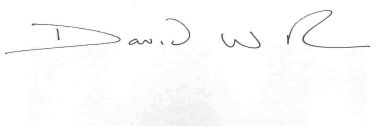
Public Document Pack

Health and Wellbeing Board

Wednesday, 15 January 2014 1.00 p.m.
Karalius Suite, Stobart Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 12 March 2014

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 13 November 2013 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Philbin, Polhill and Wright and L. Birtles Smith, G Ferguson, D. Hooley, K. Hough, D. Johnson, D. Lyon, A. McIntyre, D. Nolan, E. O'Meara, M. Pickup, N. Rowe, C. Samosa, N. Sharpe, S. Smith J. Williams and E. Williams.

Apologies for Absence: Councillor Morley and S. Banks, D. Parr, D Sweeny, K.Fallon, A. Marr, I. Stewardson, A. Williamson and S. Yeoman

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB36 MINUTES OF LAST MEETING

The minutes of the meeting held on the 18th September 2013 were taken as read as a correct record.

HWB37 NORTH WEST AMBULANCE SERVICE - PRESENTATION

The Board received a presentation on behalf of North West Ambulance Service from Donna Hooley, Sarah Smith and Karl Hough which gave an overview of the service and outlined current priorities, performance figures including response times and key achievements. Members also received information on ambulance stations within Halton and the number of staff employed.

Arising from the discussion it was noted that:

- Members of the Board were invited to the emergency control centre in Anfield;
- calls were increasing but resources were reducing;
- 2 Urgent Care Centres, 1 in Runcorn and 1 in Widnes were being developed and would be launched shortly;
- the Ambulance Service had reached agreement with local GP's to provide a joined up 24 hour service;
- 16 out of 17 GP surgeries had signed up to multi-disciplinary meetings each month with the 1st meeting

in October, it was proposed that the Ambulance Service and the Police Service should be invited to a future meeting; and

- as at October 2013, 17 public defibrillators had been installed in sites within Halton

RESOLVED: That the presentation be received.

HWB38 HALTON MODEL OF CARE FOR PEOPLE WITH A LEARNING DISABILITY

The Board considered a copy of the Halton Model of Care for Adults with Learning Disabilities which set the range of local community based and acute sector support for adults with learning disabilities and their family carers. The Model had been developed by the Learning Disability Quality and Performance Board.

Members were advised that the model was based on the values set out in Valuing People and Healthcare for All and took on board the recommendations of the Winterbourne View Final Report. The model was intended to facilitate reduction in the number of individuals requiring admission to hospital or being sent out of area by offering local community-based services that were consistent with best practice.

Also included within the model was a performance framework of both quantitative and qualitative measures and outcomes to monitor progress and ensure that what was envisaged was being delivered. In addition, a Quality Check Template and guidance was being tested and amended by practitioners as a prompt “to open their eyes wider” when visiting individuals in supported living or residential services to identify both best practice and any areas of concern.

RESOLVED:

1) the report be noted; and

2) the Halton Model of Care for Adults with Learning Disabilities be endorsed.

HWB39 CARE QUALITY COMMISSION CHILDREN'S INSPECTION REVIEW

The Board considered a report of the Strategic Director, Children and Enterprise, which provided information on the programme of Children Looked After and

Safeguarding Reviews being undertaken by the Care Quality Commission (CQC). Following deferment of the planned multi-agency inspections of child protection arrangements, the CQC announced its intentions to undertake a review of how health services keep children safe and promote the health and wellbeing of looked after children. The CQC implemented its programme of Children Looked After and Safeguarding Reviews on 30th September 2013 and this would run until April 2015.

It was noted that the inspections would take place in areas where the CQC believed there was a greatest risk within health services and where they identified that there were deficiencies in the effectiveness of safeguarding arrangements and services for looked after children in the NHS. There would be two working days' notice of the review prior to a five day site visit by CQC children's services inspectors. Following the review a report would be published within each local area, there would also be a national report to bring together findings from across the country.

RESOLVED: That the report be noted.

HWB40 DISABLED CHILDREN'S CHARTER

The Board was advised that Every Disabled Child Matters (EDCM) and the Children's Trust, Tadworth, had developed a Disabled Children's Charter for Health and Wellbeing Boards. The Charter had been developed to support Health and Wellbeing Boards to meet their responsibilities towards disabled children, young people and their families. The Charter contained a vision statement and specific commitments and Boards who signed up to the Charter must agree to each of the seven commitments within a year of signing. Health and Wellbeing Boards would be asked to provide evidence of how they had met the commitments and this information would be published on the EDCM website.

The seven commitments which Health and Wellbeing Boards were being asked to make were outlined in the report. A copy of the Charter had been previously circulated to Members of the Board.

It was noted that a Strategic Group had been set up to address the changes required in the Children and Families Bill in terms of children and young people with health and special educational needs. It was suggested that this group would be asked to ensure each of the seven commitments were addressed and to provide an update

report to the Board in six months' time.

RESOLVED: That

1) the Board sign the Disabled Children's Charter for Health and Wellbeing Boards; and — A McIntyre

2) an update report on progress be submitted to the Board in six months' time.

HWB41 BETTER HEALTH OUTCOMES FOR CHILDREN AND YOUNG PEOPLE: OUR PLEDGE

The Board considered a report on the Government's Pledge to improve health outcomes for children and young people. On the 20th July 2013, the Children's Health Minister, Dr. Dan Poulter, wrote to lead members for children's services and Chairs of Health and Wellbeing Boards to invite them to sign up to the Government's pledge: Better Health Outcomes for Children and Young People. The Pledge was part of the February 2013 system-wide response to the Children and Young People's Health Outcomes Forum Report (2012).

The introduction to the pledge emphasised that whilst children and young people growing up in England today were generally healthier than they had ever been, international comparisons and worrying long-term trends demonstrated there was room for improvement, with poor health outcomes for too many children and young people compared with other countries. The document also stated that vulnerable groups, such as looked after children suffered much poorer outcomes.

The report provided an outline of the shared ambitions set out within the Pledge and examples within Halton that demonstrated the commitment of the Health and Wellbeing Board towards considering the Health and Wellbeing needs of children and young people.

RESOLVED: That

1) the report be noted; and

2) the Board agree to sign up to the Pledge. — A McIntyre

HWB42 UPDATE ON SECTOR LED IMPROVEMENT

The Board considered a report of the Strategic Director, Communities, which described the benchmarking

process that had been set up in the North West region to inform the process of Sector Led improvement and highlighted the performance in Adult Social Care in Halton over the last 12 months.

The Board was advised that Sector Led Improvement (SLI) was the new framework for ensuring continuous improvement and development within adult social care services. Led nationally by the Towards Excellence in Adult Social Care Board, it was driven in this region by the North West Towards Excellence Board. It was noted that the North West Performance Leads (NWPL) group had in place a framework for lead performance officers to benchmark their performance against key national adult social care performance indicators. The first submission was in September 2012 but was backdated until the start of that financial year.

Members were advised that Halton's data showed exceptional performance and a sustained picture from previous years, this applied to at least 75% of submitted items. The Towards Excellence in Adult Social Care overview analysis for 2012/13 provided the Council with very positive outputs across a number of domains and these were detailed in the report.

Arising from the discussion Members were advised that it was anticipated that The Priory, Widnes would have begun to admit patients by the end of 2013. In addition M. Pickup reported that Warrington Hospital, Accident and Emergency Department, had experienced an 8% reduction in non-elective admissions, this was unlike the national trend.

RESOLVED: That the report be noted.

HWB43 DRAFT SAFER HALTON PARTNERSHIP DRUG STRATEGY 2014-18

The Board considered a report of the Strategic Director, Communities, which presented a draft copy of the Safer Halton Partnership Drug Strategy 2014-2018 and an accompanying evidence document. The Strategy had been drafted during a period of change as drug budgets and services transferred to Public Health England and the Police and Crime Commissioners. This provided an opportunity to draft a four year Drug Strategy with an action plan that all key partners could deliver upon. It was noted that the Strategy had been extensively consulted upon with a range of partner agencies, service users, carer groups and

voluntary agencies.

The Board was advised that the draft Strategy was designed to be a short document that focused on the strategic objectives and priorities linking to a drugs service action plan that would become the focus of the substance Misuse Task Group, with quarterly themed updates to the Safer Halton Partnership Board and annual amendments and updates to the action plan and reprioritisation of key areas.

RESOLVED: That the drug strategy be agreed.

HWB44 PROGRESS WITH THE HEALTH AND SOCIAL CARE SETTLEMENT 2015/16

The Board considered an update report on the progress on the Health and Social Care Settlement 2015/16. Since the last meeting of the Board on the 17th July 2013, when the Strategic Director, Communities, tabled a report which outlined the Department of Health approach to integrating health and adult social care services, the following had taken place:-

- A letter was received on the 10th October from NHS England on "Planning for a Sustainable NHS responding to the "call to action";
- A letter was received on the 17th October from NHS England and the Local Government Association on "the next steps" on implementing the Integrated Transformation Fund", along with a spreadsheet template of the plan;
- Meetings had taken place to discuss the requirements of the guidance that had now been issued and the process of the development of the plan had begun;
- A letter had been received last week from NHS England which set out the operational and strategic concerns CCG's must address;
- A small working group had begun populating each of the sections within the spread sheet template for the plan; and
- It was proposed that NHS providers on the Board, as well as Health and Wellbeing Board Members, be consulted on the plan by arranging a facilitated event in January 2014.

RESOLVED: That

1) the report be noted; and

2) the proposals as set out in 3.5 of the report be agreed.

HWB45 MARKETING GUIDELINES FOR HEALTH AND WELLBEING BRANDING

The Board considered a report of the Director of Public Health, which provided details on the branding guidelines for the use of the Health and Wellbeing brand and logo. It was noted that the logo was not intended to displace an organisations' individual logo but rather complement and sit alongside this. It was also recognised that embedding the usage of the logo would need to be driven from a senior level in partner organisations. Marketing and Communications teams would need to be made aware of the existence of the logo and the guide lines for usage. Additional help and support would be provided from within the Council's Communications and Marketing Team if required.

RESOLVED: That

1) the report be noted;

2) the proposed guidelines be endorsed; and

3) the Board agree and support the usage of the guidelines and logo within partner organisations.

HWB46 SEASONAL FLU VACCINATIONS

The Board received a report which provided details on the 2013/14 season flu vaccination campaign and local implementation. In order to protect those at risk, immunisation was recommended and it was particularly important that front line staff that had direct contact with patients of all ages were offered immunisation against influenza. Therefore staff had been offered free seasonal flu vaccinations on the 29th and 31st October. They had also been given the opportunity to attend at the ASDA Pharmacy in Widnes or Runcorn up until the first week of December.

RESOLVED: That the report be noted and Senior Managers be requested to promote the benefits of the vaccine to all appropriate staff. E. O'Meara

Meeting ended at 3.45 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 15th January 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Local Government Declaration on Tobacco Control

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to inform the Health and Wellbeing Board of the Local Government Declaration on Tobacco Control.

RECOMMENDATION: That

1. **The Board note the contents of the report; and**
2. **Agree to support the declaration (attached as Appendix 2)**

2.0 SUPPORTING INFORMATION

2.1 In May 2013 Newcastle City Council passed a declaration setting out their commitment to tackle the harm that smoking causes our communities. This has become known as the Local Government Declaration on Tobacco Control. Further details are attached as Appendices to this report, however the declaration commits councils to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

3.0 POLICY IMPLICATIONS

3.1 Smoking is the primary cause of preventable illness in the UK. It is responsible for 80% of deaths from lung cancer, around 80% of deaths from bronchitis and emphysema and 17% of deaths from heart disease. More than one quarter of all cancer deaths can be attributed to smoking.

4.0 OTHER/FINANCIAL IMPLICATIONS

4.1 None identified at this time.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children and Young People in Halton

Being exposed to secondhand smoke has a significant impact on the health of a child before birth, in childhood, and can continue to have an impact on their health into adulthood. Therefore policies to reduce smoking prevalence will directly contribute to improving the health and wellbeing of children and young people.

5.2 Employment, Learning and Skills in Halton

Smoking related absence has an impact on employment and the wider economy. Therefore workplace smoking initiatives and the wider implementation of tobacco control policies will contribute to reducing absenteeism and improving productivity.

5.3 A Healthy Halton

All of the areas outlined within this report focus on improving the health and wellbeing of Halton residents.

5.4 A Safer Halton

N/A

5.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Whilst the smoking ban has eradicated smoking in public places more could be done to reduce smoking prevalence in and around community settings and reduce smoking waste.

6.0 RISK ANALYSIS

N/A

7.0 EQUALITY AND DIVERSITY ISSUES

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

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

There are none within the meaning of the Act.

Newcastle City Council

Councillor Nick Forbes
Leader of the Council
Labour, Westgate Ward

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Fax: 0191 211 4815
nick.forbes@newcastle.gov.uk
www.nickforbes.org.uk

23 October 2013

Our reference: NF/KC/AS

Dear

Local Government Declaration on Tobacco Control

In May Newcastle City Council passed a declaration setting out our commitment to tackle the harm smoking causes our communities. This has become known as the Local Government Declaration on Tobacco Control and been endorsed by, among others, the Public Health Minister, Chief Medical Officer and Public Health England. I'd like to invite your council to join us and sign up to the Declaration.

The Declaration commits councils to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

Many of you may already have seen media coverage or attended a briefing about the Declaration. If you are not already planning to do so then I would like to invite you to join us and sign-up. Councils representing all the major parties have already taken a lead and signed up to the Declaration including Salford City Council, Warwickshire County Council and Bath & North East Somerset Council. I am keen that other councils have the opportunity to get involved ahead of a formal launch in early December in Parliament.

Tobacco remains the single greatest cause of preventable deaths in England – killing over 80,000 people every year, more people each year than obesity, alcohol, road accidents and illegal drug use put together.

Thousands of children also suffer harm as a result of smoking. Not only are 17,000 children under the age of five admitted to hospital every year as a result of passive smoking but cancer Research UK also estimate that 430 children in England start smoking every day.

Although smoking has fallen from 40% to 20% since 1980 there has been little change within our poorest communities and smoking is responsible for half the difference in life expectancy between the richest and poorest. There can be no doubt that, in the context of our public health responsibilities, smoking is the greatest challenge facing us today.

In response, this declaration has been developed to provide a very visible opportunity for local government: to publically acknowledge the significant challenge facing us; to voluntarily demonstrate a commitment to take action; and to publish a statement of our dedication to protect local communities from the harm caused by smoking.

The Declaration includes a specific and important commitment to protect health policy from the influence of the tobacco industry. This is an obligation already placed on local authorities through the World Health Organisation treaty on tobacco – however the Declaration reminds us of our obligations and restates our commitment.

The threat is a real one. In the past there have been examples of local councils allowing tobacco companies inappropriate access through, for example, their funding of city academies, museums and smoking shelters on council property. This summer representatives of a British American Tobacco subsidiary contacted councils across England, almost certainly yours too, to speak to local councils about their tobacco harm reduction strategies.

It is also true that almost all local government pension schemes in England have some investment in tobacco companies. I share the frustrations of many in public health regarding these investments, however our fiduciary duties makes effective action difficult. The greatest threat from the tobacco manufacturers comes not from investments by our pension fund managers but from their influence on our health policy. This Declaration is about taking effective action against real threats.

I have attached a copy of the declaration for you to look at along with some additional information, which should answer any initial questions that you may have. Formal launch of the declaration will take place at the House of Commons on Wednesday 11 December, where the Health Minister and some of the councils who have already signed-up will be available to discuss why they considered it so important to give their support to this initiative.

If you would like any further information or details about the declaration or the launch event please do not hesitate to contact Hazel Cheeseman at Action on Smoking & Health at hazel.cheeseman@ash.org.uk or on 020 7404 0242; or Karen Christon at karen.christon@newcastle.gov.uk or on 0191 211 5024.

Yours sincerely

Councillor Nick Forbes
Leader of Newcastle City Council

If you need this information in another format or language, please contact the person who sent it.

Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

We commit our Council from this date .....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories

Leader of Council

Chief Executive

Director of Public Health

Endorsed by

Anna Soubry, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Professor Dame Sally Davies, Chief Medical Officer, Department of Health

Dr Janet Atherton, President, Association of Directors of Public Health

Dr Lindsey Davies, President, UK Faculty of Public Health

Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute

Department of Health | Public Health England | Association of Directors of Public Health | Faculty of Public Health | Chartered Institute of Environmental Health | trading standards institute

REPORT TO: Health & Wellbeing Board

DATE: 15th January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Halton's Dementia Strategy

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present Halton's Dementia Strategy to members of the Health & Wellbeing Board.

2.0 **RECOMMENDATION: That Members of the Board note and comment on Halton's Dementia Strategy.**

3.0 **SUPPORTING INFORMATION**

3.1 The local dementia strategy was completed in February 2010 and was a direct response to the National Dementia Strategy – Living Well with Dementia (Department of Health, Feb 2009). The local strategy adopted the national targets as well as developing a specific implementation plan to deliver a range of improvements for people diagnosed with dementia and their carers.

3.2 There can be no doubt about the current and the future challenge posed by dementia. There are an estimated 24.3 million people with dementia worldwide, while in the UK, best estimates suggest that the number is currently 700,000, of whom approximately 570,000 live in England. Dementia costs the UK economy £17 billion a year, and in the next 30 years the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

3.3 The table below outlines the current level of people diagnosed with dementia in Halton, the projected number for 2025 and the estimated costs to the local economy.

	2012	Cost to economy in millions	2025	Cost to economy in millions
Halton	1,143	£25.7*	1613	£39.2**

**calculations based on projected cost to the UK economy divided by number of people in the UK with dementia, multiplied by number of people diagnosed in Halton.*

*** calculations based on projected cost to the UK economy divided by number of people in the UK with dementia, multiplied by number of people estimated to have dementia in 2025 diagnosed in Halton.*

This cost is based on a national calculation and relates to a number of different elements including, primary care visits, secondary care, costs associated to specialist services, mental health services, cost to other services for example Police, voluntary sector. In addition to this the anticipated cost of informal carers in giving support to their families.

3.4 The revised local dementia strategy, 'Living well with dementia in Halton' (Appendix 1), and the associated 'needs' paper (Appendix 2) looks at the progress that has been made since the original strategy publication, as well as identifying some key actions that need to be completed over the next 5 years.

3.5 Key achievements made since the original strategy:

- A project Manager was appointed and employed by the 5 Borough Partnerships. Supported by a multi-agency steering group the project manager completed a mapping exercise of all of the existing pathways, referral processes and service delivery for people diagnosed with dementia. This work initially concentrated on the service delivered within Health, Social Care and 5 Boroughs, but was extended to incorporate voluntary and community services and has informed the recent development of the local dementia pathway.
- Implementation of the Later Life and Memory Service and associated pathway with the aim of a reduction in assessment waiting times.
- Dementia Care Advisors have been commissioned.
- Three Dementia Cafés have been established and more are being planned.
- Improved information provided on diagnosis from the Alzheimer's Society.
- Workforce development training commissioned to deliver basic awareness training, practitioner training and work based vocational training.

3.6 Priorities for 2013-2018 focus on the following areas:

- Prevention and raising awareness
- Early diagnosis, information and advice
- Living well in the community
- End of Life
- Workforce development
- Links to other workstreams

3.7 The 2013-2015 Strategy implementation plan outlines the key actions for future development in improving the outcomes for people with a dementia diagnosis, their families and carers. The implementation plan can be found within the 'Living well with dementia in Halton' Strategy document.

Research and Consultation

3.8 The strategy was developed taking into account findings from large scale national and international research and consultation, along with the local findings of the 2009/10 Halton Borough Council and Alzheimer's Society consultation and research project, 'Dementia Journey Halton'. HealthWatch Halton and the dementia support group 'Lunch Bunch' also provided feedback on the strategy objectives.

4.0 POLICY IMPLICATIONS

4.1 National Policy is directing the future of dementia treatment and support. The launch of the Prime Ministers Challenge on Dementia and the Care Bill places the focus on early diagnosis and person centred support, highlighting the role that families and carers play and the support that must be offered to them. These principals are reflected in the Living well with Dementia in Halton Strategy.

5.0 FINANCIAL IMPLICATIONS

5.1 All financial and commissioning decisions will be managed through the Dementia Partnership Board in accordance with Standing Orders and financial regulations of both the Local Authority and the Clinical Commissioning Group.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

The strategy has a direct impact on the health outcomes of people with a dementia diagnosis, and their families and carers.

6.4 A Safer Halton

The strategy has an impact on people with a dementia diagnosis in living well and living safely within our community.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 A risk log will be completed and managed through the Dementia Partnership Board.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Policies and procedures that are developed or amended as a result of this strategy will be subject to an Equality Impact Assessment.

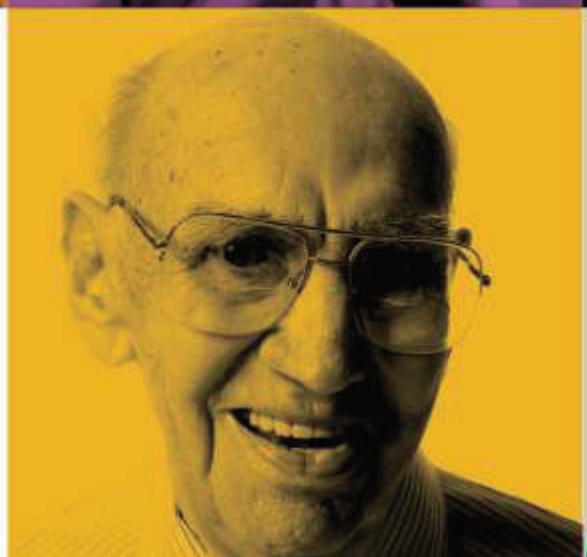
9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None identified.

Living Well With Dementia in Halton

Halton Dementia Strategy and Implementaion Plan 2013-2018

myhalton
living life well



NHS
Halton Clinical Commissioning Group

HALTON
BOROUGH COUNCIL

CONTENTS

Foreword

As people live longer, Dementia is an increasing problem across the country and this picture is mirrored in Halton. It is a complex condition with widespread effects on the individual, the family and the health and social care system.

Current estimates show that about half the numbers expected in Halton have been diagnosed. Often, the first time the problem is recognised is when a crisis occurs, causing a great deal of distress to all concerned.

There seem to be two main reasons why there is a reluctance to diagnose dementia early; a fear of stigma and a belief that nothing much can be done. Yet, there is no reason why people with dementia cannot live full, happy lives. It is important for health and social care services to work with the public in order to ensure that those with dementia are identified early and are fully supported to enjoy life.

Nationally and locally it is clear that dementia is one of the biggest challenges facing the health and social care economy. Although dementia can affect adults at any age, it is most common in older people becoming more prevalent with increasing age, but this does not mean it is a natural part of the ageing process or inevitable for all older people - a message we need to communicate more widely.

This strategy aims to encourage early, accurate diagnosis and to ensure health and social services are positively organised so that those with dementia receive all the care they need.

Our Vision

Our vision is clear: It is for all people with dementia and their carers to continue to 'live well'. To do this we will create an environment where people feel empowered to seek help early, know where to go for help and what services to expect, have access to the care and support that they would benefit from, and are confident that this care is of high quality, where the public and professionals are well informed and where fear and stigma associated with dementia has decreased.

Councillor Marie Wright.
Halton Borough Council Portfolio Holder for Health and Wellbeing

Dr David Lyon. GP, Clinical Lead for Dementia and Community Services. Halton Clinical Commissioning Group Governing Body Member

Introduction

Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases with age, and the condition usually occurs in people over the age of 65. [i]

The term 'dementia' describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease and damage caused by a series of small strokes.

Dementia is progressive, which means the symptoms will gradually get worse. How fast dementia progresses will depend on the individual person and what type of dementia they have.[ii] Alzheimer's disease is the most common cause of dementia, where there is a progressive loss of brain cells.

The exact cause for this is unknown. However, there are a number of things thought to increase the risk of developing the condition, including:

- increasing age
- a family history of the condition
- previous severe head injuries
- lifestyle factors and conditions associated with vascular disease

Most types of dementia can't be cured, but if it is detected early there are ways it can be slowed down and mental function can be maintained for longer.

The 'Living well with dementia in Halton' strategy is coordinated by the Halton Dementia Partnership Board and is based on the requirements identified within 'Living well with dementia in Halton Needs Paper'. The action plan that accompanies this strategy is to be implemented over 5 years, with an update on progress to be published annually.

Whilst there is still much to do, there has been a number of positive national and local developments relating to dementia since 2009. From the national 'Prime Minister's Challenge on Dementia' to the introduction of the 'Halton Later Life and Memory Pathway' (see appedix 1) , living well with dementia is a priority for all. Seventy five percent of the objectives within the 2009 Dementia Strategy Action plan have been implemented, for example:

- Improving awareness and understanding of dementia through a range of literature and the Dementia Care Advisor service.
- Good quality early diagnosis and intervention through the Later Life and Memory pathway
- Improved intermediate care for people with dementia through professional and vocational training

The 2009 action plan and progress is available on request.

This strategy and associated implementation plan includes the remaining objectives from the 2009 action plan along with new, stretching objectives. The strategy complements other work programmes including the local Halton Sustainable Communities Strategy, Mental Health Strategy, the Halton

Health and Wellbeing Strategy, Carer's Strategy Action Plan, Falls Strategy and Loneliness Strategy, and should be read in conjunction with these pieces of work.

This strategy provides plans for the future against the four themed objectives of the national strategy:

1. **Raising Awareness**
2. **Early Diagnosis and Support**
3. **Living Well with Dementia**
4. **Delivering the Dementia Strategy.**

Why do we need a dementia strategy?

The population of Halton is aging. That is, a larger proportion of the total population will be found in the 60-plus age bands by 2031 compared to 2006. This section of the population will increase by 61% to 36,300 by 2031.

- The number of people with dementia is set to rise by 62% by 2030, largely due to the projected increase in the older population. It is projected that there are 1180 people aged 65+ living in Halton who have some form of dementia in 2012 and by 2020 this figure is estimated to be as high as 1518. In addition it is estimated that there are currently about 34 people aged between 30-64 who early onset dementia
- Our current diagnosis rate is **63.3%,** with an aspiration of taking this to over 66% during 2014/15
- Based on National Audit Office research it is estimated that of the people with some form of dementia 788 will live in the community and 392 in a care home. This will rise to 1367 living in the community and 683 requiring care home places by 2030.

With prevention, an early diagnosis and appropriate information and support, a good quality of life is possible. While the costs of dementia are expected to rise in coming years because of growing numbers of people affected, there is significant scope for spending money more efficiently and effectively. A local dementia strategy, over 5 years, will provide the focus and direction of actions to be taken to achive better outcomes for people with a dementia diagnosis.

What would success look like?

Through consultation and research undertaken by Health Watch Halton[iii] and Halton Borough Council and Alzheimer's Society [iv] we have been able to understand what success for people with a dementia diagnosis, their family and carers would look like in Halton.

Raising Awareness and Understanding

"*Need to ensure that health and social care professionals have an awareness of dementia"* "Need *to raise awareness across Halton of how to prevent dementia"*
"Need to raise awareness of care staff in residential and community settings."
"young people need to understand Dementia."
This led to an overall agreement and discussion that dementia *'does have an impact on children and grandchildren.'*

Early Diagnosis and Support

"I think there has been improvement in dementia care but it appears to be sporadic, it is not right across the board"
"*Health Passport to improve communication between staff and between staff and patients"*

Living well with Dementia

"Dignity needs to be included in the training and All health staff need training but it needs to be done properly."
"there *should be an awareness of telecare products and services to help people remain independent."*

Raising Awareness

A sustainable and skilled workforce in the care of people with dementia, their family and carers. Our communities are supported to adapt to become dementia friendly to tackle the fear and stigma of dementia.

"First of all is getting my wife to accept there's something wrong"

Early Diagnosis and Support

Early assessment and diagnosis, so that appropriate treatment and support can be put in place as soon as possible to help maintain a good quality of life.

"We want quality time with somebody who knows"

Living well with dementia

People with a dementia diagnosis, their family and carers have access to appropriate information at the right time, help to understand information and are supported through treatment and support.

"I had so many questions"

Delivering the strategy

Seamless, wrap around support commissioned through integration of Public Health, Halton Clinical Commissioning Group and Adult Social Care

"The quality of our lives has changed so much"

Halton Dementia Pledges

Complementing the person centred ouctomes devised by the National Dementia Partnership [v] through consultation with people with a dementia diagnosis, their family and carers, a set of local dementia pledges have been developed and are to be adopted in Halton.

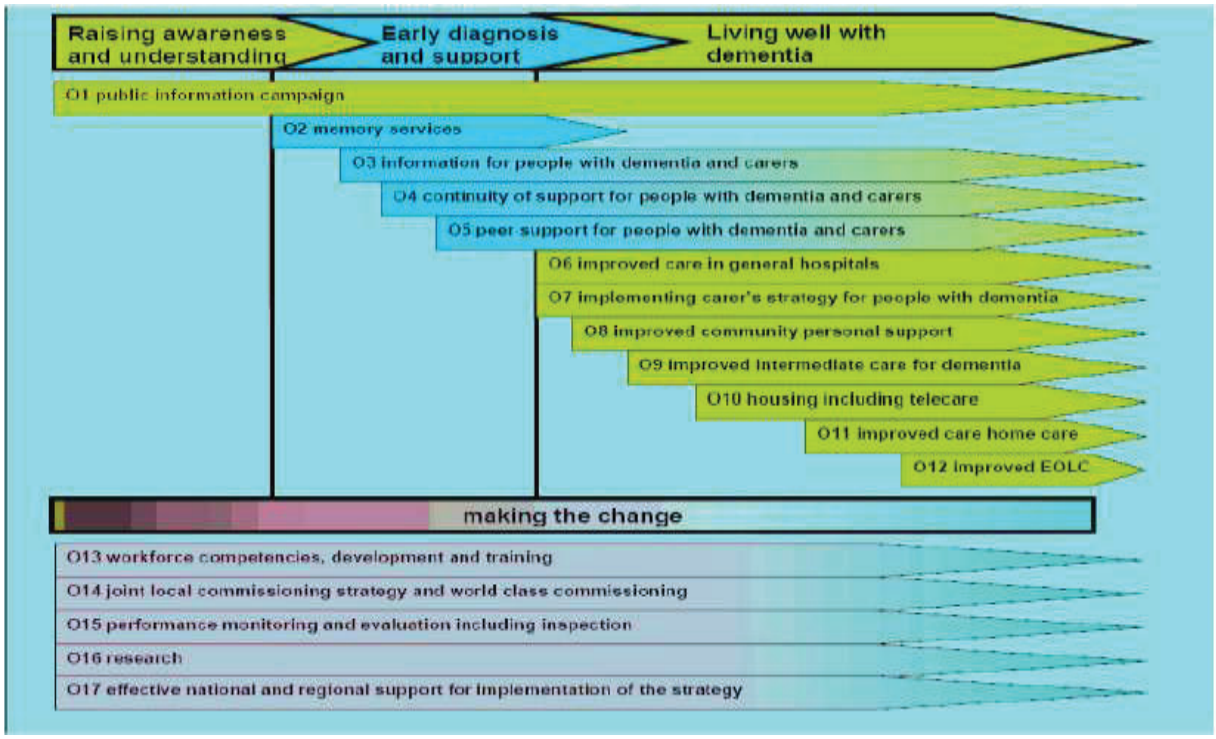
Our pledges are:

1. You will be diagnosed early
2. You will be supported to understand information so that you can make good decisions and you know what you can do to help yourself and who else can help you
3. You will get the treatment and support which are best for your dementia and your life
4. Those around you and looking after you are well supported
5. You will be treated with dignity and respect
6. You will be supported so that you can enjoy life
7. You will be supported to feel part of a community and be inspired to give something back
8. You will be supported to ensure that your end of life wishes will be respected.

The pledges not only demonstate commitment to developing and providing excellent services for people with a dementia diagnosis, their families and carers, but define the quality of those services. The pledges set the bar for expectations, and against which patient, family and carer experiences can be measured and outcomes improved for them over the lifecourse of this strategy.

Realising the vision

The National Dementia Strategy 2009-2014, in its development, was clear that Local Authorities and Primary Care Trust's (at the time) should take a radical approach to whole system transformation to meet the twin aims of better outcomes at lower cost, with outcomes defined within the care pathway, as illustrated below:



When translating the national objectives to local action, a number of priority areas are highlighted for action.

Priorities for 2013-2018

1) Prevention and raising awareness

Actions within this theme are focussed on better public information about dementia, reducing stigma, informing the public what services are available, informing staff how to signpost and support people with dementia and their carers. To achieve this we will work with a wide range of colleagues, including those in Public Health, Housing, Social Care, Police, Fire, Health and voluntary sector to improve the way we provide information.

2) Early diagnosis, information and advice

The first step is to encourage people to visit their GP for an assessment, as soon as they become aware of a problem with their memory. In this way people with dementia and their carers are identified and part of the system. From then on they can be pro-actively offered information and support and helped to access services appropriate to their needs. To achieve this we will link up primary and secondary care services via the simple but effective, multidisciplinary Later Life and Memory Service care pathway, enhance the dementia adviser's service, offer more and varied peer support opportunities, provide training to GP-practices, increase Quality Outcome Framework (QOF) registrations, have screening in place for people with learning disabilities and for people at risk of vascular dementia and ensure capacity in secondary care memory clinic.

3) Living well in the community

More people with dementia are living well for longer in their community. Key factors are keeping physically and socially active, getting the right encouragement and support, knowing the right coping strategies and supporting carers. Providing a variety of peer support networks across the borough is crucial in achieving this. Also, current housing, health and social care services need to be more joined-up and able to offer greater flexibility and continuity. Mainstream services in particular need to be dementia-friendly and provided by well-trained staff. Furthermore, GP-practices need to offer service users a regular health check and dementia advisers need to be in regular contact with service users and carers so they can signpost them to the right services at the right time to avoid a crisis developing. (Such services may include extra care housing / supported housing, telecare, carers support, well-check, peer support, and home care support). Clear pathways for different groups of people with dementia are being designed ensuring appropriate services are joined up and service provision is commensurate with the changing needs of service users and their carers as the disease progresses. Aiming to advance equality of opportunity for dementia patients , carers and wider communities, in line with The Equality Act 2010, by empowering people with a dementia diagnosis to have high aspirations and feel confident to continue to partake in activities within the community, achievable by Halton becoming a dementia friendly community.

4) End of Life

End of life care has to be considered early when the person with dementia still has capacity to express their future preferences regarding their preferred place to die. To achieve good end of life care we are ensuring that all staff and providers within dementia care utilise the principals of the Gold Standards Framework for end of life care and are trained and competent in the use of end of life tools and policies so that decisions and preferences for care at the end of life can be communicated and documented effectively.

In addition, the dementia end of life pathway will be supported by a robust clinical support network, including GP's, District Nurses, Consultants in Palliative Care, Speciality Doctors, Macmillan Nurses and Social Care teams operating within an Integrated Care Network. The service provision in Halton is designed to take a whole system approach to delivering end of life care, which includes an End of Life Social Service, Palliative Care Sitting Service, 7 day access to Macmillan Nurses, Family support and bereavement services, Palliative Care advice services along with access to Specialist Palliative care teams within in the community, hospice and hospital environments.

5) Workforce development

Developing dementia friendly services requires a whole system approach. Mainstream staff from Older People's and Adult Services are often in contact with people with dementia. It is therefore important that all staff are able to signpost people to the right services, that they can encourage people to visit their GP when they have concerns about their memory and know in general how best to approach and actively support people with dementia. Work with 'Skills for Care' (an organisation that provides work force development resources for Adult Social Care employers in England) is already underway in Halton, with funding secured to implement dementia awareness training and life story work. Reminiscence work and House of Memories[vi] are already in place in nursing homes across the borough.

