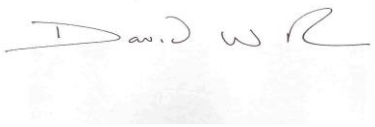
Public Document Pack

Health Policy and Performance Board

Tuesday, 20 September 2016 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Joan Lowe (Chair)	Labour
Councillor Shaun Osborne (Vice-Chair)	Labour
Councillor Sandra Baker	Labour
Councillor Marjorie Bradshaw	Conservative
Councillor Ellen Cargill	Labour
Councillor Mark Dennett	Labour
Councillor Charlotte Gerrard	Labour
Councillor Margaret Horabin	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Stan Parker	Labour
Councillor Pauline Sinnott	Labour

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 15 November 2016

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

Part I

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

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 21 June 2016 at Council Chamber, Runcorn Town Hall

Present: Councillors J. Lowe (Chair), Osborne (Vice-Chair), S. Baker, M. Bradshaw, E. Cargill, Dennett, C. Gerrard, Horabin, M. Lloyd Jones and Sinnott

Apologies for Absence: Councillor Parker

Absence declared on Council business: None

Officers present: S. Wallace-Bonner, A. Jones, S. Shepherd, D. Nolan, L Wilson and D. Parr

Also in attendance: professor Steve Cox – Clinical Chief Executive, NHS St Helens CCG; Ann Marr – Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust; Mel Pickup – Chief Executive, Warrington & Halton Hospitals NHS Foundation Trust and Simon Banks – Chief Officer, NHS Halton CCG.

ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HEA1 MINUTES

The Minutes of the meeting held on 22 February 2016 having been circulated were signed as a correct record.

HEA2 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA3 HEALTH AND WELLBEING MINUTES

The draft minutes of the Health and Wellbeing Board meeting dated 9 March 2016 were submitted to the Board for information.

Councillor Martha Lloyd Jones declared a Disclosable Other Interest in the following item as her husband was a Governor of Halton and Warrington Hospitals which was referred to in the report.

HEA4 HEALTH POLICY AND PERFORMANCE BOARD ANNUAL REPORT : 2015/16

The Board received the Health Policy and Performance Board's Annual Report for April 2015 to March 2016. It was noted that the Board had examined in detail many of Halton's Health and Social Care priorities and details of the work undertaken was outlined in the Annual Report.

RESOLVED: That Annual Report for April 2015 to March 2016 be noted.

HEA5 TRANSFORMING CARE PROGRAMME

The Board received a report from the Strategic Director, People and Economy, which provided details of the purpose and associated processes of the Governments Transforming Care Programme and the local progress for Halton residents.

It was reported that further to the publication of the Government's response to Winterbourne View Hospital (2012) a concordat plan of action was developed. By the time of the report *Winterbourne View – time for change 2014*, it was evident that the intended reduction in the use of in-patient beds had not been achieved. The Government had therefore, now set clear targets for the reduction of in-patient beds and this was to be a 50% reduction nationally over the next three years.

It was noted that the Transforming Care Agenda encompassed both Children and Adults with Learning Disability and/or Autism, and in particular those who displayed behaviour that presented challenges. The key areas of the Transforming Care Programme were noted as:

- Empowering individuals;
- Right care in the right place;
- Regulation and inspection;
- Workforce; and
- Data and information.

The report discussed where Halton fitted in to the Programme and Members were referred to:

- the *National Service Model* at Appendix 1;
- the Governance Structure of the Cheshire and Merseyside Transforming Care Board at Appendix 2;

- The latest version of the Mid-Mersey Plan at Appendix 3.

Following Members' queries it was confirmed that there were mechanisms in place to receive feedback from young people with disabilities so that services could be improved and developed. The Chair suggested that a glossary would be useful if abbreviations are to be used in the reports.

RESOLVED: That the Board notes the report.

Councillor Osborne declared a Discloseable Other Interest in the following item as his wife works for the Council.

HEA6 SOCIAL WORK CASELOAD MANAGEMENT

The Board received a report from the Director of Adult Services apprising them of the Adult Social Care's approach to caseload management. The report was requested by Councillor Dennett, as it linked to the Children, Young People and Families Policy and Performance Board and he wished to raise awareness of the subject with Members in light of the 'Climbie' case.

Members were advised that caseload management was an important part of overall workload management in the care management services, particularly in ensuring that social workers had a manageable workload; that they had a good mix of cases; and that peaks and troughs with individual workers are co-ordinated effectively across the whole team. It was noted that an average caseload was 25; however this could vary depending on complexity of cases.

It was reported that currently caseloads were manageable and the Council had good staff retention of permanent social workers with no vacancies at present. Further due to a new progression route policy for social work staff, there was a good mix of experienced staff and newly qualified staff and regular placements were offered to social work students. Further, the Council operated within the *National Employer Standard for Social Workers,* published by the Local Government Association (LGA), which was in place to sustain high quality outcomes for service users and their families, carers and communities.

The report continued to discuss the approach to caseload management in Halton making reference to the *Professional Capability Forum*; the *Caseload Management Framework for Adult Social Care teams*; and the revised

Supervision Policy, Procedure and Practice.

An invitation was made to Members to attend the *Social Work Matters Forum* where the Principal Social Worker met quarterly with social workers to discuss professional and topical issues for social work. This was noted by Members and Officers would forward the dates of the Forum to them.

RESOLVED: That the Board

1) notes the report and comments made; and
2) notes the invitation to attend a future Social Work Matters Forum.

Director of Adult Services

HEA7 ONE HALTON - HEALTH & WELLBEING OPERATIONAL PLAN 2016-17

The Board received a report from the Strategic Director, People and Economy, informing them of the initial operational plan for 2016-17, submitted to NHS England (NHSE) as part of the annual planning around and to identify further work that would be undertaken to develop the priorities for the five year Sustainability and Transformation Plan and the Financial Recovery Plan, with the clear actions to be delivered during the year.

It was reported that NHSE issued their *Five Year Forward View* planning guidance in October 2014, with a set of priorities for the NHS up to 2020 and the direction of travel for new models of care and the improvement of care, quality and financial efficiencies. In October of the first year of the Five Year plan, NHSE published its revised planning guidance, '*Delivering the Forward View'*, that extended the planning period to 2021, with a continuation of the existing direction of travel but with a number of new challenges.

The '*One Halton Health and Wellbeing Operational Plan 2016-17'* was attached to the report and acted as Halton's response to NHSE with details of the assumptions and trajectories to evidence the values submitted.

The new challenges were discussed in the report and Members debated the NHS Halton CCG's forecasted end of year £8.5m deficit. It was noted that better utilisation of budgets was needed and to achieve this all budget lines would be scrutinised. Members referred to the stock piling of medication by GP's pharmacies and care homes etc, and that money could be saved by eradicating this. In response it was noted that this was being looked at presently.

A paper would be prepared with further detail for a future meeting of the Health and Wellbeing Board and this Board, for September.

RESOLVED: That the Board

1) Notes the report and appendix; and
2) Supports the commissioning teams(s) in identifying the priorities and delivering the subsequent actions.

HEA8 WINDMILL HILL - CONTRACTING GENERAL MEDICAL SERVICES

The Board received a report from the Strategic Director, People and Economy, which set out the background and options for commissioning a General Practice Service at Windmill Hill from April 2017.

Officers reported that Windmill Hill Medical Centre was located within the Ward of Windmill Hill and it had a branch surgery located in Widnes. Originally it was two separate practices, both developed as part of the Equitable Access to Primary Medical Care (EAPMC) Programme. In 2011-12 it was agreed to reorganise the Widnes service as a branch of the Windmill Hill site. The current contract was held with Liverpool Community Health NHS Trust (LCH) which ends on 31 March 2017. It was noted that due to the organisational restructure that was currently being undertaken at LCH there was no opportunity to extend the contract beyond 2017.

The report provided information on the numbers of patients registered and the complement of staffing for the practice. It further presented details of the health and wellbeing of residents of Windmill Hill and the health concerns within the Ward such as long term sickness and disability.

Two options were presented to Members for comment and were discussed in the report:

- Option One: Commission as a Branch Surgery; and

- Option Two: List Dispersal of Widnes Patients (which could sit alongside Option One).

Members agreed that Windmill Hill needed its own surgery and discussed the *Windmill Hill Big Local* joining Halton CCG as part of the Big Local Partnership to deliver health services. It was noted that negotiations were

continuing with the School regarding the land and the Board would be kept updated with any progress on this.

RESOLVED: That the Board notes the update on the contracting of General Medical Services at Windmill Hill.

HEA9 ALLIANCE LOCAL DELIVERY SYSTEM (LDS)

The Board received a report from the Strategic Director, People and Economy, which provided the Board with some background to the development of the Alliance Local Delivery System (LDS) and progression to date. To accompany the report Members received a presentation from Professor Steve Cox: Clinical Chief Executive, NHS St Helens CCG and Mel Pickup, Chief Executive Warrington and Halton Hospitals NHS Foundation Trust, titled *Cheshire and Merseyside Sustainability and Transformation Plans* for the Alliance Local Delivery Systems.

It was reported that the NHS shared planning guidance 2016-17 to 2020-21 outlined a new approach to help ensure that health and care services were planned by place rather than around individual institutions. As in previous years NHS organisations were required to produce individual operational plans for 2016-17. In addition, every health and care system was expected to work together to produce a multi-year *Sustainability and Transformation Plan (STP)* showing how local services would evolve and become sustainable over the next five years, ultimately delivering the *Five Year Forward View* vision.

The report explained to Members how local health and care systems and organisations had come together to do this. It was noted that the Cheshire and Merseyside (C&M) STP was formed in January 2016 and the report went on to explain how this would be delivered through three levels.

The presentation included details of the organisations included in the Alliance and provided some details of the underlying proposition which included three main areas that would be focussed upon:

- Out of Hospital New Models of Care;
- Secondary Care Transformation; and
- Wellbeing, Prevention and Self Care.

Following the presentation, Members raised concerns regarding:

- Financial implications and who would spend what;
- Accountability;
- Would experiences of service users being listened to;
- Whether the prevention agenda would be included;
- The future of the urgent care centres considering the rise in attendance figures;
- That this would split up the NHS; and
- The continuation of mental health services for children and adolescents.

On behalf of the Board the Chair advised the presenters of the disappointment with the way Halton Council had not been advised of the Alliance LDS much earlier in the process. Further, to expect the plans to be signed off by the end of the week was unreasonable and unacceptable to the Board and to the Officers of the Council. No consultation had been made prior to this request for sign off and it was the consensus that the Council and other partners had been put in a difficult position by this expectation.

Members wished to have their concerns noted and suggested the Board sought collaboration with the other Local Authorities to write to NHS England in response to this.

The Chair thanked Professor Cox and his colleagues for their attendance.

RESOLVED: That the Board notes the update.

HEA10 PERFORMANCE MANAGEMENT REPORTS - QUARTER 4 2015-16

The Board received the Performance Management Reports for quarter 4 of 2015-16. Members were advised that the report introduced, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in quarter 4 of 2015-16. This included a description of factors which were affecting the service and identified key issues in performance.

It was noted that the data for Key Performance Indicators PA16 and PA20 was collected annually, so would be included on the next meeting's report.

RESOLVED: That the quarter 4 reports be received.

Meeting ended at 8.20 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 20 September 2016

REPORTING OFFICER: Strategic Director, Enterprise Community & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

- Requires the disclosure of confidential or exempt information.

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Health Policy & Performance Board

DATE: 20th September 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health & Wellbeing

SUBJECT: Public Health Update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform and update the Health Policy & Performance Board of:-

A. Public Health Functions and Activities within Halton
B. 2015/16 Public Health Annual Report
C. Impact of the reduction in Public Health funding

2.0 **RECOMMENDATION: That:**

i) The Board note the content of the report and associated appendices

3.0 **SUPPORTING INFORMATION**

3.1 **A. Public Health within Halton**

Since the NHS reforms, Halton Borough Council has assumed responsibility for the planning and commissioning of public health services for the people of Halton.

Local Councils have the commissioning responsibility for the following areas: -

- Sexual health services including STI testing and treatment and Advice, prevention, contraception and promotion
- NHS Health Check programme,
- Local authority role in health protection,
- Public health advice,
- National Child Measurement Programme,
- Obesity – adults and children,
- Physical activity – adults and children,
- Drug and, Alcohol misuse – adults,
- Substance misuse (drugs and alcohol) - youth services,
- Stop smoking services, interventions and wider tobacco control,
- Children 5-19 public health programmes,
- Children 0-5 services (including Health Visitors and the Family Nurse Partnership),

Other areas of responsibility include:

- Nutrition initiatives,

- Health at work,
- Programmes to prevent accidents,
- Public mental health,
- General prevention activities,
- Community safety, violence prevention & social exclusion,
- Dental public health and Fluoridation,
- Local authority role in surveillance and control of infectious disease,
- Information & Intelligence,
- Any public health spend on environmental hazards protection,
- Local initiatives to reduce excess deaths from seasonal mortality,
- Population level interventions to reduce and prevent birth defects (supporting role),
- Wider determinants of health.

Local Authorities are expected to set their health priorities based on their Health and Wellbeing Strategies, with a robust understanding of local needs set out within Joint Strategic Needs Assessment (JSNA) and take into account the indicators within the Public Health Outcomes Framework.

Between 2012 and 2015 Halton's Health and Wellbeing Strategy identified the following priority areas using evidence from the Joint Strategic Needs Assessment (JSNA) and extensive consultation with stakeholders and local people.

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

A new Health and Wellbeing Strategy and Action Plan is now in development, aligned with the One Halton priority areas for action.

3.2 **B. 2015/16 Public Health Annual Report**

Since 1988 Directors of Public Health (DPH) have been tasked with preparing annual reports - an independent assessment of the health of local populations. The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively.

The annual report is an important vehicle by which a DPH can identify key issues, flag problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action. The annual report remains a key means by which the DPH is accountable to the population they serve.

The 2015-16 Public Health Annual Report focusses on the work of the Public Health Evidence and Intelligence Team. This topic has been chosen to highlight some strategic pieces of work, their key findings and how they have been used or will be used by Halton Borough Council and its partner organisations.

The Public Health Annual Report 2015-16 is available online at: -

http://www4.halton.gov.uk/Pages/health/PDF/health/Phar1516.pdf

The report uses a life-course approach around the following chapters:

- Starting Well
- Living Well
- Ageing Well

Each chapter covers the following areas:

- Summary of piece of work
- Why and how it was done
- How the work has been or will be used

The pieces of work highlighted in the report are:

- Children's Joint Strategic Needs Assessment (JSNA)
- GP JSNA
- JSNA on Long Term Conditions
- Older People's JSNA

The report uses infographics and other methods to highlight key achievements in an easy to read format. Notable among the successes are:

- Reduction in under 18 alcohol admissions
- Reduction in teenage pregnancy
- Better flu vaccination uptake in over 65s compared to England average
- Older people aged 65 - 74 have the highest level of wellbeing In the UK

3.3 **C. Impact of the reduction in Public Health funding**

In 2015/16 the Public Health grant received an unexpected in-year cut from the Chancellor to the value of £630,000. This impacted on the settlement for 2016/2017 where Halton Borough Council received a financial settlement for Public Health of £10,718,000. This figure included a £1.5m reduction on the expected budget. In addition, the Government has indicated that the ring fenced public health budget will be further reduced by a minimum of 10% over the next four years, with an additional £500,000 reduction projected for the financial year of 2017/18.

As such, the public health ring fence grant will, by the end of 2016/17, be in a position where approximately 20% of its total budget will have been reduced.

Work is constantly underway with providers to seek efficiencies in contract values. In November 2015, an exercise was undertaken with all providers to consider a reduction of 5%, 10%, 15% and decommissioning.

All providers indicated that any reduction greater than 10% in current contract values would have a detrimental impact on their ability to deliver services and possibly affect the safety of service users. There will be a health impact assessment to assess risk if cuts greater than 10% are required.

Currently efficiency savings have been made through re-aligning activities within existing contracts.

4.0 POLICY IMPLICATIONS

4.1 A. 2015/16 Public Health Annual Report

The Public Health Annual Report should be used to inform commissioning plans and collaborative action for the NHS, Social Care, Public Health and other key partners as appropriate.

4.2 B. Impact of the reduction in Public Health funding

It is anticipated that future financial challenges will continue to arise over the coming months and years, which will have implications for the local authority in continuing to meet their public health responsibilities and response to local needs.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 N/A

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a priority in Halton

6.2 Employment, Learning & Skills in Halton

The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

7.0 RISK ANALYSIS

7.1 The risks outlined in the report are currently being managed in line with the Councils

budgetary policy if greater cuts are required there will be a Health Impact Assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

Document	Place of Inspection	Contact Officer
Public Health Annual Report	HBC Website	Eileen O'Meara Director of Public Health

Public Health

What is Public Health?

"The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society" — Faculty of Public Health

Public Health Practice Domains

- HEALTH IMPROVEMENT
- HEALTH PROTECTION
- WIDER DETERMINANTS OF HEALTH
- HEALTHCARE PUBLIC HEALTH & PREVENTING PREMATURE MORTALITY

Indicators assessed through Public Health Outcomes Framework

NINE KEY AREAS

1. Surveillance and Assessment
2. Assessing the evidence of effectiveness
3. Policy and Strategy
4. Strategic Leadership & Collaboration
5. Health Improvement
6. Health Protection
7. Quality
8. Public Health Intelligence
9. Academic Public Health

COMMISSIONING AND PUBLIC HEALTH SERVICES IN HALTON BOROUGH COUNCIL

START WELL
Giving children the best start in life

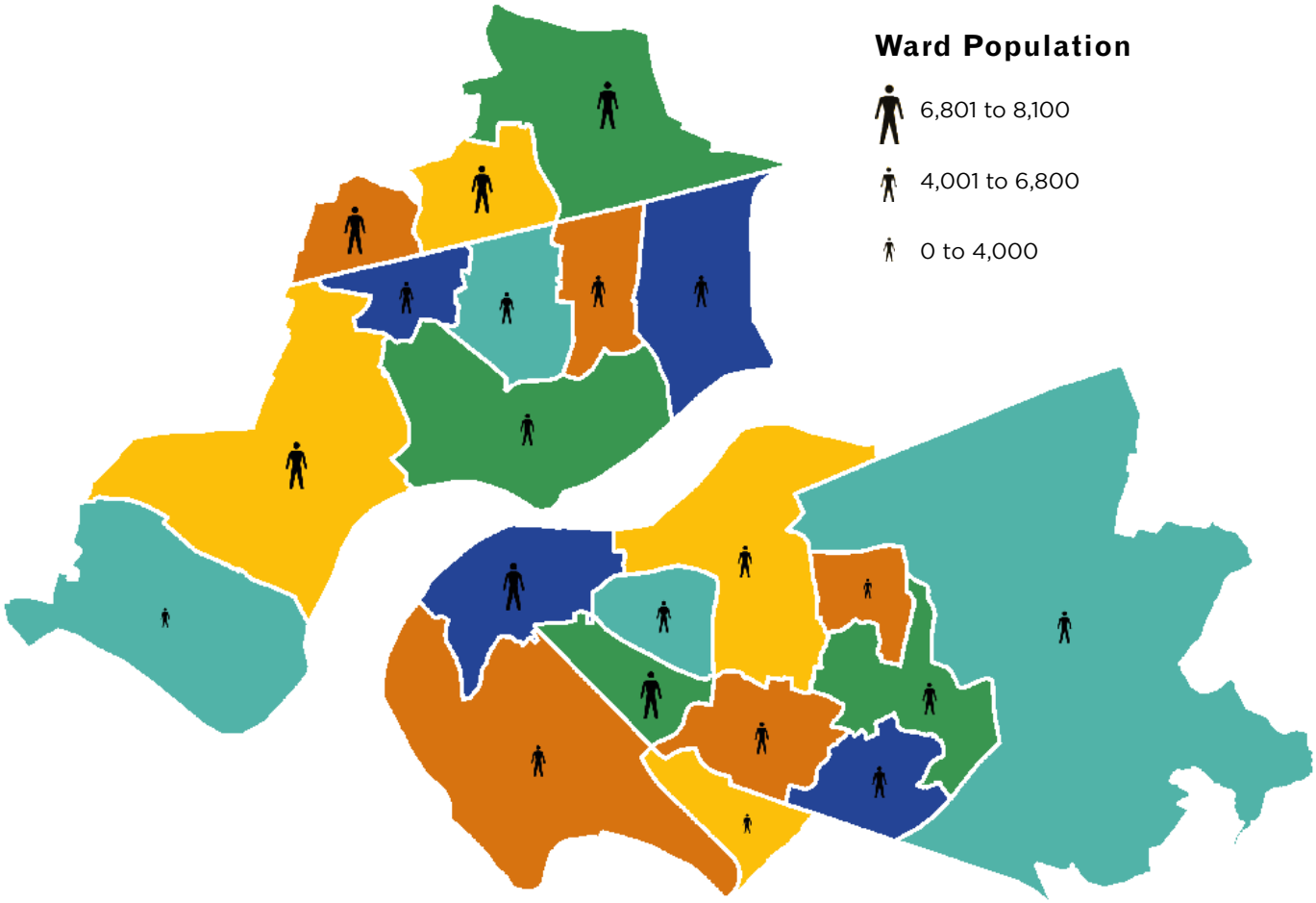
- Smoking Cessation and Alcohol Services in Pregnancy
- Infant Feeding Support and Weaning
- National Child Measurement Programme
- Healthitude in Schools
- Dental Health eg. 'Tasty Tuck for Life' and toothbrush scheme
- Fit for Life— Increasing Physical Activity
- Health Visiting, School Nursing and Family Nurse Partnership
- Support Immunisation Services eg. Primary, Flu and HPV

LIVE WELL
Helping adults lead healthier lifestyles

- Tobacco Control—Trading Standards
- Smoking Cessation Services
- Alcohol and Drug Misuse Services
- Fresh Start—diet & exercise
- Sexual Health Services
- Environmental Health Services
- Health Protection Incidents, Outbreaks and Emergencies
- Support to NHS Screening Services eg. Breast, Bowel, Lung, Cervical
- Mental Health campaigns eg. Time to Talk

AGE WELL
Supporting healthy and active ageing

- NHS Health Checks
- Affordable Warmth Activity
- Age Well Exercise Classes—Falls Prevention & Increasing Physical Activity
- Sure Start for Later Life—Social Isolation
- Support NHS Immunisation Services — eg. Flu Vaccine



PUBLIC HEALTH
ANNUAL REPORT
2015 - 16

Assessing Needs and Taking Action

HALTON BOROUGH COUNCIL

ACKNOWLEDGEMENTS

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IFEOMA ONYIA
Consultant in Public Health

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Public Health Development Manager

The Annual Report editorial board would like to acknowledge and thank all who contributed to the production of this year's report, as well as all those involved in the pieces of work highlighted.

We welcome your comments about this report.

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Further copies of this report may be obtained via the contact details above or accessed online at
www.halton.gov.uk/PHAR

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

CONTENTS

FOREWORD

This year, the Annual Report of the Director of Public Health focuses on how we use data, information and intelligence to influence health outcomes in the borough. Much of the data on local health is drawn together, analysed and presented in the Joint Strategic Needs Assessment (JSNA). The JSNA is not one static document, rather it is a collection of reports that cover a wide range of information about the current and future health and wellbeing needs of the local population. It looks to the future so that we can plan now for likely changes in needs. The data and intelligence we derive from it have a direct influence on deciding the services we commission.

Public Health has a long tradition of relying on data, which in turn depended on a system for routine collection and monitoring, something we refer to as 'health surveillance'. One such source of data was the Bills of Mortality established in London in 1532. Later, in 1842, Edwin Chadwick was able to link poor living conditions with the occurrence of disease and death. Following this, in 1854 John Snow used data to correctly work out that an outbreak of cholera could be linked to a particular water supply in a district of London. Both these events led to improvements in health and sanitation.

Nowadays data is used to describe the health of the local population, highlighting the key health improvement challenges and priorities and showing where action needs to take place to improve health outcomes. Producing a clear description of health issues locally is the first step in having a shared understanding of where action should be focused. This is achieved by:

- monitoring and analysing the changing population, including inequalities.
- investigating patterns of disease and health of the population.
- identifying vulnerable groups at risk of social disadvantage and poorer health outcomes.
- analysing patterns of health and social care service use to inform changes to services.
- ensuring decisions on which services to fund are based on a balance of up-to-date, high-quality research evidence alongside professional expertise.
- investigating variations in service activity to improve health outcomes.
- assessing future trends in population health and impact of services.

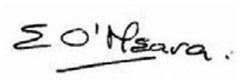
PUBLIC HEALTH ANNUAL REPORT 2015 - 16

FOREWORD
RECOMMENDATIONS
LIFE COURSE STATISTICS
STARTING WELL
LIVING WELL
AGEING WELL
FUTURE STRATEGIC DIRECTION
UPDATE ON LAST YEAR'S RECOMMENDATIONS
DATA ON HEALTH & WELLBEING

This report is divided into three sections using a life course approach which looks at the various factors that influence a person's health throughout the course of their life. Because we are always striving for improvement we call these stages **starting well**, **living well** and **ageing well**.

The approach taken in this report means that you will only have an overview of what goes in to creating any one of the JSNA reports. It will however give you a flavour of what the JSNA is, what is involved in developing one, who it is used by and what the results of this are. For those looking for further information on the JSNA please see **www.halton.gov.uk/jsna.**

Health data, information and intelligence are key ingredients in the work we do in Public Health and this year's report is intended to showcase the range of content that is available.



Eileen O'Meara

"I never guess. It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts."

Sir Arthur Conan Doyle,
Author of Sherlock Holmes stories

"Welcome to the 2015-2016 Public Health Annual Report for Halton. All Directors of Public Health are required to produce an independent annual report on the health of their population, highlighting key issues.

This year, Eileen O'Meara, Director of Public Health, has chosen to focus attention on the very important Joint Strategic Needs Assessment, that continuously reports on the health of local people and influences the strategic planning for health.

The strategies are of crucial importance in making Halton a better place to be born, live and grow old in."

Councillor Rob Polhill
Halton Borough Council Leader and Chair of Halton Health and Wellbeing Board

"This focus is particularly important when set against a background of decreasing resources and highlights the importance for having a clear evidence base for making decisions that will affect the future health of people in Halton."

Councillor Marie Wright
Halton Borough Council portfolio holder for Health

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

RECOMMENDATIONS

The Joint Strategic Needs Assessment (JSNA) is used to underpin the planning and development of key local health plans including Halton's five year Sustainability and Transformation Plan.

The findings of the JSNA are used to support Devolution planning and priorities from a Halton perspective.

The JSNA is used to support the development of local health and social care improvement plans and strategic developments including providing the evidence to support a reduction in health inequalities.

The JSNA is accessible to the public and works to incorporate the voices of local groups and people through specific research and consultation projects that help identify the needs of local communities and explore topics of interest or priority.

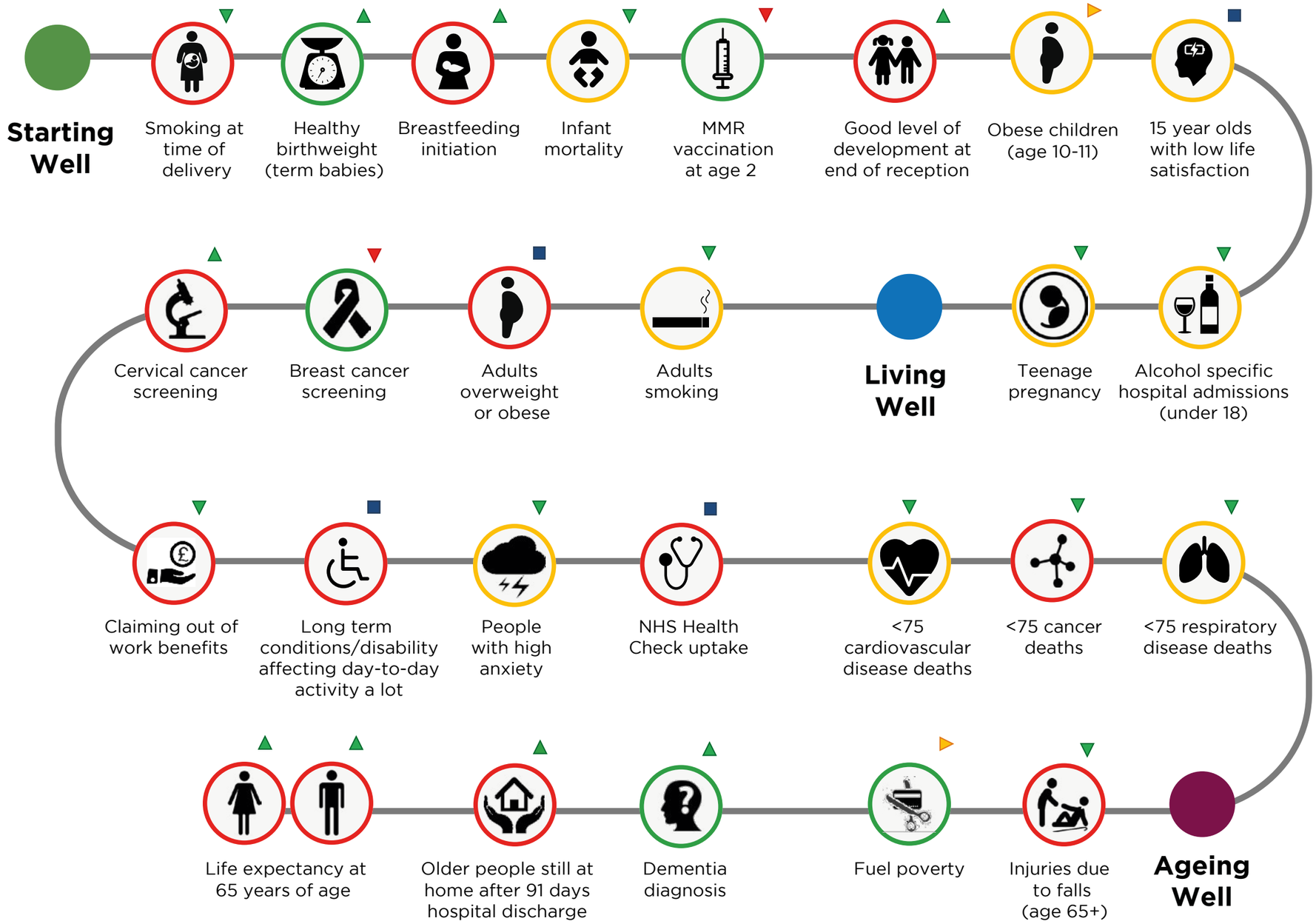
The findings of the JSNA are used to support One Halton planning and commissioning priorities.

The Public Health Evidence and Intelligence Team continue to work with partners to improve access to data in order to provide robust information to support the JSNA as well as health planning and priorities.

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

Halton's Life Course Statistics 2015-16

A comparison to the North West



HALTON FACTS

Population

About **126,350** people live in Halton. By 2030, this is projected to change:

age 0 - 18	↓ 3.7%
age 19 - 64	↓ 7.6%
age 65+	↑ 46.4%

Deprivation

48% of Halton's population live in the top **20%** most deprived areas in England.

Child Poverty

24.5% of children aged 0 - 15 live in poverty in Halton

KEY

Direction of travel

- ▲ Improved since last period
- ▶ Similar to last period
- ▼ Worse than last period
- ■ No Comparator

Statistical significance to North West

- ○ Better
- ○ No different
- ○ Worse

For more information & data sources

Please contact Halton Borough Council's Public Health Intelligence Team:
health.intelligence@halton.gcsx.gov.uk

Icons made by Flaticon and available here:
www.flaticon.com
Concept developed from Gateshead PHAR 2013/14 and Leicestershire PHAR 2015

STARTING WELL

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

CHILDREN'S JOINT STRATEGIC NEEDS ASSESSMENT

This piece of work involved multiple organisations coming together to contribute. It took over a year to produce and one of its strengths is how comprehensively it covers subjects identified. This is an example of a completed JSNA that covers a range of issues with the ability to inform long term planning.

WHY DID WE DO IT?

In 2010 a major national report 'Fair Society Healthy Lives' (The Marmot Review) looked at inequalities in health across England. It underlined the vital role having a good start in life makes to children and young people's health and social experience and also that this follows people into adulthood. Unfortunately the reverse is also true, with the impact of a poorer start having impacts in later life. Halton Children's Trust is a partnership of staff representing many different organisations across the borough, all working to a common goal. As such they wanted to know more about some of the issues highlighted in the Marmot Review and to what extent Halton's children and young people were getting that all important 'best start in life'.

> **"Halton's ambition is to build stronger, safer communities which are able to support the development and learning of children and young people so they grow up feeling safe, secure, happy, healthy and ready to be Halton's present and Halton's future."**
>
> Halton Children and Young People's Plan 2014-17, page 6

HOW DID WE DO IT?

A team was set up to bring together a wide range of different data, information and expert knowledge. More than 60 people were involved in developing the Children's JSNA and its two supplementary reports: speech and language needs and the health of young offenders. The work was coordinated and led by the Public Health Evidence and Intelligence Team. It reported back regularly to the Children's Trust and the Halton Safeguarding Children Board.

The interpretation of this information allowed us to understand where health is good and progress has been made but it also identified gaps and poor performance that needed to change.

The Children's JSNA looks at the overall health and social needs of children and young people, but considered inequalities in outcomes and experience for specific groups. This relates to children living in areas of deprivation, age and gender, disability, and to vulnerable groups.

A life course approach was followed, as advocated by The Marmot Review. There are chapters for:

- Maternal health
- Early years
- School age
- Education and employment
- Safeguarding
- Disabilities and complex needs
- Children in care

Go online to view the complete JSNA
www.halton.gov.uk/jsna
or the dedicated page for the childrens JSNA on
www.haltonchildrenstrust.co.uk/jsna

as well as the supplementary reports on:

- Speech, Language and Communication Needs
- Health Needs of Young Offenders

KEY FINDINGS

Most children lead happy, healthy lives with good relationships with family and friends. However, some do experience ill health or exhibit behaviours which put them at risk of harm or development of ill health. Whilst many findings and priorities are specific to a particular life course stage or group, issues such as emotional health and unintentional injuries cut across all ages. Issues such as smoking at time of delivery and breastfeeding remain significant and resistant to change. Even for areas that have improved, such as education attainment for children in care compared to general population, there remain inequalities across the borough that need to be addressed. The major contributory factor is the high level of deprivation experienced over years due to a range of historical and more recent social and economic factors.

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

CHILDREN'S JSNA

KEY THEMES

MENTAL HEALTH

67% of 15 year olds reported high or very high life satisfaction

10% of children are estimated to have a mental health disorder

154 children and young people admitted to hospital for self harm in 2014/15

The rate is higher than the England and North West averages

IMPROVEMENTS

Over 5 years

42 ALCOHOL ADMISSIONS 17 per year under 18

142 TEENAGE PREGNANCY 72 per year

49 MENTAL HEALTH ADMISSIONS 20 per year under 18

80% MMR VACCINATION 91% coverage of 2 doses age 5

45 LOW BIRTH WEIGHT 27 per year

24% OBESITY 21% age 10 - 11

ACCIDENTS

376 children aged 0 - 14 admitted to hospital for injuries in 2014/15

The rate is higher than the England average

TIME OF CHANGE

welfare reforms

organisational change

economic hardship

POPULATION

CHILDREN AGED 0-15

25,162 live in Halton

20% of the total population

8% Number projected to fall in the next 20 years

1 in 4 under 16s live in poverty

This is more than the England and North West averages

Icons made by Flaticon and available at www.flaticon.com

FOREWORD RECOMMENDATIONS LIFE COURSE STATISTICS STARTING WELL LIVING WELL AGEING WELL FUTURE STRATEGIC DIRECTION UPDATE ON LAST YEAR'S RECOMMENDATIONS DATA ON HEALTH & WELLBEING

HOW HAS THE CHILDREN'S JSNA BEEN USED?

The two major health issues that emerged across the Children's JSNA were mental health and wellbeing and accidental injuries. There was also recognition that there have been a lot of improvements in health. It was agreed that we must maintain these and continue to improve some of our health, educational and social indicators. To do this the Children's Trust and all partner organisations have been using the JSNA in a number of ways:

- To evidence need and level of partnership working during the Ofsted inspection of children in care and safeguarding in Halton.

"Good interagency working in Halton is exemplified by the very high quality children's Joint Strategic Needs Assessment (JSNA), which is focused, detailed and up-to-date and which clearly informs the priorities within the children and young people's plan"... it is being "used effectively to drive improvement."

Ofsted inspection report, 2015

- Informing the development of a range of strategies including the Infant Nutrition Strategy.
- It has been used by Children's Centres and service providers to develop their services.

"Young Addaction deliver a wide variety of services across the Borough, delivery is creative and innovative with a targeted approach on outcomes. There are areas of the provision that map to the JSNA, Ward & School Profiles and using the data provided in these reports allows the service to deliver tailored packages of support in areas where it is needed."

Manager, Young Addaction

FOREWORD RECOMMENDATIONS LIFE COURSE STATISTICS STARTING WELL LIVING WELL AGEING WELL FUTURE STRATEGIC DIRECTION UPDATE ON LAST YEAR'S RECOMMENDATIONS DATA ON HEALTH & WELLBEING

- Informing the recommissioning of mental health services for young people.
- Influenced the development of the Children's Trust priorities.
- As part of the business case to secure a member of staff to work with young offenders with mental health problems.

"Partners in Halton have used the recommendations to inform and influence local decision making to enhance the local offer with regards to health, and this has resulted in the commissioning of a dedicated Mental Health worker who will be embedded within the YOS service."

Commissioning Manager, Halton Borough Council (talking about the influence of the health needs assessment of young offenders)

- Informed marketing of services available for children e.g. Children's Centre magazines and Feeding Your Baby magazines (Wellbeing Web Mags).
- Emphasised the importance of early interventions and development during the early years of life. A new programme of work has been developed to tackle the issues it raised in these areas.
- It has informed how schools tackle mental health and healthy eating issues.

"A regular supplement of the Children's JSNA is the annual National Child Measurement Programme (NCMP) report. Schools identified in the higher end category of overweight/obesity are targeted for our schools Fit4Life programme".

Health Improvement Manager, Halton Health Improvement Team

LIVING WELL

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

GP JOINT STRATEGIC NEEDS ASSESSMENT

In this instance a shorter piece of work pulls together data and information from a large number of sources to allow easy cross reference and support planning decisions around primary care. As the data is regularly updated and new data sources can become accessible, it is an example of work that needs to be refreshed regularly. This is done annually.

WHY DID WE DO IT?

As general practice is one of the chief locations that people have conversations and make key decisions about their health, it is very clear that there is a wealth of useful information that can be collected and fed back to GPs to help their planning and organisation of health services. While practices see individual people, pulling together a collection of data can enable GPs to understand their local population and how they compare to other practices in Halton as well as the national average.

HOW DID WE DO IT?

Each practice receives a Halton level information pack, including data from all practices, targets, as well as local and national averages for comparison. A separate pack summarises intelligence for their individual practice and includes information on previous performance and tailored recommendations. For example, where applicable, the report highlights the outstanding numbers required to achieve set standards and targets. Ward health, economic, academic and crime indicators are also included.

The packs provide a directory of services and summary data for a range of topics including:

- Levels of deprivation
- Cancer screening uptake & coverage
- Immunisation uptake
- How many people have conditions e.g. cardiovascular disease
- How many people smoke, drink alcohol and are obese
- Hospital activity for key conditions e.g. COPD & cancer
- Breastfeeding

The combined GP JSNA covering all practices can be accessed online **www.halton.gov.uk/jsna.**

KEY FINDINGS

The findings are fed back to each practice and would relate to their own practices. Summary findings from combining the data indicates that Halton residents do take up screening services at a similar level as the England average for breast, bowel and cervical screening. There is a high level of long term conditions seen in general practice and this includes diabetes, hypertension and COPD; all of which are higher than the England average. Overall, Halton performed above the national average for flu vaccinations in the over 65s, flu vaccination in 2 and 3 year old children, and blood pressure checks on those aged 45 and over. There was a similar take up of flu vaccination in comparison to the England average for people with at risk chronic health conditions such as asthma or diabetes aged under 65 and pregnant women; however these are still well below the national target.

SUMMARY: GP JSNA

HALTON SUMMARY

130,000 GP registered population

17 practices

Flu vaccination uptake better than England average for those aged 2, 3 and 65+

Breast cancer screening target exceeded

Proportion of people living with a chronic disease (e.g. diabetes, asthma) is higher than the national average

PRACTICE SUMMARY

"You need to vaccinate 7 more pregnant women against flu to meet the 75% national target."

"The rate of bowel cancer screening uptake was above the Halton average but did not meet the national target of 60%."

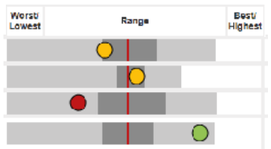
% offered smoking cessation support

% breastfeeding

NHS Health Checks uptake

WARD PROFILE

Unemployment
Education
Mortality
Hospital admissions
Crime
Life expectancy



DIRECTORY OF SERVICES

Health Improvement Team

addaction

Wellbeing enterprises

HDFA Halton Domestic Abuse Forum

sure start to later life

and many more...

Icons made by Flaticon and available at www.flaticon.com

HOW HAS THE GP JSNA BEEN USED?

- Motivation to effect a positive health change.
- Used as a source of evidence during Care Quality Commission inspections.

"We used the GP JSNA for CQC preparation and found it helpful to highlight the needs of our population."

Primary Care Clinical Lead, NHS Halton Clinical Commissioning Group

- Influenced receptionist to give reminders e.g. Health Checks, flu clinics.
- Used to plan campaigns and targeted wellbeing work by Wellbeing Enterprises CIC.

"We use the GP JSNAs to inform our practice action plans for delivering community wellbeing and health initiatives...We try to theme our community wellbeing approaches around identified priorities (as identified in the GP JSNAs) for each practice population."

Chief Executive Officer, Wellbeing Enterprises CIC

- As a local signposting resource to refer patients to a range of local services.
- Inform GP priorities and internal planning.

"We use it as a benchmark for our performance; we often reflect on the contents and as a result has often influenced changes in the way we work."

Practice Manager

- Used by Senior Primary Care Engagement Facilitator to support practices on cancer referrals and screening.
- Inform CCG service development group of general practice demography.

The GP JSNA "has enabled an understanding of the local population and the inequalities within the practice population. NHS Halton CCG has developed and supported through its commissioning programme in 14/15 the on-going development and embedding of a Multi-Disciplinary Team approach to the identification of high risk patients and a proactive case management system...This approach of using the JSNA has enabled local teams to target certain areas and patient/ population groups to improve the health and wellbeing of those identified at risk."

Forward View and 2015/16 Operational Plan, NHS Halton Clinical Commissioning Group

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

FOREWORD RECOMMENDATIONS LIFE COURSE STATISTICS STARTING WELL LIVING WELL AGEING WELL FUTURE STRATEGIC DIRECTION UPDATE ON LAST YEAR'S RECOMMENDATIONS DATA ON HEALTH & WELLBEING

JOINT STRATEGIC NEEDS ASSESSMENT ON LONG TERM CONDITIONS

The JSNA contains a number of short chapters or profiles on a range of long term conditions. This approach allows the various conditions to have an in depth review often involving local people who responded to surveys, attended focus groups or through having their views represented by interested voluntary sector organisations.

WHY DID WE DO IT?

Long term conditions is a general term for a range of health problems that can't be cured but can be controlled by medication or other treatments. There is increasing concern both nationally and locally about the rise in the number of people with long term conditions and especially those who have more than one of these conditions. Both the local authority and CCG wanted to understand what was happening in Halton around this issue. We worked together to look in detail at both long term conditions as a collective group of conditions and also at some of the main conditions separately, including heart disease and diabetes. For the first time in the JSNA we also looked at musculoskeletal conditions such as arthritis and back problems and long term neurological conditions such as Multiple Sclerosis (MS) and Parkinson's Disease.

HOW DID WE DO IT?

The Public Health Evidence and Intelligence Team worked with colleagues in NHS Halton Clinical Commissioning Group (CCG) and social care to gather data, information and local people's views on both the prevention and management of long term conditions. This included:

- How many people have long term conditions
- How many people smoke, are obese and use alcohol (avoidable risk factors)
- GP data
- Data on admissions to hospital
- Data on how many people die from long term conditions
- Social care packages for people with long term conditions
- Results from a variety of local engagement sessions

The full JSNA can be accessed online at **www.halton.gov.uk/jsna.**

In addition to this general chapter, there are other specific sections of the JSNA or health profiles relating to:

- Cardiovascular disease
- Coronary Heart Disease
- Stroke and transient ischaemic attack (TIA)
- Hypertension
- Diabetes
- Chronic obstructive pulmonary disease
- Severe mental health conditions (e.g. schizophrenia, bipolar affective disorder and other psychoses)
- Dementia
- Asthma
- Epilepsy
- Parkinson's Disease
- Multiple Sclerosis

KEY FINDINGS

In Halton there are a higher proportion of people with more than one long term condition, than both the North West and England averages.

Most people who develop long term conditions do so from middle-age (40 years of age and over). Older people, those in their 60s and above, are most likely to have more than one long term condition. Not everyone who has a long term condition knows they have it. Yet it is important to have a diagnosis as early as possible as this reduces the risk of complications developing and the person having to have an admission to hospital. Halton has had a lot of success finding people who have long term conditions and putting them on the best treatments. Despite this there is variation in the level of diagnosis and proportions on best available treatment; reducing this remains a key priority locally. Nevertheless the gap between the total numbers we estimate have long term conditions and those who have a diagnosis has narrowed over the last five years.

There are still people who have a long term condition but have not been diagnosed. Therefore continued public awareness raising is needed.

SUMMARY: LONG TERM CONDITIONS JSNA

PREVENTION

Many long term conditions are preventable through:

- healthy eating
- physical activity
- limited alcohol
- not smoking

Organisations should:

- Focus on wider determinants of health
  - access to green space
  - housing
  - air quality
  - low cost healthy food
  - access to services
- Offer evidence - based interventions

DIAGNOSIS

41% have taken up an NHS Health Check

12% have not had their blood pressure checked in the last 5 years or more

90% interested in being more active in managing their own care

Population diagnosed
(of those expected)

Hypertension	Kidney disease	Coronary heart disease
60%	80%	98%

These are significantly better than the England average

WHO HAS LONG TERM CONDITIONS?

1 in 3 have one or more long term condition

these make up

- 50% GP appointments
- 64% outpatient appointments
- 70% inpatient bed days
- 70% health & social care spend in England

DEPARTMENT OF HEALTH

"The increasing number of people who have more than one long term condition is one of the most important issues facing health systems".

HOW HAS THE JSNA ON LONG TERM CONDITIONS BEEN USED?

- To undertake service reviews such as the review of physiotherapy services for people with musculoskeletal conditions.
- To start conversations around the needs of people with long term neurological conditions.

"The report on long term neurological conditions was useful in developing my understanding ... it was useful to see medical data put alongside some of the potential social consequences of neurological conditions such as data linked to benefits claimed. The report is a report for other CCGs to benchmark themselves against as they pick up more of the commissioning role for neurological conditions."

Regional Officer, MS Society

- To support the development of local strategies such as the Respiratory Strategy.
- To inform priorities for the 5 Year Forward View and Halton Sustainable Transformation Plan.

"When starting a significant transformational programme called One Halton, the first place I went to for my research was the JSNAs and the Health & Wellbeing Strategy. Each provided me with the necessary demographic, population based information that I needed to progress this work. The information was succinct, clear and concise. The data was presented in an easy to read format and illustrated the variance in health outcomes for our local population benchmarked against the national average."

Director of Commissioning & Service Delivery, NHS Halton Clinical Commissioning Group

"This is a great example of Halton working in a clear integrated manner. The alliance of research and data adds to clear vision direction. This also adds to a robust planning system in which the JSNA has helped prioritise our major health issues."

Director of Transformation, NHS Halton Clinical Commissioning Group & Halton Borough Council

AGEING WELL

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

OLDER PEOPLE'S JOINT STRATEGIC NEEDS ASSESSMENT

This final example illustrates a piece of work in progress and highlights again the importance of bringing together a range of stakeholders who can advise and support the gathering of information and more importantly understand what's required to make sure that where needs are identified, solutions are also found.

WHY DID WE DO IT?

The number of older people (those aged 65 and over) living in Halton has been rising for over a decade and this trend is set to continue. This is likely to have an impact on how we provide health and social care services. To this end, the Health & Wellbeing Board asked the Public Health Evidence and Intelligence Team to lead on the development of JSNA work on older people during 2015/16.

HOW HAVE WE DEVELOPED IT?

There has been a lot of interest in this work from across the borough which resulted in the establishment of a multi-agency steering group.

The group adapted the 'life course' approach that has been the cornerstone of local action since the Marmot Review was published in 2010. The JSNA has been divided into a 'functional' life course from being generally fit and well; to being unwell and needing support to remain independent; to needing to live in a care home. Safeguarding and end of life care were also included looking at the needs of all adults around these issues.

Steering Group membership includes:

- Halton Borough Council (HBC) Public Health
- HBC Adult Social Care Commissioners, Policy leads and performance team
- HBC Health Improvement Team
- NHS Halton Clinical Commissioning Group Commissioners
- Halton & St Helens Voluntary Action
- Halton Healthwatch
- Age UK Mid-Mersey
- Halton Older People's Empowerment Network (OPEN)

And lots of others have helped too.

EMERGING THEMES

At the time of writing this Public Health Annual Report, the JSNA for older people is not yet completed. However, a number of themes are emerging.

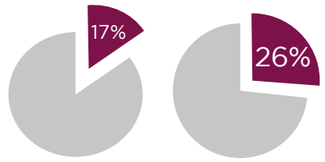
Older people are a key local resource. Many older people remain in paid employment past age 65 and this is likely to continue as the state pension age rises. They offer skills and experience to their employer and colleagues. Yet they may also have specific support needs to help them remain productive members of the local workforce. These are likely to relate to the level of long term conditions in this age group and also that a significant portion of them will also be unpaid carers. The number of unpaid carers is larger than the NHS and social care workforce. A substantial number of these are older people, especially those providing over 50 hours of care per week. Older people are also the mainstay of volunteering.

Yet, many older people do have a number of health and social care needs. They are more likely to have long term conditions and especially to have more than one condition. They have higher levels of hospital admissions than younger people. Many also need informal (unpaid) or formal (paid) support at home to carry out daily tasks like washing, dressing and preparing food. For some, these issues combine to form complex needs requiring health and social care to work together to provide personalised care packages. Being able to remain independent and living in their own homes continues to be one of the main issues older people identify as being of concern to them.

SUMMARY: OLDER PEOPLE'S JSNA

POPULATION

21,200 people aged 65 and over live in Halton



Population aged 65 and over is projected to increase

Life expectancy at age 65 (years)

17.2 18.9

LIVING & WORKING

1 in 5 provide some unpaid care (aged 65+)

This is higher than the national average

86% aged 85+ live at home

8% employed (aged 65+)

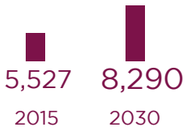
HEALTH & WELLBEING

Older people are more likely to have one or more long term condition

42% feel they have good or very good health (over 65s in Halton)

Cases of dementia estimated to rise

Number of falls estimated to rise



Older people aged 65 - 74 have the highest level of wellbeing in the UK

This is mainly due to the ageing population

Icons made by Flaticon and available at www.flaticon.com

HOW DO WE INTEND TO USE IT?

Whilst the work is still developing at time of writing, a number of uses of the older people's JSNA have already been identified.

- To help commissioners to understand the needs of local people.

"It's great to see an older person specific section in the JSNA. It demonstrates Public Health's commitment to the older citizens of Halton and will inform our older people's service plan."

Principal Manager, Halton Borough Council

"I foresee the Older People's JSNA being a vital piece of the underlying evidence base on which the future revision of the Halton Dementia Strategy will be developed. (The strategy is until 2018, but likely that a refresh will be done before then).

I would promote the JSNA to any member organisation of the Halton Dementia Alliance seeking funding, to help them identify dementia related support opportunities and support their business case though local evidence."

Policy Officer, Halton Borough Council

- As the basis for a range of work programmes to improve the health and social care of people living in care homes.
- To support the One Halton older people priority work stream.
- To support the development of the Adult Safeguarding Board business plan.

"Halton Safeguarding Adults Board will use the Older People's JSNA to inform its Prevention Strategy and associated Action Plan in order to identify key priority areas to target preventative work in relation to adult safeguarding. The Older People's JSNA will also help to identify and inform other key safeguarding work streams for the Board in relation to the needs of the local population."

Adult Safeguarding Executive

- To support the development of the Adult Social Care Market Position Statement.
- To support the development of the Dementia Delivery Group's business plan.

"The Older People's JSNA will be of tremendous benefit when working with the local voluntary sector to develop new activities and services for older folk. The JSNA allows us to align real grassroots neighbourhood level work with the wider priorities for the borough, it helps us to all pull in the same direction and focus our work on the real areas of need. In addition the document can act as a platform for partnership work as it helps to align the priorities of the many excellent organisations that benefit Halton's elders."

Halton & St Helens Council for Voluntary Services

"As the voice for older people in the Borough, Halton OPEN has been pleased to contribute to the JSNA by submitting its two most recent surveys which have been directly utilised in the relevant section. These surveys provide a qualitative snap shot of the issues and priorities of our membership and we hope that this will inform decision makers at a local level so that we can continue to work collaboratively to improve the health and wellbeing of older residents."

Halton Open Development Officer, AGE UK Mid Mersey

FUTURE STRATEGIC DIRECTION

Needs do not exist in isolation, the health and wellbeing of any person is shaped by the social and environmental determinants they experience throughout their life. The challenge of persistent health inequalities and complex or multiple needs cannot be satisfactorily addressed by any single agency acting alone. Partnership is the only workable solution to the big challenges that we face. A clearer picture of needs from the JSNA means stronger partnerships. The NHS England Five Year Forward View sets out a clear direction for the health economy: the first of these is a radical upgrade in prevention and public health. All partners in Halton are working together to achieve this aim, the creation of a joint plan illustrates the integration that exists in Halton and the willingness for the CCG, Local Authority and other local providers to work together to improve services relating to prevention. This ethos of joint working is captured in the One Halton Vision.

One Halton is a new approach that will involve joining up all the services that deliver care and wellbeing to the people of Halton ensuring that they have the right support, at the right time, in the right way to provide the best possible outcomes. By joining resources and working together across the Borough, One Halton aims to simplify the current system. Effective JSNA will help local leadership to decide on priorities in a more joined-up, effective and efficient way. It will underpin the future strategic direction of health planning and highlight where improvements in health can be achieved and inequalities reduced. The JSNA process also ensures that all partners were able to contribute to the JSNA and jointly own the strategic direction of travel identified through the process.

We invite you to get involved and contribute to this too by completing a short online survey at **www.halton.gov.uk/PHAR.**

PUBLIC HEALTH ANNUAL REPORT 2015 - 16

"The Halton Joint Strategic Needs Assessment has enabled NHS Halton CCG to inform their strategic direction in terms of priorities and planning for the future."

Simon Banks, Chief Officer, NHS Halton Clinical Commissioning Group

"The voluntary sector really benefits from using the Halton JSNA to highlight vulnerable groups in our community and recognise our local assets."

Sally Yeoman, Chief Executive, Halton & St Helens Voluntary and Community Action

"Halton Borough Council uses Health Needs Assessments to provide insight into local health inequalities, gaps between areas of the borough and where we need to place our resources."

David Parr, Chief Executive, Halton Borough Council

FOREWORD RECOMMENDATIONS LIFE COURSE STATISTICS STARTING WELL LIVING WELL AGEING WELL FUTURE STRATEGIC DIRECTION UPDATE ON LAST YEAR'S RECOMMENDATIONS DATA ON HEALTH & WELLBEING

UPDATE ON RECOMMENDATIONS FROM 2013-14

ALCOHOL FREE PREGNANCY

Recommendation	Commentary on progress
Develop a local education campaign to increase the awareness of the harm of drinking alcohol when pregnant or trying to conceive.	Public Health and the Halton Health Improvement Team developed an awareness campaign to educate women of the harm that drinking alcohol in pregnancy can cause, in order to reduce alcohol related harm to the unborn baby. The campaign launched on the 20th February 2015 and ran until July 2015, and included billboards, posters in supermarkets and on buses plus social media activity. Campaign materials have been distributed across the borough including GP surgeries, children centres, and community centres.
Ensure staff in Halton who come into contact with women planning for a baby or pregnant consistently give the advice that the healthiest and safest option is not to drink alcohol when trying for a baby or when pregnant.	As part of the awareness campaign to educate women of the harm that drinking alcohol in pregnancy can cause, a new leaflet was developed for midwives to assist them in delivering key messages around alcohol harm, this will continue to be used on an ongoing basis. Feedback from local women is that the leaflet provides them with a good understanding of alcohol harm and means they are less likely to drink during pregnancy.
Review alcohol treatment pathways for pregnant women identified as misusing alcohol.	Public Health are working in partnership with primary care, midwifery, Halton Health Improvement Team and CRI to review alcohol treatment pathways for pregnant women identified as misusing alcohol. The pathway will ensure that all professionals are aware of how to support local women to stop drinking during pregnancy.

PROTECTING BABIES AND TODDLERS FROM ALCOHOL-RELATED HARM

Recommendation	Commentary on progress
Ensure local parenting programmes include messages of the harms of parental drinking may have upon young children.	Local parenting programmes have been mapped and work has commenced to ensure that programmes include information about the low risk weekly guidelines and the impact of parental drinking upon young children.
Develop an information resource for new parents which includes key messages around safe drinking guidelines, safe sleeping and reducing the risk of accidents.	The public health team are currently undertaking work to better understand the causes of childhood accidents in Halton. As part of this work messages will be delivered by midwives and health visitors for new parents around safe drinking, safe sleeping and reducing the risk of accidents.
Develop referral pathways between alcohol services and children and family services (to include the early identification, assessment and referral of children who need to be safeguarded).	Referral pathways between alcohol treatment services and children and family services have been reviewed and a local protocol developed.

SCHOOL AGE CHILDREN

Recommendation	Commentary on progress
Work to ensure all local schools take up the offer of alcohol education programmes.	The Halton Health Improvement Team continues to deliver the Healthitude programme in primary and secondary schools across the Borough. In addition Young Addaction deliver programmes across the 2 colleges in Halton focusing on risk taking behaviour, knowing your limits and the impact of alcohol.
Promote a family approach to alcohol treatment to ensure that young people affected by family alcohol misuse are well supported.	In Halton we believe that all professionals who come in contact with alcohol misusers and/or their children have a responsibility to ensure that children in these circumstances are identified as early as possible and are given appropriate support and protection. Young Addaction and CRI are working in partnership to promote the early identification and effective support of both parents and children.
Review alcohol treatment pathways for young people who misuse alcohol in Halton (to include pathways for vulnerable young people including truants and those excluded from school, young offenders, looked after children, children with special educational needs).	Public Health are working in partnership with Halton Health Improvement Team, Young Addaction, School Nursing, local schools and Halton community safety to review alcohol treatment pathways for children and young people identified as misusing alcohol. The pathway will ensure that all professionals are aware of how to support children and young people to delay the onset of drinking or reduce their alcohol intake if they are already drinking.

WORKING AGE ADULTS

Recommendation	Commentary on progress
Develop a coordinated alcohol awareness campaign aimed at working age adults to include supporting the local promotion of national alcohol awareness campaigns e.g. Dry January, Alcohol awareness week and Drink Wise campaigns.	Public Health and the Halton Health Improvement Team have been reviewing alcohol awareness messages in light of the newly published guidelines for safe alcohol consumption. Halton Borough Council and local partners promoted the Alcohol Concern Dry January campaign. Further joint campaigns are planned for 2016.
Support local workplaces in developing workplace alcohol policies.	The Halton Health Improvement Team have been working with local businesses across Halton Borough to develop alcohol workplace policies.
Review alcohol treatment pathways for working age adults (aged 18 to 64) in Halton. To include a review of pathways for vulnerable adults e.g. the unemployed, veterans, offenders, people with mental health problems, the homeless.	Public Health are working in partnership to review alcohol treatment pathways for working age adults identified as misusing alcohol. The pathway will ensure that all professionals are aware of how to support local people to reduce their alcohol intake in line with the new national guidelines.

OLDER ADULTS

Recommendation	Commentary on progress
Undertake insight work with older people to better understand the nature of the problem and what prevention strategies and treatment approaches work best with older drinkers.	Work is currently being planned to engage with local older people via community groups to identify current drinking habits and motivations to reduce their alcohol intake.

Develop an alcohol awareness campaign aimed at older people – to be targeted at older peoples settings (social groups, bingo etc), general practice, local faith groups. To include experienced based interventions (peer to peer).	The community insight work being undertaken will be used to inform a local alcohol awareness campaign aimed at older people in Halton. We also plan to train community champions to deliver peer to peer advice and support.
Develop and train key staff who work with older people in delivering brief interventions which focus on motivating factors for older people.	The Halton Health Improvement Team have been training staff working with older adults to enable them to identify those at risk as a result of their drinking. This enables people to receive brief alcohol advice based on their screening result and/or a referral into specialist alcohol services can be made if appropriate.

COMMUNITIES

Recommendation	Commentary on progress
Work with partners to influence the Government and other key decision makers in relation to issues such as introducing a minimum unit price for alcohol and restricting alcohol promotions and advertising.	Work continues to push for policies at a regional and national level to reduce alcohol-related harm. The Directors of Public Health across the North West fund Tobacco free futures to influence the Government and other key decision makers in relation to issues such as introducing a minimum unit price for alcohol and restricting alcohol promotions and advertising.
Work in partnership to review Halton Borough Council's statement of licensing policy to ensure it supports the alcohol harm reduction agenda.	The legal services department in Halton Borough Council led on refreshing the Halton Statement of Licensing Policy. They worked in partnership with local Responsible Authorities (Halton Council Licensing Team, Cheshire Police, Public Health, Trading Standards) to ensure Halton's Statement of Licensing Policy reflects national best practice in protecting children from harm and reducing crime and antisocial behaviour.
Work towards the completion of a self-assessment / gap analysis for the town centre areas in Widnes and Runcorn, using the Purple Flag criteria as a guide Benchmark.	Benchmarking has been undertaken against Purple Flag criteria and an action plan for diversification of the night time economy is being developed.

DATA ON HEALTH AND WELLBEING IN HALTON

Data on health and wellbeing in Halton is available in the various chapters of the Joint Strategic Needs Assessment (JSNA).

The JSNA and Children's JSNA are available from:
www.halton.gov.uk/JSNA

For further information contact the Public Health Intelligence Team:
Health.Intelligence@halton.gcsx.gov.uk

REPORT TO: Health Policy & Performance Board

DATE: 20th September 2016

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Older Peoples Mental Health and Dementia Care

WARD(S) Halton Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 5 Boroughs Partnership NHS Foundation Trust is seeking support for a revision of its inpatient services for older people and adults. This paper sets out this review in the context of the journey of the implementation of the new model of care, and recommends the 5 Borough footprint configuration of beds for adults and older adults.

2.0 RECOMMENDATION: That the Board:

i) Notes the content of the report;

ii) Comment on the proposal to redistribute the older people's beds currently provided on Grange Ward at the Brooker Centre in Halton to Leigh for older people with functional mental health problems, and to Hollins Park or Leigh for those with complex dementia; and

iii) Support the proposed bed based model pending the result of the consultation process.

3.0 SUPPORTING INFORMATION

3.1 Background

The model of care (driven by Halton) was implemented in 2012 for Older People with Dementia and Memory loss which is a high quality community service pathway, designed to support people in their own home as long as possible. The objective was to re-design services for people in later life in order to ensure that effective, timely and personalised services are available, to support the growing number of people who will experience memory and cognitive loss and the onset of dementia.

The Building on Strengths model (2011) was developed by lead clinicians and managers within the Later Life and Memory Services within 5 Boroughs Partnership NHS Foundation Trust, and outlined a community based service supporting people to remain at home, whilst improving and maintaining the quality of life of service users and their carers. To support the community provision, the model proposed the redesign of inpatient care to provide specialist assessment and care where this could not be safely supported within a community setting.

This service provision, set out in 'Building on Strengths' (2011) continues the

development of early and skilled intervention and the timely and appropriate support of people through their life experiences of living with the cognitive and emotional impact of the ageing process. The first phase of this work has been the implementation of the community redesign. The Trust is now ready to proceed with re-design of inpatient care, as the 'Building on Strengths' model includes changes to the *whole* service pathway from early intervention, assessment and diagnosis through on-going support and care and, importantly, inpatient care.

3.2 Implementation and Impact of the Community Pathway

The new community model was implemented as a pilot in the Wigan Borough in March 2012 and across all other boroughs by May 2013. The model was designed to provide high quality early diagnosis and intervention for all who require it. The model includes:

- A Single point of access
- Same Day Screening by Senior Nurse
- Same day Face to Face Assessment for urgent referrals.
- Face to Face Assessment within 10 working days for non-urgent referrals
- Crisis Intervention and Rapid Response
- A Needs Led Care Framework/Supporting people to live independently
- Service users directed to appropriate path of service
- Offering a comprehensive and appropriate range of interventions including Psychological Interventions

3.3 Clinical Model for Later Life and Memory Services in-patient

The Royal College of Psychiatrists recommends a needs-based criteria for older people's mental health services which includes;

- People of any age with a primary dementia
- People with mental disorder and *significant* physical illness or frailty which contributes to, or complicates the management of their mental illness – exceptionally this may include people under 60
- People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people.

3.4 Key Principles of Change

- To provide inpatient care tailored to meet the specific needs of adults and offering greater choice and flexibility by providing an effective therapeutic environment.
- To develop a new admission option for older adults with a non-memory related mental illness who may be too frail or vulnerable to have their needs appropriately met within an adult acute mental health ward.
- To address the needs of those people whose condition is defined by physical and social factors leading to multiple conditions or diseases usually associated with later life.

3.5 Clinical Benefits

- Integrated Organic and Functional Care Models
- Management of severe Behavioural and Psychological Symptoms of Dementia
- Psycho-social approaches
- Enhanced Therapy support
- A Therapeutic Environment
- Enhanced Care
- Physical Health Factors
- Seamless Pathway Development
- Links to Social Care / 3rd Sector / Acute care
  Carer Support

3.6 Mental Health Service Review

An independent review of mental health services across the 5 Boroughs NHS Foundation Trust footprint (The Tony Ryan Review)

An independent review of the acute and older adult care pathways across the footprint of the 5 Boroughs Trust was collaboratively commissioned by the five Clinical Commissioning Groups (CCGs) for Halton, Warrington, Knowsley, Wigan and St Helens in 2015. The methodology for the review included analysis of routinely collected data, examination of policies and procedures and interviews with over 350 stakeholders including users, carers, staff working and managing services, commissioners and other interested parties.

Five key areas ("Big Ticket Items") for future development were identified following the review:

- The interface between primary and secondary care.
- How people with a personality disorder or highly distressed emotional disorders are supported by the whole system.
- The whole service model across the Borough (including 5BP services and all others).
- Step down from in-patient services and the use of out of areas placements in the private sector.
- The proposed future bed model.

The review referenced the pressure within the whole system of health and social care resulting in high demand for adult acute mental health admission beds. Although the exact usage and spend for out of area beds was not available for the review, NHS Halton CCG experiences a significant overspend in 2015/16 for both complex and acute patients who have been unable to access an adult acute mental health bed within the 5 Boroughs footprint. This is in addition to the contracted spend and remains a financial risk.

3.7 Current bed state and proposal

The original proposal recommended a two site model for Later Life and Memory Services;

Table 1;

Site 1	**Site 2**
Atherleigh Park	Brooker Centre
Organic – 26	Organic – 18
Functional – 16	Functional – 20

Two major concerns have been expressed by commissioners;

i. That pressure continues on adult acute mental health beds and out of area placements continue.

ii. The two sites of Brooker Centre and Atherleigh Park would not be easily accessible for older patients and their families from some areas of the 5 Boroughs footprint.

The current bed state for adult mental health and Later Life and Memory Service provision has each borough with locality based general adult mental health beds, locality based beds for organic conditions with the exception of the St Helens borough who access the beds across the 5 Boroughs Partnership NHS Foundation Trust footprint but predominantly Knowsley.

The psychiatric intensive care unit is centrally provided in one unit currently based at Leigh Infirmary.

All five CCGs were represented at a senior level at a meeting with the 5 Boroughs Partnership NHS Foundation Trust Chief Executive and Chief Nurse on 18 April 2016 to discuss and seek approval for the new proposals for bed configuration;

Current state;

Halton (Brooker Centre)		
Male Adult	Female Adult	Organic
14	14	8

Knowsley		
Male Adult	Female Adult	Organic
18	15	12

Warrington		
Male Adult	Female Adult	Organic
18	15	18

St Helens		
Male Adult	Female Adult	Organic
17	16	0 (access Knowsley beds)

Wigan			
Male Adult	Female Adult	PICU	Organic
25	25	8	23

Proposal;

Halton (Brooker Centre)		
Male Adult	Female Adult	Organic
14	14	0 (access Warrington beds)
Knowsley		
Male Adult	Female Adult	Organic
18	15	12

Warrington		
Male Adult	Female Adult	Organic
18	15	18

St Helens		
Male Adult	Female Adult	Organic
17	16	0 (access Knowsley beds)

Wigan				
Male Adult	Female Adult	PICU	Functional	Organic
20	20	8	16	18

3.8 Benefits for Halton

Community based services aim is to support people to remain at home whilst improving and maintaining the quality of life of their service users and carers.

In order to meet the specific needs of older people within Halton borough, the Later Life and Memory Service has developed high quality locally based community services, which provide rapid access, assessment, diagnosis and treatment. This provision includes assessment team, memory team, community mental health team, care home liaison team and Admiral nurses.

However, there may be times when service users require in-patient care to provide specialist assessment and care where this could not be safely supported within the community setting.

In this instance, Halton residents will be able to access the new in-patient unit at Leigh, which will deliver short term assessment and treatment within an excellent physical environment which is tailored to care for older people with organic or functional mental health needs, delivered by specialist multi professional teams of staff.

This will give them the opportunity to access services that specifically meet the needs of older people and are separate from wards for adults of working age.

Service users and carers will be given the choice to access older people's in-patient facilities on other sites within the five boroughs if the purpose built site at Leigh is too difficult to access for them. The service users and carers will make this ultimate decision.

Whilst in an in-patient setting the LLAMS community teams will be actively involved with both the service user and carer, ensuring communication between all agencies involved is shared and to facilitate discharge as early and timely as possible.

The Later Life and Memory Service community pathway has demonstrated a significantly reduced requirement for in-patient organic beds. The average number of beds accessed by Halton residents over the past three years has been eight.

The proposed model will enable access for Halton residents at the following sites should a specialist organic bed for assessment and short-term treatment be required;

- Kingsley ward – Hollins Park Hospital, Warrington
- Golborne unit – Atherleigh Park Hospital, Leigh.

During pressured times there will be overflow beds available at:

- Rydal ward – Knowsley Resource and Recovery Centre Whiston Hospital, Prescot

3.9 Currently there is no dedicated ward across the 5 Boroughs Partnership NHS Foundation Trust footprint to provide specialised assessment and treatment for patients who have functional mental health conditions (e.g. depression or schizophrenia) who also have physical health conditions. This could include a variety of co-morbid long term conditions causing frailty or additional vulnerabilities. These patients would currently be admitted to adult acute mental health wards but evidence tells us that outcomes are significantly improved if the environment and the staff are tailored towards supporting this patient group.

The proposed model would support Halton residents to access this single ward at the newly established hospital at Atherleigh Park in Leigh.

The profile for accessing adult acute mental health beds for Halton residents has not reduced in the same way as LLAMS. Indeed, in line with national demand, there is significant pressure for adult mental health beds resulting in increased use in private beds and therefore increased costs going out of the borough of Halton.

The average number of adult acute mental health beds accessed across the Trust footprint over the last three years for Halton residents has been 32. The proposed model secures 28 adult mental health beds within the Brooker Centre which will clinically support the improvements in patient pathways across locality. based services.

In addition, services have been reconfigured to ensure that Halton borough now has a dedicated assessment team operating over 24 hours and a separate home treatment team for Halton residents.

There are further opportunities to discuss and progress with risk share arrangements to improve the financial management of out of area "overspill" arrangements and affords further opportunities to work collaboratively to deliver efficient and effective services.

Key messages

- The proposal is in line with the clinical commitment to older people's mental health. Sustainability opportunities could be realised through better use of services. For example a reduction of bed stay will bring efficiencies for health and social care.

- This is about improving quality of care for vulnerable people with complex dementia and older people with functional mental health problems.

- The majority of care for people with dementia is provided in the community or patients' own homes, the evidence of this is proven to help people remain physically and mentally well.

- For the short intensive periods people with dementia and memory loss may need specialist hospital care, for this cohort this redesign will provide improved outcomes

- The proposal is to utilise and clinically maximise the number of beds for older people – the move is driven to moving to specialist facilities within the 5 Boroughs Partnership footprint.

3.10 Consultation Process

Public consultation, for a 12 week period, is due to commence mid to late August/early September 2016, led by NHS Halton Clinical Commissioning Group and supported by all key stakeholders, i.e. carers, Alzheimer's society etc. supported by Halton Healthwatch.

4.0 POLICY IMPLICATIONS

4.1 The proposed model is in line with the current local mental health strategy and national the mental drive for parity of esteem/improved quality for frail elderly.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any change will be within current financial envelope. There is an expectation that this redesign will help secure the sustainability of services. However through reducing the spread of staff teams and estate we expect the service to be sustainable and counter some of the financial pressure that health and social care services are currently under.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Young carers who are identified as caring for older people with dementia or mental health problems will be consulted within the process.

6.2 Employment, Learning & Skills in Halton

None identified

6.3 A Healthy Halton

Dementia is a key priority within Healthy Halton and is in line with strategic drive. Mental Health remains a key priority of the Health and Well Being Board

6.4 A Safer Halton

Ensuring the safety of vulnerable older people in mental health settings.

6.5 Halton's Urban Renewal

There are opportunities to align with Health New Towns Vision of Dementia friendly towns.

7.0 RISK ANALYSIS

7.1 The key issues have been logged on the NHS Halton CCG risk register and have been monitored through the robust Mental Health Governance. The risks will be reviewed during the implementation process. Risks have been identified by Halton Borough Council in respect of their social work teams in terms of additional travel time, patient visits and associated costs; these risks will need mitigating through the redesign process.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 5 Boroughs Partnership NHS Foundation Trust are currently carrying out an Equality Impact Assessment which will feed into the public consultation as required. This will cover questions that will no doubt be raised such as transport solutions for carers, robust consultation with effected groups. This will align with the wider engagement that will ascertain public opinion.

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

9.1

Document	Place of Inspection	Contact Officer
Independent review of mental health services (Tony Ryan Review)	Runcorn Town Hall	Dave Sweeney Dave.sweeney@halton.gov.uk

REPORT TO: Health Policy & Performance Board

DATE: 20th September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Transforming Domiciliary Care

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the proposed developments in relation to Domiciliary Care delivered through Halton Borough Council.

2.0 RECOMMENDED

2.1 RECOMMENDED: That the Board:

1) Note contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Current Picture

In Halton there are currently 9 providers who work in four different zones as agreed through the last tender process carried out in 2014. Some of the providers receive a block of hours and some are part of a spot purchase framework agreement. The providers support a total of 736 people and deliver in excess of 350,000 hours of care per year with an annual expenditure of more than £4.3million.

3.2 The amount of care and the overall expenditure is set to rise over the coming years at an estimated rate of between 2-3% per year and although there are some excellent examples of high level care within the sector, it is clear that we will need to make improvements to meet the needs of an ageing population in the coming years.

3.3 The current contract runs until June 2017 and we are in the process of conducting a review of the domiciliary service in Halton. This review will support the development of a new service specification and will form the basis of the tender process that will be undertaken towards the end of 2016.

3.3 We have already commenced with reviewing the current domiciliary care sector in the borough. This has led to understanding the key principles that are at the heart of an outcome based domiciliary care service, these include:

- Moving away from a one size fits all approach

- Adopting a preventative model
- Keep people independent
- Improve quality of life
- Increase community participation
- Improve Health and Wellbeing

3.4 Consultation

As part of the review we have carried out a significant amount of engagement with people who use the service and carers. The views expressed were as follows:

- Services can be too time and tasked focused opposed to providing quality and interaction
- Restrictive role of some carers “that is not my job”
- Carers are not recognised for the role they do
- Professional barriers are put in place by services and agencies who should be working together
- Carers play a crucial part in safety – they need to be better equipped in identifying risks as well as understanding social isolation.
- Unsatisfactory assessment process – not always face-to-face, social worker may have limited contact with an individual and not always have an ongoing process in place
- Lack of continuity with care teams
- Need more access to preventative support and services
- Assessments and care plans need to identify possible solutions to help people improve their outcomes
- Increased knowledge of domiciliary care providers on the support and services available and how to access them
- More flexibility
- Emergency response

We have also had the initial meeting with providers, the voluntary sector, social work teams, GPs and CCG colleagues.

3.5 The New Model of Care

It is clear from the feedback that we have already collected that there is a need for change, too many pressures on times, limited capacity, poor recruitment, financial pressures, waiting lists. It is also clear that when we start to consider “the ideal” that people would like to see; then we have challenges on just how practical it will be to deliver. To help we have set out five broad groups that can define need:

1. Prevention and promotion – large number of the population who remain healthy and can access information to continue to support their health and wellbeing
2. Limited need / community participation – people who need some form of low-level support, but this can often be delivered through volunteer or community organisations
3. Service users with personal care needs – people who still have some independence, but have traditional personal care needs that need to be addressed

4. Service users with higher / long term care needs – people currently supported by domiciliary care providers but who have complex or specialist needs
5. Reablement – people who require an intensive short-term intervention that will help them to achieve a specific outcome.

By using these broad groups we can start to map the numbers and also the financial burden in these areas. Therefore if we consider groups 3 and 4 we know that these two groups support 376 people as a total, we have also concluded that 42% of these people fall into group 4 and have complex needs, whilst 58% of people are in group 3.

3.6 Opportunities for New Ways of Working

In 2015 The National Lottery opened up a new funding initiative aimed at Local Authorities developing changes within existing service provision to realise significant improvements in outcomes, both for an individual and financial for health and social care. The fund that was established was not a traditional grant funding pot, but was being offered through a Social Impact Bond (SIB).

The application was in three stages:
Stage 1 – Expression of Interest
Stage 2 – Application for development grant funding (up to £50,000)
Stage 3 – Full application for Social Impact Bond (up to £1,000,000)

So far we have been successful at stage 1 and stage 2 and we now have until September 22nd 2016 to submit our full application.

3.7 What is a Social Impact Bond?

Social Impact Bonds are a new concept in public service delivery. National research suggests that they have many benefits, including bringing additional investment into public services, encouraging more innovative service delivery and creating a better contract management. However, they can also be complex and challenging to establish and implement.

A Social Impact Bond is essentially a type of payment by results (PbR) contract. Like other Payment by Results, a commissioner (usually one or more public sector bodies) agrees to pay for outcomes delivered by service providers, and unless those outcomes are achieved, the commissioner doesn't pay. Where a SIB differs from PbR is that the providers do not use their own money to fund their services until they get paid – instead, money is raised from so-called 'social investors' who get a return if the outcomes are achieved. Usually the providers get paid up front by a third party body who holds the contract, rather than holding the contract directly.

4.0 POLICY IMPLICATIONS

There are significant changes that will need to happen in relation to full implementation, however the design, action plans and overall implementation plan will be completed as part of the National Lottery funding application and will be available from September 2016.

5.0 FINANCIAL/ RESOURCE IMPLICATIONS

5.1 None identified through this report

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

There are no implications for this priority.

6.2 Employment, Learning & Skills in Halton

There are no implications for this priority.

6.3 A Healthy Halton

The 736 people who are supported through Domiciliary Care are an important part of the overall Health and Social Care landscape. They account for a significant amount of the budget and capacity continues to be stretched. Any changes in this area will impact internally, but will also have an impact on the care that individuals receive. This must be managed sensitively and safely for each person.

6.4 A Safer Halton

There are no implications for this priority.

6.5 Halton's Urban Renewal

There are no implications for this priority.

7.0 RISK ANALYSIS

7.1 None identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no implications for this priority.

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

9.1 None under the meaning of the Act.

REPORT TO:	Health Policy and Performance Board
DATE:	20th September 2016
REPORTING OFFICER:	Director of Adult Social Services
PORTFOLIO:	Health & Wellbeing
SUBJECT:	NHS Halton Clinical Commissioning Group (CCG) - Financial Recovery and Sustainability Plan
WARDS:	Borough Wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Health Policy and Performance Board of the actions being undertaken by NHS Halton CCG to achieve financial recovery and sustainability.

2.0 **RECOMMENDATION: That**

The Health Policy and Performance Board note the report.

3.0 **SUPPORTING INFORMATION**

3.1 Over the previous three financial years (2013/14, 2014/15 and 2015/16) NHS Halton CCG had managed to deliver with the business rules set for the organisation by NHS England. The achievement of these business rules, which include a statutory requirement to deliver a balance year end budget and a 1% surplus, was challenging but the scale of this challenge for the next five years is immense. To deliver financial recovery and sustainability will involve some difficult and potentially contentious decisions about what services NHS Halton CCG chooses to commission or decommission and what partnerships and activities we invest in and disinvest in.

3.2 Table 1 shows NHS Halton CCG's allocations and projected expenditure through to 2020/21. This shows that the core allocation, including delegated co-commissioning of general medical services, will increase over the next five years. However, this increase does not keep pace with the costs of commissioning services over the same period of time and the requirement to continue to deliver a 1% surplus. These initial figures suggest that, over the next five years, NHS Halton CCG will need to find a cumulative total of £55.6m in savings.

3.3

	Notified 2016/17	2017/18	2018/19	2019/20	2020/21
Total Allocation	213,662	217,961	222,215	226,861	235,018
Total Costs	219,933	223,578	228,583	233,644	238,761
QIPP Requirements	(8,408)	(11,680)	(12,506)	(12,997)	(10,071)
Surplus/Deficit	2,136	2,180	2,222	2,269	2,350

Table 1: NHS Halton CCG projected allocations and expenditure

3.3 On 7th April 2016 the Governing Body of NHS Halton CCG agreed an annual budget for 2016/17 that included the achievement of £8.4m cost savings in year. The Governing Body also agreed, based on the above forecasts, that a Financial Recovery and Sustainability Plan was required by July 2016 to deliver recurrent savings over the next five years to deliver more efficient and effective health and care services.

3.4 NHS Halton CCG's Financial Recovery and Sustainability Plan will explore four areas of action:

- improving health care
- improving value for money
- reducing costs by reviewing existing services
- considering more difficult decisions

Focus will be placed on:

- reducing planned (elective) and unplanned (non-elective) activity in secondary care settings whether new or follow up, by using and, where necessary, developing integrated community service provision, including general practice, to manage demand for secondary care services.
- continuing to invest in preventative services that deliver high returns for low investment.
- focusing resources and targeting those people who use secondary care services most frequently to reduce their dependency on these services.
- utilising contract management to reduce spend in secondary care settings around coding, high cost tariffs, consultant to consultant referrals and procedures of low clinical priority.
- full review of all commissioned services and each budget line against the triple aim principles (better care, better outcomes and value for money) – which may result in some services being decommissioned or disinvested in.

- full review of all clinical commissioning policies and guidance to ensure implementation in practice, this will include joining with other CCGs to look again at the Procedures of Lower Clinical Priority Policy and explore prior approval processes – which may lead to further restrictions on the treatments and interventions that the NHS can support.
- internal budgetary management and efficiencies.

3.5 NHS Halton CCG has always sought to work in partnership with local people and the organisations that serve those people. It is our intention that the development and implementation of our Financial Recovery and Sustainability Plan will be taken forward openly, transparently and honestly. On 2nd June 2016 the Governing Body agreed to some core principles and a process for decision making on cost improvement identification to contribute to financial sustainability. The supporting document can be found in the NHS Halton CCG Governing Body papers which are available at http://www.haltonccg.nhs.uk/about/governing-body-meetings. The process that has been agreed will ensure that the impact of any commissioning decisions, whether about investment or disinvestment, takes into account quality and equality issues and are taken forward following engagement with interested parties.

4.0 POLICY IMPLICATIONS

4.1 NHS Halton CCG remains committed to delivery of the 'must do' objectives and targets set out in *Five Year Forward View* and the associated guidance. All the activity of the organisation will therefore be focused on delivery of the service transformation required to deliver these 'must do' areas and deliver financial recovery and sustainability.

5.0 FINANCIAL IMPLICATIONS

5.1 By producing a Financial Recovery and Sustainability and Recovery Plan and reporting a £8.4m cost improvement plan for 2016/17 it is likely that NHS England will place NHS Halton CCG under additional scrutiny. This may include bring in an external consultancy/turnaround agency.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None as a result of this report, although the Financial Recovery and Sustainability Plan will look at all commissioned services and partnerships including those involving children and young people.

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

None as a result of this report.

6.3 **A Healthy Halton**

The Financial Recovery and Sustainability Plan will potentially impact on all commissioned services, expenditure and partnerships that NHS Halton CCG is currently committed to.

6.4 **A Safer Halton**

None as a result of this report.

6.5 **Halton's Urban Renewal**

None as a result of this report.

7.0 **RISK ANALYSIS**

7.1 Risks will be managed within the governance framework of NHS Halton CCG.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 These are taken into account as part of the Financial Recovery and Sustainability Plan and the processes that will be put in place for its development and implementation. NHS Halton CCG will ensure that it is compliant with the statutory duties of the Equality Act 2010.

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

None.

REPORT TO: Health Policy & Performance Board

DATE: 20th September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: The National Living Wage – Care Provider Contracts

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Board with details of the latest known position with regards to the impact that the introduction of the National Living Wage is having on Care Providers in Halton.

2.0 **RECOMMENDATION: That the Board:**

i) Note contents of the report.

3.0 **SUPPORTING INFORMATION**

3.1 In July 2015 the Chancellor of the Exchequer announced that the UK Government would introduce a compulsory minimum wage premium for all staff aged 25 and over.

The new mandatory national living wage (NLW) took effect from 1st April 2016 and pushed up the minimum hourly rate for all workers aged 25 and over from £6.70 to £7.20. Initially, this has been set at £7.20 an hour, but with a target of it reaching more than £9 an hour by 2020.

Part-time and full-time workers will benefit from its introduction.

The national minimum wage (NMW) will remain in place, and the compulsory national living wage (NLW) will be a top-up for workers aged 25 and over.

3.2 It should be noted that in order to help businesses afford the increases in wages the Chancellor of the Exchequer cut Corporation Tax by 2% to 18% and employers are also able to reduce the amount of national insurance contributions they pay for their employees by 50%, up to £3,000.

3.3 A finance model was developed and adopted across the North West Region which provided some initial analysis of the potential increased costs involved and impact.

In summary, as the age profile of workers was/is not clearly known, the finance model assumed potential percentages of 100%, 90% and 75% of the total workforce,

which showed that potential additional costs incurred, for Halton, would be between £1million to £1.3million in 2016/17, rising to between £4.6million and £6.2million by 2020/21.

Further details can be found at paragraph 5 of *Appendix 1*.

3.4 An options appraisal was carried out as to how the increase in costs could be met and was presented to Executive Board in February 2016.

It was agreed to enter into discussions with Care Providers to agree how the additional costs would be met.

3.5 Following discussions, taking into account that 41% of the increased costs could be met by the care providers (Domiciliary, Residential and Nursing Care), via the reduction in corporation tax and the reduction in national insurance contributions, in addition to the £0.5m cost, as outlined in the Medium Term Financial Forecast towards the cost of the NLW, a provisional offer of a 3.2% increase was presented to domiciliary and care home providers.

At this point all providers who found this financially compromising were offered the opportunity to follow an 'open book' accounting process whereby their accounts would be examined to prove financial hardship.

3.6 At the point of writing this report only 3 Domiciliary Care providers have asked for this to take place and work is currently ongoing with these providers, however financial hardship hasn't yet been evidenced or substantiated with any detailed cost information or accounts etc.

No residential/nursing care providers have taken up this offer.

It should also be noted that the Local Authority has not received any concerns from Service Users in respect of care providers increasing their contributions to fund any gap in costs.

It is therefore very difficult at this stage to evidence the actual impact the introduction of the NLW is having on care providers or Service Users in Halton.

3.7 As part of the on-going contract monitoring arrangements undertaken by the Quality Assurance Team, there is an opportunity for discussions to take place between the Local Authority and care providers concerning any related financial issues; this will continue.

Care Quality Commission (Registration) Regulations 2009: Regulation 13 – also covers financial position. In summary the intention of this regulation is to require providers to make sure they take all reasonable steps to meet the financial demands of providing safe and appropriate services. It goes on to state that in order to meet this regulation, providers must have the financial resources needed to provide and continue to provide the services as described in the statement of purpose to the required standards.

3.8 On-going work continues to take place with providers to try and fully understand the impact of not only the introduction of the NLW (NB. Provider Forum is due to be held on 8th September where this issue will be addressed/discussed further), but also looking at future capacity and demand across the whole of the Adult Health and Social Care economy in Halton as part of the Joint Strategic Needs Assessment and Market Position Statement work, in addition to exploring ways in which will can incentivise the market to produce better outcomes for people locally.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Details of the possible financial implications were presented to Executive Board and these can be found in paragragh 5 of the *Appendix 1.*

5.2 The issue of NLW needs to be considered alongside high quality care and market stability in general and associated costs.

A contractual agreement has been in place for considerable time with a range of residential and nursing care providers in Halton and as there had been various National issues raised regarding a “fair price for care” fees it was agreed with care home providers that a review of fees take place in Halton during 2014/15 to ensure that they were financially sustainable for the Council and were able to support the continuance of high quality care and provide for market stability. The Council currently spends circa £18m per annum on residential and nursing home placements.

5.3 As a result external consultants were engaged in November 2014 to undertake this work. This was necessary because of the specialist nature of the financial work involved in determining the ‘Fair Price for Care’, to provide a level of independence and to engage consultants who have worked with other Councils facing similar issues.

5.4 The resulting report from the consultants provided the necessary analysis of the costs and prices associated with the provision of residential and nursing care provision in the Borough and the findings included that the fees currently paid were appropriate to cover the average costs of a care home in the Borough.

Further work was conducted with a view to maintaining market stability and it was agreed that a 0.82% inflation would be applied to fees in 2015/16, 2016/17 and 2017/18. This increase applied to Older People in residential and nursing care provision.

In respect of those service users in mental health and learning disability residential placements we have moved to an approach where a standard base fee is set but recognise that additional package costs may need to be negotiated.

As there are very few homes in the Borough for adults with physical disabilities it

was agreed that individual fees be agreed with each home.

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 Adult Social Care budget supports the delivery of services which contribute towards this priority.

6.4 A Safer Halton
None identified.

6.5 Halton's Urban Renewal
None identified.

7.0 RISK ANALYSIS

7.1 The option agreed by Executive Board i.e. sharing the financial burden with care providers, does mean that we share the risk. However, the position does need to be reviewed annually through open book accounting and increased information sharing and transparency with providers.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

Document	Place of Inspection	Contact Officer
The National Living Wage – Care Provider Contracts Executive Board Report 25/02/16	Municipal Building	Sue Wallace-Bonner Director of Adult Services

REPORT TO: Health Policy & Performance Board

DATE: 20th September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Deprivation of Liberty Safeguards (DoLS)

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board and highlight key issues with respect to Deprivation of Liberty Safeguards (DoLS) and the refresh of the Mental Capacity Act 2005 policy.

2.0 **RECOMMENDATION: That:**

The report be noted and the refresh of the Mental Capacity Act 2005, Policy, Procedure and Practice' document

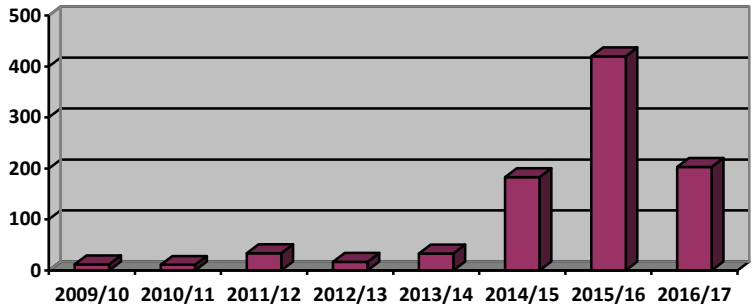
3.0 **SUPPORTING INFORMATION**

3.1 The Deprivation of Liberty Safeguards (DoLS) are 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 that this is only done when it is in the best interests of the person and there is no other way to provide appropriate care.

3.2 On 19th March 2014 a Supreme Court ruling P v Cheshire West and Chester and P and Q v Surrey Council was significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty and introduced a new 'acid test'. The implication being that all people who do not have capacity and are not free to leave their environment need to be supported under the framework of the DoLS.

3.3 The judgment is important as it holds that a DoL can occur in a domestic setting where the State is responsible for imposing those arrangements. This will include a placement in a supported living accommodation in the community. Hence, where there is, or is likely to be, a deprivation of liberty in such placements that must be authorised by the Court of Protection.

3.4 An action plan was developed to address and co-ordinate the Halton response to the judgement. The Safeguarding Unit co-ordinates and manages the DoLS assessments and reviews and acts on behalf of the Supervisory Body (The Local Authority). The team members include a DoLS co-ordinator and two dedicated DoLS assessors. The team is supported by a pool of 18 Best Interest Assessors (BIA) drawn from care managers, 5 of whom have completed their training within the last 3 months. There is an ongoing training programme established to ensure that all appropriate staff are trained to undertake this role going forward. Additionally, there is now a DoLS administrator in place to ensure a co-ordinated response to all requests, and the effective dissemination of the outcomes of assessments to all relevant parties.



3.5 In the period April 2015 to the end of March 2016 the Local Authority received 420+ referrals. Since April 1st 2016 the Local Authority has received 203 applications for Deprivation of Liberty Authorisations, compared to 162 for the same period last year.

3.6 **Mental Capacity Act 2005**

The changes to this policy have been made as part of a scheduled review of the document. As with all policies being revised this involved analysis of legislative changes, current best practice and operational requirements.

3.7 What has changed:

- Greater emphasis on safeguarding.
- Re-structuring of content to aid understanding and application in practice (reducing the content by eleven pages).
- Elimination of duplication (as above, leading to a more concise document)
- Reference to the Care Act 2014, pertinent case law and Government commissioned enquiry.
- Addition of information around the duty of candour and the right to dignity.
- Inclusion of information on fluctuating capacity.
- Clearer communication on governance arrangements, data

management and performance needs.

- Distinct development pathway for practitioners.
- Simplified flowcharts of process.
- Details of assessments document which match those used in practice.
- The addition of a ‘Quick Guide’ reference document in the appendices for ease of understanding.

4.0 POLICY IMPLICATIONS

4.1 The policy highlighted will assure current legislation, case law and practice is documented appropriately enabling consistent application.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL’S PRIORITIES

6.1 Children & Young People in Halton

Safeguarding Adults Board (SAB) membership includes a Manager from the People Directorate, as a link to the Local Safeguarding Children Board. Halton Safeguarding Children Board membership includes adult social care representation. Joint protocols exist between Council services for adults and children. The SAB chair and sub-group chairs ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

The safeguarding of adults whose circumstances make them vulnerable to abuse is fundamental to their health and well-being. People are likely to be more vulnerable when they experience ill health.

6.4 A Safer Halton

None identified.

6.5 Halton’s Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 Failure to consider and address the Statutory duty of the Local Authority could expose individuals to abuse and the Council as the Statutory Body vulnerable to complaint, criticism, and potential litigation.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 It is essential that the Council addresses issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its safeguarding policies and plans. Policies and procedures relating to Safeguarding Adults are impact assessed with regard to equality.

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

None under the meaning of the Act

HALTON BOROUGH COUNCIL

People Directorate - Adult Social Care

DRAFT
Mental Capacity Act 2005

Policy, Procedure and Practice
August 2016

CONTENTS

INFORMATION SHEET

Service area	People and Economy Directorate – Adult Social Care
Date effective from	
Responsible officer(s)	Divisional Manager (Mental Health)/ Divisional Manager (Independent Living)
Date of review(s)	August 2016
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory/Statutory
Target audience	Adult Social Care staff within the People and Economy Directorate
Date of committee/SMT decision	
Related document(s)	• Deprivation of Liberty Safeguarding (DoLS) Policy, Practice and Procedure – March 2016 • Mental Capacity: Advance Planning – August 2016 • Restrictive Physical Interventions - Policy, Procedure and Practice - For Professionals Working With: Adults of all ages within a supported housing aspect of direct care services - January 2015 • Mental Health Act 1983 • The Deprivation of Liberty Safeguards 2008 • Care Standards Act 2000 • Care Act 2014 • Data Protection Act 1998 • Human Rights Act 1998 • Safeguarding Vulnerable Groups Act 2006 • The Protection of Freedoms Act 2012
Superseded document(s)	Mental Capacity Act 2005 Policy, Practice and Procedure – December 2013
Equality Impact Assessment completed	

1.0	POLICY	*PRACTICE*
1.1	**Introduction** The Mental Capacity Act (MCA) 2005 sets out statute applicable to England and Wales. It came into force in 2007 and represents an important part of health and social care practice. The legislation determines a framework for acting, and making decisions, on behalf of people (over 16 years of age) who lack the mental capacity to make specific decisions for themselves. The MCA and associated Code of Practice establish how capacity is determined. It aims to ensure that any decision made or action taken on behalf of an individual, who lacks the capacity to make that decision themselves, will always be made in their **best interests**. The MCA sets out five statutory principles which are designed to empower and protect individuals. It makes it clear who can make decisions, in which situations and how they should go about this. It also enables people to plan ahead for a time when they may lose capacity.	*The MCA provides a statutory framework within which staff must work with service users when determining capacity and best interest decisions. Careful adherence to the Act and its Code of Practice (CoP) will protect those working with individuals who lack capacity provided that decision-making processes are fully recorded and any decisions justified.* *Decisions around capacity concern the basic rights and principles set out in the Human Rights Act 1998.*
1.1.2	**The Principles of the MCA:** • A person must be assumed to have capacity unless it is established that they lack capacity. • A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. • A person is not to be treated as unable to make a decision merely because they make unwise decisions. • An act done or decision made, under the Act for or on behalf of a person who lacks	*There are certain decisions that can never be made on behalf of a person lacking capacity, either because such decisions are too personal to the individual concerned or because they are governed by other legislation. These decisions concern: family relationships, treatment under the Mental Health Act, voting rights, unlawful killing and assisted suicide.*

1.0	POLICY	*PRACTICE*
	capacity must be done, or made, in their best interest. • Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.	
1.2	**Policy Remit** The overall aim of this Policy is to ensure that: • Staff working within the requirements of the MCA have a clear understanding of their roles and responsibilities. • Practice is consistent and in-line with case-law developments. • Operational processes and paperwork are unified and coherent. • Individuals with capacity issues receive the support which is appropriate and proportionate to their needs. • Information about the MCA is accessible to families, carers and the public. • Independent Mental Capacity Advocates (IMCA) services are appropriately allocated. • The training and development needs of the workforce are identified and delivered. • Systems are in place to support relevant multi-agency collaborations and associated partnerships.	*This policy is to be read in conjunction with the MCA, the Code of Practice and related documents as described in the information sheet. It does not supersede any of the associated statute but is intended as a guidance document to drive the local response to mental capacity issues.* *Halton's partner agencies may wish to work within the values of this policy. They may also have developed their own MCA procedures and guidance, specific to the needs of their own context and function, while remaining within the scope of the MCA and related legislation and guidance. Consequently, where partnership working or multi-agency collaboration is taking place this policy must be read in conjunction with any specific agency policies and procedures.*

1.0	POLICY	*PRACTICE*
1.3	**Safeguarding Adults in Halton** Safeguarding the welfare and wellbeing of individuals is integral to Halton Borough Council's (HBC) responsibilities and one of its strategic priorities, aligned to the provision of 'A Safer Halton'. Safeguarding is everyone's business. Staff within HBCs Adult Social Care teams and across the Health and Social Care sector in Halton will frequently play a key role supporting and helping people with impaired mental capacity and functioning. In the course of doing this they must ensure that they protect those people. This includes protecting them from harm, coercion and control, abuse, neglect or exploitation. It involves promotion of their wellbeing, their views, wishes and feelings, their beliefs, dignity and right to independence. The values are fundamental to the provision of high-quality health and social care services. **Staff should always work on the basis of an assumption of capacity**. Specific decisions or actions may need to be taken where an adult has shown to lack capacity. HBC is committed, on behalf of all partner agencies, to the principles and objectives of the Mental Capacity Act. Staff may help a service-user to understand what decisions have to be made, why they are important and what the consequences of making them are likely to be. Occasionally, those in health and social care roles are the only people in a position to provide information to such individuals about the options available to them and where they can obtain help, further information and advice. Staff should not make decisions on people's behalf, unless a lack of capacity has been determined, and the decision being made has been determined as	*Local Authorities, under the Care Act 2014, have a set of legal duties and responsibilities. These include the requirement to lead multi-agency systems including establishing a Safeguarding Adults Board to develop, share and implement a joint safeguarding strategy. They have the responsibility to make or request safeguarding enquiries; carry out safeguarding adults' reviews; and appoint independent advocates to support those subject to an enquiry or review, as required.* *Section 42 of the Care Act defines risk of abuse to include 'financial abuse'. The Bournemouth University Financial Scamming guide calls for all agencies to recognise that "consumers / clients with dementia [and therefore others with capacity issues] are by definitions more at risk of being scammed... measures to protect this population group are required as part of a 'duty of care'."*

1.0	POLICY	*PRACTICE*
	being in their best interest.	
1.3.1	Halton Borough Council will: • Safeguard and meet the needs of adults who may lack capacity by working with service users, carers and partner agencies to implement the principles and aims of the Mental Capacity Act 2005. • Ensure that all staff are aware of and able to work with partner agencies as a means of meeting the needs of people lacking capacity. • Work in partnership wherever possible with people who lack capacity as well as their carers in order to provide treatment and services that are in their best interests. • Safeguard the interests of people who lack capacity where they are without support or considered to be at risk of abuse.	
1.4	**Who does this Policy apply to?** The Policy applies to all those covered under the MCA, and all those working with the legislation and its related Code of Practice. The MCA applies to all people over the age of 16 years old* who may lack capacity to make specific decisions.	**Exceptions:* *1. Only those 18 and above can make a 'Lasting Power of Attorney'.* *2. Only those 18 and above can make an 'Advance Decision' to refuse medical treatment.* *3. The Court of protection can only make a 'statutory*

1.0	POLICY	*PRACTICE*
	This includes people with: • A severe learning disability. • A mental health problem, including those whose condition can be variable. • Dementia. • