Table 9: Summary of risks

Risks	Mitigating actions
Modelling assumptions As the proposed pathway is a novel approach, a number of assumptions (see section 7) have been used to model the impact on services and the costs savings. The risk is that, if these assumptions are incorrect, activity may be either more or less than expected.	• A comprehensive audit was undertaken of over 400,000 patient records in order to identify the potential number who would be eligible for the proposed pathway. • Sefton has piloted a Local Enhanced Service, the activity data from which can be used to verify some of the assumptions. • Once implemented, performance is to be managed and activity and outcomes data to be collected and reviewed.
Change management Both the NHS and the local authority are going through a period of substantial organisational change. The processes for agreeing and implementing the pathway are changing as are the personnel. Therefore, the risk is that agreement and implementation could be delayed.	• Regular stakeholder engagement. • Clear communication. • Ensuring commissioning leads from each locality are identified and involved in regular communication and in decision making. • Succession planning. • Ensuring the project team keep to agreed time frames.
Dependences There are several interfaces along the pathway: phlebotomy, laboratories, primary care, providers of IGR specific patient education, and weight management. The pathway is also dependent on primary care referring patients into patient education and weight management.	• Developing a robust service level agreement with the providers with clear parameters. • Establishing clear roles and responsibilities. • Performance management and monitoring of referrals. • Considering alternative ways of generating referrals.
Financial Constraints Although implementing the pathway is likely to produce cost savings in the long-term, in the short term additional funding is required to be found in order to implement the pathway. This funding is likely to come from making changes to current contracts and/or additional investment. In order to fund the whole pathway, agreement will need to be reached with the CCGs and the directors of public health. Although the pathway has been agreed, the additional funding is still to be agreed.	• Using the business case format. • A menu of options and the respective costs and benefits are provided to assist decision makers. • Joint commissioning. • Once implemented the programme will be evaluated and performance managed.

Risks	Mitigating actions
Local configurations There are 6 CCGs, within which the current patient pathways and commissioning mechanisms vary. Thus, although the pathway is to be implemented across Merseyside, it may be commissioned differently by each location; as a result, there may be inequity of delivery across Merseyside. There are also differences in the composition of weight management provision.	• Business case to include preferred options. • Outcomes data collected to be standard across Merseyside to assess effectiveness and benchmark local delivery against the pathway. • Ensuring that wherever possible the same referral criteria are used to facilitate equity of access. • Project co-ordination.
Sustainability Maintaining the momentum and the funding. Ensuring enough people enter the pathway for the project to be sustainable.	• Where possible, incorporate the pathway into established services. • Performance management. • Patient and stakeholder engagement. • Make every effort to align contract review dates across the services within the IGR pathway and across Merseyside.

6. Implementing the model

6.1 Programme Management

The business case development has been managed by the IGR steering group, which is a sub-group formed from the Merseyside Diabetes Network / Diabetes QIPP.

It is proposed that the primary care aspect of the proposal will be implemented through CCGs. The IGR specific patient education is to be implemented by public health with the support of CCGs, and the Diabetes Network. The weight management intervention element of the proposed pathway is to be implemented by public health. Funding has been secured through the Diabetes QIPP to provide patient and public engagement, clinical guidelines to support the pathway, and to launch the pathway.

As the business case progresses it is expected that the diabetes leads will progress the primary care aspects via their CCG boards. It is expected that public health will progress the patient education and weight management aspects via the health improvement leads. Local funding arrangements may be agreed for lifestyle services. The business case may also be taken to local health and wellbeing boards.

It is likely that the oversight of the whole pathway may be through the diabetes network, although additional project management support may be required to facilitate this.

6.2 Implementation plan

Table 10: Proposed Implementation timetable

Timescale	Activity	Responsibility
July/August 2012	Circulate draft business case for final comment.	Steering group
September 2012	Present business case to CCG boards for a decision on the proposed options for primary care and, where appropriate education and lifestyle intervention.	Diabetes Leads
September 2012	Present business case for a decision on the proposed options for patient education and lifestyle intervention.	Public Health Leads / Health Improvement Leads
September / October 2012	Opportunity to engagement with patients and the public and gain insight into aspects of implementation.	Steering group to oversee
November/December 2012	Develop template for IGR review, review data sharing and monitoring.	Network / IM&T sub-group
November/December 2012	Plan launch events.	Steering group / network
January/February 2013	Produce local materials for patient education and professional guidance.	Primary care network lead, PH lead in conjunction with

		communications
January/February 2013	Begin training staff to deliver IGR specific education.	Life style commissioners
March / April 2013	Launch event.	Steering group / network
March/April 2012/13	Amendments to contract of weight management services.	Public Health
April 2013	Commence IGR pathway.	Primary care/ Public Health

6.3 Patient, Public and Stakeholder Involvement

6.3.1 Patients and the public

Patient and public involvement has been and will be undertaken in line with local and national policy and standards. The North Mersey Diabetes Action group, a forum for patients with diabetes from across Liverpool, Sefton and Knowsley have had 'prevention' as an aspirational objective since their commencement in January 2010.

Once the business case is approved, wider consultation will take place. A representative sample of patients will be identified by linking in to local patient participation groups such as; Healthwatch, LINKS and patient groups linked to CCGs. This will be organised in consultation with the Cluster lead for patient and public involvement. It is proposed that a focus group will be established to:

- Identify criteria on which to score service delivery options.
- Score the options against the chosen criteria.
- Identify potential options for lifestyle services available for this cohort to access.
- Develop localised patient information resources.
- Discuss awareness raising campaigns.

6.3.2 Stakeholders

The IGR business case and pathway has been a regular agenda item for the QIPP board and the Merseyside Diabetes network. There have been a number of meetings with primary care clinicians focusing on specific aspects of the pathway and business case development. There is an established steering group which meets monthly with representation from public health, weight management and the Merseyside Diabetes Network.

It is envisioned that the draft business case will be circulated to CCGs via local diabetes leads and to public health consultants for a decision on the options and future investment, as well as being presented to the Merseyside QIPP leads. The patient education and weight management aspect of the business case will be presented to Public Health, Health Improvement Leads.

6.3.3 Summary of patient, public and stakeholder engagement activity

Communications activity will need to be targeted and tailored to be appropriate for different audiences. There are some overarching messages for each group, but specific messages will need further development for the audiences within the groups. **See Appendix 7 which provides some indicative examples of those to engage and some of the engagement that has taken place to date.**

6.4 Performance management

Once the business case has been agreed, there will be a need for monitoring, reacting to and assessing progress and effectiveness. It is crucial that a management structure is in place to monitor progress and to take the necessary steps to ensure that activity and outcomes are achieved across the services delivering the IGR pathway. The purpose of the performance monitoring is to:

- Help to define performance targets / goals across the key aspects of service delivery, including management of resources (personnel, infrastructure), customer service and financial viability.
- Provide a comprehensive picture of the organisation's progress towards achieving its performance targets / goals.
- Provide an early indication of emerging issues / cost pressures that may require remedial action.
- Indicate where there is potential to improve the cost effectiveness of services through comparison with other organisations.

The suggested mechanisms to do this are:

- Key performance indicators (KPIs) which help define and measure progress towards goals for the project and for the elements of the pathway.
- Performance management system that will track performance and enable review of targets and investment. This is to include patient experience and patient satisfaction, as well as activity and outcome measures.
- Evaluation and audit to provide internal and external assessment of whether the project is a success or not by taking an in depth look at outputs and performance.

The performance mechanisms are to be decided in consultation with key stakeholders and budget holders to determine whether the project has achieved its goal of improving identification and management of IGR and that this in turn has resulted in preventing or slowing the progression to Type 2 diabetes in this cohort of patients. A clinical audit tool was developed to identify registered prevalence and management if IGR, this could be adapted as a performance monitoring tool providing data at GP practice level and across Merseyside. Possible indicators for inclusion in performance monitoring are set out in **Appendix 8.**

7. Financial Planning

7.1 Funding

Implementing the pathway will result in future cost avoidance through delaying and/or preventing the onset of Type 2 diabetes. Once diagnosed, 86% of IGR patients will have approximately a 1 in 3 risk of going on to develop diabetes if no intervention is made; the remainder will have approximately a 2 in 3 risk of developing diabetes (see Appendix 9).

Some of the costs will already be covered by existing contracts and this has been taken into account in the modelling. For example, some capacity already exists in weight management services which could be filled without requiring additional funding. Table 11 shows costs per patient of identifying and managing cases through the IGR pathway. For a more detailed breakdown of how cost-effectiveness has been calculated, please see appendix 9. Please note that these calculations do not include the initial cost of launching the pathway and producing self-care materials (see Appendix 8).

Table 11. Costs per patient of each element of the IGR pathway

	Basic costs covered by existing arrangements	Basic costs not covered by existing arrangements	Additional primary care costs*	Estimated patient volume**
Phlebotomy at initial consultation/ health check	£14	-	£2.50	100% of patients entering pathway.
Inviting patient for annual review	-	-	£3	100% of patients entering pathway through search of practice records. 2.3% of patients entering pathway through NHS Health Checks.
Undertaking annual review	-	-	£23	65% of all patients invited for annual review.
Phlebotomy at annual review	-	£14	£2.50	65% of all patients invited for annual review.
Weight management	£152	-	-	50% of all patients invited for annual review.
Patient education	-	£45.50***	-	50% of all patients invited for annual review.

* Based on costs of current IGR LES in Sefton
** Estimates based on audit, published evidence, local NHS Health Check outputs and DH NHS Health Check modelling
*** Includes cost for training staff and capacity to deliver, does not include licence fees or resources

7.2 Cost effectiveness modelling

Cost effectiveness has been modelled for two distinct phases of implementing the pathway:

Years 1 & 2

Patients whose practice records show a previous diagnosis of IGR or a previous raised FPG or OGTT result that meets the threshold for IGR will be invited to attend for an HbA1c test. The modelling assumes that this look-back exercise will be complete by the end of Year 2, with 50% of the identified patients entering the IGR pathway in Year 1 and the remainder in Year 2.

During this period, patients will also enter the IGR pathway through having been identified as at high risk of IGR through an NHS Health Check.

Year 3 onwards

Once the look-back exercise is complete, new patients will continue to enter the IGR pathway annually through the NHS Health Check route. (Additional patients may also enter the pathway as a result of being identified at high risk of IGR through routine consultations; however, there is currently insufficient evidence to enable this to be incorporated into the modelling).

For each phase, figures have been calculated to show cost effectiveness both with and without putting in place a LES to cover the annual review aspect of the IGR pathway, the assumption being that 65% of those invited would attend. **For more detailed costing and assumptions see appendix 9.**

Table 12. Annual number of diabetes cases postponed for 8 years as a result of implementing IGR pathway in Years 1 & 2

Merseyside	Knowsley	Halton	St Helens	Liverpool	Southport and Formby	South Sefton
657	99	125	171	177	76	106

Table 13. Annual cost effectiveness of implementing IGR pathway in Years 1 & 2

	Merseyside	Knowsley	Halton	St Helens	Liverpool	Southport and Formby	South Sefton
Total cost of IGR patient management (£)	717,127	117,794	163,544	225,847	142,983	62,171	85,855
Total cost of diabetes patient management avoided (£)	2,785,680	419,760	530,000	725,040	750,480	322,240	449,440
Overall cost saving over 8 years (£)	2,068,553	301,966	366,456	499,193	607,497	260,069	363,585

Table 14. Annual cost effectiveness of implementing IGR pathway in Years 1 & 2 with a LES

	Merseyside	Knowsley	Halton	St Helens	Liverpool	Southport and Formby	South Sefton
Total cost of IGR patient management (£)	1,509,863	236,563	313,519	432,954	357,367	154,402	213,222
Total cost of diabetes patient management avoided (£)	2,785,680	419,760	530,000	725,040	750,480	322,240	449,440
Overall cost saving over 8 years (£)	1,275,817	183,197	216,481	292,086	393,113	167,838	236,218

Table 15. Annual number of diabetes cases postponed for 8 years as a result of implementing IGR pathway from Year 3

Merseyside	Knowsley	Halton	St Helens	Liverpool	Southport and Formby	South Sefton
156	20	18	24	54	16	24

Table 16. Annual cost effectiveness of implementing IGR pathway from Year 3

	Merseyside	Knowsley	Halton	St Helens	Liverpool	Southport and Formby	South Sefton
Total cost of IGR patient management (£)	111,568	14,624	12,506	17,269	38,707	11,954	16,508
Total cost of diabetes patient management avoided (£)	661,440	84,800	76,320	101,760	228,960	67,840	101,760
Overall cost saving over 8 years (£)	549,872	70,176	63,814	84,491	190,253	55,886	85,252

Table 17. Annual cost effectiveness of implementing IGR pathway from Year 3 with a LES

	Merseyside	Knowsley	Halton	St Helens	Liverpool	Southport and Formby	South Sefton
Total cost of IGR patient management (£)	300,375	39,373	33,669	46,494	104,211	32,183	44,444
Total cost of diabetes patient management avoided (£)	661,440	84,800	76,320	101,760	228,960	67,840	101,760
Overall cost saving over 8 years (£)	361,065	45,427	42,651	55,266	124,749	35,657	57,316

8. Conclusions

- There is a need to implement a standard pathway for the identification and management of IGR patients across Merseyside, due to evidence of current under-diagnosis, major inconsistencies in IGR patient management and emerging evidence of effectiveness.
- This business case sets out the preferred options for implementing the approved Merseyside IGR pathway (see Appendix 1) along with estimates of cost effectiveness based on local and national evidence.
- Due to the limitations of available evidence, unknown variables and complexities of local variations in practice and contracts; the financial modelling can only provide a best estimate of cost effectiveness. Based on these estimates, implementing the Merseyside IGR pathway to actively identify currently undiagnosed IGR patients and to diagnose and manage those presenting for an NHS Health Check will be cost effective. Managing only those patients already recorded on GP systems as having had a raised blood sugar result in the past and those identified through NHS Health Checks will be highly cost effective either with or without a LES.

9. Recommendations

It is proposed that a shared pathway is put in place across the Merseyside Cluster for the identification and management of IGR patients. It is likely that whilst the proposed pathway will be the same across Merseyside, the way the pathway is implemented may vary depending on local circumstances and this is for individual Clinical Commissioning Groups (CCGs) and Health Improvement Leads to decide.

It is recommended that primary care take responsibility for funding annual reviews for patients known to have IGR and those identified as IGR through NHS Health Checks. The source of funding for training staff to patient education is still to be identified. It is recommended that Public Health ensure funding is available to build the capacity to deliver the patient education, support to change lifestyle and appropriate follow-up. It is recommended that an agreed performance management structure is in place to monitor and review activity and outcomes.

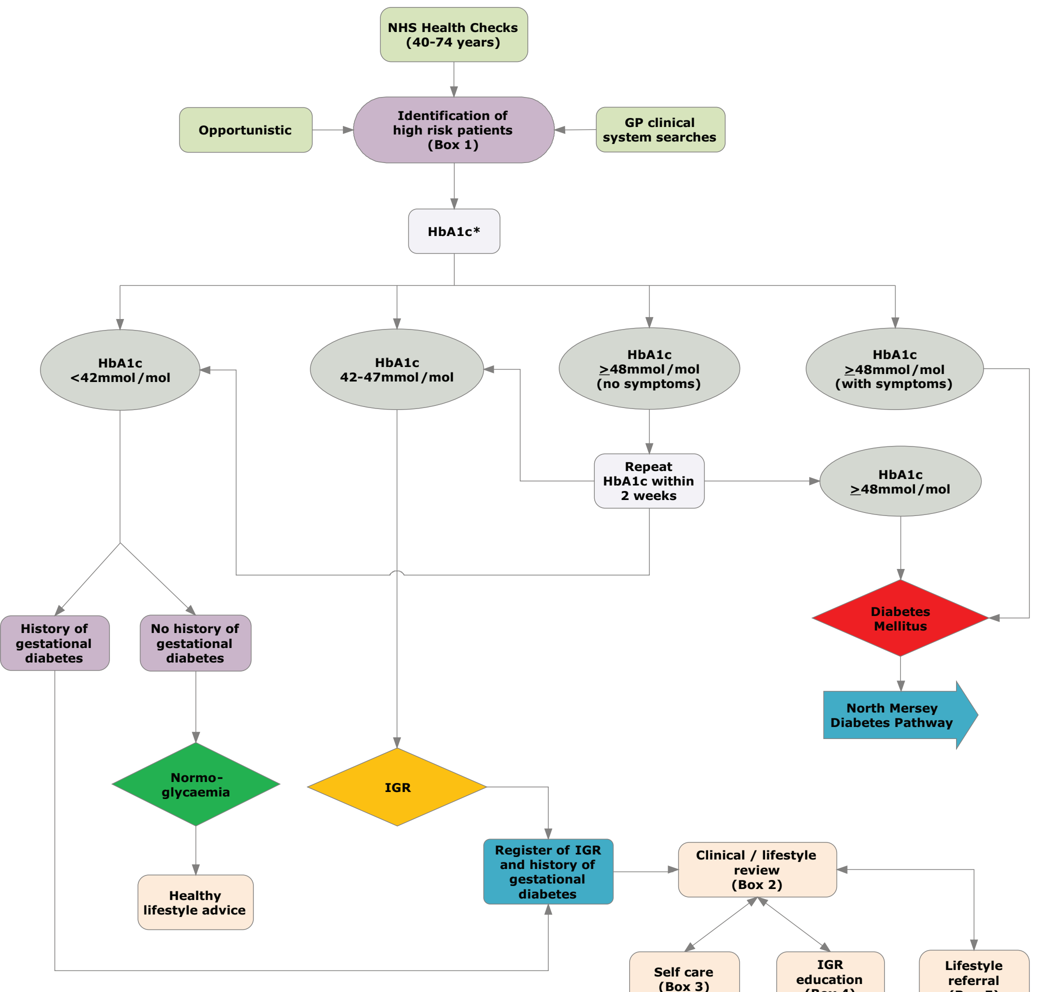
References

[1] Nathan DM et al. Impaired Fasting Glucose and Impaired Glucose Tolerance: Implications for care. Diabetes Care 30:753-759, 2007
[2] http://www.who.int/diabetes/publications/report-hba1c_2011.pdf
[3] John WG, Hillson R, Alberti G et al. Use of Haemoglobin A1c (HbA1c) in the diagnosis of diabetes mellitus. The implementation of World Health Organisation (WHO) guidance 2011. NHS Diabetes.
[4] Mostafa SA, Davies MJ, Srinivasan BT, et al. Should glycated haemoglobin (HbA1c) be used to detect people with Type 2 diabetes mellitus and impaired glucose regulation? Postgrad Med J (2010). doi:10.1136/pgmj.2009.091215
[5] American Diabetes Association. Pre-diabetes. Available at: http://www.diabetes.org/pre-diabetes.jsp
[6] Paulweber B et al. A European evidence-based guideline for the prevention of Type 2 diabetes. Horm Metab Res. 2010 Apr;42 Suppl 1:S3-36. Epub 2010 Apr 13.
[7] Sony Anthony, Tina Odgers, and William Kelly. Health promotion and health education about diabetes mellitus. The Journal of the Royal Society for the Promotion of Health, Mar 2004; 124: 70 - 73.
[8] The Diabetes Prevention Program Research Group: Reduction in the incidence of Type 2 diabetes with lifestyle intervention or Metformin. *N Engl J Med* 346:393–403, 2002
[9] Tuomilehto JLJ, Eriksson JG, Valle TT, Hamalainin H, Ilanne-Parikka P, Keinanen-Kiukaanniemi S, Laakso M, Louheranta A, Rastas M, Salminen V, Uusitupa M: Prevention of Type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. N Engl J Med 344:1343–1392, 2001
[10] Moore LLVAJ, Wilson P, D'Agostino RB, Finkle WD, Elliso RC: Can sustained weight loss in overweight individuals reduce the risk of diabetes mellitus? *Epidemiology* 11:269–273, 2000
[11] Coutinho M, Gerstein HC, Wang Y, Yusuf S, The relationship between glucose and incident cardiovascular events. A metaregression analysis of published data from 20 studies of 95,783 individuals followed for 12.4 years. Diabetes Care, 1999;22:233-240.
[12] Dunstan DW, Zimmet PZ, Welborn TA, et al. The rising prevalence of diabetes and impaired glucose tolerance: the Australian Diabetes, Obesity and Lifestyle Study. Diabetes Care 2002; 25: 829-834
[13] DECODE Study Group. Is the current definition for diabetes relevant to mortality risk from all causes and cardiovascular and noncardiovascular diseases? Diabetes Care 2003; 26:688–696.
[14] Knowler WC et al. Reduction in the incidence of Type 2 diabetes with lifestyle intervention or Metformin. N Engl J Med. 2002 Feb 7; 346(6):393-403.
[15] Orchard TJ, Temprosa M, Goldberg R, et al. DPP Research Group. The effect of Metformin and intensive lifestyle intervention on the metabolic syndrome: the Diabetes Prevention Program randomized trial. Ann Intern Med. 2005 Apr 19;142(8):611-9
[16] Pratley R, Matfin G. Pre-diabetes: Clinical Relevance and Therapeutic Approach. Br J Diabetes Vasc Dis 2007; 7(3):120-129.
[17] Diabetes UK; Position Statement: Early identification of people with Type 2 diabetes, (Jun 2006); *Overview of the evidence for the likely effectiveness of Type 2 diabetes screening and the views of Diabetes UK on how screening might operate.*
[18] UK Prospective Diabetes Study Group VI. Complications in newly diagnosed Type 2 diabetic patients and their association with different clinical and biochemical risk factors. Diabetes Research (1990) 13:1-11
[19] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058939.pdf
[20] Wanless, D. *Securing Good Health for the Whole Population* London HM Treasury (2004)
[21] The Health and Social Care Information Centre. *Prescribing for Diabetes: England 2005/06–2010/11.* 24th August 2011
[22] Diabetes UK . *Diabetes. Beware the silent assassin.* October 2008
[23] Diabetes UK. Position Statement: Impaired glucose regulation (IGR) / Non-diabetic hyperglycaemia (NDH) / Prediabetes. Sep 2009.
[24] IMAGE. A European Evidence-Based Guideline for the Prevention of Type 2 Diabetes. *HMR* 2010; 42 S1-S64

[25] NICE. Public Health Guidance: Preventing Type 2 diabetes: risk identification and interventions for individuals at high risk. July 2012.
[26] Srinivasan BT, Davies MJ, Webb D et al. (2007). Baseline characteristics and risk of progression from pre-diabetes to Type 2 diabetes in a multi-ethnic population based screening. Diabetes Medicine: 24(Supplement 1): 73
[27] International Diabetes Federation. Diabetes Atlas (5th Edition). 2011. Brussels: IDF
[28] http://www.yhpho.org.uk/default.aspx?RID=81090

Merseyside Impaired Glucose Regulation (Prediabetes) Pathway

Approved pathway - May 2012



<u>Box 1: Individual Risk Factors</u>

BMI >28 (or >24.5 in South Asians).

Stage 1 Hypertension

Waist circumference >88cm/34.5in for a woman or >104cm/41in for a man.

Family history of Type 2 diabetes (a first degree relative with T2D).

History of gestational diabetes.

<u>Box 2: Clinical/Lifestyle assessment</u>

CVD risk assessment (as appropriate). *Blood test: lipids, serum creatinine/eGFR*, LFT, HbA1C (if not had one within previous 3 months).*

Measurements: BP, BMI, waist circumference.

Lifestyle assessment: diet & alcohol (AUDIT-C), smoking status, physical activity (GPPAQ).

Pharmacological review (as appropriate).

Women of childbearing age: consider preconception counseling (may require high dose folic acid).

Patients will be reviewed annually, which will include all of the above plus HbA1c.

* If <60ml/min/1.73m^2 consider ACR

<u>Box 3: Self Care</u>

(Local resource will be developed in line with IGR educational materials)

<u>Box 4: IGR education</u>

(Options for IGR patient education model currently under consideration)

<u>Box 5: Lifestyle referral(s)</u>

Weight management (in accordance with local healthy weight pathway).

Alcohol services.

Smoking cessation services.

Exercise on referral.

Health Trainers.

* FPG and OGTT should be used with patients for whom HbA1c is not appropriate (See Appendix - 'Use of HbA1c in the diagnosis of diabetes')

REPORT TO: Health and Wellbeing Board

DATE: 17th July 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Adults

SUBJECT: Health and Wellbeing Action Plans

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Health and Wellbeing Board with an update on the progress with the development of the Health and Wellbeing Action Plans.

RECOMMENDATION: That

1. **the Board note the contents of the report and appendices; and**
2. **feedback comments to the Director of Public Health**

3.0 SUPPORTING INFORMATION

3.1 The Joint Health and Wellbeing Strategy for Halton 2013-16 was launched by the Health and Wellbeing Board in January 2013. Since the launch, work has taken place to develop action plans for each of the five priority areas contained within the report. Work has progressed in these areas whilst the plans have been developed.

3.2 The Action Plans have been developed within the scope of the Health and Wellbeing Strategy using a set of core principles as set out on page 11 of the document. These are outlined below:

Core Principles:

1. Have an emphasis on prevention and early detection/intervention
2. Maintain quality, cost and resource effectiveness
3. Ensure equity of access, providing appropriate levels of support to meet needs
4. Be evidence based, e.g. National Institute of Health & Clinical Excellence (NICE) guidance, Marmot Review, and meet quality standards

5. Promote community engagement, using and building local assets and listening to local people. The Action Plans support universal services for all Wellbeing Areas and targeted services in areas where there is particular need. These will be delivered through training of service providers or key members of the community that can then cascade messages and training to the local people. This will enable individuals and communities to act to improve their health.

6. Take account of national policy as well as joining up co-dependent local strategies and commissioning plans to avoid duplication. Many behaviours and wider determinants are co-dependent, complement and overlap other strategies. Use the JSNA and other local intelligence (data, surveys, impact assessments and performance) and customer feedback

7. Balance between borough level action and targeting within key settings and the Wellbeing Areas

8. Consider action at all stages of life as appropriate

9. Be innovative where evidence of effective interventions is limited, making sure evaluation is built in from the beginning and outcomes are monitored

3.3 Draft action plans are attached as Appendix 1 to this report.

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing Strategy will provide the overarching framework within which commissioning plans for the NHS, Social Care, Public Health and other services which the Health and Wellbeing Board agrees are relevant, are developed.

4.2 Therefore the implementation of the strategy and associated action plans will have policy implications for the future implementation and delivery of services. These implications are evidenced within individual action plans and have been considered in their development.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will continue to be addressed through the Health and Wellbeing Strategy whilst taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication.

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

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to address health inequalities

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime has an impact on health outcomes particularly on mental health. There are also close links between partnerships on areas such as alcohol and domestic violence

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and will therefore need to be addressed in public health annual reports.

7.0 RISK ANALYSIS

Halton Borough Council may be at risk of not meeting national targets if recommendations outlined in the report are not met. There are no financial risks. The recommendations are not so significant they require a full risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

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

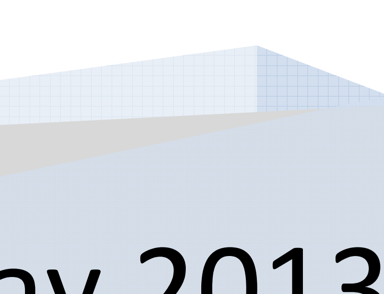
Document	Place of Inspection	Contact Officer
Health and Wellbeing Strategy 2013-2016	Runcorn Town Hall	Diane Lloyd

Health and Well Being Priority Area Action Plans

Halton Health and Well Being Board

APPENDIX 1 – DRAFT Action plans for the Health and Well Being Priority Areas (VER 4 28/06/13)

Eileen O'Meara Director of Public Health



May 2013

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

Name of Priority: Prevention and Early Detection of Cancer

Overall Target - 1% Reduction in under 75 mortality rate from cancer (Baseline 2010 – 147.96/100,000)

Pregnancy & Early Years					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead**
Reduction in incidence of skin cancer.	100% of nurseries and Children's centres provided with sun awareness training in year 1	C1	Health Improvement Team to run sun awareness training for all nurseries and Children's centres in Halton in 2013/14 (this is to be part of Halton Healthy Early Years Standard accreditation).	2013-14	Health Improvement Team
Reduction in incidence of skin cancer	**Local Policy/guidance on sun protection** To develop sun protection policy during 2013/14	C2	To ensure implementation in all Children's centres and nurseries via training programme outlined above.	2013/14	Health Improvement Team Public Health CYP Team
Children to reach a good level of physical development and make healthy choices.		Detail included in child development action plan			
School Age School age					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead**

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Reduction in obesity rates for school age children.	Ensure Fit for Life is available in 70% of primary schools in year 1. 100% in year 2 Year 1- Run Fit for Life as a pilot in 20% of secondary schools	C3	Health improvement team to extend Fit for Life programme across Halton.	2013-16	Health Improvement Team
Reduction in sunbed use amongst children under 16 years.	Educational events across all secondary schools in Halton in year 1.	C4	Liaise with school head-teachers to organise collaborative educational events run by HIT & school nurses.	2013-16	Health Improvement Team
Reduced incidence in skin cancer. **All children protected against sunburn**	Development of sun protection guidance for schools by 2014. Educational awareness raising in PHSE lessons in all schools by 2015	C5	Public Health/ Health Improvement Team to work with local head teachers to develop simple policy/guidelines with clear messages on sun risks and how to prevent them.	2013-15	Public Health to develop policy. Health Improvement Team to deliver implementation.
Maintain HPV vaccine uptake and herd immunity.	Maintenance of 95% compliance	C6	Regular communication with Halton schools to provide information on benefits of vaccination including information events for lowest performing schools.	2013-16	NHS Commissioning Board / Public Health commission service, School Nursing to deliver service with Health Improvement Team to support promotion.
Reduced number of children starting to smoke. **Reduced number of children using counterfeit and illegal tobacco.**	Smoking prevention and illegal and counterfeit tobacco training for all teachers and school nurses. Raised awareness of the dangers of smoking for all children	C7 C8	HIT to deliver smoking prevention training to teachers & school nurses. Teachers & school nurses to raise awareness with all children.	2013-16	Health Improvement Team Schools School Nurses Health

Outcomes	Targets		Actions	Timescales	Lead
Reduced prevalence of smoking in school children.	33% staff trained year 1 33% staff trained year 2 33% staff trained year 3				Improvement Team
Young Adulthood (16-24)/ Healthy Adulthood (25-64) Older People (65+)					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead**
Improved healthy lifestyles for young people & adults.	Meet NICE guidelines of 5% reduction in obesity after completion of the active phase of the healthy weight programme	C9	HIT implement and extend weight management programmes.	2013-16	Health Improvement Team
	Reduce smoking by 0.5% year on year to 2016. (baseline 24% based on Halton Health Profile 2012)	C10	HIT implement training & stop smoking services.	2013 - 16	Health Improvement Team
Reduction in incidence of skin cancer.	**Increased awareness of Sun and UV Risks** Halton Council endorsed information displayed in 50% of sunbed shops in Halton Year 1, 100% in Year 2	C11	Trading standards contact local sunbed shops to agree standard information to be displayed informing of the risks of UV and sunbed use so that customers can make informed choices. Support regional and national initiatives to combat the use of sunbeds and raise awareness of the link with skin cancer	2013-14	Halton Borough Council
Increased awareness of resources available for early detection and prevention of cancer for service providers and the public.	Information workshop to be carried out in **ALL** GP practices on role of Merseyside and Cheshire Cancer Network and support they can offer.	C12	CCG to liaise with MCCN to establish dates for all practices in Year 1. Continue to commission use of the iVan based on GP profile data in 13/14, targeting areas where uptake is lower with support from local voluntary groups.	2013	Merseyside & Cheshire Cancer Network Health and Wellbeing Service Steering Group CHaMPs.
Increase uptake of national cancer screening programmes.	**Increased uptake of Screening Services:** **-Breast** **-Bowel** **-Cervical**	C13	CCG lead in collaboration with cancer lead and MCCN to visit practices and discuss cancer profile to establish priorities. All practices should have established an achievable screening target by Year 1 and met their specific target by year 3.	2013-16	NHS Commissioning Board Local Area Team

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	100% of all Halton GP practices to agree practice specific target in Year 1 and to maintain all other screening levels Improved screening uptake of vulnerable and hard to reach groups. GP training to improve early detection.		Development of user friendly materials for vulnerable and hard to reach groups (CCG lead to investigate potential for incentive schemes where target is not part of contractual obligations)		Health Improvement Team
Improved detection of cancer.	**Increased uptake of Primary Care Cancer Audit** 100% of GP practices to take part in annual primary care cancer audit.	C14	CCG to distribute communication on Primary Care Audit All practices to audit on an annual basis	2013-16	CCG Lead, GP Practices
Improved detection of cancer.	GP Practice Staff training programmes on Cancer Awareness All low performing GP Practices to receive staff training.	C15	Extension of staff training programme (Health Improvement Team) to **all** GP practices below CCG average for breast, cervical, lung or bowel screening with input from Cancer Support Group	2013-16	Health Improvement Team
Access to staging data	Routine monthly staging data to be reported to Halton Action on Cancer Board (HACB) in Year 1	C16	Develop requirement (or potential CQUIN) for staging data to be sent to HACB as routine monthly information Secondary care representative to be established to attend HACB meetings Merseyside and Cheshire Support to Unit to require staging data from Acute Trusts	2013	CCG/Secondary care provider
Rise cancer awareness	Utilisation of iVAN: Targeted use of iVan in **9** GP Practices that have significantly lower screening rates than	C17	Continue to commission use of the iVan based on GP profile data in 13/14, targeting areas where uptake is lower with support from local voluntary groups.	2013	Public Health

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	CCG average for either breast, cervical, lung or bowel screening.				
Improved early detection	Maintenance or improvement of 2 week wait referrals	C18	Utilising GP practice profiles identify practice specific targets based on referral rates. CCG lead and GP lead to establish targets and action plans with GP practices.	2013-16	CCG Lead/Clinical Lead
Improved early detection	Reduce cancer related A&E admission rates	C19	Target the 6 GP practices that have above national average emergency presentations Work with Wellbeing Areas to promote symptoms of cancer in these areas and encouraging populations to visit GP sooner.	2013-16	Wellbeing Areas / Health Improvement Team
Link to Alcohol strategy outcomes		Detail included in alcohol action plan			

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Name of Priority: Improved Child Development

Overall Target – 2% year on year increase in children achieving a good level of development at age 5 (Baseline 2011 – 49.9%)

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Antenatal

Outcomes	Targets		Actions	Timescale	Lead
Improved parenting skills	100% of expectant parents will have access to a session on parenting	CD1	Review current provision of existing programmes Delivery of antenatal session on expectations of parenting	Overview of current service by June 2013 April 2014	Health Improvement Team Midwifery Service
Improved ante-natal health	90% women have seen a midwife by 12 weeks and 6 days of pregnancy	CD2	Design targeted/specific antenatal classes, to attract vulnerable families Timely GP referral to community midwifes to ensure early booking	Monitor quarterly June 2013	Midwifery Service CCG
Improved early detection and treatment of maternal depression	100% of women screened for mental health issues at booking appointment 100% of women offered	CD3 CD4	Determine if current pathway is in line with national evidence and guidelines for detecting depression, including ensuring women who book in late are screened Monitor screening rates	September 2013 Ongoing	Midwifery Service

Outcomes	Targets		Actions	Timescale	Lead
	screening at home antenatally, targeting uptake in high risk women				
To reduce risks associated with vulnerable socially excluded women.	Establish a targeted programme to support vulnerable women.	CD5	Midwives produce Individual care plans for vulnerable women to reduce risk and minimize harm. Explore the Commissioning of Family Nurse Partnership, a targeted programme to support young mothers Explore Evidence for families needing additional support but who are not eligible for family nurse partnership Midwives link with Speech and language therapy to implement "talk to bump"	Ongoing development, all elements available by March 2014 On-going 2013-14 June 2013 March 2014	Midwifery Service Public Health Health Visitors Midwifery Service
Increased opportunities for antenatal access to health visitors available to assess risk and improve outcomes	100% parents to be offered antenatal contact from health visiting from March 2015 (staged increase)	CD6	Universal antenatal contact from Health visitors All staff to be trained in motivational interviewing.	Year on year increase to March 2015 March 2014	Health Visitors
Reduce smoking in pregnancy to improve maternal and child health, and reduce infant hospital admissions.	Reduce number of women Smoking at the time of delivery by 2% per annum	CD7	Continue Antenatal incentive scheme	Ongoing	Midwifery Service
	100% of women and their partner who smoke are offered smoking cessation	CD8	Follow the smoking and pregnancy pathway	Sept 2013	Health Improvement Team

