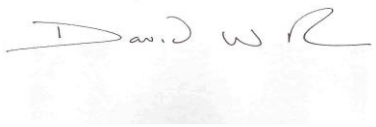
Public Document Pack

Health and Wellbeing Board

Wednesday, 13 January 2016 2.00 p.m.
The Halton Suite - Select Security 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, 9 March 2016

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, 4 November 2015 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillor Polhill (Chairman)
Councillor Woolfall
Councillor Wright
P. Cooke, Healthwatch
T. Holyhead, HSCB
D. Lyon, Halton CCG
K. Mackenzie, Democratic Services
L. McDonnell, Cheshire Police
A. McIntyre, People & Economy
E. O'Meara, Public Health
D. Nolan, HBC/CCG
H. Patel, Citizens Advice Bureau & Healthwatch
M. Pickup, WHH NHS FT
N. Rowe, Five Boroughs Partnership
C. Samosa, Bridgewater Community Healthcare NHS FT
L. Thompson, NHS HCCG
T. Tierney, HHT
S. Wallace-Bonner, People & Economy
P. Williams, SH&K NHS Trust

Action

HWB18 APOLOGIES FOR ABSENCE

Apologies had been received from David Parr, Councillor Ged Philbin, Simon Banks, Colin Scales, Ann Marr, Sally Yeoman, Michelle Creed and Nick Atkin.

HWB19 MINUTES OF LAST MEETING

The Minutes of the meeting held on 16 September 2015 having been circulated were signed as a correct record.

HWB20 BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST - STRATEGY FOR HEALTH AND WELLBEING BOARD 2015/16 TO 2020/21 - PRESENTATION

The Board received a presentation from the Director of People, Planning and Development of Bridgewater Community Healthcare NHS Foundation Trust. The presentation outlined the Trust Strategy for Health and Wellbeing 2015/16 to 2020/21. The Strategy aimed to improve the health and wellbeing of all the local authorities that commission Bridgewater Community Healthcare NHS

Foundation Trust.

The Board noted that the trust had evolved over its first year in operation, and was working in partnership with all sectors to put together a strategy for each individual partner. The next step would be to measure the difference that was being made by the work of the Trust, with a Borough based structure responding to local need.

RESOLVED: That the content of the presentation be noted.

HWB21 FOOD ACT!VE PRESENTATION

The Board received a presentation from the Chief Executive of the Health Equalities Group on Food Act!ve. This was a collaborative programme launched by the North West Directors of Public Health in November 2013 to tackle levels of obesity. This would focus on population level interventions which took steps to address the social, environmental, economic and legislative factors that affected people's ability to change their behaviour.

The Board noted the current initiatives on offer by the Group, such as "Give up loving Pop!" and the Sugar Rush Programme, which both concentrated on the impact of too much sugar in a diet and providing an informed choice. The Group was promoting a local government declaration to promote healthy weight.

The Board noted that local initiatives such as "Crucial Crew" also informed teachers and students of the importance of informed food choices.

RESOLVED: That the presentation be noted.

HWB22 A STUDY TO EXAMINE ACCESS TO HEALTHY & AFFORDABLE FOOD IN HALTON

The Board received a report from the Director of Public Health which informed them of a study to examine the ability of residents in Halton to access a healthy, affordable diet. The project, which was at the planning stage, would examine the ability of residents to access a healthy and affordable diet by mapping the availability of food across the Borough and assess the barriers that could prevent residents from accessing a healthy diet. The project findings would provide an evidence base to inform future policy with regard to improving the diet and reducing levels of obesity in Halton.

RESOLVED: That the report be noted.

HWB23 BETTER CARE FUND UPDATE

The Board considered a report from the Strategic Director of People and Economy, on the progress, performance and financial aspects of the Better Care Fund Quarter 1 for 2015/2016. The Board agreed the submission of the Better Care Fund plan in December 2014. This was authorised by the Department of Health in January 2015 without conditions.

The Better Care Fund plan outlined key areas for development, performance metrics and associated finance. Progress against these areas was subject to a quarterly return to the Local Government Association and NHS England.

The template for the return was published by the national Better Care Support Team. The time between publishing and submission precluded review at the Health and Wellbeing Board prior to submission. The submission was reviewed by the Better Care Board Executive Committee who monitored the plan on a monthly basis.

The submission demonstrated that Halton had made substantial progress on the implementation of the plan, had achieved the national and local targets and was delivering within the budget as planned.

RESOLVED: That the report be noted.

HWB24 HALTON SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT 2014-15

The Board considered a report which contained the Halton Local Safeguarding Children's Board (LSCB) Annual Report 2014 – 2015 and Business Plan 2015 - 2017.

The Annual Report provided a rigorous and transparent assessment of the performance and effectiveness of local services to safeguard and promote the welfare of children and young people. It identified areas of weakness, the causes of those weaknesses and proposals for action. The report included lessons from learning and improvement activity within the reporting period.

The LSCB was currently funded via contributions from the Council, Schools, Cheshire Constabulary, NHS Halton CCG and Cafcass. Contributions had reduced during

recent years with the LSCB losing contributions from Connexions, the Child Death Grant and year on year reductions from the Schools Forum. The LSCB was undertaking work with partners to uplift financial contributions and increase in kind contributions, as well as approaching partners who did not currently contribute financially to the Board.

RESOLVED: That the content of the report and associated Annual Report appended to the report, be noted.

HWB25 SCAMS VICTIMS PROJECTS - PREVENTION & IMPACT REPORT

The Board considered a report from the Director of Public Health, which informed Members that in September 2014 the Trading Standards Team began work on a Scam Victims Project following receipt of a list of 190 likely victims of mail mass marketing fraud in Halton. The report advised Members of the impact of the work to date, and the potential funding sources that were being explored to extend the project.

The project was important as the victims the Team were working with were largely regarded as vulnerable adults – 60% of people on the list were either currently or previously involved with Adult Social Care in Halton. The Team had undergone training to develop techniques to communicate effectively with the vulnerable and coach them towards behaviour change. This was often a lengthy process.

The Board were informed that the service cost £45,000 in total. Due to a reduction in the Public Health budget the funding would not be available in April 2016. Future options for consideration were:

- Cease running the project;
- Identify joint funding with partners;
- Reduce the number of older people worked with, to target the most vulnerable and cease providing the wider prevention element; and
- Focus on the wider prevention element and cease the help and education element for people at risk.

It was suggested that each Area Forum could be asked for £1,500 in future funding.

RESOLVED: That the Health and Wellbeing Board

Director of Public Health

1) note the report;

2) identify joint funding with partners; and

3) explore the possibility of seeking £1,500 from each Area Forum.

HWB26 COMPLEX DEPENDENCY / EARLY INTERVENTION AND TROUBLED FAMILIES

The Board received a report which summarised the outcomes achieved in Phase 1 of Troubled Families in Halton. The report outlined the key criteria for Phase 2 of the programme and provided the Outcome Plan.

An overview of the Cheshire Complex Dependency Project was included with the report, and how it supported the Early Intervention and Troubled Families agenda within the Borough.

RESOLVED: That the Health and Wellbeing Board

1) note the positive developments in Halton's Troubled Families Phase 1 Programme;

2) note and supports the key criteria and the Outcome Plan for Phase 2 of the Troubled Families Programme; and

3) supports the Complex Dependency Project and recognises the contribution it will make to establishing multi-agency, integrated working to tackle children, families and individuals with complex needs.

HWB27 LGC AWARD APPLICATION - EFFECTIVE HEALTH & WELLBEING BOARDS

The Director of Public Health provided the Board with an update on an application to the Local Government Chronicle Awards 2016 on behalf of the Halton Health and Wellbeing Board. The application was the "Effective Health and Wellbeing Board" category and had focused on "Tackling the Harm Caused by Alcohol."

RESOLVED: That the application be supported.

Meeting ended at 3.22 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 13 January 2016

REPORTING OFFICER: Director of Housing & Wellbeing (HHT**)**

PORTFOLIO: Health and Wellbeing

SUBJECT: Impact of Welfare Reform

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 This report identifies the impact of the Welfare Reforms since 2010. It identifies the changes already introduced and further reforms to reduce the welfare budget. It highlights research which shows the impact that these have especially on health and wellbeing and details how the changes have impacted on claimants within Halton and specifically Halton Housing Trust customers.

2.0 RECOMMENDATION: That

1) the contents of this report be noted; and

2) further reports be submitted to track the ongoing impact of the reforms as they are rolled out further.

3.0 SUPPORTING INFORMATION

3.1 The creation of the Coalition Government after the election in 2010 is widely regarded as introducing the biggest changes of the welfare system since its post war inception the key reforms were:

- Universal Credit - It was first rolled out in Halton in November 2014 and there are currently 1639 Halton claimants
- Benefit Cap - There are currently 33 benefit cap cases in Halton
- Under Occupation Charge for social housing tenants (bedroom tax) - There are currently 1853 claimants affected by the bedroom tax in the borough
- Personal Independence Payment replacing Disability Living Allowance.
- Changes to the work commitment with an increase use of sanctions if claimants fail to meet the targets agreed in the work commitment
- Abolition of council tax benefit with the introduction of localised council tax relief
- Abolition of the social fund with the replacement by a localised Discretionary Support Scheme

3.2 Further reforms were announced in the July 2015 emergency budget and these included:

- From April 2016 lowering of the benefit cap from to £26,000 to £20,000 (£23,000 in London)
- Housing benefit to be abolished for 18-21 year olds
- Freezing of working age benefit rates at current level for the next four years
- Phasing out of tax credits
- Social renting tenants whose household income is above £30,000 to pay market rent

3.3 Further cuts in Welfare were announced in the Comprehensive Spending Review in November 2015 and these included:

- An abolition of the planned cuts in tax credit with the changes integrated to the full roll out of Universal Credit
- Capping of social housing sector rent to the local housing allowance which means that single claimants under 35 will only receive the shared room rate

3.4 The Welfare Reforms introduced to date have been calculated to have the average financial impact on the following groups:

Group	Income loss per annum £
Pensioner Couple	30
Single Pensioner	60
Couple no children	340
Couple one dependent child	1480
Couple 2 plus dependent children	1540
Lone parent one dependent child	1950
Lone parent 2 plus dependent children	2120
Single person Household	520

In addition claimants with health problems or disabilities are expected to be hardest hit by the reforms as reductions in Incapacity Benefit are estimated to lead to an average £2000 income loss per annum in addition there are potential further losses in DLA. It has also been identified that nearly half the reduction in benefit may be expected to fall on working households

3.5 There have been a number of studies which have identified the potential health impact of poverty and unemployment and by extension the impact of welfare reform and the main concerns are as follows:

- Increase in homelessness
- Poorer mental health with an increase in self harm
- Increase in cardiovascular disease and respiratory illness
- Poorer nutrition and diet with associated health problems
- Increase in substance abuse
- Increase in stress and anxiety from both loss of income and stigma of unemployment
- Increased incidence of violent crime including domestic abuse and child protection issues

3.6 As part of a consortium Halton Housing Trust tracked the impact of welfare reform on up to 100 households for 18 months up to February 2015. One aspect tracked was the impact on health and wellbeing with:

- 77% of respondents identifying that they agree that Welfare Reform is strongly or very strongly having a negative impact on the health and wellbeing
- At the end of the review in February 2015
    - 44% identified that there health had got worse
    - 50% had identified that their health had stayed the same
    - 6% identified that their health had improved

3.7 Halton Housing Trust has identified how the following welfare changes have impacted on its customers

3.8 *Employment and Support Allowance*

To assist claimants to receive Employment and Support Allowance (ESA), for those unable to work due to illness and disability, medical evidence is required to support claims. There is some evidence that locally GPs are reluctant to provide medical letters/reports to support a claim and in addition there can be a charge ranging from £10 to £80 for the report.

3.9 The medical evidence often helps to support ESA claim and failure to provide medical evidence can lead to ESA claims being disallowed. To increase the potential for a successful claim there is a need to provide a specific and detailed description of the medical circumstances and if appropriate identify that the condition has deteriorated and the impact on the claimant.

3.10 Delays or failure to provide medical evidence can cause delays in benefit decision and awards being made which can increase applications to DSS for food/energy top ups and increase use of food banks, Housing Benefit suspensions leading to stress over rent arrears in addition to the mental (and related physical) aspects the claimant experiences due to the financial hardship caused.

3.11 *Personal Independence Payments*

For Personal Independence Payments (PIP) if a customer fail a PIP medical and is in receipt of ESA then they can potentially lose additional premiums (mainly Severe Disability and Enhanced Disability) which has the effect of reducing their ESA payment by £77.60 pw currently. So not only do they lose the PIP award some claimants on ESA can lose ESA payments also

3.12 If a PIP medical is failed mandatory reconsideration requests are mainly only successful if further medical evidence can be provided (same issues as with ESA above) or there is a significant error with the decision made at the assessment centre

3.13 There has been a migration from Disability Living Allowance (DLA) to PIP and if PIP is not awarded DLA ends and this may have a larger impact than those on existing PIP as some people, in addition to the linked benefit financial loses, will lose access to a mobility vehicle applying further additional financial pressure and potential increased social isolation

3.14 In Halton there are currently 1627 claiming PIP but only 257 of this total are in receipt of the highest PIP awards possible meaning the remainder will either be on one enhanced benefit only or the standard awards.

3.15 *Universal Credit*

The biggest change in the benefit system is the introduction of Universal Credit and although numbers are relatively low with 158 Trust customers currently in receipt of UC the following issues are already emerging for Trust customers.

3.16 There is a minimum 5 week wait from making a claim to receiving a payment, which had been further exacerbated by recent changes whereby for the first week of any claim no benefit is payable leading to financial hardship for claimants especially those previously paid weekly.

3.17 This has led to greater reliance on DSS, food banks and families and friends for support, with potentially the first UC payment used to clear immediate debts leading to ongoing financial hardship.

3.18 For Trust customers who are paid weekly they can struggle to cope with budgeting and managing UC claim that vary from month and month, In addition to the new responsibility for some of paying their rent direct to the landlord. The average rent arrears of UC recipients is currently £680.

3.19 Claimants can request a benefit advance on their first payment and although this assists in resolving the immediate financial hardship the requirement to repay the advance over a 6 month period can lead to ongoing financial difficulties.

3.20 For claimants on UC deduction from benefit for examples to clear rent arrears, council tax debt and court fines can be levied at 20% of the benefit leading to additional financial pressure by reducing the overall payment on households struggling to adjust to coping with UC.

3.21 With the need to complete online claimants for UC this impacts on claimants who have limited literacy and it skills leading to delays in claims being made and payments received.

3.22 As part of any UC claim there is the offer of Personal Budgeting Support, however there is concern that this is a basic service often signposting and not helping the most vulnerable claimants.

3.23 *Spare Room Subsidy (Bedroom tax)*

This has impacted on Trust customers, most of whom have chosen to "pay and stay". When initially introduced there was an increase in possession action as customers with long standing static debts went further into arrears. Over time the impact of the bedroom tax has been mitigated by the use of the Discretionary Housing Payment (DHP) however these funds are only granted for a limited time and where not available the average additional cost of £16.96 per week which has added to financial hardship on struggling households

3.24 Although the benefit cap currently only impacts on a small number of households within the borough the reduction in the level to £20,000 will impact on more households and will impact on households with 3 children rather than the small number of larger families

3.25 The removal of the Social Fund has impacted on customers with a reliance on the local authority via DSS for (food and energy) and food banks. There is also an Increase on reliance to other sources of grant help with - time scales for outcome can take some time (i.e. Charis Grants 12 weeks or more). In addition customers may access high interest and illegal money lenders with the impact on limited financial resources

3.26 To assist in mitigating the impact on the health and wellbeing of Welfare Reform on residents within Halton the following actions may be considered

- An understanding of the reforms and how this may impact on claimants within Halton especially the most vulnerable
- An understanding that health issues as presented may be impacted by underlying issues either brought on or exacerbated by welfare reform
- Consideration of how limited resources can be targeted to assist those with greatest vulnerability or most impacted by the changes
- Continue to monitor and track the impact of the changes on residents within Halton

4.0 POLICY IMPLICATIONS

There are no direct policy implication from this report.

5.0 FINANCIAL IMPLICATIONS

There are no direct financial or resource implication from this report**.** However the potential impact of the changes on the health and wellbeing of residents impacted by Welfare Reform may lead to a greater call on services provided of the local authority

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

With the increase in financial hardship as a result of the reforms there are likely to be a negative impact on families with young children. Also with the removal of housing benefit for under 21 years olds this will have an impact on the ability for some young people to maintain and sustain an independent home with potential increase in street and other homeless issues

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

With the emphasis within the welfare reforms to "make work pay" and the support offered and; potentially the sanctions imposed this may enable some to obtain employment more quickly than before the changes

6.3 **A Healthy Halton**

The long term impacts on health and wellbeing have been identified and these include the following:

- Poorer mental health with an increase in self harm
- Increase in cardiovascular disease and respiratory illness
- Poorer nutrition and diet with associated health problems
- Increase in substance abuse
- Increase in stress and anxiety

6.4 **A Safer Halton**

There are potential negative impacts of a safe Halton with an increase in violence with concerns that there may be increased incidences of domestic abuse

6.5 **Halton's Urban Renewal**

None

7.0 RISK ANALYSIS

There are no risks or direct opportunities arising from the report.

8.0 EQUALITY AND DIVERSITY ISSUES

There are no Any Equality and Diversity implications arising as a result of the report.

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

None within the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 13 January 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Better Care Fund Quarter 2 report 2015/16

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform the Board of the Quarter 2 report for July to September 2015/16 for the Better Care Fund (BCF) that has been submitted to NHS England and progress with the implementation of the BCF, following approval at the Better Care Board on 26th November 2015.

2.0 RECOMMENDATION: That the content of the report be noted.

3.0 SUPPORTING INFORMATION

3.1 **Quarterly Reporting Template**

Each quarter, the Better Care Support Team publish a template for submission detailing various elements of the Better Care Fund. For Quarter 2 July to September 2015/16, the template included the following sections:

- Budget Arrangements
- National Conditions
- Non-elective and payment for performance
- Income and Expenditure
- Local Metrics
- Preparations for BCF 16/17
- New Integration Metrics
- Narrative

Due to the timescales involved with the submission of the templates, Quarter 2 is coming to the Board retrospectively.

3.2 **Submission Points**

The quarterly reports are due for submission to NHS England at 5 points during the year:

- 29th May – for the period January to March 2015
- 28th August 2015 – for the period April to June 2015
- 27th November 2015 – for the period July to September 2015

- 26th February 2016 – for the period October to December 2015
- 27th May 2016 – for the period January to March 2016

3.3 **Annual Reporting/Year-End Reporting**

NHS England and the LGA are developing Year-End reporting guidance and an annual report template which will build on the quarterly reporting. There are currently some outstanding queries around accounting and audit being worked through before these can be finalised and issued. Once finalised, they will be available on the Better Care Fund webpage.

4.0 **Quarter 2 Report July to September 2015/16**

Quarter 2 was submitted to NHS England on 27th November. The detail of this is attached at the Appendix. A summary of the Q2 report is as follows.

Tab 2 – Budget Arrangements:

This page just confirms that the budget arrangements for the BCF are contained within a Section 75 Joint Working Agreement.

Tab 3 – National Conditions

This page confirms that we are on track with all the National Conditions.

Tab 4 – Non-Elective Admissions and Payment for Performance

The target for Q2 was 4,293 non-elective admissions into hospital, all-age per 100,000 population. The actual figure for Q2 is 4,139, therefore the target has been achieved.

Tab 5 – Income and Expenditure

Actual expenditure to date is £193 below forecast due, in the main, to the delay in providers sending invoices into the Council, the host of the pool. However, this is actively being progressed to ensure payments are made in a timely manner. The Urgent Care Centres are now operational and the current financial position is as expected at the mid-point of the year.

Tab 6 – Local Metrics

- **Permanent admissions to residential care** – The Q2 figure is 53 admissions. As we are halfway through the year, we are on track to meet our year-end target of 138 admissions.
- **Reablement** –This data is collected on an annual basis between 1st October and 31st December, so is not available to assess progress.
- **Hospital Readmissions where original admission was due to a fall**. The target for Q2 was 40 and the actual was 23. This performance metric has shown a considerable improvement at 23 hospital readmissions where the original admission was due

to a fall. This is the lowest performance recorded in a single quarter and is due to the changes in the falls pathway that have seen significant improvements to the overall system.

- **Do Care and Support help you to have a Better Quality of Life?** As this is an annual survey, there is no information for this quarter.

Tab 7 – Preparations for the BCF 16/17

Following the announcement that the BCF will now continue through into 2016/17, the Q2 template has questions relating to the planning of this. In Halton we have begun discussions around next year's BCF and are planning, at this stage, for the funding to be the same as this year.

Tab 8 – New Integration Metrics
This is a new set of integration metrics that NHS England is developing for next year. This includes Integrated Digital Records, Use of Risk Stratification and Personal Health Budgets.

5.0 POLICY IMPLICATIONS

5.1 None identified.

6.0 FINANCIAL IMPLICATIONS

6.1 The success of the BCF is reliant on the success of the schemes within it. These schemes will be regularly monitored through the BCF ECB and Better Care Board.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children & Young People in Halton

Effective arrangements for children's transition services will need to be in place.

7.2 Employment, Learning & Skills in Halton

Any long-term integration arrangements will need to focus upon staffing issues.

7.3 A Healthy Halton

Developing integration further between Halton Borough Council and the NHS Halton Clinical Commissioning Group will have a direct impact on improving the health of people living in Halton. The plan that is developed will be linked to the priorities identified in the Integrated Commissioning Framework.

7.4 **A Safer Halton**

None identified.

7.5 **Halton's Urban Renewal**

None identified.

8.0 **RISK ANALYSIS**

8.1 If an area fails to meet any of the standard conditions of the BCF, including if the funds are not being spent in accordance with the plan with the result that delivery of the national conditions is jeopardised, the Better Care Support Team may make a recommendation to NHS England that they should initiate the escalation process. The process ultimately leads to the ability for NHS England to use its powers on intervention provided by the Care Act legislation, in consultation with DH and DCLG as the last resort. The quarterly reporting templates allow for any variation in spending from the plan to be explained.

9.0 **EQUALITY AND DIVERSITY ISSUES**

9.1 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

None within the meaning of the Act.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

3. National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Any unreleased funds were used for: Q2 15/16	Q4 2015-16 confirmed NEA plan figures
Yes	Yes	Yes	Yes

5. I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes			
	Actual					
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes			
	Commentary	Yes				

6. Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential Care		Yes	Yes
	Reablement	Yes	Yes
Local performance metric	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
	Yes	Yes	Yes
Patient experience metric	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
	Yes	Yes	Yes

7. Preparations for BCF 16-17

Have you begun planning for 2016/17?	Yes
Confidence in developing BCF plan?	Yes
Pool more, less, or the same amount of funding?	Yes
Support in developing plan?	Yes

If yes, support area?	Interested in support?	Preferred support medium	If preferred support medium is 'other', please elaborate
Developing / reviewing your strategic vision	Yes	Yes	Yes
Building partnership working	Yes	Yes	Yes
Governance development	Yes	Yes	Yes
Data interpretation and analytics	Yes	Yes	Yes
Evidence based planning	Yes	Yes	Yes
Financial planning	Yes	Yes	Yes
Benefits management	Yes	Yes	Yes
Other	Yes	Yes	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS number being used as the primary identifier?	Yes	Yes	Yes	Yes	Yes	Yes
Open API in place?	Yes	Yes	Yes	Yes	Yes	Yes

Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?
Yes

Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs?	
Yes	
If 'Yes', please provide details of how risk stratification modelling is being used to allocate resources	
Yes	
How many local residents have been identified as in need of preventative care during the quarter?	
Yes	
What proportion of local residents identified as in need of preventative care have been offered a care plan during the quarter?	
Yes	

Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population?	Yes
How many local residents have been identified as eligible for PHBs during the quarter?	Yes
How many local residents have been offered a PHB during the quarter?	Yes
How many local residents are currently using a PHB during the quarter?	Yes
What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare during the quarter?	Yes

9. Narrative

Brief Narrative
Yes

REPORT TO:	Health & Wellbeing Board
DATE:	13 January 2016
REPORTING OFFICER:	Director of Adult Social Services
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Better Care Board – Quarterly Update
WARD (S):	Borough Wide

1.0 PURPOSE OF REPORT

1.1 This report provides an update for the Health and Wellbeing Board on the main issues that the Better Care Board has been focused on progressing and monitoring over the past few months.

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

3.0 SUPPORTING INFORMATION

Better Care Board

3.1 The Better Care Board (previously known as the Complex Care Board until it was renamed during 2014) was originally established in 2013, to ensure that an integrated system was developed and appropriately managed to ensure that the resources available to both Health and Adult Social Care, including the Better Care Fund, are effectively used in the delivery of personalised, responsive and holistic care to those who are most in need within our community.

The Better Care Board meets on a quarterly basis and the following paragraphs are intended to provide an overview to the Health and Wellbeing Board as to the work the Board have been progressing recently in support of its overall aim as outlined above.

3.2 **One to One Care : St Lukes**

A review of One to One provision at St Luke's Nursing home has taken place in light of an increase in the numbers of One to One support packages over recent years and the impact that this was having on service delivery etc.

As such a new policy and funding arrangements have been implemented which continues to ensure a high quality service, cost effective services is delivered.

3.3 **Continuing Health Care**

In July 2014, four Continuing Health Care (CHC) nursing posts were integrated with Care Management Teams (Complex Care Widnes and Complex Care Runcorn). The main aim of this integration was to ensure that the resources available to both Health and Social Care are effectively used in the delivery of services.

A CHC Action plan was developed to ensure a smooth transition and identify actions to

ensure that the service be effectively delivered. Recent activity has focused on the completion of outstanding reviews that need to be completed.

As of the 1st October 2015 the Commissioning Support Unit functions for CHC have been devolved to the Complex Care service; a transition plan is in place to manage this process over the next 3-6 months.

3.4 **Falls**

A detailed Falls Business case that outlined current performance in Halton and plans/proposals for the future has been recently considered.

As a result of the implementation of the Falls Strategy a number of positive changes have been seen, as follows:-

- 115 fewer older people attending hospital due to a fall in 2014/15 compared with 2011/12.
- 75 fewer admissions to hospital for older people due to a fall in 2014/15 compared with 2011/12.
- 52 less hip fractures in 2014/15 compared with 2011/12.

During the last four years we have seen an improvement in three of the four performance metrics that are being used (Hospital admissions due to a fall, injuries due to a fall or due to a fracture of femur and hospital readmissions). Readmission rates have fluctuated, but overall have changed only marginally over the same period.

The next stage requires further redesign and development to maintain the success that we have seen over the last four years, as well as improving further and addressing the issues in relation to readmissions. The four areas of further redesign are;

1. Hospital discharge – specifically plugging the referral route from discharge to community intervention
2. Pre-fall exercise programme – ensuring that there is a link and a referral process in place between sports development and the Health Improvement Team
3. Tai-chi – Improve access to Tai-chi and offer a co-ordinated approach between sports development and Health Improvement Team
4. Care homes – Establish a base line and agree best practice and reporting procedures.

The majority of the recommendations within the falls business case should be delivered within existing budget as they are more about working practices and improving links between different parts of the service, however some additional resources will be required and the Better Care Fund will be used for this purpose.

The Better Care Board will continue to monitor these developments.

3.5 **Minor Adaptations**

There has been a change in service provider for the delivery of the Minor Adaptations Service between 1st October 2015 to 30th September 2017.

In January 2015 the Better Care Board agreed to extend the contract with Helena Property Services for Minor Adaptations to 30th September 2015. This would allow commissioners sufficient time to explore options for future service delivery and complete a procurement process for services from 1st October 2015.

A number of options were explored with housing associations and voluntary sector

organisations. However, commissioners determined that proposed pricing levels and limited experience of delivering this type of service presented a high risk of costly, poor quality service provision. The decision was taken to test the market and an open procurement process was initiated.

Operational staff and commissioners completed robust evaluation of 9 submitted bids and the three top scoring agencies were interviewed. Housing Maintenance Services (HMS) scored highest overall on both quality and price and have been offered a contract from 1st October 2015 to 30th September 2017. There is an option to extend on an annual basis to 30th September 2020 subject to satisfactory performance.

3.6 **Lilycross Care Home - Widnes**

The Care Quality Commission (CQC) had previously identified a number of risks at Lilycross and made a series of recommendations. The care home developed an action plan, the delivery of which was supported by the Council and NHS Halton CCG. All new admissions were suspended until the recommendations were fulfilled.

However, the home was unable to show sustained improvement and the CQC secured a court order to close down the home.

Lilycross closed on 12th August.

The wellbeing of residents was the Council and CCGs priority and we worked closely with CQC and providers to ensure the smooth transition of residents from Lilycross into alternative care.

3.7 **Better Care Fund Review**

The Board received a copy of the report produced by the Mersey Internal Audit Agency regarding the governance arrangements in place for managing the Better Care Fund.

The report outlined that Halton were given 'significant assurance' in relation to the arrangements in place.

3.8 **Halton System Resilience Group**

The Better Care Board also monitors the activity of the Halton System Resilience Group (SRG); Halton SRG reports to the Better Care Board. The SRG provides multi-disciplinary strategic direction and guidance across health and social care in relation to non-elective and elective care. It is responsible for ensuring that locally there are quality processes in place which are safe and efficient for patients and cost effective

The following paragraphs outline a number of key issues that have been dealt with via the SRG over the past few months.

3.9 **NHS 111 Mobilisation**

NHS Blackpool is the Lead Commissioner for the NHS 111 service contract in the North West. Since the preferred providers of the North West NHS 111 service were announced as the North West Ambulance Service NHS Trust (NWAS) and its delivery partners, Out of Hours providers FCMS and Urgent Care 24 (UC24), they have been working in conjunction with the North West NHS 111 Programme Board to effectively mobilise the new service. NB. In Halton the new service went live from 1st October.

Following service commencement, all calls to GP Out of Hours services now go through to NHS 111, where the caller's health care needs are assessed and sign-posted to the most suitable service to best meet those needs - this may include GP in or out of hours

services, Walk in Centres, pharmacy, self-care and, if appropriate, referral to A&E or 999.

Members of the public calling NHS 111 directly have seen no change in the service they are accessing, but patients calling their GP Out of Hours service will hear an answerphone message, asking them to redial the free to caller NHS 111 number

3.10 **Improving and Sustaining Cancer Performance**

During July and August Clinical Commissioning Groups received tripartite correspondence from Monitor, Trust Development Agency and NHS England that described the approach to improving the 62 cancer standard.

The 62 day cancer standard is that 85% of patients referred under a 14 day urgent referral for cancer will start receiving treatment by day 62 (there should be no more than 62 days between date of referral and the date they start treatment)

The tripartite approach has stated that; nationally, performance against the cancer 62 day referral to treatment standard was consistently below the required 85% at national level. Overall in Halton during 2014/15 we achieved this standard, achieving 85.81%.

The correspondence received also outlined that the remit of SRGs were to be explicitly expanded to cover the 62 day cancer standard given the need to drive better and sustained performance. As such Halton's SRG received it first report in this area at its August meeting, which focused on current performance and current work being progressed.

Performance and any necessary actions will continue to be closely monitored via the SRG in addition to other monitoring mechanisms currently in place within NHS Halton CCG.

3.11 **NHS England – SRG Assurance**

Substantial work has taken place since August in responding to NHSE's assurance requirements in preparation for Winter 2015/16.

As with other SRGs, Halton have been self-assessing themselves against the following areas:

- Winter readiness
- Governance and leadership
- Capacity, Demand & Data Analysis
- Non-acute demand
- 24/7 Liaison Mental Health service
- 8 high-impact interventions
- Ambulance high impact changes (in conjunction with lead commissioning CCGs)

Information has been returned in line with NHSE requirements and discussions have been ongoing with NHSE regarding Halton's level of assurance.

3.12 **Winter Preparation 2015/16**

A number of issues have been considered by SRG as part of winter preparations for 2015/16, as follows:-

3.12.1 **Marketing Campaign 2015/16**

The SRG received proposals in respect of the marketing campaign planned for Winter. The proposals were agreed in respect of where we will advertise and when and it was

agreed that the local focus would be very much focused on the promotion of the Urgent Care Centres.

3.12.2 **Winter 2015/16 – Schemes**
Funding for schemes that will support the operational delivery of managing the changing demand particularly during the winter period has been discussed at the SRG. The schemes proposed for this Winter are similar to those that evaluated well last year.

The schemes identified will:-

- Support the flow within A&E within Whiston and Warrington Hospitals;
- Support the flow through acute bed base; and
- Deflect admissions from A&E.

3.12.3 **Flu Preparations - Winter 2015/16**
The SRG considered a report from Public Health which provided an overview of changes to and requirements of, the annual seasonal influenza vaccination campaign for the 2015 – 2016 flu season. The SRG considered the implications of this for the Local Authority and health and social care partner agencies.

4.0 POLICY IMPLICATIONS

4.1 None associated with this report.

5.0 FINANCIAL IMPLICATIONS

5.1 None associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The Better Care Board has a role to play in ensuring that there are effective arrangements for children's transition services are in place.

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

6.3 **A Healthy Halton**
The Better Care Board has a significant role in driving forward the further integration of Health and Adult Social Care Services which will have a direct impact on improving the health of people living in Halton.

6.4 **A Safer Halton**
None identified.

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

7.0 RISK ANALYSIS

7.1 None associated with this report.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None associated with this report.

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

9.1 None associated with this report.

REPORT TO: Health & Wellbeing Board

DATE: 13 January 2016

REPORTING OFFICER: Strategic Director, People and Economy

PORTFOLIO: Health & Wellbeing

SUBJECT: Halton Safeguarding Adults Board Annual Report 2014-15

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health and Wellbeing Board with a copy of the 2014-15 Halton Safeguarding Adults Board Annual Report. This report provides a summary of the key actions and priorities the Safeguarding Adults Board has been working towards in the last year.

2.0 **RECOMMENDATION: That the Health and Wellbeing Board**

1) **note the contents of the report; and**

2) **approve the Halton Safeguarding Board Annual Report 2014-15.**

3.0 **SUPPORTING INFORMATION**

3.1 All Safeguarding Adults Boards are required to produce an Annual Report, which summarises all of the key achievements and priorities the Safeguarding Adults Board has been working towards over the last twelve months. The report sets out the national and local developments on safeguarding adults at risk.

3.2 Membership of the Halton's Safeguarding Adults Board includes senior representatives from all partner agencies, including Directors; Lead Clinicians and Lead Officers responsible for safeguarding adults in Halton. It is everyone's responsibility to ensure that we work together as a community to support and safeguard all adults who are most at risk in society.

3.3 To achieve this, the Board continues to develop and establish strong partnerships to ensure that the most vulnerable in society are safeguarded and are free from fear; harm; neglect and abuse.

3.4 All partners are expected to share the following values which

underpin their work:

- Everybody within our society deserves, and is entitled to, good quality care and support to meet their needs
- Some people have difficulty expressing their needs and require careful consideration of their individual circumstances
- Everybody has a right to live in a safe and secure environment without fear of abuse, harassment or injury
- Everybody has a right to live as independently as they are able
- Everybody has a right to make choices and decisions about their lifestyle, which can involve risk-taking
- Everybody should have access to relevant services for addressing issues of abuse and neglect. This includes the civil and criminal justice system and victim support services

3.5 Halton's Safeguarding Adults Board contributes to the objectives of the Health and Wellbeing Board's Joint Health and Wellbeing Strategy and Halton's Strategic Partnership's Sustainable Community Strategy. During 2014/15, the Safeguarding Adults Board focused on four key priorities:

1. Promote awareness of abuse and the right to a safe and dignified life – particularly among the "vulnerable" and "at risk", but also among staff, volunteers and the wider community
2. Increase the contribution from service users and carers, ensuring their views and experience inform the Board's work and service developments. Provide individualised services that keep people safe, but permit informed decisions about risk.
3. Ensure there is a strong multi-agency approach to the safety, wellbeing and dignity of all adults at risk
4. Equip employees with the necessary tools and training to safeguard adults at risk and ensure their dignity is respected

3.6 The future priorities for Halton's Safeguarding Adults Board can be Summarised as follows:

- Empowerment
- Protection
- Proportionality
- Prevention
- Partnership
- Accountability

These priorities will be achieved by ensuring that there is a full range of policies, strategies and action plans in place, that provide a framework within which partner organisations can work together

effectively to respond to abuse and neglect. These documents will reflect emerging developments in national guidance and legislation, as well as national, regional and local learning and new approaches to safeguarding practice.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified

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

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

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

6.3 **A Healthy Halton**
The Annual Report highlights the key actions undertaken and the priorities that the Safeguarding Adults Board have worked towards during the last twelve months.

6.4 **A Safer Halton**
The Annual Report highlights the key actions undertaken and the priorities that the Safeguarding Adults Board have worked towards during the last twelve months.

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

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

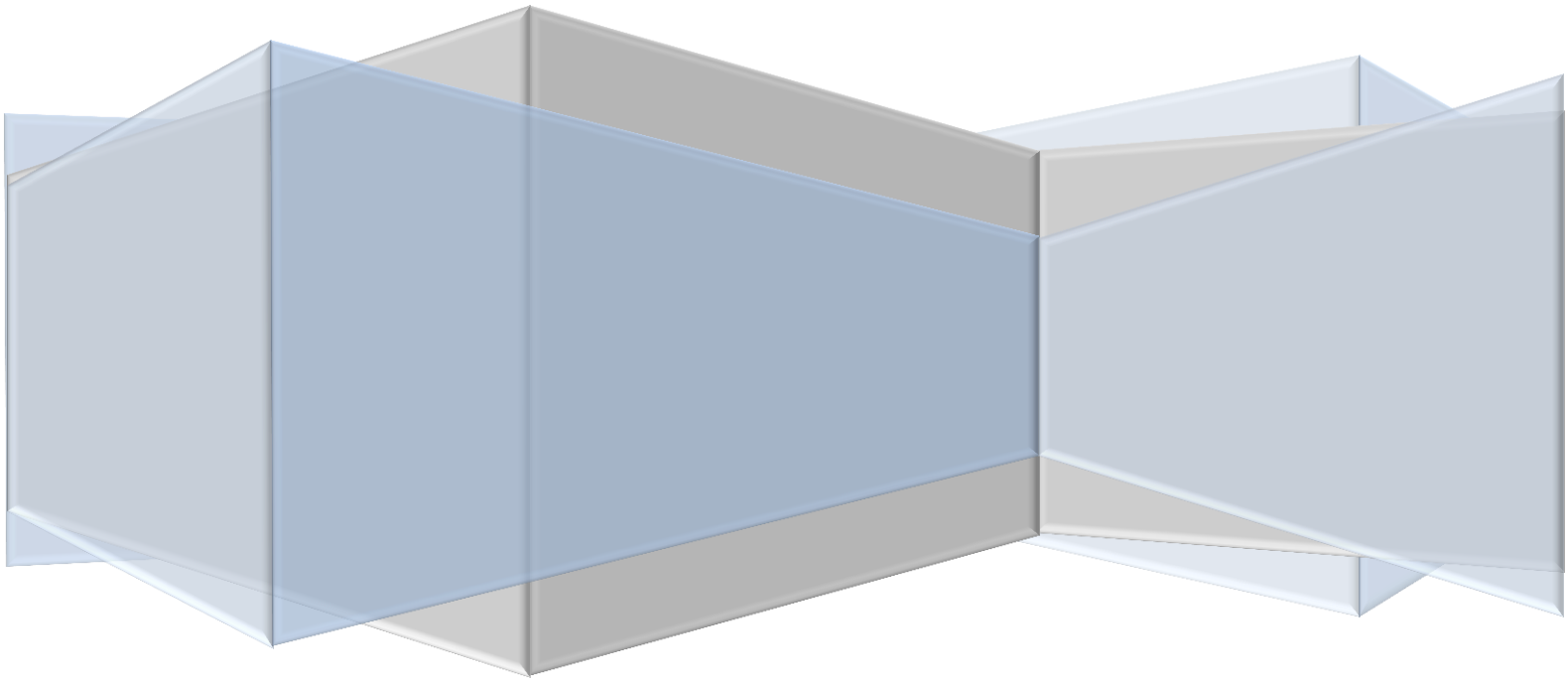
8.1 An Equality Impact Assessment is not required for this report.

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

None within the meaning of the Act.

Halton Safeguarding Adults Board

Annual Report 2014-15



FOREWORD

Halton's Safeguarding Adults Board believes that the safeguarding of vulnerable people is everybody's business, with all communities playing a part in preventing, detecting and reporting neglect and abuse. Although safeguarding adults is a complex and challenging area of work, effective measures are in place locally to protect those least able to protect themselves. As Chair of the multi-agency Safeguarding Adults Board, I am pleased to present this Annual Report which describes how organisations and individuals across all sectors, are working together to safeguard vulnerable people.

As well as reporting on its work over the past year, the Annual Report explains the national context in which we all operate and lists our priorities for the coming year. Some of the key highlights from the past year include working towards implementation of the Care Act from April 2014; continuation of the Safe in Town scheme in Halton; addressing key areas of safeguarding such as the increase in financial abuse and working with our partners in order to raise awareness of safeguarding across our various organisations and ensuring staff members have received appropriate training

I want to assure local people and partner agencies of our continuing commitment to this work, which is essential to the quality of life and experience of people whose circumstances make them vulnerable and take the opportunity to thank all those involved for their vital contribution to this essential area of activity. I am grateful to all those managers and practitioners who seek to ensure that adults at risk are safeguarded and who uphold the highest standards of care and support. I hope that you find the Annual Report both informative and reassuring.

From September 2015, the role of Chair of Halton Safeguarding Adults Board will be undertaken by an Independent Chair – Audrey Williamson and I wish the new Chair all the very best in their future work with the Board.

Dwayne Johnson

Chair of Halton Safeguarding Adults Board
Strategic Director – Communities
Halton Borough Council

1. OVERVIEW OF HALTON SAFEGUARDING ADULTS BOARD

Halton Safeguarding Adults Board
nosecrets
Don't turn your back on abuse

The purpose of Halton's Safeguarding Adults Board is to:

- **Act as a multi-agency partnership board of lead officers and key representatives, which takes strategic decisions aimed at safeguarding vulnerable adults in Halton**
- **Determine and implement policy, co-ordinate activity between agencies, facilitate training and monitor, review and evaluate the safeguarding of adults**
- **Promote inter-agency cooperation activity between agencies**
- **Develop and sustain a high level of commitment to the protection of vulnerable adults**
- **Ensure the development of services to support people from hard to reach groups**

The HSAB has four main priorities, which underpin the work of the Board and its annual plan ensures all members are actively engaged/involved in supporting these priorities:

Priority 1: To promote awareness of abuse and of all individuals' right to be safe and be afforded dignity, particularly amongst people who are "vulnerable" or at risk and others, including the wider community, staff and volunteers

Priority 2: To increase the contribution from service users and carers and wider communities, by seeking to ensure that the views and experience inform the Board's work and service developments and by ensuring that personalised services are available in a way that keeps people safe but enables them to make informed decisions about risk

Priority 3: To ensure there is a strong multi-agency approach to assuring the safety, wellbeing and dignity of vulnerable adults

Priority 4: To equip employees with the necessary tools to both safeguard vulnerable adults and ensure their dignity is respected.

2. CURRENT PICTURE IN HALTON

From taking a closer look at the data collated for the statutory statistical Safeguarding Adults Return in 2014/15, we can start to build a profile of who are the most vulnerable to potential abuse in Halton and start to focus the work of the Board around addressing the needs of the community, in order to help keep people safe in Halton.

The 2014/15 data indicated that the most potentially vulnerable in our community were females, aged 65 and over, have an ethnicity of white british and who primarily require support for their physical needs from adult social care. The most prominent type of alleged abuse in Halton is physical abuse, followed by neglect / acts of omission. This year also saw an increased in referrals regarding alleged financial / material abuse, which was also identified as a trend nationally. The alleged abuse is most likely to occur in the person's own home and by someone who is known to the individual, for example a relative or a care worker.

By using this data, the following information highlights the work that has been undertaken by the Halton Safeguarding Adults Board in order to keep the people of Halton safe from potential abuse or neglect.

3. HOW HAS HALTON SAFEGUARDING ADULTS BOARD HELPED TO KEEP PEOPLE SAFE?

The Safeguarding Adults Inter-Agency Policy, Procedure and Good Practice Guidance has been updated for Halton, in terms of our safeguarding referral process and the new statutory requirements for safeguarding adults in light of the implementation of the Care Act 2014. The policy was agreed by members of the Halton Safeguarding Adults Board and the policy has now been circulated to all agencies for implementation. The policy is also available to view on the Halton Borough Council website at www.halton.gov.uk/safeguardingadults

A Multi-Agency Domestic Abuse and Sexual Violence Strategy 2014-17 has been developed. The purpose of the strategy is to set out what Halton intends to do over the next 3 years, to tackle the issue of domestic abuse and sexual violence within our communities. Halton Domestic Abuse Forum as a partnership will aim to create equality for all our residents through reducing fear and harm experienced from this form of violence and abuse. The strategy will seek to improve the risk identification, assessment and management processes and to target educational and support services effectively. No single agency can adequately deal with domestic abuse and sexual violence. The issue needs to be addressed by joint working and multi-agency strategies.

This year has also seen the implementation of Domestic Violence Prevention Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs). The implementation is legislated through the provisions of the Crime and Security Act 2010. DVPOs were designed to provide immediate protection for victim-survivors following a domestic violence incident in circumstances where, in the view of the Police, there are no other enforceable restrictions that can be placed upon the perpetrator. DVPOs aim to give victim-survivors time, space and support to consider their options by placing conditions on perpetrators, including restricting/removing perpetrators from households and preventing contact with, or molestation of, victim-survivors. Cheshire Police have committed to appoint dedicated resources to support this work. A newly developed role of DVPO Coordinator/Court Presentation Officer has been established. From Monday 2nd June 2014 – Friday 19th December 2014, there has been a total of 48 Domestic Violence Protection Notices issued. All notices were taken to court within the time limit of 48 hours. Of the 48 applications, 8 were contested by the offender at court and 3 orders were not granted by magistrates. The impementation of DVPNs and DVPOs has provided an opportunity to build upon established multi-agency working and strategies to intervene in

domestic abuse by providing additional measures to safeguard victims and their children. Effective multi-agency working is critical to ensuring the success of these orders.

A summary of the Independent Inquiry into child sexual exploitation (CSE) in Rotherham was presented to Halton Safeguarding Adults Board in October 2014. An Independent Inquiry into Rotherham Borough Council's internal processes and procedures, as well as its work alongside partners, in responding to historical cases of child sexual exploitation during the period 1997-2013 was undertaken. The inquiry was commissioned by the Council's Cabinet in September 2013 and was carried out by Alexis Jay OBE. No one knows the true scale of child sexual exploitation in Rotherham over the years. A conservative estimate is that 14,000 children were sexually exploited during 1997-2013. The abuse is not confined to the past, but still continues to this day. In May 2014, the caseload of the Specialist Child Exploitation Team was 51, with more CSE cases being held by other Children's Social Care Teams. In 2013, the Police received 157 reports concerning child sexual exploitation in Rotherham.

Following the publication of the Alexis Jay report, David Parr – Chief Executive of Halton Borough Council, wrote to all 23 North West Local Authorities requesting they all consider a review in light of the report's findings. Gerald Meehan, Strategic Director People & Economy - Halton Borough Council, is chairing a multi-agency group to agree a Terms of Reference to be used by partners across Cheshire and to report to Local Safeguarding Children Boards. A Pan-Cheshire Missing From Home and Child Sexual Exploitation Group has been established by the Police. This group has produced a Pan-Cheshire Strategy and Protocol which each Local Safeguarding Children Board has approved and an action plan developed.

A presentation was delivered to Halton Safeguarding Adults Board in March 2015, in regards to the establishment of a Child Sexual Exploitation Team within Halton. It was agreed that regular updates would be presented to both the Children and Adult Safeguarding Boards.

In January 2015, a report was presented to the Board regarding reporting financial abuse incidents during July-December 2014, due to an identified increase in the number of safeguarding referrals relating to alleged financial / material abuse. In the Care Act 2014, it states that financial abuse includes:

- Having money or property stolen
- Being defrauded
- Being put under pressure in relation to money or other property
- Having money or other property misused

Many types of financial crime can go unnoticed and factors, such as the economy, technology and social change are diversifying the threat. In 2008, Help the Aged reported that 60 - 80% of financial abuse against older people takes place in their own home and 15 - 20% in residential care. Research suggests that financial abuse is most frequently perpetrated by a person acting in a trusted capacity, for example, a family member or friends, neighbours or care workers/other professionals.

In order to address the local and national increase in financial abuse incidents, it was agreed by Halton Safeguarding Adults Board to establish a Task and Finish Group to develop a Financial Abuse Toolkit. The purpose of the toolkit is to raise awareness of both professionals and members of the public, in recognising the potential indicators of financial abuse and what support and services are available to help prevent such abuse occurring in the future. The toolkit has now been drafted and is in its final stages of development.

A launch event is being considered in order to help raise awareness of this type of abuse and to provide training to professionals to help support potential victims of financial abuse.

The Safe in Town Scheme has been running in Halton since 2012, to provide a safe haven for people who may feel vulnerable when out in the community. Once individuals enter a shop which has the Safe in Town logo sticker displayed and declare themselves as part of the scheme by showing their laminated card, one of the staff members would phone a dedicated number for the individual and a family member or carer would come to collect them. The Halton scheme has widened the range of beneficiaries and now includes adults and young people (aged 14 years plus) who have a learning or physical disability and anyone over 60 years of age. The logo for the scheme was designed and agreed by the Halton People's Cabinet and is now being used by Cheshire Police to roll out the scheme across the whole geographical footprint. Easy read comic books, which were produced for both individuals and organisations, to ensure the scheme's guidelines and safeguarding messages were consistent when shared with participants, have also been used by the Police, with thanks given to Halton Speak Out who produced the comic books.

As at November 2014:

- 504 people have signed up to the scheme
- 31 venues in Runcorn Shopping Centre are now Safe in Town havens
- 22 venues in Runcorn Old Town are now in Safe in Town havens
- 18 venues in Widnes Town Centre are now Safe in Town havens
- 10 local shops on housing estates throughout Halton are Safe in Town havens

- 3 Community Centres are Safe in Town havens
- 2 Health Centres are Safe in Town havens

It was anticipated that by the end of March 2015, the numbers would have further increased, with targeted activity to sign up more local shops, non-commercial premises and in particular, health centres and GP surgeries. Widnes Vikings Rugby Team are in discussions to put the Safe in Town logo on the t-shirts of their younger players and the scheme has been included as part of the Bright Sparks Kitemark and the purple handbook for people experiencing Alzheimer's and other forms of dementia.

A report was presented in March 2015 to the Board regarding reported medication errors, as it was identified that an increased number of safeguarding referrals were relating to medication errors in both domiciliary and residential care. The National Patient Safety Agency (NPSA) defines a medication error as an error which occurs in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred. Care providers who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people using the service, will have their medicines at the times they need them and in a safe way. The statutory requirements of care providers around medication errors requires that the registered person must protect service users against risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the obtaining; recording; handling; using; safe keeping; dispensing; safe administration and disposal of medicines used for the purposes of regulated activity. All medication errors should be reported in line with care provider's Management of Incidents policy, as soon as possible after the incident. Medication incidents have a number of causes, such as lack of knowledge; failure to adhere to systems and protocol; interruptions, staff competency; poor handwriting and instruction and poor communication. The National Patient Safety Agency has divided definitions of medication errors into the following areas:

- Prescribing errors
- Dispensing errors
- Preparation and Administration errors
- Monitoring errors
- Other errors (including poor or inadequate communication and recording etc.)

In Halton, in line with the NPSA definitions, local data suggests the majority of reported medication errors involve poor administration by care providers; this includes administration of the wrong medication or dose, administering medication too early or late and that the administration or medication has been recorded incorrectly or not recorded at all. Where medication errors are reported action is required by the provider service to protect the adult at risk from harm and to ensure that no other adults are put at risk. In many cases, the safeguarding investigation identifies that the worker needs more training and where this occurs, the worker is supported to deliver safe care. The Care Home Support Team is now well established in Halton with a dedicated Pharmacist, who provides support and advice to the care homes. All data regarding medication errors are shared with the NHS Halton Clinical Commissioning Group Medicines Management Team, so that trends, themes and ongoing support can be identified.

Halton Borough Council's Human Resources & Development Manager has chaired the Safeguarding Learning and Development Sub Group and has implemented Learning and Development Strategies that give a framework that contributes to helping to keep people safe. Core programmes for Adults and Children's

Safeguarding Training has been delivered, covering a wide range of subjects, such as:

- Alerter Workshops (0.5 days)
- Safeguarding Adults Basic Awareness (e-learning)
- Safeguarding Adults Safer Recruitment (e-learning)
- Safeguarding Children Basic Awareness (0.5 days)
- Safeguarding Adults Referrers Training (1 day)
- Safeguarding Adults Investigators Training (2 days)
- Safeguarding Adults Chairing Skills (1 day)

The chair of the Safeguarding Learning & Development Sub Group has worked closely with Halton's Safeguarding Children Business Manager, to ensure that:

- Quality assurance arrangements are in place in respect of safeguarding training delivered or commissioned by partners, agencies or the Boards
- Recording, monitoring, analysing and reporting on the volume, profile and impact of the training delivered under the direction of the Board
- A range of Learning & Development opportunities and to implement them as appropriate
- Promotion of key safeguarding messages through the organisation at workshops/events and engaging in local and national campaigns
- Engage a range of stakeholders in safeguarding development activity
- Links are esablished with other groups in order to ensure that safeguarding knowledge and practice is embedded in strategies and priorities

During the year, training packages from Halton Borough Council, Schools, Youth Federation and Early Years and Day Care providers have gone through a training validation process to ensure the quality of training is meeting the expectations of the Board. Each year the Safeguarding Learning & Development Sub Group undertake a Training Needs Analysis to establish emerging training requirements and to ensure appropriate levels of training are available.

Disclosure and Barring Service requirements are well established within Halton Borough Council and work is ongoing into the implementation of an online registration process that will ensure efficient processing of applications.

In September 2014, the Halton Borough Council Trading Standards Team began a Scams Project to raise awareness of mass marketing fraud, after they became aware that at least 190 people in Halton had been targeted. The team have been trained in clean questioning and coaching skills for behaviour change. Trading Standards work with individuals to understand what scams they respond to, why they respond and work with them to find alternatives to fill the gap. The individual often feels a sense of belonging/friendship or purpose from responding to these scams. The team will also try to assist with the resolution of other problems that the individual may be experiencing, by referring to other agencies if necessary. As part of this work, the team have been raising awareness of this form of financial abuse with other Council services and agencies, as well as giving talks to community groups. For the purposes of the Scams Project, Trading Standards shared information with Adult Social Care, developing links with various teams. The team have also liaised with the Police and gathered information about services provided by local agencies and organisations that may be useful to the people they work wih.

Some members of the Trading Standards Team have also received Dementia Awareness training and all have been trained in clean questioning techniques to improve their ability to communicate with vulnerable people.

Case Example

Mr E is a 97 year old victim who has lost approximately £6,000 to scam mail but is reluctant to stop spending money. He is now receiving approximately 20 letters per day and numerous phone calls. Adult Social Care is involved and reported to Trading Standards that in a week Mr E's bank balance had gone from £60 credit to £220 overdrawn. The victim had no money for food and he had stopped paying his care bills.

Adult Social Care have worked with Mr E and his bank and arranged for him to have a new card as his current account is being drained by a series of direct debits that he has set up to the scam companies. The victim has agreed to have his mail redirected to Trading Standards so that the team can filter out any scam mail.

Mr E walks with the aid of sticks and the team was concerned that he was receiving a lot of scam and nuisance phone calls and his eagerness to reach the phone was likely to result in a fall. Trading Standards have provided him with a call blocker device, which should stop all of the scam and nuisance calls that he is receiving.

Working with Adult Social Care, Trading Standards have been able to remove the risk of continued financial abuse for this vulnerable person.

NORTH WEST AMBULANCE SERVICE

The North West Ambulance Service NHS Trust has a legal duty to protect patients, staff and the public from harm. This includes harm from others as well as avoidable harm to patients. The Clinical Safety and Safeguarding Team have worked hard during the year to identify patients at risk and have focused the following work streams to ensure patients and the public receive appropriate care and protection when required. The following summarises some of the achievements for the Trust over the last financial year: The Trust took part in the Care Quality Commission pilot assessments of Ambulance Service NHS Trusts. The result is that a number of standards have been developed for Ambulance Services and good assurance was received in relation to safeguarding arrangements. The Trust has a named contact for each of the 46 Safeguarding Adults Boards across the North West. This strengthens working together and information sharing relationships and is reflected in the increased number of Serious Case Reviews/Safeguarding Adult Revews and Domestic Homicide Reviews. Staff also access multi-agency training and share learning and expertise with their peers. The Safeguarding and Frequent Caller Teams are regularly identifying and sharing information, to enable a joined up approach to ensure vulnerable people are afforded the assessment and care they require, in accordance with their wishes. When appropriate they are protected from harm of abuse and a significant amount of patient data is now shared to ensure the best outcomes for these patients. This also includes sharing concerns in relation to nursing and care homes. A significant amount of work has been done to update the policy and associated procedures. These now include the principles of adult safeguarding and pathways are included for victims of Child Sexual Exploitation, Female Genital Mutilation and the radicalisation of vulnerable people. Over 75% of all North West Ambulance Staff have received WRAP 3 training, which is the “Workshop to Raise Awareness of Prevent” – part of the Government’s Anti-Terrorism Strategy. WRAP is included within mandatory training for all staff and compliance with this national requirement continues to increase monthly.

The following summarises some of the proposed developments for the Trust in 2015-16: The Electonic Information Sharing System (ERISS) is a bespoke web-based system used by the Trust for sharing safeguarding referral information with Children's and Adult Social Care. This system has the functionality to place warning flags, to alert the attending crew about child or adult protection issues. The application will be piloted over the forthcoming year. The current position of staff raising alerts with the Trust Safeguarding Team remains in place. The Trust is continuing to develop processes in relation to Domestic Abuse. Following the success of the pilot last year, a referral form for domestic abuse will be developed with provision for enhanced information sharing which links to the national guidance (NICE). The Trust Safeguarding Team is in the process of developing links with all the Child Sexual Exploitation Teams in the North West, to enable efficient and timely information sharing in relation to child sexual exploitation. This is over and above the current safeguarding procedures already in place. There is also a process to capture data relating to female genital mutilation, which has been communicated to all staff and this will be monitored during the year. The Trust is working with partners to help tackle issues relating to Slavery and Trafficking of children and adults. This work is in the initial scoping phase and any identified actions will be added to the safeguarding work plan for the year and progress monitored.

NHS ENGLAND NORTH (CHESHIRE & MERSEYSIDE)

NHS
North West

The following provides a summary of the activities and initiatives which have been undertaken by NHS England North in order to help keep people safe in 2014/15:

- Baseline Safeguarding Audit undertaken across all GP surgeries
- Safeguarding Training Assurance discussed at annual GP appraisal

- All NHS England Merseyside staff have undertaken Level 1, 2 or 3 training dependent on position held
- Second National Safeguarding Conference held in October 2014 hosted in Merseyside
- Safeguarding Report is presented to the Merseyside Quality Surveillance Group bi-annually
- All Clinical Commissioning Groups in Merseyside are assured for Safeguarding Service accountability
- A robust Serious Untoward Incident System and process is in place to monitor child deaths, Serious Case Reviews/Safeguarding Adult Reviews and Domestic Homicide Reviews
- NHS England North are members of all Local Safeguarding Children and Adults Boards
- A Merseyside Safeguarding Forum has been established for Designated Professionals
- Additional funding for Mental Capacity Act/Deprivation of Liberty Safeguards has been secured for training independent contractors (GPs, Dentists, Optometrists and Pharmacists)

NHS England North have identified the following as priorities for 2015/16:

- NHS England Assurance and Accountability implementation
- Review of Health Key Performance Indicator framework for all NHS contracted services
- Implementation of the Care Act 2014 in relation to adult safeguarding
- Develop in partnership with Clinical Commissioning Groups and Local Authorities – Mental Capacity Act/Deprivation of Liberty Safeguards awareness training
- Focus on PREVENT
- Implementation of Female Genital Mutilation mandatory recording for GPs

- Implementation of key recommendations from the Lampard Report 2015

WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust have participated in promoting public awareness by holding 'Safeguarding Events' in the main foyer of the hospital, providing the general public with up to date information on 'what is safeguarding?' and 'what to do if you have a concern or need to report abuse?'. Further engagement has taken place with partner agencies on National World Elder Abuse Day, Learning Disability Week and Domestic Violence Week, which has included promotional posters for Polish speaking families in the various departments across the hospital. Additional information resources have been added to the Patient Information HUB at the main entrance, which includes contact names and numbers for internal and external safeguarding teams. The Trust has also established a network of Safeguarding Champions in clinical areas to promote safeguarding and dignity standards. The Safeguarding Team within the Trust are triangulated with the Trust DATIX reporting system and Complaints Department. This allows for any incident that is reported and has a safeguarding element to it, to be reviewed by the Safeguarding Team to ensure correct investigation, referrals and processes have been undertaken. For example, investigation of any internal allegations made by patients or families against members of staff. The outcome of any internal investigations are shared with the Clinical Commissioning Group lead and Local Authorities. The Safeguarding Team are also participating members of the Trust Patient Experience Committee, Equality and Diversity Group and Learning Disability Group which all have third sector representation and patient representatives to allow for feedback. The Safeguarding Team have worked closely with other professional groups to allow for risks to be identified and plans put in place to, wherever possible, allow patients to continue to maintain their right to a family life.

Case Example

Mrs S lived alone and had a history of falls and of being alcohol dependent. She had a private carer who she paid to do her shopping and washing. She was admitted to hospital following a fall whist intoxicated. Her paid carer would supply the alcohol if requested to. Her daughter raised concerns with the staff that she felt her mother needed to go into a Care Home as she could no longer take care of herself.

A referral was made to the hospital Safeguarding Team to ask for help and support. The team along with the clinical staff, completed a mental capacity assessment on Mrs S regarding her wishes and choice of home. It was apparent that when not under the influence of alcohol, Mrs S had capacity to determine her own choices and wished to remain at home for as long as possible.

Along with the Discharge Planning Team, Mrs S was supported to understand the risks she was putting herself at by asking the paid carer to buy her alcohol and not providing her with appropriate nutritional needs. Mrs S agreed that her paid carer was not supporting her correctly and agreed to a package of care and to not have a private carer. Her daughter was also supportive of the new arrangements and Mrs S remained in her own home.

The Trust is represented at both the Halton Safeguarding Adults Board and the Safeguarding Childrens Board and subsequent sub groups. The Trust also has a representative at the Domestic Abuse Partnership and Multi Agency Risk Assessment Conference (MARAC). The Safeguarding Team cooperate with partner agencies to develop and agree protocols and policies that all staff can adhere to. The Trust have in place an agreed Information Sharing Protocol with partner agencies, which allow for the passing of information that is in the best interests of the patient. All requests for safeguarding information is channelled through the Safeguarding Team, where a record of the request for information and the information provided in response, is logged. This year the Safeguarding Team have

agreed a change of process with the Local Authority regarding the reporting of patients who have undergone a DoLS assessment. The Local Authority now informs the Safeguarding Team if a DoLS request has been made to them from the clinical areas. This allows for the team to provide additional support to the ward and the Local Authority, to ensure the correct process is being followed and patients' reviews are monitored. This has allowed for less duplication and errors in the process. This year has also seen the introduction of an Independent Domestic Violence Advocate (IDVA) service 2 days per week. This allows staff to refer any patient who discloses domestic violence to this service for guidance and support and provides a confidential service for low and medium risk clients, therefore, supporting prevention to the high risk category. There are a number of robust policy and procedures in place, that are accessible to all staff. These policies reflect local and national guidance. These include the process, procedure and guidance for Safeguarding Children and Adults; Domestic Violence; Mental Capacity Act and Deprivation of Liberty Safeguards; Prevent Agent; Clinical Holding and Restraint of Patients and are all widely promoted through the governance structure and available to all staff by the internal electronic intranet, known as the HUB.

The Trust views Safeguarding Adult training as a priority and is a mandatory requirement for all staff. Safeguarding Training Level 1 includes all clinical and non-clinical staff and is delivered in all Trust induction programmes. This programme is also delivered to all volunteers who join the Trust. Level 2 training is delivered by e-learning and twice monthly a 2.5hr session is delivered face to face to clinical staff. Bespoke one to one training is provided on request and to support action plans from internal investigations. Training has expanded to include Child Sexual Exploitation, Honour Based Violence including Female Genital Mutilation, Human Trafficking and the PREVENT agenda. There is a 3 yearly update session that all consultants have to undertake. The latest has been running since October 2014 and this will continue to run through to September 2015. Safeguarding Champion Days have taken place twice in the last twelve months, which is a multi-agency event to share learning and embed good practice. Each year we participate in the Halton audit of training evaluation and review the programme of training that staff require in accordance with national and local policy. The Safeguarding Team participated in the Crucial Crew Education Forum held at Select Security Stadium, which was in partnership with the Halton Safeguarding Adult Board's Learning & Development Sub Group. It is an

annual event that aims to offer Year 5 students across Halton advice regarding how to keep safe across a range of areas. The event received excellent feedback from all those who attended the event.

ST HELENS & KNOWSLEY HOSPITALS NHS TRUST

The following summarises the work undertaken by St Helens & Knowsley Hospitals Trust over the last year, in regards to helping keep people safe in Halton. The Trust has reviewed and ratified its Safeguarding Adults Policy to take account of the Care Act and statutory guidance. Safeguarding Adult activity issues are reported on a monthly basis to the Patient Safety Council supported by a Trust Safeguarding Adult Steering Group. The Trust has a Safeguarding Adult Work Plan which details all outstanding actions and progress is monitored through a Steering Group. The Trust has an Integrated Performance Report which includes a range of safeguarding metrics which is reported on a monthly basis to Trust Board level. The Trust reports on a quarterly basis to its commissioners on a range of Safeguarding Key Performance Indicators and is currently judged as providing reasonable assurance in respect of its safeguarding adult processes. On 26th June 2014, the Trust hosted a Care and Compassion Conference which was held at Whiston Hospital and attended by over 120 delegates, with internationally renowned speakers focusing upon creating a high quality care environment. The Trust Governance Process includes Patient Safety and Patient Experience Councils, both of which include representation from two local HealthWatch and parent carers. The Trust has a Learning Disability Pathway Group which includes representation from the local community disability services, advocacy groups and parent carers. The Trust has a number of Carer Focus Groups involving the on site Carer Support Team.

In January 2015, the Trust successfully bid for funding to develop and implement a single standardised pathway to enable adults who lack capacity and who may be resistant, phobic and challenging and who require acute care, to obtain that care through consistent best interest decision making and pathway planning. The aim is to deliver this in September 2015. The Trust ensures that it is well represented at all multi-agency meetings from Board to individual case level and achieved a 90% attendance in the period. The Trust has implemented the Halton Multi-Agency Procedures and has a good record of making appropriate safeguarding referrals, which are progressed through to an outcome. The Trust has signed up to the Crisis Care Concordat and is working with its partners in implementing its Local Action Plan.

The trust has a well established Dignity Champions Network which was reviewed and relaunched in 2015, leading to a much wider representation which includes both HealthWatch members and care providers. The Trust has a Safeguarding Adult Training Needs Analysis which supports four levels of training. Level 1 compliance is 97%, Level 3 is 80% and Level 2 compliance has been achieved in line with the trajectories agreed with the Trust's commissioners. The Trust has a range of policies and procedures which support safer workforce initiatives, identifies allegations made against professionals, makes safeguarding referrals to the local authority and collaborates with the investigative process. The Trust has a central reporting system known as DATIX, which generates reports and which feeds into the process of learning from such incidents. The Trust Safeguarding Team provides guidance to all areas of the Trust and provides quarterly reports on all activity, demonstrating that all areas of the Trust now raise safeguarding adult concerns at an increasing rate for advice and guidance, but the proportion referred on formally to the local authority continues to be consistent. The Trust has maintained a regular level of review of its processes relating to identifying and managing Deprivation of Liberty Safeguards over the period and is reviewing its Mental Capacity Act/DoLS policies. The Trust has adopted NICE Guidance in respect of managing incidents of Domestic Abuse and has achieved good progress against full compliance.

HALTON CLINICAL COMMISSIONING GROUP

NHS
Halton Clinical Commissioning Group

NHS Halton Clinical Commissioning Group (CCG) requires that all its commissoned services, Governing Body Members, Member Practice staff and Clinical Commissioning Group staff are appropriately trained to ensure that they are aware of

abuse and the right to a safe and dignified life. The NHS Halton CCG through its contracts require that all providers evidence appropriate policies and procedures. Providers are required to evidence that their policies and procedures are in line with those approved at the Halton Safeguarding Adults Board. The NHS Halton CCG has developed and approved appropriate policies and procedures for staff to have completed appropriate training and this is monitored internally. All commissioned providers are required to assure the NHS Halton CCG of their compliance with staff training trajectories and to evidence how they are ensuring that staff are aware of risks of abuse and mitigate against these. The Designated Nurse for Safeguarding Adults has worked to support the development and review of a number of policies and procedures in relation to prevention on behalf of the NHS Halton CCG. One of the key functions for NHS Halton CCG is engagement and involvement of local people, on all areas of work undertaken. During 2014/15, NHS Halton CCG was involved in a large number of patient and service user engagement events obtaining views on commissioning plans and service delivery. NHS Halton CCG requires all providers to evidence how they enable and encourage service users and carers to share their views to influence service delivery and change. This information is shared with the Board to inform them of its work. Individualised care is a requirement in all health provision and currently providers are providing evidence of 'I Statements' from patients to evidence the level of involvement in care planning, the level of understanding of care planning and delivery and how confident patients feel of their ability to influence what happens to them. The NHS Halton CCG received regular reports from all providers in relation to comments, compliments and complaints which includes evidence of how this has led to service changes. Whilst this does not relate specifically to safeguarding, it will impact on the care of adults at risk. The NHS Halton CCG has supported and facilitated a string of multi-agency approaches to safety, wellbeing and dignity across all care areas. It provides a wellbeing service to all practices, which all local people can access. The development of a Multi Disciplinary Team around practices and patients has improved our ability to support vulnerable people to facilitate and encourage safety, dignity and independence. NHS Halton CCG in collaboration with all local stakeholders have enabled the development of person-centred planning to enable self care and independence whilst ensuring vulnerable people are protecting themselves from harm.

CHESHIRE CONSTABULARY

The following summarises some of the key work undertaken by Cheshire Constabulary during 2014/15 to help keep people safe in Halton:

- Active use of social media to promote all aspects of safeguarding, including Force Twitter, Neighbourhood Twitter accounts and Public Protection Unit Twitter accounts

- Reviewed and implemented the Force Adult at Risk procedure in line with the Care Act 2014

- Worked with all four Local Authorities and Safeguarding Adult Boards to develop a new Adult at Risk procedure

- Delivered training to all front line officers as part of regular monthly training days. Training focused on Adults at Risk in April to coincide with the launch of the new Force procedure

- The Force have committed to the delivery of regular safeguarding training across the whole workforce, as safeguarding is identified as a priority for the Force

- Training also includes other specific vulnerable groups - Domestic Violence and Stalking and Harassment

- Developed revised system to record concerns around vulnerable people through the new reporting system – Vulnerable Persons Assessment (VPA). This replaces the older IT system CAVA.

- Introduction of new reporting system was supported by training provided to all officers and staff about identification of vulnerability, local problem solving and escalation through submission of a Vulnerable Persons Asssessment

- A dedicated Adult at Risk Officer has been appointed by the Force

- The Force has supported a number of Domestic Homicide Reviews across the county. Learning from these reviews is coordinated through the Strategic Public Protection Unit

NATIONAL PROBATION SERVICE - CHESHIRE

The National Probation Service which was established as a separate entity by the Government in June 2014, has a dual responsibility to offenders (some of whom are at risk and vulnerable) and to their victims who can at times be exploited/abused by offenders and who indeed may target such victims. Victims of serious crimes have been advised over the last year of their right to have some protection written into offender's prison licenses on release, via no contact clauses and exclusion zones where the offender may not pass through or visit. They are also given support and advice and guidance linked into Independent Domestic Violence Advocates/Adult Social Care/Police as relevant and with their permission and active participation wherever possible.

The main multi-agency partnerships that the National Probation Service link into, in order to ensure safety and dignity of both victims and offenders are Multi- Agency Public Protection Arrangements (MAPPA) for our dangerous offenders and Multi-Agency Risk Assessment Conference (MARAC) and Domestic Violence Forums for domestic violence victims, where our offenders are the perpetrators and similarly in child safeguarding and in particular the developing strategy over 2014/15 of Child Sexual Exploitation. MAPPA meetings are primarily concerned with the past and potential victims of dangerous offenders and links are made with agencies that can assist in the protection of those who are vulnerable and they are invited to the meetings to contribute to the risk of management plans of the offender. All potential victims are tracked and constraints as well as therapeutic interventions are placed on offenders including, where necessary, proportionate disclosure to new partners/families etc.

The National Probation Service undertake victim feedback audits each year, which the Victim Contact Service have been in contact. An Offender Survey is also analysed and working practices altered where indicated. The offenders responding to the last survey indicated that they felt treated with respect in the way they were responded to; waiting times; interventions and transparency of the service they received. Feedback both positive and negative, as well as learning from reviews and

investigations and complaints from service users, are responded to by the management of the service.

Service User Forums are held in most of the offender management units. These are active and lively forums, which also contribute to the development of policy and practice. One of the biggest strengths/skills a Probation Officer requires, is their ability to be transparent with service users about the danger they are seen to represent to others more vulnerable than themselves, whilst at the same time supporting and respecting the needs of the offender who may also be vulnerable to others. They understand that often the best way of reducing the risks that an offender represents, is to meet their needs that have often been neglected in the past. It is well recognised that many offenders have mental health needs that can, if untreated, influence their negative behaviour to others.

CARE QUALITY COMMISSION

As a regulator, the main responsibility of the Care Quality Commission (CQC) is to ensure that all health and adult social care providers have clear and robust systems in place to keep people who use their services safe and employ staff that are suitable skills and supported. The role and overarching objective of the CQC in safeguarding is to protect people's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. As a regulator, CQC are keen to work with local safeguarding teams and to establish effective working relationships. These relationships help to keep people safe.

CQC commit to representation to a Halton Safeguarding Adults Board meeting as least once per year. Local agreements should be in place to ensure that local CQC Inspection Managers receive minutes from all Board meetings. As a partner, as opposed to a member of the Board and a national regulator, the focus of our local inspection teams is on inspecting regulated services against their five key questions of safe, effective,caring, responsive and well-led. In doing this, CQC work in partnership with Local Authorities and local Clinical Commissioning Groups, to highlight areas of concern within regulated services. CQC will take regulatory action as appropriate.

CQC has implemented a specialist approach to the inspection of health and social care services, informed by intelligent monitoring. This informs when and how they inspect health and social care services and with the use of real time data, results in appropriate and timely action to safeguarding concerns. The CQC's position with

regard to working with Local Authorities does not change under the implementation of the Care Act 2014 and therefore CQC will not be implementing a Designated Adult Safeguarding Manager for each Local Authority across England. CQC have two National Advisors for safeguarding, who work across all Directorates and offer advice and support to staff and who work with national bodies, such as the Department of Health. All CQC staff are offered role appropriate safeguarding training. CQC has, and continues to, raise awareness amongst the general public about their role. Safeguarding concerns raised with CQC come from members of the public or from community organisations. People who use services and their carers are involved as partners in inspections. CQC is continually working to forge closer links with local organisations.

5 BOROUGHS PARTNERSHIP

Over the reporting year the Trust has introduced the Duty of Candour into our delivery of services as a key recommendation of the Mid Staffs enquiry. This places a duty on us, as a health provider, to be open with patients when things go wrong. The safeguarding service are working with partners to ensure that our Duty of Candour is embedded into the culture of the organisation and works alongside ither agendas such as Making Safeguarding Personal.

The Safeguarding Team in the Trust continue to provide advice and support to all our services. Practitioners reporting concerns to the team are guided to asking the individual concerned what they want to happen in the first instance, are they aware of safeguarding and what this means t them and more importantly what they don't want to happen.

Safeguarding Adults training is mandatory for all clinical staff who have patient facing contact. This training highlights what abuse is, the effects abuse has on an individual and how to report it. Safeguarding Adults training has undergone an extensive review over the reporting year and the Trust will now commence embedding the National Competency Model (Bournemouth) into training provision. This will seek to further embed the key knowledge and training expected of all staff in the Trust in relation to Adults at Risk.

The Trust continues to support the work of the Board and to implement the changes in safeguarding practice in line with the requirements of the Care Act which came

into force in April 2014. One of the key challenges for our staff is the process of "making an enquiry" on behalf of the Board. This will continue to be driven by the safeguarding process and advice sought from our Local Authority partner in the first instance as to how much involvement is needed by our staff.

The Trust has reviewed its Consent Policy and the Safeguarding Team are heavily involved with the review of how this works in practice Trust wide across all of our busines streams. This seeks to ensyre that service users are fully informed of the care and treatment being provided to them and when concerns are raised what happens next. This has been run in conjunction with a series of Mental Capacity Act workshops looking at how to complete assessments and maximise an individual's ability to make decisions for themselves.

The Safeguarding Team in the Trust continue to provide advice and support to all our staff. Safeguarding concerns are communicated to the team on an electronic form as well as telephone advice being available in working hours. The team will quality assure all safeguarding activity across the Trust to continually improve practice and maintain a safe, effective service. This involves support being given to practitioners who are working with complex cases and managing high levels of risk.

The Trust has "what to do" flowcharts in all clinical areas that guide staff through the reporting process of reporting abuse. The presence of the flowcharts are checked within our Internal Quality Review process to ensure staff have easy and quick access to the appropriate contact numbers and advice. Both the Trusts internal safeguarding team and the Local Authority Contact Centre details are on the flowchart.

The Trust has a robust Information Governance procedure that guides staff through the handling of sensitive information. We are also signed up to Information Sharing agreements across our partner agencies for processes such as MARAC. Training is mandatory for staff and advice available from our Information Governance Lead.

Trust staff are aware that information must only be shared on a need to know basis and that consent should always be sought to disclose information unless inappropriate to do so. This is covered in existing safeguarding training with case examples being used to highlight the scenarios staff may face when out in practice.

Under the Care Programme Approach, service users who are classed as "CPA" will have a care plan which clearly documents the roles and responsibilities of all those involved. Care plans are subject to rigorous audits to ensure they are of high quality and meaningful to the individual in receipt of the service. For those service users who are not meeting the threshold of CPA, in that their needs/presentation is not as complex, there is a statement of care provided. Again, this will outline what service is being provided and by whom.

The Trust runs regular inspection of services which we call Internal Quality Reviews. These involve a team of "experts" who visit a service/team over the course of a day looking at standards of care and the patient experience. Within the reviewing team will be service user/carer representatives who will lead on speaking to other service users/carers on their experience of services and how we can improve as an organisation. This will include asking about the care plan/statement of care and if they are happy with this.

4. KEY ISSUES WHICH HAVE HAD AN IMPACT ON THE BOARD

Deprivation of Liberty Safeguards: The Deprivation of Liberty Safeguards (DoLS) is one aspect of the Mental Capacity Act 2005. The safeguards are to ensure that people in care homes and hospitals are cared for in a way that does not inappropriately restrict their freedom and, if necessary, restrictions are only applied in a safe and correct way and is only done when it is in the best interests of the person and there is no other way to provide appropriate care.

On 19th March 2014, the Supreme Court made a judgement, which is significant in determining whether arrangements made for the care and/or treatment of an individual, lacking capacity to consent to those arrangements, amount to a deprivation of their liberty.

There are a number of implications for Local Authorities as a result of this judgement:

- There is likely to be an increased number of applications for DoLS authorisations, which will inevitable place pressue on the Best Interest Assessors across the Council and other agencies

- There is likely to be a need to revisit previous decision making and address it in some cases. There is a need to scope settings outside of residential care homes and hospitals and proceed with those that need authorising

- Communication and guidance will be required for all stakeholders

An initial scoping exercise has been completed to estimate the number of assessments that may be required and a risk assessment undertaken. In addition to the Best Interest Assessors, there is a requirement for a Mental Capacity Assessment to be completed by an appropriately qualified Doctor. NHS England are to address the increased need for Doctors qualified in this area.

Period	DoLS Applications 2014-15	DoLS Applications 2013-14
Quarter 1	38	10
Quarter 2	51	12
Quarter 3	53	5
Quarter 4	48	6

Care Act 2014

Care Act 2014: The Care Act come into effect from 1st April 2015. Regular updates regarding the implementation of the Care Act and the statutory requirements for Safeguarding Adults Boards, have been presented to Halton Safeguarding Adults Board. A Care Act Compliance Checklist has been developed in order to monitor if the Board is meeting all of its statutory requirements. Updates in relation to this checklist will be presented to the Board at regular intervals.

In relation to the North West Ambulance Service, the implementation of the new Care Act 2014 provides a legal framework for the assessment and protection of adults including those at risk with an emphasis on the wellbeing of the patient. This may account in part, for the noticeable rise in safeguarding adult activity over the year, which includes concern for the welfare of vulnerable adults requiring assessment. Likewise, safeguarding children activity steadily increased across the trust, particularly within the Paramedic Emergency Service, but at a slower rate than for adults. A number of high profile national investigations have resulted in an update to safeguarding procedures and training, to ensure that adults and children who are at risk or victims of exploitation and radicalisation are also safeguarded.

The National Probation Service – Cheshire: The service has managed vulnerable offenders over the last 12 months. Elderly sexual offenders or those serving life for other serious crimes have to be assessed for release when their risk to others is deemed to have been reduced to a safe enough level or where they have reached a determinate release date whatever their risk levels. Such offenders can be quite frail and in need of care and support to live in the community. At times they have become dependent on the prison regime and their ability to look after themselves is severely diminished. Advocating for their needs to be met can be very challenging for their Probation Officers. Such needs are taken account of in the Service's Vulnerable Adults Practice Guidelines, where needs of the service users need to be balanced with the risks that they may still pose to others.

Case Example

A Probation Officer had to find appropriate care for an elderly male who had been convicted of serious child and adult sexual offences. He needed residential care and was released from prison at the end of a determinate prison sentence. As he still presented some risk and this may have increased with the onset of early dementia, the Probation Officer had to ensure that sufficient safeguards were present in any residential setting for both visitors/fellow residents and staff, that was being investigated, but that his needs could still be met and that only those who needed to know about his background were informed and that he was still treated with dignity and respect.

This was very challenging for the Probation Officer simply to have him accepted anywhere and the safeguards and needs met, but this was achieved and the officer worked very closely with the management of the residential setting that was accepting and respecting of him.

The Care Act now includes those in the National Probatin Service, who reside temporarily in their Approved Premises. These house, in the main, those offenders who are deemed to still present a significant risk to others. As above, the responsibility for those offenders who may be vulnerable to the exploitation of others because of their physical and mental health needs, has to be combined with ensuring that meeting their needs and wishes does not present a risk to others. The main challenge in relation to communities that abound our Approved Premises, is getting across that if such offenders were not housed in this facility, they would be subject to much less oversight and monitoring if they were out in the community and that they too have rights and needs and can be vulnerable and need assistance themselves, to live a worthwhile life post prison. The Probation Service work through multi-agency partnerships such as Multi Agency Public Protection (MAPPA), to try and achieve the balance of protecting the public, whilst meeting the needs of the individual offender to allow them to live as independent a life as possible in the community.

2014/15 has been a very turbulent year for the Probation Service as the Government legislated that the high risk offenders would be dealt with by a National Probation Service and the others managed by a private company, generically known as a Community Rehabilitation Company. This split took place in June 2014 and created much disruption to both staff and clients for a considerable period and hampered innovation in all areas of work. Currently policies and practice guidelines are all being reworked, as the National Probation Service has developed the necessary management and infrastructure to allow the basics to be in place. In the interim, the Probation Service has continued to use the Probation Trusts' previous policies, with amendments as required. Workshops and events around both child and adult safeguarding are planned for the summer months covering all the offender management units.

Despite the disruption, the adult safeguarding concernsfor both victims and offenders have been uphelad via forums, such as MAPPA, and in individual supervisions sessions of Probation Officers managing offenders and those staff whose primary role is victim contact and support. The service has also developed reflective practice sessions in particular for those offenders with Personality Disorders, often presenting a high risk of harm to others whose own needs have not been met by established systems. There is a well established complement of psychology staff, advising Probation Officers as to how best to combine both risk and need management. This has been an invaluable resource and has aided Probation Officers to work more effectively with that complex dynamic.

5. PERFORMANCE

The Safeguarding Adults Return is based on a data collection from 1st April 2014 - 31st March 2015. This is a mandatory collection which records information about individuals for whom safeguarding referrals were made during the reporting period.

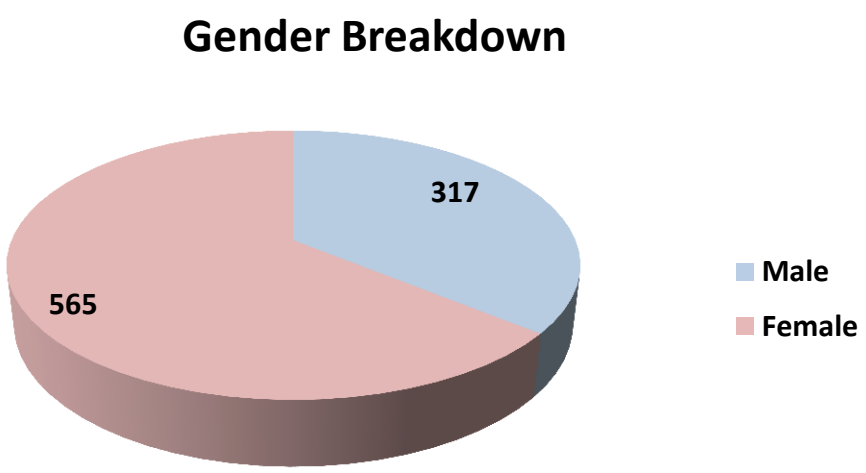
A safeguarding referral is where a concern is raised about a risk of abuse and this instigates an investigation under the safeguarding process. A referral can involve more than one location of abuse, type of abuse or more than one person alleged to have caused harm.

An adult at risk is the person who is alleged to have suffered the abuse. The adults at risk included in the Safeguarding Adults Return are aged 18 and over and have some level of care and support needs.

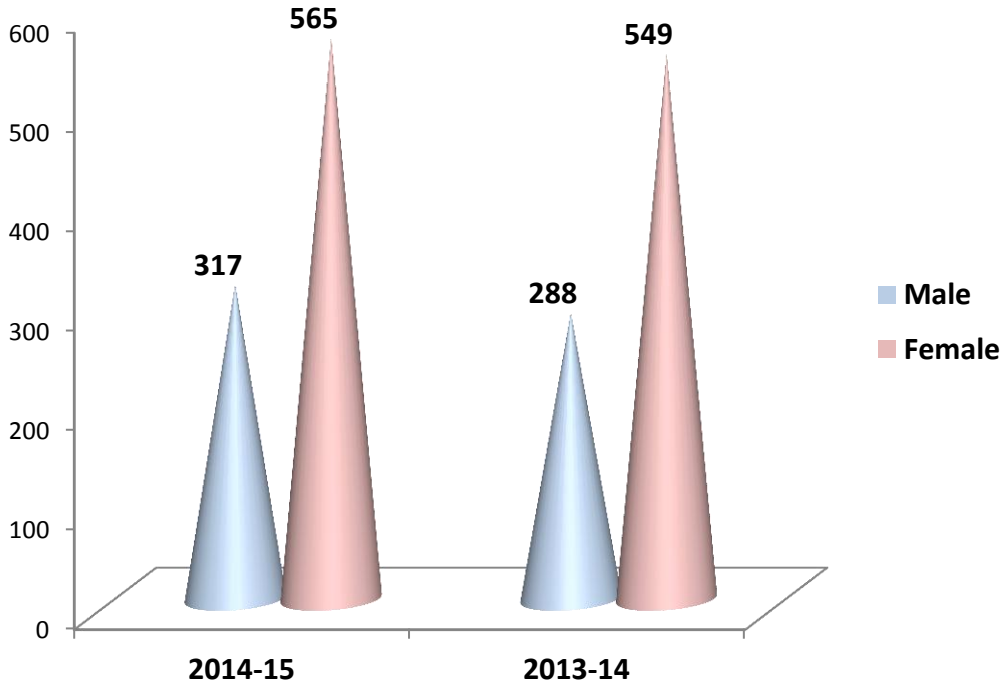
Please find below a summary of the findings from the Safeguarding Adults Return and a comparison of figures between 2013/14 and 2014/15, where applicable.

The total number of safeguarding referrals received during 2014/15 was **882**. This compares to **837** safeguarding referrals received in 2013/14.

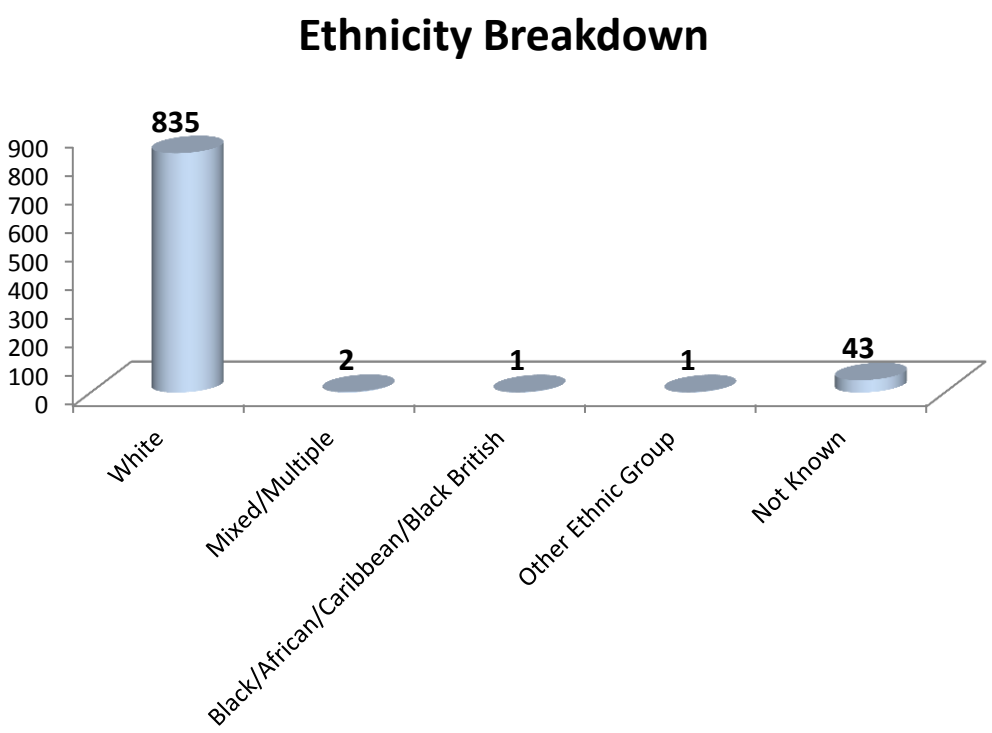
Gender	2014/15 Total
Male	317
Female	565



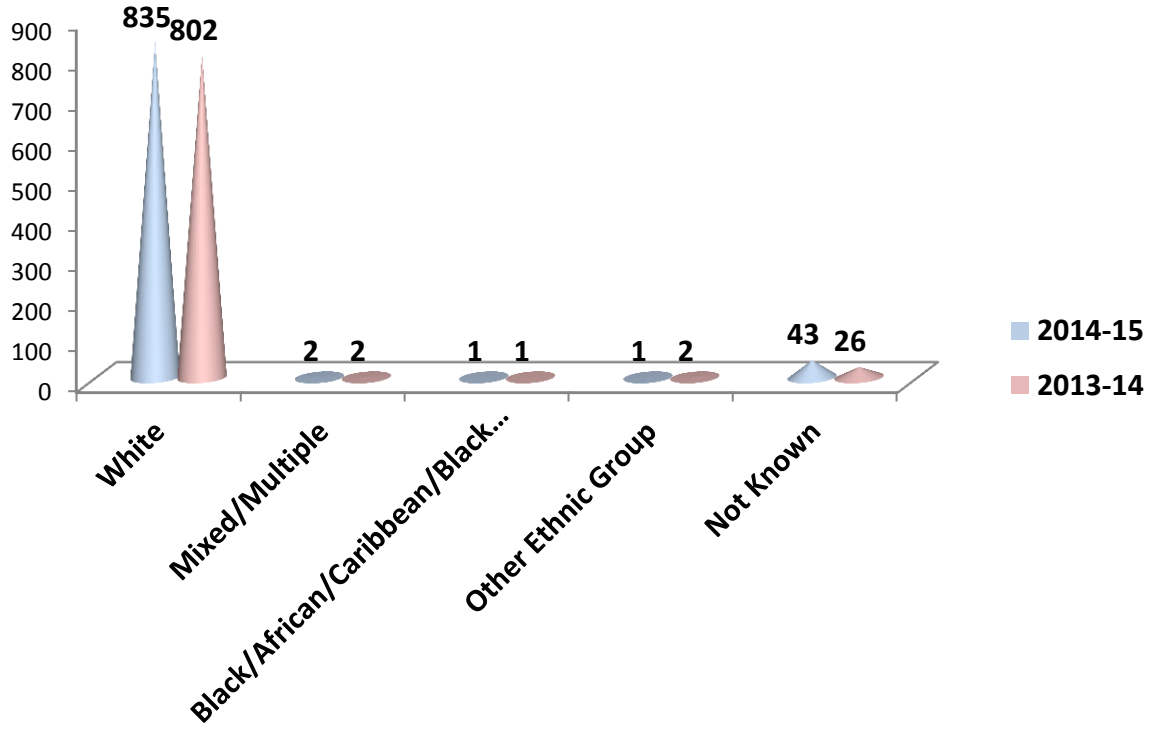
Gender	2014-15	2013-14
Male	317	288
Female	565	549



Ethnicity	2014/15 Total
White	835
Mixed/Multiple	2
Black/African/Caribbean/Black British	1
Other Ethnic Group	1
Not Known	43

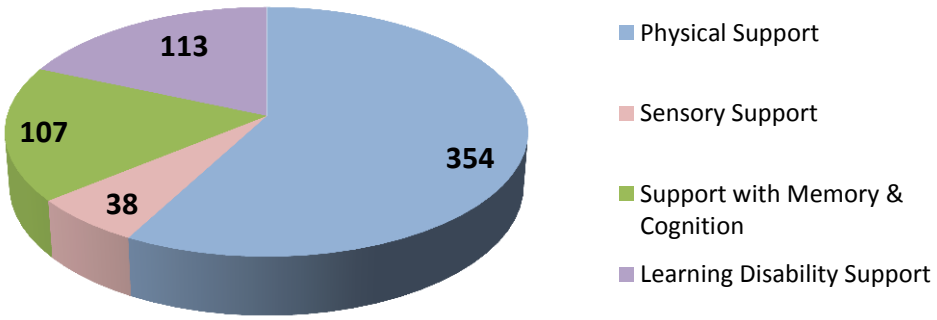


Ethnicity	2014-15	2013-14
White	835	802
Mixed/Multiple	2	2
Black/African/Caribbean/Black British	1	1
Other Ethnic Group	1	2
Not Known	43	26



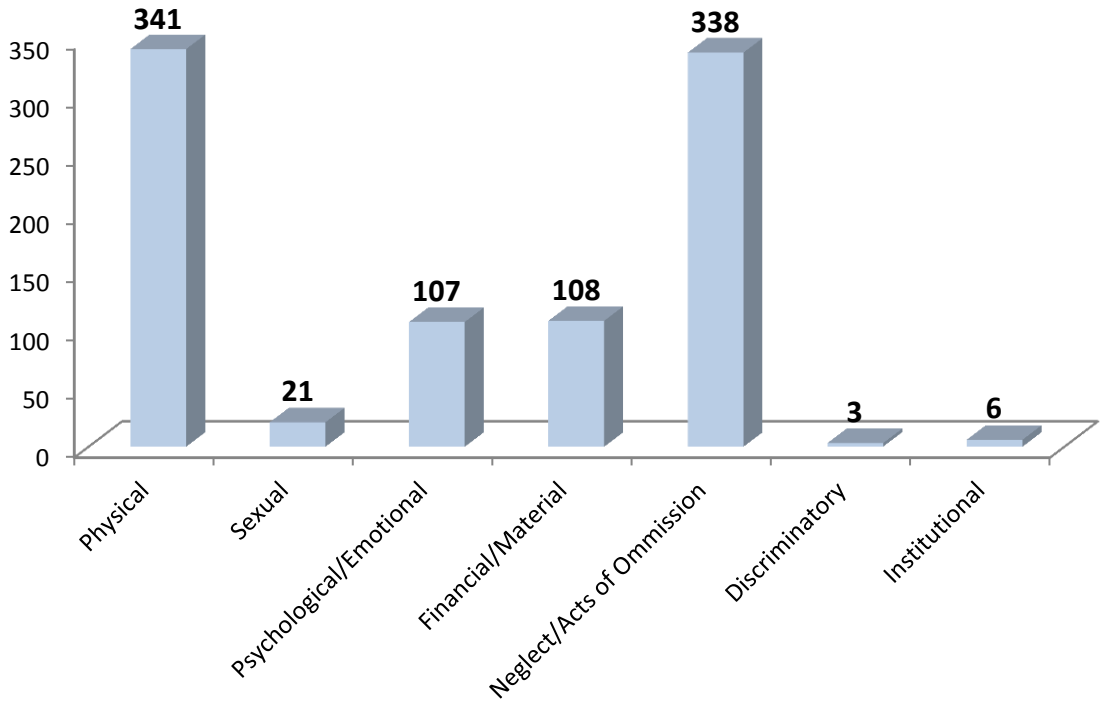
Primary Support Reason	2014/15 Total
Physical Support	354
Sensory Support	38
Support with Memory & Cognition	107
Learning Disability Support	113

Primary Support Reason Breakdown



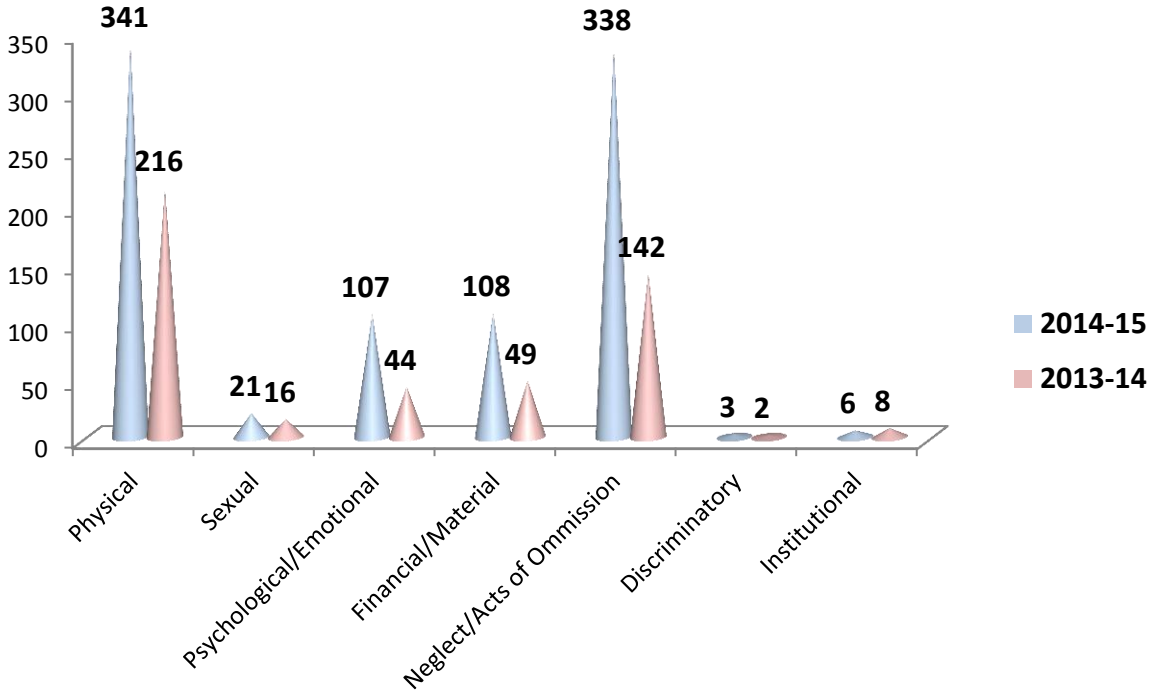
Type of Abuse	2014/15 Total
Physical	341
Sexual	21
Psychological/Emotional	107
Financial/Material	108
Neglect/Acts of Omission	338
Discriminatory	3
Institutional	6

Type of Abuse Breakdown



please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one type of abuse

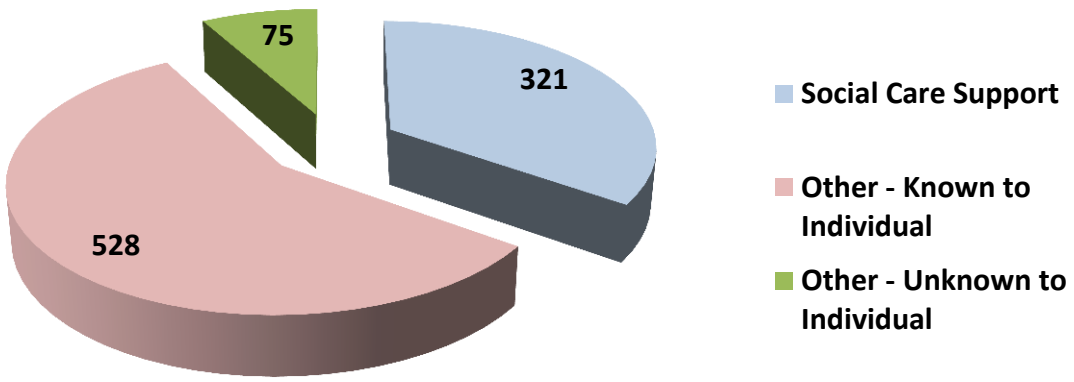
Type of Abuse	2014-15	2013-14
Physical	341	216
Sexual	21	16
Psychological/Emotional	107	44
Financial/Material	108	49
Neglect/Acts of Omission	338	142
Discriminatory	3	2
Institutional	6	8



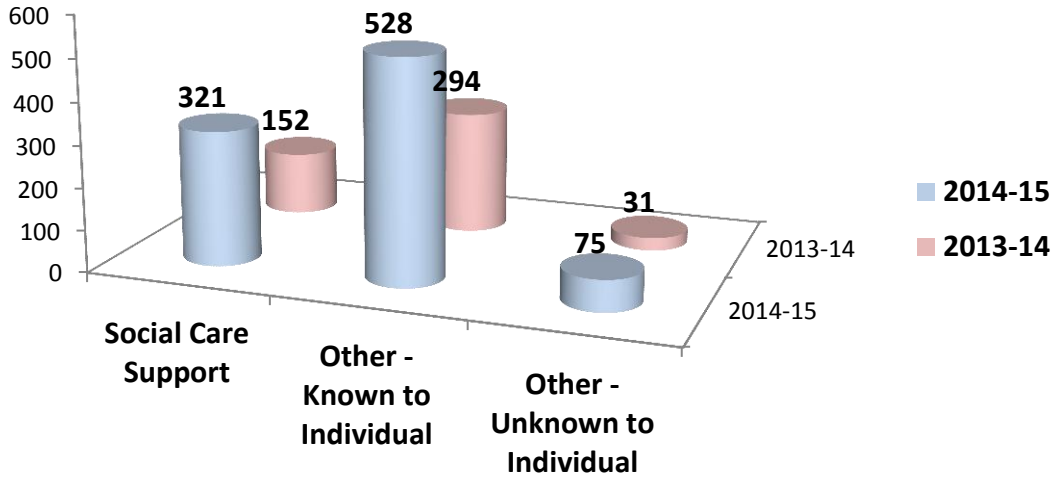
Source of Risk	2014/15 Total
Social Care Support	321
Other - Known to Individual	528
Other - Unknown to Individual	75

*please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one person alleged to have caused harm

Source of Risk Breakdown



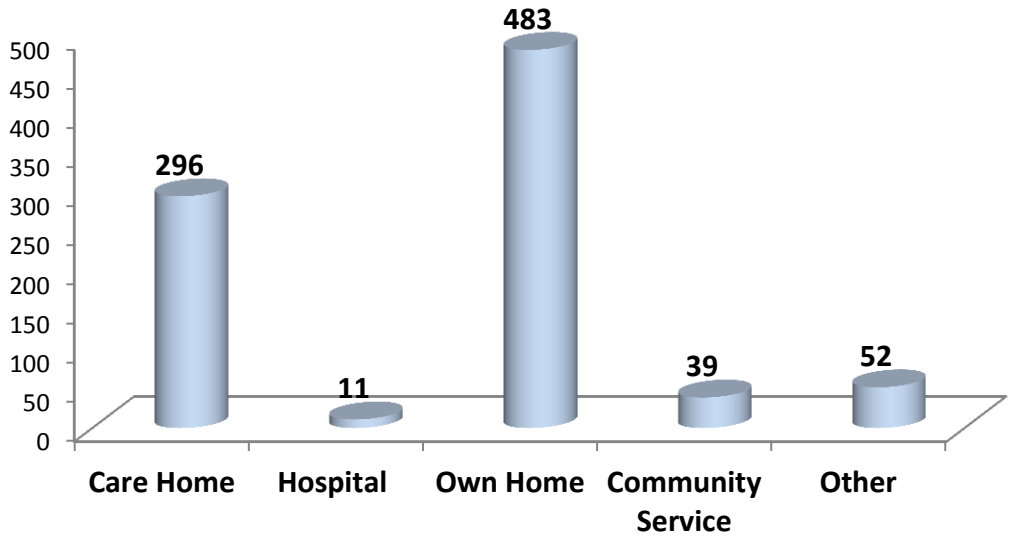
Source of Risk	2014-15	2013-14
Social Care Support	321	152
Other - Known to Individual	528	294
Other - Unknown to Individual	75	31



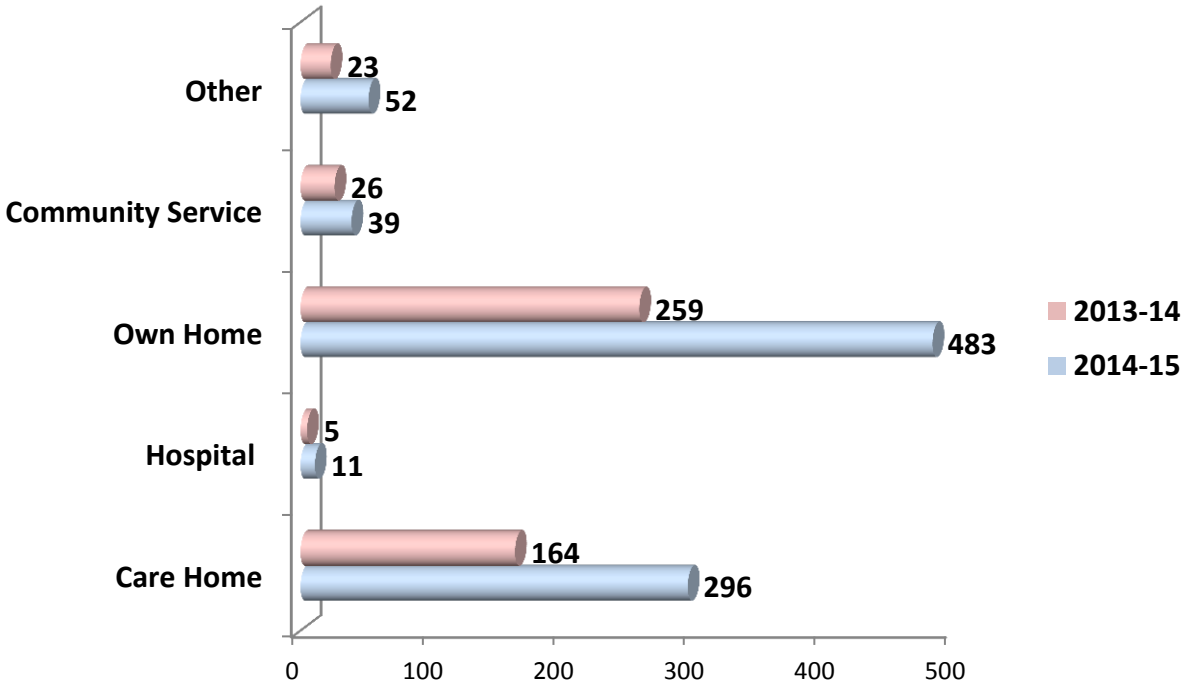
Location of Abuse	2014/15 Total
Care Home	296
Hospital	11
Own Home	483
Community Service	39
Other	52

**please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one location of abuse*

Location of Abuse Breakdown

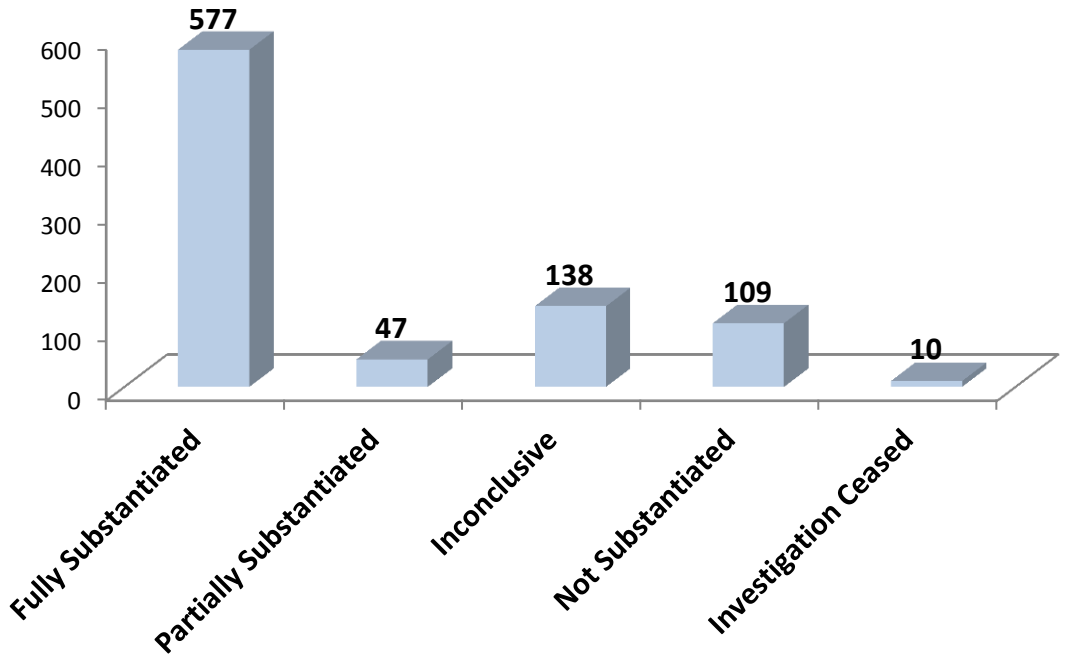


Location of Abuse	2014-15	2013-14
Care Home	296	164
Hospital	11	5
Own Home	483	259
Community Service	39	26
Other	52	23

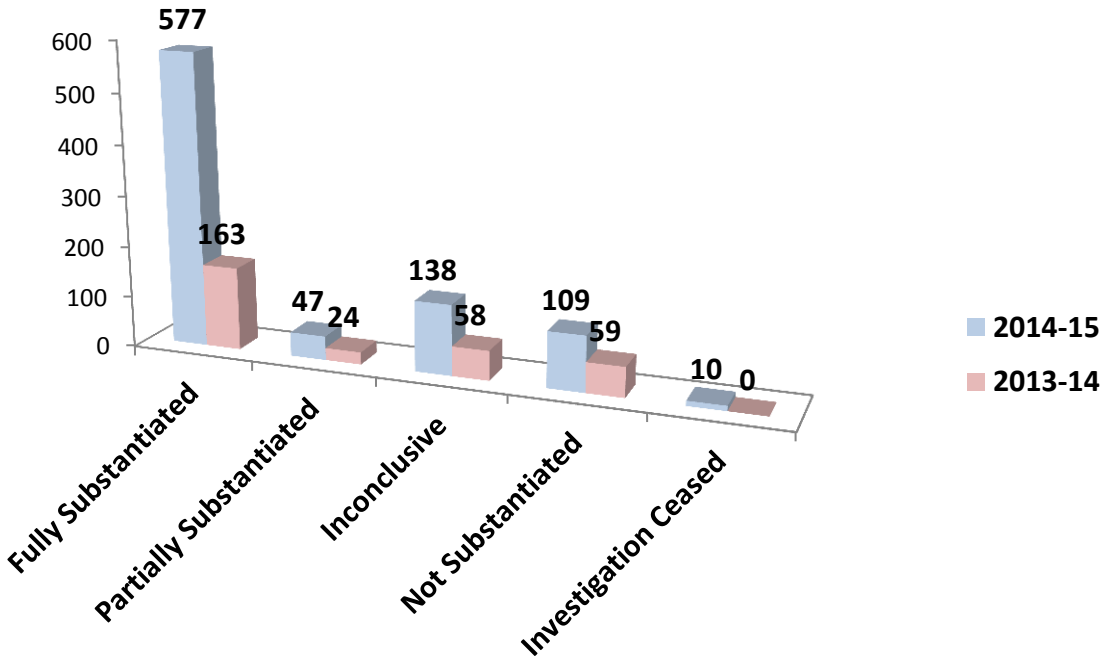


Conclusion of Referral	2014/15 Total
Fully Substantiated	577
Partially Substantiated	47
Inconclusive	138
Not Substantiated	109
Investigation Ceased	10

Conclusion of Referral Breakdown



Conclusion of Referral	2014-15	2013-14
Fully Substantiated	577	163
Partially Substantiated	47	24
Inconclusive	138	58
Not Substantiated	109	59
Investigation Ceased	10	0



6. FUTURE PRIORITIES

The priorities for 2015-16 which Halton Safeguarding Adults Board will be working towards are as follows:

EMPOWERMENT – *I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens*

PREVENTION – *I receive clear and simple information about what abuse is, how to recognise signs and what I can do to seek help*

PROPORTIONALITY – *I am sure that the professionals will work in my interests, as I see them and they will only get involved as much as needed*

PROTECTION – *I get help and support to report abuse and neglect. I get help so that I am am able to take part in the safeguarding process to the extent to which I want*

PARTNERSHIP – *I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me*

ACCOUNTABILITY – *I understand the role of everyone involved in my life and so do they*

REPORT TO: Health and Wellbeing Board

DATE: 13 January 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Infant feeding Strategy 2016-19

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report presents a new infant feeding strategy, which outlines Halton's approach to infant feeding over the next 4 years. The strategy aims to create a culture and services that support families and carers within the borough to make informed healthy choices when feeding their baby and young child, to ensure the best possible health and wellbeing outcomes are achieved.

This Strategy will contribute to Halton's Readiness for School Indicator. Encouraging parents and service providers to enable infants and young children to breast feed, be weaned and commence solids at the appropriate age leads to well-developed facial muscles and speech and language skills which in turn means young children are ready for school.

2.0 **RECOMMENDATION: That the Board approve the Infant Feeding Strategy and recommendations.**

3.0 **SUPPORTING INFORMATION**

3.1 How a child is fed in their first year of life leaves a lasting impact throughout their life. Good nutrition enables optimal growth to be achieved, allowing a child's body and brain to grow, building important physical functions such as neuro-connections in the brain and the immune system. An infant's diet influences their future ability to self-regulate their appetite, their likelihood of becoming obese, and their subsequent risk of developing conditions such as diabetes and heart disease. Their susceptibility to conditions, such as gastroenteritis and constipation are also influence by their diet.

3.2 Conditions that relate to diet are impacting upon the health of Halton's infants. In recent years there has been a slow increase in the number of women who breastfeed but there is still a long way to go to catch up with the rest of England. Similarly the rates of obesity remain a priority for Halton, while childhood obesity rates

have improved for year 6 children, reception age children remain higher than the England average.

3.3 In order to optimise the health of Halton residents the infant feeding strategy aims to achieve the following three overarching outcomes:

1. Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.

2. Increase the number of infants who are introduced to solid foods at or around 6 months of age.

3. Increase the awareness of parents and the general public of healthy feeding practices for infants; and change behaviour accordingly.

A full and detailed action plan underpins the strategy and measures the achievement of the aims and outcomes.

3.4 **Recommendations**

The main recommendations in the infant feeding strategy are:

1) For health and social care organisations and leaders to prioritise infant nutrition and the prevention of obesity.

2) Critical to the success of this strategy is partnership working across health and social care, and between community and hospital settings.

3) Continue to fund an infant nutrition coordinator role.

The infant nutrition agenda runs across disciplines, and the role of the infant nutrition coordinator is central to driving this agenda forward across disciplines.

4) Commission baby friendly health and social care services.

Endeavour for commissioned services, such as maternity services to be performance managed against their breastfeeding outcomes.

5) Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.

a. Make breastfeeding the norm
b. Raise awareness of the benefits of breastfeeding amongst the general public and increase its acceptability
c. Ensure that women have the information, support and skills to breastfeed
d. Achieve and maintain UNICEF Baby Friendly Initiative

6) Support staff to breastfeed upon returning to work following maternity leave, through breastfeeding policies and supporting local businesses to adopt similar policies.

7) Increase the number of infants who are introduced to solid foods at or around 6 months of age, through partnership working with health visitors, children's centres and the health improvement team

8) Increase the awareness of parents and the general population of healthy feeding and drinking practices for infants; and change behaviour accordingly.

4.0 **POLICY IMPLICATIONS**

The strategy addresses some key issues to improve the short and long term health of infants in Halton. As such the recommendations will cover a broad scope of policy areas across the council, CCG and health and care partners.

5.0 **FINANCIAL IMPLICATIONS**

5.1 There may be financial implications in the implementation of recommendations within the strategy which will be assessed and managed within the Halton Healthy lifestyles board and through partner agencies for which the implication affects.

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

6.1 **Children & Young People in Halton**

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

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

The short and long term health of children and young people directly influences their educational performance and chances of employment. Therefore in the long term the issues outlined in this report will impact directly on this priority term.

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 There are no risks associated with the development and implementation of this strategy.

8.0 **EQUALITY AND DIVERSITY ISSUES**

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

9.0 **REASON(S) FOR DECISION**

To provide a coordinated approach to improving infant nutrition for Halton residents.

10 **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

None.

11 **IMPLEMENTATION DATE**

January 2016 -2019.

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

.

None under the meaning of the Act.

Halton Infant Feeding Strategy 2016-2019

HALTON BOROUGH COUNCIL

Halton Infant Feeding Strategy 2016-2019

Foreword

Welcome to the infant feeding strategy for Halton. Our vision is to create a culture and commission services that support families and carers to make healthy choices when feeding their young child. We know that what a baby eats can influence not only how they grow and develop when they are young, but also throughout their childhood and into adulthood. Evidence suggests that a child from a low-income background who is breastfed is likely to have better health outcomes in the early years, than a child from a more affluent background who is formula-fed, enabling them to leapfrog over some of the disadvantages that come with poverty.

There are some things we know will improve infant health; such as supporting mothers to breastfeed, families introducing solid foods when their baby is around six months old, and providing young children with a balanced diet. We also know that parents with young families have a lot to juggle. There can be lots of people giving advice on how to bring up your child and we aim to help families get the right advice and support at the right time.

This strategy builds upon the excellent and effective work that is already underway in health and community services. The strategy outlines the work we will do in partnership to support young families to understand how to help their young baby to thrive and grow, and how this will support them throughout their life to be healthy, do well in school and fulfil their potential.

Eileen O'Meara, Director of Public Health, Halton Borough Council

We fully support the introduction of this new infant feeding strategy for Halton. We all know how important a nutritious diet is throughout life but especially in the early years. This is why it is important that the strategy recognises the importance of offering timely information and advice. We know however, that managing the demands of a young family can often be difficult, so it is encouraging to see that the strategy also emphasises the importance of supporting families to make healthier choices. By working in partnership across local agencies and with the local community we hope we can make a real difference to improve the life chances of Halton children.

Cllr Marie Wright, Halton Borough Council's portfolio holder for Health and Wellbeing

Cllr Ged Philbin, Halton Borough Council's portfolio holder for Children, young people and families

I welcome the Halton infant feeding strategy, and look forward to working together with partners across agencies to deliver against these actions. Having worked as a Health Visitor for much of my career I know how important early nutrition is in forming a strong foundation for the child's health and wellbeing. As the clinical lead for children in Halton CCG I know we have children seeing their GP or attending hospital for preventable conditions which relate to diet or problems with feeding, such as gastroenteritis or constipation and I believe that this strategy can help to keep children well and out of hospital.

We are proud that having worked together Bridgewater Community NHS Foundation Trust, Halton and St Helens division have achieved full Unicef Baby Friendly accreditation. This accolade is awarded where services have a holistic approach to supporting mothers to establish breastfeeding. We look forward to maintaining the standard in our health services and expanding the good work into community settings.

This strategy sets out our ambition to get it right for the children of Halton and consolidates work that is already underway to create a culture of breastfeeding; whereby women believe breastfeeding to be the normal way to feed their child. Delaying weaning until the child is around 6 months and understanding how to go about that process are important for the families of Halton to adopt. I look forward to GP's, health visitors, children's centres and health improvement staff working together to provide a package of care for local families

Gill Frame, Registered Health Visitor and Children's Clinical Lead, Halton CCG

Executive summary

How a child is fed in their first year of life leaves a lasting impact throughout their life. Good nutrition enables optimal growth to be achieved, allowing a child's body and brain to grow, building important physical functions such as neuro-connections in the brain and the immune system. An infant's diet influences their future ability to self-regulate their appetite, their likelihood of becoming obese, and their subsequent risk of developing conditions such as diabetes and heart disease. Their susceptibility to conditions, such as gastroenteritis and constipation are also influence by their diet.

This strategy outlines Halton's approach to infant feeding over the next 4 years. The period of infancy is from the birth of the child until their first birthday. The strategy aims to create a culture and services that support families and carers within the borough to make informed healthy choices when feeding their child, to ensure the best possible health and wellbeing outcomes are achieved.

In order to optimise the health of the population of Halton this strategy aims to achieve the following outcomes:

1. Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
2. Increase the number of infants who are introduced to solid foods at or around 6 months of age.
3. Increase the awareness of parents and the general population of healthy feeding practices for infants; and change behaviour accordingly.

In recent years there has been a slow increase in the number of women who breastfeed in Halton but there is still a long way to go to catch up with the rest of England. Similarly the rates of obesity remain a priority for Halton, while childhood obesity rates have improved for year 6 children, reception age children remain higher than the England average.

A detailed action plan underpins how this vision will be achieved.

The main recommendations are

1) For health and social care organisations and leaders to prioritise infant nutrition, and the prevention of obesity.

2) Critical to the success of this strategy is partnership working across health and social care, and between community and hospital settings.

3) Continue to fund an infant nutrition coordinator role.
   The infant nutrition agenda runs across disciplines, and the role of the infant nutrition coordinator is central to driving this agenda forward.

4) Commission baby friendly health and social care services.
   Endeavour for commissioned services, such as maternity services to be performance managed against their breastfeeding outcomes, and ideally put in place CQUINs/performance related pay.

5) Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
   a. Make breastfeeding the norm
   b. Raise awareness of the benefits of breastfeeding amongst the general public and increase it's acceptability
   c. Ensure that women have the information, support and skills to breastfeed
   d. Achieve and maintain Unicef Baby Friendly Initiative

6) Support staff to breastfeed upon returning to work following maternity leave, through breastfeeding policies and supporting local businesses to adopt similar policies.

7) Increase the number of infants who are introduced to solid foods at or around 6 months of age, through partnership working with health visitors, children's centres and the health improvement team

8) Increase the awareness of parents and the general population of healthy feeding and drinking practices for infants; and change behaviour accordingly.

Contents

Introduction

Good nutrition is essential to a person's health at any stage of life. It is particularly important in the first few years of life. Good nutrition is crucial for babies and infants to achieve their optimal growth and development, and to give them the best start in life. Establishing successful feeding is an important part of parenting, in addition to the physical health aspects, feeding is social and important for forming bonds between parents and their children.

Infancy is when a child starts to build their relationship with food and determine their food preferences. These are the foundations from which lifetime health and eating habits are created. When deciding how to feed their child, families are influenced by a wide range of factors from over-arching social and cultural expectations, to wider family and community norms, to the availability of appropriate health and support services.

This strategy outlines Halton's approach to infant feeding over the next 4 years. The period of infancy is from the birth of the child until their first birthday. The strategy aims to create a culture and services that supports families and carers within the borough to make informed healthy choices when feeding their child, to ensure the best possible health and wellbeing outcomes are achieved.

The strategy's underpinning themes or values to achieve this vision are:

- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Promoting evidence based practice and cost effectiveness (value for money)

Each chapter outlines what we are looking to achieve against three overarching outcomes. Describing why the issue is important for child health nationally and in Halton, identifying evidence of what works to improve nutrition and current activity being undertaken, including what local services are providing. The strategy is supported by a detailed action plan outlining responsible leads, timescales and outcomes to be achieved, and examples of these are include.

Our Local Strategy

This strategy draws together international, national and local policy and guidance to outline a series of actions to ensure local families are supported in making informed choices in relation to feeding their child, and in particular to improve breastfeeding rates in the borough.

Vision

Mothers and babies benefit from good, safe infant feeding as breastfeeding and introducing solid foods at six months becomes the cultural norm for families in Halton, women choose to breastfeed their baby for longer and are supported and enabled to do this. Where mothers choose to bottle feed they have the information and skills to do so safely.

Aims of the Strategy:

In order to optimise the health of the population of Halton this strategy aims to achieve the following outcomes:

1. Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
2. Increase the number of infants who are introduced to solid foods at or around 6 months of age.
3. Increase the awareness of parents and the general population of healthy feeding practices for infants; and change behaviour accordingly.

In recent years there has been a slow increase in the number of women who breastfeed in Halton but there is still a long way to go to catch up with the rest of England. Similarly the rates of obesity remain a priority for Halton, while childhood obesity rates have improved for year 6 children, reception age children remain higher than the England average.

A detailed action plan outlines how this vision will be achieved. The actions focus on seven main areas of work including:

1. Women have the information, support and skills to breastfeed
2. Making breastfeeding the norm
3. Raising awareness and support of breastfeeding amongst the general public

4. Achievement and maintenance of Unicef Baby Friendly Initiative
5. Women who choose to formula feed their baby do so as safely as possible
6. Robust data collection mechanisms are in place to enable progress to be measured and areas of need addressed
7. Families are supported to introduce solid foods in a timely and appropriate way

Examples of relevant actions from the action plan are included within the report, to give a flavour of the actions that are required under each aim.

Chapter 1

Aim 1: Breastfeeding

Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.

Why is breastfeeding important?

Prior to World War II breastfeeding was common place, however following the widespread introduction and marketing of infant formula in the 50s and 60s breastfeeding rates in England began to decline, with a low reached in the 1960's due to the creation of a 'bottle feeding culture'.

This trend has started to change in recent years with increasing numbers of mothers choosing to breastfeed their babies. However, despite this rise, England still has one of the lowest breastfeeding initiation rates in Europe.

The reasons for this low breastfeeding rate are varied and complex. Commonly cited reasons by mums for not breastfeeding or continuing to breastfeed their baby include insufficient:

- knowledge or confidence in how to breastfeed,
- support from partners and/or family members,
- professional help/support,
- appropriate places and/or facilities to breastfeed in public areas
- insufficient support from employers and pressures of returning to work
- social acceptability of breastfeeding.

In addition to these common issues, the cultural norms of a local area play a key part in feeding practices. In particular there are certain groups that are less likely to breastfeed or breastfeed for a shorter period of time including:

- women from deprived communities,
- teenage mothers,
- single mothers,
- working mothers,
- women who have a twin or multiple pregnancy,
- women who have premature babies.

The impact of infant feeding choices on health

Breastfeeding provides the foundation for a healthy start in a child's life. Breast milk supplies all the nutrients a baby needs for healthy growth and development and adapts to meet a baby's changing needs. Breastfeeding prevents illness in both the short and long term for both babies and their mothers.

In the short term, because of natural antibodies in mother's milk breastfeeding reduces chest and ear infections, reduces the chance of diarrhoea vomiting and constipation, and prevents asthma and eczema. In the long term, breastfeeding reduces the risk of obesity and diabetes in later life.

For mums, breastfeeding reduces the risk of breast and ovarian cancer, as well as anaemia after birth. Breastfeeding also helps mothers to lose any weight gained after birth, breastfeeding naturally uses up 500 calories per day.

In addition to the physical health benefits for mother and baby, breastfeeding contributes to a baby's psychological, emotional and social development by providing a unique early bonding experience for baby's and their mothers. Babies who are formula fed are not afforded any of the protective health benefits and financially it is estimated that compared to infant formula, breastfeeding can save a family approximately £500 in the first year of the child's life.

Breastfeeding can help to reduce health inequalities, as evidence suggests that breastfed babies born into the lowest socioeconomic groups have better health outcomes than formula fed babies born into the highest socioeconomic groups (Forsyth,S. 2004). The prevalence of breastfeeding is lower in disadvantaged groups - with younger, less educated and lower income groups being less likely to breastfeed, exacerbating the poor health outcomes Thereby, encouraging breastfeeding among these groups will contribute to improvements in health outcomes and will contribute to a reduction in health inequalities.

Any amount of breastfeeding has benefits for both baby and mother, the longer the duration of breastfeeding, the greater the benefits. Exclusive breastfeeding offers the maximum benefit to mother and child, but women who mix feed should also be encouraged to continue to breastfeed for as long as they can. The Department of Health recommends exclusive breastfeeding for around the first six months of a baby's life, after which the child can be introduced to solid food, with breast milk continuing to be an important part of the child's diet. The WHO similarly

recommends that women breastfeed their child exclusively for 6 months, and then alongside appropriate complementary foods for two years and beyond[1]

What is the Local Picture?

Breastfeeding rates

Halton has lower rates of breastfeeding than the regional and national average. Prior to 2013/14, breastfeeding data was collected for Halton Primary Care Trust (PCT) (as shown in figures 1 and 2), but figures can now also be obtained separately for the Halton population.

The proportion of women breastfeeding their child at birth has increased year on year and is now over 50% (figure 1 and 2), but well below the England average. The proportion of women initiating breastfeeding ranges from 32% to 70% across different wards in Halton (figure 4), although the numbers by ward are small.

In England the most rapid decline in the number of women breastfeeding occurs in the first few days after the birth and data also suggests 10-14 days is also a pivotal time. This is the period of time when many women need the most support to get feeding established. In Halton 28% of women are breastfeeding at 10-14 days (figure 4) and fewer than half of the women who initiated breastfeeding (22%) are still breastfeeding at 6-8 weeks (figure 5, 6 and 7). This breastfeeding rate is well below regional and national averages and there is seasonal variation (figure 5). These low breastfeeding rates continue to be a concern within the borough and increasing the number of mothers choosing to breastfeed remains a key priority.

[1] http://www.who.int/topics/breastfeeding/en/ Accessed 29th July 2014

Breastfeeding initiation

Figure 1: Breastfeeding initiation from 2004-2013 in Halton and St Helens PCT

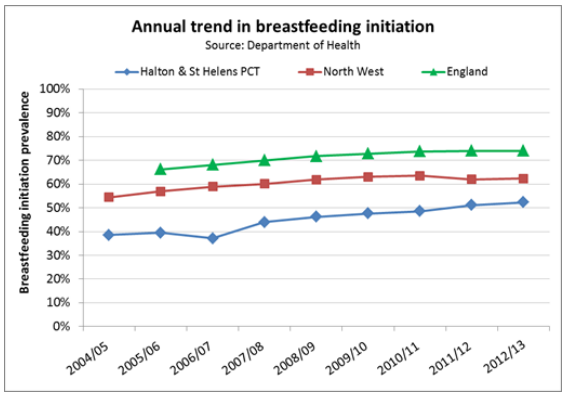


Figure 2: Breastfeeding initiation by CCG 2013-2015

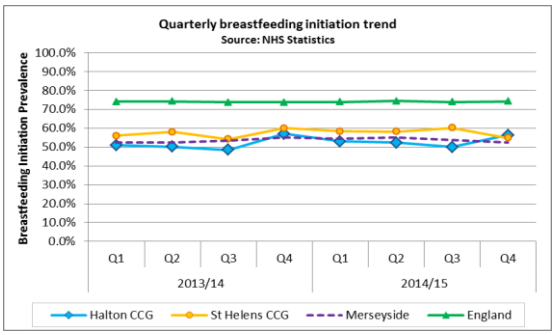
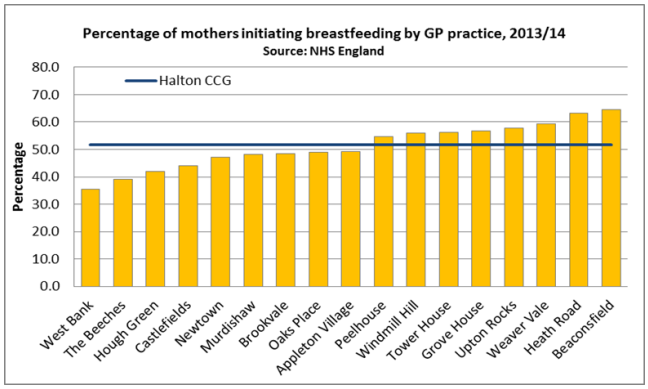
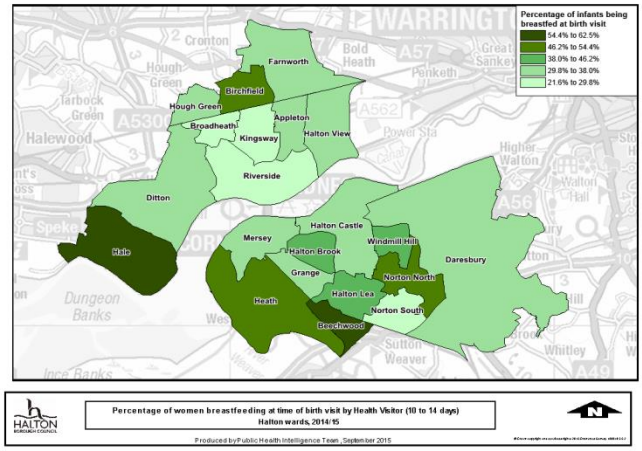


Figure 3: The Percentage of mothers initiating breastfeeding by GP Practice in Halton 2013/14



Breastfeeding at 10-14 days

Figure 4: Percentage of women breastfeeding at 10-14 days by Halton wards (2014/15)



2013/14 was the first year that data was collected on the proportion of women breastfeeding at 10-14 days, in Halton 27.9% of mothers were breastfeeding at this point in time, which shows that similar to elsewhere, the biggest fall off is in the first few days. In 2014/15 the figure increased to 36.2%. Figure 4 shows that the proportion of women breastfeeding at 10-14 days varies across the wards ranging from 21%-62%.

Breastfeeding at 6-8 weeks

Figure 5: Breastfeeding rates at 6-8 weeks in Halton from 2010-2015

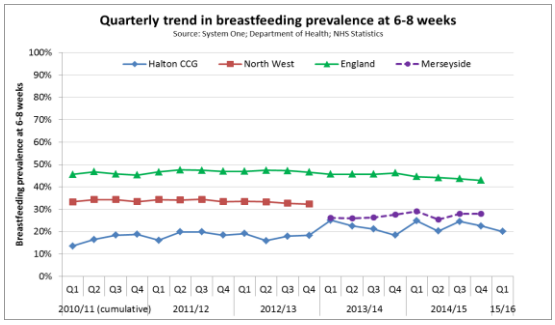


Figure 6: The Percentage of mother's breastfeeding at 6-8 weeks by GP Practice in Halton 2014/15

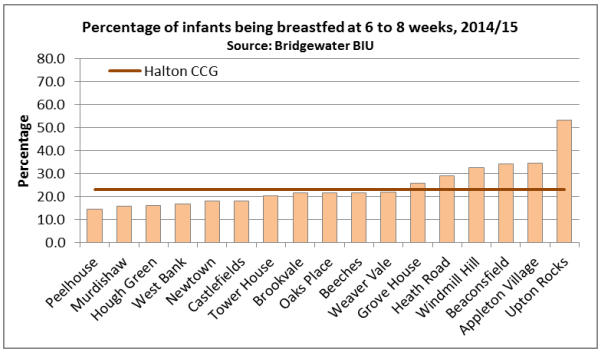


Figure 7: Percentage of women breastfeeding at 6-8 weeks by Halton wards (2013/14)

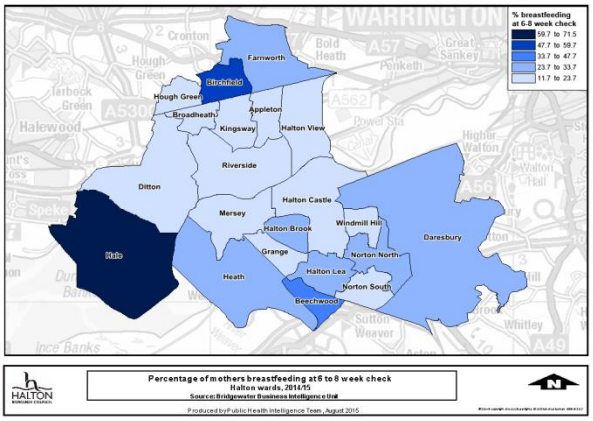
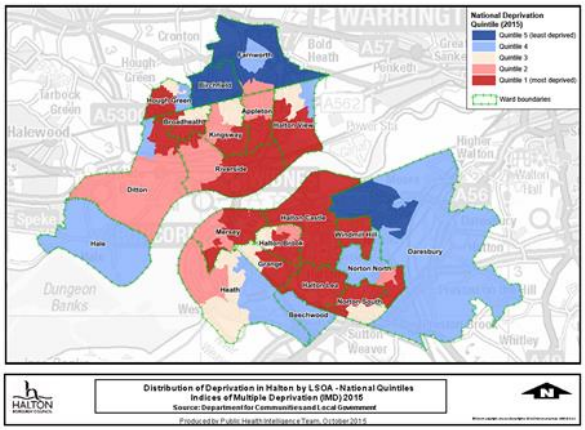


Figure 8: Distribution of Deprivation in Halton 2015



The maps in figures 3 and 6 identify that more mother's breastfeed in Hale, Beechwood and Birchfield at each stage from birth to 6-8 weeks. At 10-14 days the wards with the lowest proportion of mother's breastfeeding are Broadheath, Kingsway, Riverside and Norton South. At 6-8 weeks breastfeeding rates are below one in four mothers breastfeeding in the majority of wards.

Figure 8 shows, that with the exception of Hale, the rate of breastfeeding by ward is associated with the level of deprivation. For all the wards in the lowest quintile of deprivation, the rate of breastfeeding is also low. However the converse is not true. While some of the wards in the highest quintile, have higher rates of breastfeeding, such as Hale, Birchfield and Beechwood, there are wards in quintile 4, such as Daresbury that have low breastfeeding rates with less than a third of women breastfeeding at 6-8 weeks.

What Works?

There is a large international evidence base on effective action to increase breastfeeding rates. Implementation of the Unicef Baby Friendly Initiative (BFI) in hospital and community settings is widely recognised as a key action to increase the uptake and continuation of breastfeeding (NICE, WHO). The BFI programme introduces evidence-based standards for maternity, neonatal, health visiting/public

health nursing and children's centre services. Implementation of these standards improves the care and support that pregnant women, new mothers and their families receive to build a strong relationship with, and feed and care for, their baby. Achieving BFI contributes to ensuring that staff are able to support parents in making informed decisions about infant feeding and are able to provide on-going support and information for breastfeeding mothers and safe bottle feeding for those mothers who choose not to breastfeed whilst supporting all parents to have a close and loving relationship with their baby.

The National Institute for Health and Clinical Excellence (NICE) has compiled a series of best practice guidance relating to breastfeeding, recognising there are key points when information and support is particularly important for mothers and families when choosing how to feed their baby. The guidance on Infant feeding standards is also incorporated into Nice's Maternal and Child Nutrition (2008) and Postnatal care (2014) guidelines.

Evidence of how to support parents feeding choices:

NICE has outlined 8 evidenced based actions to increase the initiation and continuation of breastfeeding which are outlined in detail in Appendix A, the summary of what services need to provide to support parents in their feeding choices are outlined below:

Parents' experiences of maternity services

- Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.
- Support all mothers and babies to initiate a close relationship and feeding soon after birth.
- Enable mothers to get breastfeeding off to a good start.
- Support mothers to make informed decisions regarding the introduction of food or fluids other than breast milk.
- Support parents to have a close and loving relationship with their baby.

Parents' experiences of health visiting services

- Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.
- Enable mothers to continue breastfeeding for as long as they wish.
- Support mothers to make informed decisions regarding the introduction of food or fluid other than breast milk.

- Support parents to have a close and loving relationship with their baby.

Parents' experiences of children's centres

- Support pregnant women to recognise the importance of early relationships to the health and wellbeing of their baby.
- Protect and support breastfeeding in all areas of the service.
- Support parents to have a close and loving relationship with their baby.

What is available in Halton to support breastfeeding families?

There is a long history in Halton of working in partnership across agencies to improve breastfeeding rates:

Health professionals and children's centres

All health professionals that work with mothers including midwives, health visitors, and children's centre staff receive regular training on infant feeding, including breastfeeding, so as to provide support and advice to families when making the decision on how to feed their child and to provide on-going support. Infant feeding is one of the areas covered within the national Healthy Child Programme, and as such it is part of the core offer from health professionals, and will be discussed and assessed at different stages of the child's development. Training for staff on breastfeeding and nutrition has taken place over a number of years but has recently been strengthened and audited through the Baby Friendly Initiative, both in local hospitals and the community settings.

Action
Give all families an appointment to attend the infant feeding workshops before the baby is born, to support their informed consideration of feeding choices.

Work with children's centres

In Halton children's centres have been central in supporting breastfeeding work. The Breastfeeding support teams hold many of the groups in children's centres, and work closely with the families and staff in the centre. Children's centres have also supported events such as breastfeeding picnics, and awareness raising during breastfeeding week.

Further steps are needed to make breastfeeding the norm in Halton and to encourage more mums to breastfeed their babies and to continue to breastfeed for longer, whilst supporting mums who choose to bottle feed.

Action

Work closely with children's centres to deliver family friendly breastfeeding support and advice close to the community.

Unicef Baby friendly (BFI)

The Unicef Baby Friendly Initiative is an internationally recognised standard that provides a framework for the implementation of best practice in relation to breastfeeding. The aim of the initiative is to ensure that all parents can make informed decisions about feeding their babies and are supported in their chosen feeding method. It encompasses policies, training and practice. Accreditation takes place in stages:

Stage 1
Building a firm foundation

- Have written policies and guidelines to support the standards.
- Plan an education programme that will allow staff to implement the standards according to their role.
- Have processes for implementing, auditing and evaluating the standards.
- Ensure that there is no promotion of breast milk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

Stage 2
An educated workforce

- Educate staff to implement the standards according to their role and the service provided.

Stage 3
Parents' experience of maternity, Health Visiting, neonatal and Children's Centres
Building on good practice

- Demonstrate innovation to achieve excellent outcomes for mothers, babies and their families.

Bridgewater Community NHS Foundation Trust, Halton and St Helens division have achieved full Unicef Baby Friendly accreditation in July 2015. Both local hospitals, St Helens and Knowsley Hospital Trust and Warrington and Halton Hospital Trust have also achieved full BFI accreditation.

Action

Continue to work to achieve BFI status, and maintain the standards across community services and children's centres

Infant feeding support

Breastfeeding incentive scheme

Having received funding from the North West Strategic Health Authority Halton piloted a breastfeeding incentive scheme in Widnes, from June to December 2011. Women self-referred or were referred onto the scheme by their midwife or health visitor and participants received a "love to shop voucher" at the point of breastfeeding initiation, after one week, and at six weeks. The aim of the incentive was to encourage women to consider breastfeeding and to engage with Breastfeeding peer support services.

Breastfeeding rates at 6-8 weeks in Halton increased during the incentive scheme by 7.2%. Although not all breastfeeding women were referred to the scheme 75% of those that were, breastfeed up to 6 weeks. This is considerably more than the baseline figure of 41% in Halton and St Helens (Q1 2010/11).

The incentive scheme was positively evaluated by participants who were grateful for the vouchers, and complementary about the peer support service that they received. The women also commented on the wider benefits of the programme and how it gave them opportunities to socialise and make friends.

The incentive scheme was a vehicle through which the profile of the breastfeeding agenda increased, improving partnership working, communication between teams and increasing the commitment to the breastfeeding agenda. It provided an incentive to the organisation (as well as the mothers), necessitating the organisations to work together to improve the patient pathway, and ensure staff work together effectively. The funding for this service is no longer available, however the legacy of the incentive scheme was an established breastfeeding support team.

Quotes from participants on the Breastfeeding Incentive Scheme

'Yes [it impacted on how long I breastfed] as I was having some difficulty at some stage and nearly gave up at 2 to 3 weeks but continued after ringing for help and support' (mother, aged 18)

'I didn't plan on breastfeeding at all and I then decide to for 10 weeks because of the support I received in hospital and at home. My experience of breastfeeding has been extraordinary and if it weren't for the support I probably wouldn't have breastfed for as long as I did' (mother aged 18)

Breastfeeding Support Service in Halton

A Breastfeeding Support Team operates in Halton, and is available for all breastfeeding mothers on a drop in or referral basis to provide advice and support to local mums.

The team works closely with local hospitals, maternity services, health visitors and children's centres to ensure that new mums and mums to be are supported to breastfeed and are provided with information about breastfeeding and the community breastfeeding support services available in their local area.

Breastfeeding support workers delivery antenatal infant feeding workshops in the community. Support workers are also present on the maternity ward at Whiston Hospital, offering practical breastfeeding advice and support.

The service provides telephone support, 1 to 1 and home visits. Support groups are held regularly across the borough in Children's centres and Ditton Library where local mums can get advice and support and socialise with other breastfeeding mums.

There are currently two local mothers, who have trained as peer support workers, and volunteer with the service.

Case Study

Local mum Amy contacted the Breastfeeding Support Team in January following the birth of her second child. Amy had experienced problems feeding her first child and wanted support to ensure she didn't have the same problems with feeding this time around.

The Breastfeeding Support Team provided support and reassurance to Amy over a 10 month period via home visits and telephone support. Amy required support and advice with a number of issues including correct positioning and attachment, hand expression, frequency of feeding and introducing solid foods.

Despite the various problems she experienced, Amy and her baby were able to have a fulfilling and successful breastfeeding experience as a result of the continued support received from the Breastfeeding Support Team. Amy is continuing to breastfeed her baby who is now aged almost 11 months.

Action

To maintain the provision of breastfeeding support across the borough and to increase the number of mothers volunteering to provide breastfeeding peer support

Social marketing campaigns

There have been a number of campaigns to promote breastfeeding in Halton, for example the "Get Closer" campaign in 2008 which focused on the provision of information on breastfeeding and training health professionals. Innovative new resources on breastfeeding were developed to be used by health staff working with pregnant women and to provide information for families in Halton, in particular in deprived areas of the borough. Breastfeeding brief intervention training was completed with local midwives and for the first time, a number of local mothers were trained as peer support counsellors to support other mothers in breastfeeding. As a result of the campaign, there was an increase in breastfeeding initiation of 17% from 21% to 38% in the most disadvantaged areas compared with an 8% increase to 42% in the borough overall, showing that targeted action can reduce health inequalities and narrow the health gap.

'breast milk it's amazing!' campaign

The 'breast milk it's amazing' campaign across Merseyside was developed in response to a large scale consultation with local families about infant feeding. The campaign includes social marketing images that were placed on the back of buses and on bill boards across Merseyside, to encourage women to breastfeed.

Central to the campaign is a website that has been developed to help families make informed choices about how to feed their baby. The website includes a vast array of information and tips including maps of which venues are baby welcome and therefore good places to breastfeed when out and about in Halton, an honest account of what breastfeeding is really like and information on where and how to get local help and support.

In response to a consultation with health care staff resources have been distributed to health care staff with the 'breast milk it's amazing' campaign logo on. This was in order to replace existing resources that staff were using that had been provided by, and advertised formula milk companies. For example stickers were produced to put up in baby welcome premises and diary bands.

In November 2015 Public Health England launched a breastfeeding social marketing campaign, as part of their Start4life work. It is unclear at this stage how long this will run for and what the campaign will entail.

Action

To secure the continuation of a breastfeeding social marketing campaign in Halton, to encourage a culture of breastfeeding, either through the 'breastmilk it's amazing' campaign or the 'Start4life' breastfeeding campaign.

The 'Baby Welcome' Scheme

The Breast Feeding Support Team have been working closely with local businesses to increase the number of premises in Halton designated 'baby welcome' in which breastfeeding mothers are welcomed, there access for pushchairs and baby changing facilities available. In addition to all NHS premises and Children's Centres across the borough, 128 cafes and shops have been designated 'baby friendly'. This list is increasing all the time. However local women and their partners don't always perceive that Halton is welcoming to mothers who wish to breastfeed. This baby welcome scheme needs to be promoted more widely and engage parents in awarding and monitoring the scheme. Information is provided on an app and updated every 6 months.

Action

To maintain and improve the Baby Welcome scheme, and increase awareness of the scheme.

Work with Local Schools

School age children are an important group to influence in creating a culture of breastfeeding. Evidence from research suggests that young women start to form their view of how they will feed their children when they are at school. A breastfeeding support booklet was produced and circulated to schools in 2013 for use in Personal, Social and Health Education (PSHE) lessons and other lesson plans. The aim of the booklet is to give schools suggestions of how to incorporate breastfeeding into their teaching plans for each Key Stage. It aims to normalise breastfeeding and make it something that is regularly portrayed in lessons: For example resources are suggested, where illustrations in a story are of a mother breastfeeding her child. The booklet supports schools to develop children's understanding that breastfeeding is a natural way to feed babies and the way that many babies are fed.

Action
The booklets have been refreshed and recirculated to schools, with the offer of the health improvement team and breastfeeding support team to come into the school and deliver a session on breastfeeding.

Chapter 2.

Aim 2: Healthy eating for infants

Increase the awareness of parents and the general population of healthy feeding practices for infants; and change behaviour accordingly.

There are a range of factors that influence an infant's diet and nutrition, that link closely with breastfeeding and the introduction to solid foods. This chapter outlines a range of different issues that are important to support safe, healthy infant feeding practices in Halton families.

Formula feeding

For mothers who choose to bottle feed safe sterilisation of equipment and correct make up of feeds is important to avoid infections and nutritional problems in babies. The milk must be stored at the correct temperature and used within the specified time. Feeding formula milk of an incorrect concentration negatively impacts upon the infant's health and weight gain. If the formula is too diluted the infant will not receive sufficient nutrients and may become malnourished and over concentrated formula can lead to dehydration and obesity. Hygienic preparation and clean water is also essential to prevent contamination, and as such preparation and storage instructions need to be adhered to, to reduce the risk of infection.

In the national Infant feeding survey (2010) almost half (49%) of all mothers who had prepared powdered infant formula in the last seven days had followed all three recommendations for making up feeds (only making one feed at a time, making feeds within 30 minutes of the water boiling and adding the water to the bottle before the powder). This is a substantial increase from 13% in 2005 (Mc Andrew 2012), but means that half of parents are potentially increasing the risk of infection to their children through their method of preparation. Parents need advice from independent qualified professionals on the importance of following Department of Health recommendations to reduce the risk of infection and prevent the side effects of over or under-concentrated feeds. Formula fed babies are also more likely to develop constipation.

The importance of responsive feeding.

Responsive feeding is a component of ensuring optimal child growth and development. It is more than "demand feeding" in that it is a sensitive reciprocal relationship between a mother and her baby. Infants display signals about their

readiness or not to feed and the mother therefore needs to provide an environment that is sensitive to the infant's cues. A supportive environment where mother and baby are in tune with each other allows them to adapt and modify their behaviour to meet their need.

Responsive feeding is an important component of breastfeeding, however formula feeding can also be responsive and it is important that parents are aware of signs their baby wishes to stop feeding, because the bottle fed baby has less control over the feed than a baby at the breast (Bartok and Ventura,2009). All parents who decide to give their baby infant formula should be offered support and information to help them to respond to the needs of their baby while feeding.

Guidance circulated to families should not only relate to information on making up feeds, sterilization of equipment and storage for feeding out and about, but also evidence based information on suitable infant formula. The Department of Health recommend that all babies up to one year old are fed on a first stage infant milk. Information for health professionals and parents is available in the Department of Health Guide to bottle feeding and the health professionals guide to infant formula. A full breakdown of current UK milks is available from First Steps Nutrition (Infant Milks in the UK, A practical guide for Health Professionals, 2015)[2].

Managing infants with a milk intolerance or allergy.

Babies who are difficult to settle and colicky are regularly seen in General Practice by parents worried that their child has an intolerance to milk or an allergy. Lactose intolerance in babies is extremely rare, whereas Cow's Milk protein allergy is more common. The details of these conditions are outlined below.

What is Lactose Intolerance?

Lactose Intolerance is a condition in which the body is unable to break down the sugar lactose which is found in dairy products. The symptoms include bloating, flatulence, diarrhoea/constipation, vomiting and abdominal pain. Lactose intolerance can be diagnosed by primary care staff.

[2] http://www.Unicef.org.uk/Documents/Baby_Friendly/Leaflets/Formula_guide_for_parents.pdf

There are different types of lactose intolerance:

- Primary – Very rare in northern Europeans, more common at an older age.
- Secondary – More common in children in developing countries, due to damage from acute illness and resolves after the illness.
- Congenital – Extremely rare (only 100 cases worldwide) (Agostoni et al., 2010)
- Developmental – Occurs in premature babies (<34/40 gestation) and improves when intestine matures.

What is Cow's Milk Protein Allergy (CMPA)?

Cows' milk protein allergy is an allergic response to proteins in milk. It is one of the most common childhood food allergies in the developed world, with the highest prevalence during the first year of life.

There are two types of Cows' milk protein allergy:

- **Immunoglobulin E (IgE)- mediated reaction** which causes acute and frequent reaction soon after ingesting milk. By 5 years of age more than half of children have outgrown the allergy.

- **Non-IgE-mediated reaction** – these are non-acute and generally delayed reactions. Most children with non-IgE-mediated cows' milk allergy will be milk tolerant by 3 years of age.

Strict exclusion of cows' milk protein from the child's diet (or maternal diet for exclusively breastfed babies) is currently the safest strategy for managing confirmed CMPA.

- IgE-mediated cows' milk protein allergy is usually managed in secondary care.
- Non-IgE-mediated cows' milk protein allergy can be managed in primary care with dietetic input

CMPA is more common in young children, lactose intolerance in older children and adults (Wilson 2005). There are currently no NICE guidelines regarding the management of Lactose Intolerance. However, there are guidelines in place for cow's milk protein allergy[3].

[3] Guideline 116, http://pathways.nice.org.uk/pathways/food-allergy-in-children-and-young-people

Pan Mersey area prescribing committee produced a document in November 2014 regarding prescribing in Lactose Intolerance and Cow's Milk Protein Allergy. The treatment pathways for patients can be found in appendix B[4].

Action

Ensure all healthcare professionals follow Pan Mersey guidelines, including not prescribing lactose free formula.

[4] http://www.panmerseyapc.nhs.uk/guidelines/documents/G16.pdf

What constitutes a healthy diet for infants?

During the first 12 months of an infant's life their diet develops from being solely milk based, to starting to try solid foods. At 6-9 months infants are exploring the taste, textures, smells and feel of food and still deriving the majority of their energy requirements from milk. By the age of 9-12 months solid food increasingly becomes the main source of energy to the child. At around one year of age a child should be eating three main meals a day, with 2-3 nutritious snacks. The foods eaten by infants should be similar to the rest of the family (with some exceptions). As the child moves from infancy into early childhood their diet should include each of the four main food groups every day, in the quantities illustrated below in the eat well plate.

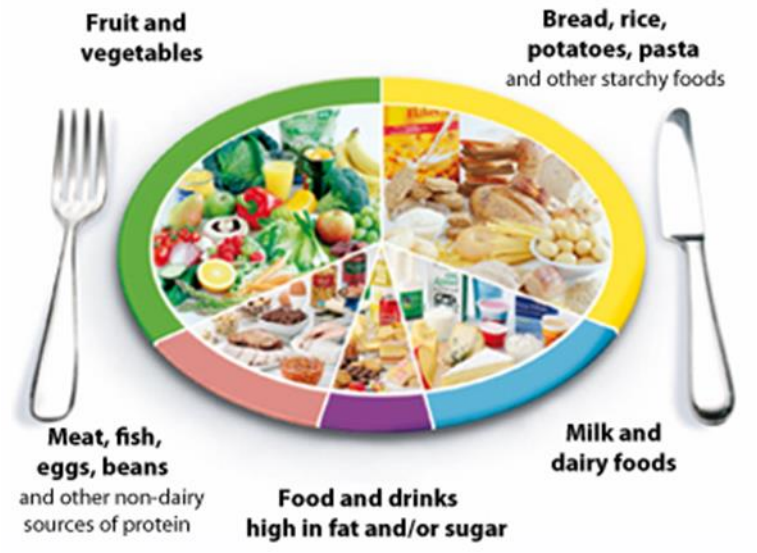


Figure 9: The eat well plate, Public health England

Constipation

Constipation is a common childhood condition causing pain and distress to the child and family which often goes unrecognised and untreated. Constipation is a term used to describe the difficult and painful defecation of dry, hard, delayed or infrequent stools. It can be defined as fewer than three complete stools per week and a change in consistency (NICE, 2010, Mason, 2004).

In older children and adults being active, eating a variety of fruit and vegetables and keeping well hydrated lowers the risk of developing constipation. Children's food should contain full fat milk, cheese, yoghurt, nuts; fortified breakfast cereals, oily fish meat, green vegetables, and

two portions of fish per week. Constipation is unusual in an exclusively breastfed baby. It is more common in bottle fed babies as a result of either inadequate fluid intake, which can occur due to the incorrect dilution of the feed or underfeeding.

95% of cases of constipation cannot be explained by any physical abnormalities and are more likely to be as a result of diet and low fluid intake.

Analysis of inpatient and outpatient data revealed that only 5% of cases present for treatment in the UK. NICE estimates that constipation is prevalent in between 5-30% of the child population depending on criteria used for diagnosis, with younger children affected most often. Based on a 2013 population estimate of 8,537 children aged 0-4 living in Halton, a local estimate for the year would be between 457 (5% of population) to 2,561 (30% of population).

Common advice for the treatment of constipation is to make dietary changes to increase fibre in the diet through fruit and vegetable consumption and ensure adequate hydration. However small children's digestive systems do not cope well with high fibre foods such as wholemeal pasta and brown rice and too much fibre can reduce the amount of minerals absorbed, such as calcium and iron. If children do become constipated NICE guidance recommends treatment with medication.

Analysis of hospital admissions data 2010/11 at Halton & St Helens PCT level showed that there were 8 elective (planned) admissions and 42 non-elective (emergency) admissions for constipation. 24 out of the 42 emergency admissions were for children under 1 year of age. Further analysis of outpatient appointments estimated that 143 of all outpatient appointments for children aged 0-4 and 50 gastroenterology specialist appointments were likely due to constipation, (using NICE guidance to provide prevalence).

Action
Healthy eating advice to parents to include information on the importance of diet and hydration to prevent constipation.

Oral health

Poor oral health can affect children and young people's ability to sleep, eat, speak, play and socialise. Other impacts include pain, infections, poor diet and impaired nutrition and growth. Examples of how breastfeeding has a positive impact on oral health are listed:

- Breastfeeding promotes good alignment of the upper and lower jaw
- Exercises facial muscles and those in the inner ear, which reduces the risk of ear infections
- Babies/toddlers will have better tongue control and better control over speech
- Upper jaw develops into a wide arc because of the tongue and nipple pressure applied on the palate. This gives erupting teeth plenty of space to grow and helps to eliminate overcrowding
- Babies take a wide mouthful of breast with the nipple way back ensuring that the milk is directed at the back of the throat therefore bypassing the teeth
- The mouth has its own line of defence against decay- friendly bacteria contained in the saliva cleanse and neutralise acids that cause decay and restore natural balance

The Oral health promotion team work in Halton to raise awareness of the importance of Oral Health, and change behaviour. The messages for parents and carers to improve oral health in infants (and children up to 3 years old) are outlined below:

- Breastfeeding provides the best nutrition for babies
- From six months of age infants should be introduced to drinking from a free-flow cup, and from age one year feeding from a bottle should be discouraged
- Sugar should not be added to weaning foods or drinks
- Parents/carers should brush or supervise tooth brushing
- As soon as teeth erupt in the mouth brush them twice daily with a fluoridated toothpaste
- Brush last thing at night and on one other occasion during the day
- Use a smear of fluoride toothpaste containing no less than 1000ppm fluoride (In Halton 1450ppm is used due to the high tooth decay rate)

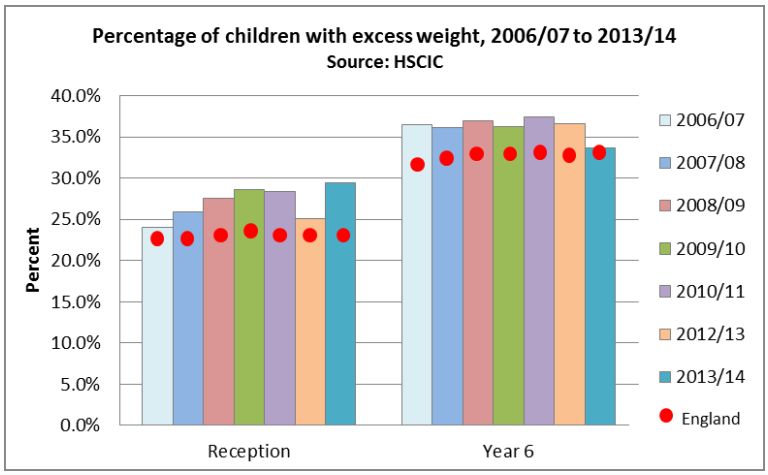
- The frequency and amount of sugary food and drinks should be reduced
- Sugar free medicines should be recommended

Action
Encourage families to move the child from bottle to cup at age one

Childhood Obesity

The Halton National Child Measurement Programme (NCMP) is a national measurement programme to determine the number of children who are overweight or obese across England. Figure 10 illustrates that while there has been progress in reducing levels of excess weight (overweight and obesity) in year 6 children by 2.8%; from 36.5% in 2012/13 to 33.7% in 2013/14, levels of excess weight have increased in reception aged children by 4.4%; from 25.1% in 2012/13 to 29.5% in 2013/14. As outlined previously good infant feeding practices and nutrition are critical in reducing childhood and adult obesity and reversing the national trend.

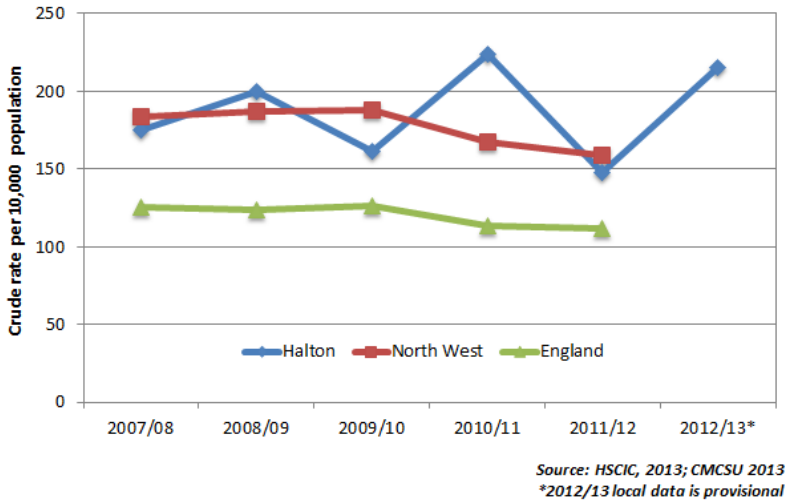
Figure 10: Change in percentage of children who are overweight or obese in Halton, compared to England, 2007/08 to 2013/14



Gastroenteritis

There is a relationship between low levels of breastfeeding and increased cases of children developing gastroenteritis. This is because children are not afforded the protective effects of breastmilk and there is an increased risk of contamination when bottle feeding. In figure 11 the numbers of children being admitted to hospital as emergency cases due to gastroenteritis are consistently higher in Halton than those seen across England as a whole. Levels do fluctuate each year and the relationship between the borough and North West rates are less clear cut.

Figure 11: Trend in rate of emergency hospital admissions for gastroenteritis (children aged 0-4)



What is available for families

Universal healthy child programme

Every Halton family is entitled to the universal healthy child programme, whereby a midwife supports the family from early pregnancy through to the first weeks of the child's life, and a health visitor will then work with the family through infancy. As part of this programme all families will receive support and advice regarding: diet (as appropriate), the safe use of infant formula in the antenatal and postnatal period, and support with feeding difficulties if required. A healthy weight service has recently been commissioned for residents in Halton, which includes dietetic support to health professionals and families for infants with nutrition related issues.

Action
At the first home visit the midwife will provide all families who have chosen to formula feed their baby with information on how to make up feeds correctly and suitable first milk.

Healthy start vitamins

The Healthy Start Program is a Department of Health-funded program that provides low-income families which include a pregnant woman or a child under the age of four years (and all pregnant women under the age of 18 years), with vouchers to exchange for food and vitamins.

Weekly food vouchers can be spent on milk, fruit and vegetables, or infant formula milk. Eligible pregnant women (more than 10 weeks pregnant) and those with a baby under the age of one year are entitled to free maternal vitamins. Children aged between six months and four years are entitled to vouchers for free vitamin drops. Each voucher is exchanged for an eight-week supply of vitamins.

Healthy Start vitamins contain the recommended amount of vitamin A, C and D for young children, and folic acid and vitamin C and D for pregnant and breastfeeding women. Healthy Start vitamins are intended to supplement the diets of low-income children and mothers, whose diets are more likely to be deficient in key vitamins.

An audit was conducted in Halton and estimated that 3.2% of mothers and young children across the borough accessed a year's supply of vitamins (2013). Due to the low uptake of

vitamins a pilot was initiated and has been running since July 2014 to encourage families to access the vitamins, the pilot was based on NICE guidance to increase uptake of Healthy Start vitamins and included:

- Free vitamins to all pregnant and breastfeeding women
- One free bottle of infant vitamins per child
- Increase the availability of child vitamins, via children's centres and health centres
- Publicity and resources to raise awareness of Healthy Start

An evaluation of the programme found that:

- 92% of women had been offered vitamins during their pregnancies by their midwives, and 85% of all mothers reported taking pregnancy vitamins
- 56% of infants aged over 6 months had been offered vitamins, and most mothers reported that babies took the drops well.

Action
To continue to provide free healthy start vitamins to pregnant and breastfeeding women

Wellbeing magazines

The Halton Wellbeing magazine is an electronic magazine that compiles useful resources for parents to support them to improve the health and wellbeing of their children. This method of communication is being used as an avenue to circulate information, support and articles of interest to families to encourage them to make healthy choices. It is intended to provide an interesting and engaging format, through which families can engage in the issues.

Action
For Wellbeing magazines to have an infant nutrition focus, to include work resources on healthy eating and introducing solid foods.

Chapter 3

Aim 3: Introducing solid foods (weaning)

To increase the number of infants who are introduced to solid foods at or around 6 months of age.

The timing of when solid foods are introduced influences child health. Traditionally this was in the first few months of life, however in the last twenty-years guidance has changed in light of new evidence linking early introduction to solid foods to health risks, including the development of childhood obesity. During this time the recommended age for introducing solid foods changed from three, then to four-months, before the World Health Organization (WHO) revised its recommendations in 2001 (which were introduced across England in 2003) recommending exclusive breastfeeding for the first six-months and that:

"Complementary foods should be introduced at about six-months of age. Some infants may need complementary foods earlier, but not before four-months of age." (WHO 2001)

NICE echo this recommendation:

"Once infants are aged 6 months, encourage and help parents and carers to progressively introduce them to a variety of nutritious foods, in addition to milk". (NICE 2008)

The guidance to begin introducing solid foods at six-months corresponds to a time the infant is developmentally ready, and interested in food. The ability to safely consume solid food requires:

- A mature neuromuscular system to move food in the mouth and swallow it.
- Sufficient maturity to sit up, holding the head up and to swallow.
- A mature digestive system that can digest starch, protein and fat from the non-milk diet.

The Department of Health recommends that food of appropriate types and in appropriate amounts is introduced alongside breast or infant formula milk, when babies are six months old and show 3 key signs of developmental readiness:

- Stay in a sitting position and hold their head steady.
- Co-ordinate hand, eyes and mouth so they can look at food, pick it up and put it in their mouth by themselves.
- Swallow food, babies who are not ready for solid will push food back out with their tongue.

A more uncommon concern would arise if the introduction of solid foods is delayed beyond six months. Such a delay would have a detrimental impact on the child's growth and development due to milk alone no longer being sufficient to meet a child's nutritional requirements at this age.

The current recommendations for how to introduce solid foods are (WHO 2010):

- Babies should also continue to have breast or infant formula milk until a minimum of 12 months old.
- Practice responsive feeding: feed slowly and patiently, encourage babies to eat but do not force them, talk to the infant and maintain eye contact.
- Practice good hygiene and food handling.
- Start around 6 months with small amounts and increase gradually.
- Increase the number of feed times, 2-3 meals per day 6-8 months, 3-4 meals per day 9-23 months, with snacks as required.
- Feed a variety of nutrient rich foods.
- Use vitamin and mineral supplements as needed e.g. vitamin D
- When baby is sick, increase fluid intake, include more breastfeeding and offer soft, favourite foods[5]

It is important to gradually introduce a variety of food in small amounts, as babies will still be getting most of their nutrition from breast milk or infant formula. The current recommendation is that full fat cow's milk should not be introduced to babies as a drink until they are 12 months old and babies should have breast or if formula fed, first stage infant formula milk until then. This is longer than previously recommended to prevent iron deficiency. Once on solid food, as long as the child has a varied, balanced diet, there is no requirement to give them 'follow on' milks.

The impact of introducing solid foods too early

Introducing solid foods too early can cause nutritional problems and be detrimental to a child's growth in infancy, through childhood and into adulthood. Evidence suggests that introducing solid food early increases the risk of respiratory illness, allergies and anaemia; in addition it can cause too rapid weight gain and later increase the risk of childhood obesity.

It is important that a variety of foods of different tastes and textures are introduced at this stage. During this developmental phase infants are learning about the qualities of food, and

[5] http://www.who.int/mediacentre/factsheets/fs342/en/

introducing a wide range of foods, will build their knowledge and expectations of different foods, and support them to develop a wide range of taste preferences. Limiting choice of food of different flavour or textures in the early years can lead to children becoming fussy eaters in the future. It is also important that infants are introduced to a healthy family diet, to meet their nutritional needs and to put in place the foundations of food preferences in later life.

What is the local picture

There is no routinely collected data on when solid foods are introduced to infants. Locally data is collected at sessions held to educate families on introducing solid foods. This data showed that 24% of infants were weaned before the recommended 6 months of age. This figure is likely to be lower than the Halton figure, because the data came from a self-selected group of families who were motivated to attend the session and may well have introduced solid foods later as a result of the information from the session.

What works

Baby led feeding

Baby led feeding facilitates a baby in exploring for themselves the touch, texture, taste of food whilst allowing the opportunity of feeding themselves and joining in family meals. It gives the baby control of what they eat. Rapley and Murkett (2008) propose that this helps the baby learn about healthy family food and develops the babies' chewing skills, manual dexterity and hand eye co-ordination.

A review of the evidence by Sachs (2010) and Cameron et al (2012) concluded that developmentally ready babies appear to have the capacity to feed themselves and parents can feel confident in current policy recommendations.

Not all health professionals have been trained in baby led feeding, and this has resulted in a mismatch between knowledge and skills and support for parents.

NHS Choices have outlined some tips for getting started on introducing solid foods:

- Always stay with your baby when they are eating in case they start to choke.
- Let your baby enjoy touching and holding the food.
- Allow your baby to feed themselves, using their fingers, as soon as they show an interest.
- Don't force your baby; wait until the next time if they are not interested this time.
- If you are using a spoon, wait for your baby to open their mouth before you offer the food. Your baby may like to hold a spoon too.
- Start by offering just a few pieces or teaspoons of food, once a day.
- Cool hot food and test it before giving it to your baby
- Don't add salt, sugar or stock cubes to your baby's food or cooking water

What is available for families

Health professionals and children's centres

The introduction of solid foods is universally discussed by heath visitors with families, during their routine checks. Health visitors also invite the families to attend workshops that they jointly run with the health improvement team. The workshops cover 'introducing solid foods' and healthy eating in young children and are available for all families across the borough. The workshops aim to delay the introduction of solids until the child is developmentally ready and give parents the skills and understanding to introduce the child onto a healthy family diet. This process is critical in improving the long term health of children and reducing childhood obesity.

Action

- Health visitors to refer high risk families for one to one support as appropriate
- Frontline children's centre staff to attend training on introducing solid foods
- Expert dietetic support to be made available to families and health professionals, for children who are fussy eaters.

Recommendations

1) For health and social care organisations and leaders to prioritise infant nutrition, and the prevention of obesity.

2) Critical to the success of this strategy is partnership working across health and social care, and between community and hospital settings

3) Continue to fund an infant nutrition coordinator role
   The infant nutrition agenda runs across disciplines, and the role of the infant nutrition coordinator is central to driving this agenda forward across disciplines

4) Commission baby friendly health and social care services
   Endeavour for commissioned services, such as maternity services to be performance managed against their breastfeeding outcomes, and ideally put in place CQUINs/performance related pay.

5) Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
   a. Women have the information, support and skills to breastfeed
   b. Making breastfeeding the norm
   c. Raising awareness and support of breastfeeding amongst the general public
   d. Achieve and maintain Unicef Baby Friendly Initiative

6) Support staff to breastfeed upon returning to work following maternity leave, through breastfeeding policies and support local businesses to adopt similar policies.

7) Increase the number of infants who are introduced to solid foods at or around 6 months of age, through partnership working with health visitors, children's centres and the health improvement team

8) Increase the awareness of parents and the general population of healthy feeding and drinking practices for infants; and change behaviour accordingly.

Appendix A
Nice guidelines on how to increase the initiation and continuation of breastfeeding

1. Implementation of the Baby Friendly Initiative (BFI) in maternity and community services.

2. A coordinated mix of education and support programmes within different settings, routinely delivered by both health professionals/practitioners and peer supporters in accordance with local population needs:
   - Informal, practical breastfeeding education in the antenatal period should be delivered in combination with peer support programmes to increase initiation and duration rates among women on low incomes.
   - A single session of informal, small group and discursive breastfeeding education should be delivered in the antenatal period (including topics like the prevention of nipple pain and trauma) to increase initiation and duration rates among women on low incomes.
   - Additional, breastfeeding specific, practical and problem solving support from a health professional/practitioner should be readily available in the early postnatal period to increase duration rates among all women.
   - Peer support programmes should be offered to provide information and listening support to women on low incomes in either the antenatal or both the antenatal and postnatal periods to increase initiation and duration rates.

3. Changes to policy and practice within the community and hospital settings:

   Routine policy and practice for clinical care in hospital and community should:

   - Support effective positioning and attachment, using a predominantly ‘hands off’ approach
   - Encourage unrestricted responsive baby-led breastfeeding which helps prevent engorgement; and for women experiencing mastitis,
   - Encourage regular breast drainage and continued breastfeeding
   - Encourage the combination of supportive care, teaching breastfeeding technique, sound information and reassurance for breastfeeding women with ‘insufficient milk’.

4. Changes to abandon specific policy and practice for clinical care in hospital and community

In order to increase the duration of any and exclusive breastfeeding among all women, routine policy and practice for clinical care in hospital and community settings should abandon or continue to abandon:

- Restriction of the timing and/or frequency of breastfeeds during immediate postnatal care
- Restriction of mother-baby contact from birth onwards during immediate postnatal care
- Supplemental feeds given routinely or without medical reason in addition to breastfeeds (for example, in Baby Friendly Hospitals, The supplementation rate is usually below 10%)
- Separation of babies from their mothers for the treatment of jaundice
- The provision of hospital discharge packs and any informational material given to mothers which contain promotion for formula feeding including the advertising of 'follow on' formula milks to mothers of new babies (this practice has for the most part disappeared from normal NHS care. It is important to ensure that it is not reintroduced).

5. Complementary telephone peer support
    - Peer or volunteer support should be delivered by telephone to complement face-to face support in the early postnatal period to increase duration rates among women who want to breastfeed.

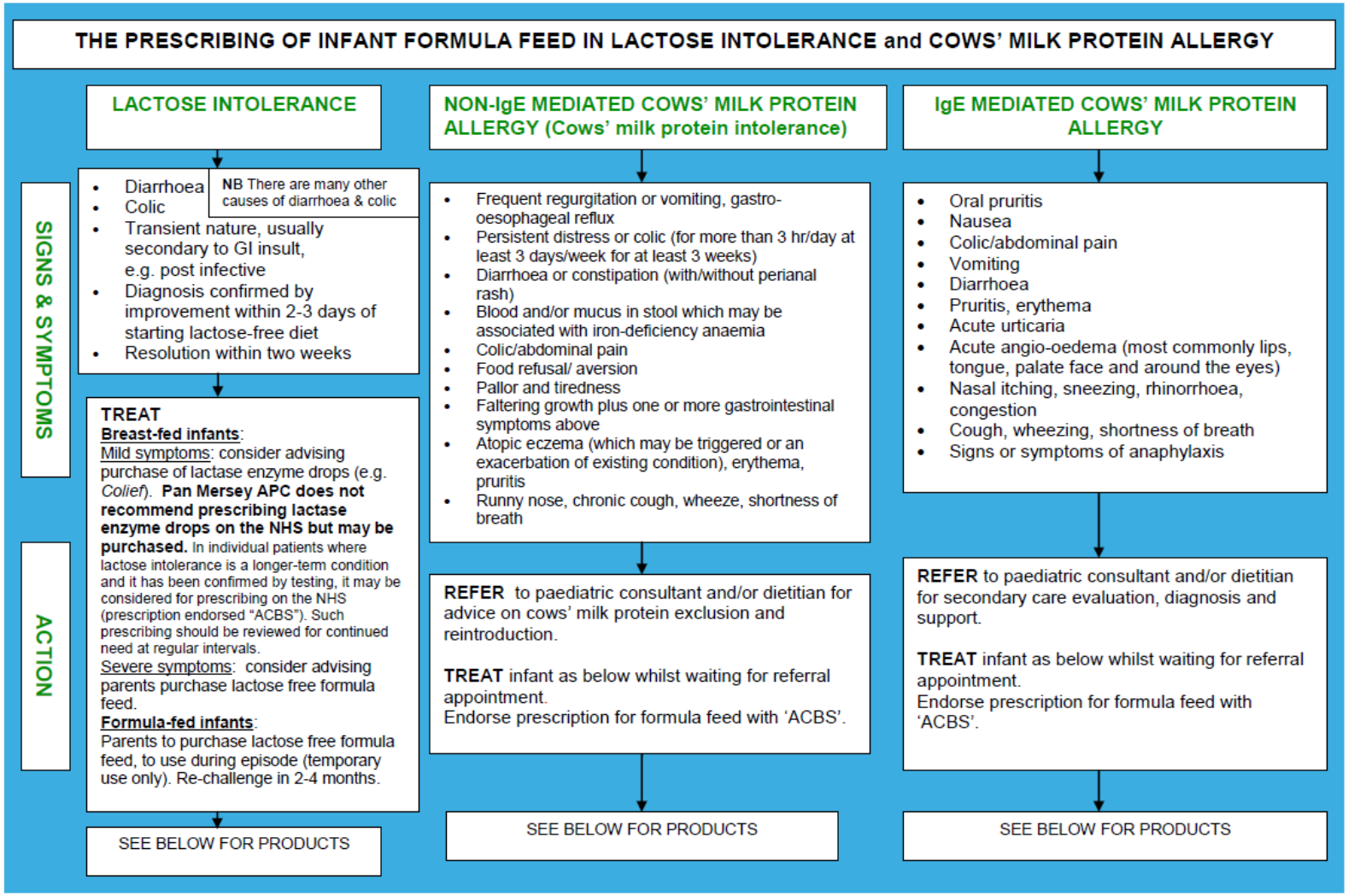
6. Education and support from a single professional
    - Infant feeding education and support should be from one professional, such as a midwife or health visitor and be targeted to women on low incomes to ensure consistent advice and support to increase rates of exclusive breastfeeding.

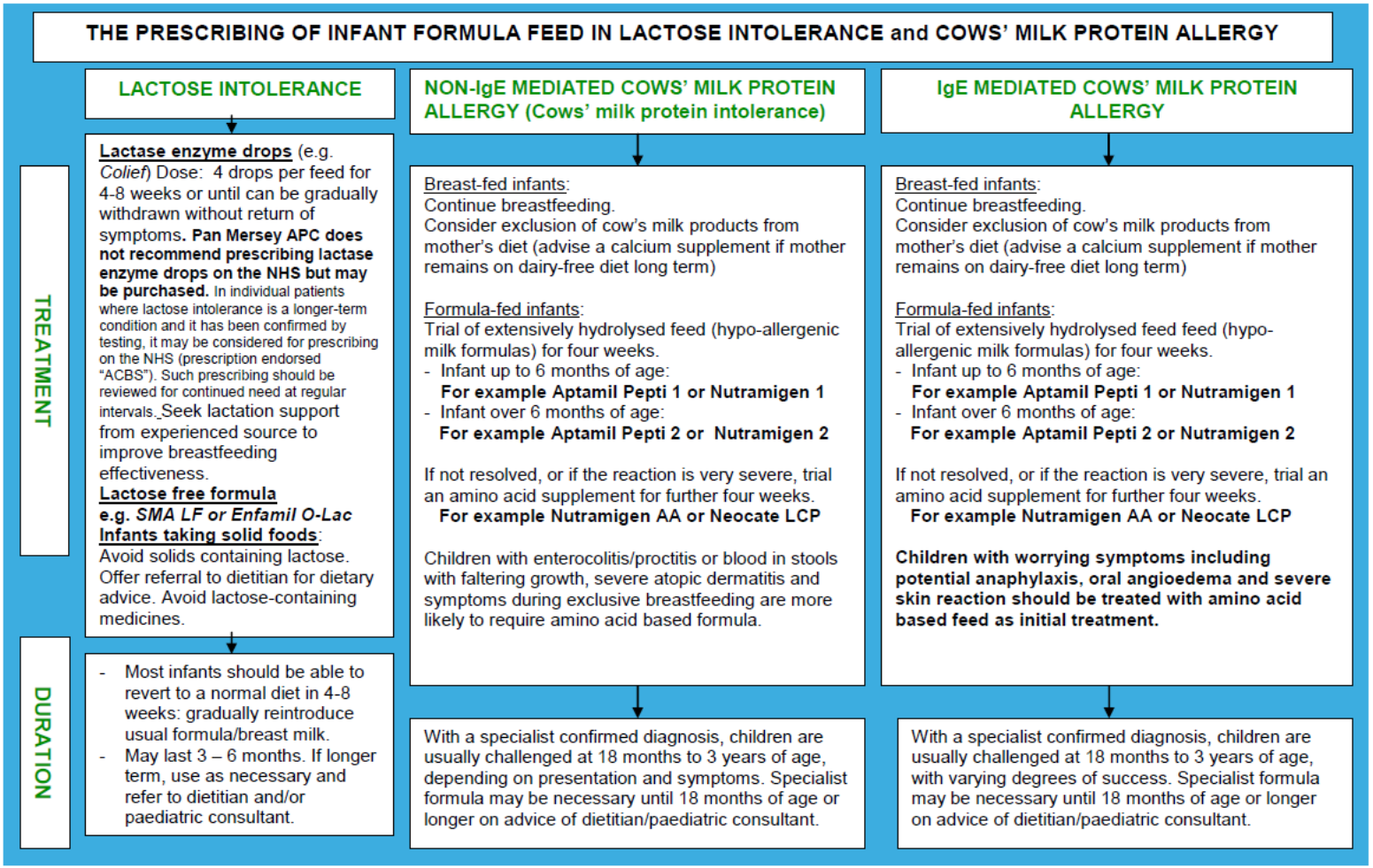
7. Education and support for one year
    - One-to-one needs-based breastfeeding education in the antenatal period combined with postnatal support through the first year should be available to increase intention, initiation and duration rates.

8. Media programmes
    - Local media programmes should be developed to target teenagers to improve and shift attitudes towards breastfeeding

Appendix B

The prescribing of infant formula feed in Lactose intolerance and Cow's Milk Protein Allergy. Pan Mersey area prescribing committee guidance, November 2014.




THE PRESCRIBING OF INFANT FORMULA FEED IN LACTOSE INTOLERANCE and COWS' MILK PROTEIN ALLERGY
LACTOSE INTOLERANCE
NON-IgE MEDIATED COWS' MILK PROTEIN ALLERGY (Cows' milk protein intolerance)
IgE MEDIATED COWS' MILK PROTEIN ALLERGY
TREATMENT
Lactase enzyme drops (e.g. Colief) Dose: 4 drops per feed for 4-8 weeks or until can be gradually withdrawn without return of symptoms. Pan Mersey APC does not recommend prescribing lactase enzyme drops on the NHS but may be purchased. In individual patients where lactose intolerance is a longer-term condition and it has been confirmed by testing, it may be considered for prescribing on the NHS (prescription endorsed "ACBS"). Such prescribing should be reviewed for continued need at regular intervals. Seek lactation support from experienced source to improve breastfeeding effectiveness.
Lactose free formula
e.g. SMA LF or Enfamil O-Lac
Infants taking solid foods:
Avoid solids containing lactose. Offer referral to dietitian for dietary advice. Avoid lactose-containing medicines.
Breast-fed infants:
Continue breastfeeding.
Consider exclusion of cow's milk products from mother's diet (advise a calcium supplement if mother remains on dairy-free diet long term)
Formula-fed infants:
Trial of extensively hydrolysed feed (hypo-allergenic milk formulas) for four weeks.
- Infant up to 6 months of age:
For example Aptamil Pepti 1 or Nutramigen 1
- Infant over 6 months of age:
For example Aptamil Pepti 2 or Nutramigen 2
If not resolved, or if the reaction is very severe, trial an amino acid supplement for further four weeks.
For example Nutramigen AA or Neocate LCP
Children with enterocolitis/proctitis or blood in stools with faltering growth, severe atopic dermatitis and symptoms during exclusive breastfeeding are more likely to require amino acid based formula.
Breast-fed infants:
Continue breastfeeding.
Consider exclusion of cow's milk products from mother's diet (advise a calcium supplement if mother remains on dairy-free diet long term)
Formula-fed infants:
Trial of extensively hydrolysed feed feed (hypo-allergenic milk formulas) for four weeks.
- Infant up to 6 months of age:
For example Aptamil Pepti 1 or Nutramigen 1
- Infant over 6 months of age:
For example Aptamil Pepti 2 or Nutramigen 2
If not resolved, or if the reaction is very severe, trial an amino acid supplement for further four weeks.
For example Nutramigen AA or Neocate LCP
Children with worrying symptoms including potential anaphylaxis, oral angioedema and severe skin reaction should be treated with amino acid based feed as initial treatment.
DURATION
- Most infants should be able to revert to a normal diet in 4-8 weeks: gradually reintroduce usual formula/breast milk.
- May last 3 – 6 months. If longer term, use as necessary and refer to dietitian and/or paediatric consultant.
With a specialist confirmed diagnosis, children are usually challenged at 18 months to 3 years of age, depending on presentation and symptoms. Specialist formula may be necessary until 18 months of age or longer on advice of dietitian/paediatric consultant.
With a specialist confirmed diagnosis, children are usually challenged at 18 months to 3 years of age, with varying degrees of success. Specialist formula may be necessary until 18 months of age or longer on advice of dietitian/paediatric consultant.

References

Agostoni et al., (2010) Scientific opinion on lactose thresholds in lactose intolerance and galactosaemia. EFSA Journal; 2010; 8(9):1777

Forsyth, S. (2004) Influence of Infant feeding practice on Health Inequalities during childhood.

Heyman MB; Lactose intolerance in infants, children, and adolescents. Pediatrics. 2006 Sep;118(3):1279-86.

McAndrew F., Thompson, J., Fellows, L., Large, A., Speed, M., and Renfrew, M., (2012) Infant feeding survey 2010 London: Health and Social Care Information Centre

NICE guidelines 116 (2011). Food allergy in children and young people. Diagnosis and assessment of food allergy in children and young people in primary care and community setting.

Nice public health guidelines 11 (2008) Maternal and Child nutrition

Nice guidelines CG37 (2006 updated 2014) Postnatal care

Pan Mersey Area Prescribing Committee (November 2014) Pan-Mersey Prescribing Guidelines for Specialist Infant Formula Feeds in Lactose Intolerance and Cows' Milk Protein Allergy, ref G16 V01. Available from http://www.panmerseyapc.nhs.uk/guidelines/documents/G16.pdf

WHO (2010) Infant and young child feeding. Fact sheet No. 342. Available from: http://www.who.int/mediacentre/factsheets/fs342/en/index.html

Wilson J. Milk intolerance: Lactose intolerance and Cow's milk protein allergy. Newborn and Infant Nursing Reviews 2005;5:203-207

Halton Infant Nutrition Action Plan 2016-19

The action plan follows the following priority areas:

1. **Women have the information, support and skills to breastfeed**
2. **Making breastfeeding the norm**
3. **Raising awareness and support of breastfeeding amongst general public**
4. **Achievement and maintenance of Unicef Baby Friendly Initiative**
5. **Women who choose to formula feed their baby do so as safely as possible**
6. **Robust data collection mechanisms are in place to enable progress to be measured and areas of need addressed**
7. **Families are supported to introduce solid foods in a timely and appropriate way**

**Monitoring unless stated to be via the Commissioners and/or Halton Health in the early years Steering Group

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
Priority 1 -Women have the information and support to breastfeed					
1.1	**Antenatal Period** All Halton mums to receive information on breastfeeding as part of a meaningful discussion on infant feeding to meet their individual needs and information on the support services available at numerous points antenatally, at routine midwife appointments (booking, 20 weeks) and	All Midwives to give out information on breast feeding support services and infant feeding workshops at all antenatal and postnatal contacts Maintain and encourage midwives to refer into the breastfeeding support service	Carole Brazier (Infant feeding Coordinator) Karen Worthington Children's Centres Rose Douglas (St Helens and Knowsley Hospital Trust)	Ongoing Annual audit of practice	Recorded in maternity notes Audits of practice Feedback from mothers Lesson plan and

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
	at additional antenatal classes were appropriate	Multi agency Parent education programme to be developed, staff trained and delivered	Corina Casey-Hardman (Halton)	Jan 16	timetable
1.2	**Antenatal Period** All mums to be to be given an appointment to attend an infant feeding workshop, mums given the choice to attend a community session and/or hospital session (information provided on all options available)	Make infant feeding workshops a routine appointment within antenatal care Identify families eligible for Healthy start voucher and support application. Encourage uptake of vouchers for food and vitamins	Corina Casey-Hardman (Halton) Corina Casey-Hardman, Karen Worthington	Ongoing Ongoing	% uptake at infant feeding workshop (out of total number of births)
1.3	**Antenatal Period** Ensure information sharing agreements between the breastfeeding support Service and Midwifery services are in place for the antenatal period Health visitors to provide support at the antenatal contact	Midwives to ask if mums consent to information being shared with breastfeeding support service at antenatal appointments Maintain antenatal information sharing agreement to obtain contact details of mums with all acute providers	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall Corina Casey-Hardman (Halton)	Ongoing	Information sharing agreements in place Breastfeeding support team report receiving regular information from maternity units
1.4	**Antenatal Period** Mums who express an interest in breastfeeding during the antenatal period to receive information and support from Breastfeeding support	Breastfeeding support team to provide antenatal visits To be contacted by the Breastfeeding Support Team and	Midwifery services to identify Pam Worrall Pam Worrall	On-going Ongoing	Infant feeding team KPIs

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
	team Target 50% of women to be identified and referred 80% of these to receive visit 2015/16, 100% 2016/17, 100% 18/19	offered a 1 to 1 discussion either face to face or over the telephone to discuss issues/concern Outline of planned support to be given to all women in hospital Audit effectiveness of interventions	Carole Brazier (Infant feeding Coordinator) Carole Brazier (Infant feeding Coordinator)	March 16 Sept 16	Audit report
1.5	**On Delivery** All mothers to be offered and supported with skin to skin contact until after the first feed independent of feeding choice. Midwifes to support new mothers with first breastfeed and again, second feed within 6 hours of birth Formula feeding mothers are shown how to fed their baby responsively	Midwives as part of routine care	Rose Douglas (St Helens and Knowsley Hospital Trust) Melanie Hudson (Warrington Hospital) Shelia McHale (Halton CCG Commissioner) Corina Casey Hardman	On-going	BFI status of providers Maternity performance data and audit
1.6	**On discharge from Hospital** Ensure information sharing agreements between the Breastfeeding Support Service and Maternity Units are in place for all hospitals	Maintain / modify postnatal information sharing agreements	Pam Worrall HBC	Ongoing	Information sharing agreements in place Breastfeeding Support Team report receiving

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
					regular information from maternity units
1.7	**On discharge from Hospital** 100% of Halton breastfeeding mums who consent, to be contacted by the breastfeeding Support Team within 48 hours. A full breastfeeding assessment to take place within the first 7 days All breastfeeding mothers who give birth at home are referred to the breastfeeding support service at the time of birth or the next working day	100% of Halton breastfeeding mums who consent, to be contacted by the breastfeeding Support Team within 48 hours and offered a home visit or telephone support. A full breastfeeding assessment to take place within the first 7 days following birth (target-80% uptake) All breastfeeding mothers who give birth at home are referred to the breastfeeding support service at the time of birth or the next working day	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall HBC Corina Casey-Hardman	On-going	100% of consented mums contacted within 48 hours Of which 80% have a full breastfeeding assessment within 7 days.
1.8	**On discharge from Hospital** Community based Breastfeeding support to be available to mums outside office hours	Health visitors and midwives to be available to support women with feeding issues as required as part of routine care. Audit of women's views and needs for out of hours breastfeeding support service	Michelle Bradshaw, Corina Casey-Hardman (Halton) Carole Brazier (Infant Feeding Co-ordinator)	Ongoing Sept 2016	Audit report
1.9	**On discharge from Hospital** 100% of mums to receive a feeding	CCG Commissioner to ensure this is in the contract and to	Shelia McHale (Halton CCG Commissioner)	In place but	Quarterly audits

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
	review consistent with BFI standards on responsive formula feeding and supporting initiation and continuation of breastfeeding. Halton mums to have a minimum of two breastfeeding assessments first home visit and 5 /6 days by midwife, if issues identified, a plan put in place and a further assessment to be completed at a later date	performance manage providers against this. (Halton) Midwives have the access to breastfeeding assessment forms	Michelle Bradshaw (Bridgewater) Rose Douglas (St Helens and Knowsley Hospital Trust) Corina Casey-Hardman (Halton)	assurance through annual audits	Report to breastfeeding steering group)
1.10	**Community** All breastfeeding mothers receive a breastfeeding assessment as part of the Health visitor primary assessment (10-14 days) All formula feeding mothers to receive information regarding responsive and safe feeding appropriate to their needs.	Health Visitors to complete a breastfeeding assessment at the primary visit (10 days) Health visitors to complete formula feeding checklist in new birth template Implement the Pan Mersey lactose intolerance and Cows Milk Protein Allergy prescribing guidelines, and ensure all health visitors, FNP, midwives and GPs are familiar with the guidelines All breastfeeding women to receive Healthy start vitamins free, via the health visitors	Karen Worthington (Bridgewater) Karen Worthington Carole Braizer/CCG Karen Worthington	On-going March 16 Ongoing	KPI in health visiting contract Prescribe formula audit Audit of vitamin uptake June 2016

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
1.11	**Community** Services work seamlessly to provide support for women to continue to breastfeed.	Midwifery, health visiting and breastfeeding support teams to work together to ensure that a breastfeeding mum is supported to continue breastfeed Pathway to identify lead professional where breastfeeding issues exist	All Carole Brazier (Infant Feeding Co-ordinator)	Quarterly review	Increased rates of women Breastfeeding at 6-8 weeks.
1.12	Women who are least likely to breastfeed during the antenatal and postnatal periods have additional targeted interventions. This includes women in lower socio-economic groups, Teenage mothers, single mothers, mothers who have premature births/multiple pregnancies	Establish what support midwives gives to the higher risk groups to support them to breastfeeding, and identify appropriate actions Availability of targeted interventions for parents less likely to engage e.g. attendance at consultant clinics by support workers Family nurse partnership to provide enhanced support to first time teenage mothers.	Carole Brazier (Infant Feeding Co-ordinator) Carole Brazier (Infant Feeding Co-ordinator) Therese Woods, Family Nurse Partnership	Sept 16 Ongoing Ongoing	Increased uptake of breastfeeding and at 6-8 weeks in these vulnerable groups.

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE How
Priority 2- Making breastfeeding the norm					
2.1	Services are meeting the needs of women and their families/ Obtain the views of local mums on breastfeeding in the community so as to direct provision of support groups and future support work	Completion of regular consultation with mums and partners to understand the needs of local breastfeeding mums by all staff. Review /audit of both antenatal and postnatal support *	Carole Brazier (Infant Feeding Co-ordinator)	September and January annually	Operation group report twice a year on emerging issues expressed from mums
2.2	Fathers and wider family members encourage support women to breastfeed	Explore new ways of working with fathers and wider family members to understand issues and raise their awareness of the importance of breastfeeding Workshop/ focus group for first time teenage fathers Link in with existing networks & groups	Carole Brazier (Infant Feeding Co-ordinator) Use Halton fathers and grandparent group Therese Woods, Family Nurse Partnership	September 2017 Sept 16	Feedback to Breastfeeding steering group

2.3	Breastfeeding women feel confident to breastfeed outside of the home	All staff to provide mothers with practical information to support breastfeeding in front of others and outside the home as part of postnatal care (BFI standard) Promote existing baby welcome premises in Halton Advertise the 'breast milk it's amazing' app to mums at venues	All Carole Brazier (Infant Feeding Co-ordinator) All All	Ongoing	Feedback from mothers shows that they know where breastfeeding is welcomed and
2.4	Maintain and increase the number of baby welcome premises across Halton in venues identified by mothers	Baby welcome Task and finish group Engage mothers and volunteers to audit and identify suitable premises Work with environmental health officers to support the audit of premises (Halton) Establish baseline and enrol more local organisations	Carole Brazier (Infant Feeding Co-ordinator) with support from Public Health, Baby welcome and breastfeeding champions. Pam Worrall (Halton)	Jan 2016	Feedback from Baby welcome and breastfeeding champions Task and Finish Group
2.5	Build capacity for breastfeeding support and advocacy	Establish community breastfeeding champions to include breastfeeding mothers and others to support baby welcome Provide buddy support to women	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall	5 in place by April 2016	Quarterly update to breastfeeding steering group

2.6	Support long term breastfeeding for women returning to work	DH leaflet is available, to be given when discussing how to continue breastfeeding on returning to work including practical solutions, employers' obligations and how to negotiate with their employer Offer childminders, foster carers, nursery schools training on currant infant feeding practices	Health visitors Karen Worthington (Bridgewater) Carole Brazier	On-going Sept 2016	By Report Numbers of sessions and attendees
Priority 3 -Raising awareness of breastfeeding among the general public					
3.1	Increase awareness and appreciation of breastfeeding as the norm through the 'breast milk its amazing' social marketing campaign All staff having contact with new mums direct them to information on baby welcome premises	Update the map of baby welcome premises in Halton on website and Breast start app Include a link from the local authority websites and other appropriate websites such as children's services to' breast milk it's amazing' website	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall HBC	6 monthly	Monitoring via Champs, LCR Breastfeeding group
3.2	Ensure that all services who come into contact with mums to be or new mums have access to the' breast milk its amazing social marketing campaign materials	breast milk it's amazing is advertised on all resources - Red book - Midwifery notes - Leaflets antenatally and postnatally - On all posters	Carole Brazier (Infant Feeding Co-ordinator) Corina Casey Hardman Karen Worthington	By Jan 2016	Feedback to steering group

3.3	Develop and maintain a profile via social media and in the local media via release of regular press releases	Develop more detailed communication plan to include: Events and press release in June to coincide with breastfeeding awareness week Updates and blog on website Regular information on support groups in maternity & children's venues.	Pam Worrall (Halton) Link with PH leads and LA Comms leads	June 2016 June 2017 June 2018 Tbc Ongoing	Feedback to steering group Press coverage
3.4	Children see breastfeeding as the norm through promotion in PSHE and work with local schools	The PSHE Breastfeeding booklet has been updated and will be launched Training to secondary schools to include breastfeeding work Halton to review the use of the breastfeeding support booklet by local schools Preschool setting resources work with the early years consultant teachers Add to the HHEYs award and include in Baby welcome award – around storage of breast milk	Pam Worrall (Halton) Breastfeeding support team Deb Cornes Early years consultants Carole Brazier	Jan 2016 September 2016 July 2016 Sept 16 January 16	Feedback from schools via healthy schools coordinators

3.5	Local organisations are supportive of breastfeeding for visitors and staff and have policies in place	Ensure that all public health and Health commissioned organisations also have a breastfeeding HR policy for staff and visitors Work with local organisations and the chamber of commerce regarding the policy for breastfeeding for local businesses- customers, visitors and staff Ensure all early years settings support mothers to continue to breastfeed when their child is in child care, for example through facilities to store breast milk	Carole Brazier CCG Leanne Needham Carole Brazier (Infant Feeding Co-ordinator) /Jill Farrell	June 2016 September 2016	Explore avenues for influencing local businesses Develop an action plan for encouraging local business to have breastfeeding policy for staff Develop education programme for early years setting on infant feeding standards
Priority 4: Achievement and maintenance of Unicef Baby Friendly Initiative stage 3 Implement Baby Friendly Action Plan by 2015					
4.1	All relevant staff (Midwives/Health Visitors/Breastfeeding Support Service/children's centres) have adequate resources to provide advice and information on infant feeding	All services to ensure resources are in place and ensure long term supply	Carole Brazier (Infant feeding coordinator) Corina Casey Hardman Karen Worthington Children's Centres	Ongoing	Feedback to steering group

4.2	Work towards all children's organisations being Stage 3 baby friendly	Explore with Unicef potential for extending BFI status to other children's organisations in borough & children's centres- develop action plan.	Carole Brazier (Infant Feeding Coordinator) working with Veronica Wright	June 2016	Feedback to steering group
4.3	Breastfeeding steering group to provide leadership and performance manage the achievement of BFI Stage 3 (community/hospital)	Group to be led by public health leads and maintain strategic focus on delivery., links to Health and Wellbeing board, Maternity and Children's Agenda	Halton Breastfeeding Steering group	On-going	Progress reports to steering group
4.4	All relevant healthcare staff induction including Midwives (community), Health Visitors and Children's centres are aware of and compliant to the breastfeeding policy	Maintain training and focus on Breastfeeding through staff briefings Develop a robust system to record training and induction status of new starters To be included in staff inductions	Michelle Bradshaw (Bridgewater) Carole Brazier Children's Centres Pam Worrall	On-going	Progress reports to steering group Feedback from listening events

4.5	GPs are competent in treating common breastfeeding related conditions, prescribing for breastfeeding women and support services available	Develop and implement training for GPs and practice nurses Explore different methods of encouraging GPs to complete the training. Protected learning time slot Include regularly in GP bulletins Identify GP liaison for training and feedback re care	Shelia McHale (Halton CCG Commissioner) Carole Brazier (Infant feeding Co-ordinator)	Training plan for 2016 onwards	Uptake of training Feedback to steering group
Priority 5: Women who choose to formula feed their baby do so as safely as possible					
5.1	Women receive during the antenatal and postnatal period, information on responsive feeding and ensure women who have chosen to bottle feed, do so safely.	During pregnancy, all women are given the opportunity to discuss feeding their baby and receive information appropriate to their needs. All midwives on first home visit to formula feeding mothers ensure they have information on and are able to make up feeds to the current guidelines and are using suitable first milk.	Carole Brazier Karen Worthington Corina Casey Hardman	Ongoing support	

5.2	Health professionals use the evidence to inform the appropriate use of different infant formulas	Awareness raising in health professionals of the First steps nutrition evidence Support the implementation of the Pan Mersey lactose intolerance and cow's milk protein allergy prescribing guidelines across all health professionals.	Carole Brazier Carole Brazier/ pharmacy	Sept 16 Sept 2017	
Priority 6:Robust data collection mechanisms are in place to enable progress to be measured and areas of need					
6.1	Maintain accurate data collection systems on breastfeeding uptake so as to use real time data to inform practice and to develop future action plans (all breastfeeding data, initiation, 5-7 days,6-8 weeks)	Maintain accurate , quality assured data systems to ensure correct reporting of uptake Review data coverage and correct prior to data submissions, to ensure compliance with DH standards	Michelle Bradshaw Bridgewater Carole Brazier/James Cowley (Bridgewater) Public Health Intelligence Teams (Halton) Shelia McHale (Halton CCG Commissioner) Karen Worthington(Bridgewater) Corina Casey-Hardman (Halton)	Ongoing Ongoing	Data meets DH standards and is published. Accurate data on 5-7 days (and all measures) available locally

Priority 7: Families are support to introduce solid foods in a timely and appropriate way

7.1	Ensure all families have access to Introducing solid food support and advice	Introduction of set timescale when parents receive information on introducing solid food . 3/4 month contact/invitation to solid food session, 121, clinic attendance. All frontline health and children's centre staff to attend introducing solid food training. Offer training to childminders, foster carers and early year settings Health visitors to discuss in their routine visits, and refer all families to the Health improvement team Standardise resources on Introducing solid foods, including bottle to cup message Audit and evaluation of information and support offered by all Dietetic support to be made available to families who experience fussy eaters. Training support to be provided to health visitors from dietetics in how to support families who have fussy eaters.	Karen Worthington Pam Worrall Carole Brazier Karen Worthington, Pam Worrall Carole Brazier Carole Brazier 5 boroughs TBC	March 2016 Ongoing September 2016 Jan 2016 Sept 16 Annually Jan 16	

7.2	Access to healthy start vitamins for infants	All families to receive a free bottle of healthy start vitamins via Health visitor at 4 month review. Support to families in applying for Healthy start vouchers were eligible.	Karen Worthington, Julia Rosser Karen Worthington Corina Casey Hardman	Ongoing Ongoing	Uptake of vitamins Audit
7.3	Encourage families to transfer from bottle to cup at age 1	Include in training for healthcare and children's centre staff as appropriate Include in resources for families Article in Wellbeing magazine	Carole Brazier Karen Worthington/Carole Brazier Helen Parker	Ongoing March 16	Report