6) Links to other workstreams

The dementia strategy doesn't stand alone. In order to improve dementia care links are identified with other strategies including End of Life Care, Telecare, Housing and Carers Strategies, and to other workstreams including Personalisation and Dignity in Care.

Underlying principles in developing dementia treatment and support services

- regularly consult people with dementia and their carers to ensure we take account of their needs;
- support equality in access and service provision;
- commission quality and state of the art services and regularly monitor actual provision against agreed outcomes;
- encourage best use of available resources across the borough;
- facilitate working in partnership between providers of dementia care;
- consistency with priorities of the Health and Well-being Partnership Board and Halton Dementia Partnership Board
- Facilitate training and awareness raising for dementia.
- Safeguarding is a priority for all

Resources

Budget received for 2013/14 for Mental Health Services (as a whole)

	£000T
Halton Clinical Commissioning Group	17,223
Halton Borough Council Adult social Care	2,934
Halton Clinical Commissioning Group – Continuing Health Care (Mental Health)	2,500
Halton Borough Council Public Health	250
Halton Borough Council Children's and Enterprise	191
TOTAL	**23,098**

How the budget was allocated 2013/14

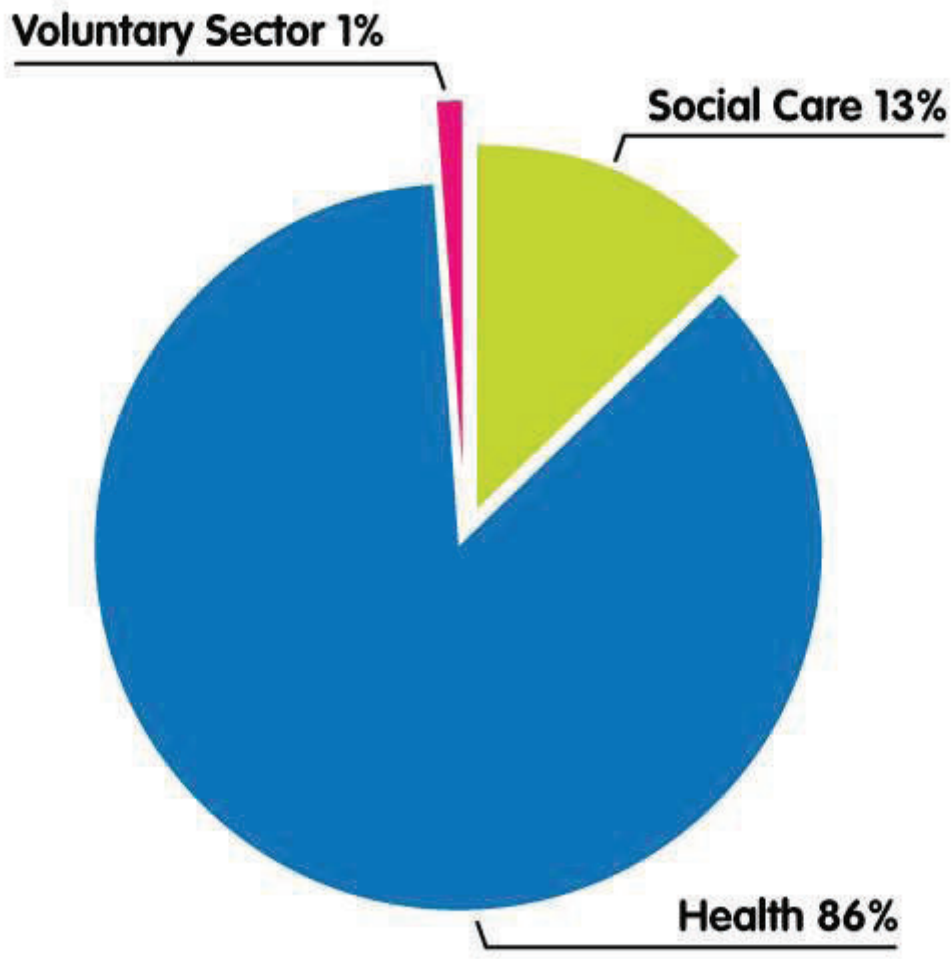
Halton Clinical Commissioning Group	£000
5 Boroughs Partnership NHS FT	13,508
5 Boroughs Partnership ADHD Clinic	35
5 Boroughs Partnership Asperger's Pilot	23
5 Boroughs Partnership State of Mind	4
5 Boroughs Partnership ADOS (CAMHS)	8

Cheshire & Wirral Partnership	44
Manchester Mental Health & Social Care	6
MerseyCare	64
CAB Halton	116
Making Space	22
Women Supporting Women	20
MIND	20
Halton Service User Forum	10
SHAP	22
Bereavement Service	1
Youth Offending Team	8
IAPT (Including Open mind and Well Being Nurses)	986
MH Access	737
PICU - Vancouver House	150
PICU - Other	50
MH Capacity	77
Dementia Nurses and Care Advisors	**200**
WHHFT (A&E Liaison)	35
StHKHFT (A&E Liaison)	85
Primary CAMHS	492
High Cost Mental Health Funding	500
Continuing Health Care	2,500
Adult Social Care	
Older people community mental health team	147
Mental Health Support (Outreach)	194
Mental Health Resource Centre	117
Mental Health Recovery Team and Community Care	2,366
Emergency Duty Team	103
Women's Centre	7
Public Health	
Campaign against living miserably (CALM)	10
Health Improvement Team & Weight Management Service – Bridgewater	240
Children's and Enterprise	
Children in Care Service	59
Hear 4 U	132

It is important to understand the complexities of the existing budget and the challenges in ensuring that people are diagnosed and supported in an appropriate way. The budget above and the chart below is for the total mental health allocation in Halton, however it is not always straight-forward to align a particular expenditure against dementia. For example there is a wide range of generic activity with older people and also in relation to awareness raising and prevention, that may not necessarily be captured specifically as dementia expenditure.

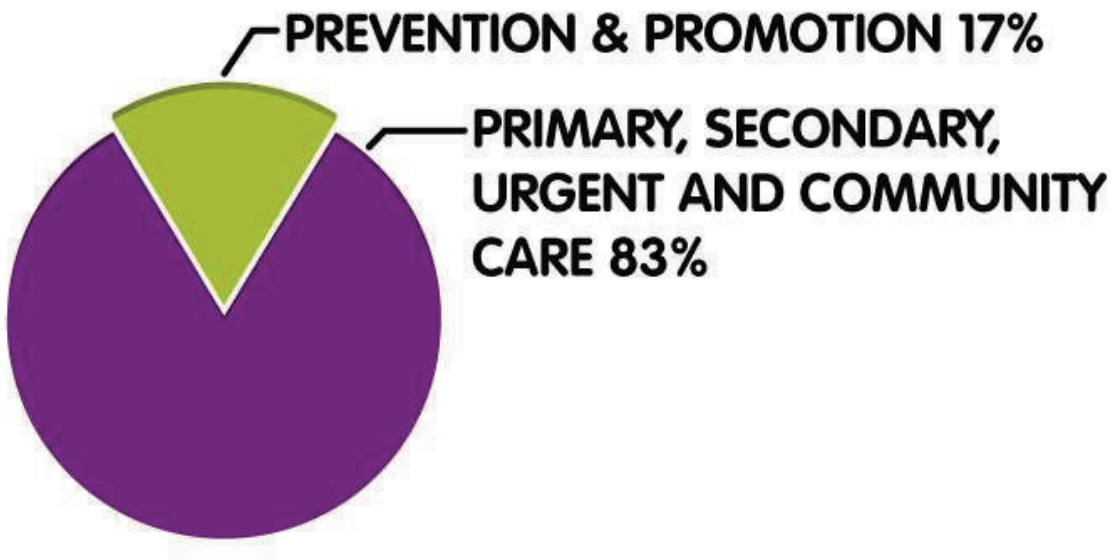
The chart below does begin to demonstrate the challenge facing commissioners in the next five years. Shifting the budget allocation away from high end health interventions to earlier voluntary sector and prevention measure is a key priority. This in turn will help to support the improving early diagnosis rate in Halton.

How the budget was allocated between health, social care and voluntary sectors 2013/14



The pie chart overleaf illustrates how the £22.9 million budget for mental health (as a whole) has been invested. It is clear that the majority of resource is currently invested in health treatment and services. In the future the focus for mental health disorders, as whole, will be on supporting people within the community to improve person centred outcomes for individuals and their carers.- The CCG are currently working with 5 Boroughs Partnership to scope out and pilot Payment By Results (PBR) Cluster packages for adult mental health and Children and Adolescent Mental Health Services (CAMHS) and Later life and memory services. In the future this will mean a more robust costing structure based on diagnosis and care pathways.

The pie chart below illustrates that 17% of the £5.7 million health budget for organic mental disorders (including dementia) is spent on prevention and promotion. It is well documented that promotion can increase awareness and therefore early diagnosis, enabling people to access lower level treatment and support at an earlier stage to slow the progression of the disease. We intend to rework our reconfiguration of this allocation and focus on prevention and promotion investment. This will be governed by the Dementia Partnership Board.



Given the complex nature of funding arrangements within the council, it is difficult to determine the precise amount of funding available and used for people with dementia. This is primarily because of the difficulties in diagnosing someone with dementia and the fact that the expertise to meet individual needs are based within older people mental health teams. Whilst the prevalence of dementia continues to grow and will become a significant factor in future years, it is not economically viable to separate out the needs of people with dementia from other older people with mental health issues, such as depression.

There are a variety of different factors that will 'push and/or pull' the funding for services, for example; residential care – price inflation and demographics will push the price but at the same time improvements in Public Health, Telecare and Prevention, will all pull expenditure on residential care down. For each type of expenditure there are all these factors pushing and pulling. We will shift resources from the point of crisis to prevention and early intervention.

How are we going to achieve the priorities?

The implementation plan that follows below details what actions will take place over the life course of the strategy to achieve the vision of living well with dementia in Halton

[i] What is Dementia? NHS Choices

[ii] What is Dementia? Alzheimer's Society Web site

[iii] Halton HealthWatch consultation with 'Lunch Bunch' group for carers of people with a dementia diagnosis. Sept 2013

[iv] 'The Dementia Journey Halton 2009/10'

[v] Transforming models of care for people living with dementia - Improving experiences and outcomes for people with dementia and their carers and families Report 2012

[vi] House of Memories is a training and delivery programme built around the objects, archives and stories held within the Museum of Liverpool. It aims to provide social and

health care staff (in domicile and residential settings) with new skills and resources to share with people living with dementia, and to promote and enhance their wellbeing

and quality of life, as a potential alternative to medication

Implementation Plan 2013 - 2018

1: Prevention & Raising Awareness

Outcome	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager /Officer	When
1.1 **Establish a Halton Dementia Training and Information Alliance**	250 health and social care staff dementia awareness trained. 17 GP practices to attend dementia awareness training within Protected Learning Time	Phase 1: Dementia awareness raising and training delivered to front line social care, primary care and secondary care staff Phase 2: Dementia awareness raising and training to other service areas within the Local Authority, Fire Service, Police Service, Housing providers Utilise Dementia Friends awareness raising sessions Training to include advice on reducing risks of developing dementia e.g. advise around healthy lifestyle and referral to support services as appropriate Awareness raising sessions delivered throughout each year to GPs via Practice Learning Time Events delivered by CCG and Learning Disability Clinical Lead. Dementia Clinical Lead to champion raising awareness within practices through general duties as a CCG clinical lead	**You will be treated with dignity and respect.** **You will have access to a skilled workforce** **Your GP will be more able to diagnose you earlier**	Dave Sweeney, Halton NHS CCG	Brian Hilton Linda Birtles-Smith Dr David Lyon	October 2014
1.2 **Develop Dementia Ambassadors within teams/organisations to maintain awareness raising and promote dementia friendly service**	Minimum of 1 Dementia Ambassador within each member organisation of the Dementia Partnership Board.	Each Dementia Ambassador to undertake Alzheimer's Society Dementia Friends awareness raising session and Dementia Champions Training	**You will be treated with dignity and respect.** **Halton will adopt a consistent approach to your care**	Dementia Partnership Board member from each partner organisation		August 2014

Outcome	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager /Officer	When
1.3 **Ensure dementia is defined in the delivery of the NHS Health-checks programme in Halton**	7667 people will be invited to attend an NHS Healthcheck 75% (5750) of people invited will receive an NHS Healthcheck Baseline of 850 people aged 65-74 are eligible to receive the dementia component of the Healthcheck, of which 76% (650) will be given information on the signs of dementia	Over a five year rolling period, everyone aged between 40 and 74 (who hasn't already been diagnosed with one of a series of specific conditions) will be invited for an NHS Health Check at their GP surgery. The check will include personal and family history, a range of physical checks and the provision of information and advice. For those aged 65 and over the check will also include the provision of general information about dementia.	**You will be diagnosed early. You will receive care and support at the earliest possible point**	Dr Ifeoma Onyia, Halton Borough Council Public Health	Joanne Sutton and Commis-sioned Practices	2013-2018

2: Early Diagnosis

Outcome	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager /Officer	When
2.1 **Delivery of Direct Enhanced Service for Dementia (DES) within general practice, to increase awareness and screening for dementia.**	CCG Quality Premium target is a 62.1% (807 people) diagnosis rate based on a prevalence of 1300 people with dementia.	DES payment data via NHS England Primary Care Team (annually). Dementia Board will request exception reporting from NHS England relating to delivery outcomes	**You will be diagnosed early.**	NHS England contractual arrangements Dave Sweeney, Dementia Board Dr David Lyon, Halton NHS CCG	Jo O'Brien, Primary Care Commission-ing Manager	2013-2014
2.2 **Dementia Preliminary Screening Pilot Develop and evaluate a dementia case finding pilot with non-clinical community based workers.**	Output figures to be determined as the pilot is developed. Anticipated outcomes are increased awareness amongst community based staff about dementia. Increased awareness of dementia risk factors and symptoms amongst those most vulnerable within the community. Increased attendance at GP with screened cognition concerns, seeking further investiga-tion from GP. Increased referrals to Later Life and Memory Service Pathway. Increase in diagnosis rate.	The pilot will be delivered in partnership with Liverpool Housing Trust, Riverside Housing and Halton Housing Trust, Halton Borough Council Bridge Building Team, Sure Start to Later Life team and Community Development Workers. Working with the CCG Clinical Lead for Dementia to develop referral, information sharing and data protection protocols and evaluation methods. Non clinical Community based staff already supporting people who may have expressed concern, or display symptoms of cognitive impairment, to be offered the 6CIT screening test and referred to GP for further investigation where indicated.	**You will be diagnosed early.**	Dave Sweeney, Halton Borough Council Dr David Lyon, Halton NHS CCG	Emma Bragger, Policy Officer Communities Directorate	Evaluation of pilot completed by October 2014
2.3 **Develop a business case around the evidence of the effectiveness of the Rapid, Assessment, Interface and Discharge (RAID) programme for people with dementia that could be applied within local hospitals.**	Recommendations to be made to the Dementia Partnership Board	The business case will identify potential improvements/risks relating to • satisfaction for dementia patients • experience for staff • choice for the acute trust • better health outcomes for the patient with dementia • value for our economy.	**You will be diagnosed early.**	Commissioning Managers	Mark Holt	March 2015

3. Living well with dementia

Outcome	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager /Officer	When
3.1 **Improve quality of residential and domiciliary care for people with a dementia diagnosis.**	Pooling of health and social care budgets to commission an integrated model of clinical, social and dementia care across all residential care, not just dementia nursing homes. NICE Care Audit Tool for people with Dementia (due for publication during 2014) is implemented across domiciliary and residential care	The Dementia Partnership Board to contribute to the evaluation of the 5 Boroughs Partnership Care Home Pilot and the Halton Borough Council care Home Model. Implementation of the NICE Care Audit Tool to be included as a contractual requirement in future service specifications. Provide specialist training and support to social workers, residential and domiciliary care staff to support individual and carers in making end of life plans. Consider the results of the evaluation of the 5 Boroughs Partnership Care Home Liaison Project and the existing Halton Borough Council Care Home model and make commissioning recommendations.	**You will get the treatment and support which are best for your dementia and your life.** **You will receive a better level of care in your own home** **You will be confident of the standards of care being delivered in residential care**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Damien Nolan, Divisional Manage, Halton Borough Council	Summer 2014
3.2 **Provision of appropriate information to people with a dementia diagnosis, and their carers, at the appropriate time**	100 % of people accessing Dementia Care Advisor or Support Worker service to have access to the dementia guide 100% of the Dementia Training and Information Alliance (to be formed) members to receive a copy of the Dementia Guide. 100% of carers of people accessing the Dementia Care Advisor and Support Worker service to be informed of the services available through IAPT	Requirement to provide Dementia Guide and IAPT information to be included in future service specification of Dementia Care Advisor and Support Worker Dementia Care Advisors and Support Workers to provide the Alzheimer's Society resource 'The Dementia Guide. Living well after diagnosis'. Promote to carers of individuals with a dementia diagnosis the availability of psychological therapies through the Improved Access to Psychological Therapies (IAPT) investment programme	**You will get the treatment and support which are best for your dementia and your life.** **Those around you and looking after you are well supported**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council	Mark Holt, Commissioning manager, Halton Borough Council	October 2014

Outcome	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager /Officer	When
3.3 **Development of a Carer's on line forum to enable carers to get direct access to clinicians for information and advice on the condition.**	Measure – standardised tool of wellbeing to be used	Evaluation of the on line Carer's Forum pilot, with analysis considered in development of future commissioning intentions.	**Those around you and looking after you are well supported** **You will have direct access to key professionals**	Dementia Partnership Board Carers Board	Steve Eastwood	March 2015
3.4 **Delivery of community based care and support**	50% increase in the number of people diagnosed with dementia who have access to a Dementia Care Advisor/Support Worker or equivalent trained staff in the voluntary sector	Develop a business case for the Dementia Care Advisor/Support worker service and the potential to skill the voluntary sector and make commissioning recommendations. Evaluate current Dementia Care Advisor and Dementia Care Support Worker Service, including,– capacity and outcomes and impact of any change in service (increase/decrease in capacity) on other services. Evaluate the use of voluntary sector organisations in supporting the dementia agenda. Including skilling of volunteers who are already providing support to people in their own home .	**You will be supported to understand information so that you can make good decisions and know what you can do to help yourself and those who can help you.** **Those around you and looking after you are well supported.**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Mark Holt, Commissioning manager, Halton Borough Council	2014/15
3.5 **Halton to become a recognised Dementia Friendly Community**	Measures for the Safe in Town scheme to be determined. Anticipated outcomes include: • Improved social inclusion for person with dementia diagnosis • Improved independence for person with a dementia diagnosis • Increased awareness of dementia amongst retailers and service providers Awarded the Alzheimer's Society 'Dementia Friendly Communities' recognition	Use the Alzheimer's Society Dementia Friendly Society web resources and support to achieve dementia friendly status. Expansion of the 'Safe in Town' pilot to include people with dementia. Work towards achieving the Alzheimer's Society Dementia Friendly Community Award.	**You will be supported to feel part of a community and be inspired to give something back.** **You will be supported so that you can enjoy life.**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council	Safe In Town Steering group	May 2014

Outcome	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager /Officer	When
3.6 **Coordinated approach to assistive technology for people with a dementia diagnosis.**	Increase in number of people who are prescribed specialist equipment.	Base line of use of assistive technology amongst people with a dementia diagnosis to be established. Scope the use of alternative technologies to improve outcomes for people with a dementia diagnosis and their carers by participating in the Innovate Dementia programme Needs analysis to be undertaken Recommendations to be considered in commissioning intentions.	**You will be supported so that you can enjoy life.** **You will be able to access equipment that will improve your quality of life**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Steve Eastwood, Commissioning Manager, Halton Borough Council	2014/15
3.7 **Provide specialist input to Care Management and Care Planning teams to improve the quality of end of life care plans for people with dementia.**	Increase in the number of people supported to complete an end of life plan.	End of life tools training delivered by Advanced Care Planning Team	**You will be supported to ensure that your end of life wishes will be respected.**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Jenny Owen/Emma Alcock, Commissioning Manager, Halton NHS CCG	On going
3.8 **Improve access to out of hours service for end of life patients**	Increase in number of completed Special Patient Notes for diagnosed dementia patients within Halton	Cleansing and auditing of current Special Patient Notes to provide baseline. Training to be provided to GP practices as part of Gold Standard Framework of care by Advanced Care Planning Team Utilising the red flag system for end of life dementia patients – to highlight as emergency to be seen within 1 hour.	**You will be supported to ensure that your end of life wishes will be respected.**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Jenny Owen/Emma Alcock, Commissioning Manager, Halton NHS CCG	On going

4 Delivering the strategy

Outcome	Output Measure	Delivery Method	Outcomes for person with dementia and their carer	Accountable Organisation & Manager	Delivery Manager /Officer	When
4.1 **Development of a performance dashboard**	Qualitative and quantitative evidence of improved outcomes for people with a dementia diagnosis and their carers	Dashboard to be devised around Halton's 8 dementia pledges Development of patient/carers group to enable their qualitative contribution to performance management.	**You will be confident that decisions are being made based on the most up to data information available**	Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council Dr David Lyon, Halton NHS CCG	Mike Shaw, Performance Officer, Halton NHS CCG	Quarter 1 2014/15

Appendix 1 Later Life and Memory Service Pathway

Halton Later Life and Memory Service Pathway for Professionals. September 2013

Click here for NICE Pathway for Dementia Diagnosis and Assessment

Patient undertakes '6 CIT' Test (or other). Link to '6 CIT' questions and scoring:http://www.patient.co.uk/doctor/six-item-cognitive-impairment-test-6cit

Routine bloods and ECGPrimary Care Referral to Dementia Care Advisors

Click here for NICE Pathway for Dementia Specialist Assessment

Referral triaged at single point of access (5BP) Patient offered face to face assessment appointment within 10 days (routine) and 24/48hrs if Urgent
Full Assessment within 6 weeks

- History taking
- Cognitive and mental state examination
- Physical examination
- Review of medication to identify any drugs that may impair cognitive functioning.
- Specialist Interventions

Later Life and Memory Service – New Referral letter faxed to 01925 666641
Tel. 01928 753162

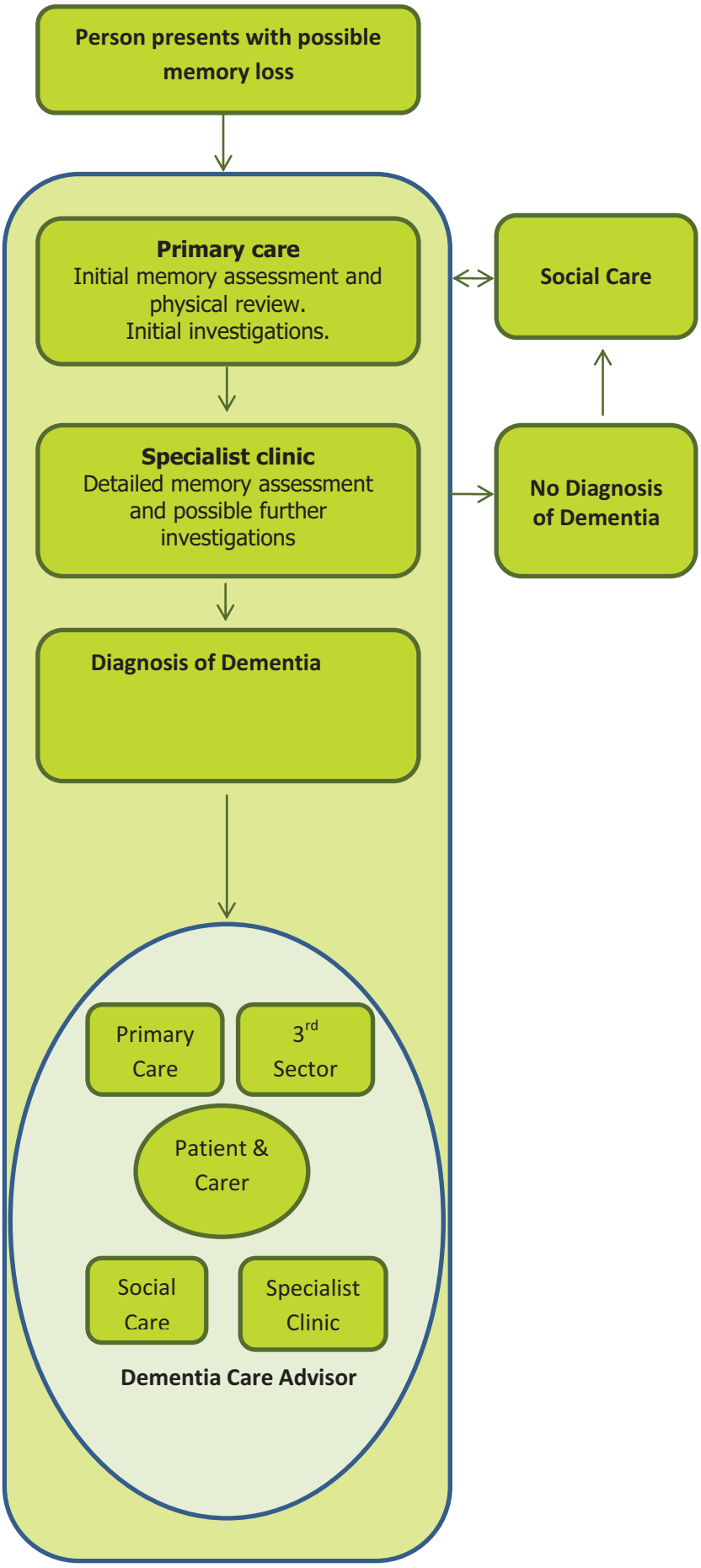
Click here for NICE Pathway for Dementia Diagnosis and Assessment

- Holistic approach
- Brain scan
- Clarify diagnosis
- Prescribe Medication
- Ensure social support

If non dementia diagnosis refer back to Primary Care

Dementia Care Advisors to assist patient and carer to navigate pathway and provide information on services available, including community delivered services Call Alzheimer's Society for referral to Dementia Care Advisors 0151 420 8010

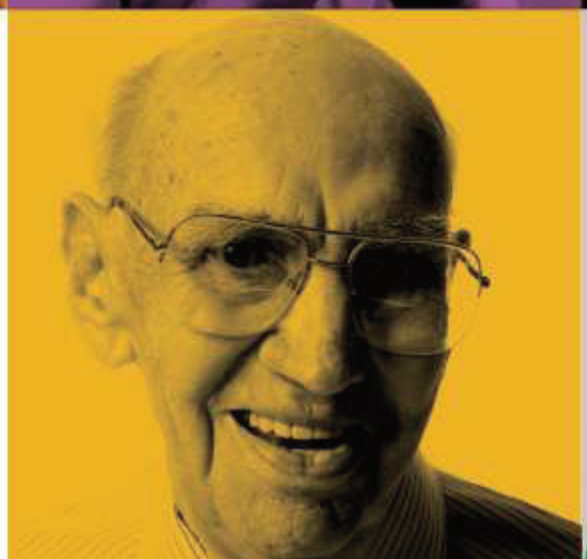
Social care referrals via Later Life and Memory Service Social Care Support Service Pathway



Living Well With Dementia in Halton

Halton Dementia Strategy Needs Paper 2013-2018

myhalton
living life well



NHS
Halton Clinical Commissioning Group

HALTON
BOROUGH COUNCIL

Contents

Introduction

This strategy needs paper highlights the national policy drivers and local needs analysis. It sets out current initiatives designed to improve the lives of people with dementia, their carers and families, enabling them to have a more fulfilled life and is the culmination of work led by the Dementia Partnership Board. The associated strategy paper and implementation plan shows how these drivers will be translated into action, and the outcomes. It is anticipated that the commissioning process will take five years in total to deliver and is a whole system transformation supported by collaboration of all agencies working to improve both the experience and outcomes of people with dementia and their families.

National Context

'Living Well with Dementia: A National Dementia Strategy' aims to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. Since its launch in 2009 the strategy has provided a catalyst for change at a local level with the vision of positive transformation of dementia services. Click here to see the national strategy.

The Prime Minsters Challenge on Dementia

Since the publication of the Joint Halton Dementia Strategy in 2009, the Coalition Government have set The Prime Minster's Challenge on Dementia (March 2012), to deliver major improvements in dementia care and research by 2015. The Prime Minister's Challenge on Dementia builds on the National Dementia Strategy to provide a framework which directs action. The goal is to make a real and positive difference to the lives of people affected by dementia. The ambition is to ensure that people with dementia and their carers receive high quality, compassionate care whether they are at

home, in hospital or in a care home. The person with dementia, and their family and carer, are to be at the heart of everything health and social care providers do, with their wellbeing and quality of life to be first and foremost in the minds of those commissioning and providing services for them. click here to see the Annual Report on Progress.

The Care Bill

The Care Bill was announced in the Queen's Speech in May 2013 and aims to modernise adult social care law, in order to clarify the issues of eligibility and service delivery. It is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. To promote individual wellbeing, their needs, views, feelings and wishes should be considered in all aspects of their wellbeing from physical and mental health, through dignity and respect to control over their daily needs, access to employment, education, social and domestic needs and the suitability of their accommodation.

Whilst the Bill incorporates care and support across the board, when thinking about how dementia services are developed in the future, the Local Authority and health care partners will need to consider the following:

- access to services that help prevent their care needs from becoming more serious
- access to good information to help them make informed choices about their care and support
- have a range of good care providers to choose from
- the public know how to access independent financial advice
- the public know how to raise concerns over the safety or welling being of someone with care needs

Locally, it will require the integration of care and support with the local authority, health and housing services and other service providers to ensure the best outcomes are achieved for the individual. For example, care services will need to consider the strengths and interests of older people and to connect them to local clubs and social groups. This will strengthen communities themselves and helps to keep people safe and reduce, delay or prevent needs for acute care.

House Of Lords Committee on Public Service and Demographic Change report 'Ready For Ageing?'

The report published in March 2013 contained 10 principal conclusions and recommendations for action across Government. In particular the committee emphasised the need for Government to respond to the impact of our ageing population on public service provision. Dementia features heavily in the report, focusing on more ambitious targets for dementia diagnosis rates – to increase to two-thirds by 2015. Click here to see the report

NHS Operating Framework

The NHS Operating Framework 2012/2013 includes requirements for a renewed push on implementation of the national dementia strategy and increased support for carers. One of the key themes is putting patients at the centre of decision making and improving dignity and service to patients. The care of older people and dementia services are given priority within the framework and the move towards an outcomes focused approach provides incentives to improve services for older

people. Local implementation of the proposed dementia Quality Outcome Framework indicators for 2014/14 places emphasis on the recognition and support of carers. Click here to see the NHS Operating Framework 2012/2013

National Outcome Frameworks

The Government's outcome frameworks provide accountability that focuses on how well services are improving outcomes for people. Locally this translates into monitoring how services are providing quality support that meets the needs of those with a dementia diagnosis, their family and carers.

The Prime Minister's Dementia Challenge has put the spotlight on improving diagnosis rates, research and the creation of dementia friendly communities. The NHS placeholder indicator 'Enhancing the quality of life for people with dementia' has been updated and extended. Accordingly, the 2013/14 NHS framework includes the two-part indicator, which measures diagnosis rate for people with dementia (there being evidence that receiving early diagnosis is important for people living with dementia, enabling them to cope better with their condition). A second complementary measure i.e. concerning the effectiveness of post-diagnosis care in sustaining independence and improving quality of life, is being developed. This indicator also appears in the Adult Social Care Outcomes Framework.

Data relating to the Public Health Outcomes Framework can be found at the Public Health Outcomes Framework data tool. As at September 2013 the baseline was still being established so there is no data available at this time. Click here to see the latest data for the outcome framework.

Public Health Outcomes Framework		**Adult Social Care Outcomes Framework**		**NHS Outcomes Framework**	
4.16 Estimated diagnosis rate for people with dementia	Baseline Baseline data not yet published (baseline is not yet available as at Sept 2013)	1B. The proportion of people who use services who have control over their daily life	Performance 79.4% as at June 2013 (AQuA Benchmarking from Adult Social Care Survey)	1.5 Excess under 75 mortality rate in adults with serious mental illness	Baseline 850.7 (period: 2010/11)
		1D. Carer-reported quality of life	Performance 8.2 as at June 2013 (AQuA Benchmarking Carer's Survey)	2.1 Proportion of people feeling supported to manage their condition	Baseline Baseline Data not yet published
		2F Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Baseline Placeholder	2.4 Health-related quality of life for carers	Baseline Baseline data not yet published

	(Placeholder)			
	3C. The proportion of carers who report that they have been included or consulted in discussion about the person they care for	Performance 76.7% as at June 2013 (AQuA Benchmarking Carer's Survey)		
	3D. The proportion of people who use services and carers who find it easy to find information about services	Performance 75.8% as at June 2013 AQuA Benchmarking (Adult Social Care Survey/Carers Survey)		

Indicates Halton's performance is within the top 6 Authorities in the region

Indicates that Halton's performance is within 7-12 place within the region

Potential new indicators for the 2014/15 Quality and Outcomes Framework (QOF)

As part of a consultation that was undertaken in early 2013, there are 14 potential new QOF indicators being considered, 4 of which related to Dementia.

1. The percentage of patients with dementia with the contact details of a named carer on their record.
2. The practice has a register of patients who are carers of a person with dementia.
3. The percentage of carers (of a person with dementia) who have had an assessment of their health and support needs in the preceding 12 months.
4. The percentage of patients with a new diagnosis of dementia (after 1 October 2012) who have attended a memory assessment service up to 12 months before the date of diagnosis.

As part of the final menu of QOF indicators for 2014/15, GPs could be encouraged to record the percentage of patients with dementia who have attended a memory assessment service.

A new dementia indicator will encourage practices to record the name and contact details of the carers of each patient with dementia. This is to help improve communication between practices and other teams, such as out of hours care.

Practices could also be encouraged to measure the percentage of patients with a new diagnosis of dementia, with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded.

Comments received during the consultation were considered by the independent Primary Care QOF Indicator Advisory Committee in June 2013, along with the results of the piloting of these indicators across a representative sample of general practices. The Committee will then recommend which of these indicators should be considered for inclusion on the NICE menu for consideration for the 2014/15 QOF in September 2013. For the latest on QOF indicators please click here

Should the proposed QOF indicators be authorised , consideration will need to be given locally by practices on how they could impliment this guideline with the potential for poor access to this group of people. General Practices will need to follow best practise in making contact and arranging the tests, bearing in mind factors such as means of making contact and transport issues.

Local Context

The 'Living well with dementia in Halton ' strategy and implementation plan that accompanies this needs paper compliments other work programmes including the Halton Sustainable Communities Strategy, Mental Health Strategy, the Halton Health and Wellbeing Strategy, Carer's Strategy Action Plan, Falls Strategy and Loneliness Strategy, and should be read in conjunction with these pieces of work.

Halton Health and Wellbeing Board have prioritised Mental Health in their related strategy. The Halton Clinical Commissioning Group (CCG) also supports this priority.

The Halton Joint Strategic Needs Assessment identifies, as a priority, that the early detection and treatment of mental health issues should be improved as this will lead to a quicker recovery and reduce the negative impact on a person's quality of life.

The commissioning of initiatives that promote increased understanding of the needs for people with Long Term Conditions and mental health needs and develop integrated care pathways as a priority, as identified in the Halton Joint Strategic Needs Assessment.

Substantial impact on levels of ill health and costs to health and care budgets, as well as wider economy, can be achieved through integrated commissioning of services that meet the person centred outcomes as evidenced by NICE Dementia Quality Standards. Click here for the NICE Dementia Quality Standards.

Performance

'Putting dementia on the map' is a Department of Health performance tool that sets out what we currently know about dementia care and support across the country. The map draws on data and information about dementia health and care, dementia friendly communities and research. It highlights where improvements are being made and where we can see progress, but it also shows where we need to improve, including where we need better data. The performance information for Halton, in the table below, shows that Halton is performing well in the areas of assessing for and receiving a diagnosis of dementia, with more work to be done within the hospital settings

Measure	Description	Data relating to	Data as at Dec 2013 from Map	Traffic Light	Comment
In the community					
Checking for Dementia	How many people with dementia have had a formal diagnosis of their condition	NHS Halton CCG	59.40		Map data from 2012/13, re base lined from pre April 2013 PCT data. Actual figure for Halton as at Nov 2013 is **63.3%** When comparing at estimated numbers, including those with early onset dementia, in practice-by-practice analysis, with 2012/13 QOF data released from the Health & Social Care Information Centre (The QOF register is all ages and may well include some with early onset dementia) the 63.3% CCG average diagnosis rate stands, with a

					range of 34.2% to 100%.
Waiting to be tested	How long someone will wait to be seen by memory clinic	5 Boroughs Partnership	2 weeks		Halton is the only 'green' in the NW
Waiting for results	How long someone will wait for results from memory clinic	5 Boroughs partnership	12 weeks		Halton LLAMS target is 6 weeks from assessment to diagnosis
Prescribing of anti-psychotic drugs	What proportion of diagnosed dementia patients were prescribed an anti psychotic drug within the 1st year of diagnosis	No data available	No data available	No data available	
At Hospital					
Looking for dementia at hospital	Of people over 75 who come to hospital in an emergency, how many are assessed for signs of dementia	Warrington & Halton NHS FT	91.59%		
		St Helens & Knowsley NHS	91.27%		
Assessing dementia at hospital	Of people over 75 who come to hospital in an emergency and show signs of dementia, how many have further assessment?	Warrington & Halton NHS FT	53.75%		
		St Helens & Knowsley NHS	96.72%		
Referring people for further tests	Of people over 75 who come to hospital in an emergency and have had a full assessment of their dementia, how many are referred for further tests?	Warrington & Halton NHS FT	100%		
		St Helens & Knowsley NHS	93.55 %		
Length of stay in hospital	Do people with dementia stay longer in hospital than similar patients without dementia?	Warrington & Halton NHS FT	Longer		
		St Helens & Knowsley NHS	Longer		
Going back into hospital	Is someone with dementia more likely to be readmitted after a spell in hospital than similar patients with out dementia?	Warrington & Halton NHS FT	More		
		St Helens & Knowsley NHS	More		
Dying with dementia	Are people with dementia more likely to die in hospital than	Warrington & Halton NHS FT	More		

	similar patients without dementia?	St Helens & Knowsley NHS	More		
The Future of Care					
Dementia In England today	How many people are expected to be living with dementia in this area, based on what we know about the local population?	NHS Halton CCG	0.99%		
Dementia Friendly Communities	Communities signed up to Alzheimer's Society Programme	Halton	Not yet registered		
Involving people in research	How many research studies into dementia treatment and care are being run by memory clinics?	5 Boroughs Partnership LLAMS	44 studies		

Halton Dementia Profile

The term 'dementia' describes a set of symptoms that include loss of memory, mood changes, and problems with communication and reasoning. There are many types of dementia. The most common are Alzheimer's disease and vascular dementia. Dementia is progressive and diagnosing dementia is often difficult, particularly in the early stages. The risk of developing dementia increases with age, and the condition usually occurs in people over the age of 65.

The population of Halton is aging. That is, a larger proportion of the total population will be found in the 60-plus age bands by 2031 compared to 2006. This section of the population will increase by 61% to 36,300 by 2031. This will then constitute 28% of the Halton population.

Dementia diagnosis and estimated prevalence

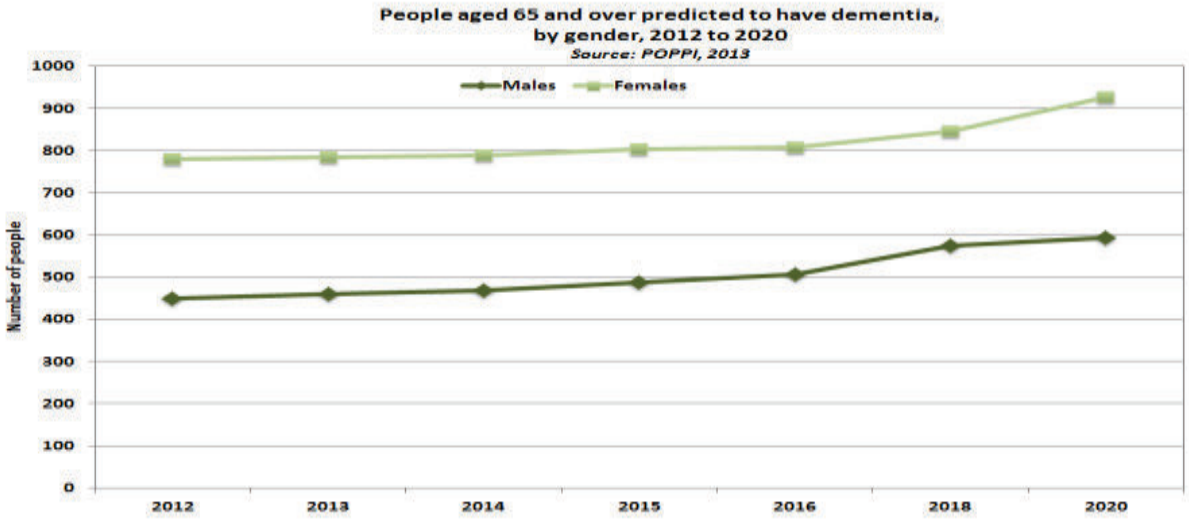
The number of people with dementia is set to rise by 62% by 2030, largely due to the projected increase in the older population. It is projected that there are 1,229 people aged 65+ living in Halton who have some form of dementia in 2012[i] and by 2020 this figure is estimated to be as high as 1518. In addition it is estimated that there are currently about 34 people aged between 30-64 who early onset dementia[1].

The graph below shows the estimated numbers of dementia patients by gender for Halton. There are predicted to be more females than male patients, and the greatest increases are in the 85+ age group. These projections, developed by POPPI[2] and based on national research applied to Office of National

1 Estimates from PANSI: Projecting Adult Needs & Service Information System: It is managed by the Institute of Public Care http://www.pansi.org.uk/

2 POPPI = Projecting Older People Population Information System. It is managed by the Institute of Public Care http://www.poppi.org.uk/

Statistics population projections, estimate that the number of males aged 65+ diagnosed with dementia is set to rise from 449 in 2012 to 593 by 2020 and for females that rise is 780 to 925.



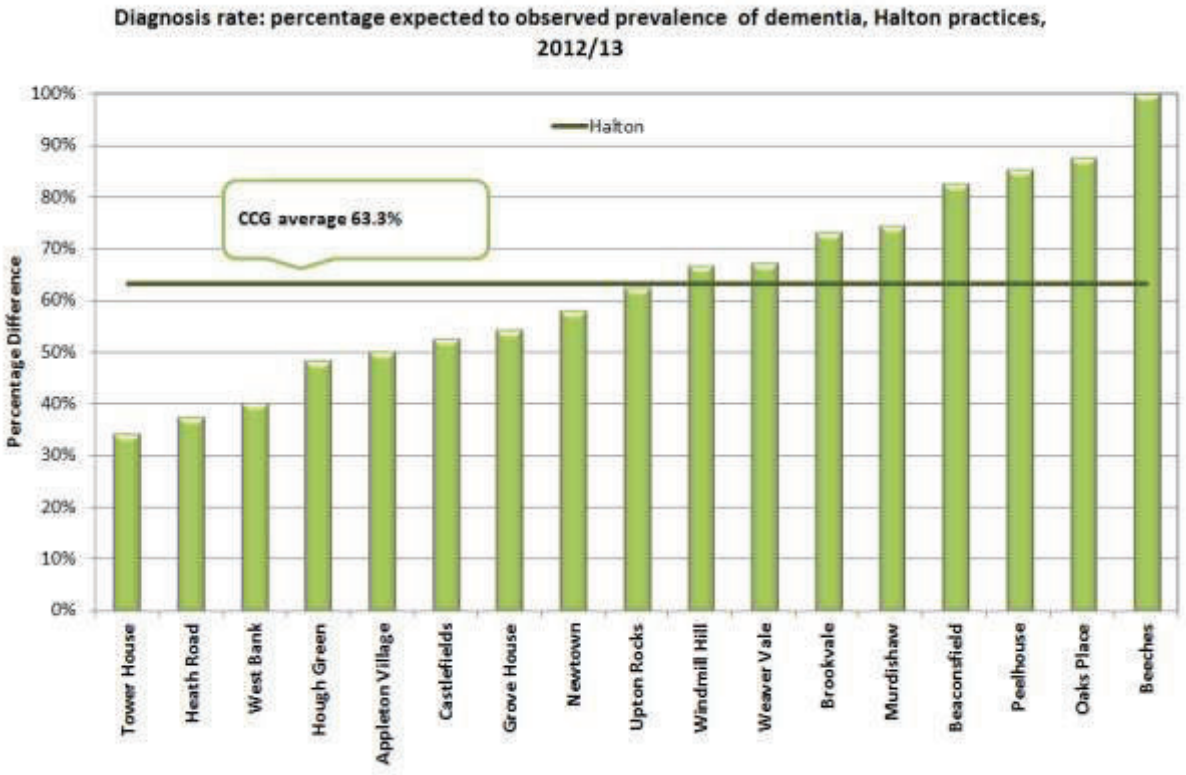
Diagnosing dementia in General Practice

The GP contract includes the requirement for practices to establish a disease register for people with dementia. The diagnosis of dementia may be from correspondence with secondary care or via the GPs own diagnosis.

Quality Outcome Framework (QOF) data for 2012/13 indicates 747 patients registered at Halton GP practices as having dementia, an increase on the 2011/12 figure of 689 patients and 634 in 2010/11. Using the same age-specific prevalence rates utilised by POPPI (Projecting Older People's Population Information) and PANSI (for early onset dementia) and applying these to GP registered population gives an overall estimate for 2012/13 of 1,180 patients with dementia.

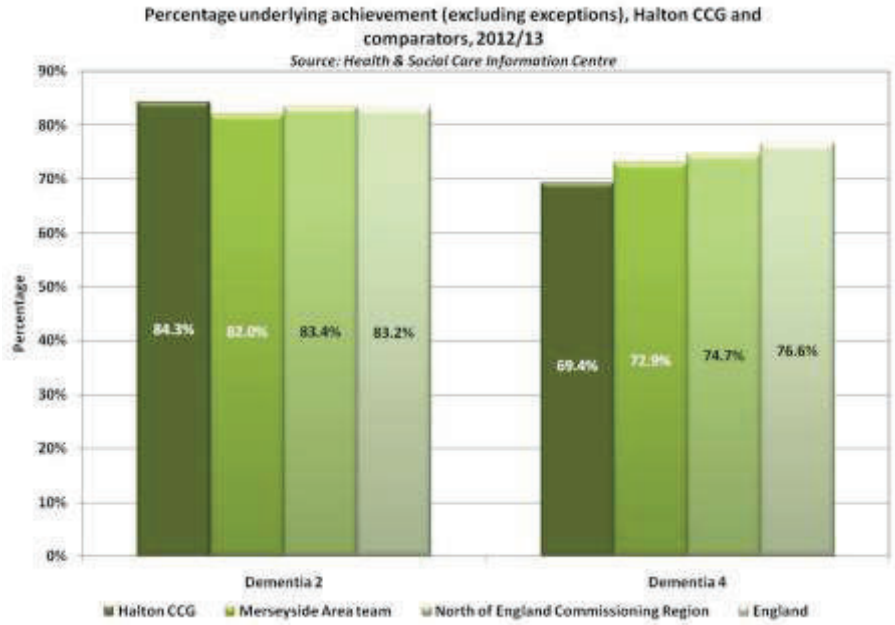
This method thus enables practice level estimates to be made which can then be compared to the dementia register numbers. This enables a diagnosis rate to be calculated (percentage of people diagnosed compared to expected/predicted numbers). Practice rates vary considerably from 34.2% to 100%. The CCG average rate was **63.3%.**

Whilst there has been an improvement there are still considerable levels of under diagnosis. Using this method suggests there are still 433 people with undiagnosed dementia in the CCG catchment.



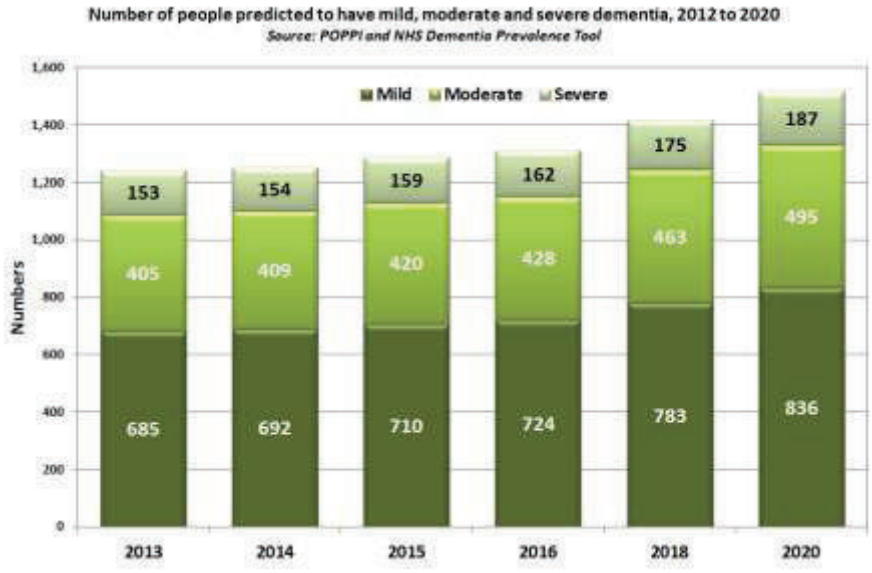
GP: Care Assessments

A further requirement of the GP contract is that patients on the dementia register should have had a care assessment within the previous 15 months. For 2012/13 Halton Clinical Commissioning Group (CCG) performance was 79.5%. This was above comparators (chart Dementia 2 indicator). For patients with a new diagnosis of dementia, practices are also required to record the percentage who have had FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register (between the preceding 1 April to 31 March). For this indicator the CCG achievement was slightly lower than comparators (chart Dementia 4 indicator). There was wide variation across practices. For Dementia 2 indicator this ranged from 70%-100% with three out of the 17 practices achieving 100%. For Dementia 4 indicator the range was much wider 0%-100% (five practices achieved 100%). However, it should be noted that numbers per practice were very small for some practices. The total number of newly diagnosed patients for 2012/13 was 238 of which 180 were eligible for the tests and 125 received them. There were 58 exceptions, ranging from 0-8 per practice.



Different Levels of Severity

The Dementia UK 2007 report estimated that 55.4% of people with dementia have mild dementia, 32.1% moderate and 12.5% severe dementia. It also noted that these proportions change with increasing age with the percentage of those with severe dementia increasing and those with mild dementia decreasing. For example only 6.3% of dementia cases in the 65-69 age band are estimated to be severe rising to 23.3% in the 95+ age group. Using the NHS Dementia Prevalence Calculator tool, we can forecast numbers of dementia by severity in Halton.



Early onset of dementia

Dementia is rare before the age of 65; however, there will be a small number of people who develop the condition before this age. It is estimated that at age 30-34, 8.9 per 100,000 men and 9.5 per 100,000 women will develop dementia. This rate rises with each 5-year age band and equates to 33 people for Halton.

Although the numbers for early onset of dementia are low in Halton, these people are faced with a different set of challenges that include:

- Health care professionals generally don't look for the disease in younger patients and it can therefore be months or years before the right diagnosis is made and proper treatment can begin.
- Many people with early onset Alzheimer's and other dementia are still working when their symptoms emerge. Due to the nature of the condition, changes in their job performance or behaviour may not be understood or addressed. In addition the workplace can become a difficult environment.
- Those who leave their jobs before diagnosis may be denied certain Government assistance that would otherwise be provided to individuals with disabilities.
- Many individuals with early onset Alzheimer's and other dementia have low incomes and are in need of assistance, but have a difficult time getting it.
- Existing healthcare, home care or community service provision may not be appropriate for early onset individuals

Family members and other carers often lack the information and support they need to provide care to the person they support.

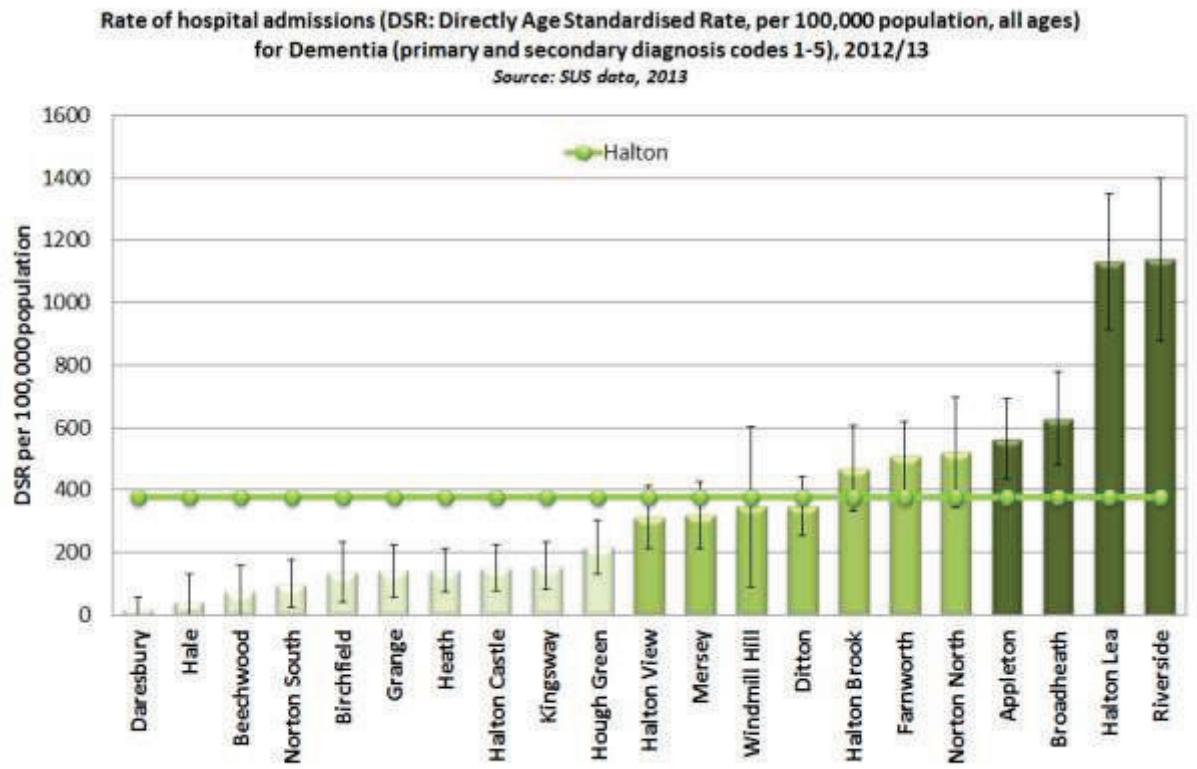
Dementia beds

Halton has a 244 registered dementia beds in residential and nursing homes, 82 of these are dual registered. There are also 249 nursing beds available of which 196 are registered as EMI Nursing. It is not clear how many of the residents in residential care have dementia, national research from the Alzheimer's Society suggests that underreporting could lead to 80 % of people in residential care actually have some form of dementia, if we compare this to figures based on National Audit Office research, they estimate that of the 1,180 residents thought to have dementia in Halton 788 will live in the community and 392 in a care home. It is estimated that by 2030 1,367 people diagnosed with dementia will be living in the community and 683 will be requiring care home places.

Work is required to fully assess the current registration levels of care homes in Halton.

Hospital admissions due to dementia

Few people are admitted to hospital primarily due to dementia. In total 747 people across Halton who were admitted to Hospital during 2012/13 had some form of dementia (only 76 had dementia as the primary reason for the admission). This is an increase on the 2011/12 figure of 563, with the figure for 2010/11 being 705. This figure for 2012/13 included 39 admissions for people under the age of 65. Some of these may be one individual who is admitted multiple times throughout the year.



In Halton during 2012/13, 76 people were admitted to hospital with a primary diagnosis of dementia. However many older people with dementia will have more than one health problem. As such some people admitted for another health reason will also have dementia. This is likely to have implications for the support they need both whilst in hospital and how to manage / level of care needed once they leave hospital.

Social Care

Key findings from the National Audit Office's 2007 *Improving Services and Support for people* with dementia indicate that almost two thirds of patients live in the community and one third are in care homes. If we apply this to Halton data it would suggest that there are 793 people living in the community and 427 in a care home. However, if we consider data from Carefirst there are only 308 people identified with dementia. 113 are supported in the community and 195 are in residential care.

The above data collection issues may well be the main reason for the reduction in the number of clients with dementia who have received a review. Although year on year there has been a slight increase the trend has been downwards for a period of six years.

It is clear that there are significant differences in the estimated to the actual figures. At first reading it might be pertinent to suggest that there is some significant under delivery within the system, however, this may attribute for a small amount, but the bigger issue is the quality of the data collection and inputting at source.

When we consider the type of services we can see that 56.5% of clients with dementia received community based services in 2011/12. This is a fall from the previous year of 69%. Residential care has become a feature of reporting since 2008/09 with 39% of clients receiving this type of care in 2011/12. The percentage of clients receiving nursing care has fallen from 32% in 2005/06 to nearly 18% in 2011/12; this represents a decrease in both percentage totals and number of people with dementia.

Of the clients receiving community based care nearly half received home care during 2011/12, just under a quarter received day care, meals and professional support and just under half received some other form of service for example, wardens, equipment etc.

A1: Number of clients with whom a review was completed during the period, by age group

	2005/06				2006/07				2007/08				2008/09				2009/10				2010/11				2011/12			
	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total	18-64	65-74	75+	Total
Dementia	5	30	140	180	10	35	140	185	15	25	110	145	15	15	100	130	15	10	95	115	10	15	95	120	10	20	95	125
Mental Health Total	260	80	275	615	270	75	255	600	380	80	215	680	310	60	180	550	330	55	150	535	325	65	155	545	325	60	150	535

It's important to note that the number of clients receiving various services does not add up to the total number in receipt of services as many clients will receive more than one service.

click here to see the full Halton Dementia Profile produced by Public Health

Cost of Dementia

Dementia UK found that the total costs of dementia in 2007 amounted to £17.03 billion per annum. Since 2007 the total cost of dementia has continued to rise: updated figures for 2012, published with the Society's Dementia 2012 report, put the cost at £23 billion with 800,000 people living with the condition, with an average cost of £29,746.

The Dementia UK report [ii]estimated that the total annual cost per person with dementia in different settings in 2007 was as follows:

People in the community with mild dementia - £14,540

People in the community with moderate dementia - £20,355

People in the community with severe dementia - £28,527

People in care homes - £31,263.

Over a third of the total cost (36%) was due to informal care inputs by family members and other unpaid carers. Not included in this amount is the estimated £690 million in lost income for those carers who have to give up employment or cut back their work hours. This lost employment means a loss of £123 million in taxes paid to the Exchequer. Accommodation accounted for 41% of the total cost.

The greatest proportion of direct costs of dementia care is associated with institutional support in care homes. This is often provided at a crisis point, is always costly and often precipitated by a lack of effective support.

Data collection within the local authority is such that it is difficult to assess the exact number of people with dementia in receipt of a personal budget. However, a national study identified that uptake of personal budgets among people with dementia still lags behind most other client groups. Three in five people with dementia assessed as eligible for a care package were not even offered a personal budget, while 15% declined an offer of one, found a study by Alzheimer's Society[iii]. The perceived risk of financial abuse; issues of capacity; lack of information and support for families and carers, and the fact that many people with dementia only access social care at crisis point – when setting up a personal budget is more complicated – have all been put forward as causes.

A report by the Mental Health Foundation[iv] has shown that individualised, tailored support and care that a personal budget can facilitate can have enormous benefits to a person with dementia.

Considerations when assessing a person with a dementia diagnosis for a personal budget should include:

- Training for social work staff specifically on personal budgets and how they can work for people with dementia
- Support social workers, individuals and carers to really understand what support is available in the marketplace so that they can ensure outcomes really match individuals' wishes.

The costs of delivering personal budgets to people with dementia are higher than some other care groups. With uncertainty regarding the social care budget in the context of cuts across the whole of the public sector, personal budgets for people with dementia will need to be introduced with great care and within the realistic context that resources are limited. The additional costs of brokerage and managing the money need to be considered by the local authority.

Prevention

The strength of evidence around dementia prevention is currently not very strong. However, the evidence that is available suggests that the most promising approach to reducing the prevalence of all forms of dementia is a more general promotion of healthy lifestyles, particularly for those in mid-life. It has been estimated that by promoting and adopting healthy lifestyles in middle age, an individual's risk of developing dementia could be reduced by approximately 20%[v]. Other research suggests that decreasing the prevalence of risk factors including midlife hypertension, poor educational attainment and depression, could have a positive effect on the prevalence of Alzheimer's. American researchers[vi] analysed the strength of the association between these factors and Alzheimer's and showed that cutting down these risk factors by 25 per cent could reduce Alzheimer's cases by 3 million worldwide.

While it is not possible to prevent all cases of dementia, there are some measures that can help prevent vascular dementia, where problems with blood circulation result in parts of the brain not receiving enough blood and oxygen. According to a World Health Organisation report in 2012[vii], research identifying modifiable risk factors of dementia is in its infancy, but prevention should focus on countering risk factors including diabetes, midlife hypertension, midlife obesity, smoking, and physical inactivity.

Evidence also highlights the value of early intervention and diagnosis, as up to two thirds of people and their families are living with dementia unaware of its existence[viii]. Early intervention, both pharmacological and non-pharmacological, can help to slow the progress of dementia and its symptoms. It can also help to better prepare individuals and their families for the future of living with the condition.

Any interventions that could reduce the burden of the condition by preventing or delaying the onset of dementia could not only provide health and well-being benefits to the person with dementia, but to society in terms of reduced carer responsibility and improved productivity, and also the public purse in terms of reduced health and social care costs. This is especially pertinent with regards to an increasing population of older people projected for Halton.

There are a number of local actions being implemented as part of Halton's Sustainable Community, Health and Wellbeing, Mental Health and Loneliness Strategies that are key to tackling both the wider determinants and direct health factors identified in the bodies of research. Whilst it may be not be possible to identify what direct impact this has had on preventing dementia, measures are in place to monitor the effectiveness of the strategies on the general health and wellbeing of Halton residents.

Developing dementia friendly communities

Evidence from the Alzheimer's Society report '**Dementia-friendly Communities:** A priority for everyone'[ix] suggests that many people with dementia do not feel supported and a part of their local area. Findings from a recent Alzheimer's Society and YouGov Poll suggest that:

- Less than half of the respondents to the Dementia Friendly Communities survey think their area is geared up to help them live well with dementia (42%).
- Less than half feel a part of the community (47%). Results become considerably lower the more advanced the person's dementia is.
- People from seldom heard communities expressed complex issues around feeling part of their community. Stigma was particularly highlighted by people with dementia and carers.
- More than half of UK adults surveyed in the YouGov poll feel that the inclusion of people with dementia in the community is fairly bad or very bad (59%).
- Nearly three quarters (73%) of UK adults surveyed in the YouGov poll do not think that society is geared up to deal with dementia.

During the life course of the strategy that accompanies this needs paper, Halton will be working towards becoming a dementia friendly community. That is, a community that shows a high level of public awareness and understanding so that people with dementia and their carers are encouraged to seek help and are supported by their community. Such communities are more inclusive of people with dementia, and improve their ability to remain independent and have choice and control over their lives, contributing to better outcomes for people with a dementia diagnosis, their families and carers.

Key developments since 2009

Raising Awareness

The Alzheimer's Society has developed a range of literature to support a local public information programme drawing on, and aligned with the national campaign and will includes awareness of the risks of developing dementia at a younger age.

The Bridgewater Community Health Care Trust's Live Life Well website is being promoted as a central source of health and wellbeing self help resources, information and links services. There are resources and information relating to dementia contained in the Mental Health Directory on the site.

Consultation tells us that self-help resources, information and links to services will enable individuals, their family and carers to access information at the appropriate time and understand what services are available to them. This may go some way to addressing the sometimes common misconception that there are no, or limited, services to support people with dementia once a diagnosis has been made.

Like Minds Campaign

Halton Borough Council and Halton Clinical Commissioning Group have lead on the development of a local intergenerational anti stigma campaign, 'Like Minds', which was launched on World Mental Health Day 2013. The campaign aims to tackle perceptions of mental health generally, and has a call to action of encouraging people who may be suffering with the early signs of mental health problems to talk (to anyone, not just their GP) to share their concerns, thoughts and feelings and seek help.

The campaign will offer information about where support can be sought and direct people to the information, services and self help resources available from the livelifewell website, managed by NHS Bridgewater Community Health Care.

This campaign targets carers (including carers of people with a dementia diagnosis) and people hwo may be vulnerable to a dementia related illness, who may be at a greater risk of anxiety and depression related mental illness.

Dementia Training

Halton Broough Council has been successful in a recent funding application to deliver bespoke training in dementia via Skills for Care. This project will focus on:

1. Raising awareness of dementia across the whole community, by bringing local people and professionals together in two planned events;
2. Using the Family Carers Matters and People with Dementia Matter courses, life story training will be provided to individuals with dementia and their carers.
3. Sessions will be held with Housing Providers that will include managers and front line staff, one at the beginning (September 2013) and one in March 2014 with a view to establishing a commitment from providers to develop a coherent housing response to the local dementia strategy;
4. Working with local tenants, using the Volunteers Matter course, training will be provided to support them in recognising the needs of people with dementia and enabling them to provide additional support;
5. Develop the skills and confidence of GPs, managers and staff in the Well Being Practices (CCG);
6. Aligning this with our work on re-commissioning domiciliary care, we are offering training, using the Your Story Matters approach, on the value and impact of life story work to underpin a person centred approach to care.

The training will be developed from August 2013 until March 2014.

This training may contribute to the reduction in use of antipsychotic medication (through life story work) and equip professionals and the public with the skills to provide support to people with a dementia diagnosis.

Early Diagnosis and Support

NHS Health Check

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. From April 2013, as part of the NHS Health Check programme, people aged 65-74 are given information about dementia at the time of risk assessment to raise their awareness of dementia and the availability of memory services.

The intention is to raise awareness of memory assessment clinics for those attending an NHS Health Check.

5 Boroughs Partnership Later Life and Memory Service

In June 2013 the redesigned Later Life and Memory Service (LLAMS) pathway was implemented in Halton. Initially a pilot was agreed and this was run in the Wigan Borough until mid-September 2012. The pilot involved re-configuring existing teams and services to deliver the new model for community focussed dementia care.

Preliminary analysis of the Wigan pilot's findings demonstrated that the changes introduced delivered a positive impact upon service efficiencies and the timeliness of response to referrals. That contributed to a positive experience of the new service for Service Users and Carers. Similarly, there is evidence to show that collaborative working between staff and the integration of teams improved the speed with which diagnoses were arrived at, the availability of support for the management of memory problems and an increase in the levels of support provided within community settings. Further detailed analysis will be needed however before firm conclusions can be drawn about the long-term impact of the new model of care and care pathway upon the likely demand for in-patient care. During the pilot period however, there was a reduction in the need for in-patient care, although those requiring it exhibited more complex needs. Similarly, the pilot appears to support the new service model's assertion that increasing the availability of community-based support and the therapeutic approaches of in-patient teams will result in shorter lengths of stay for service users within in-patient care.

The following specific key findings were observed:

The service received between 100-120 referrals each month (in-line with same period in 2011)

- **96% of referrals were non urgent**
- **80% of referrals were seen within the 10 working day target (typically, where the 10 day target was not met this was because of a Service User request for a later appointment)**
- **35% of Service Users were referred onwards to the memory function**
- **30% of Service Users had more complex needs and were referred onwards to the Community Mental Health Team function**
- **35% of the Service Users referred benefitted from the service's short term interventions and were then discharged back to primary care**

- **Of the 60% of face-to-face contacts for which the time of contact was recorded, only 4.5% took place during extended opening hours**
- **In-patient units within the pilot area experienced:**
- **Occupancy levels well below capacity (67.5% on average during the pilot's first 3 months)**
- **a reduction in length of stay per episode (this fell by 8 days to 44.6 over the pilot's first 3 months)**
- **Service Users' self-reported experiences of the service were positive**
- **There were increased levels of collaborative working between Trust teams, and Trust teams & external agencies (local authority and acute Trust teams for example). It appears that increased collaborative working directly contributed to the perceptions of service quality (on the part of Service Users and Carers), and staff satisfaction (by Trust staff)**

A Primary Care pathway has been developed and is now being used. The pathway can be found in appendix 1

The enhanced service has been designed by the NHS Commissioning Board to support practices in contributing to system wide improvements by supporting timely diagnosis, supporting individuals and their carers an integrated working with health and social care partners.

The assessment for dementia offered to consenting at-risk patients shall be undertaken following initial questioning using the 6CIT (Cognitive Impairment Test) to establish whether there are any concerns about the attending patient's memory.

For the purposes of this enhanced service, 'at-risk' patients are:

- Patients aged 60 or over with cardiovascular disease, stroke, peripheral vascular disease or diabetes
- Patients aged 40 or over with Down's syndrome
- Other patients aged 50 or over with learning disabilities
- Patients with long-term neurological conditions which have a known neurodegenerative element, for example Parkinson's disease.

This enhanced service will be reviewed for 2014/15 in light of possible changes to the Quality and Outcomes Framework (QOF) for 2014/15.

The aims of this enhanced service in 2013/14 are to encourage GP practices to:

1. Identify patients at clinical risk of dementia;
2. Offer an assessment to detect for possible signs of dementia in those at risk;
3. Offer a referral for diagnosis where dementia is suspected; and,
4. Support the health and wellbeing of carers for patients diagnosed with dementia.

In Halton, 16 out of 17 GP practices have signed up to the scheme.

Living well with dementia

Community Dementia Care Advisors

A key development since the launch of the dementia strategy is the successful commissioning and implementation of the local Dementia Care Advisors and Dementia Cafés.

The service is delivered in partnership by the Alzheimer's Society and Age UK Mid Mersey, drawing on the learning from the Department of Health National Dementia Advisor pilots to deliver positive outcomes for people living with dementia and their carers. Following consultation days people with dementia and their carers highlighted what they wanted from the service; which included the following

- Provide timely information and advice for the carer and cared for
- Provide individualised and timely practical and emotional support for the carer and cared for
- Improve communication between professionals/services in order to reduce unnecessary service duplication and enhance partnership working

The service has been developed to ensure that individuals are kept informed of their choices throughout the dementia journey so that they do not fall through the net and out of the system which will then prevent them going into crisis.

The service offers a pre diagnosis advice service and post diagnosis support including information, awareness and advice, signposting to services and supports, continued consultation, planning and involvement, as well as supporting the development of peer support, group sessions, self-help/ expert patient approaches, the development of user and carer led services and educational programmes.

In addition the service provides a highly responsive information and signposting support service to people with dementia as the first priority, and to those who support and care for them. The role of Dementia Care Advisor is the key person who is responsible for coordinating all the services available to the service user ensuring that agencies and professionals communicate with each other over the delivery of their services.

The service currently has a capacity of 1,200 face-to-face contacts with service users in Halton per annum. Of these some only require initial support and signposting but others need more comprehensive on-going support and case management and the Dementia Advisor ensures that the service user is navigated through the system to ensure that the whole service available is coordinated with all relevant agencies.

The Dementia Care Advisor service works in partnership with key stakeholders and partner services including primary health care services, primary mental health care, adult mental health, older persons social care services and third sector services. The Dementia Care Advisors although based within Alzheimer's Society and Age UK offices also have a presence within the Later Life and Memory Service locations (currently the Norton Day Unit in Halton).

In June 2013 the Halton Dementia Support service and Dementia Adviser service evaluation questionnaire was sent out to a random selection of 100 service users who have within the current contract engaged with services.

The questionnaire was designed to gain an understanding of how both carers and people living with dementia feel about the service that the society provides to them in relation to both the Dementia Support Service and the Dementia Adviser Service. There was a 52% response rate.

Overall it seems that from questionnaire responses, people who are accessing services from Alzheimer's Society in Halton are happy with the service they receive. It's clear that people feel that they are listened to and treated with respect and dignity. In addition to this people feel that they have received clear and easy to understand information which is useful.

It seems that service users appreciate the different roles that the Dementia Adviser and the Dementia Support Worker offer as some people enjoy the weekly emotional support which the activity groups offer whilst others want the more practical or written information which the Dementia Adviser is able to provide.

It is also clear that the information which is provided upon diagnosis by the Dementia Adviser is more comprehensive than information given by the health service and this information is a lot easier to understand.

"I found that the Dementia Adviser offered more information than any other service we have come into contact with"

"I have enjoyed meeting new people every Friday"

"The Dementia Adviser who visited me was easy to speak to and didn't use jargon"

"The Dementia Adviser involved my mum in all aspects of our meeting. Myself as a carer learned more in the 1.5 hours spent with the Dementia Adviser than I have in the countless meetings with other services"

"More equipment at activity groups to stimulate those with dementia"

"Social outings for carers and people with dementia"

"I would like to attend a course to learn more about my condition"

"I would like half an hour sing-along incorporated into the activity groups"

Needs analysis and business cases are being undertaken during quarter 2 of 2013/14 for further development of the Dementia Care Advisor service, along with Reader Groups and the requirements for a late night dementia respite provision. This will identify where resources could be targeted to ensure the needs of people with a dementia diagnosis and their carers are more fully met.

Advancing Quality Alliance (AQuA)

Halton has committed to be an active partner in the AQuA Living Well with Dementia Programme for 2013/2014 and are working with leaders in the field to develop needs analysis and business cases for dementia provision locally.

This work will contribute to addressing fear and perceptions associated with receiving a diagnosis of dementia by aiding the development of appropriate, seamless services to meet the real needs of people with a dementia diagnosis.

Carers

Research has been undertaken to identify exactly what the key points of intervention for carers are and what types of information, advice and support they require at these junctures[x].

The evidence has highlighted a number of critical points when carers' needs for information, advice and help are particularly acute – and these are also points at which they are likely to encounter professionals and service providers. This means that all professionals and service providers will need to check that carers have the information and advice appropriate for the challenges they are currently experiencing and that they know where to go for further information and advice when future difficulties arise. Failure to recognise carers' needs at these points risks the breakdown of care-giving and the carer's health and other costs for carers and wider society. What is clear from the report is that integration of health and social care information, services and follow up is key to providing a holistic service for the carer. Information provided at the right time, with detail of who to contact for more information is key.

Work undertaken by the Council's Customer Intelligence Unit (Carer's Discussion Groups) highlights the needs of Halton carers generally, in relation to provision of information and support. Often carers of a person with a dementia diagnosis report of receiving too much information in one go, much of which may not be relevant to them or their loved one at the time, or not receiving the much information at all. The role of the Halton Dementia Care Advisor will be key to supporting access to information and assistance in interpreting that information.

Findings from the Carer's discussion groups include:

- Make sure that information about 'Formal' carers groups provided to carers directly and via networks is timely and consistent.
- How can we use current networks and carers to communicate and engage with hidden carers, young carers or those carers who do want / cannot attend meetings?
- Perception of a lack of trustworthy knowledge about specialist conditions / or who to ask for the information
- Listening to carer opinion when discussing health treatment – What about an 'official carer' card – so that professionals can share information with the carer.
- Too much information given / no support / expected to remember everything that was discussed.
- Assessment: lots of agencies and professionals visiting - becomes stressful not knowing who you are talking to person they care for.

Carers Dementia Forum

To better understand the experiences of people caring for those with dementia, the Alzheimer's Society, Council Commissioning Managers and the Customer Intelligence Unit are developing a web based tool whereby Carers can ask questions about and provide feedback on their care to health and social care professionals. It is anticipated that the results of the first round of questions and the usefulness of the tool will be available towards the end of 2013.

Carers will be encouraged to use the forum, accessing timely professional advice and the opportunity to provide feedback, on which services can further develop to meet the needs of those who utilise them.

Carers Assessments

Work is currently being undertaken to streamline the process through which carers are assessed and access direct payments to fund a break away from caring. Once in place the revised arrangements will have a significant positive effect on those individuals who care for people with dementia.

Current Council data shows that 4.9% of carers on the Carefirst system receiving a Direct Payment are caring for a person with a dementia diagnosis.

Dementia Support Service (part of the Positive Behaviour Support Service)

'Active Support' is one approach to increasing engagement, and increasing independence that has received much attention with learning disability populations. This is a system that relies on structured daily activity planning, and graduated levels of support and assistance based on the individual's needs to increase activity. A recent research project in Halton Borough Council's Oak Meadow day service conducted by members of the Positive Behaviour Support Service [xi] found the Active Support approach to be equally as effective with people with dementia. They found significant increases in social interaction, and in domestic, personal care and leisure activities of the service users. Although the greatest statistical gains were found with the most able (most recent onset) service user, more socially significant effects were evident for the person in the latter stages of the illness.

The 'Living Well with Dementia' national strategy objectives identify goals for improving dementia services such as home care, carer support, intermediate care, residential care and end of life care. The work of a Behaviour Analyst has the potential to enhance support in the community and in care settings.

Care at hospital

During 2013 Warrington Hospital was successful in their bid for Dementia Care Scheme funding. The total value of the funding is £1,053,322, which will be used to transform the care environment for patients with dementia in the hospital. Plans for the funding include a redesign of an existing ward at Warrington Hospital and a new garden area to promote relaxation, stimulation and a calmer environment for patients with dementia.

Funding comes from a £50 million fund from the Department of Health for projects that demonstrated how practical changes to the environment within which people with dementia are treated in will make a tangible improvement to their condition.

The projects will form part of the first national pilot to showcase the best examples of dementia friendly environments across England, to build evidence around the type of physical changes that have the most benefit for dementia patients.

Role of the Fire and Police Services

Older people are significantly more at risk from fire and account for higher representation in the numbers of fire deaths than any other group.

- Within the over 80 age group risk increases significantly, particularly for those living alone.
- Males living alone are at greater risk than same age females and therefore at ages below 80.
- The risk of fire related incidents increases with bereavement
- Fire risk will increase as other vulnerabilities and risks affecting independence start to emerge, including those associated with a dementia diagnosis.

Extensive work has been undertaken locally by Cheshire Fire Service in developing their partnership working with Age UK . Briefing and referral information has will be continue to be widely distributed to professionals, landlords and the public detailing fire related advice available for older people, and those with a dementia diagnosis. The Fire Service also provided fire related advice and support to all Care Quality Commission registered providers in the past 12 months.

Cheshire Fire Service currently joint fund two dementia advisors, one in Cheshire East and one in Cheshire West and Chester. These are co-funded with CCG's and Age UK Cheshire but could potentially replicated with a number partners, including Halton.

Working with the Fire Service will form an important part of developing dementia friendly communities

Cheshire Fire Service are exploring 'dementia friends' training for their advocate teams to better meet the needs of people with a dementia service accessing Fire Services.

Cheshire Fire Service are exploring a transition from hospital to home pilot in Macclesfield, and the support that can be offered by the Fire Service to vulnerable older people, including those with a dementia diagnosis. This may provide a learning opportunity for Halton to review how the Fire Service can further support vulnerable people in Halton.

Delivering the Dementia Strategy

Development of a performance dashboard

There are few national and local indicators that expressly measure the impact on people with a dementia diagnosis or carers of people with a dementia diagnosis. Whilst inferences can be made, links are not explicit. In addition, much of the data in the national indicator set is captured annually, and therefore will not make suitable indicators for a 'real time' dashboard.

A performance dashboard is currently being developed by the Halton Dementia Partnership Board to assess progress and improve outcomes for people with a dementia diagnosis and their carers against the 8 Halton Dementia Pledges. Two sources of information will be used to inform progress against improved outcomes. These are:

- Metrics, for example, the diagnosis level in relation to prevalence;
- Qualiative information on the experience of people with dementia, their family and carers

Gap Anaylysis

Providers have told us[xii] that they are increasingly seeing individuals presenting with very complex needs. It has been suggested that there is increasing demand for a number of placements/beds for people that do not require hospital or a specialist placement but need more than the usual residential/nursing care and at times one-to-one care. As the number of older people with increasing complex needs is set to increase, there is some urgency to identifying current and future local need and developing the local market to meet increasingly complex needs. Further exploration between Commissioners and Providers is required.

Work has already been undertaken as part of the Halton's Joint Strategic Needs Assessment that identified the following key issues and gaps in relation to Dementia;

Improving public and professional awareness and understanding of dementia

Gaps include the quantity, quality and frequency of information that is available. There are also possible gaps within information that would support early diagnosis and access to improved community services. In relation to community services there is a gap in specialist knowledge that often leads to people with dementia being unable to access some generic community services and facilities.

Good-quality early diagnosis and intervention for all

There are no designated teams specifically designed to address early diagnosis and intervention. However, this is being addressed through the development of the Assessment, Care and Treatment Service.

Good-quality information for those with diagnosed dementia and their carers

Information is available; however it needs to be consistent, timely and widely available for people with dementia and their Carers.

Development of structured peer support and learning networks

Capacity for the Dementia Peer Support Network will need to be monitored to ensure that there are appropriate levels of service provision.

Implementing the Carers' Strategy

The specific needs of carers of people diagnosed with dementia are addressed in the Carers Commissioning Strategy. However, the additional support needs of carers of younger adults with dementia require further consideration.

Improved quality of care for people with dementia in general hospitals

Plans are being developed to identify a specific lead for dementia in general hospitals**.**

Living well with dementia in care homes

Improved professional training relating to dementia is required.

Improved end of life care for people with dementia

There needs to be greater clarity around direction of service provision and multi-agency working.

Recommendations are already being acted upon through the Dementia Partnership Board Group. This multi-agency group is tasked with implementation of the dementia strategy and is specifically targeting the following areas:

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

Keeping up the momentum

The 'Living well with dementia in Halton Strategy and Implementation Plan' that accompanies this paper outlines key actions to be undertaken during 2013-2018.

Appendix 1 Later Life and Memory Service Pathway

Halton Later Life and Memory Service Pathway for Professionals. September 2013

Click here for NICE Pathway for Dementia Diagnosis and Assessment

Patient undertakes '6 CIT' Test (or other). Link to '6 CIT' questions and scoring:http://www.patient.co.uk/doctor/six-item-cognitive-impairment-test-6cit

Routine bloods and ECGPrimary Care Referral to Dementia Care Advisors

Click here for NICE Pathway for Dementia Specialist Assessment

Referral triaged at single point of access (5BP) Patient offered face to face assessment appointment within 10 days (routine) and 24/48hrs if Urgent
Full Assessment within 6 weeks

- History taking
- Cognitive and mental state examination
- Physical examination
- Review of medication to identify any drugs that may impair cognitive functioning.
- Specialist Interventions

Later Life and Memory Service – New Referral letter faxed to 01925 666641
Tel. 01928 753162

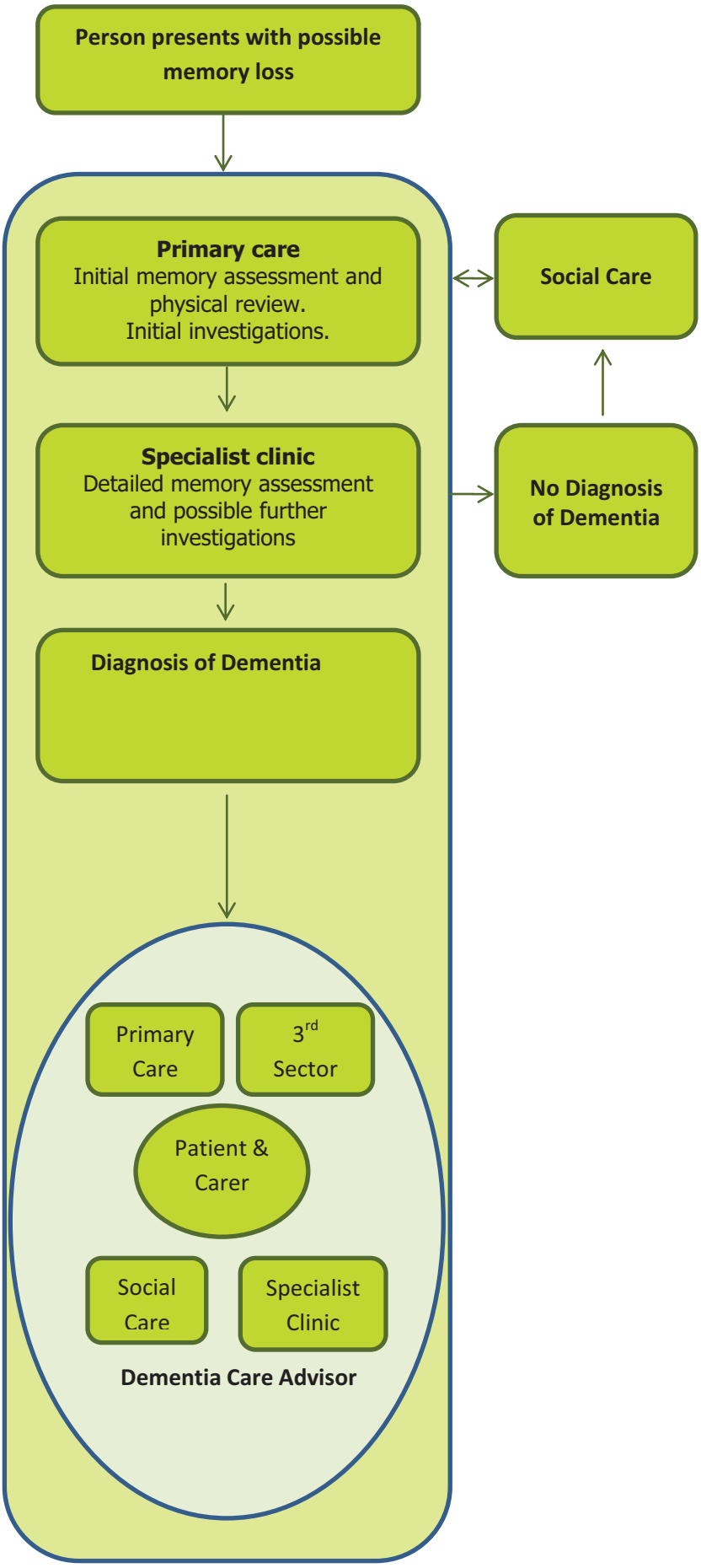
Click here for NICE Pathway for Dementia Diagnosis and Assessment

- Holistic approach
- Brain scan
- Clarify diagnosis
- Prescribe Medication
- Ensure social support

If non dementia diagnosis refer back to Primary Care

Dementia Care Advisors to assist patient and carer to navigate pathway and provide information on services available, including community delivered services Call Alzheimer's Society for referral to Dementia Care Advisors 0151 420 8010

Social care referrals via Later Life and Memory Service Social Care Support Service Pathway



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x. A Road Less Rocky – Supporting Carers of People with Dementia. Carers Trust 2013

xi. Toogood, Doherty & Welch, 2012

xii. Halton Adult Social Care Market Position Statement 2013

REPORT TO: Health and Wellbeing Board

DATE: 15th January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Autism Self-Assessment Framework 2013

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 Autism Self-Assessment Framework 2013.

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

3.0 **SUPPORTING INFORMATION**

3.1 Autism Self-Assessment Framework Government passed the Autism Act (2009) with an accompanying Autism Strategy, *Fulfilling and Rewarding Lives* (2010), with publication of statutory guidance for health and social care and full delivery plan in December 2010. Fulfilling and Rewarding Lives, the Government's vision is that "All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them".

Department of Health – local self-assessment for adults with autism for Local Authority's and Clinical Commissioning Groups – for commissioners to plan how they are going to respond to the statutory guidance.

Events at Winterbourne have highlighted the vulnerability of those with Autism who challenge services. The inappropriate use of restrictive practices, the insufficient skills of staff teams that support individual with Autism.

The purpose of the SAF is to:

- Assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy
- See how much progress has been made since the baseline survey, as at February 2012
- Provide Evidence of examples of good progress made that can be shared and of remaining challenges.

Health Inequalities have been highlighted as a key area that needs to be targeted this includes access to mainstream NHS services:

- Prevention of diseases
- Screening
- Health promoting activities
- Knowing the local Autistic population
- Services available for individuals who are described as having behaviours that challenge services.

3.2 The Autism SAF was submitted on the 30th September 2013 as instructed by the ministerial letter (Appendix B).

The submission was presented:

- To individuals with Autism
- The Autism Strategy Group
- Learning Disability Partnership

The submission will be joint owned by both the Local Authority and Clinical Commissioning Group and is monitored via Autism Strategy Group..

A Joint Strategic Needs Assessment has been completed by Public Health colleagues across the Cheshire and Merseyside Region.

3.3 The Autism SAF has 42 questions based on the below themes. (Appendix A)

The questions focus on specific themes to enable with a comparison to the base line submission in February 2012.

17 questions used a Red, Amber, Green rating this will enable the LA and CCG to focus resources to improve outcomes for individuals.

Key themes Autism SAF 2013

1. Initial questions on local authority area
2. Planning
3. Training
4. Diagnosis
5. Care and Support
6. Housing and Accommodation
7. Employment
8. Criminal Justice Service
9. Optional Self Advocate story - To be completed by individuals with Autism that work with Halton Speak Out.

The Autism SAF 2013 submission

- Red 0
- Amber 5
- Green 12

4.0 **POLICY IMPLICATIONS**

4.1 None

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None

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 captured through the Autism SAF, and support future developments and service planning.

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 and implementing the Autism SAF

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
- Services not meeting the needs of those individuals with Autism.
- Reputation damage for both the Council and CCG if score is poor.

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**

Public Health England

Improving Health and Lives:
Learning Disabilities Observatory

Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

1

Comment

Halton Borough Council and Halton CCG are working together to implement the Autism Strategy. Commissioners from both organisations have clearly defined roles and responsibilities with an overarching action plan to co-ordinate an integrated lifespan approach across Health, Education and Social Care.

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

- [x] *Yes*
- [ ] *No*

If yes, how are you doing this?

Merseyside and Cheshire regional approach to the completions of the Learning Disability and Autism Joint Strategic Needs Assessment, including an easy read version for individuals with Autism and or Learning Disabilities.

Halton and neighbouring Local Authorities took a Mersey region partnership approach to develop the Adult Autism Diagnostic pathway.

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

- [x] *Yes*
- [ ] *No*

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Senior Manager with strategic responsibility for Autism is Paul McWade - Operational Director.

paul.mcwade@halton.gov.uk

Commissioning Manager with operational lead for Autism is John Williams -

john.williams@halton.gov.uk

4. Is Autism included in the local JSNA?

- [ ] *Red*
- [ ] *Amber*
- [x] *Green*

Comment

JSNA -completed as a Merseyside and Cheshire Regional approach led by Local Authority (PH).

Alternative Easy read version developed to ensure individuals with Autism are able to access the information.

Links for reports:

Full report
http://www.liv.ac.uk/PublicHealth/obs/publications/report/94%20HNA%20for%20learning%20disabilities%20FULL%20REPORT.pdf

Summary
http://www.liv.ac.uk/PublicHealth/obs/publications/report/94%20HNA%20for%20learning%20disabilities%20full%20summary%20+%20recommendations.pdf

Easy Read
http://easy-read-online.co.uk/Liverpool-health-observatory.aspx

5. Have you started to collect data on people with a diagnosis of autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Data is manually collected annually.

Social Care recording systems are being updated to capture Autism within assessment documentation.

Diagnostic pathway data is recorded by health colleagues.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- ⊗ *Yes*
- ◯ *No*

If yes, what is

the total number of people?

122

the number who are also identified as having a learning disability?

87

the number who are identified as also having mental health problems?

13

Comment

The data search is a manually collected.

7. Does your commissioning plan reflect local data and needs of people with autism?

- ⊗ *Yes*
- ◯ *No*

If yes, how is this demonstrated?

Halton's commissioning plans reflect the needs of vulnerable or disabled adults, taking into account specific areas such as housing, employment, education and health. services are delivered using a person centred approach .

The Autism Strategy specifically focuses on commissioning services across a lifespan approach for health, education and social care.

8. What data collection sources do you use?

- ◯ *Red*
- ◯ *Red/Amber*
- ⊗ *Amber*
- ◯ *Amber/Green*
- ◯ *Green*

Comment

Data is collected manually, the social care system is being updated to include Autism that will provide a more robust data collection.

Further work is required with GP practices and health coding to truely reflect local population.
The data represents the individuals known to social care.

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

CCG are key partners implementing the Autism Strategy and developing services that meet the needs of individuals with Autism.

10. How have you and your partners engaged people with autism and their carers in planning?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Please give an example to demonstrate your score.

The Autism Strategy Group has informal carers and voluntary sector representation as part of the group providing advice, support and an alternative perspectives to service planning.

The Learning Disability Partnership - People Cabinet - facilitated by Halton Speak Out has individuals with Autism represented on the board this has a direct impact on planning.

The Autism Strategy was written with individuals with Autism and informal carers and professionals.

The Autism diagnostic pathway was developed including individuals with Autism, carers and voluntary sector, this input ensure a service that was responsive to the needs of individuals and carers.

As part of planning the commissioning manager (Autism) will meet with local groups, individuals and informal carers to discuss proposals.

As a result of informal carer engagement an Autism post has been created within the local carers centre funded by the CCG and LA.

A strategic group that is developing housing options for individuals with Autism (and other needs) has representation from informal carers.

The National Autistic Society in 2012 reviewed services in Halton across children's and adults services, the review included meetings with parents and informal carers, individuals with Autism (Children and Adults) feedback from the review has supported on going developments and planning.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- ◯ Red
- ⊗ Amber
- ◯ Green

Please give an example.

Halton Borough Council's Single Equality Scheme for 2013 - 2015. It outlines the action that the Council will be taking to ensure equality of opportunity for all who may use and wish to use the extensive range of services that it provides, including residents of Halton, businesses based and operating in Halton, visitors to the area, and to the existing and potential employees of Halton Borough Council. It is difficult to evidence specific examples to demonstrate wide spread implementation.

12. Do you have a Transition process in place from Children's social services to Adult social services?

- ⊗ Yes
- ◯ No

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

During the young person's annual reviews both the young person's and parental consent is requested as part of the referral process to adult social care.

Transition planning begins when the young person is 14 years of age a multi-agency tracking panel meets quarterly to discuss individuals (14yrs to 25yrs) and facilitate planning, social care (children and adults) mangers meet on a bi-monthly basis to discuss specific cases and ensure a seamless transition.

13. Does your planning consider the particular needs of older people with Autism?

- ◯ Red
- ◯ Amber
- ⊗ Green

Comment

Services are developed based on the presenting needs of individuals as part of the data collection age is considered to inform future developments. The services will be person centred, there is a range of age related provision within the borough that is adapted to the changing needs of those accessing the services. Supported and sheltered accommodation schemes have been developed to provide a range of housing based services with appropriate training provided to staff teams. Autism awareness training is available to providers of services and individual training packages can be provided based depending on the needs of the individual.

Training

14. Have you got a multi-agency autism training plan?

- ⊗ Yes
- ◯ No

15. Is autism awareness training being/been made available to all staff working in health and social care?

- ◯ Red
- ◯ Amber
- ⊗ Green

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

A menu of Autism Awareness training is available. This ranges from e-learning to half-day awareness raising training. The training has been designed and delivered in-conjunction with people on Autistic Spectrum. Training programmes have been delivered to staff working directly with Autism focusing on communication, planning & problem solving.

Halton Speak Out has assisted in the development of bespoke Autism awareness training for the self advocates and LD Partnership - People Cabinet members.

the ASC workforce development Group - monitors and captures the training provided by partners. this identifies gaps in training.

The Autism Strategy has training as part of the overall action plan.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comments

A range of Approach and Communication Training is available to staff, this includes Makaton, Social Stories and Total Communication Training. The Learning & Development Team is currently developing a 4-day programme on Intensive Interaction Training. The Positive Behaviour Team delivers Intervention training focusing on the individuals needs that complements the 2 day Practitioner Training delivered by the local NHS Trust.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- ⊗ *Yes*
- ◯ *No*

Please comment further on any developments and challenges.

The CCG and other health colleagues are key partners in developing the workforce planning.

GP's are informed of national updates via the CCG bulletins. GP have undertaken e-learning via the Royal College of GP's website.

18. Have local Criminal Justice services engaged in the training agenda?

- ⊗ *Yes*
- ◯ *No*

Please comment further on any developments and challenges.

Yes, Cheshire Constabulary have been key partners of the Autism Spectrum Condition Workforce Development Sub Group. Front line police officers have recieved autism awareness training.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Please provide further comment.

There are two established pathways for adults with an agreed process between childrens and adults services for those individuals that are 17 1/2 yrs. old.

1. LD - Autism diagnosis pathway
2. non-LD Autism diagnostic pathway.

Nice guidelines had been considered when the pathway was developed.

GP practices have been made aware of the pathway.

The wait from referral to diagnostic is less than 6 months.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

4

Year (Four figures, e.g. 2013)

2013

Comment

The pathway was developed as part of the Mersey region approach with individuals with Autism, informal carers, health and social care professionals.

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

13

Comment

The pathway was initially piloted in March 2012 and feedback from informal carers and individuals with Autism has been positive.

22. How many people have completed the pathway in the last year?

12

Comment

12 individuals have completed the pathway with a further 3 currently on the pathway.

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- [x] *Yes*
- [ ] *No*

Comment

Developed by the PCT (including LA) the CCG and LA have continued with the diagnostic pathway work, and have ensured both the children's and adults pathways complement each other.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- [ ] *a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis*
- [x] *b. Specialist autism specific service*

Please comment further

Developed by the PCT the CCG have continued with the diagnostic pathway work, and have ensured both the children's and adults pathways complement each The diagnostic pathway are specialists

1. 5 Borough Partnership Model (LD & Autism)
2. Merseycare - Liverpool Asperger's Team (Autism)

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

- [x] Yes
- [ ] No

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

Consent is requested from the individual to complete a referral to social care as part of the diagnostic process, once consent is received a referral is sent to the Integrated Assessment Team for social care assessment.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

There is a range of local services for those individuals that have completed the diagnostic pathway. Services and support include advocacy, carers support via the carers centre, social care assessment of need, education provision. there are several well established support groups including Halton Autistic Family Support (HAFS) and Cheshire Asperger's Parent Support. The Community Bridge Builders team provide support to individuals. Halton Speak Out also have a range of services that individuals can access with a focus on empowerment, self-confidence and promoting independence. Halton Day Service provide a community based service with volunteers learning valuable skills to increase their employment opportunities.

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

60

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

9

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

51

Comment

The data search is a manual search.

Adult Social Care system is being developed to capture Autism.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

◯ Yes
⊗ No

If yes, please give details

Halton Borough Council have an established one stop shop in key locations and contact centre for individuals to contact with any queries.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

⊗ Yes
◯ No

If yes, please give details

All individuals on the pathway are offered a referral to social care that would automatically trigger an adult social care assessment and signposting as appropriate.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

◯ Red
◯ Amber
⊗ Green

Comment

St Helens Advocacy Project (SHAP)
Halton Speak Out

Both providers have their own training programme independent of the Local Authority. Autism training is available to service providers. Halton Speak Out have commissioned specialist awareness training for their self advocates.

specialist support may be requested to enable advocates to fully engage with individuals with Autism

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

◯ Red
◯ Amber
⊗ Green

Comment

Yes all individuals with autism have access to advocacy. there is evidence to demonstrate that advocacy is used on a regular basis by individuals and informal carers.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

⊗ Yes
◯ No

Provide an example of the type of support that is available in your area.

Halton has developed the Community Bridge Building service, this service supports individuals that are both eligible and non-eligible under the Fair Access Criteria.

The service has developed befriending support, social inclusion, links to employment etc. the service continues to work with educational establishments, social care and health services depending on the needs of the individual.

33. How would you assess the level of information about local support in your area being accessible to people with autism?

◯ *Red*
◯ *Amber*
⊗ *Green*

Comment

Halton has a range of service to meet individual needs, from low level preventive services such as the Community Bridge Building Team who provide a befriending service, social inclusion support, independent travel training etc, and other voluntary sector providers. There is an Outreach team that work with individuals with Autism on a case by case basis depending on the needs of the individual, there is a range of specialist services provided by the 5 Borough Partnership NHS Trust and also Halton's Positive Behaviour Support Team. depending on individual needs. supported or specialist accommodation is also available with based on presenting needs, with intensive training provided to support staff.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

◯ *Red*
◯ *Amber*
⊗ *Green*

Comment

The term Autism is not used but vulnerable adults and adults with Learning or Physical Disabilities is a key priority in which those individuals with Autism are captured. There are a range of support housing placements and specialist placements commissioned for individuals with Autism.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

Autism awareness training is linked to needs of the individual. Connexions and Community Bridge Builders are aware of Autism and continue to access employment opportunities for individuals. Halton People into Jobs have a disability advisor as part of the supported employment role that continues to work with employers and individuals. Halton Day Service utilise an employment model within their service delivery to support individuals to learn the necessary skills and also to develop community links, partnership working with a specialist project called BREN has been piloted to increase the employment options of individuals with Autism.

36. Do transition processes to adult services have an employment focus?

◯ *Red*
◯ *Amber*
⊗ *Green*

Comment

Halton Speak Out are commissioned to provide Jigsaws for Jobs a 3 year action plan to support young people through transition to build their skills and confidence, to try a variety of roles within the employment market, Community Bridge Builders work with education establishments to support young people as they are leaving college to access voluntary roles if they need to increase their confidence, or to gain further experience to increase employability chances. Social care plans consider employment and this is captured within the annual social care review where appropriate.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Cheshire constabulary have been key partners in the Autism training sub group they have rolled out a training programme across the Police force.

Autism Attention card has been developed locally by Cheshire Asperger's Parent Support (ChAPS) with the support of all emergency services and Cheshire based local authorities (Halton). Representatives from a variety of CJS meet as part of the CJS Forum Cheshire

National Autistic Society hold an area based CJS forum with partners from Local Authorities, Health Services and CJS service.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

10

Comment

Halton Speak Out worked over a period of months. Starting by looking what was working and not working in A's life and supporting them to think about their future aspirations. A was in the centre of the information gathering. Halton Speak Out also worked with A's family to find out what was working/not working with them. Although A had some positive activities in his life including paid employment but he felt that some of the activities he was involved in were not meeting his needs nor enabling him to move forward. Following these meeting Halton Speak Out engaged with a number of professionals both from social care and welfare rights. A reassessment of the support needs of A was undertaken and a review of benefits was conducted. Halton Speak Out then worked with A to develop a personalized support plan and A recruited a personal assistant to support him to reach his goals/dreams. Being in control of his own service has made a massive difference to A and his family and part his story was recently told in a local newspaper. A s now supported on a regular basis to look at his support plan to ensure his life is moving in the direction he wants and changes are made according to his wishes. These meetings are informal and he choices who he wishes to attend, this ensures he is always the one 'driving' his life forward. On an annual basis Halton Speak Out facilitate A's outcome focused review.
A's employer (Halton Speak out) have been working with a number of training agencies to support A to access training in order to aid his personal development and develop his skills. The training provider has redesigned these courses in order to meet A's and other participants needs. He recently undertook first aid training and will shortly attending an autism awareness course. A has been able to support his employer in understanding the needs of people on the autistic spectrum so enabling them to understand how they should best support others.

Self-advocate story two

Question number

15

Comment

S was employed by Halton Speak Out as a peer advocate, She was specifically employed to work with people on the autistic spectrum, as it was felt she would have a greater understanding of the issues faced by people with autism. Part of her initial assessment was to work with her in identifying her strengths and weaknesses in order to identify her particular training needs. Once this was established S was supported to look at mainstream courses that could possibly meet her needs. She attended various courses/events and along with her line manager she evaluated her experiences. It became evident that often the pace and delivery of these courses/events did not benefit S style of learning. Her line manager worked with her to develop a one page profile that would support S when in work, on training or at an event. To implement these arrangements within the work environment and at events was relatively easy. The hardest thing was to enable S to achieve maximum benefit from any training she was to receive. Working with S her line manager highlighted training priorities with S and then supported the training to adapt their material accordingly. S worked with her line manager to adapt the training booklet that would be used by one of the trainers to make it more accessible for people with Autism. This course when delivered will be, as we understand it the first adapted course for people on the autistic spectrum in Halton. S has said she is happy to evaluate following the course to see if any further adjustments or changes need to be made

Self-advocate story three

Question number

31

Comment

X is a young man on the autistic spectrum and lives at home with both parents Mum tends to X's day to day needs

X was referred to Halton Speak out 3 years ago as his family had limited experiences of universal services as they had only accessed a specialist autistic support group prior to working on the project. Mum had concerns about others supporting her son.
The work with X has enabled him to join the planning for life and jigsaws for jobs projects has included 1:1 sessions with both young person and family at home, school and HSO offices, group sessions with the young person and working directly with all staff and professionals who come into contact with him. He also worked with a peer advocate on a specially adapted course 'Positive You' along with his friends and engaged in a number of creative and fun exercise that enabled the staff from planning for life to build up a clearer picture of the young man's and his future needs.

Staff from Halton Speak Out continued gathered information directly from X over a number of months. and established he had a very clear plan of what he wanted for his future. Halton Speak Out supported him in his meetings keeping his voice central to the process and has continued to work closely with mum regarding her concerns for her son.

From the beginning of this work x has never changed their ideas around their own future that being they would like a paid job in a local supermarket. We have spoken with both children and adult services about a personalised package of support for his work placement and this was passed by children services. Although this has been a long drawn out process with the family it has proven to be successful as mum and x have both learned to trust the facilitators working on this case.
X continues his work placement and still attends regular transition meetings about his future.. He lives with X

Self-advocate story four

Question number

35

Comment

X lives with his parents. He has Asperger's Syndrome. Halton Speak Out first had contact with him around two and a half years ago through our Adult Person Centred Planning Project. At this time, he was at a particularly low point in his life. He had been working with another organisation for a year after his previous work placement had failed, and services were struggling to find him another job. His confidence was low and his anxiety about all this was affecting his family life considerably, especially as his parents health was deteriorating, as they got older.
Halton Speak Out supported him to prepare for his person centred review. Using person centred thinking tools, he thought about his life: what is important to him, how he needs and wants to be supported, things that were working and not working, his gifts, skills and strengths etc. All this was recorded to be presented at his meeting, so those important in his life could help him to move forward. Since his review, he has a paid job and has undertaken a number of voluntary roles within his community

His responsibility has increased and he has achieved some qualifications in management skills. He is an asset at Halton Speak Out and has grown in confidence as part of the team. He makes a full contribution to the team and enjoys being part of it. He will be taking part in training specially designed to be accessible for people with disabilities on autism awareness and he has recently become part of a group looking into a local issue that affects people with a disability.

All this has improved his social life as well. He joined Facebook and all his colleagues are friends. He has also been out on a number of staff social events.
He is continuing to have ongoing support relating to his Asperger's. And support in all issues relating to his future. He is currently working with a member of Halton Speak Out's team in prepare for as review he has asked for to help him thing about his future

Self-advocate story five

Question number

36

Comment

X open to both the jigsaws for jobs and Planning for life project for two years.

It was during the 1:1 sessions with X he told the facilitators he wanted to work in the police force. The facilitator spent many hours working with X determining why this was and it was discovered that the police were a group of people that he respected and who he viewed as instrumental in protecting and safeguarding others.

During his meeting X spoke about his dream of being a police officer however professionals were keen to direct him in another direction.

X had so much to offer and it was clear that further work needed to be done around raising the expectations of those around him

The facilitator continued to work with the young person, family and professionals and it was identified that Halton had a brand new project being piloted within the borough called "Safe in Town". This project was all about keeping the groups thought to be most vulnerable safe. The facilitator approached the project and X was accepted as a work placement on this project. During their time with the project X liaised directly with both Cheshire and Merseyside police and both police forces gave glowing reports for his performance on this project.

X has grown in confidence and now co facilitates his transition meetings. He has spoken at regional conferences about his experience in the hope of encouraging others to think differently about what is possible for young people with autism.

He continues to work on the project and it is expected that should the pilot be commissioned that he will be offered a paid position.

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

15

Month

1

Year

2014

From Norman Lamb MP
Minister of State for Care and Support

Department of Health

To: **Directors of Adult Social Services**

Copied to: **Directors of Public Health**
Directors of Children's Services
Clinical Commissioning Group Leads and Accountable Officers
Chairs of Health and Wellbeing Boards

Richmond House
79 Whitehall
London
SW1A 2NS

Telephone: 020 7210 3000

2 August 2013

Dear Colleague

The 2010 Adult Autism Strategy *Fulfilling and Rewarding Lives:* Evaluating Progress – the second national exercise.

This letter is to obtain your assistance in taking forward the second self-assessment exercise for the implementation of the Adult Autism Strategy. Local Authorities play a key role in implementing the recommendations of the Strategy and the statutory guidance that supports it.

The purpose of the self assessment is to:

- assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;
- see how much progress has been made since the baseline survey, as at February 2012;
- provide evidence of examples of good progress made that can be shared and of remaining challenges.

An on-line return to Public Health England via the Improving health and lives website is required **by Monday 30 September 2013**.

I am sorry that this exercise is to a broadly similar timescale as the one on Learning Disabilities. We had tried to avoid this but with the information

launched in April 2011 to support localities with the delivery of the Adult Autism Strategy and the statutory guidance for health and social care which was issued in December 2010. The individual returns received and related reports from February 2012 can be found at www.improvinghealthandlives.org.uk/projects/autsaf2011.

We hope to get a national overview of local area implementation of the strategy, identify the good progress made with examples of the impact for people with autism where possible and for this to assist the review in developing next steps for the strategy. We are also keen to understand the challenges which may be impacting on progress and local solutions.

The list of questions is more focused than last time but will still enable a comparison with results from the 2012 exercise. For some questions there is a RAG rating system with scoring criteria for that question. If a question is scored Red or Amber, respondents will be asked to say what is stopping progress and for Green scores there will be the opportunity to say what actions have enabled progress. Examples of good practice and where actions have made a positive impact on individuals are also being sought.

It is important to come to a multi-agency perspective, including liaison with Clinical Commissioning Groups, to reflect the requirements of the implementation of the strategy, although the Local Authority is tasked with the consolidation of the return as the lead body locally. The returns will be analysed by the Public Health England learning disabilities observatory. The on-line questionnaire can be accessed at www.improvinghealthandlives.org.uk/projects/autism2013.
Respondents should be aware that all local responses will be published in full online.

Action needed

I would be grateful if you could draw attention to and discuss this letter with the person who is responsible for adult autism within your authority, so that they lead the co-ordination of the return in your area. The timescale for completion of this part of the exercise is **Monday 30 September 2013**.

The response for your Local Authority area should be agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism. I am also asking that you are aware of the content of the return when it is submitted and that it is discussed by the local Health and Well Being Board by the end of January 2014 as

evidence for local planning and health needs assessment strategy development and supporting local implementation work.

Technical detail on how the returns are to be made can be found on the improving health and lives website.

Queries on:

- The Autism Strategy Review itself can be sent to autism@dh.gsi.gov.uk
- Questions on the self assessment exercise can be sent via the ADASS Network e-mail address Team@ADASS.org.uk for the attention of Zandrea Stewart, the ADASS National Autism Lead.

The letter has been prepared with the support of Zandrea Stewart and Sam Cramond (Head of Partnerships, NHS England). A briefing for all Directors of Social Care on the Review will also be sent via the ADASS network. The letter will be circulated to CCGs via the NHS England CCG bulletin on 8 August.

NORMAN LAMB

REPORT TO: Health and Wellbeing Board

DATE: 15th January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Falls strategy

1.0 PURPOSE OF REPORT

1.1 **To update the Board on progress in relation to the implementation of the Halton falls strategy and plans that are in place for the future.**

2.0 RECOMMENDATION: That the Board note the report.

3.0 SUPPORTING INFORMATION

3.1 There is clear evidence on the importance of ensuring that falls prevention and falls care are a high priority within any Local Authority. Halton has a falls rate that is higher than the national average. The hip fracture rate in people over 65 in Halton is 499 per 100,000, this is significantly higher than the national average of 452 per 100,000 people and when you consider that 1 in 3 people over 65 will have at least one fall per year you can see the scale of the problem.

3.2 The Halton falls strategy covers 2013-2018 and aims to address a number of issues that Halton faces including the level of falls, hospital admissions, readmissions and fractures. The strategy identifies 8 key deliverables that form the basis of the strategy:

1. **Develop current workforce training**
2. **Develop a plan for awareness raising with both the public and professionals**
3. **Improve partnership working**
4. **Set and deliver specific targets to reduce falls**
5. **Develop an integrated falls pathway**
6. **Develop a prevention of falls pathway**
7. **Identify gaps in funding of the pathway**
8. **Improve Governance arrangements to support falls**

3.3 **Progress against deliverable 1 – Develop current workforce training**

Specialist falls training has been delivered to 6 members of staff from Bridgewater, this has increased the training capacity within the sector, but has also increased the falls specialist nurse capacity to deliver falls assessment and clinical interventions. A 12 month programme of training for professionals is being developed and will form the substantial part of skilling up the current workforce.
An initial falls awareness session was delivered in January 2013 and a second one

has been arranged for January 13th 2014. These sessions are delivered free of charge by the Royal Society for the Prevention of Accidents (ROSPA). The sessions are for 20 staff and are focussed on raising awareness of the environment. The session next year will be targeted at community groups, voluntary sector, Community safety groups and faith groups who access people's home on a regular basis.

3.4 **Progress against deliverable 2 – Develop a plan for awareness raising with both the public and professionals**

Falls awareness week in July saw a range of activities from dance to slipper exchanges. The week was delivered in partnership between Halton Borough Council, Bridgewater, Halton Housing Trust and Wellbeing Enterprises. 326 people attended at least one event over the course of the week. This is by far the biggest awareness raising event we have conducted in Halton and there is an evaluation report attached at appendix 1. Plans for next year will begin in January and despite the success of this year, it is anticipated that we will run a number of smaller events in different communities, thus taking the message to the public.

3.5 **Progress against deliverable 3 – Improve Partnership Working**

This can be clearly evidenced in the falls awareness work which showed that working across a number of partners could have a bigger outcome. The falls steering group is also working across a number of organisation and is currently working on information sharing protocols to support data collection across Local Authority and Health.

3.6 **Progress against deliverable 4 – set and deliver specific targets to reduce falls**

The strategy identifies 7 separate targets that are designed to measure the effectiveness of the falls interventions in the borough. Some of the data can only be collected on an annual basis and some has not been collected previously, however we can report the following:

- Reported hospital admissions in over 65s due to a fall reduced by 7.7% (target 5%) in quarter 1 (compared to baseline)
- A 31% (target 10%) increase in referrals to the falls service. This has been managed by redesigning the training and increasing capacity in the falls service.
- A 16.6% (target 5%) decrease in readmissions to hospital where the original admission was due to a fall in over 65s.

Although these figures are encouraging more work needs to be completed in relation to screening, care homes, impact of falls and prevention. These figures are the initial performance from quarter 1 and will be reported on a quarterly basis to illustrate progress.

3.7 **Progress against deliverable 5 – Develop an integrated falls pathway**

This was completed as part of the strategy and is currently being finalised ready for rollout across Halton. Part of this process has been to build service capacity and skill

up other areas of the system, which has occurred. As part of the annual review of the falls strategy the pathway will be evaluated to understand its efficacy, this will take place in October 2014.

3.8 **Progress against deliverable 6 – Develop a prevention of falls pathway**

This was also completed as part of the falls strategy and whereas it initially was a stand alone pathway became part of the overall integrated falls pathway as mentioned 3.7.

3.9 **Progress against deliverable 7 – Identify gaps in the funding of the pathway**

This is a piece of work that has not yet been completed, most of the work that has been led by the falls steering group has focussed on building capacity in the existing services by redesigning the current delivery methods. This has been really successful in the short-term, however for the longer term sustainability of the falls work there will need to be more clarity on the financial position in Halton. This will be the priority of the steering group for 2014.

3.10 **Progress against deliverable 8 – Improve Governance arrangements to support falls**

Before the falls strategy was developed falls were not considered separately. The topic was subsumed in other boards and this often meant that they were not recognised as a priority locally. The first step was to establish a falls steering group that has been operational for 12 months and oversees the implementation of the strategy. The strategy has also been signed off through both the Local Authority and Clinical Commissioning Group Management Teams. Finally this update report will be presented to Council members and the Health and Wellbeing Board in early 2014.

4.0 POLICY IMPLICATIONS

4.1 There is limited national guidance in relation to falls although there is a wealth of academic research into the importance of fall prevention and the impact of falls on an individual.

4.2 In terms of National papers, the National Service Framework for Older People 2001 was the last document that specifically mentions falls, however there have been a number of Government documents since then that recognize the importance of falls. For example Healthy lives, healthy people, the Darzi review and the recent Dilnot report.

4.3 In addition there is a specific NICE guidelines on falls that were drawn up in 2004, reviewed in 2011.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 As mentioned above in section 3.9 a separate business case is being developed to assess the gaps in funding to deliver the full pathway. It is important to note that the progress that has been made this year has been due to a successful partnership

approach as there has been no additional resource added to the service area.

6.0 RISK ANALYSIS

6.1 Risks for implementation of the strategy are identified and reported to the falls steering group on a monthly basis.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 No issues identified in the Equality and Impact Assessment that was completed for the strategy.

REPORT TO: Health & Wellbeing Board

DATE: 15th January 2014

REPORTING OFFICER: Strategic Director Children and Enterprise

PORTFOLIO: Children Young People and Families

SUBJECT: Halton Children's Trust Structures from 2014

1.0 PURPOSE OF THE REPORT

1.1 To outline the proposed structures for Halton Children's Trust from April 2014 and update on work on the new Halton Children & Young People's Plan 2014-17 so far.

2.0 RECOMMENDATION: That Board members

1. **note the contents of the report;**
2. **note the structures outlined in 5.1;**
3. **support and comment upon work on the Halton Children & Young People's Plan 2014-17 as outlined in Section 6 and Appendix A.**

3.0 BACKGROUND

3.1 Halton Children's Trust was established in 2008 as the next stage in the development of inter-agency co-operation within Halton. The Trust built on the progress made by the Children & Young People's Strategic Partnership and Alliance Board arrangements.

3.2 The strategic priorities of Halton Children's Trust are agreed for a three year period, alongside the development of each Children & Young People's Plan (CYPP).

4.0 HALTON CHILDREN'S TRUST PRIORITIES FROM 2014

4.1 Following discussions throughout the Trust, all partners represented on the Trust Board have reached an agreement on the priorities from 2014 for Halton Children's Trust, these are:

- Integrated Commissioning
- Early Help & Support
- Closing the Gap

4.2 A working group has been established to meet regularly between November 2013 and March 2014 to develop the new CYPP and progress reports will be brought to each Trust meeting during its development.

4.3 As working titles, and in line with a proposal to link all aspects of the new CYPP to the Halton Children's Trust strapline of 'Working together to make the difference' (see logo above), the full priority statements from 2014 could be as follows:

1. ***Working together to*** deliver services in a joined up way to make sure children and their families get the right help at the right time *(Early Help & Support)*

2. ***Working together to*** plan and fund services for children together, to make sure we deliver high quality services that are value for money *(Integrated Commissioning)*

3. ***Working together to*** focus services towards the needs of our most vulnerable children and young people to *'close the gap'* by improving health and education outcomes

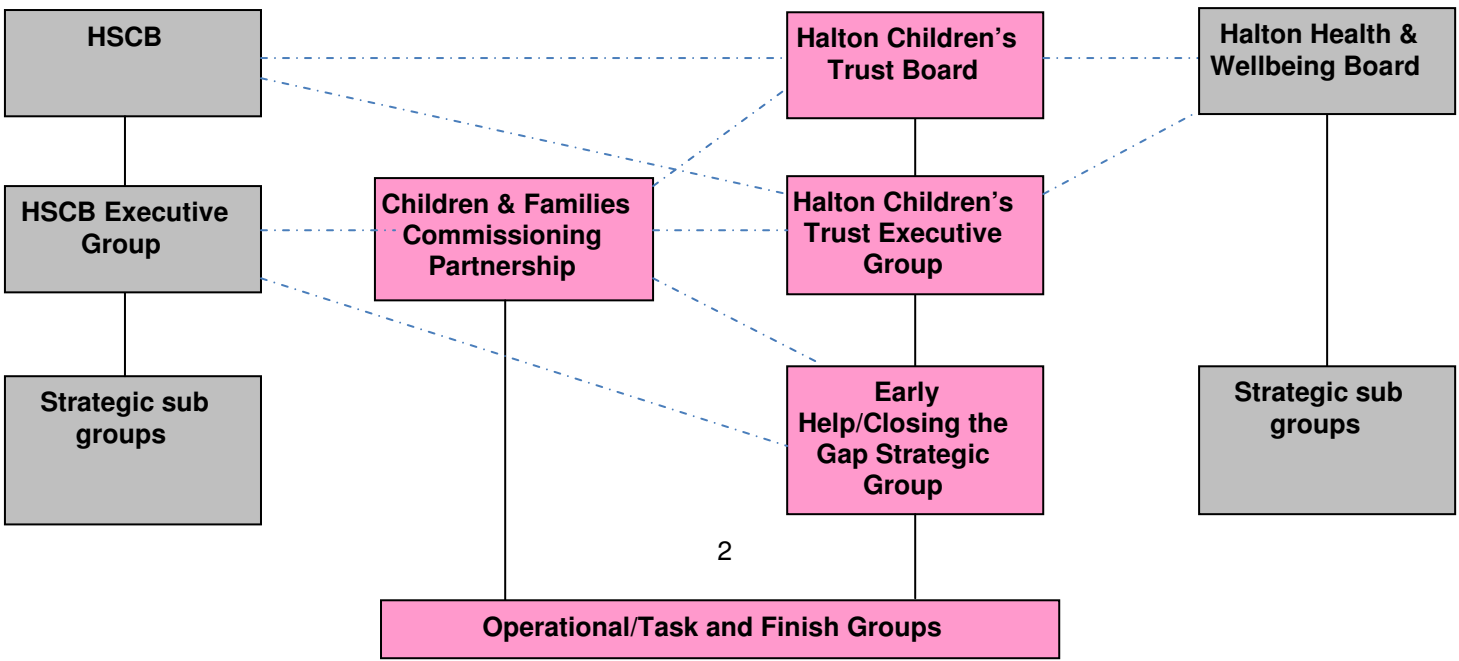
5.0

5.1

HALTON CHILDREN'S TRUST STRUCTURES FROM 2014

5.2 A number of possible options for the future structures of the Trust have been discussed at various meetings in autumn 2013. In October, Halton Children's Trust Executive Group tasked a small working groupk Grady to look at all alternatives and bring possible options back to the Executive at its November meeting. From these, the structures below for the Trust (in pink) were agreed to be implemented from April 2014.

The diagram below shows how, in simple terms, the Trust structures would sit alongside the HSCB and Halton Health & Wellbeing Board, including the two-way challenge as appropriate.



5.3 More detail of the interrelationship across the three can be found in the joint protocol approved by each of the three in September 2013.

6.0 HALTON CHILDREN & YOUNG PEOPLE'S PLAN 2014-17

6.1 Initial draft elements of the Plan as of early December 2013 are attached in Appendix A. As way of explanation of these, the following should be noted:

- Multi-agency working group is meeting fortnightly.
- Each meeting includes an update on progress so far and two topics of focus for the Plan.
- It has been agreed that wherever possible, language will be simplified, the detail is often found in other documents and so the new Plan will be an introduction to the work of the Trust that is accessible to both professionals and other stakeholders. An example of this is included as page 6 of this document (page 2 of Appendix A) in relation to the contextual information on the Trust, Plan and priorities
- The intention is to focus on a web version primarily with a limited number of printed copies for partners on request and for inspection purposes.
- A simple indicative version of how the electronic version of the Plan will work is shown on page 7 of this report (page 3 of Appendix A). The format will allow colleagues to click straight to the information they require from the appropriate section of the Plan.
- Utilising the new Halton Children's Trust site (www.haltonchildrenstrust.co.uk – live from January 2014) gives scope for additional information in some areas. The final two pages of Appendix A provides indicative information on this as an example around data and stats. Previously this has been a single page around the format 'if Halton was a village of 100 CYP'. The new format allows further information to be included, split per priority as per the table and different methods to pictorially capture this will be used, as per page 8 of this report.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children and Young People in Halton

All of the considerations outlined within this report directly contribute to improving outcomes for Children and Young People.

7.2 Employment, Learning and Skills in Halton

The Plan will contribute towards a broad range of aspects of the priority, for example improving educational attainment, skills and maximising employment opportunities.

7.3 **A Healthy Halton**

All of the areas outlined within this report focus on the linkages to improve the health and wellbeing of children and young people.

7.4 **A Safer Halton**

There are close links between partnerships on areas such as alcohol and domestic violence. It therefore remains a key consideration for the Health and Wellbeing Board.

7.5 **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.

8.0 RISK ANALYSIS

Without the agreement of a Plan to outline the work and direction of the Trust, there are risks of duplication, overlap and/or issues disappear through 'gaps' between the partnerships. The agreement of the new Plan from 2014-17 should significantly reduce these risks.

9.0 EQUALITY AND DIVERSITY ISSUES

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

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

Document	**Place of Inspection**	**Contact Officer**
Halton Children & Young People's Plan 2011-14	2nd Floor, Rutland House, Runcorn	Mark Grady

Contact details for more information or to get involved:

Mark Grady
Principal Policy Officer, Children & Enterprise

Tel: 0151 511 7396
Email: mark.grady@halton.gov.uk
Twitter: @HaltonCT

Appendix A – Halton Children & Young People's Plan 2014-17

Proposed CYPP 2014-17 Chapters

- Foreword

Welcome to Halton's C&YP Plan

- What is a C&YP Plan?
- Key focus of the plan
- Introduction to the CT (include vision etc. link to purpose of the plan)
- How we developed the plan (include national context, update since the last plan/you said we did, where we are now & consultation)
- Understanding our community (what is Halton like, successes & If Halton was a village of 100 C&YP)

Our New Priorities in Detail

- Integrated Commissioning (tbc)
- Early Help and Support (tbc)
- Closing the Gap (tbc)
- How will we deliver our priorities?
- How will we measure success?
- Governance Arrangements

Underpinning Processes or Managing Our Services

- List similar to Integrated Processes opposite

Other options for CYPP 2014-17

- Strapline/Catchphrase for Plan e.g. Utilise 'Working together to make a difference'

Welcome to Halton's Children and Young People Plan 2014-2017

What is a children and young people plan?

Halton's Children & Young People's Plan 2014-17 is the main plan for all partners within Halton Children's Trust, and the services they provide for children and young people in Halton. It sets out what we are going to do together to make things better for our children and young people.

What is the purpose of this plan?

This document provides a basis for what we must do together in Halton to ensure that regardless of their circumstances, every child and young person has access to the best services.

Introduction to Halton Children's Trust

What is Halton Children's Trust?

Halton Children's Trust was established in 2008 and is a partnership of all the different people that work with children and young people and their families.

We are the Doctors and Nurses, Teachers, Police Officers, Youth and Social Workers and all other staff children and young people may come across working together to meet the needs of and to make things better for all children, young people and families in Halton.

> *"Halton's ambition is to build stronger, safer communities which are able to support the development and learning of children and young people so they grow up feeling safe, secure, happy and healthy, and ready to be Halton's present and Halton's future"*

Our priorities for 2014-2017 at a glance

The Children's Trust has 3 main areas for improvement over the next 3 years. Our priorities are:

1. ***Working together to*** deliver services in a joined up way to make sure children and their families get the right help at the right time *(Early Help & Support)*
2. ***Working together to*** plan and fund services for children together, to make sure we deliver high quality services that are value for money *(Integrated Commissioning)*

3. ***Working together to*** focus services towards the needs of our most vulnerable children and young people to *'close the gap'* and improve outcomes around health, education, etc.

Indicative Halton CYPP 2014-17 Electronic Home Page

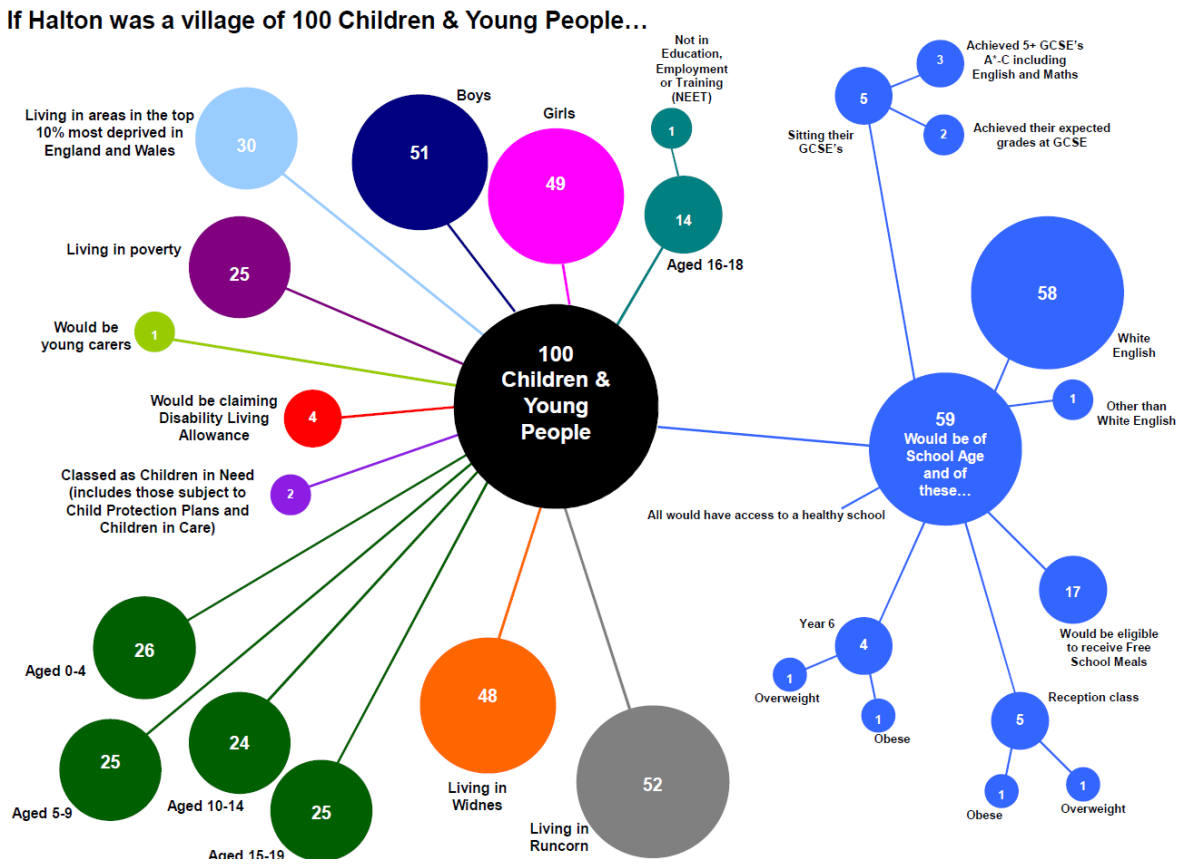
Executive Summary

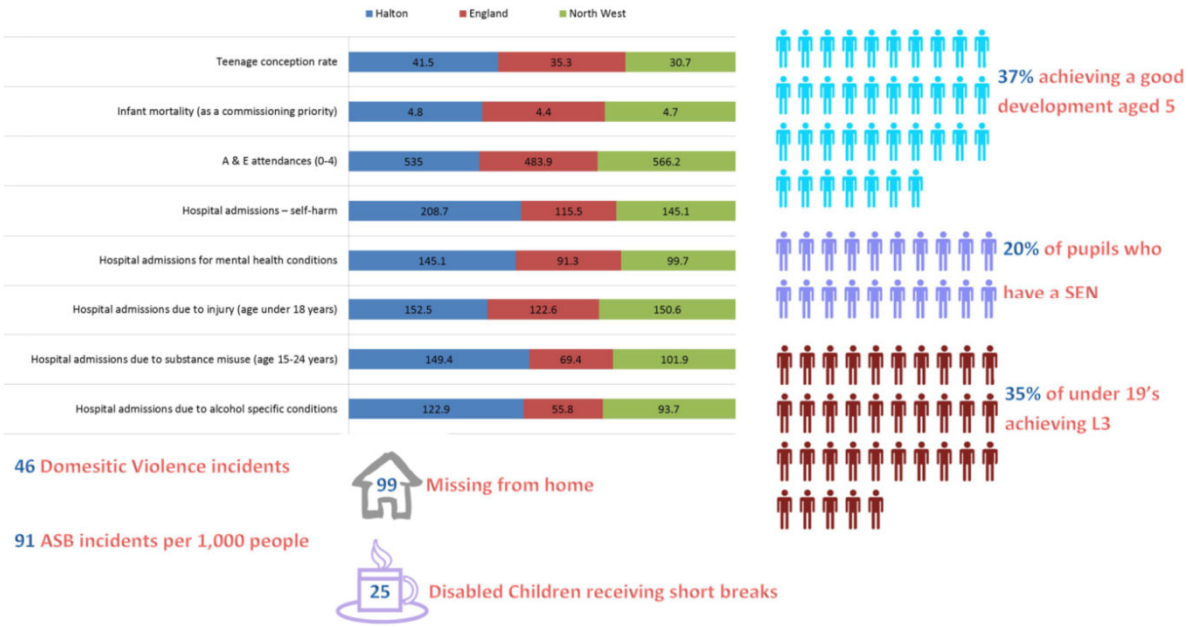
Vision & Priorities

Halton Context

Involve

Information for CYPP Context – If Halton was a village of 100





Overall CYP	**Early Help & Support**	**Closing the Gap**	**Integrated Commissioning**
Child Protection	Initial consultation each month	CiC immunisations	Infant mortality (as a commissioning priority)
Number of CYP 0-19	Family Support Services	CiCOLA	Children achieving a good level of development at age 5
Child Mortality	Number of open CAFs	GCSEs 5 A*-C CiC (Eng and Maths)	Teenage conception rate
GCSE 5 A*-C overall (Eng and Maths)	Low birthweight	NEET	Hospital admissions due to alcohol
Excess weight (4-5)	Smoking in pregnancy	First time entrants into YJ Sysem	Hospital admissions due to substance misuse
Excess weight (10-11)	Breastfeeding initiation	Children living in poverty (u-16)	A & E attendances (0-4)
Population 0-4	Breastfeeding at 6-8 weeks	CiC rate per 10000 (0-18)	Hospital admissions due to injury (u-18)
Population 0-19	EYFS – Good level of development	0-4 living in IMD top 10% most deprived	Hospital admissions – mental health
No. births	EYFS – Comm & Lang	FSM eligible pupils	Hospital admissions – self-harm
Unemployment rate	EYFS – Physical Dev	BME	SEN
Lone parents	EYFS - PSE	No. CiN	Domestic Violence
Incidents with crime	Number of referrals to CSC	No. LAC	ASB
	Vulnerable 2 year olds benefitting from free 2 year old entitlement	No. Child Protection	Disabled Children receiving short breaks
		No of households with 0-4 where dependent on workless benefits	Achieving L3 at 19
		FSM attainment gap KS2	Missing from Home or Care
		FSM attainment gap GCSE	
		FSM Gap L3 at 19	

REPORT TO: Health & Wellbeing Board

DATE: 15th January 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: A Mental Health and Wellbeing Commissioning Strategy for Halton 2013-2018

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To seek Health and Wellbeing Board approval for the adoption and implementation of Halton's integrated Mental Health and Wellbeing Commissioning Strategy 2013-2018.

2.0 RECOMMENDATION: That:

The Health and Wellbeing Board:

i) endorses the Mental Health and Wellbeing Commissioning Strategy 2013-2018.

ii) agrees to receive regular progress updates through the Mental Health Strategic Commissioning Board on progress in delivering the strategy action plan.

3.0 SUPPORTING INFORMATION

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

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

3.2 Mental health problems are the single largest cause of ill health and

disability in the Borough. The Health and Wellbeing Board has recognised this by including "Prevention and early detection of mental health conditions" as one of its 5 priorities. The Health and Wellbeing Strategy 2013-16 includes actions to begin addressing this.

3.3 The Mental Health and Wellbeing Commissioning Strategy embraces the six objectives of NHWMH as the framework to address the challenge of improving mental health and wellbeing in the Borough.

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

3.5 The Mental Health and Wellbeing Commissioning Strategy sets out the strategic objectives and priorities for the next 5 years. An action plan is currently in development on how these will be achieved and resources required.

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

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

3.8 The strategy was considered by Health Policy and Performance Board on 7th January and will be presented to Executive Board on 23rd January. The overview of progress in implementing the strategy will be through the Mental Health Strategic Commissioning Board which reports to the Health and Wellbeing Board.

4.0 POLICY IMPLICATIONS

4.1 This strategy will support progress in delivering the three national

outcomes frameworks locally.

5.0 OTHER/FINANCIAL IMPLICATIONS

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

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The strategy takes a whole life course approach and thus promotes the health and wellbeing of children and young people from birth.

6.2 Employment, Learning & Skills in Halton

Employment is a key determinant of health and wellbeing. The recovery model referred to above encourages individuals to think about work and if appropriate set this as a goal to work towards.

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

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

The primary risk of not implementing this strategy is failure to improve the mental health and wellbeing of Halton citizens.

A full risk assessment has been completed for the Directorate's Risk Register.

8.0 EQUALITY AND DIVERSITY ISSUES

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

An equality impact assessment (EIA) has been completed.

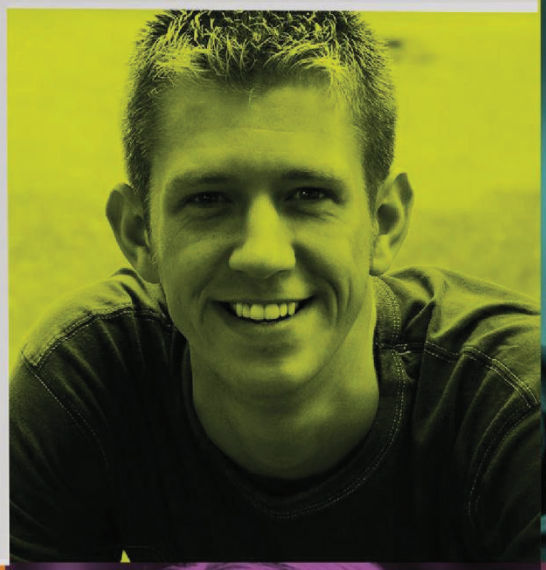
9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

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

A Mental Health and Wellbeing Commissioning Strategy for Halton

2013 to 2018

myhalton
living life well



NHS
Halton Clinical Commissioning Group

HALTON
BOROUGH COUNCIL

Contents

Foreword

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

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

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

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

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

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

Why do we need a mental health strategy?

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

In Halton:

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

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

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

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

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

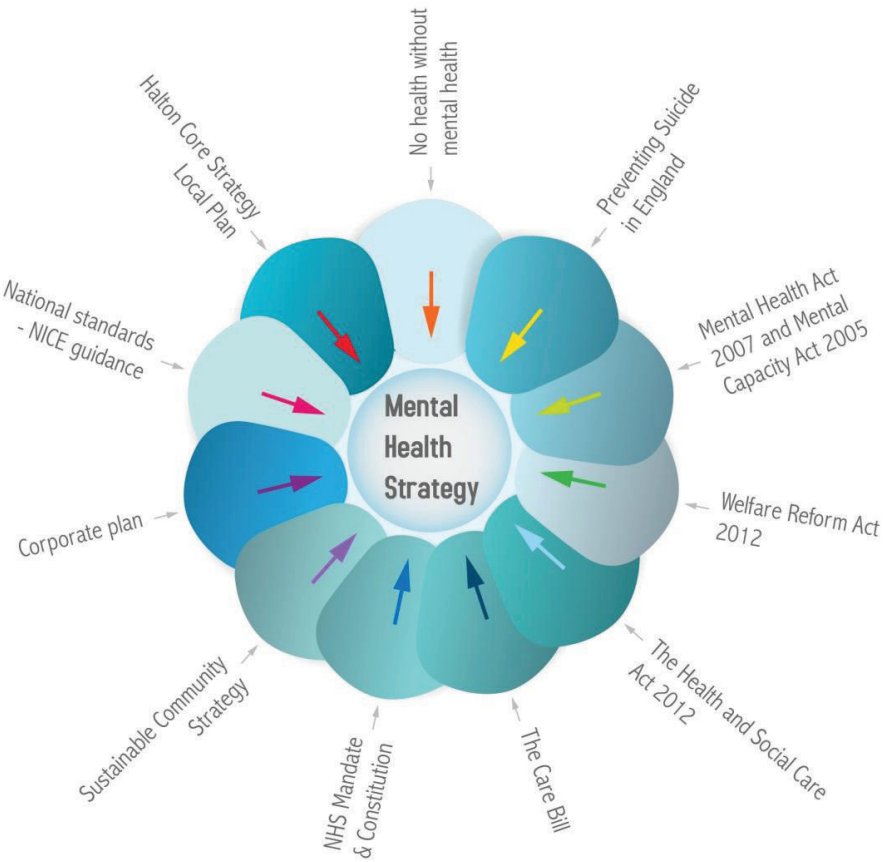
By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does. Only a sustained approach across the life course will equip Halton to meet the social, economic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

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

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

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

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



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

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

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

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

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

Consultation

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

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

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

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

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

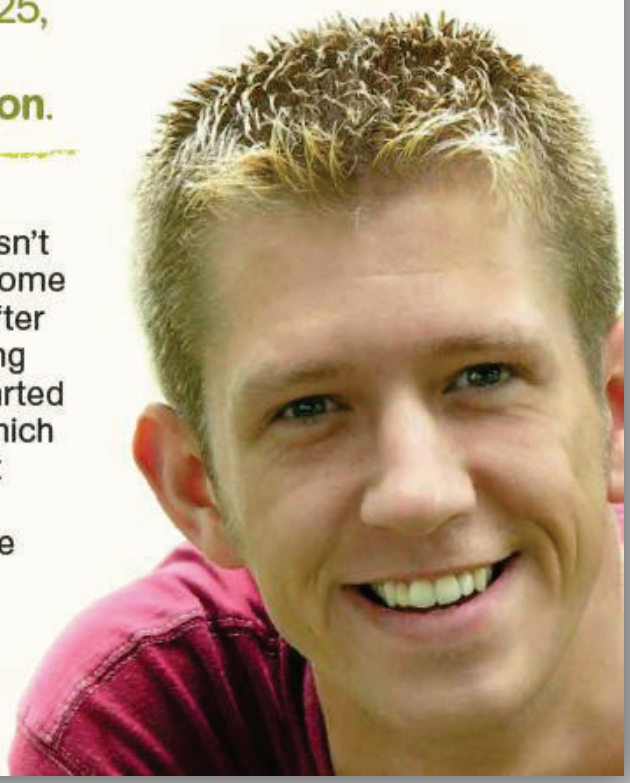
- **Promotion:** Of a healthy lifestyle, healthy eating, leisure and activities to reduce isolation, loneliness and stigma.

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

Like Minds
For better mental health in Halton

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

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



Local Concerns

People

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

Health & Well-being

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

Communities

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

Our vision, objectives and priorities

Our vision for improved mental health in Halton is:

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

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

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

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

(i) More people will have good mental health

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

(ii) More people with mental health problems will recover

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

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

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

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

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

(v) Fewer people will suffer avoidable harm

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

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

(vi) Fewer people will experience stigma and discrimination

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

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

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

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

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

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

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

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

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

This will be achieved by:

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

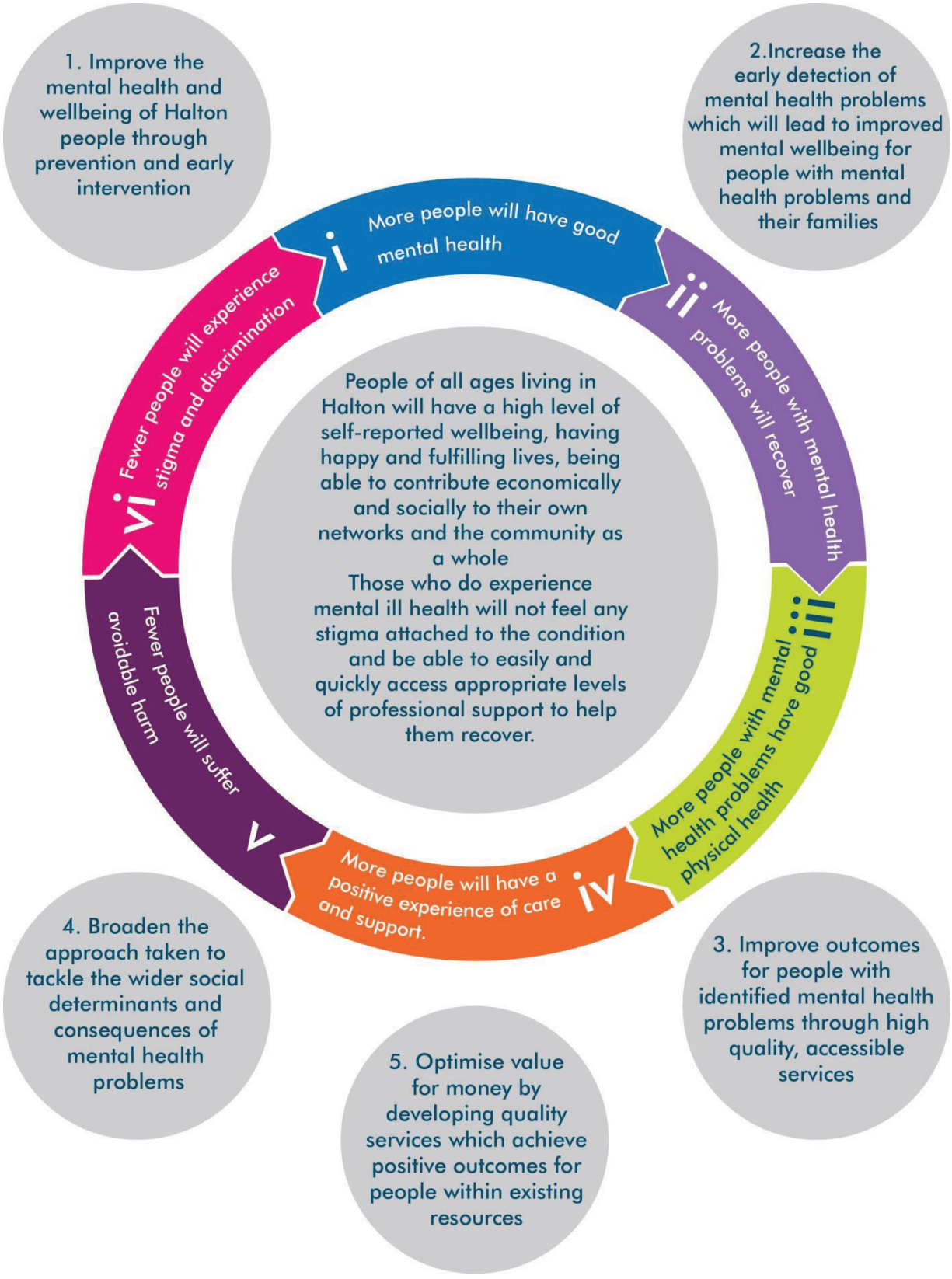
The accompanying evidence paper shows that current investment in mental health services is primarily focussed on long term support and acute care. This is not sustainable against a backdrop of treatment costs expected to double in the next twenty years and the current economic climate.

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

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

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

Our vision, priorities and objectives



Implementing our priorities

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

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

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

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

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

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

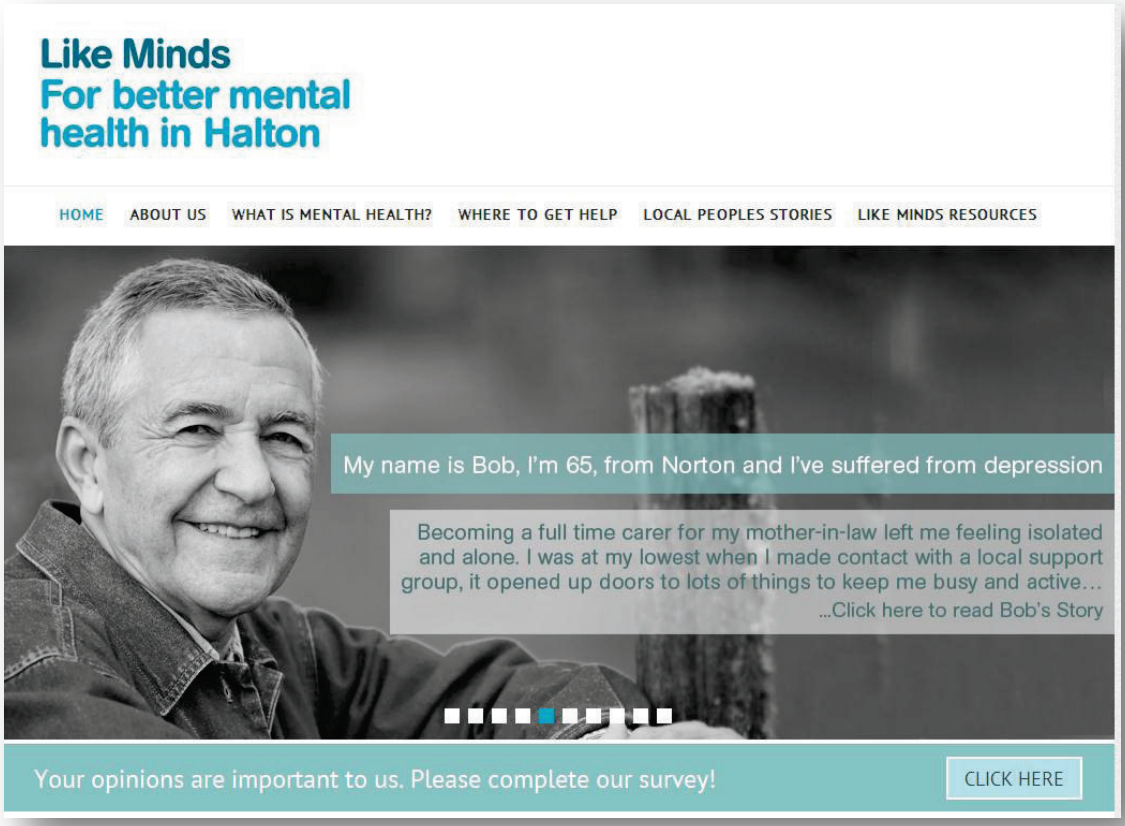
The success of the Strategy will depend upon partnership working in its broadest sense, if we are to achieve the best possible outcomes for everyone who lives or works in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in the delivery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

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

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

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

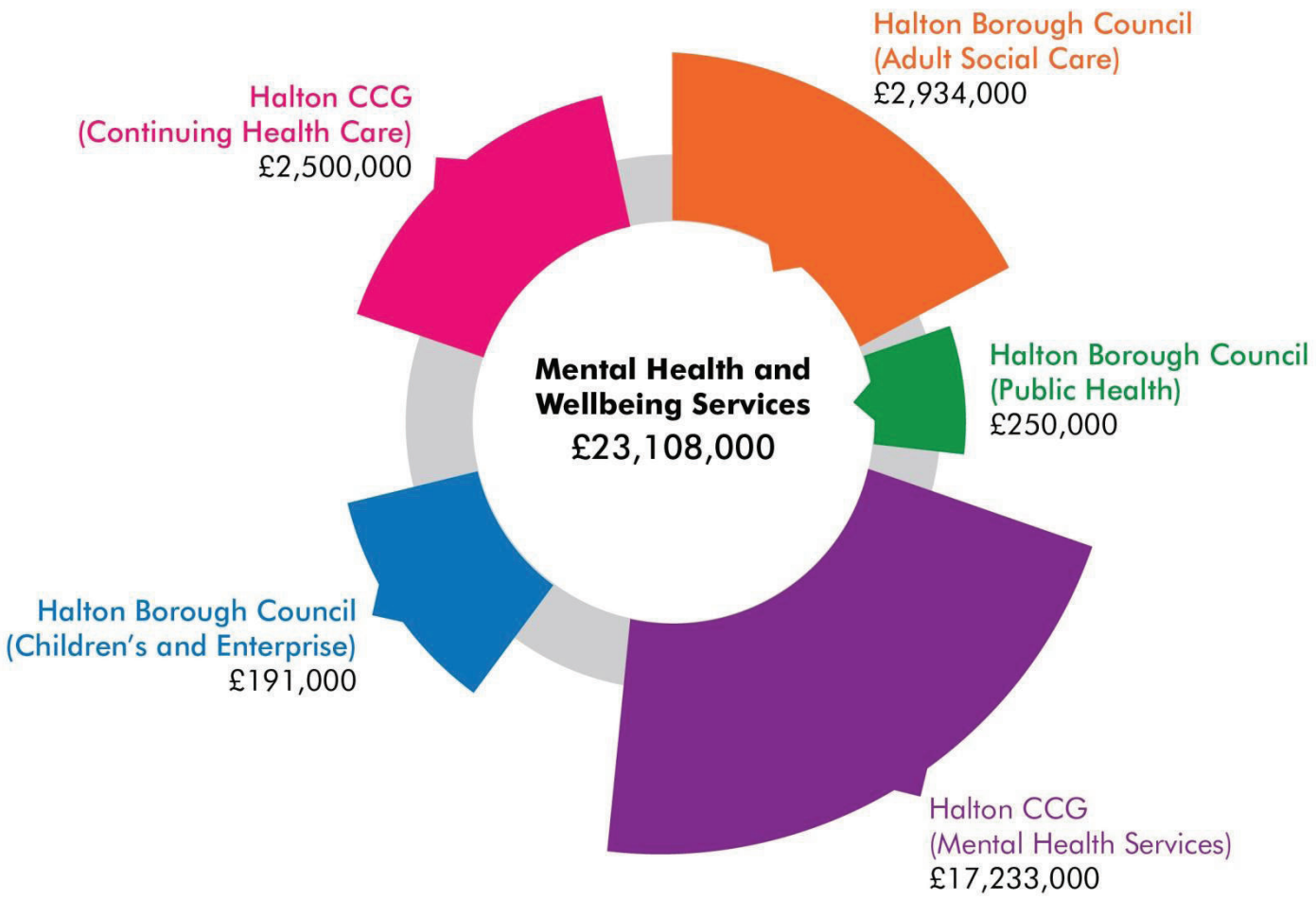
This approach is complemented by the development of the Well Being Practice model by NHS Halton CCG and their commissioning intentions to focus provision around local communities. GP Practices working as part of the Health and Wellbeing Practice approach will seek to deliver a culture change by enabling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



How will it be paid for?

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

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



How will we know if we have been successful?

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

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

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

People with dementia would have good levels of support.

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

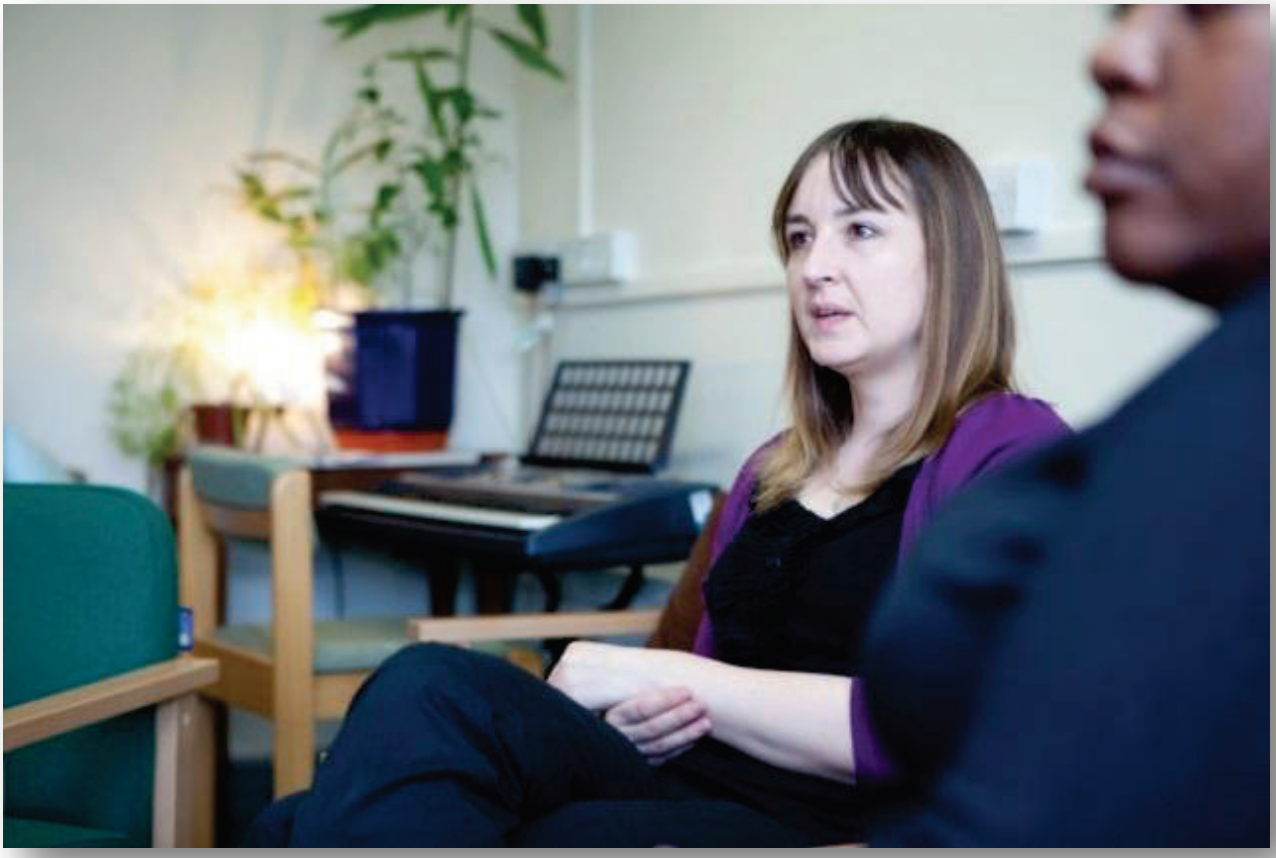
The Overarching Outcome for the Strategy is to improve the health and wellbeing of Halton people so they live longer, healthier and happier lives. This will be achieved by focussing efforts on delivering against the priorities and achieving the five priorities.

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

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

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

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

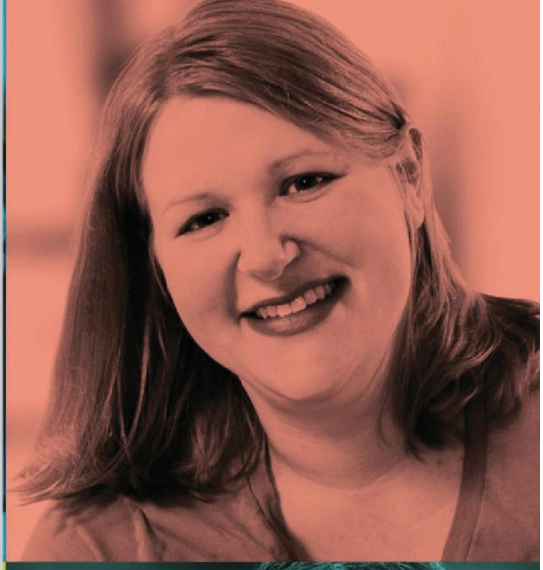


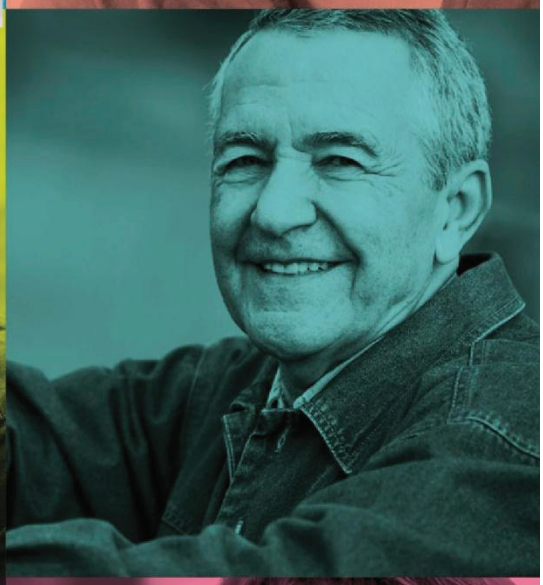
A Mental Health and Wellbeing Commissioning Strategy for Halton

2013 to 2018

Evidence Paper

myhalton
living life well







NHS
Halton Clinical Commissioning Group

HALTON
BOROUGH COUNCIL

Contents

Glossary

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

Foreword

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

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

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

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

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

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

Part One – What are mental health and mental wellbeing?

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

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

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

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

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

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

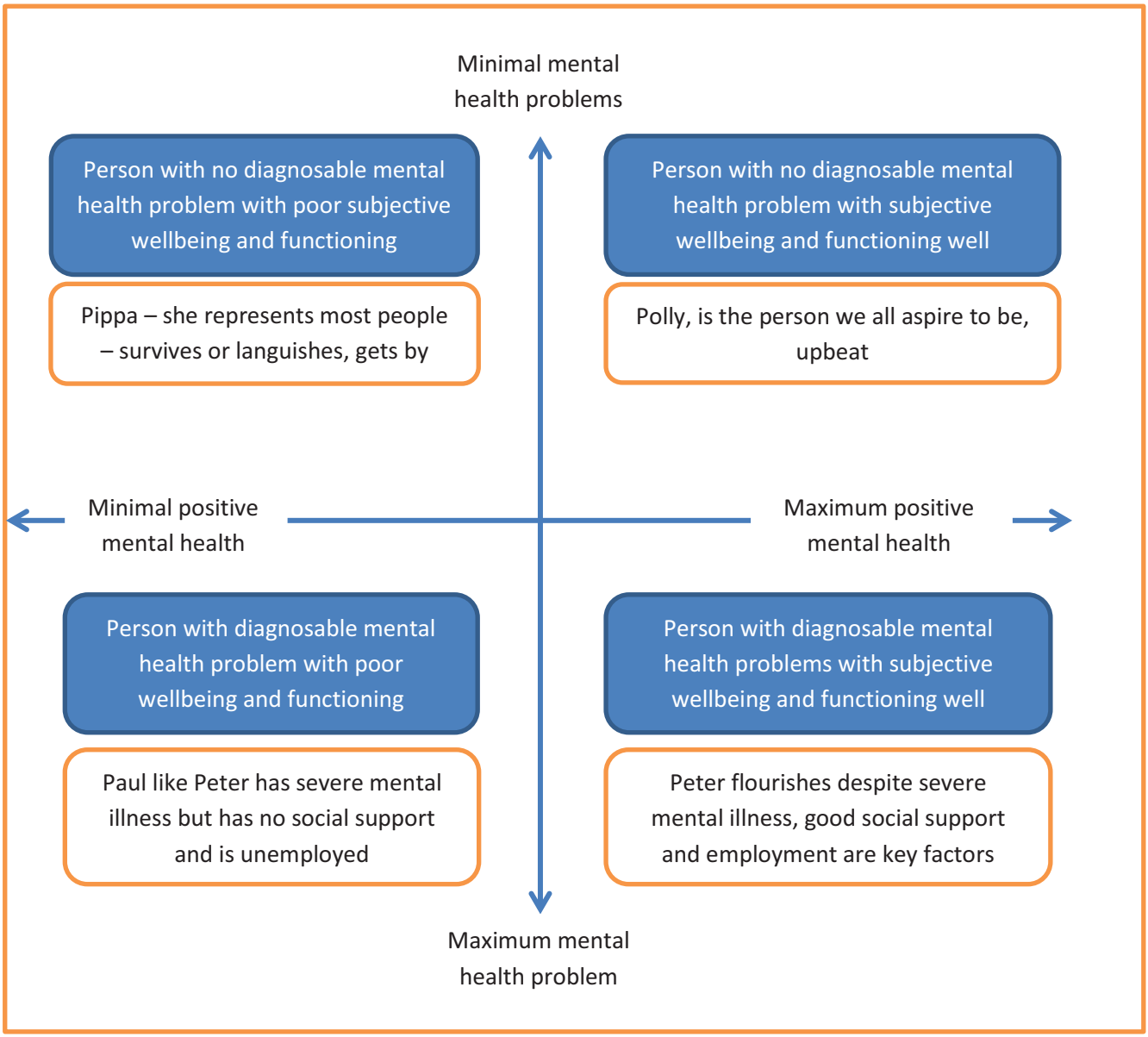
Mental illness is common and is associated with significant individual, social and economic costs. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes. This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

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

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

The Mental Health 2 Continua

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



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

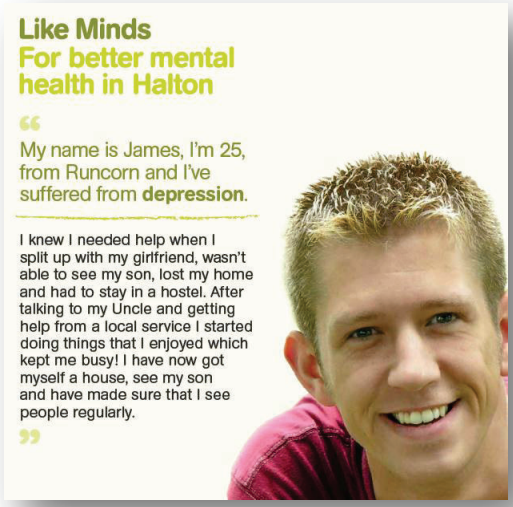
Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.[2]

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

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

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

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



[2] www.fivewaystowellbeing.org

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Welfare Reform Act 2012 and resilience to the economic downturn

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part Three – Mental Health and Wellbeing in Halton

Halton's Vision

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

Halton Core Strategy Local Plan

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

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

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

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

Halton Priorities

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

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

Corporate Plan

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

Health and Wellbeing Board and Strategy

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

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

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

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

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

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

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

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

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

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

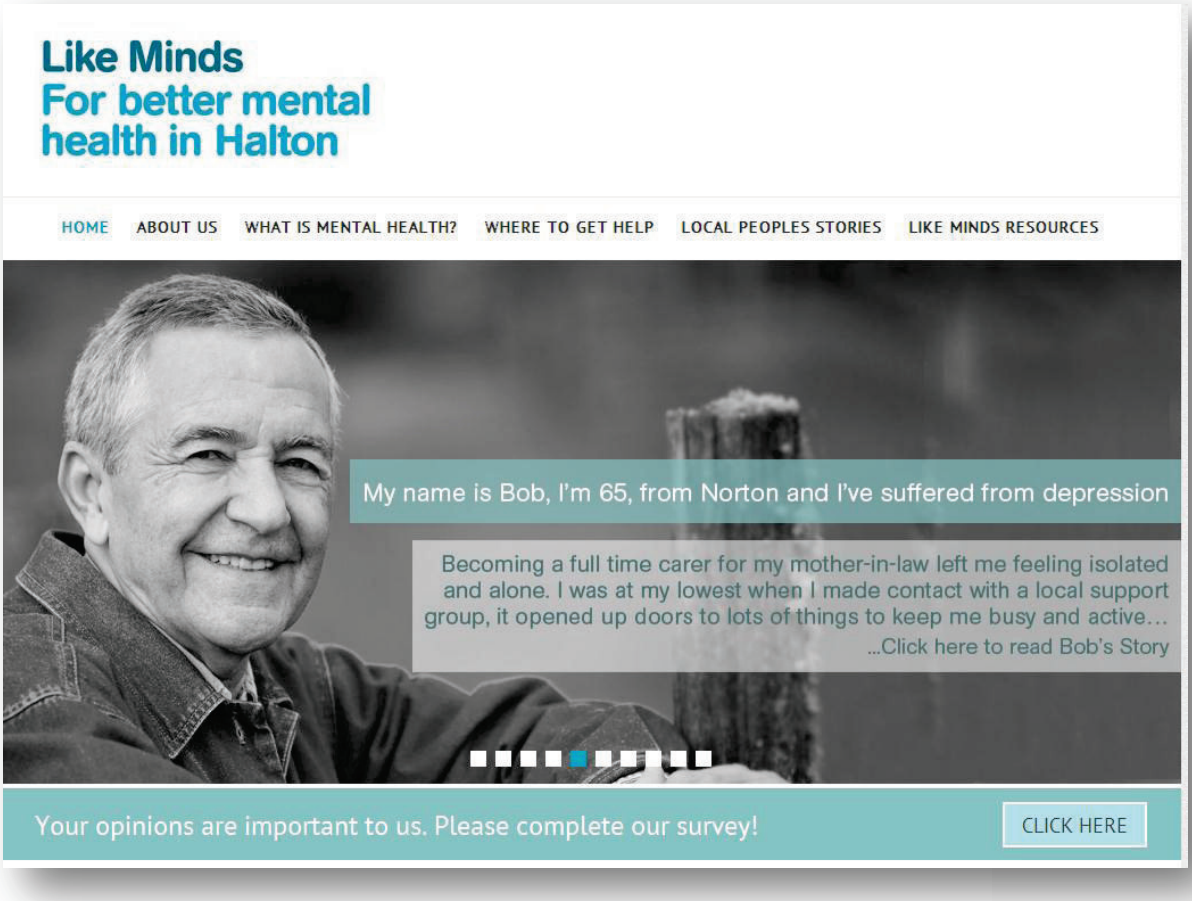
Integrated working

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

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

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

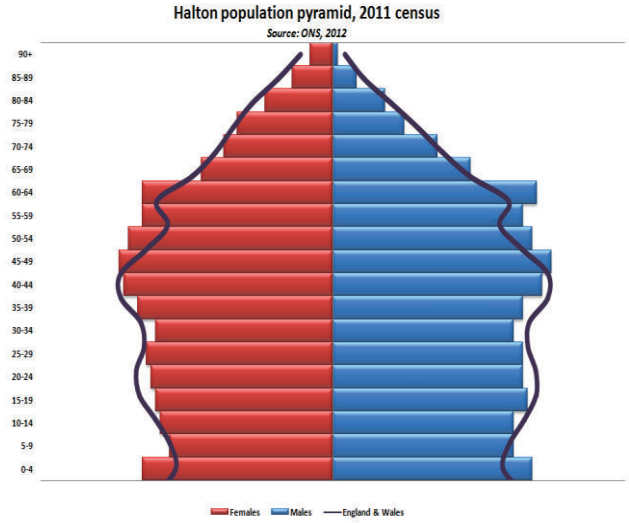
- joint commissioning
- culture change through community development
- training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work

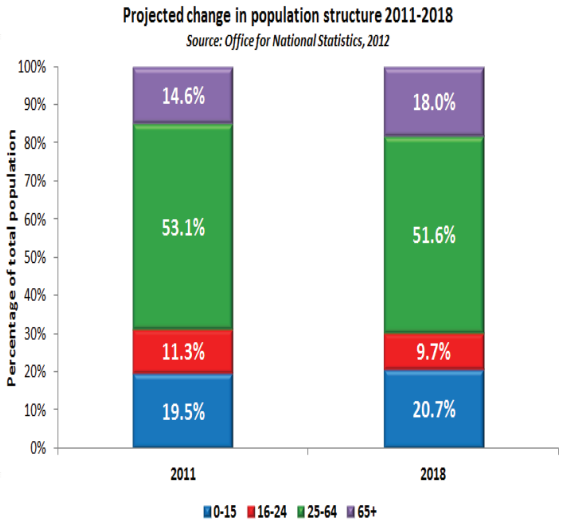


Halton's Demographic Information

Population

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





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

Deprivation

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

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

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

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

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

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

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

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

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

The headline messages conveyed from these analyses are:

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

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

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

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

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

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

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

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

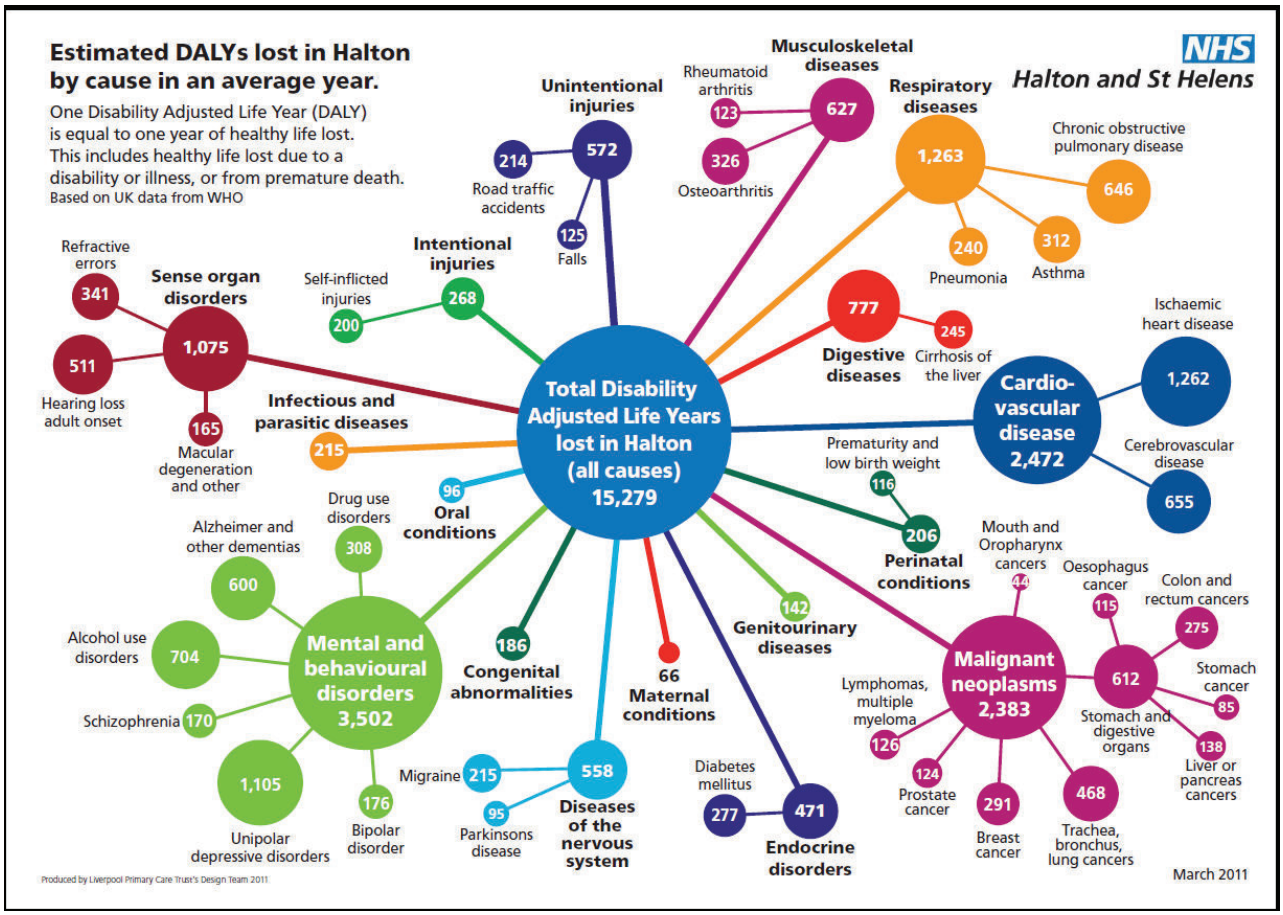
[13] Royal college of psychiatrists (2010) No health without public mental health http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

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

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

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

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



The prevalence of mental illness

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

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

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

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

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

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

Source: Green 2005 & ONS 2012

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

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

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

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

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

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

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

- Depressive episodes
- Obsessive compulsive disorders
- Psychotic disorders

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

Estimated number of children aged 16-19 with neurotic disorders

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

Source: McManus et al 2009 and ONS 2012

Children's emotional and mental health and wellbeing

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

Children with disabilities

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

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

Young people who smoke and drink

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

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

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

* local data

Not in education, employment, or training (NEET)

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

Pregnant teenagers

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

Asylum Seekers, Refugees and Immigrants

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

Gypsy, Roma and Traveller children

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

Young carers

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

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

Children with a parent/carer experiencing mental ill health

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

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

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

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

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

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

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

Self-harm

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

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

Halton Rate per 100,000 population

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

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

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

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

Suicide

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

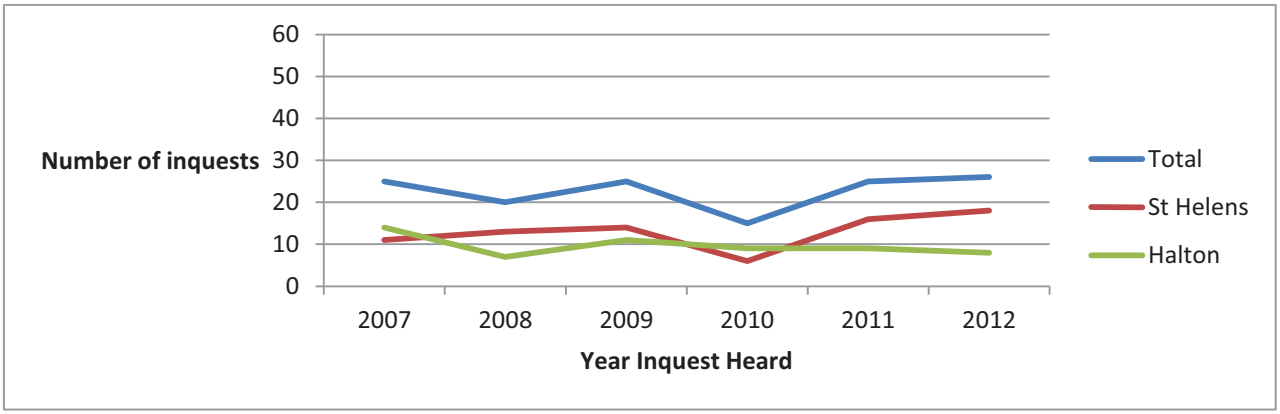
It is known that the circumstances surrounding suicides are complex; however, there are important recurring features. Most people who complete suicide are male (18.2 per 100,000 population vs. 5.6 per 100,000 population), they live alone and often have or have had mental health problems.

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

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

[26] Data from 5BP NHS FT CURT Team

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



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

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

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

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

Dual diagnosis

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

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

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

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

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

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

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

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

Drug use amongst people with mental health problems

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

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

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

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

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

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

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

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

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

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

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

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

Source: PANSI,2013

Mental illness and physical ill health

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

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

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

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

Learning Disabilities and Mental Health

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

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

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

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

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

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

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

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

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

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

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

Autistic Spectrum Disorder

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

People with ASD may experience higher rates of:

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

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

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

Mental health and Wellbeing in Older People

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

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

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

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

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

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

Loneliness and Social Isolation

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

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

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

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

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

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

[44] Holt-Lundstad 2010

National statistics about loneliness:

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

Depression

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

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

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

Physical illness is associated with increased risk of depression:

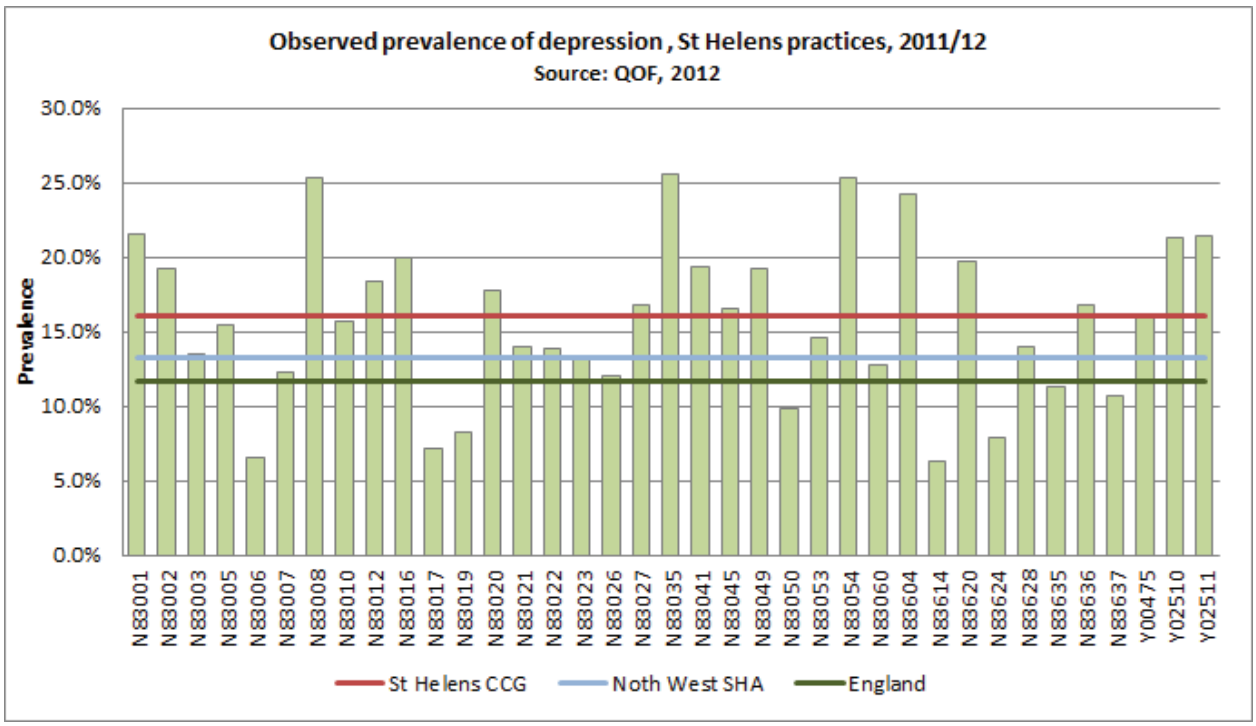
- Depression is three times as common in people with end-stage renal failure, chronic obstructive pulmonary disease and cardiovascular disease as in people who are in good physical health.

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

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

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

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



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

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

Identified risk factors for depression in older people include:

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

Dementia

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

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

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

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

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

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

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

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

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

Ex-Armed Forces Personnel and their families

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

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

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

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

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

Armed Forces Personnel – Community Covenant

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

Mental Health and the Criminal Justice System

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

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

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

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

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

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

Young Offenders

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

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

Youth Offending Services

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

Youth justice liaison and diversion schemes

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

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

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

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

Section 136 – Mental Health Act 1983 – Place of safety

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

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

1. The custody suite should be used in exceptional circumstances only.
2. A vehicle supplied by the ambulance provider should be able to attend promptly so that it is used for conveyance unless the person is too disturbed.
3. The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3 hours in all cases where there are not good clinical grounds to delay assessment.
4. The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act.

[49] **Police Custody as a "Place of Safety":** Examining the Use of Section 136 of the Mental Health Act 1983 http://www.ipcc.gov.uk/sites/default/files/Documents/guidelines_reports/section_136.pdf
[50] Guidance for commissioners: Service provision for Section 136 of the Mental Health Act 1983

5. A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases.
6. Commissioners should ensure that there is a multi-agency group meeting to develop, implement and quality assure the agreed policy. This group should review the monitoring data. It should also consider how the need for use of Section 136 might be reduced

The place of safety is generally a designated NHS resource in the area if the person does not have any additional injury or illness requiring treatment at an Emergency Department. Alternatives include a domestic address - the persons own home or friend a relative's home.

It has been nationally reported that the use of Section 136 has been increasing, placing additional demands on Police, Health and Social Services resources. To gain a greater understanding of how the use of Section 136 was impacting upon resources within the Cheshire Police area an analysis of data from Section 136 assessments completed in 2012 has been undertaken:

Profile of 2012 Section 136 detentions in Halton

- 92 S136 assessments completed
- 61% of detainees were male
- Average age of detainees is 35
- 5 detainees were aged under 18 no detainees were aged 65+
- 62% were classed as unemployed

Place of Safety following detention

	Brooker Centre	Hollins Park	Runcorn Custody Suite	Warrington General Hospital	Other	Unknown
Number	26	7	39	13	5	2
Percentage	28%	8%	42%	14%	6%	2%

In Halton a revised S136 is being drafted. Within the current protocol attendance as described in recommendation 3 above is two hours rather than three. The local designated place of safety was the Brooker Unit at Halton Hospital. Recent redesign of the Acute Care Pathway has centred support at Hollins Park in Warrington leading to more local options being considered. These alternatives are often not the most appropriate and a review of local provision is needed.

Psychiatric Liaison Service - Warrington and Halton Hospitals Foundation Trust and St Helens and Knowsley

Accident and Emergency (A&E) Services are involved with the assessment and treatment of acute illness and injury suffered by patients of all ages including patients with an acute change in mental status. It also addresses the needs of people who have presented themselves to the A&E department rather than seeking help from their GP or directly from local mental health services.

For patients with mental health problems, this might include those who have suffered self-inflicted injuries, or management of patients presenting with acute mental health problems.

A&E Departments have a short stay ward which has the facilities for the temporary observation of patients who have taken minor toxic overdoses, where more thorough mental health evaluation can be carried out following recovery.

Across the Mid Mersey footprint 5BP liaison teams carry out the assessment and management of care of identified patient within AED. The service aims and Objectives are:

- To ensure that people attending the A&E Department who have mental health needs have them addressed and receive the psychiatric care or social support required or arranged to improve their physical and psychological wellbeing.
- Improve the quality of care provided by A&E staff to mental health service users by improving their knowledge and skills regarding common psychiatric conditions.
- Conduct Risk Assessments for self harm and harm to others.
- Provide brief interventions and advice to people who present with self harming behaviour and arrange for referral to primary care or specialist mental health services depending on risk and severity.
- To provide specific advice to people with depression, anxiety or other mild to moderate mental health problems.
- Provide signposting to appropriate mental health services following discharge from A&E.
- Provide support and advice to the acute general hospital staff for people with physical health problems caused by alcohol or substance misuse that are not linked into appropriate services for these conditions.
- Support people with complex behaviour patterns requiring interventions under the Mental Health Act 2007 and Mental Capacity Act 2005.
- Conduct Mental Health Act and Mental Capacity Act Assessments.
- Provide expert advice regarding capacity to consent for medical treatment in complex presentations.

Physical Health Care

- Physical health needs other than the reason for A&E attendance should be assessed at the same time where possible and action and/or advice given if indicated. Assessing and addressing the physical health needs of the service user should be given a high priority particularly those people on anti-psychotic medication.

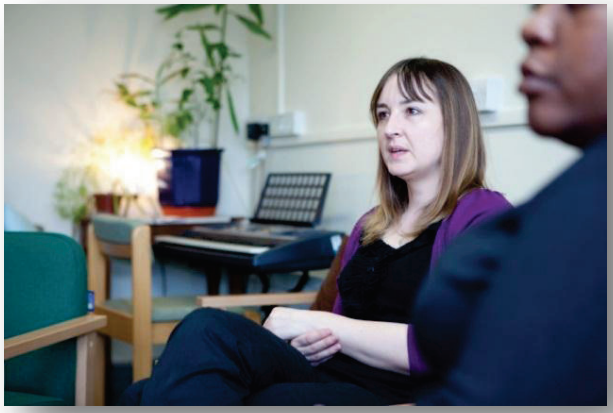
- Opportunity taken to address physical health promotion such as improving lifestyle where the presenting problem is likely to affect the patient's physical health. E.G. diet, smoking, alcohol consumption, breast, bowel and cervical screening.

- Activities should be recommended to improve diet, nutrition; substance misuse, sexual health, smoking cessation, and exercise will be facilitated and encouraged. This service should also encourage access to dental and optical examinations and flu vaccinations where appropriate.

- Where the patient's mental state allows, the assessment/ liaison service will also address the adequacy of housing needs and where appropriate service users employment and accommodation status should be assessed and action taken to signpost to appropriate agencies for assistance. This information will be shared with other mental health services when signposting to them.

Future redesign should include:

- Development of arrangements for Section 136 including liaison suite and wet rooms
- Review and manager of Section 12 (mental health act trained) doctors
- Continued review of both Psychiatric liaison service and its impact and potential redesign to meet local need
- Review of assessment team activity and links to Acute Care Pathway
- Mental health capacity assessments
- Ward liaison



Personality disorder

Personality disorder typically occurs in adolescence, though it may start in childhood, and continues into adulthood. It is a condition in which an individual differs significantly from an average person in terms of how they think, perceive, feel or relate to others. These changes in feelings and distorted beliefs can lead to odd behaviour which can be distressing and upsetting to others. Those experiencing personality disorder are known to encounter significant social exclusion which impacts on demand for health, social care and other public services.

It is estimated that 1 in 20 people have a personality disorder. For many this is mild and they may only require help at time of stress e.g. bereavement. Nationally hospital admissions 2009-10 suggest 70% of inpatient personality disorder cases are diagnosed in females. Borderline and Histrionic Personality Disorder are more common among females whilst Antisocial and Obsessive Compulsive Personality Disorder are more commonly diagnosed among males.

With help many people can lead a normal and fulfilling life and for those with mild to moderate personality disorder access to psychological (talking) therapies can be an effective alternative to medication. Research[51] suggests that progress in recovery is a continuum of co-existing support drawing on crisis support, therapy services and social inclusion development with an emphasis on human interaction rather than drug treatment. Working in groups alongside people with similar problems can be very helpful. Therapeutic Communities have traditionally been residential settings but alternative service user-led networks are developing using web-based messaging as well as face-to-face meetings.

Carers

Carers are key partners in the service user's journey through mental health services. The Triangle of Care: Carers Included: A Guide to Best Practice in Mental Health Care (Carers Trust 2013) sets 6 standards to engage with carers creating an inclusive attitude where they are listened to and consulted more closely. Commissioners will ensure local service provision adopts these standards for engagement within working practices.

In the North West it is estimated that 17% of the adult population over age 16 are carers while only 7% are known to services. Carers themselves are at increased risk of developing mental health problems particularly anxiety and depression. Halton Carers Action Plan June 2013 is owned by the Halton Carers Strategy Group and sets four key objectives for offering support to those in a caring role to alleviate some of the pressures experienced and enable carers to maintain their own health and emotional wellbeing:

[51] A Recovery Journey for People with Personality Disorder (May 2013, The Institute Journal of Psychiatry)

- Supporting those with caring responsibilities to identify themselves as carers at an early stage
- Recognising the value of Carers contributions and involving them from the outset both in designing local care provision and in planning individual care packages
- Enabling those with caring responsibilities to fulfil their educational and employment potential
- Personalised support both for carers and those they support enabling them to have a family and community life
- Supporting carers to stay healthy and well

Promoting Equality and Reducing Inequality

No health without mental health and the Marmot Review place emphasis on tackling health inequalities and promoting equality. Marmot showed that, among other factors, poor childhood, housing and employment (and also unemployment) increase the likelihood that people will experience mental health problems and that the course of any subsequent recovery will be affected. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

Aspects of people's identity and experiences of inequality interact with each other, for example people from black and minority ethnic (BME) groups are more likely to live in deprived areas and have negative experiences, both as a result of their ethnic identity and because of their socio-economic status and living environment.

It is important to work with local communities when developing services, facilities and resources to ensure that they promote equality through the inclusion and equitable treatment whilst eliminating discrimination, advancing equality of opportunity and fostering good relations within communities without disadvantaging people as a result of any of the nine protected characteristics under the Equality Act 2010[52]

People with some of these characteristics for example disabilities, Lesbian, Gay Bisexual and Transgender people and those from BME groups, may already face significant challenges to their resilience and wellbeing as a result of stigma, discrimination and other issues. It is therefore all the more important that they are able to access appropriate services, leisure facilities and other activities to promote wellbeing and resilience.[53]

[52] These can be found at: https://www.gov.uk/discrimination-your-rights/types-of-discrimination

[53] Building Resilient Communities: Making every contact count for public health (August 2013 Mind, Mental Health Foundation)

- People from Black and minority ethnic groups are nearly three times more likely to attempt suicide
- The risk of suffering from depression and anxiety disorders is about twice as high for lesbian, gay and bisexual people.
- Rates of depression among those with two or more long term physical conditions are almost seven times higher than in the rest of the population.

No heath without mental health identifies three aspects to reducing mental health inequality:

i. tackling the inequalities that lead to poor mental health;

ii. tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and

iii. tackling the inequalities in service provision – in access, experience and outcomes.

Whilst tackling inequalities in service provision is addressed through delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers, so that they have more control over the support they receive.

Stigma and Discrimination

People with mental health problems say that the social stigma attached to mental ill health and the discrimination they experience can make their difficulties worse and make it harder to recover. [54]

Mental illness is common as already evidenced it affects thousands of people in the UK, and their friends, families, work colleagues and society in general.

Most people who experience mental health problems recover fully, or are able to live with and manage them, especially if they get help early on. But even though so many people are affected, there is a strong social stigma attached to mental ill health, and people with mental health problems can experience discrimination in all aspects of their lives.

Many people's problems are made worse by the stigma and discrimination they experience – from society, but also from families, friends and employers.

[54] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stigma-discrimination/

Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives.

We know that people with mental health problems are amongst the least likely of any group with a long-term health condition or disability to:

- find work
- be in a steady, long-term relationship
- live in decent housing
- be socially included in mainstream society.

This is because society in general has stereotyped views about mental illness and how it affects people. Many people believe that people with mental ill health are violent and dangerous, when in fact they are more at risk of being attacked or harming themselves than harming other people.

Stigma and discrimination can also worsen someone's mental health problems, and delay or impede their getting help and treatment, and their recovery. Social isolation, poor housing, unemployment and poverty are all linked to mental ill health. So stigma and discrimination can trap people in a cycle of illness.

The situation is exacerbated by the media. Media reports often link mental illness with violence, or portray people with mental health problems as dangerous, criminal, evil, or very disabled and unable to live normal, fulfilled lives.

Research shows that the best way to challenge these stereotypes is through first-hand contact with people with experience of mental health problems. A number of national and local campaigns are trying to change public attitudes to mental illness. These include the national voluntary sector campaign Time to Change and Halton's social marketing campaign Like Minds.

The Equality Act 2010 makes it illegal to discriminate directly or indirectly against people with mental health problems in public services and functions, access to premises, work, education, associations and transport.

Part Four – Outcomes Frameworks

Outcomes Frameworks 2013/14

Outcome measures provide a description of what a good mental health system should aim to achieve, as well as a method of checking progress against achieving these aims. All three of the Outcome Frameworks – Public Health[55], NHS[56], and Adult Social Care[57] contain objectives related to mental illness, with several of the outcomes being shared across outcome frameworks. This close alignment reflects that in order to improve the wellbeing of communities and to improve outcomes for individuals with a mental illness all three sectors must play an effective role.

The 3 outcomes frameworks 2013/14

Public Health Outcomes Framework	NHS Outcomes Framework	Adult Social Care Outcomes Framework
1. Improving the wider determinants of health		
2. Health improvement		
3. Health protection		
4. Healthcare public health and preventing premature mortality	1. Preventing people from dying prematurely	
	2. Enhancing quality of life for people with long term conditions	1. Enhancing the quality of life for people with care and support needs
		2. Delaying and reducing the need for care and support
	3. NHS Outcomes Framework	
	4. NHS Outcomes Framework	3. Ensuring that people have a positive experience of care and support
	5. NHS Outcomes Framework	4. Safeguarding adults who are vulnerable and protecting them from avoidable harm

The detailed indicators relating to Mental Health and Wellbeing are summarised below along with the outcomes they contribute to:

[55] Available from: http://www.phoutcomes.info/
[56] Available from: https://www.gov.uk/government/publications/nhs---outcomes---framework---2013---to---2014
[57] Available from: https://www.gov.uk/government/publications/the---adult---social---care---outcomes---framework---2013---to---2014

Mental Health and Wellbeing Indicators and outcomes framework domain

Indicators in italics are placeholders pending development or identification

National Indicators	NHS	Public Health	Adult Social Care
Excess under 75 mortality rate in adults with serious mental illness	1.5	4.9	
Proportion of people feeling supported to manage their condition	2.1		$
Health related quality of life for carers	2.4		1D
Employment of people with mental illness	2.5	1.8	1F
Estimated diagnosis rate for people with dementia	2.6i	4.16	
A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	2.6ii		2F
Total health gain as assessed by patients for elective procedures – Psychological therapies	3.1v		
Patient experience of community mental health services	4.7		
Adults with a learning disability in contact with secondary mental health services who live in stable and appropriate accommodation		1.6	1G 1H
People in prison who have a mental illness or significant mental illness		1.7	
Employment for those with long-term health conditions including adults with a learning disability or who are in contact with a secondary mental health services	2.2 2.5	1.8	1E 1F
Hospital admissions caused by unintentional and deliberate injuries in under 18s		2.7	
Suicide Rate		4.10	
Proportion of people who use services and who reported they had as much social contact as they would like			1I

$ Indicator complementary with Adult Social Care Outcomes Framework

NHS England (supported by NICE) has developed a Commissioning Outcomes Framework (COF)[58], which builds upon the NHS Outcome Framework and measures the health outcomes and quality of care provided by Clinical commissioning Groups (CCGs).

COF indicators related to mental illness include:

- 1.30: People with severe mental illness who have received a list of physical checks
- 2.79: People on Care Programme Approach (CPA) followed-up within 7 days of discharge from psychiatric inpatient stay
- 3.26i: Recovery following talking therapies for people of all ages
- 3.26ii: Recovery following talking therapies for people older than 65
- 4.20: Access to community mental health services by people from black and minority ethnic groups
- 4.21: Access to psychological therapies services by people from black and minority ethnic groups

Children's Outcome Framework

The Children and Young People's Health Outcomes Forum was asked by the Secretary of State to look at how best the health outcomes of children in Britain could be improved. The forum included a Mental Health Sub Group which made recommendations related to promoting mental health and improving outcomes for children with a mental illness[59]. In view of the paucity of data on the scale and nature of poor mental health among children and young people, the Forum recommended a new survey to support measurement of outcomes for children with mental health problems. The Department of Health has recently published its response to the Children and Young People's Health Outcomes Forum's recommendations outlining actions the government and partners will take to improve the health of children and young people.[60]

[58] Available from: http://www.nice.org.uk/aboutnice/ccgois/CCGOIS.jsp

[59] Report of the children and young people's health forum – mental health sub group. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156063/CYP---Mental---Health.pdf

[60] Department of Health (2013). Improving Children and Young People's Health Outcomes. Available from: http://tinyurl.com/cq43yhg

Part Five – Evidence based interventions

National Standards

NICE quality standards are for use by the NHS in England and do not currently have formal status in the social care sector. However, the NHS will not be able to provide a comprehensive service for all without working with social care communities. Social care commissioners and providers are encouraged to use the standards, both to improve the quality of their services and support their colleagues in the NHS.

Quality standards are also expected to contribute to the following overarching outcomes from the Public Health Outcomes Framework; improving the wider determinants of health; health improvement; health protection; and preventing premature mortality.

The quality standards outline the level of service that people using the NHS mental health services should expect to receive. High-quality care should be clinically effective, safe and be provided in a way that ensures the service user has the best possible experience of care. The standards require that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. An integrated approach to the provision of services is fundamental to the delivery of high quality care to service users.

Quality standards describe markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for service users in the following ways:

- enhancing quality of life for people with long-term conditions.
- ensuring that people have a positive experience of care.
- treating and caring for people in a safe environment and protecting them from avoidable harm.

These overarching outcomes are from the NHS Outcomes Framework 2013/14

The quality standards are also expected to contribute to the following overarching indicators from the 2013/14 Adult Social Care Framework; enhancing quality of life for people with care and support needs; ensuring that people have a positive experience of care and support; safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

Community, in-patient and residential mental health services, where the service employs a doctor, nurse or social worker, are required to be registered with the Care Quality Commission (CQC). It is expected that CQC will align any future work it does with the NICE Quality Standards. More information on the NICE quality standards applicable to mental health services can be found on the NICE website.[61]

The No Health without Mental Health Strategy (DOH 2011) recognises the importance of early intervention to prevent serious mental health issues developing amongst children and young people. The comprehensive Children and Adolescent Mental Health Services (CAMHS) agenda has been well documented since the development of Every Child Matters (DFE 2004) and supports the tiered response to levels of need as demonstrated below.

Tiered Response to Levels of Need all children

Tier 1: Universal Provision, working with all children

This involves the adoption of a range of services designed to create the best developmental and emotional start for all children and which are sustained through to adulthood. They include family/infant mental health and emotional wellbeing approaches.

Tier 2: Early intervention/targeted provision

This involves early detection and provision of preventative support to children and families in need. At this step structured self-help approaches, behavioural, and/or family support are provided to reduce the impact of mental health and emotional problems and prevent their escalation to greater/more significant difficulties.

Tier 3: Specialist provision for those with complex needs

This involves specialist diagnostic assessment and the provision of psychological, systematic and/or pharmacology therapy. Intervention at this step is provided to children and young people who are experiencing moderate mental health and emotional difficulties which are having a significant impact on daily psychological/social/educational functioning. Intervention at this level is normally provided through specialist/specific multi-disciplinary teams.

Tier 4 Highly specialised provision.

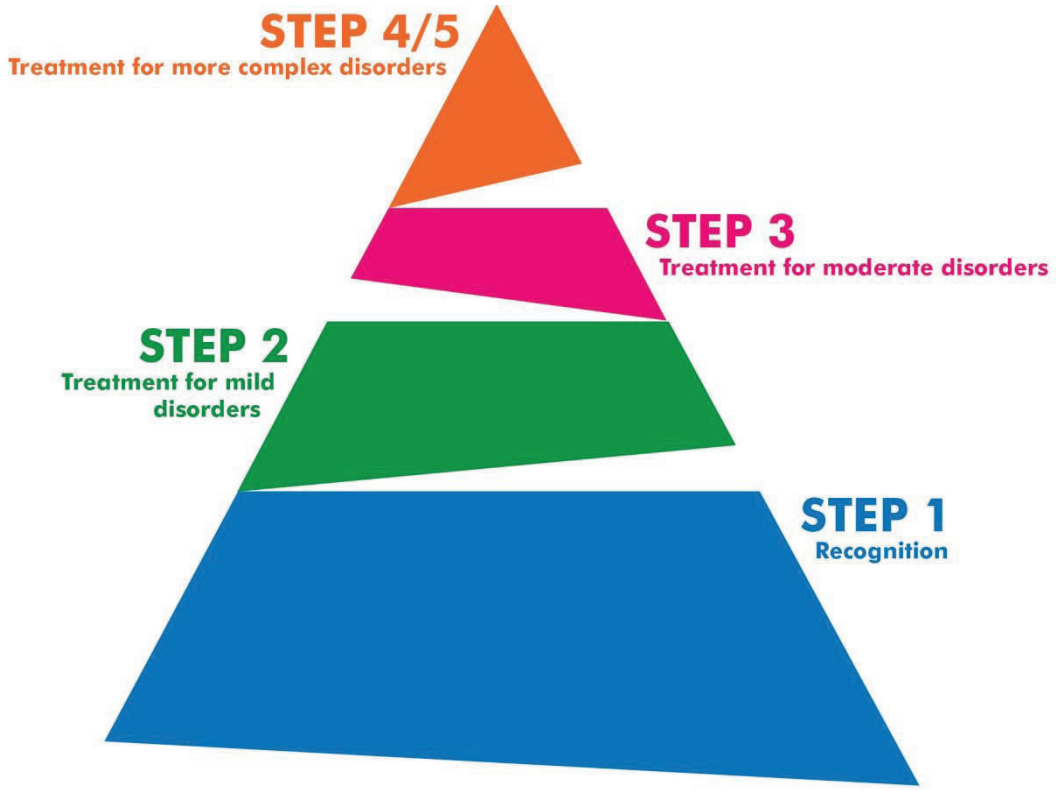
This involves provision of crisis resolution and intensive home/residential/or day care services designed to reduce and/or manage those children and young people who are at immediate risk or who need intensive therapeutic care.

[61] http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

Stepped Care Model

Halton operates a stepped model of mental health and wellbeing services where people can step up or down according to their need. Stepped care is an evidence based model of healthcare delivery with 2 fundamental features:

i. The recommended treatment/intervention should be the least restrictive of those available but still likely to provide significant health gain.
ii. The stepped care model is self-correcting through systematic monitoring and changes made (stepped up) if current treatments are not achieving significant health gains[62]



Halton's Stepped Care Model (based on Kaiser Permanente risk stratification model)

Halton is committed to providing quality evidence based, cost effective and efficient services that meet the varying needs of local people.

[62] Bower & Billbody, The British Journal of Psychiatry 2005

Part Six – Paying for local services

As the Government's policy of deficit reduction continues, the impact on the public sector is significant and with the public sector having to make unprecedented decisions about the services that it continues to deliver, this ultimately has an impact on service delivery and residents expectations. The current investment into mental health and wellbeing services within Halton will be explored within this part of the document.

It is for local commissioners to ensure that when services are commissioned, the needs of the whole population and the best evidence of what works are taken into account there are four main ways of increasing value for money in mental health services:

- improving the quality and efficiencyof current services;
- radically changing the way that current services are delivered so as to improve quality and reduce costs;
- shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and
- broadening the approach taken to tackle the wider social determinants and consequences of mental health problems.

Future costs of mental ill health are forecast to double in real terms over the next 20 years (No health without mental health: the economic case for improving efficiency and quality in mental health). Some of this cost could be reduced by greater focus on whole population mental health promotion and prevention, alongside early diagnosis and intervention. Early detection services for people with earlier symptoms of psychosis (at-risk mental state) have also been estimated to deliver savings–in this case around £23,000 per person over 10 years (about 25% of these costs were incurred in the NHS).

Intervening early for children with mental health problems has been shown not only to reduce health costs but also to realise even larger savings from improved educational outcomes and reduced unemployment and crime. These approaches not only benefit the individual child during their childhood and adulthood but also improve their capacity to parent. They can therefore break cycles of inequality running through generations of families. Conduct disorder is the most common childhood mental disorder, for which parenting support interventions are recommended as first-line treatment. A number of

studies have shown that effective parenting interventions and school-based programmes can result in significant lifetime savings.

By broadening the approach taken to tackle the wider social determinants and consequences of mental health problems, another example of this approach is providing face-to-face debt advice. Evidence suggests that this can be cost-beneficial within five years. The upfront cost of debt advice is more than offset by savings to the NHS, savings in legal aid, and gains in terms of employment productivity, even before taking into account savings for creditors.

Other areas for potential intervention identified in the document along with evidence of deliverable savings include:

1. Addressing the social determinants and consequences of mental health problems;

- Debt advice
- Befriending for older people
- Reducing stigma and discrimination
- Targeted employment support for those recovering from mental health problems
- Housing support services
- Warm housing

2. The promotion of positive mental health and prevention of mental health problems in childhood and adolescence;

- Health visitor interventions to reduce postnatal depression
- Prevention of conduct disorder through social and emotional learning programmes
- School-based violence prevention programmes

3. The promotion of positive mental health and prevention of mental health problems in adults;

- Time banks and community navigators
- Work-based mental health promotion
- Suicide prevention

4. Early identification and intervention as soon as mental health problems emerge;

- Conduct disorder - parenting interventions for families
- Early intervention for psychosis
- Early detection of psychosis
- Screening and brief intervention in primary care for alcohol misuse
- Early diagnosis and treatment of depression at work

5. Improving the quality and efficiency of current services.

- Improvements to the acute care pathway
- Managing ‘out of area’ placements in acute and secure services more efficiently
- Reducing unplanned ‘out of area’ placements
- Reducing Out of Area placements in medium secure services
- Reducing physical and mental co-morbidity
- Early detection and treatment of depression in diabetes
- Medically unexplained symptoms - CBT approach

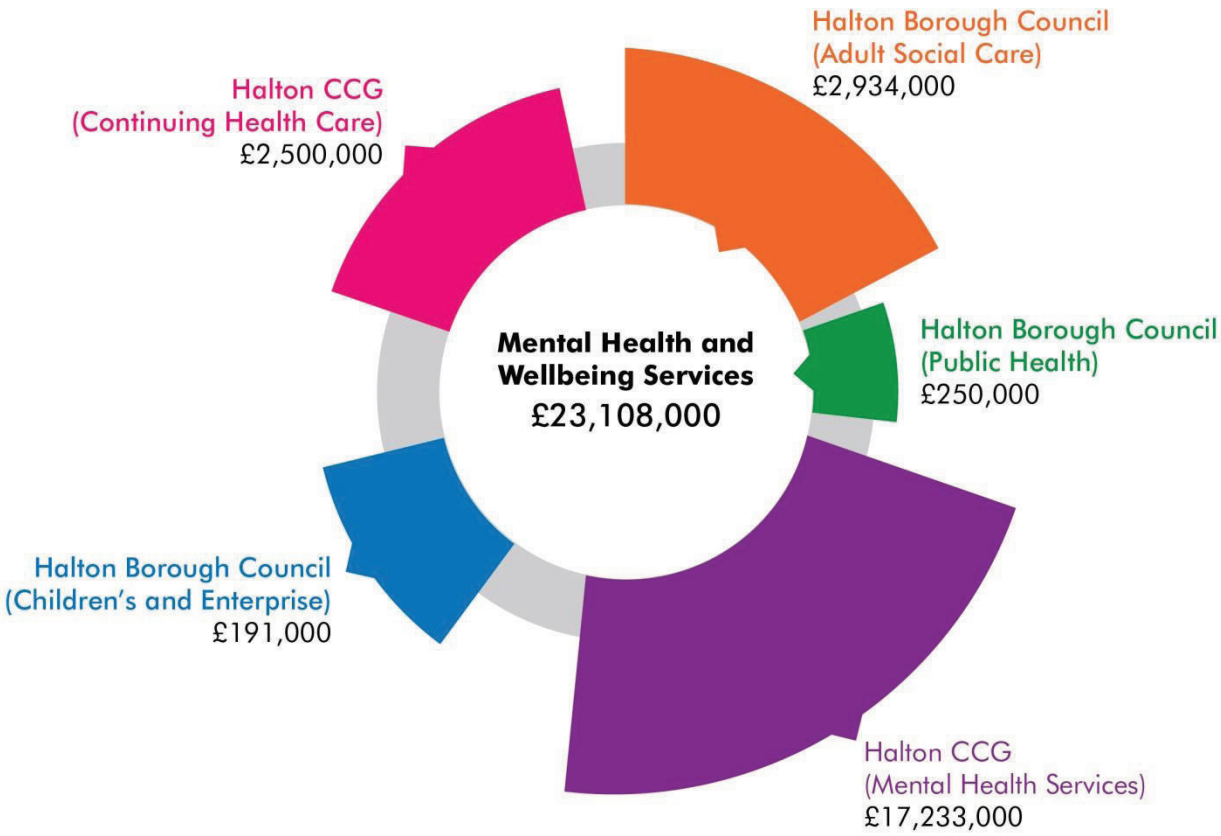
Many of these interventions are already being progressed in Halton. The commissioning intentions set out in the Mental Health and Wellbeing Strategy continues to promote action in these areas.

Current expenditure

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

Paying for Mental Health and Wellbeing Services 2013/14

The following is a breakdown of how resources have been allocated for the financial year 2013/14.



Budget received for 2013/14 for Mental Health Services

	£000
Halton Clinical Commissioning Group	17,223
Halton Borough Council - Adult social Care	2,934
Halton Clinical Commissioning Group – Continuing Health Care (Mental Health)	2,500
Halton Borough Council - Public Health	250
Halton Borough Council - Children's and Enterprise	191
TOTAL	**23,108**

How the budget was allocated 2013/14

Halton Clinical Commissioning Group	**£000**
5 Boroughs Partnership NHS FT	13,508
5 Boroughs Partnership ADHD Clinic	35
5 Boroughs Partnership Asperger's Pilot	23
5 Boroughs Partnership State of Mind	4
5 Boroughs Partnership ADOS (CAMHS)	8
Cheshire & Wirral Partnership	44
Manchester Mental Health & Social Care	6
MerseyCare	64
CAB Halton	116
Making Space	22
Women Supporting Women	20
MIND	20
Halton Service User Forum	10
SHAP	22
Bereavement Service	1
Youth Offending Team	8
IAPT (Including Open mind and Well Being Nurses)	986
MH Access	737

PICU - Vancouver House	150
PICU - Other	50
MH Capacity	77
Dementia Nurses and Care Advisors	200
WHHFT (A&E Liaison)	35
StHKHFT (A&E Liaison)	85
Primary CAMHS	492
High Cost Mental Health Funding	500
Continuing Health Care	2,500
Adult Social Care	
Older people community mental health team	147
Mental Health Support (Outreach)	194
Mental Health Resource Centre	117
Mental Health Recovery Team and Community Care	2,366
Emergency Duty Team	103
Women's Centre	7
Public Health	
Campaign against living miserably (CALM)	10
Health Improvement Team & Weight Management Service – Bridgewater	240
Children's and Enterprise	
Children in Care Service	59
Hear 4 U	132

Value for Money

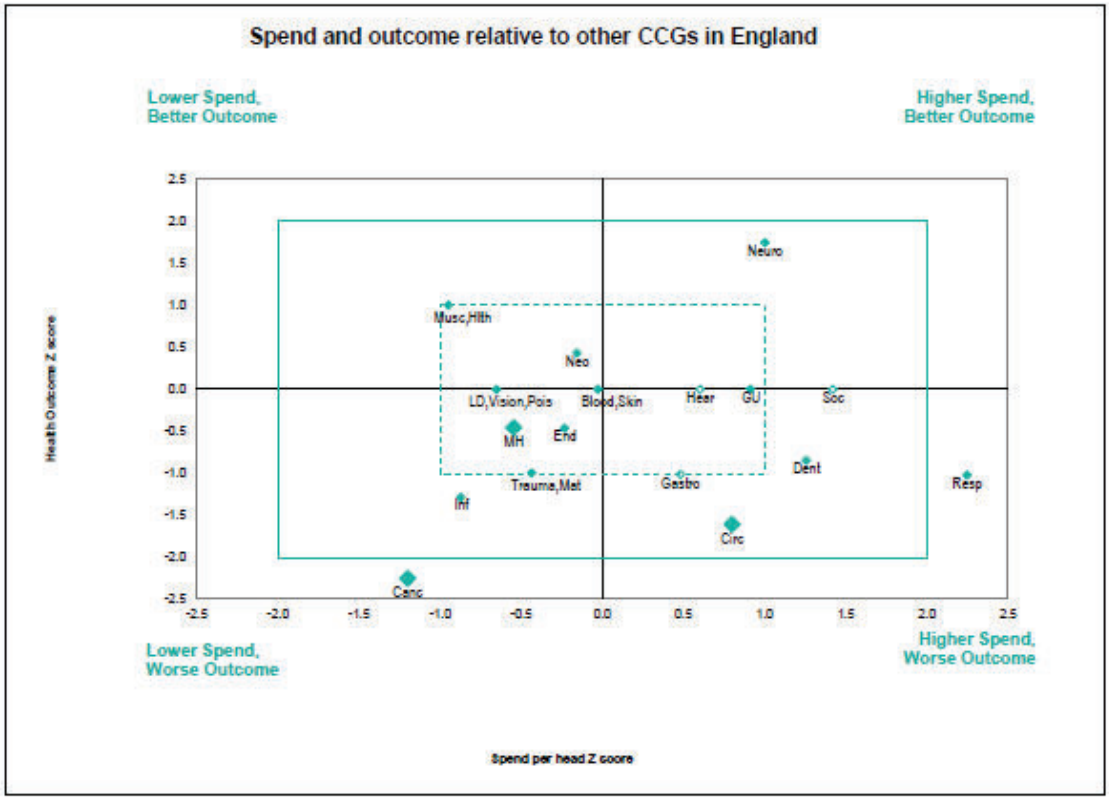
Halton Unit Costs of Adult Social Care - Mental Health

Service	2011/12 Unit Cost	2011/12 England Average	2012/13 Cost	% Change 12/13 v 11/12
Nursing	512	736	423	-17.47
Residential	873	732	878	0.61
Home Care	68	140	106	54.49
Direct payments	99	106	110	11.34
Day Care per person	50	93	59	17.64
Day Care per person per week	56	123	60	8.74

Source: PSSEX1

In general the costs of Adult Social Care appear to be below average costs for England. The exception is residential care which spiked higher than average costs in 2011/12. Whilst unit costs are a useful benchmark they are not representative as a value for money indicator as they do not consider qualitative data and outcomes achieved.

Halton Clinical Commissioning Group Spend per head (excluding Primary Care)[63]



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

This diagram represents an overview of spend and outcomes for Halton Clinical commissioning Group categorised into 4 quadrants in terms of spend and outcomes to allow easy identification of those areas that require priority attention by the CCG . The data is based on that submitted by the former Halton and St Helens PCT.

One of the highest areas of expenditure for Halton CCG is mental health at £185 per head per year. This is considerably lower than England average (£212). However outcomes being achieved are also lower suggesting that review is needed to move into the lower costs better outcomes quadrant.

[63] Source: www.yhpho.org.uk/quad/Default.aspx

Payment by Results

Payment by Results (PBR) is a system introduced in England under which commissioners pay health care providers for each patient seen or treated taking into account the complexity of patient need. The theory is that resources follow the patient rather than the traditional block contract approach.

Currencies are the unit of healthcare for which a payment is made and tariffs are the set prices paid for each currency. Tariffs are currently set locally but will be moving to national tariffs in future.

Appendix A- Local Services - 2013

Current Tiered CAMHS Provision across Halton

Tier 1: Universal Provision, working with all children

Midwifes, health visitors, school teachers, school nurses and youth workers supporting all children and young people in their development.

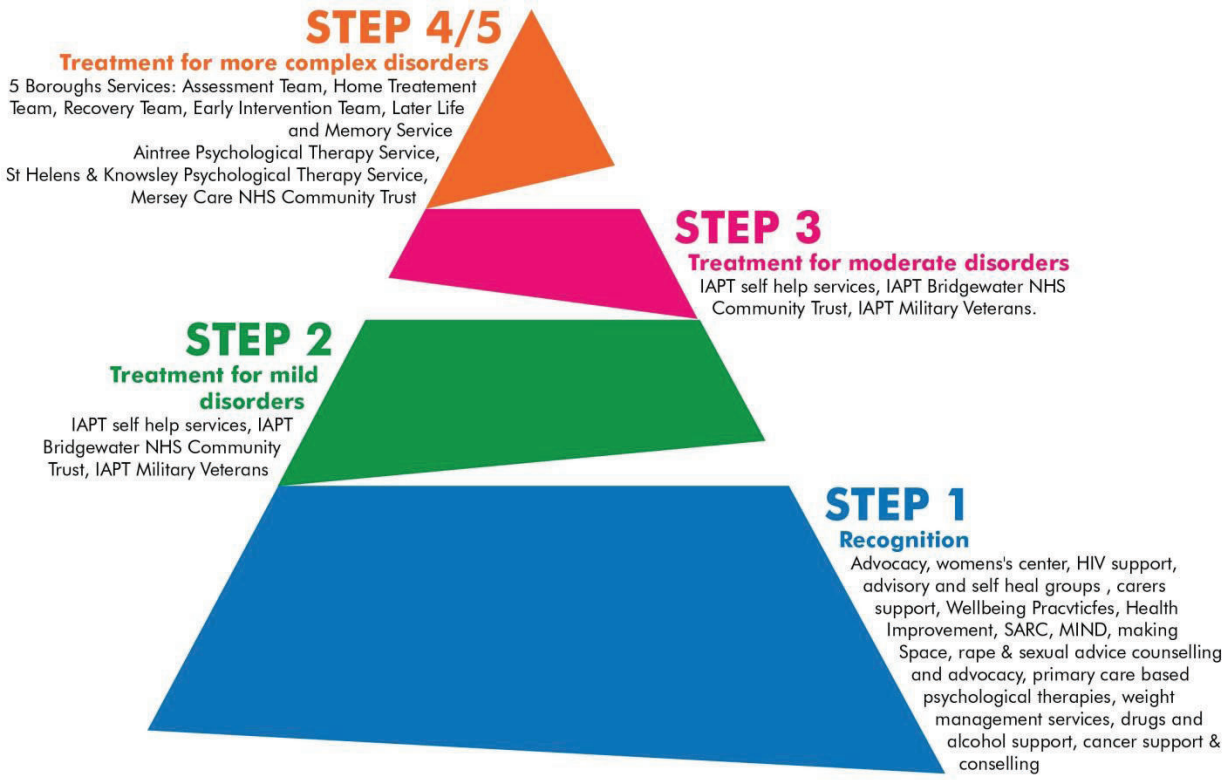
Tier 2:

- Barnardo's Hear for U provision. This service provides interventions such as individual counselling and solution focussed interventions to young people up to the age of 19.
- Barnardo's Go Forward Service (Children in Care). This service provides specialist mental health assessment, advice and support to Children in Care and their carers.
- Bridgewater Community NHS Trust Provider – This service provides consultation, training and interventions to children and young people. This includes preventing mental ill health developing and targeting vulnerable children and young people.
- Paediatric Liaison St Helens Service A+E. This service provides swift emotional and mental health support to children and young people who access A+E.
- YOS CAMHS Service. This service is specifically for children and young people who are young offenders.

Tier 3:

- 5 Boroughs Partnership CAMHS. The tier 3 specialist CAMH service is provided for the most severe, complex and persistent of child mental health problems/disorders and risk factors which have multi-factorial causation, psychological and social outcomes and which require interventions across the same domains to be delivered on a multi-agency basis. The service will deliver specialist services, including assessment, triage, consultation, diagnosis, formulation and treatment in a range of settings, including community and locality settings which meet children and young people's needs for timely and efficient service delivery.
- 5 Boroughs Partnership CURT Service. This urgent response team provide urgent assessment and service to young people up to their 18th birthday within 24 hours.

Tier 4 Highly specialised provision


STEP 4/5
Treatment for more complex disorders
5 Boroughs Services: Assessment Team, Home Treatement Team, Recovery Team, Early Intervention Team, Later Life and Memory Service
Aintree Psychological Therapy Service,
St Helens & Knowsley Psychological Therapy Service,
Mersey Care NHS Community Trust
STEP 3
Treatment for moderate disorders
IAPT self help services, IAPT Bridgewater NHS Community Trust, IAPT Military Veterans.
STEP 2
Treatment for mild disorders
IAPT self help services, IAPT Bridgewater NHS Community Trust, IAPT Military Veterans
STEP 1
Recognition
Advocacy, womens's center, HIV support, advisory and self heal groups , carers support, Wellbeing Pracvticfes, Health Improvement, SARC, MIND, making Space, rape & sexual advice counselling and advocacy, primary care based psychological therapies, weight management services, drugs and alcohol support, cancer support & conselling

Existing Mental Health Services (As at September 2013)

General mental health promotion.	Programmes related to infants and pre-school children within high-risk groups.	Programmes related to school aged children or young people within high-risk groups.	Programmes related to adults or older people within high-risk groups.	Programmes related to individuals or groups with an early or less disabling mental health or behaviour problem, or their carers.	Programmes related to individuals or groups with an identified severe mental health or behavioural problem or a diagnosed mental illness, or their carers.
Live Life Well Directory	Inspiring Families Programme	Inspiring Families Programme	Ashley House	Supported Housing	Suicide prevention section on the live life well website as an online link for suicide prevention support. **http://www.live-lifewell.net/** and click on the blue box called –thoughts of suicide
Wellbeing Areas	Inspiring Families Programme	CAMHS	Halton Employment Programme / HPIJ	The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	Carer's Assessments
Leaflets at GPs & HCRC	Team Around the Family	Team Around the Family	Community Midwives	H&STH Community Mental Health Directory Self Help guides	Social Services Mental Health Outreach Workers

The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	Children's Centres	Social care Transition Services	Halton Domestic Abuse Service	Halton Employment Programme / HPIJ	Halton Carers Centre
H&STH Community Mental Health Directory Self Help guides	Integrated Working Support Team	Children's Centres	HBC Housing Solutions	The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	MIND Halton
Sure Start to Later Life	Antenatal Groups/Community Midwives	5 Borough Partnership CAMHS Website	Extra Care Housing	H&STH Community Mental Health Directory Self Help guides	Open Mind
Carer's Assessments	Halton Family Voice	Young Addaction	Bridge Builders	Social Services Mental Health Outreach Workers	SHAP Mental health Advocacy
Help 4 Me website	Halton Health Visiting Service	Integrated Working Support Team	Suicide prevention section on the live life well website as an online link for suicide prevention support.	Halton Carers Centre	Assessment team
HealthWatch	Early Help Family Work Service	Young Carers	SHAP Mental health Advocacy	MIND Halton	Home Treatment Team
Community Wellbeing Practices	Intensive Family Work Service (IFWS)	Halton Short Break Service	British Pregnancy Advisory Service / Post Termination Support	Open Mind	Recovery Team

Health Improvement Team		Early Help Family Work Service	C.I.C Alcohol Community Link	SHAP Mental Health Advocacy	Psychological Therapy Service
Welfare Rights		Intensive Family Work Service (IFWS)	Merseyside Sexual Assault Referral Centres	Assessment Team	Merseycare NHS Community Trust
Wellbeing Enterprises		Halton School Nursing programme	Rape and Sexual Abuse Relationship Centre Independent Sexual Violence Advocates	Later Life and Memory Services	
Halton Women's Centre		Integrated Behaviour Support Team	Military Veterans IAPT Service		
Halton Citizens Advice Bureau		British Pregnancy Advisory Service / Post Termination Support	Early Intervention Team 5 Borough's Partnership		
Community Weight Management Service (Fresh Start)		Merseyside Sexual Assault Referral Centres	Merseyside Sexual Assault Referral Centres / Crisis Service		
Cancer Support Centre		Rape and Sexual Abuse Relationship Centre ISVA	Military Veterans Improved Access to Psychological Therapies Service		
IAPT Self Help Services		Merseyside Sexual Assault Referral Centres / Crisis Service			

Appendix B

Mental Health Commissioning Strategy Consultation: September 2013

Background

The World Health Organisation defines Mental Health as:
"A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community"

At least one in four people will experience a mental health problem at some point in their life and around half of people with lifetime mental health problems experience their first symptoms by the age of 14.

Halton Borough Council and the NHS Clinical Commissioning Group (CCG) are committed to involving Halton residents in shaping local services. Their views are very important and will help to inform the strategy for developing mental health and wellbeing services over the next five years.

Results

The online survey received 132 responses during September and October 2013.

In addition to this, on Oct 10th 2013 a 'Fact or Fiction' workshop was held with over 80 Healthwatch Halton members and the structure of the consultation was used in the agenda for the day – with voting buttons used to collect responses on the closed questions and discussions used to collect responses on the open questions.

The overall response from both methods of consultation is shown in this report.

Summary Findings – *key themes that are mentioned throughout (from the open comments received)*

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

Consistent: Continued service provision / after care. Clear messages to the public about mental health - the more consistent the messages are the more understanding there will be.

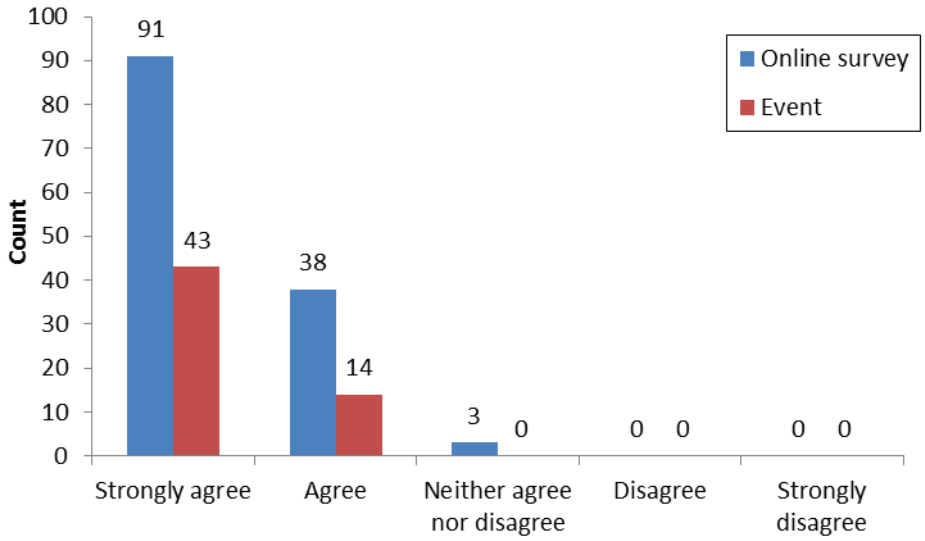
Provision of service: Out of hour's provision, support for families and carers. More service provision for children and young people. Early intervention services are important.

Local Concerns to be addressed

Through talking to local people we know you think that mental health is a priority and we know that:

- *Halton has high numbers of people suffering with depression*
- *Hospital admission rate due to self-harm in under 18's is high*
- *Current economic climate and welfare reforms are likely to increase numbers of people suffering from mental ill health*
- *Those with mental health problems have the lowest employment rate of any disability group*
- *There remains a stigma in the wider community relating to mental ill health*

How much do you agree or disagree that these concerns need to be addressed? (responses received: 132 online survey, 57 event)



Are there any other local concerns relating to mental health and wellbeing in Halton which you feel need to be addressed?

Access to service / information	11
Continued / service provision for children and young people	10
Support and advice for carers / families	8
Correct advice / experts in the field	7
Joined support for homeless and addiction	5
Isolation	4
Continued support - not just in a crisis	3
Support services	2
Support for those who are no longer a carer	1
Professionals working more closely together	1
Attitudes	1
Other	3

Main themes from comments received:

***Access**:*
Access to out of hour's services and early intervention services is a problem as is access to services such as 'Open Mind'. There should also be quicker access into current services.

***Continued / service provision for children and young people**:*
Improve services that are tailored for children and young people. Schools should be key to not only learning about mental health but also identifying people who may have issues.

***Support and advice for carers / families**:*
Information and provision for carers should be given as they provide the main support for those who have problems. Information about support groups etc. should be freely available.

***Correct advice / experts in the field**:*
Medical staff should be fully trained in Mental Health issues if they are giving advice / diagnosing problems that are mental health related. Patients should be able to gain access to staff who specialise in the field rather than a general practitioner or nurse.

***Joined support for homeless and addiction**:*
Services should be joined up e.g. drugs and alcohol, homelessness

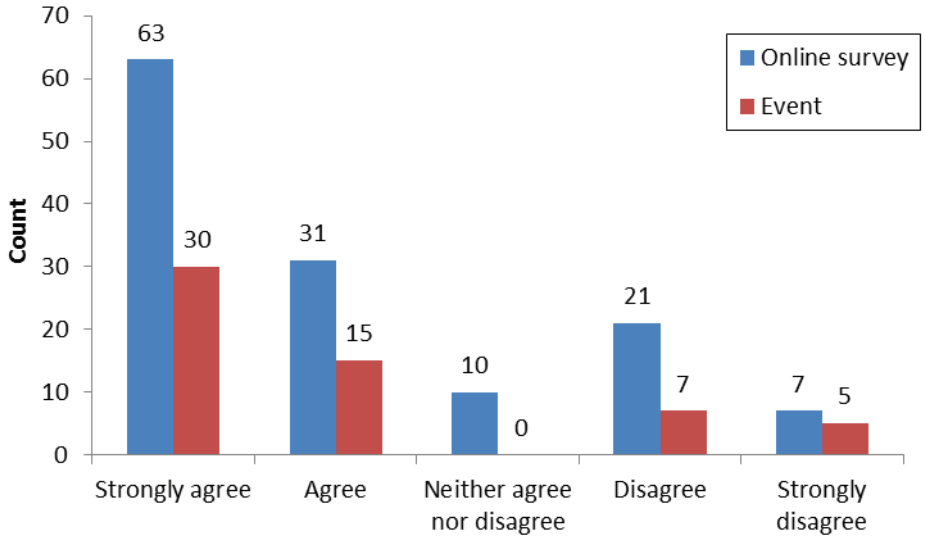
***Other**:*
Other comments focussed on continued support – not just when a person has hit crisis stage. Isolation and support for those who are no longer a carer were also mentioned.

What is our vision of improved mental health and wellbeing in Halton?

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

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

How much do you agree or disagree with this vision of mental health and wellbeing in Halton? (responses received: 132, 57)



Do you think there is anything which has been overlooked in this vision of mental health and wellbeing in Halton?

Rights / stigma for people with Mental Health	11
Loneliness / isolation	7
Access / Information	7
Happiness Statement	4
Resource	2
Monitoring	1
Other	11

Main themes from comments received:

***Rights / stigma for people with Mental Health**:*
Respondents feel that the statement “Those who do experience mental ill health will not feel any stigma..." is incorrect and will not work as it is not just about helping those with an illness to feel there is no stigma attached, but also about reducing the stigma that other people put on the illness.

***Access / Information**:*
Access to and knowledge of services is very important.

***Happiness Statement**:*
Happiness is very subjective and just because a person may feel unhappy for a certain period does not mean that they do not have good wellbeing. Feeling unhappy or sad is a natural part of life and does not mean that you automatically have mental health problems if you are experiencing it.

***Loneliness / isolation**:*
Loneliness / isolation should be tackled either through volunteers or drop in sessions, peer groups or respite for carers / families.

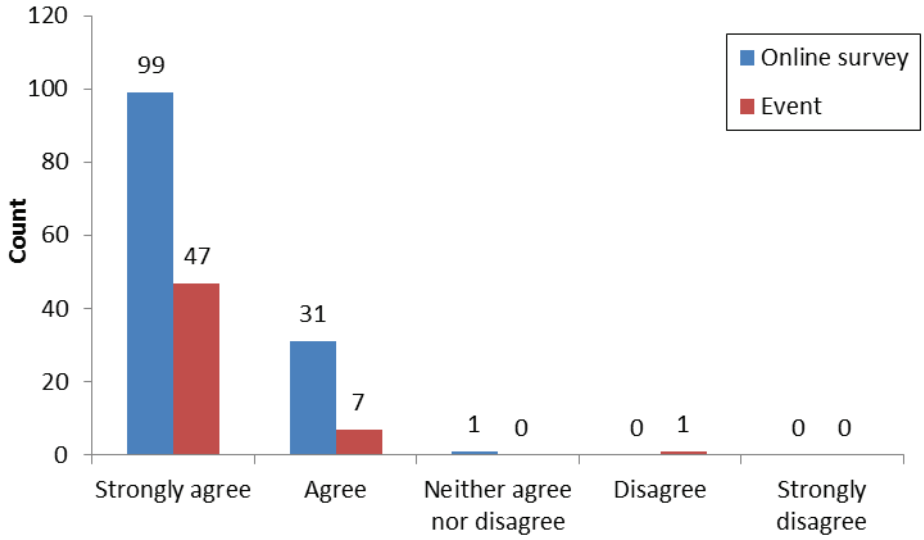
***Other**:*
Other comments related to resource and monitoring.

Our Priorities for Change

Prevention and Early Intervention

To improve mental health and wellbeing for the people of Halton we think when possible we need to prevent problems affecting mental health and when they do happen offer an early response to avoid people developing more serious problems later.

How much do you agree or disagree that prevention and early intervention is a priority? (responses received: 131, 55)



Is there anything you would like to say about the priority area of prevention and early intervention?

Early Intervention	15
Access / provision of information	12
Carers	2
Service provision	9
Support	5
Related Issues	5
Other	3

Main themes from comments received:

***Early Intervention**:*
Early intervention is key to service provision for the person needing treatment and help but also for the costs involved when a mental health problem is diagnosed at a later stage in life. Gaps in provision should also be part of this.

***Access / provision of information**:*
Information about and access to services is important but also that the provision of service is continuous. People being able to recognise the signs of somebody who has mental health issues is also important.

***Service provision**:*
Mental health leads in GP surgeries, mentors, key staff in schools and the work place.

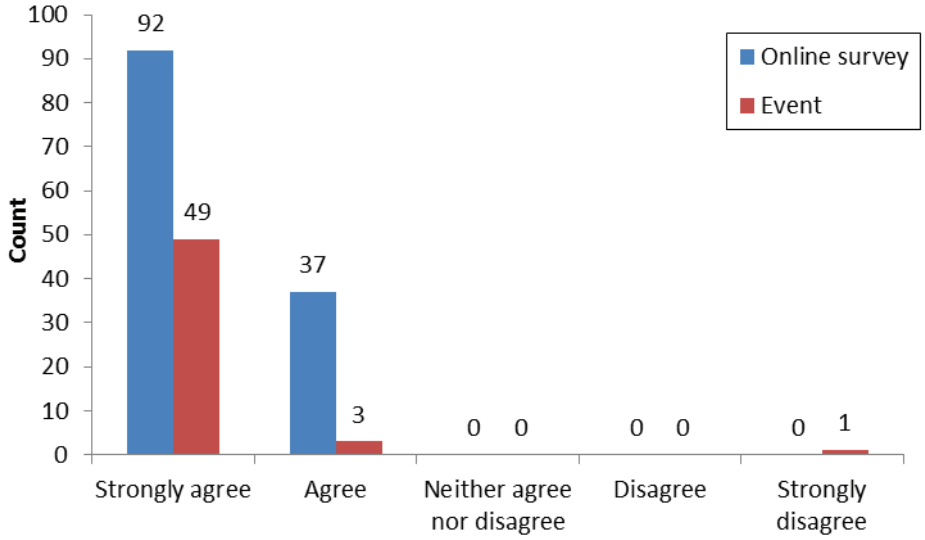
***Support**:*
Support should be available in terms of people having someone to talk to and looking at other issues in a person's life.

***Related Issues**:*
Need to look at alcohol, stress and homelessness.

Early Detection

We think that by increasing early detection of mental health problems we can improve mental wellbeing for both the person experiencing mental health problems and their families.

How much do you agree or disagree that earlier detection of mental health problems is a priority? (responses received: 129, 53)



Is there anything you would like to say about the priority area of earlier detection of mental health problems?

Education / training for professionals	16
Support / information for carers and patients	11
Education / Campaign	9
Resource	2
Other	5

Main themes from comments received:

***Education / training for professionals**:*
Professionals should be more aware of symptoms and how to refer and treat.

***Support / information for carers and patients**:*
Support should be holistic for the whole family / carers. Information should be provided to carers and services should listen to carers.

***Education / Campaign**:*
Information and advice to the public as to what symptoms, signs etc. to look out for.

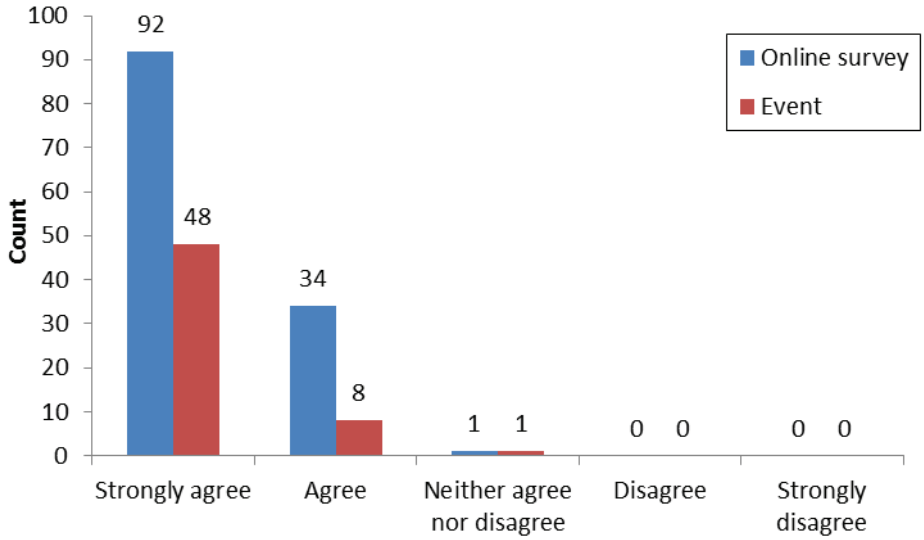
Resource
Is the resource there to be able to meet these objectives?

Other
Concern that early detection means over-diagnosis and one persons 'urgent' is not another persons 'urgent' so who makes the decision?

Better Outcomes and Quality Services

We think that those experiencing mental health problems want better outcomes from local, accessible, high quality services.

How much do you agree or disagree that better outcomes and quality services are a priority? (responses received: 127, 57)



Is there anything you would like to say about the priority area of better outcomes and quality services?

Service Provision e.g. waiting lists / opening times / specialists	13
Service Provision e.g. training / support services / whole family and carer approach	10
Not one approach	3
Other	4

Main themes from comments received:

Service Provision:

Waiting lists to receive treatment / access services are too long. Opening times of services should be looked into, people don't just have problems during the day. Also location of out of hours services should be looked at as people don't want to be taken to Warrington. More specialist staff required within services.

Service Provision e.g. training / support services / whole family and carer approach:

Aftercare is very important as is having a single point of contact. Support / information for the carer and patient, training for professional staff in how to explain what is happening.

Not one approach:

Service should be more flexible around the patient as every person is different.

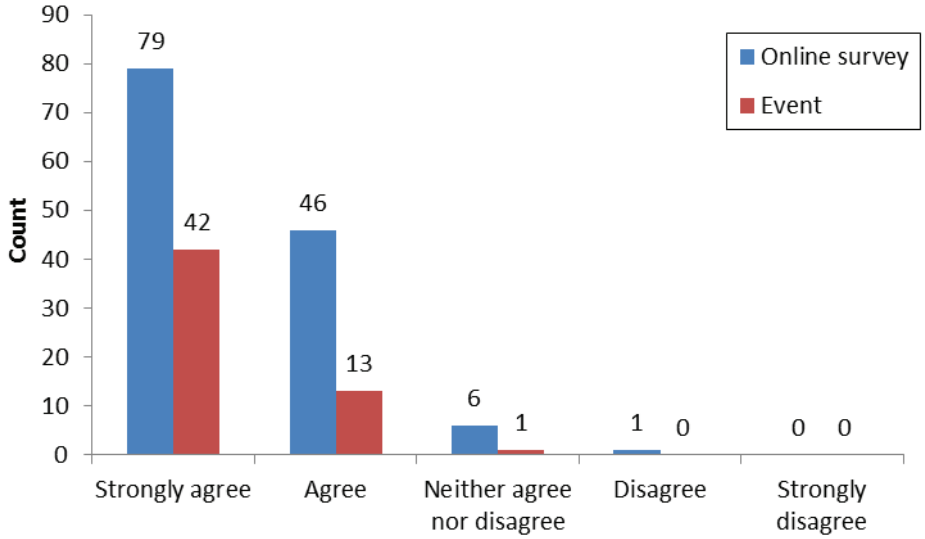
Other

Service should be measured on outcomes not the number of contacts, also the services that are more cost effective in the long term are always the first to be cut. Be honest as to what can be afforded don't make promises that can't be delivered.

Social Determinants

As the Government's policy of deficit reduction continues, both the CCG and Council must ensure value for money across all services. As well as the areas highlighted earlier we think a broader approach to tackle the wider social determinants of mental health is needed. This would place a focus on suitable housing, education, employment, local communities and the local environment.

How much do you agree or disagree that tackling the social determinants of mental health is a priority? (responses received: 132, 56)

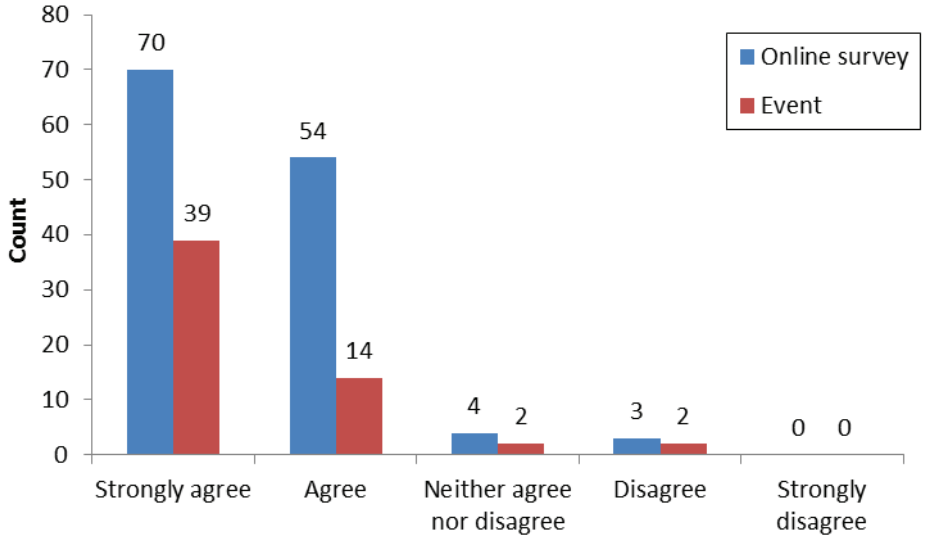


Is there anything you would like to say about the priority area of tackling the social determinants of mental health?
41 comments were received in total to this question. The comments provided were broad in nature and therefore no defined categories could be created from these comments.

The full list of open comments received from this question (and all questions in the survey) will be forwarded to the relevant team for further analysis.

Other Mental Health Related Issues

How much do you agree or disagree that there is a stigma attached to mental illness? (responses received: 131, 57)



What do you think can be done to increase the public understanding of mental illness?

Awareness / Campaigns	24
Understanding of mental health	22
Education: schools	22
Open days / Talks / fact sheets / high profile	21
Education: General	13
Other	6

Main themes from comments received:

***Awareness / Campaigns**:*
Awareness campaigns, media campaigns, clear messages about the signs and problems, clear publication of information / support available. Places to advertise, GP practice, work place, school.

***Understanding of mental health**:*
More understanding of mental health, that it can affect anybody. Mental health as a state of mind rather than an illness to be ignored.

***Education: schools**:*
Better education in schools from an early age. Mental health should be addressed along with other topics. Example of how mental health can affect people, have children help to mentor other children who may have problems.

***Open days / Talks / fact sheets / high profile**:*
Local events / open days / social media / local people who are affected / famous people who are affected / fact sheets

***Education: General**:*
Educate the general public about the signs and symptoms of mental health.

Tell us what you think?

If you could do one thing to improve general mental health in Halton what would it be? (open comment question)

Social / Economic	23
Information / support e.g. helplines, drop in	22
Access / more service provision	22
Training Professionals	17
Education / Awareness	11
Children / Young People	11

Main themes from comments received:

***Social / Economic**:*
Social and economic deprivation / community projects / jobs / lower costs for leisure activities / use current assets e.g. schools, community centre / tackle isolation

***Information / support e.g. helplines, drop in**:*
Helplines / clear information / one stops shops in GP or hospital / support for families.

***Access / more service provision**:*
Easier and quicker access to current service provision to help earlier detection. More provision or trained staff in GP practices

Training Professionals:
More understanding and more awareness from professionals / awareness training / better communication / changing attitudes and approaches

Education / Awareness
Better education and awareness, that mental health can effect anybody.

Children / Young People
More work with children and young people, especially in schools. Also provide a children drop in where children and young people can go and talk to someone. Encourage children and young people, particularly boys, to talk about any worries they may have.

How do you feel we can raise more awareness of the importance of good mental health? (open comment question)

Advertising e.g. Open days / talks / social media / raising funds	31
Schools / college	21
Advertising e.g. leaflets / posters / articles	16
Campaign the same for other illnesses / consistent / on-going / local	12
Investment	11
Other determinants	7
Isolation / Stigma	4

Main themes from comments received:

***Advertising e.g. Open days / talks / social media / raising funds**:*
Open days / awareness days / coffee and tea mornings / open days or events at schools, work place, local groups / positive stories and information via social media, press, TV.

***Schools / college**:*
Go into schools / college with DVD, drop in, chats, information

***Advertising e.g. leaflets / posters / articles**:*
Articles in paper / flyers / posters.

***Campaign the same for other illnesses / consistent / on-going / local Investment**:*
More investment in services / link with carers and families, especially at a local level.

Investment:
Investment should be made with continuous service provision, also investment should be made to work with carers, the carers centre, and those who provide services.

Other Determinants:
Promotion of healthy lifestyles e.g. healthy eating, exercise, laughter and sports.

Isolation / Stigma:
Help to reduce stigma and isolation with good role models and encourage residents to attend activities.

How do you feel we can educate younger people on the importance of good mental well-being? (open comment question)

Sessions / posters / talks	39
Curriculum / lessons	36
Other determinants / normalise / community	25
TV, Radio, Social Media	7

Main themes from comments received:

***Sessions / posters / talks**:*
Go and talk to schools, use examples that students can relate to. Train those who work with children and young people. Advisor or professionals going to schools, encouraging the students to talk about their feelings or issues they may be having.

***Curriculum / lessons**:*
Mental health should be included in lessons / curriculum / activities - including debates and leaflets. Start early in schools.

***Other determinants / normalise / community**:*
Give an understanding of what mental health is, talking about it makes it normal. Teach what good mental health is and encourage good mental health. Integration and working with those who may have mental health problems. Community activity with children and young people around mental health. Local mental health ambassadors.

***TV, Radio, Social Media**:*
Facebook, Twitter, Youtube. Local people and famous people should be highlighted in promotion. Promote eating healthy and exercise.