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Birth and postnatal care

Outcomes	Targets		Actions	Timescales	Lead Officer
Improved infant- mother bonding	100% health visitors trained	CD9	Training for staff to promote responsive parenting with new parents.	August 2013	Health Visitors
	100% new parents receive new birth visit	CD10	New Birth visit offered to all families	June 2013	Health Visitors
			Review of services to support attachment disorder	Jan 2014	Health Visitors / Public Health
Improved breastfeeding support, initiation and bonding	Achieve Baby Friendly Initiative stage 2 by March 2014	CD11	Put in place all actions to achieve UNICEF Baby friendly initiative stage 2, and subsequently stage 3	Nov 2013 (stage 2)	Health Improvement Team
	Increase breastfeeding initiation and at 6-8 weeks by 2% year on year	CD12	GPs complete online breastfeeding training	Available from Sept 2013	CCG
Earlier detection and management of Post Natal Depression to improve attachment	90% of women screened at 6-8 weeks	CD13	Measure the number of women screened and supported, and patient outcomes	On going	Health Visitors
			Review pathway against NICE guidelines	March 2014	Health Visitors / Public Health

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Early years and Preschool years

Outcomes	Targets		Actions	Timescales	Lead Officer
Early detection and support to improve physical and emotional health and wellbeing	All eligible staff have access to training in 'Every contact counts' and Healthy child programme	CD 14	Training for staff in every contact counts for children's services Promotion of healthy child programme across child and family workforce in Halton to improve signposting Terrific Two's and Positive Play available in all Children's Centre	Ongoing March 2014 By Sept 2014	Health Improvement Team / Health Visitors Health Improvement Team / Health Visitors
	95% of participating settings gain Healthy early years (HHEYS) accreditation	CD 15	Continue and improve consistency in HHEYS accreditation and target new settings Provide training on weaning to parents	June 2013 Ongoing	CYP Services / Health Improvement Team Health Visitors
Improved child development and preparation for school	100% children receiving 2-2 ½ year review	CD 16	Child development training for child and family workforce across Halton (including early years settings)	March 2014	CYP Services / Health Visitors
	Health professionals collocated in children's centres	CD 17	Co-location in 2 children's centres Development plan for further centres	Sept 2013 March 2014	CYP Services
	Increase number of 2 year placements in line with national requirement	CD 18	Increased number of vulnerable 2 year old early years places	December 2013	CYP Services

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	Rolling programme of Speech and Language training available to Early Years Workforce	CD 19	Speech and Language training to early years workforce	Ongoing	SLT Service
	Pilot Integrated reviews in 4 settings	CD 20	Health visitor and Early years provider conduct the child's 2 year review together. Roll out wider if indicated	June 2013	CYP Services / Health Visitors
	100% early years staff competently track child's development	CD 21	Provide training, and support to settings to track child's development	Ongoing	CYP Services
Improved school readiness	Children achieving a good level of development at age 5 improve by 3% points from 2012 baseline of 55%	CD 22	Commission universal SEAL (Social and emotional aspects of learning programme) Deliver Letters and Sounds; mark making and engaging boys training	Sept 13 Ongoing	Children's Trust CYP Services
Increase in MMR immunisation rates	95% of children received 1 dose of MMR by 24 months	CD 23	Ensure Department of Health childhood immunisation targets are met.	Sept 14	NHS Commissioning Board / Public Health

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Name of Priority: Reduction in the number of falls in Adults

Overall Target – 5% annual reduction in hospital admissions as a result of falls (Baseline 2011/12 – 2,962/100,000)

Adulthood (25-64) Older People (65+)					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead Officer**
Reduction in hospital admissions due to falls	5% annual reduction in hospital admissions as a result of falls (Baseline 2011/12)	F1	Increase the number of people who access the Falls service by 5%	By 1st April 2014	Falls Steering Group
	10% increase in the number of people accessing falls services (2011/12 baseline)	F2	Increase the number of people discharged from the falls service who access low level prevention services by 10%.		
	Decrease the number of repeat fallers by 5% on discharge from the falls service	F3	Increase number of people accessing community services on discharge from hospital by a minimum of 10%		
Reduction in the number of readmissions to hospital due to falls	5% annual reduction in hospital readmissions due to falls. (Baseline 2011/12)	F4	Increase the number of people who have been admitted to hospital as a result of a fall who are subsequently referred to the falls service by 10%	By 1st April 2014	Falls Steering Group
Reduction in the risk of falls at home amongst	5% annual increase in the numbers of people,	F5	Increase the number of people who access the Falls prevention service from 93 per year to 200 per year	By 1st April 2014	Falls Steering Group

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older people	at risk of falls, accessing prevention services (Baseline 2011/12) 10% annual increase in falls screening completed (Baseline 2011/12) 20% increase in the number of providers using the Falls Risk Assessment Tool (FRAT)	 F6 F7	Provide falls awareness sessions twice yearly for --- number of Older People Introduce whole system screening for people at risk of falls Targeted approach to those GP practices with higher incidences of falls. Specific training developed relating to the Falls Risk Assessment Tool (FRAT)	 1st April 2013 September 2013 March 2014	
Improved access to falls services	Redesign and implement the new service by 2013/14	F7	Develop a falls strategy for Halton. Review the falls pathway for people who have fallen Review the falls pathway for people at risk of falls. Implement performance management system, across all falls services. Review access and range of falls prevention services Review age criteria for access to the falls service Develop a business case for additional resources for falls prevention services.	April 2013 April 2013 April 2013 September 2013 June 2013 April 2013 June 2013	Falls Steering Group
Reduction in the number of people in care homes who experience a fall	5% annual reduction in recorded falls	F8	Develop robust data collection methods Carry out provider forum awareness raising Identify specific training for providers to support their individual needs.	August 2013 Sept 2013 Dec 2013	Falls Steering Group
Reduction in the severity of fall related injuries	5% annual reduction in number of fractured neck of femur's. (current baseline 499 per 100,000 people)	F9	Increase in the number of Exercise / balance programmes to six per year Develop and implement specific training programmes around the needs of different providers	April 2014 April 2014	Falls Steering Group
Increase in the number of	Provide initial training	F10	ROSPA accredited training for 20 frontline staff	January 2013	Completed

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frontline staff who receive specialist falls training	to 20 frontline staff		Increase provider training sessions to raise awareness of the risk of falling from 2 sessions to 5 sessions per year. Train 50 frontline staff in identifying the risk of falling	March 2014 March 2014	Falls Steering Group

Name of Priority: Reduction in the harm from Alcohol

Overall objective – 2% reduction in rate of increase of admission episodes for alcohol-attributable conditions (Baseline - (2011/12) – 2836.7/100,000)

Pregnancy & Early Years					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead**
Increase awareness of effects of alcohol on children, families and the unborn child. **Reduction in the numbers of people drinking to harmful levels**	The provision of a concentrated campaign aimed at new and prospective parents. All Midwives (20-30), Health Visitors (20), (Early Years Intervention workers, front line Children's Centre Staff to be identified) provided with information and training/update training on alcohol IBA.	A1 A2 A3	Develop series of messages for new parents, prospective parents and pregnant women to include: • Alcohol consumption and pregnancy • Alcohol and safety – accidents, co-sleeping, etc. • Alcohol and domestic violence • Foetal Alcohol Spectrum Disorder (FASD) Midwives / Health Visitors to be trained in identification and brief advice (IBA) for alcohol including when and how to refer to local support. Appropriate Early Years Intervention Workers and Children's Centre Staff to be trained in identification and brief advice (IBA) for alcohol including when and how to refer to local support.	By End March 2014 By End March 2014 By End March 2015	Health Improvement Team Health Improvement Team Health Improvement Team

School Age

Reduction in the number of people drinking to harmful levels	The provision of a concentrated campaign aimed at education staff, school age children and their families.	A4 A5	Explore opportunities through the curriculum and creative social networking. Areas of particular relevance to include: - Raise profile of national campaigns e.g. “talk to Frank”. - Proactive Campaign on School Help Advice Reporting Page (SHARP). - Delivery/expansion of ‘’Healthitude’ programme - Expand ‘Teen Drop Ins’ in Schools and outreach sessions including VRMZ outreach bus across Halton. - Develop work to target alcohol education work at those most at risk(e.g. NEETs, PRUs, etc.)	By End March 2014	Health Improvement Team, Young Addaction, School Nursing Service, CYP Team
	All frontline School Nurses (~30), (Youth Workers, Youth Offending staff to be identified) are offered information and training/update training on alcohol IBA. (70% uptake)		People who work with children will be trained to: recognise when children exhibit signs of either personal or parental alcohol misuse; deliver holistic screening; provide alcohol IBA; signpost appropriately.	School Nurses/ YOT by end March 2014, Other staff by end March 2015	Health Improvement Team
	20 Police Community Support Officers and 20 Special Constables trained in alcohol IBA.	A6	Expand the training programme for the Police to include all Community Safety Team staff in Halton to deliver holistic screening and alcohol IBAs and the development of an appropriate monitoring system.	By End March 2014	Health Improvement Team
Reduction in the rate of alcohol-related admissions	20% Increase in the number of IWST referrals from Adult Treatment Service.	A7	Further develop access to and the impact of specialist treatment by utilising IWST process and ensure multi-agency action planning for all young people in specialist service affected by their own or parental alcohol misuse.	By End March 2014	Integrated CYP Commissioners
	Develop data collection for local A&E and/or Alcohol liaison service data to include repeat admissions/attendance	A8	Review, improve and develop system to monitor pathways into community services for young people attending A&E and Acute Wards in hospital with alcohol related harm.	By End March 2015	Integrated CYP Commissioners

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	Increase in range of agencies referring and using screening protocols from universal, targeted and specialist youth services as a measure of increased awareness of systems.	A9	Further embed referral and screening protocols across universal, targeted and specialist treatment services, within the framework of Integrated/Targeted Youth Support. - Provision of updated information and protocols to all relevant organisations. - Monitor awareness of systems and protocols via number of referrals, range of services etc	By end March 2014	Integrated CYP Commissioners
Reduction in the level of social disruption and harm due to alcohol consumption	Maintain current test sales protocols and related enforcement / educational activity and expand to include 'test sales' against Challenge 25 campaign.	A10	Maintain Trading Standard activity around alcohol Test Sale purchases and appropriate vendor education and enforcement activity as required. Incorporate additional 'test sale' purchases to test current adoption and application of Challenge 25 campaign.	By End March 2015	Trading Standards (TS)
	Development and implementation of monitoring tool to measure Operation Staysafe activity and outcomes.	A11	Operation Staysafe will continue to operate, identifying, offering advice and removing vulnerable school age children to a place of safety and referring to appropriate agencies. A tool will be developed to monitor activity and follow up outcomes against individual referrals.	By End March 2014 and on-going	A&C, CST, CYP, PHMA, DG, JB
	Evidence of a robust Halton response to the National Alcohol Consultations and other key Government policies and initiatives.	A12	Work with partners to influence the Government and other key decision makers in relation to issues such as cheap alcohol and irresponsible promotions and advertising.	On-going	Public Health

Young Adulthood (16-24)					
Reduction in the number of people	The provision of a concentrated	A13	Develop a series of age specific messages and campaigns to address alcohol harm and other risk taking	End September 2013	Health Improvement

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drinking to harmful levels	campaign aimed at young adults between the ages of 16 and 24. An increase in the local awareness of young adults on how they can access support and information. All frontline Children's Social Care (~60) provided with information and training/update training on alcohol IBA	 A14 A15	behaviours. Monitor local services activity and contact as a proxy for measuring increased awareness amongst the young adult population. Children's Care Social Workers to be trained in identification, holistic screening and alcohol IBA. - Identify appropriate Looked after children Staff and college pastoral care staff and extend training to these staff groups.	 By End March 20 Looked After Young People Staff by end March 2014, other staff By End march 2015	Team Integrated CYP Commissioners Health Improvement Team
Reduction in the rate of alcohol-related hospital admissions	Develop data collection for local A&E and/or Alcohol liaison service data to include repeat admissions/ attendance (create baseline to measure future reduction)	A8	Review, improve and develop system to monitor pathways into community services for young people attending A&E and Acute Wards in hospital with alcohol related harm.	By end March 2015	Integrated CYP Commissioners
Reduction in the level of social disruption and harm due to alcohol consumption	Reduction in alcohol related crime/ASB in Night Time Economy Hotspots Adoption of the Purple Flag Principles.	A16 A17	Define appropriate methodology for measuring alcohol related crime and pathways for reporting in order to assess activity and set reduction target Work with local business and key stakeholders to continue to develop local action plans to reduce alcohol related harm within Halton's Town Centre and the local Night Time Economy. - Ensure that all street pastors who work in the	End March 2014 By End March 2015	Community Safety Team Adults and Communities & Public Health Community Safety Team Adults and Communities,

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		A18	night time economy are adequately trained to give brief alcohol advice and signposting information to wider alcohol services. Development of a multi-agency working group to support the adoption of the Purple Flag Principles.	 By End March 2015	Health Improvement Team & Public Health Community Safety Team Adults and
Healthy Adulthood (25-64)					
Reduction in the number of people drinking to harmful levels	Reduction of in proportion of adults drinking to harmful levels by 0.44% from baseline (2009	A19 A20	Develop a series of messages and campaigns for adults and ensure that they are disseminated through the most appropriate mediums Develop dedicated activities to support the promotion of	By End March 2014 March 2014	Health Improvement Team & Public Health Health
	synthetic estimate 6.44%) Reduction in proportion of adults who binge drink by 1.4% baseline (2007/08 synthetic estimate 22.7%)		Alcohol Awareness Week. *National synthetic data update available*	 *August 2014*	Improvement Team
Reduction in the rate of alcohol-related hospital admissions	100% of GP Practices in Halton to be provided with updated information and Training alcohol IBA Liver Disease Pathway is in place across primary and secondary care & specialist treatment services	A21 A22 A23	All 17 GP practices (to include GHPs, Practice Nurses, Health Care Assistants and co-located allied health professionals) are to be trained in alcohol IBA. Ensure that the community treatment service (CRI) is successfully embedded within pathways and meets local needs and that prevention strategies are in place for alcohol related liver disease. Embed a 'whole family approach' into CRI services: • Delivering/facilitating access to interventions to improve relationship and parenting skills • The identification of young carers • Develop local integrated treatment provision for	All GP Practices by end March 2014 By End March 2014 By End March 2014	Health Improvement Team Adults and Communities & Public Health CCG, Adults and Communities & Public Health

	Development of a full family support strategy (to support A7 activity).		families who need help to address alcohol related challenges and break the cycles of harm. This includes families identified as part of the Inspiring Families Project. • Review inpatient treatment services for people with intense need. (The Windsor Clinic - Mersey care). Robust pathway in place and effective demand management.		
	Phase 2 of Whiston A&E Alcohol Liaison Nursing Scheme implementation to manage repeat attendees (contributes to a 33% reduction in the number of admissions from the Frequent Attendee cohort).	A24	Support the full implementation of the A&E Alcohol Liaison Nursing Scheme to include identification and management of regular attendees to hospital for alcohol related harm.	By End March 2015	CCG & Public Health
Reduction in the level of social disruption and harm due to alcohol consumption	Reduction in the harm caused by alcohol to individuals and others by using repeat Section 27 (S27) notices and Police IBA interventions. - 100% of S27 notices will be followed up with an appropriate health intervention. Reduction in alcohol related crime/ASB in Night Time Economy Hotspots (cross ref A16)	A25 A26	Offers of support to parents under pressure or families with additional needs (including families who have come to the attention of the criminal justice system, through issues for example domestic violence) will also encompass alcohol treatment within that support if appropriate. Maximise forthcoming changes in licensing law to address problem premises and exploring processes for informing licensing decisions. - Roll out Arc Angel accreditation to premises running business in a well-managed way. - Maximise opportunities that arise from information sharing with local A&E departments.	By End March 2015 By End March 2015	Community Safety Team Adults and Communities, Health Improvement Team & Public Health

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Older People (65+)					
Reduction in the number of people drinking to harmful levels	The provision of a concentrated campaign aimed at adults over the age of 65.	A27	Develop a series messages and campaigns for older adults and ensure that they are disseminated through the most appropriate mediums. Areas of particular relevance to include: • Alcohol and Falls • Alcohol and Mental Health	By End March 2014	Health Improvement Team
Reduction in the rate of alcohol-related hospital admissions	All appropriate Home Care Staff are provided with updated information and access to training on signposting and brief interventions.	A28	Appropriate front-line Home Care professionals to be identified and offered training in screening and alcohol brief advice (IBA).	By End March 2015	Health Improvement Team

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Name of Priority: Prevention and early detection of mental health conditions

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

Pregnancy and early years					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead Officer**
Detection and treatment of maternal depression	100% of women screened at home antenatally at 36 weeks	M1	Determine if current pathway is in line with national evidence and guidelines for detecting depression Monitor screening rates	September 2013 Ongoing	Midwifery Service Midwifery Service
Detection and management of Post Natal Depression to improve attachment	90% of eligible women screened at 6-8 weeks	M2	Measure the number of women screened and supported, and patient outcomes Review pathway against NICE guidelines	On going March 2014	Health Visitors Health Visitors / Public Health
Improved support for families in dealing positively with toddlers	Borough-wide availability of specific programmes and activities in Children's Centres	M3	Terrific Two's and Positive Play available in all Children's Centres	By 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	M4	Getting it Right with Families training delivered to first cohort of 16 practitioners	By March 2014	CYP Services

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School age children					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead Officer**
Improved mental wellbeing of school-aged children	Early identification and support for children who are potentially more vulnerable to developing mental health problems	M5	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	September 2013	Primary Care Mental Health Team
	Reduce levels of sexual exploitation and improve self-esteem and confidence	M6	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	September 2013	Primary Care Mental Health Team
			Develop resources and packs for teachers on gender, identity, confidence and aspirations	January 2014	CAMHS team
	Reduce levels of cyber bullying	M7	4 sessions per annum on anti-cyber bullying training and materials for front line staff, teachers and school nurses.	September 2013	Health Improvement Team
	Improve healthy eating and reduce levels of obesity	M8	Enrol all schools on Healthitude programme which covers healthy eating, drinking, tobacco and drugs.	June 2014	Health Improvement Team
			Review school nurse provision and develop new school nurse specification to include social and emotional health outcomes.	June 2014	Public Health
	Emotional wellbeing of looked after children (PHOF, Placeholder)	M9			
	Increased promotion and use of materials within schools about the importance of emotional health and well being	M10	Develop information packs and resources on the impact of change on social and emotional health of children for front line staff	September 2013	Health Improvement Team
			Refresh CAYP EWB Strategy and Implementation plan Implement recommendation of HNA of children & young people's emotional wellbeing	December 2013 March 2014	Integrated CYP Commissioners
			Agree final recommendations from the Looked After Children's needs assessment and implement.	September 2013	Integrated CYP Commissioners

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			Support for children living with parents/carers who have mental health, alcohol or drug problems. Expansion of Healthitude Programme in schools which includes: • Drug and alcohol • Relationships • Peer Pressure • Sexual Health • Exam Stress • Local services on offer	Ongoing September 2013	All Health Improvement Team
Improved support for children and young people experiencing mental health problems	CAMHS needs assessment refreshed And CAHMS Strategy developed	M11	Refresh the CAMHS health needs assessment to reflect current Halton data (needs to feed strategy review detailed above) Develop new CAHMS Strategy & Action Plans Review Tier 2 CAMHS provision Ensure staff are able to meet the needs of Children and Young People with both a mental health and learning disability need.	July 2013 2013 Within 2013-14	Public Health Integrated CYP Commissioners Integrated CYP Commissioners
Few people suffer avoidable harm	A&E attendance Reduction in hospital admissions due to self-harm <18 years of age	M12	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 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	June 2013 June 2013	Integrated CYP Commissioners Health Improvement Team

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Adulthood (16-64)					
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead Officer**
More people will have & maintain good 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.	Reduce number of first time entrants into the Youth Justice System (PHOF) Baseline: Increase in self-reported wellbeing (PHOF) Reduce unemployment, including youth unemployment and long-term unemployment Increase access to green space Reduction in admissions due to alcohol and drugs, including reduced inequalities	M13 M14 M15 M16 M17	Implement recommendations from the health needs assessment of young offenders Implement recommendations from the HNA on adult mental health and wellbeing Implement recommendations of the Health impact of the economic downturn report from Liverpool Public Health Observatory	2013 2014 2014	Integrated CYP Commissioners Public Health CCG Adults and Communities
Improved information and support available to help young people maintain positive mental health	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	M18	Insight work carried out. Messages developed and disseminated. Measure use as much as possible e.g. website visits Information distributed throughout the borough	September 2013 December 2013	Health Improvement Team

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Early identification of for 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.	GP Practices support patients to access local services and facilities, use self-help tools, access training and participate in the local community 50% of practice staff participating in the initiative will undertake brief intervention training re: wellbeing Increased referral of 20% into community based services An agreed % of the practice population of those practices involved will report improved wellbeing levels using SWEMWBS before and after interventions	M19 M20 M21 M22	Rollout of the Community Wellbeing Practice Initiative GPs and primary care staff will be encouraged to use non-medical initiatives where appropriate for those with mild mental health issues eg. social prescribing Expansion of social prescribing services e.g. access to CAB, books on prescription, access to self-help website. Training for GP Primary Care staff on how to recognise mental health conditions and early non-medical treatment.	Rollout from April 2013 Commissioner will performance manage provider at quarterly contract meetings against agreed KPIs September 2013	Halton CCG/ Wellbeing Initiative/ evaluation support from Public Health Health Improvement Team
Improved access and availability of psychological therapies.	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	M23 M24	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	Tender timetable to be developed in 13/14 and timescales then set Monthly contractual reporting of	CCG

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	therapies for people with severe mental illness and long-term health problems		problems.	current contract will happen in tandem with tender exercise	
More people will recover	Pre and post treatment outcome data (PHQ9 & GAD7)on over 90% of all patients who start treatment.	M25			
Few people suffer avoidable harm *(this relates to all adults)*	Self harm: see previous section Reduction in suicide rates (PHOF) Baseline:	M26	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.	Through the year until review (below) is complete Review complete by September 2013	Health Improvement Team Public Health Health Improvement Team

Older People (65+)

Outcomes	Targets		Actions	Timescales	Lead Officer
More people will have good mental health	Reduction in the number of lonely older people.	M27	Work with Public Health England to scope suitable projects for Halton. Review health improvement services for older people that link them to community activities. E.g. Reach for the Stars.	2013 2013	Public Health Public Health

	Reduction in the number of older people with low to moderate mental health conditions in Care Homes and for those that receive domiciliary care.	M28	Implementation of Guidelines in How to Identify Treat and Refer Older People with Low to Moderate Depression in Care Homes and for those that receive domiciliary care.	2013	Health Improvement Team
Improved integration of services and support for people with dementia	Review of dementia strategy Completion of carers strategy Evaluation of the Later Life and Memory Service pathway completed	M29 M30 M31	Final sign off through Mental Health Partnership Board Final sign off through the Health and Well-being Board 6 month evaluation report signed off	May 2013 April 2013 October 2013	Adults and Communities Adults and Communities Adults and Communities

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Agenda Item 8

REPORT TO: Health and Wellbeing Board

DATE: 17 July 2013

REPORTING OFFICER: Strategic Director Children and Enterprise

PORTFOLIO: Children, Young People and Families

SUBJECT: Children in Care of Other Local Authorities (CICOLA's)

1.0 PURPOSE OF THE REPORT

1.1 To present an update report regarding the current numbers of Children in Care of Other Local Authorities (CICOLA's) and the possible impact on services with Halton.

1.2 To assess within the context of neighbouring local authorities the numbers of Residential Children's Homes operating within Halton, the types of these services and the potential financial impact on the borough.

1.3 To offer an update regarding ongoing works developments in this area.

2.0 RECOMMENDATION: That

1. **the content of the report is discussed and comments invited; and**
2. **further work is undertaken to get a more accurate picture on how many CICOLA's reside in Halton, ensuring that the procedures around notifications of CICOLA's are appropriately utilised.**

3.0 SUPPORTING INFORMATION

3.1 At any time there are a total of around 60,000 children that are looked after in the UK – this represents 0.5% of all children. Over the course of any year a total of 85,000 children will spend some time being looked after. Nationally 40% of children remain looked after for less than 6 months with 15% being looked after for 5 yrs or longer.

3.2 Local authorities have statutory duties in determining the most appropriate placement for a looked after child.

3.3 For a variety of reasons, for example type of specialist provision required, availability of specific services to meet the young persons needs locally, the young person could be placed out side of the local authority that they lived in.

4.0 THE NOTIFICATION PROCESS

4.1 The current notification process for authorities is that the placing social worker should notify the new authority with a notification form. Although this is mandatory and expected there have been instances where this has not been completed. Instances where it is recognised that there has been a delay or lack of completion then the Local Authority Designated Officer (LADO) will be informed to ensure a complaint is returned to the local authority raising safeguarding concerns.

4.2 The LAC nurse currently provides the local authority a monthly update of the list. The Looked after Child Nurse should also implement an initial health assessment. This is required to be completed within 2 weeks of a child's placement.

4.3 To improve the accuracy of the list Halton Borough Council have also developed a provider forum where all the providers are asked to complete and return when CICOLA's arrive into the borough. The process is repeated when the child leaves the placement and is discharged from the provision.

4.4 The Clinical Commissioning Group (CCG) will also be engaging the GP's within this process and encouraging the GP's to complete a notification to the local authority.

4.5 Further work is being implemented to ensure all children are accounted for and attend appropriate educational provision.

4.6 A request has also been made regionally to ascertain if there are good examples of maintain accuracy of an integrated list. There has been no positive feedback at the moment. The government are consulting on a new policy to be launched later this year 'Reforming children's homes care' and 'Improving safeguarding for looked after children'. This policy will have three functions with one of them being to improve the notification process:

1) Prior to a new provider opening a Children's home a risk assessment will be completed between the police, local authority and the new provider which will inform Ofsted in relation to registering the provider /provision and refusing

2) The provider will notify the local authority when a young person is new to the placement and area as well as when they leave.

3) Improve provider standards in preventing child sexual exploitation.

4.7 It is acknowledged that despite the new consultation Halton borough Council and its partners need to work together to improve the notification process. There are further improvements required which will improve the accuracy of the list:

1) To focus on just Halton children and young people as currently St Helens children and young people are still on the list.
2) To have separate sheet/section for end of placement/children leaving Halton (To include where have they gone to.
3) To have mandatory start date of the placement
4) The CCG have also stated that they would want date of initial health assessment completed onto list
5) To have the child's current school placement included onto the list
6) To have when the child leaves the placement

To support this the CCG are completing an audit to quality assure the information received by the specialist looked after nurse.

From a table by the Specialist Nurse (specialist nurse caseload only)

1. Length of time from receipt of notification to receiving records from the placing authority
2. The authority placing the young person
3. If the team was not notified, how did the team find out?
4. Did the placing authority send a copy of the care plan or discuss verbally the needs of the young person?
5. Did the placing authority request a health assessment?
6. Did the young person have unmet health needs on arrival? What were they?
7. Length of time from notification received to specialist nurse visiting

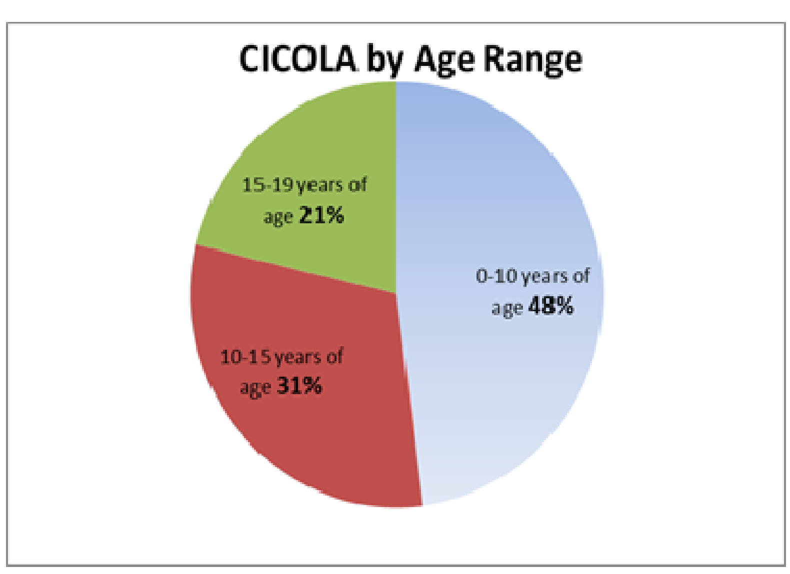
5.0 CICOLA PROFILE

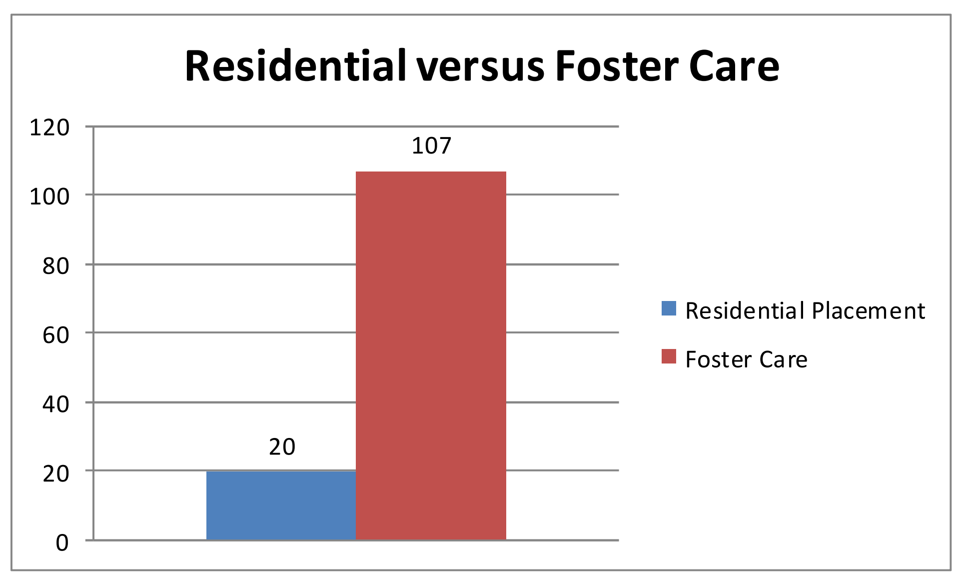
5.1 Below is an attached table demonstrating where the numbers of children are predominantly coming from. There are currently 138 Children on the CICOLA list (11 of these have an unknown address). It is not known where 7 children have come from. Recent work with the Clinical Commissioning Group (CCG) has led to the development of a joint CICOLA list.

5.2 The main referrer into the borough is Liverpool followed by Knowsley. It is worth noting that there has been a significant reduction of CICOLA's moving into Halton from boroughs many miles away.

Placing Local Authority	***Age of child 0-10***	***Age of child 10-15***	***Age of child 15-19***
Knowsley	12	1	2
Manchester	1	1	2
Liverpool	26	10	7
St Helens	4	0	0
Wakefield	1	0	0
Essex	0	1	0
Warrington	3	5	2
West Yorkshire	1	0	0

Lancashire	2	0	2
Shropshire	0	0	2
East Berks	0	0	1
South Staffordshire	1	0	0
Huddersfield	0	1	1
Buckinghamshire	0	0	1
Cheshire East	2	2	1
Wirral	2	0	1
South Devon	0	1	0
Leeds	1	0	2
Sefton	0	3	0
Blackburn/Darwin	0	1	0
London	0	0	2
Oxford	0	1	0
Rochdale	1	0	1
Birmingham	0	0	1
Aylesbury	0	0	1
Salford	0	1	0
Wigan	0	3	0
Oldham	0	2	0
Wakefield	1	0	0
Derbyshire	0	0	1
Brent	0	0	1
Telford and Wrekin	0	1	0
Cheshire West and Chester	2	1	1
Wolverhampton	0	0	1
Total	**60**	**38**	**33**





6.0 OFSTED rating of Children's Homes in Halton (31st March 2013)

6.1 There was a total of 12 external agency childrens homes operating in the borough – this represents a reduction of 3 homes within the last 18 months . In total this means that there were a total of 22 placements (beds) which represents a reduction of 11 beds in the last 18 months This reduction represents a home reduction of 20% and a bed reduction of just over 33% in the last 18 months – this has primarily been due to the Commissioning Manager working with colleagues from the Planning section to confirm providers have appropriate permissions , sharing information with local providers regarding Haltons requirements as well as close links with the Missing From Care service , Police , YOS and the sharing of qualitative information with placing local authorities

6.2 During this time Halton were also in direct discussions with OFSTED Inspectors for the local homes and shared some of the consistent practice issues (for instance young people being placed into local homes in the early hours of the morning , young people being moved from other homes at significant distance within the same organisation) The market reduction is highly favourable given that during this same time period there was a 10% increase in both the number of childrens homes Nationally and in the North West located homes as well as in the number of beds Currently 25% of the National childrens homes sector is based within the North West For information during this period North West authorities have regionally reduced the number of Residential placements by approximately 10% - this

means that the gap between the number of placements used in the North West by the North West authorities and the available resources is widening potentially meaning that other local authorities will be impacted by the number and type of CICOLAs being placed in local resources Of the homes currently in the borough 9 are rated by OFSTED (last full inspection) as good and 3 are rated as satisfactory.

7.0 Placement Provide Forum – including an update in relation to attendance, the themes covered and consideration of thematic meetings across Halton, St Helens and Warrington.

7.1 The placement provider forum has continued to meet on a quarterly basis having been instigated in January 2011.
All providers of Residential , Fostering and Leaving Care services both located in Halton as well as all providers being used for the placements of Halton young people at the time Attendance has improved continues to be good Any non attendance without apologies being received is followed up by the Commissioning Manager direct with the agency Future meetings will have to be rebooked in a larger venue due to the increase in attendance

The standing item themes that have been

CICOLA notifications
Missing from care
CSE / Safeguarding updates
Training events
Safer workforce group feedback

The thematic agenda items have included

Parent and carers engagement
Smoking ceasation
Role of LADO
Healthy placements pilot
Placements North West update
Restorative justice
Youth provision
Risk assessing / missing from care

7.2 Feedback from the providers has been positive in terms of the usefulness of the forum and also the networking opportunities that it provides In July 2012 a joint placement provider forum took place with St.Helens , the purpose of this was to consult providers in relation to the Healthy Placements pilot that Halton and St.Helens are leading on , again written feedback from this event was positive .

7.3 Discussions have taken place with colleagues from St.Helens and Warrington in relation to possible future joint provider forums taking place whilst maintaining each local authorities priorities or unique market position . Providers have also voiced that a forum led by Halton would be their

preferred option to avoid duplication – this discussion will continue however there has recently been some changes in personnel in Warrington and reallocation of tasks within St.Helens which has led to some delay The provider forum planned for 10th April 2013 had to be cancelled due to staff sickness (SM) but information was shared “virtually” to provide an update The next provider forum will take place on 10th July 2013 and will cover a reminder of “Colins Case” including actions taken and feedback from a provider representative attending the CSE launch event taking place on 28th June 2013 along with the standing items

8.0 POLICY IMPLICATIONS

There are no policy implications

9.0 OTHER IMPLICATIONS

No other implications

10.0 IMPLICATIONS FOR THE COUNCIL’S PRIORITIES

11.0 Children and Young People in Halton
There needs to be further work undertaken to identify the impact of CICOLA’s on Children’s Services within Halton.

12.0 Employment, Learning and Skills in Halton
There needs to be further work undertaken to identify the impact of CICOLA’s on future Employment and Learning Services within Halton.

13.0 A Healthy Halton
There needs to be further work undertaken to identify the impact of CICOLA’s on Health Services within Halton.

14.0 A Safer Halton
There needs to be further work undertaken to identify the impact of CICOLA’s on Criminal Justice Services within Halton.

15.0 Halton’s Urban Renewal
There needs to be further work undertaken to identify the impact of CICOLA’s on future housing demands within Halton.

16.0 RISK ANALYSIS
A risk analysis will need to be undertaken as part of the ongoing work around CICOLA’s

17.0 EQUALITY AND DIVERSITY ISSUES

The nature of this work is to support equality and diversity

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

None under the meaning of the Act

Agenda Item 9

REPORT TO:	Health & Wellbeing Board
DATE:	17th July 2013
REPORTING OFFICER:	Children & Enterprise
PORTFOLIO:	Children, Young People and Families
SUBJECT:	Domestic Abuse services for Children, Young People and Families
WARD(S):	Borough –wide

1. PURPOSE OF THE REPORT:

1.1 To inform the board of commissioning process, timeline and main elements that will encompass the new Domestic Abuse services in Halton for children, young people and families.

2. RECOMMENDATION THAT:

1. **the report be noted;**

2. **agree to the service delivery approach outlined within the attached draft service specification;**

3. **children's services support Communities directorate in the re-commission of Haltons Domestic Abuse Services; and**

4. **endorse the approach that other services supporting the hidden harm and domestic abuse agenda adopt were viable the main elements required around child safety planning.**

3. SUPPORTING INFORMATION

3.1 Commissioning in Halton is shaped by both national policy and guidance and the local need to improve outcomes for children, young people and families. The focus of commissioning is to ensure that it is coherent and effective; delivering cost effective services that promote good outcomes for children, young people and their families.

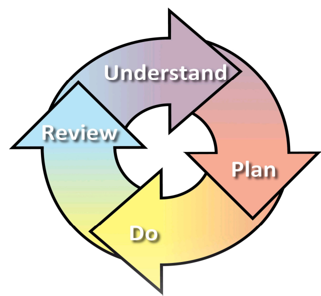
3.2 The commissioning cycle encompasses:

- a strategic needs assessment – engaging with children and families, understanding their needs and taking a sophisticated approach to the use of data
- planning and service design – identifying what services need to be put in place to promote preventative solutions, and how to develop holistic services which can address the totality of each child's needs

- deciding on how to deliver and with whom– identifying which organisations are well placed to deliver services and contracting, or putting service level agreements in place so that all parties are clear about deliverables
- reviewing and challenging the fitness for purpose of services and providers and monitoring their impact on outcomes

3.3 It is a core principle within Halton that where possible we commission services to meet local needs and priorities. Commissioning can be described in four stages:

- Understand - population needs assessment and resource identification
- Plan - aligning resources to meet needs; filling gaps between needs and services
- Do - developing or purchasing services
- Review - monitoring performance and evaluating outcomes.



3.4 The generic cycle of understand, plan, do, review, correlates with the processes of needs assessment and strategic planning, shaping and managing the market, and improving performance, monitoring and evaluating.

3.5 The above commissioning principles were used whilst drawing together the relevant information for the proposal for the new Children's Domestic Abuse Service. The following steps have place over the last few months:

- Halton Domestic Abuse Forum carried out some work during autumn of 2012 to look at the impact of domestic abuse on children and young people a draft plan was produced which is due to be refreshed alongside the borough's Domestic Abuse Strategy later this year. As part of this work the Domestic Abuse and Sexual Violence Co-ordinator undertook a piece of work to map the impact of domestic abuse across the borough. (See appendix 1)
- In January 2013 the forum asked HBC adults and children's commissioning teams to meet and look at future plans for commissioning services particularly around a perpetrator programme and services for children and young people.
- In late March 2013 funding was sourced from Children's specialist budget and a lead commissioner from the Children's Commissioning team was identified to undertake research and draw together the details required for a specification for a service to support children, young people and families.

- During April 2013, a benchmarking exercise was carried out with other local authorities to determine their approach to commissioning of domestic abuse services.
- Throughout May 2013 there were some initial consultations with service providers and practitioners around their views of the current demand and need of families around domestic abuse services. This information has fed into attached draft service specification. (appendix 2)
- The procurement process has been drawn up and the main elements within the timeline are:
    - A development day at the end June to ensure as widest participation as possible and to give providers clarification on the requirements of the service
    - Evaluate tenders during early August
    - Interviews early September
    - Award contract September
    - Mobilisation period – September and October (there will be a clear implementation plan which will include staff selection, pathways, process, publications etc.)
    - Contract start date 4th November 2013
    - Contract will be 1 year with the option to extend for a further year

4. Proposal for Domestic Abuse services for Children, Young People and Families

4.1 Domestic abuse is an intractable and widespread problem. Two women per week are killed by their current or ex-partner and CAADA estimates that there are 100,000 victims at high risk of serious harm or murder. It costs the tax payer an estimated £3.9bn per year, with high risk domestic abuse making up nearly £2.4bn of this. Domestic abuse has adverse impacts on the health and wellbeing of victims, and is closely associated with child abuse and neglect, as well as a range of other social issues including homelessness and substance abuse.[1]

4.2 It is worth highlighting that Halton does have some current resources around the Hidden Harm agenda in the form of the Specialist Youth Support Service. The primary purpose of the Service is to support people to change their risk taking behaviour and to enable them to be active citizens, playing a full and meaningful part in the community. The service is open to young people 0- 19 years up to 25 years with young people with additional needs and is in place to provide a personalised, holistic approach which looks further than their risk behaviour and addresses any underlying causes or contributory factors. However there is a clear recommendation about implementation of specialist services for children and young people to tackle the issues around domestic abuse.

4.3 There will be four main elements to the new service;

[1] CAADA Insights: A place of greater safety November 2012

- Support to parents that are victims of domestic abuse which gets parents to understand the impact of domestic abuse on how they parent and how domestic abuse has an impact on the children and young people's behaviour.
- Direct work around children/ young people safety planning where the young person is still in the situation
- Longer term recovery work therapeutic approach where the perpetrator is no longer within the family.
- Support social care with pre- court proceedings process and provide information and assessments where required.

4.2 The service will work with children and young people that link into formal process such as Children in Need and Child Protection to meet individual outcomes for each child and family as part of a formal plan. However, there will be a clear link into the new Levels of Need Framework and will relate to formal process such as Common Assessment Framework and the Inspiring Families Programme to meet individual outcomes for each child and family as part of their formal plan.

4.3 The Service will support the Cheshire and Merseyside Local Authority Pre-Court Proceedings Protocol. The decision to intervene legally in a child's life and family is a significant one which will have major consequences for that child. It is crucial that any decision to do so is based on clear, evidenced-based assessment and care planning which demonstrates what attempts have been made to manage the risks and support the child to remain in their family.

4.4 The child safety plan is a key element that needs to be adopted across service areas within Halton to ensure that children and young people are clear about the strategies they can have in place to reduce risk.

4.5 Information gathered from across the country shows that children and young people had clear concerns about their own safety and that of their parents when arguments/ issues arose. A full service evaluation undertaken in Devon highlighted that there were clear gaps in children's knowledge of safety planning at the point of engagement with services and this was mirrored across other areas. Caseworkers reported that only 1 in 3 children (37%) would know how to keep themselves safe in the event of further abuse or how to get help, and half of the children reported that they did not know, or were unsure of, how to get help if they or someone they cared about felt afraid. A third were unsure of how to keep themselves safe in the event of subsequent abuse.[2]

4.6 There will be a robust performance framework that will be out in place that will measure outputs with regard to numbers coming into the service and from where, reductions in number of young people on plans etc. There will be focused outcomes that will track and monitor progress of individuals and families. These outcomes will be reinforced with the use of recognised tools

[2] Evaluation of 'best value' in Specialist Service Provision for Domestic Violence and Abuse in Devon: October 2010 to September 2011

such as Strengths and Difficulties Questionnaire (SDQ) and the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to measure Mental Wellbeing as an outcome of the interventions.

4.7 The performance framework will also make reference to the CAADA Insights outcomes measurement tool. The Insight tool evidences the outcomes that domestic abuse services have on victim safety, enabling services and commissioners to make a business case for service improvement and funding.

4.8 Progress and impact of the service will be reported into Domestic Abuse Forum, Children's Trust, Safeguarding Board and other areas as required.

SUPPORTING INFORMATION ON DOMESTIC ABUSE INITIATIVES

Perpetrator Programme

- Perpetrator programmes provide structured group work for perpetrators of domestic violence. They support perpetrators to address the attitudes and beliefs which underpin their abusive behaviour, challenge, stop and prevent further violence and hold perpetrators accountable for their violence.

- During the last few months there has been work scoping out different models for a perpetrator programme by the Domestic Abuse and Sexual Violence Co-ordinator. The Clinical Commissioning Group has agreed to fund a pilot approach for 2013 for a perpetrator programme in Halton. The pilot will be provided under a contract with Self Help who deliver current Improving Access to Psychological Therapies (IAPT) provision. Four therapists will be trained on the Government's accredited scheme, the Respect Programme. The pilot will be for a 26 week programme for 8 individuals.

- Contract reviews will pick up learning points and the programme will go into the new specification for IAPT provision next year. Progress and impact will be reported into the Domestic Abuse Forum and the Safer Halton Partnership with links back into the Children's Trust as required.

- A specification has been drafted and work is being undertaken to agree the process and pathways around the criteria into the programme.

Young People's Violence Advocacy Programme

- In April 2013 the Local Authority received information from CAADA around the Young People's Violence Advocacy Programme. CAADA is responding to the recent change in the definition of domestic abuse to include 16 – 17year olds, CAADA and partners are launching a new two year programme which aims to support local areas to develop a care pathway, integrating safeguarding and MARAC processes, for young people over the age of 13 who are experiencing a range of intimate partner abuse including domestic abuse, sexual exploitation, gangs/young perpetrators, HBV/forced marriages and cyber stalking.

- CAADA have highlighted that each local authority area must nominate one practitioner by the 1st July 2013 to benefit from this programme to be the designated Young People's Violence Advocate for each LA area. Support and training will be provided to each Young People's Violence Advocate and their local authority through five Young People's Regional Advisors, employed by CAADA.

- The intended outcomes are for each area are:
    - To improve early identification and intervention for teenagers experiencing/at risk of serious violence and abuse.

  - To improve and co-ordinate effective, flexible local support and reduce risks.
  - To use data collected by practitioners to inform service delivery locally and policy development nationally.

- It has been agreed that a Halton will have a staff member that will be on a secondment from young addaction that will sit with the Children and Enterprise Commissioning Team and will link into the new Domestic Abuse service.

PART A: SERVICE SPECIFICATION

PROVISION OF A DOMESTIC ABUSE SERVICES FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

1.0 DEFINITION OF THE SERVICE

1.1 Provision of a Domestic Abuse services for children, young people and families within Halton.

2.0 OVERALL SERVICE AIMS

2.1 To provide a specialist Domestic Abuse service which will provide information, advice and direct support to families experiencing domestic abuse ensuring a co-ordinated approach for families.

2.2 To provide a service that gives children and young people who have lived/ or are living with domestic abuse opportunities to share their feelings in an environment which is safe.

2.3 To work directly with parents to reduce the impact of domestic abuse on parenting capacity, helping them to understand and address the impact on the child's behaviour.

2.4 To improve the safety and wellbeing of children, young people and families by reducing the incidents of domestic abuse for those that access the service.

2.5 To promote the development of positive relationships, within a safeguarding framework.

2.6 To work in partnership with children and young people and their families, carers and other professionals.

2.7 To work alongside the development of the Inspiring Families (Troubled Families Programme).

3.0 VALUES

3.1 To respect each child's and young persons' own stage of development and facilitate their progress towards improving their own safety and achieving their individual potential, whilst offering guidance to enable informed choices.

3.2 To deliver a service to all children, young people and families in a non-discriminatory manner.

3.3 To ensure that children and young people have support to access the same opportunities as other young people and are able to develop their aspirations for their future.

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4.0 SERVICE DELIVERY

4.1 The Service will adopt a flexible working approach to service delivery to ensure that the service is child / young person/ family led and is in the interests of individuals and families accessing the service and delivered to meet the needs of individual service users. This service will operate out of hours in addition to providing the service during the normal working week.

4.2 The Service will provide a range of programmes, interventions and activities that are delivered by appropriately qualified practitioners and professionals. The qualifications held by practitioners and professionals must be nationally recognised and acceptable to the appropriate professional governing bodies. Where appropriate or where this is a requirement for practice, evidence of post-qualifying experience must be provided. Individual practitioners and professionals must hold qualifications that are commensurate with the level and complexity of service delivery for which they are responsible. Practitioners and professionals must hold current membership of an appropriate professional body where this is a requirement for practice. Evidence of regular, appropriate clinical supervision for practitioners and professionals must be provided by the Service manager(s); where this is implemented by an external professional, evidence of appropriate safeguarding awareness and processes must be provided.

4.3 There will be four main elements to the service delivery;

- Support to parents that are victims of domestic abuse which enables parents to understand the impact of domestic abuse on how they parent and how domestic abuse has an impact on the children and young people's behaviour.
- Direct work around children/ young people safety planning where the young person is still in the situation
- Longer term recovery work therapeutic approach where the perpetrator is no longer within the family.
- Support social care with pre- court proceedings process and provide information and assessments where required.

4.4 The programmes, interventions and activities to be delivered by the Service must be recognised by relevant professional governing bodies and partner services within Halton Children's Trust as appropriate for the client group within this contract. Programmes, interventions and activities must have a recognised evidence base and be either locally or nationally verified as demonstrating high levels of effectiveness demonstrated through rigorous assessment and evaluation.

4.5 The Service will operate within Halton's Children and Families services model which includes both Social Care and the Team around the Family model as an integral element of its multi-agency service provision. The Service will work closely with partners to ensure optimum integration of service delivery, processes and performance management. As an essential aspect of this alignment, the Service will embed and implement the principles of the Think Family approach in all aspects of its practice and service delivery.

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4.6 The Service must make initial contact to children and families referred within 5 working days. A full assessment must be undertaken within 14 working days of the initial contact.

4.7 Parenting Support will be provided as a six session parenting intervention that can be delivered in a group setting (with one member of staff from this service together with another parenting practitioner or volunteer) or on a one-to-one basis. These sessions can also be used individually on a one-to-one basis to address a specific need. In the case of group delivery, this would take place in a small group, with an emphasis on creating a positive and nurturing environment for the participants.

4.8 The parenting support programme needs to cover the functional aspects of children's behaviour, the impact on children of domestic abuse, strategies used by abusive men to control women and an introduction to positive parenting techniques. The content needs to have an understanding of the nature of Domestic Abuse and to highlight the variety of different situations parents find themselves in. It needs to enables parents to reflect on the differing impact of these on children, as well as drawing on adapted aspects of The Freedom Programme for Women / Men (© Pat Craven) and links with Positive You within Halton's Women's Centre to look at the impact of power and control based domestic abuse in an accessible way.

4.9 Direct work with children and young people around child safety planning, this can take place when the perpetrator is still within the family. Children aged 5 – 10 years will be offered the opportunity of a joint safety planning session with their parent or another safe adult in their life. Children aged over 10 years will be offered an individual safety planning session.

4.10 The work will involve:

- Individual assessment of each child young person
- Identifying areas of risk
- Identify strategies for keeping safe
- Assessing the needs of children and young people affected by domestic abuse and ensuring risk issues.
- Agreeing with the child or young person an individual safety plan.

4.6 The worker works with the child/ young person to:

- Discuss how the child or young person can help keep themselves safe.
- Identify safe places to go, a safe network, who can help and strategies for reducing any identified risk.
- Map areas of life and identify risks and strategies for reducing these
- Ensure young person knows when and how to use 999.
- Discuss having "safe" numbers in mobile phone
- Agree who this plan will be shared with.

4.11 Recovery work will be direct work using therapeutic approaches tailored to individual need. Practitioners will work in a way which is creative, age-

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appropriate and fun, covering issues including understanding emotions, self - esteem, safety planning and healthy relationships. This can be provided through individual and group work experiences as appropriate. This support should be for a minimum of 3 months and up to a maximum of 6 months.

4.12 Where the identified needs are more complex, the Service will ensure signposting to more appropriate services and plan a clear transition with no gap of support until the individual is embedded in the new service.

4.13 The Service will support the Cheshire and Merseyside Local Authority Pre-Court Proceedings. Where required the Service will work with social care with the pre-proceedings protocol work and attendance to support the court process. Once the identified court process has started the service will engage and support individuals and families within 1 month if not known (or if known already). The Service will provide a report on the level of engagement, outcomes and any identified risks in a format for court if an application is to be made within 6 months (or earlier if the risk increases) and be prepared to attend court if required.

4.14 The Service will be delivered using a number of practices, including:

- Clear procedures for recording and sharing of information between the provider and the local authority.
- Providing case consultation for professionals and carers on specific issues in relation to domestic abuse.
- Use outcome recognised tools such as Strengths and Difficulties Questionnaire (SDQ) and the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to measure Mental Wellbeing as an outcome of interventions.
- Promote participation of children and young people at all levels of the work, by a commitment to practice that encourages their voices to be heard, and their inclusion in the planning, undertaking and reviewing of work.
- Contribute to policy and service development for children and families who have experienced domestic abuse including the identification of areas of unmet need.

4.15 The Service will contribute to the development of the Young People's Violence Advocacy programme which has a focus on the following main outcomes of:

- To improve early identification and intervention for teenagers experiencing/at risk of serious violence and abuse
- To improve and co-ordinate effective, flexible local support and reduce risks.
- To use data collected by practitioners to inform service delivery locally and policy development nationally.

4.16 Service provision will be delivered at a range of venues across Halton, in appropriate settings that are agreed with the service user(s) as meetings their needs. The views and wishes of individual service user(s) must be sought and fully taken into account when agreeing venues for service provision.

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4.17 The Service will support and monitor cohorts of families that are addressed at MARAC.

4.18 The Service will identify victims who are not accessing help via the criminal justice system and signposting them to the local IDVA service where appropriate.

4.19 The Service will link into the perpetrator programme where identified families are eligible. The acceptance on to the perpetrator programme will be dependent upon; the perpetrator of the domestic abuse showing a level of motivation to change; the perpetrator of the abuse consenting to sharing of information within the scope of the confidentiality agreement, the perpetrator of the abuse understands that their partner and children will also be offered support.

4.20 The nature of the service will require it to identify and address any safeguarding issues for both children and adults, as a matter of course. This will mean that the provider will be required operate to within and use the local Halton Safeguarding Children and Safeguarding Adults Policies.

5.0 EILIGIBILTY AND PATHWAYS

5.1 The service will be delivered as part of a formalised support package such as Child in Need or Child Protection Plan. Referral pathways will also be linked into the new Levels of Need and will include lead professional's working with a child/ young person or family who has been affected by domestic abuse where a formal process is in place e.g. Common Assessment Framework (CAF) or the Inspiring Families Programme to meet individual outcomes for each child and family as part of their formal plan. Self-referrals are not appropriate. Referrals do not have to have an existing allocated social worker.

5.2 Children and young people for whom service requests are accepted must live within Halton and be aged between 5 and 18 years, and up to 25 years if they have additional needs.

5.3 If service requests are received for children and young people who live outside Halton, these will be discussed by the Manager of the Service and the Commissioning Manager at Halton Borough Council in order to consider an appropriate course of action.

5.4 A formal assessment will take place and will identify the following:

- Level of risk to the individual / family
- Level of intervention needed and which agency and professional is responsible for carrying put the intervention
- Safety Plan to be tailored to the individual need, including management of risk to the individual
- Goals and milestones to be achieved and a record of agreed outcomes
- Record of family history and relationships
- Record historic abuse if appropriate

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- Identify feelings of individual or family
- Information sharing
- Safeguarding
- Referral to other support services if required

5.5 The initial assessment carried out by the Service will be reviewed after 6 sessions (if not before) and the review process will look at:
- Relevance of the assessment
- Progress with outcomes – including therapeutic
- Effectiveness of plans and outcomes
- Unmet needs
- Client satisfaction

5.6 The Service will attend meetings as requested by lead professionals / social workers and will provide written reports as required. The Service will contribute to on -going assessments and reviews as necessary.

6.0 STAFFING

6.1 The service will ensure all staff will have the following core skills:
- Experience of partnership working on achieving outcomes for children, young people and families
- Knowledge and understanding of the impact of domestic abuse on those affected
- Knowledge of safeguarding and child protection practises.
- Experience of undertaking needs/risk assessments with children, young people and families
- Experience of undertaking short term casework with children and young people presenting with a variety of needs.
- Experience of working with families in crisis

6.2 All staff working directly with children, young people and their families will undertake regular, appropriate clinical supervision at intervals of not less than 6 weeks, provided by their Service manager(s) and/or an external accredited supervisor in accordance with the guidelines of their professional governing body.

6.3 It will be mandatory for all staff involved in service delivery to attend appropriate levels of Safeguarding training, or to evidence appropriate Safeguarding training accessed through their own service, to be agreed with the appropriate Commissioning Manager at Halton Borough Council.

7.0 INVOLVING SERVICE USERS

7.1 Children and young people will be involved in the planning, delivery and evaluation of the service. They will also be routinely involved in the staff

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recruitment process. Evidence of consultation will be required (consultation with parents/carers and professionals is also important wherever this is possible.)

8.0 BOROUGH WIDE SERVICE

8.1 The service must provide this service within the Borough of Halton.

8.2 The service is expected to demonstrate the widest possible geographic and socio economic take up of its service.

8.3 The service will produce data quarterly to show its compliance with Part A 2.0. Failure to satisfy the service requirement shall be treated as a material default.

8.4 The service will produce details of the publicity arrangements it has in place to promote the take up of its service.

9.0 PERFORMANCE OUTCOMES

9.1 The Commissioning arm of Halton local authority will put in place a performance framework which will be monitored on a quarterly basis by the allocated Commissioning Manager and Contract Assistant. See Part B for further details.

9.2 The Service will demonstrate a direct, positive and measurable impact upon the following outcomes:

- Parents experiencing domestic abuse seek and receive advice and support to keep their children and themselves safe,
- Service users have improved self-esteem, motivation, confidence, emotional health and well- being and physical health and are able to rebuild their lives, moving to independence.
- Service users are more able to make safe choices leading to a reduction of domestic abuse incidents
- Parents report an improved experience of family life and their relationships with their children.
- Reduce the numbers of teenagers/young people likely to become either victim or perpetrator of domestic abuse
- Reduction in the number of young people on child protection plans

The following will be the outputs of the service:

- 90% of children and young people report improved resilience and emotional well- being.
- Provide the service to a minimum 100 families within the first year.
- 80% of parents report improved behaviour from their children
- 75% of service users are confident enough to consider training, employment, volunteering or returning to work.
- 85% of service users are confident to report to a statutory body e.g. police
- Provide child safety planning support young people to more than 80 young people within the first year.

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- A minimum of six group parenting sessions will be facilitated per annum.
- The service will be accessed from a minimum of three community venues across Halton
- All activities will be monitored and reported
- The Service will use a dedicated database to record both activity and impact. This will also be linked to the CAADA Insights measurement tool.

10.0 PUBLICITY OF SERVICE

10.1 The service will be promoted by the following:

- Distribution of promotional material
- Presentations to Halton Children's Trust partners
- Presentations at networking events
- Representation in local publications and guides
- Representation on Halton Children's Trust steering groups, panels, forums and partnership meetings
- Consultation events with young people and families
- Word of mouth through successful interventions with children, young people and families
- Local and national press coverage of events and campaigns
- Inclusion in the Halton4Teenz website and Help4Me service directory

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PART B: CONDITIONS OF AGREEMENT FEE

1.0 RECORDING OUTPUTS AND OUTCOMES

1.1 The Provider will record all associated outcomes in respect of Part A 9.2 and report achievement against those outcomes via the monitoring officer on a monthly basis. The associated output measures will include the following:

- 90% of children and young people report improved resilience and emotional well- being.
- 80% of women report improved behaviour from their children
- 75% of service users are confident enough to consider training, employment, volunteering or returning to work.
- 85% of service users are confident to report to a statutory body e.g. police
- Provide child safety planning support young people to more than 80 young people within the first year.
- Source of referrals
- No. of individual children benefiting from safety planning
- No. of individual parent/ carers receiving a service.
- Total number of sessions delivered to parent/ carers.
- Duration of intervention in weeks
- Number of cases supported at court
- Reduction of the number of children and young people on plans
- The age, gender, disability and ethnicity of children, young people and families accessing the Service
- The number of CIN, CP and CAF processes and reviews in which the Service participates
- The number of children, young people and families signposted to other service provision and a breakdown of the agencies and services concerned
- The nature of interventions
- Increased numbers of parents and carers completing evaluations following interventions, which then feeds into improved practice and service delivery.

1.2 The above list of measures is not exhaustive, but should be seen as a guide to future performance monitoring recording. The Provider is therefore requested to submit all other relevant and appropriate performance measures in the quarterly report to allow the Purchaser to continue to evaluate the service.

1.3 The Provider will comment on the achievement or otherwise of the outcomes specified with in a performance management framework that will be produced by the Purchaser, in the form of a written report at the end of this agreement.

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This report may be used to evaluate the effectiveness of the service and will inform for potential future years funding negotiations.

2.0 QUARTERLY PERFORMANCE MONITORING REPORTS

2.1 The Provider will supply to The Council with reports on a quarterly basis showing the data recorded in the categories set out in this agreement.

2.2 Formal review meetings will take place with The Provider during the period of the contract. This may include structured discussions regarding management committees, staff and users, observation of service delivery, examination of records documents or reports.

2.3 The Provider shall return all relevant statistical data to Halton Borough Council's monitoring officer no later than the following dates (for the duration of the contract):

Q1- April 2014
Q2 – July 2014
Q3 – October 2014
Q4 – January 2015

2.4 The Provider shall produce to The Council an annual report, in accordance with Part B Clause 1.2. This report shall include:

- An evaluation of the service provision with reference to quality standards and achievement of desired outcomes
- The level, demand and take up of services
- The total expenditure against the approved budget from the quarterly reports submitted in accordance with this agreement
- In addition, an outline of the development potential and future plans for the service

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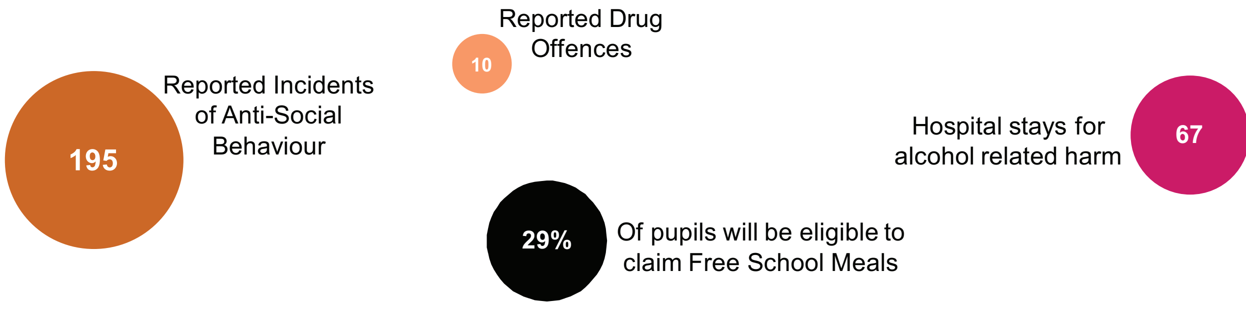
Wider determinants of Domestic Violence - an average week

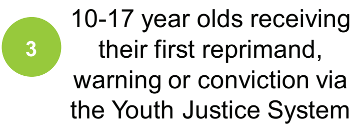


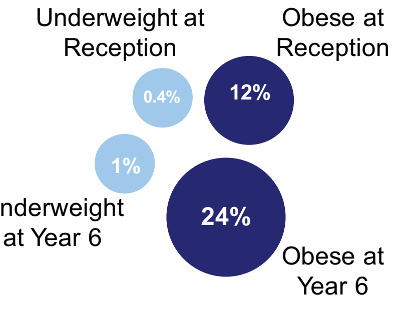
26% Living in areas in the top 10% most deprived in England and Wales

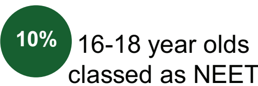
19% Of households are in fuel poverty

25% Of housing stock is Registered Social Landlord stock

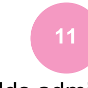
Children & Young People…







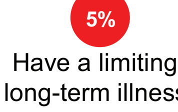
13% Youth Unemployment (% 18-24 claiming JobSeekers Allowance)



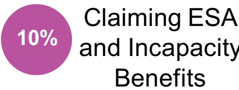
0-17 year olds admitted to hospital through injury

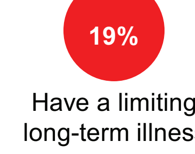
28% Living in poverty

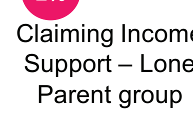
18% Reported they had been drunk at least once in last 4 weeks



Working Age…



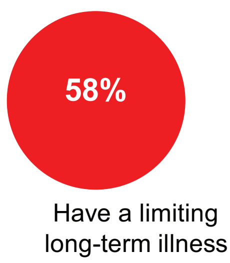




Older People…

Fastest growing section of population

older people age group (65+) projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025



6% Suffer from Dementia

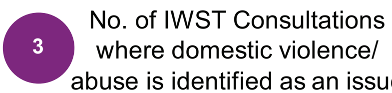
Produced by Research and Intelligence
part of Policy and Development Services
E-mail: research@halton.gov.uk

Domestic Abuse and Domestic Violence - an average week

CareFirst Data

6 – No. of referrals with presenting issue relating to Domestic Violence/ Domestic Abuse (not children)

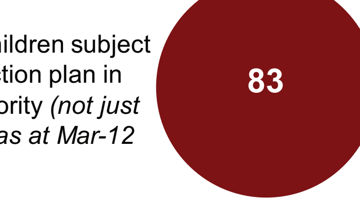
1 – No. of contacts with presenting issue relating to Domestic Violence/ Domestic Abuse (not children)



3 – No. of IWST Consultations where domestic violence/ abuse is identified as an issue

1 – No. of initial conferences where domestic violence/ abuse identified as presenting issue

2 – No. of parental factors classifications in relation to domestic violence/ abuse



83 – Total number of children subject to a child protection plan in Halton local authority *(not just new referrals) – as at Mar-12*

124 – Total number of children in care in Halton local authority *(not just new referrals) – as at Mar-12*

692 – Total number of children in need in Halton local authority *(not just new referrals) – as at Mar-12*

Community Safety Data – average of 2010/11 data

50 – Domestic Incidents between adults

- 43% of Domestic Incidents (between adults) were reported between 5pm and midnight
- The time of day with the highest reported Domestic Incidents (between adults) was between 9-10pm

10 – Pre charge cases at Crown Prosecution Service (CPS)

5 – No. of defendants at Crown Prosecution Service (CPS)

4 – People attended Level 1 or Level 2 Domestic Abuse Awareness training (average of Q4 2011/12)

MARAC Information

5 – Cases discussed at Halton MARAC

1 – Repeat cases discussed at Halton MARAC

6 – No. of children involved in cases discussed at Halton MARAC

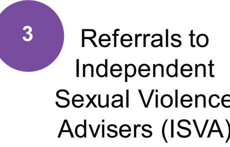
2 – Cases where alcohol is a contributing factor

1 – Cases where drugs are a contributing factor

1 – No. of violent offences identified by Youth Offending Team (YOT)

4 – High-risk referrals to Independent Domestic Violence Advocate (IDVA)

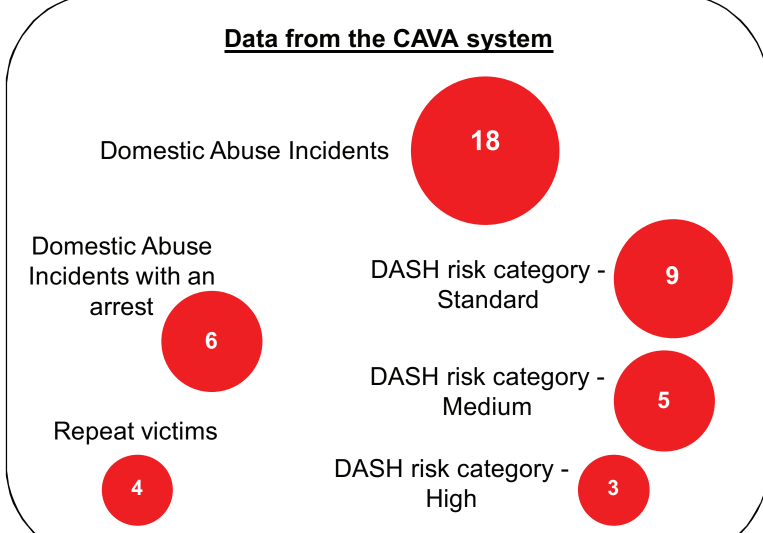
3 – Cases seen at Specialist Domestic Violence Courts (SDVC)



3 – Referrals to Independent Sexual Violence Advisers (ISVA)

4 – DV cases recorded at Warrington and Halton hospitals (average of Q4 2011/12)

Data from the CAVA system



18 – Domestic Abuse Incidents

6 – Domestic Abuse Incidents with an arrest

4 – Repeat victims

9 – DASH risk category - Standard

5 – DASH risk category - Medium

3 – DASH risk category - High

Produced by Research and Intelligence
part of Policy and Development Services
E-mail: research@halton.gov.uk

Note: Data is taken as an average of 2011/12 data unless otherwise stated

REPORT TO: Health and Wellbeing Board

DATE: 17th July, 2013

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Adults

SUBJECT: Pharmaceutical Needs Assessment

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide members of the Board with a briefing on the Pharmaceutical Needs Assessment (PNA), including risks associated with it and proposed local governance.

2.0 **RECOMMENDATION: That**

1. **a Board level sponsor for the Pharmaceutical Needs Assessment (PNA) be nominated;**

2. **the financial risks associated with the PNA be logged through Halton Borough Council's risk assessment and register process; and**

3. **a local steering group be established to develop the PNA and oversee the statutory consultation.**

3.0 **SUPPORTING INFORMATION**

3.1 The pharmaceutical needs assessment is a statutory document that states the pharmacy needs of the local population. This includes dispensing services as well as public health and other services that pharmacies may provide. It is used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. First detailed in the NHS Act 2006 where PCTs were divested with the responsibility for producing the PNA, since 1 April 2013 this responsibility now sits with Health & Wellbeing Boards.

3.2 **Background to the PNA**

A PNA details the current pharmaceutical service provision available in the area and where there may need to be changes to this in the future because of changes to the health needs or geographical location of the local population. Updating the PNA must be an

ongoing process as pharmaceutical service provision changes or local need changes. Supplementary statements document these changes.

The PNA enabled the PCT to make sure that any new contracts granted and pharmaceutical services commissioned would be based on the information provided in the document. It meant that anyone wishing to open a new pharmacy in the area needed to base their application on their plans to meet the needs of local people, identified in the PNA. The PNA informed the decision-making process of the PCT pharmacy contracts committee who reviewed and decided pharmacy applications, received by the PCT, and also informed the commissioning of advanced and enhanced services from pharmacies.

Halton & St Helens PCT published its first PNA 1 February 2011. It had established a steering group early on in the PNA development process which was chaired by a consultant in public health. Although the PCT footprint covered the two boroughs, mapping and needs analysis was undertaken against the two borough geographies separately. Also, when making decisions about provision against levels of need, pharmacy provision was not taken in isolation. In some cases pharmacies are the sole provider of the service but in others there is a mix of provision. The PCT was assisted in developing the PNA by the Local Pharmaceutical Committee and by the Local Involvement Network who carried out a range of community consultation exercises and produced an independent report of their findings.

3.3 Changes effective from 1 April 2013

From April 1st health and wellbeing boards (HWBs) have a statutory responsibility to publish and keep up to date the PNA. Health & Wellbeing Boards are also responsible for producing the Joint Strategic Needs Assessment (JSNA). Giving local authorities the responsibility for conducting both PNA and JSNA will strengthen links between the two documents and there may be opportunities, for combined working on both documents.

The responsibility for making decisions on pharmacy applications based on the PNA passes from PCTs to NHS England. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, effective from 1 April 2013, require each Health & Wellbeing Board to:

- Make a revised assessment as soon as is reasonably practicable after identifying changes to the need for pharmaceutical services which are of a significant extent and
- Publish its first PNA by 1 April 2015.

Health & Wellbeing Boards need to consider the time that will be needed to produce the PNA which includes a statutory 60 day consultation period, and to satisfy themselves that the current PNA remains fit for purpose in the meantime.

3.4 **Duties of the HWBB**

Now the Health & Wellbeing Board is responsible for the PCT's PNA it will be required by the regulations to publish a revised assessment where it identifies changes to the need for pharmaceutical services "which are of a significant extent". The only exception is where the Board is satisfied that making a revised assessment would be a disproportionate response. Health & Wellbeing Boards will therefore need to put systems in place that allow them to identify changes to the need for pharmaceutical services within their area, assess whether the changes are significant and decide whether producing a new PNA is a disproportionate response.

Health & Wellbeing Boards and NHS England will work together to manage the flow of information about the provision of pharmaceutical services by pharmacies, dispensing appliance contractors and dispensing doctors. Health & Wellbeing Boards will also need to ensure they are aware of any changes to the commissioning of public health services in the local authority and the commissioning of services by clinical commissioning groups as these may affect the need for pharmaceutical services.

In addition to the regulations placing a further statutory duty on each Health & Wellbeing Board to develop and publish their first PNA by 1 April 2015, they also set out the minimum requirements for the information to be contained in the PNA, including a list the people and organisations which must be consulted.

3.5 **Commissioning arrangements**

NHS England are mandated under the same regulations to use the PNA when making decisions on applications to open new pharmacies and dispensing appliance contractor premises, and

Public health teams and clinical commissioning groups will also use the PNA to inform their commissioning decisions, when commissioning enhanced services from community pharmacies. Robust, up-to-date evidence is important to ensure that community pharmacy services are provided in the right place and meet the needs of the communities they serve.

3.6 **Proposed arrangements for producing Halton's PNA**

Work undertaken in Cheshire prior to the closure of PCTs means

Health & Wellbeing Boards across Cheshire agreed a common framework for producing their PNAs. This will ensure that although each PNA will be developed locally and differ according to the local area and population, it will be in the same format and order which will make it easier to use and review.

This work has recently been shared with the Merseyside public health intelligence leads. Some of the information will be standard for all the PNAs, some will be taken from the JSNA but the majority will require either updating information in the current PNAs or gathering new information.

A Merseyside group with public health representation from each local authority and the NHS England team have started to meet and progress this work to develop a strategic plan for developing PNAs for each area, maximising the economies of scale, where possible, by working together in the planning, consultation and design stages, which will support work at a local level to produce individual PNAs. Similar to Cheshire, it is hoped to have a standard framework for PNAs, populated with local information and reflecting local need and commissioning arrangements.

Each Health & Wellbeing Board should nominate a board-level sponsor with responsibility for the PNA, but the management of the PNA could be passed to a steering group led by public health. The group would oversee the operational development and consultation for the PNA, reporting report back to the Health & Wellbeing Board for approval at strategic stages of the process.

It is important to ensure that all information within the PNA is accurate and up to date, and this can be achieved by ensuring that all relevant stakeholders are represented on the steering group. This should include:

- Public health teams,
- NHS England area team,
- Clinical Commissioning Group,
- Local pharmaceutical committee (LPC),
- representation from the local community,
- Healthwatch,
- a communications or consultation lead from the local authority and
- an elected representative from the Health & Wellbeing Boards.

3.7 **Resources**

This is a large piece of work which will extend over a considerable period of time. As well as information gathering from the organisations commissioning services from pharmacies as to current and future needs, there needs to be extensive work done by public

health teams mapping the health and social needs of the local population compared to provision of pharmaceutical services. Work also needs to be done looking at future changes that could impact upon pharmaceutical need such as a new housing estate, closure of a local industry, firm plans for health arising from JSNA. The local population will also need to be consulted as to their views on current provision of pharmaceutical services and aspirations for future pharmaceutical services.

3.8 **Proposed next steps**

- Nominate board level sponsor for PNA
- Nominate chairperson of steering group from public health team
- Recruit steering group who should then:
- Start to populate the PNA with information already available such as JSNA
- Start to gather information to update current PNA
- Ask the local community for feedback on current pharmacy services and aspirations for future pharmacy services
- Speak to local authority planners and healthcare commissioners to determine future planning of housing, industry and healthcare.

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA should be used to develop the PNA.

The JSNA provides a robust and detailed assessment of need and priorities across Halton borough. As such is should continue to be used in the development of other policies, strategies and commissioning plans and reviews such as those of Halton Clinical Commissioning Group.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any legal challenges to decisions based on information in the PNA may open the Health & Wellbeing Board up to Judicial Review. This can have significant financial implications.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

Improving the Health of Children and Young People is a key priority in Halton and this should be reflected in the PNA, detailing service provision that is appropriate to this age group.

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

Not applicable

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

6.4 **A Safer Halton**
Not applicable

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Pharmacies provide a vital primary health care service to residents across the borough, are located within the heart of communities and offer open access to trained health professionals for advice on a wide range of issues.

7.0 **RISK ANALYSIS**

7.1 Failure to comply with the regulatory duties fully may lead to a legal challenge, for example, where a party believes that they have been disadvantaged following the refusal by NHS England over their application to open new premises based on information contained in the PNA.

7.2 The risk of challenge to the Health & Wellbeing Board who produced that PNA is significant and Boards should add the PNA to the risk register.

7.3 A sound process, using national guidance and with support from local expertise, should be established to ensure this risk does not materialise. HBC Solicitors will be consulted at key stages in the PNA development to further ensure any potential risks are identified and mitigated.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The PNA seeks to provide intelligence on which to base decisions about service provision that are based on levels of need across the borough. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

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

None within the meaning of the Act.

Agenda Item 11

REPORT TO:	Health and Wellbeing Board
DATE:	17th July 2013
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Adults
SUBJECT:	Suicide Prevention Strategy
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Health and Wellbeing Board with information relating to the development of a Suicide Prevention Strategy for Halton.

RECOMMENDATION: That

1. **the contents of the report be noted; and**
2. **the development of a Suicide Prevention Strategy for Halton be supported.**

3.0 SUPPORTING INFORMATION

3.1 Suicide is a major public health issue. Nationally, during 2011, over 4500 people took their own lives, meaning that on average one person dies every two hours. Every suicide is both an individual tragedy and a terrible loss to society. It affects a number of people directly and often many others indirectly.
The impact of suicide can be devastating- economically, psychologically and spiritually- for all those affected.

3.2 Suicide is not inevitable. Preventing suicides is a complex and challenging issue, but there are effective solutions for many, if not most of the individual factors which contribute towards the risk of suicide. Suicide prevention work is cost effective when conducted in accordance with evidence and by working in partnership. Local Government, statutory services, the third sector, local communities and families each have a role to play.

3.3 At a local level, a recent Suicide Audit for Halton and St. Helens, completed in April 2013, demonstrates that the number of completed suicides for Halton remains relatively low. However, the existing Suicide Prevention Strategy needs to be updated in line with the National Strategy, published in September 2012. (Attached at Appendix 1). The Suicide Audit will provide some of the evidence to support the development of the Strategy.

3.4 It is proposed that the local Strategy follows the same format as the National Strategy by following six key areas for action.

These are:

- Area for action 1: Reduce the risk in key high risk groups
- Area for action 2: Tailor approaches to improve mental health in specific groups
- Area for action 3: Reduce access to the means of suicide
- Area for action 4: Provide better information and support to those bereaved or affected by suicide
- Area for action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Area for action 6: Support research, data collection and monitoring

3.5 In order to progress the development of a local strategy it is proposed that a Suicide Prevention Task Group be established and a workshop be organised for September to provide wider engagement with key stakeholders from across Halton.

4.0 POLICY IMPLICATIONS

4.1 Halton's Health and Wellbeing Strategy identifies Prevention and Early Detection of Mental Health Conditions as one of the five key priorities for action. This priority was chosen for a number of reasons including, the number of people attending GP Surgeries to seek advice on mental health, the number of people suffering from depression, hospital admissions due to self-harm and a higher than average suicide rate. Therefore the development and implementation of a Suicide Prevention Strategy will contribute to this priority and the outcomes identified within the Health and Wellbeing Strategy.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Whilst the number of actual suicides in children and young people in Halton remains low, the impact of suicides on children, young people and families is of major concern. Halton also has a higher than average rate of hospital admissions for self-harm for under 18's.

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

Throughout history periods of high unemployment or severe economic problems have also had an adverse effect on the mental health of the population and have been associated with higher rates of suicide. Evidence shows that English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men.
Therefore strategies to reduce unemployment, improve educational attainment and skills should contribute to reducing the risk factors for suicide.

6.3 **A Healthy Halton**

As outlined in 4.1 above, the development of a Suicide Prevention Strategy for Halton contributes directly to addressing Health and Wellbeing priorities.

6.4 **A Safer Halton**

Some of the risk factors for suicide include harassment/ bullying and criminal suspicion or conviction. Therefore, reducing the incidence of crime, improving Community Safety and improving community resilience should have an impact on reducing the risk of suicide and improving overall health and wellbeing.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and has been shown to have an impact on mental health which, as outlined above has a direct impact on the risk of suicide.

7.0 RISK ANALYSIS

Halton Borough Council may be at risk of not meeting national targets if recommendations outlined in the report are not met. There are no financial risks. The recommendations are not so significant they require a full risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

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

Document	Place of Inspection	Contact Officer
Preventing Suicide in England- A Cross-government outcomes Strategy to save lives	Runcorn Town Hall	Diane Lloyd

Preventing suicide in England

A cross-government outcomes strategy to save lives

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	17680
Title	Preventing suicide in England: A cross-government outcomes strategy to save lives
Author	HMG / DH
Publication Date	**10 September 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Youth offending services, Police, NOMS and wider criminal justice system, Coroners, Royal Colleges, Transport bodies
Circulation List	Voluntary Organisations/NDPBs
Description	A new strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy: sets out key areas for action; states what government departments will do to contribute; and brings together knowledge about groups at higher risk, effective interventions and resources to support local action.
Cross Ref	No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all Ages
Superseded Docs	National Suicide Prevention Strategy for England
Action Required	N/A
Timing	**N/A**
Contact Details	Mental Health and Disability Division Department of Health 133-155 Waterloo Road London SE1 8UG 020 7972 1332 www.dh.gov.uk/
For Recipient's Use	

Preventing suicide in England

A cross-government outcomes strategy to save lives

Prepared by Department of Health

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Ministerial Foreword

In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

In developing this new national all-age suicide prevention strategy for England, we have built on the successes of the earlier strategy published in 2002. Real progress has been made in reducing the already relatively low suicide rate to record low levels.

But there is no room for complacency. There are new challenges that need to be addressed. And at a time when we have economic pressures on the general population, it is particularly timely to revisit a national strategy that has demonstrated clear progress.

If we are to continue to prevent suicide, we also need to take specific actions, as outlined in this strategy.

This strategy supports action by bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available. This will support local decision-making, while recognising the autonomy of local organisations to decide what works in their area.

The factors leading to someone taking their own life are complex. No one organisation is able to directly influence them all. Commitment across government, from Health, Education, Justice and the Home Office, Transport, Work and Pensions and others will be vital. We also need the support of the voluntary and statutory sectors, academic institutions and schools, businesses, industry, journalists and other media. And, perhaps above all, we must involve communities and individuals whose lives have been affected by the suicide of family, friends, neighbours or colleagues.

We have made it clear that mental and physical health have to be seen as equally important. For suicide prevention, this will mean effectively managing the mental health aspects, as well as any physical injuries, when people who have self-harmed come to A&E. It will also mean having an effective 24 hour response to mental health crises, as well as for physical health emergencies.

The strategy has been developed with the support of leading experts in the field of suicide prevention, including the members of the National Suicide Prevention Strategy Advisory Group, under the chairmanship of Professor Louis Appleby. I would like to thank all members of this group for sharing their knowledge and expertise with us. Their continued support and leadership is central to our efforts to prevent suicides in England.

Norman Lamb MP
Minister of State for Care Services

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Preface

Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the expertise of the National Suicide Prevention Strategy Advisory Group, some of whom have experienced the tragedy of a suicide within their families.

In fact, one of the main changes from the previous strategy is the greater prominence of measures to support families (action 4) – those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

In identifying the high-risk groups who are priorities for prevention (action 1), we have selected only those whose suicide rates can be monitored – this is essential if we are to report on what the strategy achieves. However, there are also other groups for whom a tailored approach to their mental health is necessary if their risk is to be reduced (action 2). These are groups who may not be at high risk overall, such as children, or whose risk is hard to measure or monitor, such as minority ethnic communities. We have highlighted the importance of tackling certain methods of suicide (action 3) and of working with the media towards sensitive reporting in this area (action 5). We have stressed the need for timely data collection and high-quality research (action 6).

We have also had to be clear about the scope of the strategy. It is specifically about the prevention of suicide rather than the related problem of non-fatal self-harm. Although people with a history of self-harm are identified as a high risk group, we have not tried to cover the causes and care of all self-harm. Similarly, whether the law on encouraging or assisting suicide should be changed is a separate issue, outside the scope of the strategy.

No health without mental health, published in 2011, is the government's mental health strategy. An implementation framework has also been published, to set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported. This is vital, because suicide prevention starts with better mental health for all - therefore this strategy has to be read alongside that implementation framework.

The inclusion of suicide as an indicator within the Public Health Outcomes Framework will help to track national progress against our overall objective to reduce the suicide rate.

The strategy is intended to be up to date, wide-ranging and ambitious. Its publication marks the beginning of a new drive to reduce further the avoidable toll of suicide in England.

Professor Louis Appleby CBE

Department of Health, Chair of the National Suicide Prevention Strategy Advisory Group

Executive summary

1. Suicide[1] is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides and it is these that are set out in this strategy.

Objectives and areas for action

2. This strategy sets out our overall objectives:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide.

3. We have identified six key areas for action to support delivery of these objectives:

1: Reduce the risk of suicide in key high-risk groups

2: Tailor approaches to improve mental health in specific groups

3: Reduce access to the means of suicide

4: Provide better information and support to those bereaved or affected by suicide

5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

6: Support research, data collection and monitoring.

Reduce the risk of suicide in key high-risk groups

4. We have identified the following high-risk groups who are priorities for prevention:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

5. Those who work with men in different settings, especially primary care, need to be particularly alert to the signs of suicidal behaviour.

6. Treating mental and physical health as equally important in the context of suicide prevention will have implications for the management of care for people who self-harm, and for effective 24 hour responses to mental health crises.

7. Accessible, high-quality mental health services are fundamental to reducing the suicide risk in people of all ages with mental health problems.

8. Emergency departments and primary care have important roles in the care of people who self-harm, with a focus on good communication and follow-up.

9. Continuing to improve mental health outcomes for people in contact with the criminal justice system will contribute to suicide prevention, as will ongoing delivery of safer custody.

10. Suicide risk by occupational groups may vary nationally and even locally,

[1] Suicide is used in this document to mean a deliberate act that intentionally ends one's life.

and it is vital that the statutory sector and local agencies are alert to this, and adapt their suicide prevention interventions accordingly.

Tailor approaches to improve mental health in specific groups

11. Improving the mental health of the population as a whole is another way to reduce suicide. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides.

12. This strategy identifies the following groups for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

13. Children and young people have an important place in this strategy. Schools, social care and the youth justice system, as well as charities highlighting problems such as bullying, low body image and lack of self-esteem, all have an important contribution to make to suicide prevention among children and young people. Measures to help parents keep their children safe online are included in area for action 5. The call for research to support the strategy includes a focus on children and young people and self-harm.

14. Timely identification and referral of women and children experiencing abuse or violence, so that they are able to benefit from appropriate support, is of course a positive step in its own right, as well as helping to reduce suicide risk.

15. The Government is committed to improving mental health support for service and ex-service personnel through the Military Covenant.

16. In *No health without mental health* we made it clear that we expect parity of esteem between mental and physical health. Routine assessment for depression as part of personalised care planning for people with long-term conditions, can help reduce inequalities and help people to have a better quality of life.

17. Depression is one of the most important risk factors for suicide. The early identification and prompt, effective treatment of depression has a major role to play in preventing suicide across the whole population.

18. Given the links between mental ill-health and social factors like unemployment, debt, social isolation, family breakdown and bereavement, the ability of front-line agencies to identify and support (or signpost to support) people who may be at risk of developing mental health problems is important for suicide prevention.

19. Measures that reduce alcohol and drug dependence are critical to reducing suicide.

20. Staff in health and care services, education and the voluntary sector need to be aware of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm amongst lesbian, gay and bisexual people, as well as transgender people.

21. Community initiatives can be effective in bridging the gap between statutory services and Black, Asian and minority ethnic communities, and in tackling inequalities in health and access to services.

Reduce access to the means of suicide

22. One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. Suicide methods most amenable to intervention are:

- hanging and strangulation in psychiatric inpatient and criminal justice settings;
- self-poisoning;
- those in high-risk locations; and
- those on the rail and underground networks.

23. Continued vigilance by mental health service providers will help to identify and remove potential ligature points. Safer cells complement care for at-risk prisoners.

24. Safe prescribing can help to restrict access to some toxic drugs.

25. Local agencies can prevent loss of life when they work together to discourage suicides at high-risk locations. Local authority planning departments and developers can include suicide in health and safety considerations when designing structures which may offer suicide opportunities.

26. British Transport Police, London Underground Limited, Network Rail, Samaritans and partners are working to reduce suicides on the rail and underground networks.

Provide better information and support to those bereaved or affected by suicide

27. Every suicide affects families, friends, colleagues and others. Suicide can also have a profound effect on the local community. It is important to:

- provide effective and timely support for families bereaved or affected by suicide;
- have in place effective local responses to the aftermath of a suicide; and
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

28. Effective and timely emotional and practical support for families bereaved by suicide is essential to help the grieving process and support recovery. It is important the GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

29. Post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces, health and care settings.

30. It is important that people concerned that someone may be at risk of suicide can get information and support as soon as possible. For individuals already under the care of health or social services, family, carers and friends should know who to contact and be appropriately involved in any care planning. Help is available through many outlets across the statutory and

voluntary sector for people who are not known to services.

Support the media in delivering sensitive approaches to suicide and suicidal behaviour

31. The media have a significant influence on behaviour and attitudes. We want to support them by:

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.

32. Local, regional and national newspapers and other media outlets can provide information about sources of support when reporting suicide. They can also follow the Press Complaints Commission Editors' Code of Practice and *Editors' Codebook* recommendations regarding reporting suicide.

33. The Government will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. Recognising concern about misuse of the internet to promote suicide and suicide methods, we will be pressing to ensure that parents have the tools to ensure that their children are not accessing harmful suicide-related content online.

Support research, data collection and monitoring

34. The Department of Health will continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute for Health Research and the Policy Research Programme.

35. Reliable, timely and accurate suicide statistics are essential to suicide prevention. We will consider how to get the most out of existing data sources and options to address the current information gaps around ethnicity and sexual orientation.

36. Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Framework includes the suicide rate as an indicator.

Making it happen – locally and nationally

37. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines evidence based local approaches and national actions to support these local approaches.

38. Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement.

39. It will be for local agencies, including working through health and wellbeing boards to decide the best way to achieve the overall aim of reducing the suicide rate. Interventions and good practice examples are included to support local implementation. Many of them are already being implemented locally but local commissioners will be able to select from or adapt these suggestions based on the needs and priorities in their local area.

40. An implementation framework for *No health without mental health* has recently been published. The framework explicitly covers suicide prevention, and supports implementation of this strategy.

Introduction

1. Suicide is a major issue for society. The number of people who take their own lives in England has reduced in recent years. But still, over 4,200 people took their own life in 2010.

2. Every suicide is both an individual tragedy and a terrible loss to society. Every suicide affects a number of people directly and often many others indirectly. The impact of suicide can be devastating – economically, psychologically and spiritually – for all those affected.

3. Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides. Government and statutory services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and social services and at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

4. Most people who take their own lives have not been in touch with mental health services. There are many things we can do in our communities, outside hospital and care settings, to help those who think suicide is the only option.

5. Between July and October 2011, the Government held a public consultation on a new suicide prevention strategy for England. A summary of the consultation responses that were received, and the decisions that the Government has taken in the light of them is available from www.dh.gov.uk/health/category/publications/consultations/consultation-responses/

The challenge of suicide prevention

6. The likelihood of a person taking their own life depends on several factors. These include:

   - gender – males are three times as likely to take their own life as females;
   - age – people aged 35-49 now have the highest suicide rate;
   - mental illness;
   - the treatment and care they receive after making a suicide attempt;
   - physically disabling or painful illnesses including chronic pain; and
   - alcohol and drug misuse.

7. Stressful life events can also play a part. These include:

   - the loss of a job;
   - debt;
   - living alone, becoming socially excluded or isolated;
   - bereavement;
   - family breakdown and conflict including divorce and family mental health problems; and
   - imprisonment.

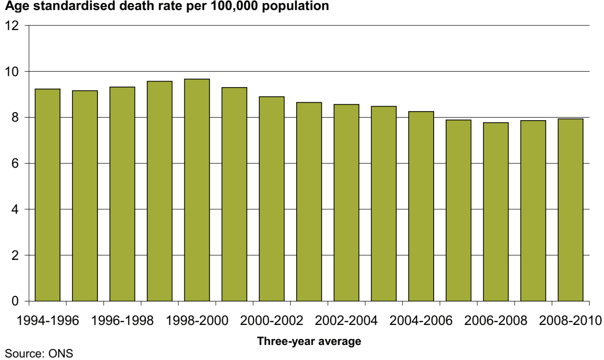
   For many people, it is the combination of factors which is important rather than one single factor. Stigma, prejudice, harassment and bullying can all contribute to increasing an individual's vulnerability to suicide.

8. Several research studies have looked at risk factors for suicide in different groups. In 2008 the Scottish Government Social Research Department undertook a Literature Review: *Risk and Protective Factors for Suicide and Suicidal Behaviour* www.scotland.gov.uk/Publications/2008/11/28141444/0. This review describes and assesses

knowledge about the societal and cultural factors associated with increased incidence of suicide (risk factors) and also the factors that promote resilience against suicidal behaviour (protective factors).

9. Suicide rates in England have been at a historical low recently and are low in comparison to those of most other European countries. In England in 2008-10, the mortality rate from suicide was 12.2 deaths per 100,000 population for males and 3.7 deaths for females.[1] The latest 15-year trend in the mortality rate from suicide and injury of undetermined intent using three-year pooled rates is shown in Figure 1.

Figure 1: Death rates from intentional self-harm and injury of undetermined intent, England 1994-2010



10. The past couple of years have seen a slight increase in suicide rates, but the 2008-10 rate remains one of the lowest rates in recent years. There has been a sustained reduction in the rate of suicide in young men under the age of 35, reversing the upward trend since the problem of suicides in this group first escalated over 30 years ago. We have also seen significant reductions in inpatient suicides and self-inflicted deaths in prison. A statistical update is being published alongside this strategy document.

11. However, we know from experience that suicide rates can be volatile as new risks emerge. The recent slight increase in the suicide rate in 2008-10 demonstrates the need for continuing vigilance and why, despite relatively low rates, a new suicide prevention strategy for England is needed.

12. Previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.[2] Evidence is emerging of an impact of the current recession on suicides in affected countries.[3] However, suicide risk is complex and for many people it is a combination of factors, outlined above, that determines risk rather than any single factor.

13. This suicide prevention strategy can help us reduce further the rates of suicide in England and respond positively to the challenges we will face over the coming years.

Objectives and priorities

14. Our overall objectives are:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide.

15. We have identified six areas for action to support delivery of these objectives which each have a chapter of this strategy devoted to them.

16. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines a range of evidence based local approaches. National actions to support these local approaches are also detailed for each of the six areas for action.

17. Interventions and good practice examples are included to support local implementation and are not compulsory.

Many of them are already being implemented locally but local commissioners will be able to select from and adapt these suggestions based on their assessment of the needs and agreement of the priorities in their local area.

18. We should always use cost-effective evidence-based approaches which work as early as possible. This is above all in the best interests of service users - and also enables the care services to make best use of limited resources. This means getting it right first time - improving outcomes and preventing problems from getting worse to avoid the need for more expensive interventions later on.

19. We need to tackle all the factors which may increase the risk of suicide in the communities where they occur if our efforts are to be effective. Suicide prevention is most effective when it is combined as part of wider work addressing the social and other determinants of poor health, wellbeing or illness.

Outcomes strategies and making an impact

20. Cross-cutting outcomes strategies recognise that the Government can achieve more in partnership with others than it can alone, and that services can achieve more through integrated working than they can through working in isolation from one another. This new approach builds on existing joint working across central government departments, and between the Government, local government, local organisations, employers, service users and professional groups, by unlocking the creativity and innovation suppressed by a top-down approach.

21. There are two other key strategy documents that, in combination with this one, take a public health approach using general and targeted measures to improve mental health and wellbeing and reduce suicides across the whole population.

22. *Healthy Lives, Healthy People: Our strategy for public health in England* (2010) gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement. The prompts for local councillors on suicide prevention published alongside this strategy are designed as helpful pointers for how local work on suicide prevention can be taken forward.

23. Health and wellbeing boards will support effective local partnerships and will be able to support suicide prevention as they determine local needs and assets.

24. Public Health England, the new national agency for public health, will also support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing, including work on suicide prevention.

25. *No health without mental health: A cross-government outcomes strategy for people of all ages* (2011) is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of *No health without mental health* aims to ensure that more people will have good mental health. To achieve this, we need to:

- improve the mental wellbeing of individuals, families and the population in general;

- ensure that fewer people of all ages and backgrounds develop mental health problems; and
- continue to work to reduce the national suicide rate.

26. *No health without mental health* includes new measures to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities. These too are powerful suicide prevention measures.

27. The stigma associated with mental health problems can act as a barrier to people seeking and accessing the help that they need, increasing isolation and suicide risk. The Government is supporting the national mental health anti-stigma and discrimination Time to Change programme.

28. An implementation framework for *No health without mental health* was published in July 2012. This sets out what local organisations can do to implement the mental health strategy, what work is underway nationally to support them, and how progress against the strategy's aims will be measured. The framework explicitly covers suicide prevention, and supports implementation of this new suicide prevention strategy so should be read alongside this document.

29. During the development of this suicide prevention strategy, Samaritans have been facilitating a Call to Action for Suicide Prevention in England. The Call to Action consists of national organisations from across sectors in England taking action so that fewer lives are lost to suicide and people bereaved or affected by a suicide receive the right support.

30. Member organisations have signed a declaration on suicide prevention for England; mapped existing suicide reduction and support activity in their organisations and identified priorities for joint action.

31. We are publishing separately an assessment of the impact on equalities of this strategy.

32. Our approach in this strategy is to:

- set out clear, shared objectives for suicide prevention, and key areas where action is needed;
- state what government departments will do to contribute to these objectives;
- set out how the outcomes frameworks for public health and the NHS will require reductions in the suicide rate; and
- support effective local action by bringing together knowledge about groups at higher risk of suicide, evidence around effective interventions and highlighting research available.

1. Area for action 1: Reduce the risk of suicide in key high-risk groups

1.1 Some groups of people are known to be at higher risk of suicide than the general population. We have been able to identify these groups from research and can monitor numbers from the routine data collected. In this way we identified:

- those groups that are known statistically to have an increased risk of suicide; and
- actual numbers of suicides in these groups.

1.2 In addition, evidence already exists on which to base preventative measures in these groups. We are also able to monitor the impact of preventative measures taken using existing data collections.

1.3 The groups at high risk of suicide are:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

1.4 There are other groups whose risk could be high, but limits on the data available mean that their risk is hard to estimate, or else there is no way of monitoring progress as a result of suicide prevention measures.

1.5 Although the strategy focuses on groups at higher risk, it recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the groups will be vulnerable to suicide.

Young and middle-aged men

- Men are at three times greater risk of suicide than women. Most suicides are among men aged under 50. Men aged 35-49 are now the group with the highest suicide rate.
- Older men (over 75) also have higher rates of death by suicide, which may reflect the impact of depression, social isolation, bereavement or physical illness.
- Factors associated with suicide in men include depression, especially when it is untreated or undiagnosed; alcohol or drug misuse; unemployment; family and relationship problems including marital breakup and divorce; social isolation and low self-esteem.[45]

1.6 Men aged under 35 were a high-risk group in the 2002 strategy. Although the suicide rate in men aged under 35 has fallen we are continuing to highlight young men within the strategy because suicide is the single most frequent cause of death, and their youth means that it accounts for a large number of years of life lost. This does not mean that older men should be overlooked. Rates of suicide in men aged over 75 remain high. Different risk factors, such as loneliness and physical illness, may be important in this age group.

Effective local interventions

1.7 Findings from three mental health promotion pilot projects launched in 2006

to address the raised suicide risk in young men show that:

- multi-agency partnership is key to promoting young men's mental health;
- community locations, such as job centres and young people-friendly venues, are more successful in engaging with young men than more formal health settings such as GP surgeries;
- front-line staff feel better able to engage with young men if they receive training; and
- community outreach programmes are seen by young men as more acceptable and approachable than services provided in formal healthcare settings.

1.8 We believe that this broad-based approach has improved the identification of risk by front-line agencies and contributed to the reduction in suicides in the younger male age group. These findings can be adapted and applied to all age groups. *Reaching Out*, the evaluation report of the three projects is available at www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

1.9 Many statutory and third sector organisations have set up regional and local initiatives and projects to support men and encourage them to contact services when they are in distress. Some of these projects take their messages out into traditional male territories, such as football and rugby clubs, leisure centres, public houses and music venues.

National action to support local approaches

1.10 Samaritans has launched a five-year campaign to address suicide in men in mid-life of lower socio-economic position. This includes research to understand why this group is at excessive risk of dying by suicide compared to other groups, stimulating debate about policy and practice to reduce suicide in this group, and encouraging men to contact Samaritans.

Helpful resources

NHS Hull has produced a short fictional film to help men in the city understand depression and its effect on their lives. 'Peter's Story' aims to encourage men, particularly in the 25–50 age group, to think and talk about issues with their mental health and wellbeing. www.peters-story.co.uk

The Men's Health Forum has published *Untold Problems: a review of the essential issues in the mental health of men and boys* and a good practice guide, *Delivering Male: Effective practice in male mental health*, setting out ways to improve men's health, including strategies to prevent suicide and encourage help-seeking.

People in the care of mental health services, including inpatients

Patient safety in the mental health services continues to improve.

- The number of people in contact with mental health services who died by suicide has reduced from 1,253 in 2000 to an estimated 1,187 in 2010, a reduction of 66 deaths (5%)
- The number of inpatients who died by suicide reduced from 196 in 2000 to 74 in 2010, a reduction of 122 deaths (62%). The number of inpatients who died on wards by hanging or strangulation reduced by 54%
- The number of patients who refused

drug treatment who died by suicide reduced from 229 in 2000 to 141 in 2010 (38%). www.medicine.manchester.ac.uk/mentalhealth/research/suicide/

- People with severe mental illness remain at high risk of suicide, both while in inpatient units and in the community. Inpatients and people recently discharged from hospital and those who refuse treatment are at highest risk.

Effective local interventions

1.11 The provision of high-quality services that are equally accessible to all is fundamental to reducing the suicide risk in people of all ages with mental health problems.

1.12 Although much has been achieved by front-line staff to reduce suicides in people with mental health problems, they remain a group at high risk, so it is important that mental health services remain vigilant and continue to strengthen clinical practice.

1.13 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) checklist 'Twelve Points to a Safer Service' is based on recommendations from a national study of patient suicides and provides key guidance for mental health services. www.medicine.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/saferservices

1.14 A recent research study suggested that these services changes (particularly 24 hour crisis teams, policies for people with drug and alcohol problems, and reviews after suicide) were associated with a reduction in the rate of suicide in implementing NHS Trusts.[6]

1.15 Approaches identified by the NCI which can contribute to a reduction in suicide rates include:

- improving care pathways between emergency departments, primary and secondary care, inpatient and community care, and on hospital discharge;
- ensuring that front-line staff working with high-risk groups receive training in the recognition, assessment and management of risk and fully understand their roles and responsibilities;
- regular assessments of ward areas to identify and remove potential risks, i.e. ligatures and ligature points, access to medications, access to windows and high-risk areas (gardens, bathrooms and balconies). The most common ligature points are doors and windows; the most common ligatures are belts, shoelaces, sheets and towels. Inpatient suicide using non-collapsible rails is a 'Never Event'.[7*] New kinds of ligatures and ligature points are always being found, so ward staff need to be constantly vigilant to potential risk;[8]
- improving safety in new models of care such as crisis resolution/home treatment;
- service initiatives to prevent patients going missing from inpatient wards, such as those in *Strategies to Reduce Missing Patients: A practical workbook* (National Mental Health Development Unit, 2009);
- good risk management and continuity of care. The recent judgment, Rabone vs Pennine Care NHS Foundation Trust, confirmed that NHS Trusts have a duty to protect voluntary mental health patients from the risk of suicide, and

[*] Never Events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

highlights the importance of risk management. Aligning care planning more closely with risk assessment and risk management is important, as is the provision of regular training and updates for staff in risk management. The Department of Health guidance on assessment and management of risk[9] emphasises that risk assessment should be an integral part of clinical assessment, not a separate activity. All service users and their carers should be given a copy of their care plan, including crisis plans and contact numbers;

- innovative approaches which may be helpful: many local services have developed ways to follow up people recently discharged from mental health inpatient units using telephone, text messaging and email, as well as letters.

Helpful resources

1.16 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines a range of evidence-based treatments and interventions to prevent people of all ages from developing mental health problems where possible, intervene early when they do, and develop and support speedy and sustained recovery. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

1.17 NCI provides regular reports on patient suicides and up-to-date statistical data. These reports highlight and make recommendations where clinical practice and service delivery can be improved to prevent suicide and reduce risk. www.medicine.manchester.ac.uk/suicideprevention/nci

1.18 The National Patient Safety Agency's (NPSA's) *Preventing Suicide: A toolkit for mental health services* includes measures for services to assess how well they are meeting the best practice on suicide prevention. www.nrls.npsa.nhs.uk/resources/?EntryId45=65297. The NPSA also published *Preventing suicide: A toolkit for community mental health* (2011). It focuses on improving care pathways and follow up for people who present at emergency departments following self-harm or suicidal behaviour and those who present at GP surgeries and are identified as at risk of self-harm or suicide. www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-community-mental-health.pdf

People with a history of self-harm

- There are around 200,000 episodes of self-harm that present to hospital services each year.[10] However, many people who self-harm do not seek help from health or other services and so are not recorded.

- Studies have shown that by age 15-16, 7-14% of adolescents will have self-harmed once in their life.[11]

- People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm.[12] At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Around one in 100 people who self-harm take their own life within the following year. Risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods of self-harm.[13]

Effective local interventions

1.19 Emergency departments have an important role in treating and managing people who have self-harmed or have made a suicide attempt. There are still problems in some places with the quality of care, assessment and follow-up of people who seek help from emergency departments after self-harming.[14] Attitudes towards and knowledge of self-harm among general hospital staff can be poor. A high proportion of people who self-harm are not given a psychological assessment. Often, follow-up and treatment are not provided, in particular for people who repeatedly self-harm. In many emergency departments, the facilities available for distressed patients could be improved.

1.20 GPs have a key role in the care of people who self-harm. Good communication between secondary and primary care is vital, as many people who present at emergency departments following an episode of self-harm consult their GP soon afterwards.[15]

1.21 Work undertaken by the London School of Economics has shown that suicide prevention education for GPs can have an impact as a population-level intervention to prevent suicide. This has the potential to be cost-effective if it leads to adequate subsequent treatment. See www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/news/2011/healthstrategy.aspx

1.22 Appropriate training on suicide and self-harm should be available for staff working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems.

Helpful resources

1.23 Clinicians can use the NICE self-harm pathway, which summarises both short and long term self-harm guidance using a flowchart based approach: www.pathways.nice.org.uk/pathways/self-harm

1.24 NICE has developed two sets of clinical practice guidelines on self-harm for the NHS in England, Wales and Northern Ireland:

- on the short-term management and secondary prevention of self-harm in primary and secondary care (see http://publications.nice.org.uk/self-harm-cg16); and
- on the longer-term management of self-harm. It includes recommendations for the appropriate treatment for any underlying problems (including diagnosed mental health problems). It also covers the longer-term management of self-harm in a range of settings (see http://publications.nice.org.uk/self-harm-longer-term-management-cg133).

1.25 The National CAMHS Support Service produced a self-harm in children and young people handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children's services can respond. www.chimat.org.uk/resource/view.aspx?RID=105602

National action to support local approaches

1.26 NICE quality standards are under development on self-harm in adults and children and young people.

1.27 The Royal College of GPs will focus on strengthening training in mental health as part of the GP training programme,

both within current arrangements and as they develop the case for enhanced (four year) training.

People in contact with the criminal justice system

- People at all stages within the CJS, including people on remand and recently discharged from custody, are at high risk of suicide. The period of greatest risk is the first week of imprisonment.[16] However, recent figures suggest that risk of self-inflicted death has decreased in the first week of custody (Ministry of Justice, Safety in Custody Statistics).
- Reasons for the increased risk include the following:
  - a high proportion of offenders are young men, who are already a high suicide risk group. However, the increase in suicide risk for women prisoners is greater than for men;
  - an estimated 90% of all prisoners have a diagnosable mental health problem (including personality disorder) and/or substance misuse problems; and
  - offenders can be separated from their family and friends, whose social support may help to guard against suicidal feelings.
- The three-year average annual rate of self-inflicted deaths* by prisoners in England was 69 deaths per 100,000 prisoners in 2009-2011. This has decreased year-on-year since 2004 when it was 132 deaths per 100,000 prisoners.

Effective local interventions

1.28 Details of proposals to improve mental health outcomes for people in contact with the CJS are given in *No health without Mental Health: Delivering better mental health outcomes for people of all ages*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

National action to support local approaches

1.29 The National Offender Management Service (NOMS) has a broad, integrated and evidence-based strategy[17] for suicide prevention and self-harm management, and is committed to reducing the number of self-inflicted deaths in prison custody. The Youth Justice Board is taking a similar approach to reduce the number of self-inflicted deaths in the Young Person's Secure Estate. Each death is investigated by the Prisons and Probation Ombudsman.

1.30 The National Safer Custody Managers and Learning Team was established in 2009. The National Safer Custody Managers provide deputy directors of custody with advice on safer custody policies and other areas where they have a direct link to the delivery of safer custody. Strenuous efforts are made to learn from each death and improve understanding of and procedures for caring for prisoners at risk of suicide or self-harm.

1.31 Since the introduction of mental health in-reach services, the Integrated Drug Treatment System and Assessment, Care in Custody and Teamwork procedures into prisons there has been a reduction in self-inflicted deaths in prison custody.

* Prisoner 'self-inflicted deaths' include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80 per cent of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

1.32 The Department of Health, NOMS and University of Oxford Centre for Suicide Research are funding an analysis of all self-harm data based on incidents from 2004 to 2009. This will inform the development of more effective ways of identifying, managing and reducing the risk of those prisoners who self-harm.

1.33 The Health and Criminal Justice Transition Programme Board is overseeing a programme to provide police custody suites and criminal courts with access to liaison and diversion services by 2014. These services will be open and accessible to people of all ages, whether they have a mental health problem, learning disability, personality disorder, substance misuse issue or other vulnerability. They will provide early identification of individuals, allow the police and courts to understand as much as possible about the individual, and inform offender management and rehabilitation. For people in the criminal justice system with mental health needs, the aim is to ensure that they receive treatment in the most appropriate setting, whether in prison, secure mental health services, or in the community.

1.34 A study commissioned by the Independent Police Complaints Commission found that deaths in or following police custody, particularly those as a result of hanging, reduced significantly between 1998-99 and 2008-09. The study report identified improvements in cell design, identification of ligature points, risk assessments and Safer Detention guidance as all possibly contributing to the reduction.
www.ipcc.gov.uk/Pages/deathscustodystudy.aspx

Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

- Some occupational groups are at particularly high suicide risk. Nurses, doctors, farmers, and other agricultural workers are at highest risk, probably because they have ready access to the means of suicide and know how to use them.

- Research[18] shows that these patterns of suicide are broadly unchanged. Among men, health professionals and agricultural workers remain the groups at highest risk of suicide. However, other occupational groups have emerged with raised risks. The highest numbers (not rates) of male suicides were among construction workers and plant and machine operatives.

- Among women, health workers, in particular doctors and nurses, remained at highest suicide risk.

1.35 This strategy maintains the focus on the highest risk occupational groups but recognises the potential vulnerability of other occupational groups.

Effective local interventions

1.36 Risk by occupational group may vary regionally and even locally. It is vital that the statutory sector and local agencies are alert to this and adapt their suicide prevention interventions and strategies accordingly. For example, GPs in rural areas, aware of the high rates of suicide in farmers and agricultural workers, will be well prepared to assess and manage depression and suicide risk.

The Practitioner Health Programme, funded by London primary care trusts, offers a free, confidential service for doctors and

dentists who live or work in the London area. www.php.nhs.uk/what-to-expect/how-can-i-access-php

MedNet is funded by the London Deanery and provides doctors and dentists working in the area with practical advice about their career, emotional support and, where appropriate, access to brief or longer-term psychotherapy. www.londondeanery.ac.uk/var/support-for-doctors/MedNet

Helpful resources

1.37 The Department for Environment, Food and Rural Affairs has a number of measures in place to support rural workers aimed at easing some of the stresses which are known to adversely affect farmers, agricultural workers and their families. These include specific support on bovine tuberculosis to the Farm Crisis Network. The Task Force on Farming Regulation aims to reduce some of the bureaucratic burden on farmers.

Rural Stress Helpline offers a confidential, non-judgemental listening service to anyone in a rural area feeling troubled, anxious, worried, stressed or needing information. Helpline 0845 094 8286 (Mon-Fri 9am-5pm); email help@ruralstresshelpline.co.uk

1.38 The Department of Health published *Maintaining high professional standards in the modern NHS* (2003) with additional guidance (2005) on handling concerns about a practitioner's health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

1.39 In 2008, The Department of Health published *Mental health and Ill health in Doctors*. This identifies a number of sources of help and recognises that many of the issues are very similar for other health professionals. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083066

1.40 *NHS Health and Wellbeing Improvement Framework*, published in 2011, is a tool for decision makers on Boards to support them in establishing a culture that promotes staff health and wellbeing. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128691

1.41 The Police Service proactively manages staff wellbeing to try to avoid individuals becoming unwell due to mental health problems such as depression, anxiety or post-traumatic stress disorder. Police officers and staff can access services through their line management, Occupational Health Departments or often via self-referral.

2. Area for action 2: Tailor approaches to improve mental health in specific groups

2.1 As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population as a whole. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides by building individual and community resilience, promoting mental health and wellbeing and challenging health inequalities where they exist.

2.2 For this whole population approach to reach all those who might need it, it should include tailored measures for groups with particular vulnerabilities or problems with access to services. They are groups of people who may have higher rates of mental health problems including self-harm. These are not discrete groups, and many individuals may fall into more than one of these groups, for example, some Black and minority ethnic (BME) groups are more likely to have lower incomes or be unemployed; children and young people may also fall into several other of these groups. The groups identified are:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the YJS;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

2.3 For many of these groups we do not have sufficient information about numbers of suicides or about what interventions might be helpful. The requirements for improved information and research are considered further under area for action 6.

Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the YJS

- The suicide rate among teenagers is below that in the general population.[19] However, young people are vulnerable to suicidal feelings. The risk is greater when they have mental health problems or behavioural disorders, misuse substances, have experienced family breakdown, abuse, neglect or mental health problems or suicide in the family. The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person.

- Self-harm is particularly common among young people.[20]

- Children and young people in the youth justice system experience many of the same risk factors as adults in the criminal justice system. Since January 2002, six young

people in custody in the Young Person's Secure Estate have killed themselves.

- Looked after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also at five-fold increased risk of all childhood mental, emotional and behavioural problems and at six to seven-fold increased risk of conduct disorders.

Effective local interventions

2.4 The non-statutory programmes of study for Personal, Social, Health and Economic (PSHE) education provide a framework for schools to provide age–appropriate teaching on issues including sex and relationships, substance misuse and emotional and mental health. This and other school-based approaches may help all children to recognise, understand, discuss and seek help earlier for any emerging emotional and other problems.

2.5 The consensus from research is that an effective school-based suicide prevention strategy would include:

- a co-ordinated school response to people at risk and staff training;
- awareness among staff to help identify high risk signs or behaviours (depression, drugs, self-harm) and protocols on how to respond;
- signposting parents to sources of information on signs of emotional problems and risk;
- clear referral routes to specialist mental health services.

2.6 The Healthy Child Programme 0-19, led by front line health professionals, focuses on health promotion, prevention and early intervention with vulnerable families. Health visitors and their teams will identify children at high risk of emotional and behavioural problems and ensure that they and their families receive appropriate support, including referral to specialist services where needed. Preventing suicide in children and young people is closely linked to safeguarding and the work of the Local Safeguarding Children Boards. Professor Munro's review of child protection (2011) made 15 recommendations to reform the system. The review emphasised the importance of evidence-based early interventions and recommended that help is provided early to children and families in order to negate the impact of abuse and neglect and to improve the life chances of children and young people. In response, the Government is working with partners to reinforce the existing legislation and revise statutory guidance, and to understand better how to make progress on early help. Inspections of child protection services will assess local provision of early help.

2.7 Local services can develop systems for the early identification of children and young people with mental health problems in different settings, including schools. Stepped-care approaches to treatment, as outlined in NICE guidance, can be effective when delivered in settings that are appropriate and accessible for children and young people. The Department of Health's *You're Welcome* quality criteria self-assessment toolkit may be helpful in ensuring that services and settings are genuinely acceptable and accessible to children and young people.

2.8 The specialist early intervention in psychosis model of community care has achieved better outcomes than generic community mental health teams for young people aged 14–35 in the early phase of severe mental illness, achieving faster and more lasting recovery. The impact of early intervention on suicide is under investigation, but it is clear that suicide in young patients has decreased in recent years.[21]

2.9 It is particularly important that interventions for children and young people who offend, and for other vulnerable children and young people in the area, are both easily accessible and engaging. This requires outreach, flexible wraparound support and persistence, so that sessions can continue, even in the face of barriers to engagement.[22] In all forms of custodial or secure settings, including detention, continuous attention is needed to minimise a young person's sense of isolation from home and family and workers should be proactive in responding to their mental health needs. What young people in these circumstances value highly from professionals is knowing that someone will listen to them and be interested in their concerns.

Helpful resources

2.10 Stonewall's Education for All campaign, works to tackle homophobic bullying in Britain's schools, and has a lot of resources. www.stonewall.org.uk/at_school/education_for_all/default.asp

2.11 Beatbullying is a UK-wide bullying prevention charity, and has developed a large range of anti-bullying teaching resources to help raise awareness of bullying in all its forms and help children to keep safe. They are available free at: www.beatbullying.org/dox/resources/resources.html

National action to support local approaches

2.12 *No health without mental health* and *No health without mental health: Delivering better mental health outcomes for people of all ages* include local and national interventions to improve the mental health of children and young people. Interventions include effective school-based approaches to tackling violence and bullying and sexual abuse. They also cover effective approaches to identifying children who are at risk and the specific needs of looked after children and care leavers.

2.13 We are also extending access to psychological therapies for children and young people. Building on the learning from the Improving Access to Psychological Therapies (IAPT) initiative for adults, a rolling national programme with a strong focus on outcomes will seek to transform local child and adolescent mental health services, equipping them to deliver a broader range of evidence-based psychological therapies for children and young people and their families.

2.14 Additional investment will extend both the geographical reach and range of therapies offered through the Children and Young People's IAPT project. It will also support development of interactive e-learning programmes in child mental health to extend the skills and knowledge of:

- NHS clinicians;

- a wide range of people working with children and young people in universal settings including teachers, social workers, police and probation staff and faith group workers;
- school and youth counsellors working in a range of educational settings.

2.15 The new e-portal will include specific learning and professional development in relation to self-harm, suicide and risk in children and young people.

2.16 The Children and Young People's Health Outcomes Strategy will identify the health outcomes that matter most to children, young people and their families and set out how the system will contribute to their delivery. Children and young people's mental health outcomes – including those in relation to suicide and self-harm – was one of four key areas considered by the Children and Young People's Health Outcomes Forum. The Forum's report[23], published in July, and the system's response to their recommendations will be key components within a Children And Young People's Health Outcomes Strategy, which will be published in autumn 2012.

Survivors of abuse or violence, including sexual abuse

- One in four people in England has experienced some form of violence or abuse in their lifetime, and almost half of all children have been the victims of bullying. Women and children are most at risk of domestic and sexual violence.
- Violence and abuse can lead to a number of psychosocial problems associated with a heightened suicide risk, including: social isolation and exclusion; poor educational achievement; conduct, behavioural and emotional problems in children, and antisocial and risk-taking behaviours. Violence and abuse are also associated with a higher risk of mental health problems and suicidal feelings.
- Adverse and abusive experiences in childhood are associated with an increased risk of suicidal behaviour.[24]

Effective local interventions

2.17 Timely and effective assessment of all vulnerable children is crucial to speedy identification and referral to appropriate support services. Screening tools such as the Strengths and Difficulties Questionnaire (SDQ) can help to prioritise referrals to local CAMHS.

2.18 A training and support programme targeted at primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence.
www.thelancet.com/journals/lancet/article/PII S0140-6736(11)61179-3/abstract

Leicestershire Police have a Comprehensive Referral Desk (CRD) of specialist officers who deal with domestic abuse, child abuse and adults in vulnerable situations. Each report from front-line officers and other agencies is assessed and dealt with by referral onto other agencies or by providing an appropriate police response to any criminal allegations or safeguarding issues. The CRD has led to improved joint working with health and other agencies. Through partnership working, the CRD

tries to reduce the likelihood of the same individuals being in situations of threat, harm or risk in the future.

National action to support local approaches

2.19 *Call to End Violence against Women and Girls (2010),* a cross-government strategy, has been followed by two cross-government action plans – the latest of which was published in March 2012. It includes actions around preventing violence, provision of services, partnership working, justice outcomes and risk reduction. The Government's continued support for Independent Sexual Violence Advisers, Independent Domestic Violence Advisers and Multi Agency Risk Assessment Conferences aims to ensure that women and girls at highest risk of violence are identified and referred for specialist help. Data sharing between emergency departments and other agencies is being encouraged to improve the identification of violence.

Helpful resources

2.20 The RCGP has produced an e-learning resource for GPs to enable them to identify and respond to victims of domestic violence more effectively.
www.elearning.rcgp.org.uk/course/view.php?id=88

2.21 Southall Black Sisters have developed a model of intervention on domestic violence amongst Black and Minority Ethnic women.[25]

Veterans

- There are five million armed forces veterans in the UK and around 180,000 serving personnel. The prevalence of mental disorders in serving and ex-service personnel is broadly the same as that in the general population. Depression and alcohol abuse are the most common mental disorders. The most recent research found that one in four veterans from the Iraq War experienced some kind of mental health problem and one in 20 had been diagnosed with post-traumatic stress disorder.

- In general, suicide rates among armed forces veterans are lower than those in the general population. There is no evidence that, as a whole, people who have served their country in armed conflict are at higher risk of suicide. An important possible exception is young armed-service leavers in their early 20s. One study suggests they may be at two or three times' greater risk of suicide than comparable groups.[26]

2.22 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines all the Government's commitments to improving mental health support for service and ex-service personnel.

People living with long-term physical health conditions

- Some long-term conditions are associated with an increased risk of suicide, e.g. epilepsy. There is also evidence that receiving a diagnosis of cancer, coronary heart disease and chronic obstructive airways disease is associated with higher suicide risk. For cancer, the risk of suicide increases by more than ten times in

the week after diagnosis.

- Physical illness is associated with an increased suicide risk.[27] Many people who live with long-term conditions - including physical illness, disability and chronic pain – will, at some time, experience periods of depression that may be undiagnosed and untreated. Disadvantage and barriers in society for disabled people can lead to feelings of hopelessness. People with one long-term condition are two to three times more likely to develop depression than the rest of the general population. People with three or more conditions are seven times more likely to have depression. Many medical treatments for long-term physical health conditions (for example, chronic pain medication, insulin treatment) also provide people with ready access to the means of suicide.

- While depression explains a substantial part of the increased suicide risk in people with physical health conditions, it does not explain all of the increase.

2.23 *No health without mental health* is clear that we expect mental health needs to be given equal consideration to physical health needs.

Effective local interventions

2.24 Support for self-management and self-care is crucial, for example, in managing chronic pain, so that people have a greater sense of choice over how their health and care needs are met, feel more confident to manage their condition on a day-to-day basis and take an active part in their care. Feeling in control of one's life is associated with increased mental wellbeing and resilience.

2.25 Routine assessment for depression as part of personalised care planning can help reduce inequalities and support people with long-term conditions to have a better quality of life and better social and working lives.

2.26 Suicide can occur in general hospitals. Providers need to be aware of this risk, and to make appropriate links between physical and mental health care.

2.27 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines a number of local approaches to improve the mental health care of people with physical health problems.

Helpful resources

2.28 The NPSA has produced suicide prevention toolkits for ambulance services, general practice, emergency departments and community mental health and mental health services. The toolkits support clinicians and managers to understand what they can do to reduce the suicides. www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx

National action to support local approaches

2.29 *Talking Therapies: A four year plan of action* (2011) sets out the Government's plans to improve access to talking therapies and expand provision for children and young people, older people and their carers, people with long-term

physical health conditions, people with medically unexplained symptoms and people with severe mental illness.

2.30 The Office for Disability Issues (ODI) is developing a new cross-government disability strategy in partnership with disabled people and their organisations. Together, they are identifying effective ways to remove the barriers that prevent disabled people, including those with mental health conditions, from fulfilling their potential and having opportunities to play a full role in society. In September we will publish a summary of responses to *Fulfilling Potential*, including current and planned actions across government. We will also outline the next steps based upon the issues and ideas disabled people have told us about. We will publish a strategy and action plan in 2013.

2.31 The Department of Health's long-term conditions model aims to improve the health and wellbeing of people with long-term conditions such as diabetes. The Department is also developing a Long Term Conditions Outcomes Strategy for publication towards the end of 2012 which will outline a vision for how Government can work with local bodies to improve outcomes for people with long-term conditions.

2.32 The Government has recently published the White Paper *Caring for our future: reforming care and support*[28], following extensive engagement with the care sector over recent months. This sets out the Government's vision for reform of care and support, with a renewed focus on high quality, personalised and joined up care, supporting people to maintain independence for as long as possible and have choice and control over how their outcomes are met.

People with untreated depression

- Depression is one of the most important risk factors for suicide and undiagnosed or untreated depression can heighten that risk. Most depression can be treated in primary care.

- Depression is now recognised as a major public health problem worldwide. In England one in six adults and one in 20 children and young people at any one time are affected by depression and related conditions, such as anxiety. Depression is the most common mental health problem in older people - some 13-16% have sufficiently severe depression to need treatment. But only a quarter (or even fewer young and older people) receive treatment, even though effective drug and psychological treatments are available.

- Untreated depression can have a major impact on quality of life and can cause other health and social care problems - for example, postnatal depression can be associated with behavioural problems in the child. There are also risks in the early stages of drug treatment when some patients feel more agitated.

- Depression, chronic and painful physical illnesses, disability, bereavement and social isolation are more common among older people.

> Men aged 75 and over have the highest rate of suicide among older people. While suicide rates among older people have been decreasing in recent years, an increase in absolute numbers is expected in the coming decades, due to the increase in number of older people.

Effective local interventions

2.33 People recover more quickly from depression if it is identified early and responded to promptly, using effective and appropriate treatments.

2.34 *No health without mental health: Delivering better mental health outcomes for people of all ages* identifies effective local approaches to treating depression and outlines some effective approaches for 'ageing well'.

Helpful resources

2.35 NICE issued updated guidance on *Depression: Management of depression in primary and secondary care* in 2009 and *Depression in Children and Young People: Identification and management in primary, community and secondary care* in 2005. NICE has also published a quality standard on depression, including with a chronic physical health problem.

2.36 Depression Alliance has produced leaflets on depression and an information pack. www.depressionalliance.org

2.37 The Staffordshire University Centre for Ageing and Mental Health has developed a set of information sheets to help health and social care providers respond to suicide risk in older clients: www.wmrdc.org.uk/mental-health/primary-care/suicide-prevention-in-elders-project-summary

2.38 The Department of Health has funded multi-centre research on suicide prevention[29] which has produced useful recommendations for services working with older people. It found that older adults who self-harm are at high risk of suicide, with men aged over 75 years at greatest risk. Use of a violent method in the first attempt is also a predictor of subsequent suicide. Alcohol dependency is also common among older adults who attempt suicide.

2.39 *Caring for our future* sets out how supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, are central elements to the Government's new vision for care and support. The Department of Health has supported the Campaign to End Loneliness to produce a digital toolkit for health and wellbeing boards to support them in understanding, and addressing loneliness and social isolation in their communities: www.campaigntoendloneliness.org.uk/toolkit

2.40 The Department of Health, the Royal Colleges of General Practice, Nursing and Psychiatry and the British Psychological Society have developed a fact sheet on depression in older people: www.rcgp.org.uk/mental health/resources.aspx

People who are especially vulnerable due to social and economic circumstances

- There are direct links between mental ill health and social factors such as unemployment and debt. Both are risk factors for suicide.
- Previous periods of high unemployment and/or severe economic problems have been accompanied by increased incidence of mental ill health and higher suicide rates.[30]
- Suicide risk is complex – we do need to be vigilant at this time of higher economic uncertainty, but it is important not to assume that an increase in suicide is inevitable.
- 34% of rough sleepers have a mental health need and 18% have a mental health need combined with a substance misuse issue (dual diagnosis).

Effective local interventions

2.41 A range of front-line agencies, including primary and secondary health and social care services, local authorities, the police and Jobcentre Plus, can identify and support (or signpost to support) vulnerable people who may be at risk of suicide. As the Government's strategy *Social Justice: Transforming Lives* also makes clear, for individuals and families facing multiple social or economic disadvantages, it is really important that these local agencies 'join up' to maximise the effectiveness of services and support. www.dwp.gov.uk/docs/social-justice-transforming-lives.pdf

2.42 Interventions that improve financial capability reduce both the likelihood of people getting into debt and the impact of debt on mental health. Local services include Citizens Advice, the Money Advice Service at: www.moneyadviceservice.org.uk and the Consumer Credit Counselling Service: www.cccs.co.uk/Home.aspx. Credit unions can provide affordable credit to and encourage saving by the most disadvantaged families.

2.43 Other useful approaches at a local level include:

- continuously improving the knowledge and confidence of front-line staff who are in regular contact with people who may be vulnerable because of social/economic circumstances. This is particularly relevant to DWP front-line businesses including Jobcentre Plus staff, people working in other advice and support agencies and front-line staff in the financial sector (banks, building societies and utility companies);
- providing public information to signpost people to information, support and useful contacts if they are in debt or at risk of getting into debt. Information can be provided in a number of different ways, for example online and accessible leaflets. A number of NHS trusts have developed information sheets for the local population on the impact of the economic crisis - these give advice on maintaining wellbeing during difficult times and offer guidance on where to go for further help; and
- developing suicide awareness and education or training programmes to teach people how to recognise and respond to the warning signs for suicide in themselves or in others. These can be delivered in a variety of settings (such as schools, colleges,

workplaces and job centres). There are several training programmes available including Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid, Safe Start and training carried out by Samaritans.

2.44 DWP has guidance in place to help their staff to manage suicide and self-harm declarations from customers safely and effectively, for themselves and the customer.

2.45 Businesses and other employers can help by investing in and supporting their staff, particularly during times of anxiety and change.

National action to support local approaches

2.46 *No health without mental health: Delivering better mental health outcomes for people of all ages* gives examples of effective national approaches to support people back into employment and improve their financial capability and to support employers to meet their business needs and statutory requirements for healthy workplaces.

2.47 The Government's Work Programme supports people who are out of work to gain and sustain paid employment. This includes providing tailored support for people with mental health conditions to work. Work Programme Prime providers and specialist service providers have pledged to improve support to people with mental health problems; an approach endorsed by voluntary and community organisations.

2.48 We are replacing a wider range of financial benefits with a single Universal Credit which will ensure that people are always better off in work. The new system will be much simpler to administer and easier for claimants to understand. It will help people to get back to work gradually and smooth over earnings fluctuations where hours of work and income can vary.

2.49 The Government is committed to preventing and reducing homelessness, and improving the lives of those people who do become homeless. The Ministerial Working Group (MWG) on Preventing and Tackling Homelessness is bringing the relevant government departments together to share information, resolve issues and avoid unintended policy consequences, with the aim of enabling communities to tackle the multifaceted issues that contribute to homelessness. The MWG produced its first report *A Vision to End Rough Sleeping: No Second Night Out* in 2011 and is working on its second report on preventing homelessness, to be published later this year. www.communities.gov.uk/publications/housing/visionendroughsleeping

People who misuse drugs or alcohol

- Many people with drug and alcohol dependence problems also have some form of mental health problem.[31][32] Similarly, about half of people with mental health problems misuse alcohol and/or drugs. Dual diagnosis (co-morbidity of drug and alcohol misuse and mental ill health) is associated with increased risk of suicide and suicide attempts.

- The use of drugs or alcohol is strongly associated with suicide in the general population and in sub-groups such as young men and

people who self-harm.

- For some people, their dependence is on prescribed drugs such as tranquilisers, and they may experience agitation on withdrawal and co-morbid mental health problems which may add to their risk.

- Smoking and nicotine dependence are associated with suicidal behaviour. There is no evidence to suggest that smoking cessation increases suicide risk.

Effective local interventions

2.50 Measures that reduce alcohol and drug dependence are critical to reducing suicide. That is why the 2010 drug strategy, *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life*, put the goal of recovery at its heart. It aims to create a recovery system that is locally led and locally owned enabling prompt access to treatment, helping people to realise the goal of recovery and ensuring appropriate aftercare to help people lead fulfilling lives.

2.51 Close working between mental health teams and local NHS stop smoking services should deliver cessation treatment strategies that complement recovery. Bupropion[33] should not be used to treat people at risk of suicide and care should be taken if varenicline[34] is prescribed.

National action to support local approaches

2.52 *Reducing Demand, Restricting Supply, Building Recovery* highlights the importance of holistic support to enable people to rebuild their lives and play their full role in society. The transfer to local authorities of responsibility for commissioning treatment for dependence on drug and alcohol will help local systems to develop effective links between treatment, housing services, criminal justice bodies, training and the wider support that is needed.

2.53 The Government Alcohol Strategy (2012) is explicitly targeted at harmful drinkers, problem pubs and irresponsible shops and sets out radical plans to turn the tide against irresponsible drinking. Chapter 3 of the Alcohol Strategy sets out how local communities and services can tackle alcohol-related issues in their area.

2.54 The NICE guidelines on management of anxiety[35] and treatment and management of depression[36] state that treatment with benzodiazepine (where appropriate) should usually be for no longer than two weeks in order to prevent the development of dependence.

Lesbian, gay, bisexual and transgender people

- A review of the research literature suggests that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm.[37] One Danish study found the suicide risk among gay men in civil partnerships is eight times higher than in heterosexual couples and twice as high as the risk in men who have never married. However, the same study showed no statistically significant increase in suicide risk among women in civil partnerships.[38]

- Lesbian, gay and bisexual people are twice as likely as heterosexual people to self-harm. Gay and bisexual men have a particularly high prevalence of self-harm. One in ten gay and bisexual men aged 16 to 19 have attempted to take their own life in the last year.[39]

- There are indications that transgender people may have higher rates of mental health problems and higher rates of self-harm.

Effective local interventions

2.55 Staff in primary and secondary health care, social services, education and the voluntary sector need to be aware of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm in these groups.

National action to support local approaches

2.56 PACE, the lesbian, gay, bisexual and transgender (LGBT) voluntary sector research, counselling and advocacy organisation, has published *Where to Turn*, a review of web-based mental health promotion and preventive information, support and advice services for LGBT people. www.pacehealth.org.uk/Where%20To%20Turn%20-%20Final%20Full%20Report.pdf

2.57 Local services and external partners working with LGBT groups and individuals may find the findings and conclusions in *Where to Turn* helpful when planning and delivering mental health promotion, substance misuse and other support and advice services for LGBT people.

2.58 *Working for Lesbian, Gay, Bisexual and Transgender Equality: Moving Forward* (2011) sets out specific actions that will be taken across government, including actions on health and social care issues. www.homeoffice.gov.uk/publications/equalities/lgbt-equality-publications/lgbt-action-plan?view=Binary

2.59 *Advancing transgender equality: A plan for action* (2011) sets out specific actions that will be taken across government to advance transgender equality. www.homeoffice.gov.uk/publications/equalities/lgbt-equality-publications/transgender-action-plan

Black, Asian and minority ethnic groups and asylum seekers

- The evidence on the incidence of mental health problems in Black, Asian and minority ethnic groups is complex. This term covers many different groups with very different cultural backgrounds, socioeconomic status and experiences in wider society. People from Black, Asian and minority ethnic groups often have different presentations of problems and different relationships with health services. Some Black groups have admission rates around three times higher than average, with research showing that some BME groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.

- There is little evidence on suicide risks in Black, Asian and other minority ethnic groups, as information on ethnicity is currently not collected through the death registration and inquest processes. This is a major obstacle to getting reliable and accurate data on suicides and to improving the evidence base and monitoring trends.
- In 2006, *Suicide prevention for BME groups in England*, summarised the literature and identified areas for future research. The message remains that we need more and better information about prevention and risk factors among different ethnic groups. www.nmhdu.org.uk/silo/files/executive-summary-suicide-prevention-for-bme-groups-in-england.doc

Effective local interventions

2.60 The Delivering Race Equality in Mental Health Care action plan has improved understanding of BME communities' mental health needs and their attitudes towards and beliefs about mental health and mental health services. The final report on the programme describes examples of good practice in reaching out to minority ethnic groups and demonstrates the value of community initiatives aimed at bridging the gap between statutory services and BME communities. It also shows how this community development approach, working across sectors and in partnership with communities, can be effective in tackling inequalities in health and access to services.

2.61 The Count Me In 2010 census[40] showed little change from those reported for previous years. Although the numbers of mental health inpatients overall have fallen since 2005, ethnic differences in rates of admission, detention under the Mental Health Act and seclusion have not altered materially since the inception of the Delivering Race Equality action plan in 2005.

2.62 Healthcare staff coming into contact with asylum seekers and refugees should be aware of the following:

- The prevalence of suicidal behaviour, suicide and self-harm among refugees and asylum seekers is difficult to ascertain. Official statistics are not readily available and data may come from unofficial sources such as the media and personal accounts.
- Social isolation, language barriers, racism, homophobia and legal uncertainties about the future may be experienced by asylum seekers and lead to depression. Factors such as differing cultural perceptions of mental illness and stigma associated with mental illness/suicide may then stop treatment being sought.
- Some asylum seekers could be suffering from post-traumatic stress disorder and severe depression caused by their experiences in their home countries, although it is difficult to gauge the number of people who will be affected in this way. Not all mental health and suicide prevention services may be geared to meet these needs and specialised help may be more appropriate.

National action to support local approaches

2.63 A Ministerial Working Group on Equality in Mental Health has been established to ensure that equality issues directly inform strategy implementation. Its initial priority is to tackle race inequality in particular, but it also aims to ensure that the full obligations of the Equality Act 2010 are met.

2.64 Asylum applications in the UK were at their lowest in 2010 at 17,790, excluding dependents, since a peak in 2002 of 84,130. The UK Border Agency is, however, considering whether its ability to identify individuals at risk of suicide or self-harm, and to refer them to the appropriate services, could be improved.

3. Area for action 3: Reduce access to the means of suicide

3.1 One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass.[41][42]

3.2 Suicide methods most amenable to intervention are:

- hanging and strangulation in psychiatric inpatient and criminal justice settings;
- self-poisoning;
- those at high-risk locations; and
- those on the rail and underground networks.

It is also important to be vigilant and respond to new or unusual suicide methods.

3.3 The media has an important role in avoiding reporting and portraying new high-lethality methods of suicide, that may increase the number of fatal suicide attempts. The internet is a ready source of detailed information concerning the use of lethal suicide methods (see area for action 5).

Reduce the number of suicides as a result of hanging and strangulation

- The most common method of suicide for men and women is hanging and strangulation.[43] Hanging and strangulation also continues to be the most common method of suicide among mental health inpatients and prisoners.

Effective local interventions

3.4 Inpatient suicides as a whole have reduced since 2004: the removal of non-collapsible fittings has resulted in no inpatient suicides as a result of hanging from non-collapsible bed or shower curtain rails, and the total number of deaths by hanging has fallen by more than half. Inpatient suicide using non-collapsible rails is a 'Never Event'[*].

3.5 Paragraphs 1.11-1.15 outline approaches which will help mental health service providers to reduce suicide risk.

3.6 Hanging accounts for over 90% of self-inflicted deaths in custody. In prison, access to certain methods will be severely restricted and this may contribute to the choice of hanging as a method. Safer cells are one example of facilities that can be used in the care of prisoners. Safer cells are designed to make the act of suicide or self-harm by ligaturing as difficult as possible, mainly by reducing ligature points. The design also takes account of the need to create not only a safer and robust environment, but also a more normalising one. However, no cell can be considered totally 'safe'. Safer cells can complement (but not replace) a regime providing care for at-risk prisoners and can reduce risks associated with impulsive acts.

[*] Never events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

National action to support local approaches

3.7 A recent Department of Health study[44] found that people choose hanging as a method of suicide because they mistakenly think it is quick, tidy and effective. These findings have important implications for suicide prevention work and the National Suicide Prevention Strategy Advisory Group will consider how best to respond to these findings.

Reduce the number of suicides as a result of self-poisoning

- Self-poisoning accounts for approximately a quarter of all suicide deaths in England. It is the second most common method of suicide in both men and women and was, until 2008, the most common method among women.

3.8 Significant progress has been made in reducing access to medications associated with suicide attempts, including:

- the phased withdrawal of co-proxamol, a prescription-only painkiller that was associated with 300–400 fatal deliberate or accidental drug overdoses a year in England and Wales alone. This reduced deaths from this cause, without evidence of a significant increase in deaths due to poisoning with other analgesics;[45] and

- the introduction in 1998 of legislation to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication (MHRA, 2009).

Restricting the availability of these medicines has led to a reduction in both deliberate and accidental overdoses.[46]

3.9 However, a substantial number of deaths still occur from paracetamol overdose. The MHRA has established an expert working group of the Commission on Human Medicines to review current guidelines for the management of paracetamol overdose.

3.10 Further consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available.[47]

3.11 The National Institute for Health and Clinical Excellence (NICE) will be developing a quality standard on safe prescribing, as part of a library of approximately 170 NHS Quality Standards covering a wide range of diseases and conditions.

Reduce the number of suicides at high-risk locations

- Jumping from a high place is an important method of suicide to address. Suicides by jumping almost inevitably occur in public places, have a very high fatality rate and are extremely traumatic for witnesses and people living and working in the surrounding area. Jumps also tend to attract media attention, which can lead to copycat suicides. All the world's most notorious suicide locations are jumping sites.

- Locations that offer easily accessible means of suicide include vehicle and pedestrian bridges, viaducts, high-rise hotels, multi-storey car parks and other high buildings, and cliffs.

3.12 Most areas have sites and structures that lend themselves to suicide attempts.

Suicide risk can be reduced by limiting access to these sites and making them safer.[48]

3.13 Evidence suggests that loss of life can be prevented when local agencies work together to discourage suicides at high-risk locations, including sites that temporarily become suicide hot-spots following a suicide death.

Examples of effective local interventions

3.14 Effective approaches to reducing suicides at high-risk locations or from jumping include:

- preventative measures – for example barriers or nets on bridges, including motorway bridges, from which suicidal jumps have been made, and providing emergency telephone numbers, e.g. Samaritans;
- working with local authority planning departments and developers to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings that may offer suicide opportunities;
- In care and hospital settings, environmental assessments should include assessing the risk of vulnerable patients accessing opening windows or balconies (see guidance in NHS Estates Health Technical Memorandum No 55 *Windows*); and
- working with local and regional media outlets to encourage responsible media reporting on suicide methods and locations (see area for action 5).

Helpful resources

3.15 *Guidance on Action to be Taken at Suicide Hotspots* (2006) supports local suicide prevention work, enabling responsible authorities to identify local places (for example bridges, cliffs, railway stations) where people who are thinking about suicide may be tempted to go. It identifies a number of evidence-based interventions that have proved effective.
www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

3.16 Work undertaken by the London School of Economics and the Institute of Psychiatry on behalf of the Department of Health includes a cost benefit analysis of bridge safety measures for suicide prevention, which would potentially also apply to other suicide hot-spots. See www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/news/2011/healthstrategy.aspx

3.17 *Falls from windows* provides HSE guidance to help organisations manage the risks of people using care services falling from windows or balconies.
http://www.hse.gov.uk/healthservices/falls-windows.htm

Reduce the number of suicides on the rail and underground networks

- Suicide by jumping or lying in front of trains and other moving vehicles is similarly an important method to address. While suicide rates have been falling generally, suicide deaths on the railway network have increased slightly, to about 210 people a year in England, Scotland and Wales. Most (about 80%) are men and most are in the 15–44 age range. The RSSB and the British Transport Police collect extensive information on railway deaths and incidents, including suicides and

attempted suicides.

Examples of effective local interventions

3.18 The British Transport Police (BTP) and London Underground Limited (LUL) have worked closely with local services to reduce risk at transport-related suicide hotspots. LUL has provided staff training to help them identify people who may be considering suicide and engage with them in the hope that they can persuade them not to. This approach has helped reduce incidence of suicide at one London Underground station close to a psychiatric inpatient unit. The training is currently being rolled out across the London Underground network.

3.19 The British Transport Police recognises that suicide attempts provide an opportunity for interventions aimed at preventing an individual from repeating their attempt at a later date, with the aim to reduce the number of fatalities on the railway. BTP has developed a suicide prevention plan, which is completed for every "determined" attempt at suicide. It is a comprehensive record of information about the individual and the incident, supported by a menu of potential actions which could be taken according to the information available, in order to minimise the risk that the individual poses. In particular, it captures the contact details of any friends, relatives or any individuals who have assisted in reducing the person's risk of suicide (e.g. social worker, doctor, and psychiatrist) for future reference and to enable follow up enquiries regarding the individual's progress/wellbeing.

National approaches to support local actions

3.20 Samaritans and Network Rail have established a joint, five-year training, communications and outreach programme. Through joint working with partners including train operators and the British Transport Police, they aim to reduce suicides on the national rail network by 20%. The project was launched in January 2010 and is initially focused on those stations most affected by suicide. www.samaritans.org.uk/support_samaritans/corporate_suppporters/network_rail/about_the_partnership.aspx

Respond to new methods of suicide

Effective local interventions

3.21 As well as understanding commonly used means of suicide, it is important to be vigilant and respond to new or unusual suicide methods and locations. Local services and external agencies may need to devise ways to ensure that they are provided promptly with information about the circumstances and methods of suicides either by the police following initial investigation of the death or through the coroner's office following the police report to the coroner.

National approaches to support local actions

3.22 The Government will work with the National Suicide Prevention Strategy Advisory Group to take a lead in identifying, monitoring and responding to new methods of suicide when they emerge.

4. Area for action 4: Provide better information and support to those bereaved or affected by suicide

4.1 To provide better information and support for those bereaved or affected by suicide we need to:

- provide support that is effective and timely;
- have in place effective local responses to the aftermath of a suicide; and
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

Provide effective and timely support for families bereaved or affected by suicide

- Family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves.[49]

- Suicide can also have a profound effect on the local community. We know from studies that, in addition to immediate family and friends, many others will be affected in some way.[50][51] They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.

- There may be a risk of copycat suicides in a community, particularly among young people, if another young person or a high-profile celebrity dies by suicide.

Effective local interventions

4.2 Effective and timely emotional and practical support for families bereaved or affected by suicide is essential to help the grieving process, prevent further or longer-term emotional distress and support recovery. There is some evidence that referral to specialist bereavement counselling and other bereavement support can be helpful for people who actively seek it[52], although evidence for efficacy of interventions is currently limited[53]. It is important that GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

4.3 Guidance that mental health trusts will have in place on how to deal with the suicide of a patient under the care of the mental health services may include information on preparing for the inquest and dealing with the family, carers and friends of the deceased, including the impact of the suicide and the inquest on the family. The need to be sensitive in their dealings with the family will continue if the clinical team have to attend an inquest.

Helpful resources

4.4 The Department of Health has recently reviewed and updated *Help is at Hand: A resource for people bereaved by suicide and other sudden, traumatic death*. This provides advice and information for anyone directly affected by suicide. It also has advice for people in contact with

those bereaved through suicide, either because of their work or because they are part of the same community. See www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/ or order from www.orderline.dh.gov.uk

4.5 This useful resource could be publicised more widely. A recent evaluation has shown that it is well received but that access to it can be a problem.[54] The Department of Health will continue to work with partners to get the document to people at the right time.

4.6 The Government has recently published the *Guide to Coroners and Inquests and Charter for Coroner Services* which has been provided to all coroners' courts. It will ensure that people have accessible, concise information on the processes and standards in a coroner inquiry, and setting out the standards in a single document will also improve consistency across the coroner system. www.justice.gov.uk/downloads/burials-and-coroners/guide-charter-coroner.pdf

4.7 INQUEST, a charity which provides advice and support to bereaved people on the inquest process, has developed *The Inquest Handbook: A guide for bereaved families, friends and their advisors*. This booklet includes specialist sections dealing with deaths in police or prison custody and when detained under the Mental Health Act 1983.

4.8 There are other sources of support, information and advice that may be helpful both for people directly affected by suicide and also for use when training and supporting staff whose work brings them into contact with suicide. They include:

- *The Road Ahead… A guide to dealing with the impact of suicide*, published by Mental Health Matters. www.mentalhealthmatters.com
- Healthtalkonline, a website where people can share experiences of ill health and bereavement, including bereavement by suicide. www.healthtalkonline.org
- If U Care Share, a website and campaign organisation with links to sources of support. www.ifucareshare.co.uk
- Winston's Wish, bereavement support for children and young people. www.winstonswish.org.uk/
- Cruse Bereavement Care. www.crusebereavementcare.org.uk
- Survivors of Bereavement by Suicide, a self-help organisation to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend. www.uk-sobs.org.uk/
- The Compassionate Friends, support for bereaved parents and their families after a child dies. www.tcf.org.uk/

National action to support local approaches

4.9 The Independent Advisory Panel on Deaths in Custody held a listening day in September 2011 for those whose family member had died whilst detained under the Mental Health Act.

4.10 As a result of what they heard, the Panel recommended to the Ministerial Board on Deaths in Custody that Trusts with responsibility for detained patients should have procedures in place for ensuring good quality family liaison with bereaved families, and to signpost them for support and advice. Policies on investigation should be explained to families to ensure they are offered an opportunity to be involved and receive ongoing information. Trusts should also keep families informed of actions taken

to learn from their relative's death including any changes as a result of the investigation or inquest.

4.11 This good practice, particularly following the judgment in *Rabone vs Penine Care NHS Foundation Trust*, is equally applicable where a voluntary patient in contact with mental health services takes their own life.

4.12 The Department of Health recently made a grant to Survivors of Bereavement by Suicide to enable the organisation to forge productive relationships with other suicide prevention organisations so that they can continue to support bereaved families and friends in the future.

Have in place effective local responses to the aftermath of a suicide

- Suicide can have devastating effects on a community. There is emerging evidence that post-suicide interventions at community level can help to prevent copycat and suicide clusters and ensure support is available. This approach may be adapted for use in schools, colleges and universities, workplaces, prisons, mental health and other care services, drug and alcohol services and residential care homes.

4.13 Samaritans has successfully piloted a Step by Step post-suicide intervention service for schools, and is now offering this service across the UK. Samaritans branches work with schools and local authorities, offering practical support, guidance and information on the impact of suicide on school communities, and ways to promote recovery and prevent suicide clusters. This approach could also be used in other settings. www.samaritans.org

4.14 Publicity about suicide, and in particular detailed descriptions of the suicide method, may lead to copycat suicide attempts. Area for action 5 describes ways to work with the media to raise awareness of this risk and promote responsible reporting and portrayal of suicides.

Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

4.15 If families, friends and colleagues become concerned that someone may be at risk of suicide it is important that they can get information and support as soon as possible.

4.16 Recent qualitative research[55] indicates that there are very significant difficulties for family members and friends recognising and responding to a suicidal crisis. Signs and communications of suicidal crisis are rarely clear: they are often oblique, ambiguous and difficult to interpret. Even when it is clear to relatives and friends that something is seriously wrong, they may be afraid to intervene for fear of saying or doing `the wrong thing' and damaging relationships or even raising suicide risks. The answer is not simply to give people information about warning signs, because the blocks to awareness and intervention may be emotional rather than factual in nature. Efforts to support families and friends to play a role in preventing suicide should highlight the ambiguous nature of warning signs and should focus on helping people to acknowledge and overcome their fears about intervening.

Effective local interventions

4.17 If individuals are already being cared for by mental health, primary care or social services it is critical that family, carers and friends know how to contact the services and are appropriately involved in any care planning. Any concerns they raise should be considered carefully and responded to in a timely and appropriate way.

4.18 The NHS Future Forum reported how people often find care systems difficult to navigate, and that having a person to help coordinate their care made a significant difference to both their experience and the effectiveness of their care. The Government wants everyone with a care plan to be allocated a named professional who has an overview of their case and is responsible for answering any questions they or their family might have. *Caring for our future* sets out how we hope this can become standard practice.

4.19 There are clearly times when mental health service practitioners, in dealing with a person at risk of suicide, may need to inform the family about aspects of risk to help keep the patient safe. The Department of Health is working with a wide range of professional bodies to raise the profile of this issue and to try to reach a consensus view on confidentiality and suicide prevention.

4.20 For individuals who are not known to services help is still available through many outlets. A list of services and contacts is being published alongside the strategy. Contact details and further information about other organisations is available in *Help is at Hand*: www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

National action to support local approaches

4.21 Samaritans has a partnership with the social networking site Facebook in the UK. Friends who are concerned about an individual will be able to tell Samaritans through the Facebook help centre. Facebook will then put Samaritans in touch with the distressed friend to offer their expert support. The Samaritans' Facebook page also has advice on how to support vulnerable friends, such as how to spot when someone is distressed and how to start a difficult conversation.

4.22 Some individuals are more likely to come into contact with people at higher risk of suicide as a result of their work, for example, staff in job centres, the police and emergency departments (see paragraph 2.38).

5. Area for action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

5.1 There are two key aspects to supporting the media in delivering sensitive approaches to suicide and suicidal behaviour:

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.

Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media

- The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk.[56][57]

Effective local interventions

5.2 Local services and agencies may wish to work with local and regional newspapers and other media outlets to encourage them to provide information about sources of support and helplines when reporting suicide and suicidal behaviour. Working with local media is particularly important where there is a specific location for suicide causing concern.

National action to support local approaches

5.3 In 2006 the Press Complaints Commission (PCC) added a clause to the Editors' Code of Practice explicitly recommending that the media avoid excessively detailed reporting of suicide methods. The 2009 edition of the PCC *Editors' Codebook* highlights the distress that can be caused by:

- insensitive and inappropriate graphic illustrations accompanying media reports of suicide;
- use of photographs taken from social networking sites without relatives' consent; and
- the re-publication of photographs of people who have died by suicide when reporting other suicide deaths in the same area.

5.4 It also commends the inclusion of details of local support organisations and helplines with any coverage of suicide deaths. www.pcc.org.uk/cop/practice.html

5.5 A number of other organisations and agencies, most notably Samaritans, have developed helpful guidance for the media on the reporting of and portrayal of suicide. www.samaritans.org/media_centre/media_guidelines.aspx

5.6 Samaritans plays a key role in monitoring media coverage of suicide, looking at examples of both poor and excessive reporting of suicide in the UK in national, regional and local media. It works closely with the media and regulators to support sensitive reporting

of suicide in line with its media guidelines and undertakes proactive training and outreach with the media.

5.7 The portrayal of suicide behaviour in TV programmes and film and advertising is also an important consideration. In regulating television programming and film, both Ofcom and the British Board of Film Classification take account of the risk of imitative behaviour which could encourage suicide. Advertising is subject to the Advertising Standards Authority's advertising codes, which contain a range of regulatory controls regarding the content of advertisements. We intend to consult with the regulators to ensure that their rules and guidelines remain robust and continue to provide suitable protections.

5.8 The Government is supporting the Time to Change anti-stigma and discrimination social marketing programme. The programme's media engagement work in 2012-13 will: provide an advisory service to broadcast media; pro-actively engage TV drama and news producers, scriptwriters and commissioners; hold seminars to improve the reporting and representation of people with mental health problems; and aim to secure board-level support from media companies. www.time-to-change.org.uk

Continue to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

- There is growing concern about misuse of the internet to promote suicide and suicide methods.[58] In particular, there has been widespread condemnation of internet sites that could help and encourage vulnerable people – particularly young people – to take their own lives. In 2005-7 there was evidence that internet use may have contributed to at least 1-2% of suicides, particularly in relation to the use of relatively unusual, highly lethal methods.

- The internet also provides an opportunity to reach out to vulnerable individuals who would otherwise be reluctant to seek information, help or support from other agencies. The internet can develop and expand the availability of sources of support to vulnerable people online and can also encourage major organisations that provide content in the most popular parts of the internet (such as social networking sites; search engine providers; and online news media outlets) to develop responsible practices which reduce the availability of harmful content and promote sources of support.

National action to support local approaches

5.9 *Safer Children in a Digital World*, the report of the Byron Review (2008), identified some confusion about the application of the law to the encouragement of suicide online. The relevant provisions of the law have since been simplified and modernised to make clear that the law applies to online as well as offline actions. The new provisions came into force on 1 February 2010.[59]

5.10 Under section 2(1) of the Suicide Act 1961 (as amended by section 59 of the Coroners and Justice Act 2009) it is an offence to do an act capable of encouraging or assisting the suicide or

attempted suicide of another person with the intention to so encourage or assist. The person committing the offence need not know the other person or even be able to identify them. So the author of a website promoting suicide and suicide methods may commit an offence if the website encourages or assists the suicide or attempted suicide of one or more of their readers, and the author intends that the website will so encourage or assist. They may be prosecuted whether or not a suicide or attempted suicide takes place. Similarly, any person making a posting to an online chat room or a social networking site which intentionally encourages another person to commit or attempt to commit suicide may be guilty of an offence.

5.11 The Director of Public Prosecutions has issued a Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide which sets out guidance to prosecutors on how to apply the law in force. The policy also provides information on the relevant evidential and public interest stages which must be considered in cases of assisted suicide. The policy is available on the CPS website.

5.12 Content providers are free to make their own policies on the publication of harmful or inappropriate material. We expect that the updated law on promoting suicide should make it easier for content providers to identify and take down any content based in England and Wales that contains potentially illegal material. However, potentially illegal material that is hosted by providers outside the UK will not be covered by these arrangements.

5.13 The Government works with the internet industry and content providers through the UK Council for Child Internet Safety (UKCCIS) to create a safer online environment for children and young people through industry self-regulation, improving e-safety education and raising public awareness.

5.14 The Government will continue to work through UKCCIS to promote active choice on domestic broadband connections and on new internet-enabled devices – prompting consumers to choose which content they wish to be able to access – enabling consumers, should they so choose, to restrict access to the most common content and sites which promote suicide. We will promote the use of default filters on public wifi networks, which could help to prevent children using public wifi from accessing adult content. Technical solutions will not offer the complete solution and UKCCIS is also working to develop greater internet safety and education tools for parents and children. We will be pressing for greater transparency from industry on their responses to the public's reporting of harmful and inappropriate content. Over the summer period, we will be seeking the views of industry, children's charities and parents on the best ways to keep children safe online.

5.15 Implemented effectively, these measures will reassure parents that they have the tools to ensure that their children are not accessing harmful suicide-related content online.

5.16 Samaritans and others have worked with search engines and social media sites to ensure that ready access is provided to trusted suicide prevention and support services. PAPYRUS, a voluntary organisation for the prevention of young suicide, has developed a leaflet *Action for Safety on the Internet*, which offers

basic advice and sources of help for anyone who wishes their child to take a safe and responsible approach to the internet; and has concerns that a young person is depressed or suicidal. www.papyrus-uk.org

5.17 See section 4.20 for a joint initiative by Facebook and Samaritans.

6. Area for action 6: Support research, data collection and monitoring

6.1 To support research, data collection and monitoring we need to:

- build on the existing research evidence and other relevant sources of data on suicide and suicide prevention;
- expand and improve the systematic collection of and access to data on suicides; and
- monitor progress against the objectives of the national suicide prevention strategy.

- Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public health importance.
- Research is essential to suicide prevention. Research studies enhance our understanding of the statistical data provided by ONS to inform strategies and interventions; highlight trends and changes in patterns; identify key factors in suicide risk and enhance our understanding of risk groups; evaluate and develop interventions to reflect changing needs and priorities, and develop the evidence base on what works in suicide prevention.
- A wealth of data is already collected by different agencies in the course of their routine work, but only limited information is collected centrally or easily accessible and available to researchers or public health specialists.

Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention

6.2 There is a range of existing research evidence and other relevant sources of data which are useful to inform local and regional strategies and interventions to prevent suicide. A brief description of and links to the key information sources is included in the statistical update being published alongside this strategy.

6.3 Nationally, the Government will work with the Devolved Administrations in the UK to share national and international evidence from research studies on suicide prevention and effective interventions, and identify gaps in current knowledge.

6.4 The Department of Health, through the National Institute for Health Research (NIHR) and the Policy Research Programme (PRP), has invested significantly in mental health research and will continue to support high-quality research on suicide, suicide prevention and self-harm.

6.5 A five-year NIHR programme grant to generate research evidence to underpin the implementation and evaluation of the 2002 Suicide Prevention Strategy is due to report during 2012.

6.6 The NIHR has approved a five-year programme grant on suicide prevention starting 1 April 2012. This new programme will collect and analyse data on suicide and self-harm as related to the recession; develop interventions to reduce the impact of the recession on suicides; evaluate different forms of risk

assessment following self-harm; review the literature and develop guidelines on the management of episodes of self-harm where individuals have made advance decisions on treatment; develop resources for parents of young people who self-harm; evaluate whether the use of some specific new methods of suicide is increasing; and identify medicines associated with high fatality in overdose.

6.7 The PRP will fund up to £1.5 million for new suicide prevention research to contribute to the delivery of policy.

Expand and improve the systematic collection of and access to data on suicides

6.8 The information in the national mortality statistics produced by ONS is useful for identifying national trends, but does not allow more detailed analysis. Preventative interventions and monitoring would be enhanced if more comprehensive information was more easily accessible. Additional information may be held in coroners' records and records from GPs or secondary care and mental health services, but it is not routinely or systematically reported.

6.9 Public Health England is establishing an evidence and intelligence function. This will include the role currently performed by public health observatories, and will include gathering information on suicide prevention activities and data on suicide and self-harm in order to publish the data to support the Public Health Outcomes Framework.

6.10 Scotland is currently establishing a Scottish Suicide Information Database (ScotSID) to improve the quality of information available on suicides in Scotland. The first national report is available at: www.isdscotland.org/Health-Topics/Public-Health/Publications/2011-12-20/2011-12-20-Suicide-Report.pdf?45182436705

6.11 The Department of Health will work with the National Suicide Prevention Strategy Advisory Group to consider how we can get the most out of the existing data sources in England and address the issues raised in paragraph 6.8. This will include considering options to address the current information gaps around ethnicity and sexual orientation, and will seek to learn from the Scottish experience in establishing ScotSID.

6.12 At a local level, coroners may work with health services and partner organisations and agencies to provide data that will give an early indication of emerging patterns, such as clusters or particular patterns of suicides, before data are compiled by the ONS.

6.13 At a national level the Department of Health will work with the Ministry of Justice and coroners to consider what access to coroners' records may be achievable for bona fide researchers, subject to relevant data protection and confidentiality safeguards and bearing in mind coroners' statutory duties.

6.14 The varying detail given by coroners in narrative verdicts and the increasing use of multi-category verdicts means that, in some cases, ONS find it difficult to classify intent accurately. ONS is confident that the overall picture of current suicide trends shown by national and regional statistics is reliable at present.[60] However, the variation in practice by different coroners means that local figures could be less reliable. Also,

if the rise in narrative verdicts continues at the same rate, the accurate reporting of injury and poisoning deaths may be affected in the future. ONS is working with coroners and others concerned to ensure that they are able to classify these narrative and multi-category verdicts accurately in order to monitor trends and draw comparisons over time.

6.15 In the light of this, ONS made changes to the processing of narrative verdicts for all deaths registered from 2011 onwards, and the work with coroners will not have an impact until later in that year. Accordingly, ONS will be able to look at data for 2011 when it has the annual dataset in summer 2012 to assess the impact of these changes.

6.16 The Government is reforming the coroner system under Part 1 of the Coroners and Justice Act 2009. These reforms, which involve the establishment of the Chief Coroner, will help to bring about much greater consistency of practice between coroner areas and improved services to the bereaved, as well as helping to speed up the investigation and inquest process.

6.17 National monitoring statistics depend on the data generated by the coroners' reporting system so it will be important to bear in mind the continuity of data and information when making these changes.

Monitor progress

6.18 The Government is committed to a new focus on outcomes that matter to people and their families both at national and local level. Three outcome frameworks have been developed: for the NHS, public health and adult social care. Together, these provide a comprehensive and coherent approach to tracking national progress against a range of critical outcomes.

6.19 Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Framework (January 2012) includes the suicide rate as an indicator. Two other indicators with direct relevance to suicide prevention are self-harm and excess under 75 mortality in adults with serious mental illness. The indicator on excess mortality is also contained in the NHS Outcomes Framework.

6.20 *No health without mental health: Delivering better mental health outcomes for people of all ages* gives examples of outcomes and indicators for consideration by the NHS Commissioning Board and local commissioners; these include the rates of inpatient suicides.

6.21 The National Suicide Prevention Strategy Advisory Group will meet regularly to assess progress on the shared areas for action and objectives outlined in the strategy.

6.22 An update on progress in the implementation of the final strategy will be published annually online. This will summarise developments at national level, identify relevant research studies and their findings, and report detailed statistical information on suicides by gender, age, method and location.

7. Making it happen locally and nationally

7.1 A key message of this strategy is that there are many sectors, groups and individuals who can help to reduce suicide. Each priority area for action, set out in chapters 1 to 6, contains suggested local and national activities to help deliver change.

7.2 This chapter describes some of the broader context, systems and bodies, such as public health and primary care, which will support several of the areas for action.

7.3 *No health without mental health* outlines the proposed reforms to the public health, health and social care systems and how the new architecture and approach will affect planning and delivery of improved public health and mental health outcomes. It also describes cross-government actions to support the delivery of the mental health strategy. Many have direct relevance to suicide prevention; for example, the work on employment being undertaken across government and the Ministerial Working Group on Preventing and Tackling Homelessness.

7.4 An implementation framework for *No health without mental health* was published in July 2012. This sets out what local organisations can do to implement the strategy, what work is underway nationally to support them, and how progress against the strategy's aims will be measured. The implementation framework explicitly covers suicide prevention, and will support local agencies in implementing this strategy.

Public Health

7.5 Public Health England (PHE) is the new national agency for public health (from April 2013) and will support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing.

7.6 PHE will take a leadership role across public health services, providing expertise and support to local areas to help improve outcomes in public health and reduce health inequalities, including on mental health and suicide prevention.

7.7 An effective local public health approach is fundamental to suicide prevention. This will depend on effective partnerships across all sectors including health, social care, education, the environment, housing, employment, the police and criminal justice system, transport and the voluntary sector.

7.8 New health and wellbeing boards (HWBs) will be able to support suicide prevention as they bring together local councillors, Clinical Commissioning Groups (CCGs), directors of public health (DsPH), adult social services and children's services, local Healthwatch and, where appropriate, wider partners (such as the Police and the Local Safeguarding Children Board) and community organisations.

7.9 HWBs will assess the local community's health and wellbeing needs and assets. Improvements in population health and wellbeing, including mental health, will reduce the risks of suicide. Specific

approaches to suicide prevention could feature in an effective local health and wellbeing approach. For example, many of the locations used for suicide are under the control of local authorities and they can act to reduce this risk.

7.10 DsPH can play a key part in developing local public health approaches and in nurturing and maintaining links across the NHS and local government. They will be appointed jointly by local authorities and Public Health England. This will place many DsPH in a unique position to contribute to taking forward the suicide prevention strategy.

7.11 Some areas have established regional or sub-regional multi agency suicide prevention groups to co-ordinate activities to reduce suicides. In many cases these groups also support more localised groups or networks of suicide prevention activists. These groups could help support DsPH and health and wellbeing boards in developing assessments and strategies.

Primary care services

7.12 Most general practices will have a patient who dies by suicide only once every few years. However, GPs can make a big difference to overall suicide rates. General practices will see a lot of people with many of the known factors for higher risk of suicide, for example long-term physical health problems, self-harming, drug and alcohol misuse and mental health problems. They are the first point of contact for many people who are experiencing distress or suicidal thoughts and who may be vulnerable to suicide. GPs are also the key gatekeepers to specialist services.

7.13 Primary care staff may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues.

7.14 Health visitors, midwives and other community staff may be in contact with children, young people and families and be the first to be aware of mental health problems or other difficulties developing. They can therefore provide direct support and also refer speedily to other services.

Commissioning reforms

7.15 The NHS Commissioning Board (NHS CB) will be committed to improving outcomes in mental health. Through its role in commissioning primary care, specialised services, prison health, military health and some specific public health services, the NHSCB will have a vital contribution to make in realising the aims of *No health without mental health* and this strategy.

7.16 The NHS CB will also have an important role in providing national leadership for driving up the quality of care across health commissioning. The Board could do this, for example, by publishing commissioning guidance and model care pathways, based on the evidence-based quality standards that it has asked NICE to develop.

7.17 NICE quality standards, defining high quality care, are relevant to both local authorities and CCGs in their commissioning roles. Existing quality standards relevant to suicide prevention include alcohol

dependence and depression in adults. Others are under development including: depression in children and young people; self-harm in adults; self-harm in vulnerable groups, children and young people; antenatal and postnatal mental health; long-term care of people with co-morbidities and or complex needs and safe prescribing. For the full list of topics referred to NICE see www.nice.org.uk/guidance/qualitystandards/QualityStandardsLibrary.jsp

7.18 Clinical Commissioning Groups will become responsible for commissioning the majority of healthcare services. In considering CCGs' applications for establishment, the NHS CB will assess whether a CCG has the capacity and capability to commission improved outcomes for the people who need support for mental health.

7.19 The National Offender Management Service (NOMS) is an executive agency of the Ministry of Justice, and brings together HM Prison Service and the Probation Service. It commissions and delivers offender management services in custody and the community as well as managing those offenders who receive hospital and restriction orders unders sections 37 and 41 of the Mental Health Act 1983. The prison population contains a high proportion of very vulnerable individuals, many of whom have experienced negative life events that we know increase the likelihood of them harming themselves such as drug and alcohol misuse, family background and relationship problems, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems.

7.20 The Youth Justice Board (YJB) oversees the youth justice system in England and Wales. The YJB works to prevent offending and reoffending by young people, and to ensure that those held in custody are safe and secure.

Coroners

7.21 Suspected suicide deaths will always be reported to a coroner, who will certify the death after an inquest. Coroners have an important role in establishing via inquest proceedings the who, how and where of these deaths. The coroner's office will be able to help bereaved families to find support from local and national organisations.

7.22 The Government is reforming the coroner system under Part 1 of the Coroners and Justice Act 2009. These reforms include establishing a Chief Coroner who, for the first time, will be responsible for providing national leadership to coroners in England and Wales. He will also play a key role in setting new national standards and developing a new statutory framework for coroners including rules and regulations, guidance and practice directions within which coroners will operate. Coroners will be under a duty to inform the Chief Coroner of any investigations lasting more than a year and the Chief Coroner will be under a duty to include a summary of these in an annual report. This will help to bring about much greater consistency of practice between coroner areas and improved service to the bereaved, as well as helping to speed up the investigation and inquest process.

Central support for delivering the strategy

7.23 The Cabinet Sub-Committee on Public Health oversees the implementation of *No health without mental health*, while the Cabinet Committee on Social Justice ensures effective cross-government action to address the social causes and consequences of mental health problems. The suicide prevention strategy is a key component of *No health without mental health.*

7.24 The National Suicide Prevention Strategy Advisory Group (NSPSAG) provides leadership and support for suicide prevention initiatives including advice on monitoring and analysing trends in suicide. Membership includes senior academic researchers, voluntary sector representatives (Samaritans and PAPYRUS), representatives from NOMS, Department of Health, public health, offender health care, professional bodies such as the Royal College of Psychiatrists and a coroner. It also includes people (often family members) with direct experience of bereavement by suicide. This group will continue to provide leadership for implementation of this strategy.

7.25 The Ministerial Council on Deaths in Custody is jointly funded by the Home Office, UK Border Agency, the Ministry of Justice and the Department of Health. The Council's remit covers deaths in prisons, in or following police custody and in immigration detention; the deaths of residents in approved premises; and the deaths of those detained under the Mental Health Act.
http://iapdeathsincustody.independent.gov.uk

Links across the UK and Republic of Ireland

7.26 This strategy relates to England only, as the majority of issues involved are the responsibility of the Devolved Administrations. Suicide prevention strategies have now been established in Scotland, Wales and Northern Ireland, as well as in the Republic of Ireland. Strong links have been maintained between the nations, and these links should continue to ensure a co-ordinated approach to suicide prevention, where necessary, across the UK and Ireland.

References

[1] Office for National Statistics and Department of Health (2010) *DH Mortality Monitoring Bulletin (Life expectancy, all-age-all-cause mortality, and mortality from selected causes, overall and inequalities)*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/dH_120638

[2] Gunnell D, Lopatatzidis A, Dorling D et al. (1999) Suicide and unemployment in young people. Analysis of trends in England and Wales, 1921–1995. *British Journal of Psychiatry* 175: 263–270.

[3] Stuckler D, King L, McKee M (2009) Mass privatisation and the post-communist mortality crisis: a cross-national analysis. *Lancet* 373: 399-407.

[4] Appleby L, Cooper J, Amos T et al. (1999) Psychological autopsy of suicides by people aged under 35. *British Journal of Psychiatry* 175: 168-174.

[5] Qin P, Agerbo E, Westergard-Nielsen N et al (2000) Gender differences in risk factors for suicide in Denmark. *British Journal of Psychiatry* 177: 546-550.

[6] While D, Bickley H, Roscoe A, Windfuhr K, Rahman S, Shaw J, Appleby L, Kapur N (2012) Implementation of mental health service recommendations in England and Wales and suicide rates, 1997—2006: a cross-sectional and before-and-after observational study. *Lancet* 379: 1005-1012.

[7] www.nrls.npsa.nhs.uk/resources/collections/ never-events/

[8] Kapur N, Hunt I, Windfuhr K, Rodway C, Webb R, Rahman M, Shaw J and Appleby L (2012) Psychiatric in-patient care and suicide in England, 1997 to 2008: a longitudinal study. *Psychological Medicine* www.journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8577655

[9] Department of Health (2009) Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services

[10] Hawton K, Bergen H, Casey D et al. (2007) Self-harm in England: a tale of three cities. Multicentre study of self-harm. *Social Psychiatry and Psychiatric Epidemiology* 42: 513–521.

[11] Hawton K, Rodham K, Evans E and Weatherall R (2002) deliberate self-harm in adolescents: self report survey in schools in England. *British Medical Journal* 325: 1207–1211.

[12] Cooper J, Kapur N, Webb R et al. (2005) Suicide after deliberate self-harm: a 4-year cohort study. *American Journal of Psychiatry* 162: 297–303.

[13] Runeson B, Tidemalm D, Ddahlin M et al. (2010) Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study. *British Medical Journal* 341: c3222.

[14] Bennewith O, Gunnell D, Peters TJ et al. (2004) Variations in the hospital management of self-harm in adults in England: observational study. *British Medical Journal* 328: 1108–1109.

[15] Bennewith O, Stocks N, Gunnell D et al. (2002) General practice based intervention to prevent repeat episodes of deliberate self harm: cluster randomised controlled trial. *British Medical Journal* 324(7348): 1254–1257.

[16] Shaw J, Baker D, Hunt IM et al. (2004) Suicide by prisoners: National clinical survey *British Journal of Psychiatry* 184: 263–267.

[17] The relevant Prison Service Instructions (PSI 64/2011) are available at: www.justice.gov.uk/offenders/psis/prison-service-instructions-2011

[18] Meltzer H, Brock A, Griffiths C et al. (2006) Patterns of suicide by occupation in

England and Wales: 2001–2005. *British Journal of Psychiatry* 193: 73–76.

[19] Windfhur K, While D, Hunt I, Turnbull P, Lowe R, Burns J, Swinson N, Shaw J, Appleby L, Kapur N and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2008) Suicide in juveniles and adolescents in the United Kingdom. *Journal of Child Psychology and Psychiatry* 49: 1155-1165.

[20] Hawton K, Rodham K, Evans E and Weatherall R (2002) deliberate self-harm in adolescents: self report survey in schools in England. *British Medical Journal* 325: 1207–1211.

[21] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, available at: www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci

[22] Department of Health, Department for Children, Schools and Families, Ministry of Justice and Home Office (2009) *Healthy Children, Safer Communities – A strategy to promote the health and well-being of children and young people in contact with the youth justice system*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dH_109771

[23] www.dh.gov.uk/health/2012/07/cyp-report/

[24] Joiner Jr T, Sachs-Ericsson N, Wingate L, Brown J, Anestis M, Selby E (2007) Children physical and sexual abuse and lifetime number of suicide attempts: A persistent and theoretically important relationship. *Behaviour Research and Therapy* 45(3): 539-547.

[25] www.southallblacksisters.org.uk/safe-and-sane-report-2011-copyright-sbs.pdf

[26] Kapur N, While D, Blatchley N et al. (2009) Suicide after leaving the UK armed forces – a cohort study. *PLoS Medicine* 6(3): e26.

[27] Webb T, Kontopantelis E, Doran T, Qin P, Creed F, Kapur N (012) Suicide risk in primary care patients with major physical diseases: A case-control study. *Archives of General Psychiatry* 69(3): 256-264.

[28] www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

[29] http://cebmh.warne.ox.ac.uk/csr

[30] Gunnell D, Platt S and Hawton K (2009) The economic crisis and suicide *British Medical Journal*, 338: b1891.

[31] Weaver T, Charles V, Madden P and Renton A (2002) *A Study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse & Mental Health Treatment Populations*. Research report submitted to the department of Health, available at: http://dmri.lshtm.ac.uk/docs/weaver_es.pdf.

[32] Singleton N, Farrell M and Meltzer H (1999) *Substance Misuse among Prisoners in England and Wales*. London: office for National Statistics.

[33] www.emc.medicines.org.uk/medicine/3957/PIL/Zyban+150+mg+prolonged+release+film-coated+tablets/

[34] www.mhra.gov.uk/home/groups/pl-p/documents/publication/con030924.pdf

[35] www.nice.org.uk/nicemedia/pdf/CG022NICEguidelineamended.pdf

[36] www.nice.org.uk/nicemedia/live/12329/45888/45888.pdf

[37] King M, Semlyen J, See Tai S et al. (2008) *Mental Disorders, Suicide and Deliberate Self-Harm in Lesbian, Gay and Bisexual People*. London: National Mental Health development Unit.

[38] Mathy RM, Cochran SD, Olsen J et al. (2009) The association between relationship markers of sexual orientation and suicide: denmark, 1990– 2001. *Social Psychiatry Psychiatric Epidemiology* 46(2): 111–117.

[39] Stonewall (2012) Gay and Bisexual Men's Health Survey, available at: www.stonewall.org.uk/documents/stonewall_gay_mens_health_final_1.pdf
[40] Care Quality Commission and National Mental Health development Unit (2011) *Count Me In 2010*, available at: www.cqc.org.uk/organisations-we-regulate/mental-health-services/count-me-2010-census

[41] Florentine JB and Crane C (2010) Suicide prevention by limiting access to methods: a review of theory and practice. *Social Science & Medicine* 70(10): 1626–1632.

[42] Mann JJ, Apter A, Bertolote J et al. (2005) Suicide prevention strategies: a systematic review. *JAMA: The Journal of the American Medical Association* 294(16):2064–2074.
[43] Gunnell D, Bennewith O, Hawton K et al. (2005) The epidemiology and management of suicide by hanging: a review. *International Journal of Epidemiology* 34: 433–442.

[44] Biddle L, Donovan J, Owen-Smith A et al. (2010) A qualitative study of factors influencing the decision to use hanging as a method of suicide. *British Journal of Psychiatry* 197: 320–325.

[45] Hawton K, Bergen H, Simkin S, Wells C, Kapur N, et al (2012) Six-year follow-up of impact of co-proxamol withdrawal in England and Wales on prescribing and deaths: Time-series study. *PLoS Med* 9(5): e1001213.

[46] Hawton K, Simkin S, Deeks J et al. (2004) UK legislation on analgesic packs: before and after study of long term effect on poisonings. *British Medical Journal* 329: 1076–1079.

[47] Hawton K, Bergen H, Simkin S et al (2010) Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose. *British Journal of Psychiatry* 196: 354-358

[48] Bennewith O, Nowers M and Gunnell D (2007) The effect of the barriers on the Clifton suspension bridge, England on local patterns of suicide: implications for prevention. *British Journal of Psychiatry* 190: 266–267.

[49] Qin P, Agerbo E and Mortenson PB (2002) Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *Lancet* 360: 1126–1130.

[50] Beautrais AL (2004) *Suicide Postvention: - Support for families, whanau and significant others after a suicide. A literature review and synthesis of evidence*. Wellington, New Zealand: Ministry of youth Affairs.

[51] de Groot MH, de Keijser J and Neeleman J (2006) Grief shortly after suicide and natural death: a comparative study among spouses and first-degree relatives. *Suicide and Life-Threatening Behavior* 36: 418–431.
[52] de Groot M, de Keijser J, Neeleman J et al. (2007) Cognitive behaviour therapy to prevent complicated grief among relatives and spouses bereaved by suicide: cluster randomised controlled trial. *British Medical Journal* 334(7601): 994.

[53] Mcdaid C, Trowman R, Golder S et al. (2008) Interventions for people bereaved through suicide: systematic review. *British Journal of Psychiatry* 193: 438–443.

[54] Hawton K, Sutton L, Simkin S et al. (2010) *Evaluation of* Help is at Hand*: A resource for people bereaved by suicide and other sudden, traumatic death*. oxford: University of oxford, available at: www.psych.ox.ac.uk/csr/EvaluationReport.pdf

[55] Owens C et al (2011) Recognising and responding to suicidal crisis within family and social networks: qualitative study *British Medical Journal* 343:d5801

[56] Blood RW and Pirkis J (2001) *Suicide and the Media: A critical review*. Canberra, Australia: Commonwealth department of Health and Aged Care, available at: www.mindframe-media.info/client_images/372860.pdf.

[57] Barbour V, Clark J, Peiperl L et al. (2009) Media portrayals of suicide. *PLoS Medicine* 6(3): e51.
[58] Biddle L, Donovan J, Hawton K et al. (2008) Suicide and the internet. *British Medical Journal* 336: 800–802.

[59]http://webarchive.nationalarchives.gov.uk/20110201125714/http://www.justice.gov.uk/publications/coroners-justice-act-key-provisions.htm

[60] Cook L and Hill C (2011) Narrative verdicts and their impact on mortality statistics in England and Wales. *Health Statistics Quarterly* 49: 81–100, available at: www.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/spring-2011/index.html

Agenda Item 12

REPORT TO: Health and Wellbeing Board

DATE: 17th July 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Winterbourne View update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of the report will be to provide members of the Health and Wellbeing Board with an update of the Winterbourne View Action plan.

2.0 **RECOMMENDATION: That the Board**

1. **note the contents of the report; and**

2. **note the Winterbourne View action plan**

3.0 **SUPPORTING INFORMATION**

3.1 *Transforming Care: A national response to Winterbourne View Hospital (Department of Health Review final report)* was produced in December 2012. The Review included a Timetabled Action Plan with 63 areas that started in June 2012. The majority of areas are focused at a national level with guidance disseminated to Clinical Commissioning Groups (CCGs) and the Local Authority (LA) for implementation. The areas that require CCG and LA input are highlighted below:

- **Area 26** – completed – handover of legacy arrangements from PCT to CCG.
- **Area 33** – Pooled budgets arrangements across health and social care.
- **Area 34** – Those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities**. –** On-going strategic review of out of borough placements as part of the LDSAF and Winterbourne Strategic Group.
- **Area 35** - Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide. – LA and CCG Commissioners and LA Quality Assurance team are working

with providers to achieve.

- **Area 38** - Joint Health and Social Care SAF to be submitted September 2013 - Strategic working group chaired by Paul McWade to lead.
- **Area 42** - Review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes. On-going with regular assurance via NHS England Area Team.
- **Area 57** - CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes. – Underway via Merseyside JSNA network.
- **Area 58** - All individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014. – on-going care management review, - database is to be drafted July for LDSAF return this will provide evidence of compliance.

3.2 The LA and CCG are working with national bodies to develop service specifications that will be utilised to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care.

3.3 A Winterbourne View update will also be presented to a range of partnership and management groups.

3.4 Appendix 1 – is an illustration of the regional teams responsible for Winterbourne View Concordant action plan – highlighting information flow from the Department of Health and assurance flow via the NHS Area Team that Halton Borough Council and Halton CCG provide.

3.5 Appendix 2 – the Winterbourne View Concordant Action Plan with the specific areas relevant to Halton CCVG and LA highlighted.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

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

6.1 **Children & Young People in Halton**

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will continue to be addressed through the Winterbourne View Action plan.

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

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing implementing actions within the Winterbourne View Action plan to address health inequalities

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**

The environment in which we live and the physical infrastructure of our communities has a direct impact on health and wellbeing of individuals.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on health and wellbeing.

7.0 **RISK ANALYSIS**

7.1 The level of national and local scrutiny is significant in relation to the Winterbourne View action plan.

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

Winterbourne View overview reporting map

Red Arrow – indicates information flow and dissemination or requests for informaiton and assurance.

Green Arrow – Assurances provided and submissions as required.

NHS England

(National Team)

NHS England

(Northwest Regional Team)

Area Team LD Network

Area Team, LA & CCG Commissioner's (Halton, Sefton, Knowsley, Liverpool and St Helens.

NHS England

(Merseyside Area Team)

Specialist Commissioning

(NHS England Cheshire Area Team)

Halton Borough Council

Halton

Clinical Commissioning Group

LD Partnership Board

Chair Cllr Wright

Health Care for All

Chair CCG

LD Quality and Performance Board

Chair Sue Wallace Bonner

LD SAF and Winterbourne View Strategic group.

Chair Paul McWade

Winterbourne Action plan						
Area	**KEY ACTION**	**DEADLINE DATE**	**PROGRESS UPDATE**	**ISSUES**	**COMPLETION DATE**	**RAG RATING**
1	CQC will continue to make **unannounced inspections of providers** of learning disability and mental health services employing people who use services and families as vital members of the team.	From June 2012	Merseyisde Area CQC Inspections 2012 Supported Living Care Providers x 12, Dentists x 6, Nursing Care Homes x 5, Residentail Care Home Provider x 6			
2	CQC will take tough **enforcement action** including prosecutions, restricting the provision of services, or closing providers down, where providers consistently **fail** to have a **registered manager in place.**	From June 2012				
3	CQC will take enforcement action against providers who do not operate effective processes to ensure they have **sufficient numbers of properly trained staff.**	From June 2012				
4	The cross-government **Learning Disability Programme Board** will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.	From November 2012	National Disability Programme Board Established by Doh with the overall aim to drive forward cross-Government work to improve outcomes for people with learning disabilities within the new health, social care and welfare structures and receive regular reports from partners.	Establishment of Merseyside LD Programme Board needs consideation		
5	The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with **Deprivation of Liberty Safeguards** provisions to protect individuals and their human rights and will report by Spring 2014.	From December 2012	to ensure complinace by spring 2014			
6	The Department of Health will, together with CQC, consider what further action may be needed to check how **providers record and monitor restraint.**	From December 2012	Review contracts compliance. Donna Ryan			

7	The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in **commissioning advocacy f**or people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs.	From December 2012				
8	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the **Action for Advocacy Quality Performance Mark** and reviewing the Code of Practice for advocates to clarify their role.	From December 2012				
9	A specific workstream has been created by the police force to identify a process to trigger **early identification of abuse**. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice,	From December 2012	Once disseminated DS and HM to work with Cheshire Constabulary to ensure process in place.			
10	The College of Social Work, to produce key points **guidance for social workers on good practice** in working with people with learning disabilities who also have mental health conditions;	From December 2012	To review point with regional Winterbourne group			
11	The British Psychological Society, to provide **leadership to promote training** in, and appropriate implementation of, **Positive Behavioural Support** across the full range of care settings.	From December 2012	To consider and implement recommendations			
12	The Royal College of **Speech and Language Therapists, to produce good practice standards** for commissioners and providers to **promote reasonable adjustments** required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.	From December 2012	To consider and implement recommendations			

13	The Local Government Association and NHS Commissioning Board will establish a **joint improvement programme** to **provide leadership and support t**o the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.	By end of December 2012				
14	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will **refresh Challenging Behaviour: A Unified Approach to support clinicians in community learning disability teams to deliver actions that provide better integrated services.**	By end December 2012	JW to review document			
15	Skills for Health and Skills for Care will develop national **minimum training standards and a code of conduct** for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.	By January 2013	Brian Hilton.			
16	Skills for Care will develop a framework of guidance and support on commissioning **workforce solutions** to meet the needs of people with challenging behaviour	By February 2013	Brian Hilton.			

17	The Department of Health will commission an **audit of current services for people with challenging behaviour** to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.	By March 2013				
18	The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: • **model service specifications; • new NHS contract schedules for specialist learning disability services; • models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and a joint health and social care self-assessment framework** to support local agencies to measure and benchmark progress.	By March 2013				
19	The NHSCB and ADASS will develop **service specifications** to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A.	By March 2013				
20	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed **guidance** on commissioning services for people with **learning disabilities who also have mental health conditions**.	By March 2013	Review and implement guidance when avaialble			
21	The Royal College of Psychiatrists will issue **guidance a**bout the different types of **inpatient services** for people with learning disabilities and how they should most appropriately be used.	By March 2013	Review and implement guidance when avaialble			
22	The NHSCB will ensure that all Clinical Commissioning Groups develop **local registers** of all people with challenging behaviour in NHS-funded care.	By 1 April 2013	Completed			
23	The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will **develop core principles on a statement of ethics** to reflect wider responsibilities in the health and care system.	By 1 April 2013				
24	The National Quality Board will set out how the new health system should operate to **improve and maintain quality**.	By 1 April 2013	Guidance published, membership established. Meeting dates currently being agreed for 2013/14. Discussed with CCG's.			

25	The Department of Health will work with key partners to agree how **Quality of Life principles** should be adopted in social care contracts to drive up standards.	By 1 April 2013				
26	The NHSCB will make clear to CCGs in their **handover and legacy arrangements** what is expected of them in maintaining **local registers**, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.	From 1 April 2013	On going discussions with CCG's following LD Self Assessment submission 2012. Handover Event 7th February 2013, Invitees CCG, LA Adult and Children Services, NCB LD leads MH Providers.			
27	The NHSCB will hold CCGs to account for their progress in **transforming** the way they commission s**ervices for people with learning disabilities/autism** and **challenging behaviours.**	From April 2013				
28	Health Education England will take on the duty for **education and training** across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.	From April 2013				
29	**CQC** will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the **new operation of its regulatory model**, in response to consultation, in Spring 2013.	From April 2013				
30	CQC will **share the information, data and details** they have about providers with the relevant CCGs and local authorities.	From April 2013	Communication with CQC			
31	CQC will assess whether providers are **delivering care** consistent with the **statement of purpose made at the time of registration.**	From April 2013				
32	Monitor will consider in developing **provider licence conditions**, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.	From April 2013	Ensure compliance			
33	The strong presumption will be in favour of **pooled budget arrangements** with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint	From April 2013	Pooled Budget Discussions underway.			

34	The NHSCB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with **learning disabilities and autism** receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people **remain in their communities.**	From April 2013	Completed			
35	Health and care commissioners should use contracts to hold providers to account for the **quality and safety of the services** they provide.	From April 2013	On-going			
36	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide **assurance that essential requirements are being met and that they have governance systems in place** to ensure they deliver high quality and appropriate care.	From April 2013				
37	The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop **measures and key performance indicators** to support commissioners in monitoring their progress.	From April 2013				
38	The NHSCB and ADASS will implement a **joint health and social care self assessment framework** to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.	From April 2013	SAF co-owned between CCG and LA. To be completed by July 2013. Awaiting final paperwork			
39	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local **Healthwatch** involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the **voice of people with learning disabilities and families** is by engaging with existing local Learning Disability Partnership Boards. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.	From April 2013	LD Partnership Board and healthcare for All Group			

40	The Department of Health will immediately examine how corporate bodies, their **Boards of Directors and financiers can be held to account** for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.	By Spring 2013				
41	CQC will take steps now to strengthen the way it uses its existing powers to **hold organisations to account for failures to provide quality care.** It will report on changes to be made from Spring 2013.	From Spring 2013				
42	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in **learning disability or autism inpatient beds and agree a personal care plan** for each individual based around their and their families' needs and agreed outcomes.	By 1 June 2013	Reviews are on-going and recorded in the register			
43	**Provider organisations** will set out a pledge or code model based on shared principles - along the lines of the **Think Local Act Personal (TLAP)**	By Summer 2013				
44	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will **identify and promote good practice** for people with learning disabilities across health and social care.	By Summer 2013				
45	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an **audit** of use of medication for this group. As the first stage of this, we will commission a wider review of the **prescribing of antipsychotic and antidepressant medicines** for people with challenging behaviour.	By summer 2013	Once guidance available, review and implement			

46	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in **making the transition to adulthood**.	By June 2013	Once guidance available, review and implement			
47	The Department of Health and the Department for Education will develop and issue **statutory guidance on children in long-term residential care.**	In 2013	Implement staturtory guidance when availble			
48	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with **learning disabilities whose behaviour is described as challenging** through both the SEN and Disability reform programme and the work of the Children's Health Strategy.	In 2013				
49	The Department of Health will work with independent advocacy organisations to drive up the **quality of independent advocacy.**	In 2013				
50	The Department for Education will revise the statutory guidance **Working together to safeguard Children.**	In 2013	Implement guidance when available			
51	The Royal College of Psychiatrists, the Royal Pharmaceutical Society ad other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the **safe and appropriate use of antipsychotic and antidepressant medicines.**	In 2013	Implement guidance when available			
52	The Department of Health will work with the improvement team to monitor and report on progress nationally, including **reporting comparative information** on localities. We will publish a follow up report by December 2013.	By December 2013				
53	The Department of Health with external partners will publish **guidance on best practice around positive behaviour support** so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.	By end 2013	Implement guidance when available			

54	There will be a progress report on actions to implement the recommendations in **Strengthening the Commitment** the report of the UK **Modernising learning disability Nursing Review.**	By end 2013	Implement actions when available			
55	CQC will also include reference to the model in their **revised guidance about compliance**. Their revised guidance about compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the **proposed changes to our registration process** about models of care for learning disability services in 2013.	By end 2013	Work with providers to support when new registration process available			
56	The Department of Health will work with the Department for Education to introduce a new **single assessment process** and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the **transition to adulthood.**	From 2014	Pending 2014 legislation SEND.			
57	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local **Joint Strategic Needs Assessment** and Joint Health and Wellbeing Strategy (JHWS) processes.	By April 2014	Sharon MacAteer leading working with the Merside Network and Liverpool Univeristy.			
58	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving **personalised care and support in** appropriate **community settings** no later than 1 June 2014.	By 1st June 2014	On-going			
59	The Department of Health will update the **Mental Health Act Code of Practice a**nd will take account of findings from this review.	In 2014				
60	The Department of Health will publish a second **annual report** following up progress in delivering agreed actions.	By December 2014				

61	The Department of Health will develop a new **learning disability minimum data set** to be collected through the Health and Social Care Information Centre.	From 2014/15	Comply to data set when available			
62	**NICE** will publish quality standards and clinical guidelines on **challenging behaviour and learning disability**.	By Summer 2015	Comply once standards and guidance available			
63	**NICE** will publish quality standards and clinical guidelines on **mental health and learning disability**.	By Summer 2016	Comply once standards and guidance available			

Agenda Item 13

REPORT TO:	Health and Wellbeing Board
DATE:	17th July 2013
REPORTING OFFICER:	Strategic Director Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Health and Wellbeing Board Revised Terms of Reference
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Health and Wellbeing Board with amended Terms of Reference to reflect the transition from a Shadow Board to a Statutory Board as from 1st April 2013

RECOMMENDATION: That

1. **the Board note the contents of the report and appendices; and**
2. **feedback comments to the Strategic Director Communities**

3.0 SUPPORTING INFORMATION

3.1 The Health and Wellbeing Board has been operating in shadow form since December 2011. However, as from 1st April 2013 the Board became a statutory board of the Local Authority.

3.2 As a result of this change the original Terms of Reference have been updated. The revised document removes reference to a “Shadow” Board and actions relating to the transitional period. Membership has also been updated to reflect changes.

3.3 The revised Terms of Reference are attached to this report at Appendix 1.

4.0 POLICY IMPLICATIONS

4.1 As a statutory board the Health and Wellbeing Board must have a set of agreed Terms of Reference in order for it to operate effectively and to fulfil legal requirements.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will continue to be addressed through the work of the Health and Wellbeing Board.

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

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration for the Health and Wellbeing Board.

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime has an impact on health outcomes particularly on mental health. There are also close links between partnerships on areas such as alcohol and domestic violence. It therefore remains a key consideration for the Health and Wellbeing Board.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. It should therefore be a key consideration when developing strategies to address health and wellbeing.

7.0 RISK ANALYSIS

7.1 N/A

8.0 EQUALITY AND DIVERSITY ISSUES

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

Document	Place of Inspection	Contact Officer

N/A

TERMS OF REFERENCE FOR HALTON HEALTH AND WELL-BEING BOARD

Aims of the Health and Well-Being Board

1. The Health & Well-Being Board (HWBB) is responsible for guiding and overseeing the implementation of the ambitions outlined in the Health White Paper "Equity and Excellence - Liberating the NHS" as well as providing the strategic direction for the Health priority in Halton. Principally this will include:

   - guiding and overseeing the Joint Strategic Needs Assessment;
   - overseeing the implementation and monitoring of theJoint Health and Well-being strategy based upon the findings of the JSNA (including priorities identified by the Sustainable Community Strategy (SCS)); ;
   - promoting joint commissioning and integrated provision between health, public health and social care.

2. The Health and Wellbeing Board will provide a key forum for public accountability of NHS, Social Care for Adults and Children and other commissioned services that the HWBB agrees are directly related to Health and Well-being in Halton.

3.

Suggested Terms of Reference based on the above:

Principle Responsibilities working within a "boiler house" approach:

- To be responsible for guiding and overseeing the implementation of the ambitions outlined in the Health White Paper "Equity and Excellence-Liberating the NHS" and "Healthy Lives, Healthy People" the health strategy for England

- To promote sound joint commissioning arrangements and integrated provision between health, public health and social care
and to safeguard adults and children.

- To assess the needs of the local population and lead the Statutory Joint Strategic Needs Assessment.

- To promote integration and partnership across areas including through promoting joined up commissioning plans across the NHS, Social Care and Public Health.

- To work with the Children's Trust to ensure that Children's Services commissioning is embedded into the role of the Health and Well-being Board and effective relationships established between the two Boards.
- Halton Health and Wellbeing Board will work closely with its statutory partners including Halton Local Safeguarding Children Board in its contribution to help protect and care for the children and young people of Halton. In doing this it recognises the importance of early help.

- To support strategic planning and joint commissioning and publish a Joint Health and Well-being Strategy

- To contribute to the developments of Health and Well-being Services in Halton which may arise as a result of changes in Government Policy and relevant legislation.

- To respond and contribute to developments in wider partnership arrangements in Halton in addition to the Consortia that contribute to health and wellbeing.

Other Responsibilities

- To give strategic direction to relevant Commissioning Activity

- To oversee the work of Joint Commissioning Groups.

- To liaise, where relevant, with new NHS arrangements regarding strategic and commissioning direction.

- To develop and monitor relevant activity and performance.

- To ensure that Health Inequalities and the priority measures are

addressed by the Joint Commissioning Group.

- To ensure that Halton's health priorities (as defined by the JSNA, SCS and relevant health targets) are addressed by Joint Commissioning Groups.
- To ensure that Joint Commissioning Groups work effectively with other Strategic Partnerships to address cross-cutting areas of work e.g. alcohol to ensure an holistic approach.
- To encourage access for service users and patients through closer working arrangements and in particular to address issues in relation to disadvantaged groups.
- To engage with relevant providers when necessary to gather requirements around need.
- To effectively monitor and review the progress of programmes designed to impact on key targets.
- To ensure dissemination of learning as a result of good practice.
- To disseminate and share strategies and action plans in order to facilitate partnership working
- To maintain appropriate linkages with other partnership boards including those relating to Adults and Children's Safeguarding.

Membership

Elected Member (Chair)

Executive Board Portfolio Holder for Health & Adults

Executive Board Portfolio Holder for Children and Young Peoples Services (Chair of Children's Trust)

Chief Executive, Halton Borough Council

CVS/Forum Representative

Health Watch Representative

GP Representatives from Widnes and Runcorn areas

Strategic Director, Communities (Chair of SAB)

Strategic Director, Children & Enterprise

Director of Public Health

Chair of LSCB

Operational Directors, Partnerships, and Child and Family Health Commissioning Halton & St. Helens NHS

Chief Executive or representative from Merseyside Cluster NHS Cluster

5 Boroughs Partnership NHS Trust

Bridgewater Community Healthcare NHS Trust

Warrington & Halton Hospitals NHS Foundation Trust

St Helens and Knowsley Hospitals NHS Trust

Housing Association Representative

Chair(s) of the Safer Special Strategic Partnership Sub Group

Chair of the Employment, Learning & Skills Special Strategic Partnership Sub Group

Chair of the Children's Special Strategic Partnership Sub Group

Chair of the Environment Special Strategic Partnership Sub Group

Chair of the Health Special Strategic Partnership Sub Group

Fire and Rescue Service

North West Ambulance Service

NHS England

In the event of a representative not being able to attend the Board, a substitute of that organisation should be made available.

Conflict Resolution

- To build consensus, members need to be aware of, and understand, the different values, outlook, skills and experience that each member brings to meetings.
- Given the range of people involved in the Board, differences of opinion will unfortunately be inevitable and this diversity is welcomed as it leads

to reasoned and challenged debate within the Partnership which helps in achieving its goals. The aim must be for differences of opinion to be dealt with in a positive and constructive manner and to avoid situations where decisions escalate into formal confrontations and breakdown of trust and conflict, as ultimately this will discredit the Board.

- The operating principles and policies of The Board, aim to show how to build consensus and deal with conflict in a positive way by stressing the key principles of diplomacy, negotiation, mediation and arbitration that all members must adopt in Board meetings

- In situations where differences of opinion are seriously escalating at Board meetings and jeopardising the work of the board, the members concerned need, with the assistance of an impartial third party, to go to mediation. Mediation should be jointly called by both parties concerned, or may be requested by other members of the meeting where conflict arose.

- Nothing in this document should be interpreted as changing the statutory or other responsibilities of partners, or their own accountabilities. It does not prevent them pursuing their own individual action if they so wish.

Meetings

- Meetings of the Health and Well-being Board will take place bi-monthly. The chair may call an extraordinary meeting at any time. The agenda and associated papers will be sent out a minimum of one week (five clear working days) in advance of the meeting. Minutes of the board will be formally minuted.

Chair

- The Chair will be an elected member of Halton Borough Council

Quorum

- The meeting will be quorate provided that at least fifty per cent of all members are present. This should include the Chair or Vice Chair and at least one officer of the PCT and one officer of the Local Authority. Where a Board is not quorate, business may proceed but decisions will need to be ratified.

Decisions

- Where a decision is required, that decision will be made by agreement among a majority of members present. Where a decision needs to be ratified by one of the statutory agencies, the ratification process will be in accordance with the agreed process within that particular agency.

Minutes

- Minutes of the proceedings of each meeting of the Board will be drawn up, circulated and agreed as a correct record at the subsequent meeting, once any required amendments have been incorporated.

Review

- The membership and terms of reference of this partnership will be reviewed regularly (normally annually) to ensure that they remain relevant and up to date.

Agenda Item 14

REPORT TO: Health and Wellbeing Board

DATE: 17th July 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Urgent Care – Progress

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 Present Members of the Board with an update report in relation to the current projects/areas of work associated with improvements in Urgent Care as referenced in Halton's Accident and Emergency Recovery and Improvement Plan.

2.0 RECOMMENDATION: That

1. note the contents of the report; and

2. note and approve the Recovery and Improvement Plan (Appendix 1).

3.0 SUPPORTING INFORMATION

3.1 Local Context

During 2012 Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (HCCG) developed the Urgent Care Partnership Board to lead on the development and management of the Urgent Care system used by the Borough's population.

3.2 Delivering on this agenda will provide the health and social care economy with sustainable improvements in performance and quality through:

- Understanding demand and capacity;
- Matching existing and redesigned resources to expected flow;
- Understanding and managing the service users experience, safety and outcome;
- Measuring quality, outcomes and performance;
- Working across partners to maintain an integrated 24/7 system that is sustainable;
- Joint working across all health and social care organisations within the economy;

- Scenario planning for periods of increased activity to better plan capacity to meet demand e.g. Winter;
- Development of robust escalation mechanisms, including clear definition of escalation triggers and processes;
- Signposting and educating people to select health care providers that are appropriate to their needs;
- Identifying patient pathways in the emergency department and assessment units which facilitate prompt decision making and timely discharge;
- Improving hospital discharge processes including proactive case finding;
- Targeted services, giving the greatest impact on outcomes; and
- Further co-ordination of services, thus avoiding duplication.

3.3 **<u>Primary Care Quality and Access</u>**

The accountability for Primary Care remains with NHS England, meaning that contractually NHS England oversees the quality elements of Primary Care within Halton.

However, evidence suggests that access remains an issue for Halton residents. As a result a Primary Care Quality Group, consisting of representatives from HBC and HCCG, will be established, whose role it will be to improve the quality and support to local practices in order for them to be able to effectively respond to the growing need for quicker and more effective access.

An evaluation report on progress will be presented by the Group to the Urgent Care Partnership Board in September 2013.

4.0 PERFORMANCE

4.1 As urgent care spans across acute, primary and community care, key performance indicators need to reflect this. Ambulance response times, A&E attendances, admissions, readmissions and lengths of stay are some of the national metrics monitored in the system. These generally reflect the state of development within primary and community care but do not provide specific understanding of the development needs within these sectors. Availability, access, pathway development within, and utilisation of, primary and community care are key to managing demand on acute services by the provision of credible, alternative pathways of care.

4.2 Where baseline measures existed, they demonstrated that Halton performed well on A&E and 18 week waiting targets, support for people to die at home and the numbers of people admitted to Long Term Care. Significant challenges were evident in the number of admissions, readmissions and lengths of stay for the 65+ population into the acute sector and the number of older people who attended

hospital following a fall. Furthermore, some of the local population are utilising multiple services for the same issue whilst some would benefit from a more targeted approach to support self and joint management of their long term conditions and health/social care needs.

4.3 Recent performance data does demonstrate improvements in some areas:

- permanent admissions to residential/nursing care; and
- proportion of Local Authority Adult Social Care spend on residential/nursing care. NB. Halton are ranked the best in the Northwest in relation to this area.

Areas that are improving include:

- non-elective re-admission rates within 30 and 90 days – Service changes contributing to this include: a post discharge telephone support service; the Local Enhanced Service scheme in primary care with a focus on readmissions; and the addition of a dedicated telephone line for GP's looking for alternatives to admission through the Rapid Access and Rehabilitation Service.

Areas that remain static include:

- proportion of deaths which occur at home – review of the end of life pathway is underway to ensure maximum use of community care planning and preferred place of care process; and
- proportion of people discharged direct to residential care – investigation work is underway to understand how this is coded as this does not reflect local authority data.

4.4 Through the continued work of the Urgent Care Partnership Board, many projects associated with improving the Urgent Care system have already been completed and implemented and it should be noted that these projects have been referenced within the Accident and Emergency Recovery Plan (see paragraphs 3.14 – 3.16 of this report) as these will contribute to the delivery of the A&E operational standard (95% of patients admitted transferred or discharged within 4 hours).

5.0 NATIONAL CONTEXT

5.1 On the 9th May 2013, Dame Barbara Hakin, Chief Operating Officer/Deputy Chief Executive of NHS England wrote to NHS England Area Directors regarding the delivery of the A&E 4 hour operational standard, the pressure the urgent and emergency care system is experiencing at the moment and the impact that this was having on the operational standard.

5.2 As a result it had been agreed that NHS England would coordinate

the production of local recovery and improvement plans to ensure operational standards were being met.

5.3 NHS England, Monitor and the NHS Trust Development Authority (TDA) have put in place a tripartite agreement which will provide regional and national oversight to the delivery of these plans. It is the intention that that they will also work closely with CCGs at national level, as well as with key partners from local government.

5.4 Together, they have agreed a national recovery and improvement plan to secure the timeliness of treatment for patients. The Plan outlines the actions expected of Area Directors to facilitate a local partnership approach and system plan. As lead commissioners, CCGs need to support their providers to ensure that each A&E department that is not within the NHS Constitution threshold can recover its position at the earliest possible time. This has therefore required the development of local recovery and improvement plans centred on each A&E department.

6.0 **Halton's Accident and Emergency Recovery & Improvement Plan (R&IP)**

6.1 Deadlines for the production of local Plans were tight, having to be submitted to Regional Directors by 31st May 2013.

6.2 Plans having been submitted to Regional Directors, the regional teams will be working in partnership with the regional arms of Monitor and the NHS TDA to ensure mutual understanding and oversight of the delivery of the local plans. The national tripartite performance oversight team, working with local government and CCGs will ensure a coordinated national approach to this process.

6.3 Within Halton, the development of the local Plan (***Appendix 1***) was co-ordinated via the Halton Urgent Care Partnership Board and in addition to being formally signed off by HCCG, has been agreed by all partners of the Board. It should be noted that prior to submission to the Regional Director each local plan has had to go through the NHS England's North Region assurance process; this exercise was completed.

6.4 The Plan and associated actions have been divided into a number of areas as follows :-

- Urgent Care Board;
- Prior to A&E;
- Flow whilst within hospital (Warrington & Whiston);
- Discharge and out of hospital care;
- Other associated actions (immediate); and
- Other associated actions (3-6months)

The R&IP contains supporting commentary and associated evidence against each of the actions outlined, in addition to a number of supplementary actions required and timescales that will support improvements within Halton's Urgent Care system as a whole, not just in terms of the A&E operational standard and address the challenges that exist within the system as outlined in paragraph 3.5 of the report.

7.0 **RISK ANALYSIS**

7.1 The Urgent Care Board has rated progress to date against each of the actions in the R&IP using R/A/G and it is planned that progress against the actions outlined in the A&E R&IP, and the impact that these are having on the current challenges within the Urgent Care system, will be monitored on a monthly basis via the Urgent Care Partnership Board.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no adverse consequences as a result of any proposals.

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

None under the meaning of the Act

Halton Clinical Commissioning Group

HALTON
URGENT CARE

RECOVERY AND IMPROVEMENT PLAN

(as at 13.6.13)

Urgent Care Board

Actions expected of the Urgent Care Board:-

Action Point No.	Expected Actions Required	Supporting Commentary & Evidence	Progress to date (R/A/G)	Additional Actions Required	Responsible Person	By When	Progress to Date
1.	Review membership. Need to include:- • All key stakeholders from H&SC • Patient representative • Appropriate Clinical Expertise	Membership reviewed. All key stakeholders from H&SC are represented, along with appropriate clinical expertise with the exception of a representative from Whiston Hospital and Healthwatch		Invite representative to join the Urgent Care Board from :- • Whiston Hospital • Healthwatch • Cheshire & Merseyside Commissioning Support Unit • 5BP	 Dave Sweeney (HCCG) Louise Wilson (HBC) Dave Sweeney (HCCG) Dave Sweeney (HCCG)	 31.5.13 31.5.13 Once Unplanned Care Team Manager is appointed 31.5.13	
2.	Review the full range of appropriate data.	Overarching Performance Management Dashboard under development Via CMCSU. This will provide on-going analytical support to the programmes of		• Data set to be agreed by the Urgent Care Board, following which a Performance Management dashboard will be	Jenny Owen & Susan Kearns (HCCG)	31.5.13	

(as at 13.6.13)

		improvement in order to measure the outcomes from the Response plan and the on-going management of capacity and demand at times of escalation ECIST reports are utilised by the Urgent Care Board on an on-going basis to support the on-going development of urgent care services in Halton, including those provided via Whiston and Warrington		developed and template uploaded via GP portal. This will allow for the effectiveness (inc. sustainability of services) to be reviewed on an on-going basis. The Dash board will reflect activity in WIC, HMIU, NWAS, NHS 111, activity being received monthly and is reflected within the contract review meetings and Quality and Performance Board within each contract. Daily SIT rep being received centrally for NHS 111 via Ian Davies as the responsible senior manager.			
				• Regular reporting through to the Urgent Care Board – Process to commence by 1.7.13	Jenny Owen & Susan Kearns (HCCG)	On-going Process	
				• Risk register and log under development to support	TBC	TBC	

(as at [illegible].6.13)

				performance/ activity dashboard and commissioning intentions through 2013/14.			
3.	Best Practice to be adopted by all concerned	Taking a collaborative approach, the Urgent Care Board is responsible for overseeing the strategic direction of urgent care service in Halton and this approach is reflected in the Terms of Reference (ToR) for the Board. **Urgent Care Board – ToR** Terms of reference 2012.docx The Halton Urgent Care Board regularly links with the St Helens Urgent Care Network and the Warrington Transformational Board to address cross boundary issues etc.		Urgent Care Board to review ToR to ensure their continued appropriateness	Urgent Care Board	30.6.13	
4.	Effectiveness of primary care service is reviewed, including out of hours and admission avoidance schemes	The effectiveness and sustainability of primary care services etc. form part of Halton's overarching Urgent Care		• On-going review of services is in line with the work streams outlined in the Response Plan	Urgent Care Board	On-going Process	Latest update of progress against the work streams in the Response Plan will be presented to the Urgent

(as at 30.6.13)

		Strategy, Response Plan and associated work streams **Urgent Care Strategy** Urgent Care Strategy (Final).docx **Urgent Care Response Plan** Halton Urgent Care - Response Plan Final (		• Ensure primary care CCG commissioner remains part of the core membership of the Urgent Care Board • Ensure the briefing outlining contractual requirements from Primary Care commissioning NHS Merseyside Area Team is fed up to the Urgent Care Board	Urgent Care Board NHS England Area Team	On-going Process On-going Process	Care Board on 21.5.13 **Urgent Care Response Plan - Update** Urgent Care Work Plan Update (as at 16
5.	Effectiveness of community services is reviewed, including any walk in centres, minor injury units and how they integrated with secondary care.	The effectiveness and sustainability of community services etc. form part of Halton's overarching Urgent Care Strategy, Response Plan and associated work streams. Development of a sustainable Urgent Care centre options in progress, including the review of Urgent Care Pathways and 7 day working **Urgent Care Options**		Urgent Care Options Appraisal includes the development of an enhanced and sustainable urgent care site for both Runcorn and Widnes, which will support: • Kitmarks • NWAS Community Care plans • NWAS Paramedic Pathways • WIC Site development – Xray, DVT, ultra sound, Doppler etc. • Development of a clinical decisions unit	Jenny Owen (HCCG)	30.9.13	Completion of PPI, Business Case and a decision made regarding the procurement process by end Spet'2013

		Appraisal urgent care options appraisal.doc **Urgent Care Options Appraisal – Engagement Plan** Urgent Care engagement plan 13.		- interface between secondary and community /primary provision			
6.	Effectiveness of Ambulance service is reviewed	The Urgent Care Board will now receive regular reports (including turnaround times/ PTS provision) from the NWAS in order to assess the effectiveness of the Service NWAS is member of the Urgent Care Board		• Performance information to be presented to the next Urgent Care Board and actions agreed based on the embed document below NWAS Call Categories.docx • NWAS data will form part of the overall Performance Management Dashboard which is to be developed (see Action point 2)	Karl Hough (NWAS) Jenny Owen & Susan Kearns (HCCG)	18.6.13 31.5.13	
7.	Effectiveness of NHS 111 is	The effectiveness of NHS		On-going review of	Urgent Care	On-going	National issues around

(as at 6.6.13)

	reviewed	111 forms part of Halton's overarching Urgent Care Strategy, Response Plan and associated work streams		services is in line with the work streams outlined in the Response Plan	Board	Process	NHS 111 are being ratified. The contingency measures will continue whilst the CCGs seek to design a long term safe, sustainable and affordable solution to the delivery of the nationally mandated NHS 111 service requirement. The CCGs are working collaboratively to oversee, manage and develop the Directory of Service (DoS) as a key component of the urgent care system. A central support team hosted by Liverpool CCG will be fully in place by the end of June and will provide direct support and expertise to the CCGs to develop the understanding, use and potential of the DoS further, harnessing it's contribution to better direct patients and health care professionals to accessible and

(as at 19.6.13)

							appropriate alternatives to a 999 ambulance, AED attendance or emergency admission. Further regional DoS support is available through the small team and lead hosted by NWAS for the north west
8.	Local plans in place to support the care of the key categories of patients who attend or are admitted frequently :- • Patients with multiple comorbidities especially those with poorly controlled chronic disease; • Frail elderly, especially those with mental health problems; • Sick children; and • High dependency individuals, especially vulnerable adults (homeless, drug and alcohol related problems, mental health problems)	Local Plans are in place for the categories outlined and are reflected in the work streams contained in the Response Plan.		• On-going review of services is in line with the work streams outlined in the Response Plan • Need to consider how community oriented responses could be mobilised to address pressures on urgent care services. Discussion paper to be presented to the Urgent Care Board for consideration, which would outline some simple, practical ways in which community psychosocial responses could be embedded into existing plans to address urgent care	Urgent Care Board Urgent Care Board and Mark Swift (CIC Wellbeing Enterprises)	On-going Process 30.6.13	

(as at 30.6.13)

				challenges.			
9.	A full range of services are available to Acute Trusts for those patients in A&E who need services not provided by Acute hospitals	A number of services are already in place which the Acute Trusts can access, including :- • Liaison Services, including mental health and alcohol services • Social Work support into A&E at Whiston with access into community services • Social Work and Community Nurse support into A&E at Warrington with access into community services		• On-going review and evaluation of services is in line with contracts or issues with performance etc.	Urgent Care Board	On-going Process	
10.	Working with LAs, a review to ensure early discharge is undertaken	Multi-Disciplinary Team (MDT) in place		Evaluation/Review MDT provision	Damian Nolan (HBC/HCCG)	By December 2013	
11.	Oversee the use of 70% funding retained from excess urgent care tariff to support the urgent care system and Acute provider's ability to deliver operational standard	Funding to be allocated to ensure the sustainability of community services, thus releasing pressure on Acute providers		Agreement to be made at the Urgent Care Board in terms of attaching the funding to those services outlined in the Response Plan	Urgent Care Board	30.6.13	
12.	Urgent Care Board to sign off all aspects of the Recovery & Improvement Plan	Recovery & Improvement Plan has been drafted		• Urgent Care Board singed off Plan on	Urgent Care Board	21.5.13	

				21.5.13, prior to submission to the Area Team on 24.5.13. • The Urgent Care Board will review progress against each of the actions outlined in the Plan at each of their monthly meetings.	Urgent Care Board	On-going process	

(as at 13.6.13)

Prior to A&E

Actions expected prior to A&E:-

Action Point No.	Expected Actions Required	Supporting Commentary & Evidence	Progress to date (R/A/G)	Additional Actions Required	Responsible Person	By When	Progress to Date
1.	Strengthen primary and community care for frail and elderly patients	A number of sustainable services/pathways exist to support frail and elderly patients, including:- • Intermediate Care • Single Point of Access • Community Wellbeing Practices • Diabetes Hypo Pathway • Falls Pathway • Respiratory Pathway • Health & Wellbeing Service • Integrated pathways for older people with mental health issues • LLAMS Pathway redesigned and launched **Examples provided to Area Team**		• Red Flagging of EOL needs to be developed • Therapy Service Review to be completed • Model for Community MDT to continue to be implemented • LLAMS Diagnostics Review within Primary Care, support by 5 Boroughs to be completed • On-going review and evaluation of services in line with contracts or issues with performance etc. • Development of Kite	Jenny Owen (HCCG) Damian Nolan (HCCG/HBC) Damian Nolan (HCCG/HBC) Dementia Board Urgent Care Board Jenny Owen	31.8.13 30.6.13 On-going Process 30.9.13 On-going Process 31.12.13	

(as at 26.6.13)

				mark as part of urgent care preferred model	(HCCG)		
2.	Use community diversion schemes	Diversion Schemes include :- • Single Point of Access • Intermediate Care • DVT Pathway • End of Life Pathway • Diabetes Hypo pathway • Respiratory Pathway • Falls Pathway **Examples provided to Area Team**		• On-going review and evaluation of services is in line with contracts or issues with performance etc. • Proposals for Xray facility in WIC and moving the ultra sound from Beaconsfiled into the WIC to be developed	Urgent Care Board Jenny Owen (HCCG)	On-going Process 31.10.13	
3.	Strengthen GP Out of Hours services	Interim contract currently in place for UC24. A new contract will be in place by 1st September 2013. Contract monitoring in place - Senior responsible Officer chairing contract review meetings is Ian Davies across Merseyside		• Appropriate pathways and specialist patient notes need to be developed with the new provider • Call handling system for OOH needs to be renegotiated and transferred back from NHS 111 including funding stream	Jenny Owen & Jo O'Brien (HCCG) Jenny Owen & Jo O'Brien (HCCG)	31.8.13 31.8.13	Further documentary evidence is being provided by Ian Davies centrally regarding NHS 111 and call back centre being transferred back to OOHs UC 24. This arrangement is now in place for a 12 month period, until the local model across the northwest can be developed as part of the NHS 111 recovery plan being led by DOH/NHS

							Blackpool CCG and NHS England
4.	Use virtual wards in the community	Community MDT Model to be used		Model for Community MDT to continue to be implemented	Damian Nolan (HCCG/HBC)	On-going Process	
5.	Support care homes to avoid emergency referrals	In place :- • Care Homes Support Team • 5 Borough's Care Team (Single supplementary dedicated MH Team in Care Homes) **Documentary evidence provided to Area Team** 5BP Care Team: Targets to be confirmed once the outcome of the evaluation is known and will form part of the service specification and business case which will be presented back to the Urgent Care Board by December 2013 – See opposite		• On-going review and evaluation of services in line with contracts or issues with performance etc. • 5 Boroughs Care Team ○ pilot to end June 2013 ○ To agree 6 months extension with 5 Boroughs ○ John Moores University to undertake a review of pilot over the next 6 months ○ Service Specification to be revised and Business case to be developed	Urgent Care Board Jenny Owen (HCCG)	On-going Process 31.12.13	

				and presented to the Urgent Care Board and 5 Borough CCGs ○ Will then form part of contract negotiations for 2014/15			
6.	Peer review of GP emergency referrals	Practice visits are made by the Chief Operating Officer and Chair of HCCG Clinical leads support individual practices around quality and good practice to improve outcomes for their local population. This is enhanced via QOF and practice leads / service improvement group meetings. All practices will participate in an annual external peer review with other practices to compare their data on emergency admissions. The practices will then engage with the		Need to ensure connectivity of Peer Reviews between Practices Further negotiation is required with member practices to establish baseline targets to reduce GP emergency referrals. This will build on the QOF frequent flyers work and roll out of the GP portal, assurance will be provides by the AED /unplanned care dashboard	Urgent Care Board TBC	On-going Process TBC	

(as at 26.6.13)

		development of and follow 3 care pathways, in the management and treatment of patients in aiming to avoid emergency admissions. This work will commence shortly and the pathways are likely to be developed within next year's commissioning intentions. For 12/13 this included a review of the DVT pathway, implementation of Advanced Care Planning with particular focus on Care Homes and enhancement of COPD management within primary care. New LES in place which will commence June 2013 (to be monitored on a quarterly basis) - *Reducing Emergency admission for Ambulatory conditions*. This will involve GPs reviewing two groups of patients; under 19yr and over 18yrs with a number of conditions that should normally be managed within primary care. The					

		aim being to reduce the need for emergency admission or patient self-presentation to A&E. PLT event planned for 31.7.13 which is aimed at increasing GP knowledge around brief interventions available					
7.	Reduce ambulance conveyance rates	In place :- • NWAS Community Care Plan for falls and respiratory conditions **Falls Strategy (Inc. targets) provided to the Area Team**		• Further work is required and links to be establish to the Quality and Performance Board within the NWAS contractual reviews with NHS Blackpool CCG via Ian Davies. AED dashboard to be established to support performance and activity schedule within the contract • End of life - red flags to be developed in line with LCP, ACP, PPC and DNAR policies. • Kite marks to be developed as part of preferred urgent care model	TBC Jenny Owen (HCCG) Jenny Owen (HCCG)	TBC 31.12.13 31.12.13	

(as at 5.6.13)

8.	Patient education on appropriate use of emergency services	Education/Marketing in place :- • Choose Well • Specific marketing on the new OHH Service • CCG website • PPGs • Halton Health Forum • PPI engagement events, including engagement plan for urgent care centres proposals **Urgent Care Options Appraisal – Engagement Plan** See page 6		• Consultation programme planed in relation to the new Urgent Care Centre Proposal which will support the awareness raising of emergency services amongst patients • Assess impact of the Choose Well Campaign - Merseyside Area Team have agreed to review the Choose Well Campaign including its impact across the Merseyside health economy.	Jenny Owen (HCCG) Jenny Owen (HCCG)	31.8.13 30.9.13	
9.	Roll out arrangements for NHS 111	In Place :- • Directory of Services • Internal and external process for the authorisation of changes to the Directory • Quarterly external clinical templates amended as part of an on-going process		Training sessions for DOS users need to be established once support are in place.	Jenny Owen (HCCG)	On-going Process	

(as at 26.6.13)

		• Governance arrangements established locally including LCAG local clinical governance group and support team which will be fully operational by the end of June. • Initially training has been provided for all DOS users. **Engagement log for NHS 111, which was submitted to the DOH as supplementary evidence pre go live was provided to the Area Team as supplementary evidence**					

(as at [illegible].6.13)

Flow within the Hospital (Warrington)

Actions expected within Warrington Hospital:-

NB. Evidence contained within the inserted documents from Warrington and Halton Hospitals NHS Trust are ECIST compliant.

Action Point No.	Expected Actions Required	Supporting Commentary & Evidence	Progress to date (R/A/G)	Additional Actions Required	Responsible Person	By When	Progress to Date
1.	Prompt bookings of patients to reduce ambulance turnaround delays	Triage nurse for ambulances on ED funded by NWAS to April 1st as pilot. From April 1st funded by Trust. HAS and Performance Dashboard embedded. Performance at 22nd May 2013 xlsx.pdf		Funding required for Triage nurse	MB ARob	Timescales	
2.	Full see and treat in place for minors	See and Treat roles and responsibilities updated March 2013. Role of the See treat clinician .pdf		On occasions when peak demands – extra resources required	MB		
3.	Prompt initial senior clinical assessment within A&E and rapid referral if admission is needed	Median time to medical assessment = 60 mins (Trust) and 63 mins ED. See attached embedded report Time to Medical assessment - May 20		Regularly monitored	MB ARob		

4.	Prompt initiation of blood and radiological tests with rapid delivery of test results	New Radiology system to be implemented for prompt review and audit of times of x-ray results.		Interfaces will be reviewed with new IT system	MB ARob		
5.	Prompt access to specialist medical opinion	Patients are referred promptly to AMU for medical assessment. GP referrals directly access this service.			MB ARob		
6.	Full use of computer aided patient tracking and system for progress chasing	Patient tracking system in place. The information system is currently being upgraded for AED and AMU which will be rolled out across the wards resulting in live patient tracking. AE Paperless Project Draft PID v0 5.pdf		On-going project	MB ARob J DaCosta		
7.	Regular seven day analysis should be in place for rapid identification and release of bottlenecks	Bed meeting happen twice daily these increase to 4 times daily with whole system information and tele-conference while escalating beyond yellow. In ED Breach analysis is reviewed and acted upon daily. Breach analysis sheet.pdf			MB		
8.	Bed Base management	A bed management team			MB		

		are in place – 7 days a week 24 hours a day					
9.	Daily consultant ward rounds	Ward rounds or board rounds are done daily across the majority of wards. This is part of rescue plan for unscheduled care TPP.pdf		Job plans are being revised to include across all wards	ADDs		
10.	Provision of specific services for patient groups such as those with mental health problems	Provision is only in place for AED which is inadequate. Ward Liaison and named clinician provision is currently in dispute.		A RAID model needs commissioning to ensure comprehensive mental health cover.	Commissioners		

NOTE

Warrington are on track to achieve operational standard at the end of Quarter 1 so no specific A&E Recovery and Improvement Plan has been developed, however the Urgent Care Board is assured that the plans outlined by WHHT above are sustainable.

Contractual reviews in place including Quality and Performance Boards to ensure performance monitoring against AED targets.

(as at 13.6.13)

Flow within the Hospital (Whiston)

Actions expected within Whiston Hospital:-

Action Point No.	Expected Actions Required	Supporting Commentary & Evidence	Progress to date (R/A/G)	Additional Actions Required	Responsible Person	By When	Progress to Date
1.	Prompt bookings of patients to reduce ambulance turnaround delays						
2.	Full see and treat in place for minors	NB. St Helens CCG are the lead for Whiston Hospital and Halton's Urgent Care Board will work with them to ensure that appropriate assurances are in place to ensure that operational standards are met.					
3.	Prompt initial senior clinical assessment within A&E and rapid referral if admission is needed	Information on Whiston Hospital submitted by St Helens CCG					
4.	Prompt initiation of blood and radiological tests with rapid delivery of test results						
5.	Prompt access to specialist medical opinion						
6.	Full use of computer aided patient tracking and system for progress chasing						
7.	Regular seven day analysis should be in place for rapid identification and release of bottlenecks						
8.	Bed Base management						
9.	Daily consultant ward rounds						
10.	Provision of specific services for patient groups such as those with mental health problems						

(as at 13.6.13)

NOTE

Contractual reviews in place including Quality and Performance Boards to ensure performance monitoring against AED targets.

Discharge and Out of Hospital Care

Actions expected following discharge:-

Action Points 1 – 4: Whiston: Please refer to the embedded documents above (page 20)

Action Point No.	Expected Actions Required	Supporting Commentary & Evidence	Progress to date (R/A/G)	Additional Actions Required	Responsible Person	By When	Progress to Date
1.	Designation of expected date of discharge on admission ***(Warrington)***	All patients should have an EDD.		Audit needs to take place to ensure happening.	All consultants		
2.	Maximisation of morning and weekend discharges ***(Warrington)***	Unscheduled care is in the process of rolling out nurse facilitated discharge across the division. This occurs in other divisions already. TPP.pdf		Implementation from a pilot ward is being rolled out in unscheduled care.	Ellis Clarke		
3.	Full use of discharge lounges ***(Warrington)***	There is no discharge lounge in place. In escalation one is often created for very short periods.			TBE		
4.	Minimisation of outliers ***(Warrington)***	Unscheduled care team have put in place an improvement and reform action plan to improve patient flows to minimise the number of outliers.		The rescue/ phase 1 of the plan is actioned. We are currently in phase 2 of the plan.	E sage A Risino M Lynch		

(as at 26.6.13)

		TPP.pdf					
5.	Delayed transfers of care reduced	No delayed transfers of Care reported in Quarter 4 of 2012/13 for Warrington Appropriate monitoring and response mechanisms are in place within Warrington Whiston Integrated Discharge Team in place to reduce delayed discharges. Service provided as a partnership between St Helens, Knowsley and Halton Appropriate monitoring and response mechanisms are in place within Whiston		No further actions identified	Damian Nolan (HCCG/HBC)	N/A	N/A
6.	Flexing of community service capacity to accept discharges	Appropriate escalation mechanisms in place if required Community Services are 'flexed' in response to demand		No further actions identified	Damian Nolan (HCCG/HBC)	N/A	N/A
7.	Review of continuing care processes	Work in progress; recently introduced		Work in progress to review associated	Damian Nolan	30.9.13	

(as at 5.6.13)

		integrated system and pooled budget arrangements		pathway	(HCCG/HBC)		
8.	Assessment of use of reablement funding by LAs	Use of reablement funds has been agreed by both HBC and HCCG		On-going monitoring of funds is conducted via the Urgent Care Board	Urgent Care Board	On-going Process	

(as at 13.6.13)

Other Associated Actions (Immediate)

Actions identified below expected to contribute to bringing performance back on track by end of Quarter 1:-

Action Point No.	Expected Actions Required	Supporting Commentary & Evidence	Progress to date (R/A/G)	Additional Actions Required	Responsible Person	By When	Progress to Date
1.	Education of GP's with regards to urgent care services	PLT event planned for June, which will be specifically focused on Urgent Care and will aim to raise awareness of the options around the Urgent Care Centre proposals, RARS, DVT Pathway and OOH Service. PLT event planned for 31.7.13 which is aimed at increasing GP knowledge around brief interventions available		PLT Event to be held on 27.6.13 PLT event to be held 31.7.13	Jenny Owen (HCCG) Jo O'Brien (HCCG)	30.6.13 31.7.13	
2.	Integrated Discharge Team in A&E	Team in place at Warrington A&E		Review in progress of provision at Whiston A&E	Damian Nolan (HCCG/HBC)	30.6.13	
3.	Pathways out of A&E at Whiston	Pathways out of A&E need to be developed		Pathways from A&E in development in relation to immobile people due to fracture	Damian Nolan (HCCG/HBC)	30.6.13	
4.	Advanced Nurse Practitioners and Cold Rooms in Walk in Centre	Options appraisal required		Options appraisal to be developed	Jenny Owen (HCCG)	30.6.13	

(as at 5.6.13)

5.	Halton Data – Patient Flow	Patent flow data in progress of being developed for Whiston		• Patient flow data being fed into the Urgent Care Collaborative across the St H&K footprint this piece of work is being led by St Helens CCG and St H&K Acute Trust • This patient flow data needs to be made available for discussion at future Urgent Care Boards in order to help the Board assess pressures in the system.	Damian Nolan (HCCG/HBC) Urgent Care Board	30.6.13 On-going	
6.	ESD for Stroke	Model developed and operational within Warrington Hospital - The Halton ESD service provides outreach specialist stroke rehab in the patient's own home in conjunction with care provided by Halton Borough Council. The rehabilitation is then continued by the Halton Community Therapy team. This service is provided for Halton residents who are		Need to develop consistency for ESD (Stroke) for people being discharged from Whiston.	Damian Nolan (HCCG/HBC) & Paula Guest (HCCG)	30.6.13	

(as at 27.6.13)

		inpatients in Warrington Hospital. The aim of the team is to facilitate safe, supported, earlier discharges into the community to reduce LOHS, but also to give patients better functional outcomes. 32 referrals were received during 2012/13, out of which only 3 were re-admitted (with unrelated conditions)					

(as at 13.6.13)

Other Associated Actions (3-6 months)

Action Point No.	Expected Actions Required	Supporting Commentary & Evidence	Progress to date (R/A/G)	Additional Actions Required	Responsible Person	By When	Progress to Date
1.	Explore the role of a Community Physician	Options appraisal needed	(Red)	Options appraisal to be developed	Jenny Owen (HCCG) & Damian Nolan (HCCG/HBC)	30.9.13	
2.	Develop and implement Falls Strategy	Falls Strategy has been developed and is scheduled to be approved by Halton's Health & Wellbeing Board on 22.5.13 **Falls Strategy** See page 15	(Green)	• Launch Strategy during National Falls Week • On-going monitoring of the associated Falls Action Plan	Sue Wallace Bonner (HBC) Sue Wallace Bonner (HBC)	17.6.13 On-going Process	
3.	Urgent Care Centre Options	Work progressing on the development of a business case to support the introduction of a an additional Walk in Centre, plus a Clinical Decision Unit at the Halton Hospital site	(Green)	• Business case to be developed • Development of StH&K, WHHFT and Bridgewater NHS Community Trust implementation plans, including procurement timetable if appropriate and interim arrangements for implementation of a	Jenny Owen (HCCG) Jenny Owen (HCCG)	31.8.13 30.9.13	

(as at 7.6.13)

				Clinical Decisions Unit within Halton Hospital Site • Development of a Service Specification and Mobilisation Plan. • Public consultation to take place between 1.6.13 – 31.8.13	 Jenny Owen (HCCG) Jenny Owen (HCCG)	 30.9.13 31.8.13	
4.	Winter Plan/Escalation Plans	Appropriate Plans were developed for 2012/13 When there are surges in the system, then appropriate mechanisms are in place for a co-ordinated health and social care response to be made **Winter Plan 12/13 provided as supplementary evidence to Area Team**		There is a need to evaluate the impact of the 2012/13 Winter Plan in preparation for Winter 2013/14. This evaluation will form the basis of ensuring the sustainability of the improvements made last year, and be incorporated/considered during the development of the Winter and escalation plans for 2013/14. Plans now currently under development which includes work stream within the response plan plus extending NWAS pathfinder	Jenny Owen (HCCG)	31.8.13	

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				schemes/community care plans, kite mark for Widnes WIC, DVT pathways and ultra sound provision/x-ray Data analysis is under development by StH&K supported by St Helens CCG to review patient flows during winter 12/13 this will inform the winter plan and be presented at the Mid Mersey Collaborative NB. Commissioning intentions for urgent care work stream 13/14 will impact on the winter plan Winter Plan and any associated escalation plans will be reviewed and approved by the Urgent Care Board			
5.	Telehealth Care	Telecare Strategy fully implemented within Halton Borough Council **Telecare Strategy**		Telehealth Care Strategy and Action Plan to be developed, agreed and implemented	Damian Nolan (HCCG/HBC)	30.11.13	

(as at 7.6.13)

		Telecare Strategy6 (2).doc No joint Telehealth Care Strategy exists between HBC and HCCG. Aim of the strategy would be to support a range of people with a variety of needs as well as their carers and family members					
6.	Warrington and Halton Hospital A&E Visioning Event	A number of actions were identified from the Visioning Event held which need to be progressed		The Board need to consider the relevant actions for Halton as a result of the Event and take appropriate action where necessary	Urgent Care Board	31.7.13	
7.	Acute Visiting Service (post NWAS call)	Need to review the feasibility of an Acute Visiting Service via NWAS (in hours and OOH)		Proposals to be developed and presented to the Urgent Care Board for consideration	Jenny Owen (HCCG)	30.9.13	

Halton Borough Council and NHS Halton Clinical Commissioning Group are both assured that the above Recovery and Improvement Plan will support the achievement of the A&E 4hr standard and has been fully signed up to by all health and social care partners, via the Urgent Care Board.

Signed:	Signed:	Signed:
Name : **Simon Banks**	Name : **Dr. Clifford Richards**	Name : **Dwayne Johnson**
Title: **Chief Operating Officer, NHS Halton CCG**	Title : **Chair, NHS Halton CCG**	Title : **Strategic Director, Communities, Halton Borough Council**
Date: **24.5.13**	Date: **24.5.13**	Date: **24.5.13**

c.c. Warrington Transformational Board

(as at 13.6.13)

Agenda Item 15

REPORT TO:	Health and Wellbeing Board
DATE:	17th July 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Health and Adult Social Care Settlement 2015/16
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Health and Wellbeing Board with a summary of the Government's Health and Adult Social Care Settlement 2015/16 and to put forward recommendations to ensure the conditions attached to funding and integration are progressed.

RECOMMENDATION: That the Board

1. **note the contents of the report;**

2. **approve the establishment of a Task and Finish Group to be chaired by the Strategic Director Communities to progress the development of a "plan" and completion of a Sense check to gain commissioning understanding and direction**

3. **approve the establishment of a Task and Finish Finance Group chaired jointly by the Operational Director for Finance HBC and Chief Finance Officer for HCCG; and**

4. **approve the delivery of a workshop in October/November to agree the "plan".**

3.0 SUPPORTING INFORMATION

3.1 On 26th June 2013 the Government announced the results of the latest spending round 2015/16 for Adult Social Care and circulated a letter to all Chairs of Health and Wellbeing Boards and Directors of Adult Services (Appendix 1). The letter details 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.

3.2 Alongside this, NHS Halton Clinical Commissioning Group (HCCG) has received a similar letter from NHS England (Merseyside) attached at Appendix 2 which sets out the Health Settlement for 2015/16 and the implications for CCGs.

3.3 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;

To ensure that we have the necessary plans in place and comply with the integration, we are proposing the establishment of 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. The Task and Finish Group would aim to conclude its work by 30th September 2013.

3.4 In addition, we are proposing the establishment of a Task and Finish Finance group to ensure that the financial elements of the settlement conditions are considered and management of the financial components are dealt with accordingly.

3.5 Both Task and Finish Groups would report progress to the Health and Wellbeing Board and the plan would also require approval through the NHS HCCG Governing Body as funding would transfer from NHS HCCG to HBC.

3.6 The Local Government Association (LGA) has outlined an approach regarding the completion of a Sense check. It is proposed that we develop a brief questionnaire that will be circulated to Board members, Chief Executive and Leader of Halton Borough Council (HBC), Chief Officer and Chair of NHS HCCG, and Operational Director for Commissioning to gain commissioning understanding, direction for integration and key leadership issues that will feed into the plan that we develop. Thereafter a number of follow up interviews will be required with key members of the Board.

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 OTHER/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.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

None identified.

6.2 Employment, Learning and 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

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.

8.0 EQUALITY AND DIVERSITY ISSUES

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

Helen Edwards
Director General
Localism
Department for Communities and Local Government

Jon Rouse
Director General
Social Care, Local Government and Care Partnerships
Department of Health

To: Chairs of Health and Wellbeing Boards and Directors of Adult Social Services

26 June 2013

Dear Chairs of Health and Wellbeing Boards and Directors of Adult Services,

The Government has today announced the results of the latest spending round covering 2015/16. We are writing to you to explain what this means for adult social care.

We have secured a £3.8 billion pool of funding to help enable some of our most vulnerable population groups to receive a properly joined up service. We have also ensured full funding for social care reform, including the introduction of a new national minimum eligibility threshold and the cap on care costs. The NHS budget will continue to be protected. Today, the overall settlement delivers on the government's promise of real terms increases in the NHS budget - with another increase in funding by £2.1billion in cash terms for 2015-16. This will increase resource funding to £110.4 billion and capital funding to £4.7 billion.

For local government, the new pool will ensure that service levels in the care and support system can be protected and will enable you to invest in prevention and early intervention. The Government is using this opportunity to invest in better integration of health and care, because this is what is needed to improve quality and prevent people staying in hospital unnecessarily.

Frail older people and people with a disability are some of the largest population groups depending on our health and care system. It is not uncommon for these people with complex needs to be pushed from pillar to post, between health and care, without getting the kind of joined-up care and support they should receive. We know this is not only frustrating, but can also result in people needing to go into hospital when this could have been prevented, or having to stay in hospital when medically well enough to be discharged. In both cases, this can lead to a loss of independence and poor outcomes.

We need to look at new ways of joining up our health and care services. Whilst this is clearly important for securing efficiency savings, it is also necessary to provide better services for local people and their families, and so to stop them falling between two systems. That is why the settlement for 2015/16 includes £3.8 billion of pooled health and social care funding for integration. This £3.8 billon investment will strengthen incentives for local authorities and the NHS to work together and deliver integrated services more efficiently, including:

- Ensuring that health and social care work more effectively together – through better sharing of information so people only need to explain their problems once;
- Intervening early so that older and disabled people can stay healthy and independent at home - avoiding unnecessary hospital admissions and reducing A&E visits;
- Delivering care that is centred on the individual needs, rather than what the system wants to provide – social care and NHS staff working together, with families and carers, to ensure people can leave hospital as soon as they're ready; and
- 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.

This innovative approach will help meet growing pressures across the NHS and social care systems by making truly joined-up local social care and health a reality. The £3.8 billion will include an additional £2 billion from the NHS. Access to the pooled budgets will be conditional on agreeing plans with local health and well-being boards to protect access and drive integration of services, to improve quality and prevent people staying in hospital unnecessarily. This provides the opportunity to protect social care, improve outcomes for individuals and deliver savings - with £1 billion linked to the delivery of outcomes, such as keeping people out of hospital.

We need to do further work with local government and the NHS on the planning process and to determine the detail of how this system will operate. We know that many areas, not just the Whole Place Community Budget pilots, are already doing great work in delivering integrated, joined-up, and person centred care and support locally.

Ministers and system leaders have reiterated the importance over recent months of delivering an integrated health and care system. Together, the national partners are inviting the most ambitious areas in delivering innovative models of integrated care and support to become 'pioneers' and will provide these areas with dedicated central support, including assistance from the Public Service Transformation Network. The pioneers will act as exemplars to address local barriers and support the rapid dissemination, promotion and uptake of lessons across the country. The closing deadline to apply to express an interest in the pioneer programme is Friday 28 June 2013. We will work collaboratively and with partners to ensure that the shared learning about Whole Place service transformation is incorporated into the design and delivery of the 'pioneers' programme.

We know many if you have already come a long way. We want local partners to continue the good work on integration and start planning for their pooled budgets. We expect plans to be agreed later this year to build momentum, and we are investing an additional £200 million for social care to enable progress through 2014/15.

We are very aware of the good collaborative work which has been developing, particularly over the last 18 months. This funding builds on the work to date and your leadership will be vital in making greater integration a reality. We look forward to working with you.

Kind regards

J Rouse

Helen Edwards

JON ROUSE
Director General for Social Care,
Local Government and Care Partnerships,
Department of Health

HELEN EDWARDS
Director General, Localism,
Department for Communities
and Local Government

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Mr S Banks
Accountable Officer
NHS Halton CCG
First Floor
Runcorn Town Hall
Heath Road
Runcorn
WA7 5TD

26 June 2013

Dear Simon,

Re: Spending Round: Health Settlement 2015-16 (Gateway Number 00211)

I am writing to you following the Chancellor's announcement of the Health Settlement for 2015-16 to share with you the initial NHS England response (see annex A) and to outline some further detail on what the settlement means for you. This letter is for your information.

Spending Round Headlines

- NHS funding will grow in real terms, consistent with the government commitment to protect the NHS
- This is a challenging settlement:
  - Given rising demand and inflation pressures, we expect the NHS would have needed to deliver c4% efficiency in order to maintain current services;
  - In addition, however the NHS, DCLG and the DH will pool c£3.8bn of funds for investment in the integration of health and social care (the "Integration Transformation Fund"). The NHS will contribute £3.4bn towards the integration fund. This compares to the £0.9bn the NHS currently transfers to support integration with social care.

Social Care integration fund breakdown

The £3.8bn Integration Transformation Fund will be a pooled fund, held by local authorities and funded from:

- The £0.9bn of funding NHS England planned to transfer to fund social care in 2014-15;
- An additional £0.2bn of investment in 2014-15 (to be agreed as part of mandate discussions for 2014-15 with DH);
- DH and other Government Department transfers of £0.4bn (capital grants), and;
- CCG pooled funding of:
  - Reablement funding of £0.3bn
  - Carers' break funding of £0.1bn
  - Core CCG funding of £1.9bn

The intention is to give NHS and Social Care commissioners' greater influence over this funding in the future to ensure it is optimised to support local integration of health and care services. To enhance this funding further, the funding CCGs currently hold for reablement and carers' breaks will also be included in the pooled budget, alongside other grants that the DH and Department of Communities and Local Government currently fund to support Social Care. The integration fund budget will represent a significant share of spend on health and care services and will give CCGs greater influence over how care services are integrated with health services.

It is vital that the NHS realises the benefits of integration in terms of reducing demand on health services, improving outcomes for patients and other efficiencies. Hence, there will be conditions attached to the pooled funding and the creation of new incentives to support integration and the delivery of improved outcomes for both health and care.

Conditionality on integration fund

The pooled funding will formally sit with Local Authorities but will be subject to plans being agreed by local Health and Wellbeing Boards (H&WBs) and signed off by CCGs and Council Leaders. Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

Plans and assurance would need 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;
- Plans and targets for reducing A&E attendances and emergency admissions;
- Risk sharing principles and contingency plans for if/when targets are not being met, and;
- Agreement on consequential impacts of changes in the acute sector.

Impact of this settlement on CCGs

The overall impact of the settlement on CCGs will be confirmed in allocations. It is NHS England's intention to explore the scope to give CCGs 2 year allocations for 2014-15 and 2015-16 to support commissioners to deliver the changes required in the NHS to realise the necessary efficiencies.

For the average CCG, the establishment of the integration fund will mean £10m of allocated funding will be transferred to the pooled budget (in addition to the pooling of reablement and carers' breaks funding that is currently within CCG baseline allocations). This is in the context that the average CCG was allocated c£300m in 2013-14 and hence the figure is equivalent to around 3% of CCG allocations.

Under current Section 256 requirements, NHS England has to make transfers to Local Authorities on behalf of CCG commissioners. We believe it would be helpful to route the funding for the Integration Transformation Fund through CCGs – this will require changes to primary legislation.

Yours sincerely

Clare Duggan
Director
NHS England – Merseyside

Encl. (1)

Annex A

Media briefing on Spending Round 2015/16

Commenting on the establishment of the new Health and Social Care Integration Fund and the overall settlement for the NHS, Sir David Nicholson, the Chief Executive of NHS England, said:

"This is a very significant settlement for the NHS. It presents both opportunities and challenges. It is a potential 'game changer' as it gives us the opportunity to accelerate the development of integrated services. It means we can provide more joined-up care for care for patients with complex needs, enabling them to be supported at home.

Merging health and social care budgets to support integrated care at a time when resources are constrained will require us to rethink how we organise services around patients. We need to begin formulating plans as soon as possible so that we are ready to take full advantage of the opportunities offered by the 2015/16 settlement."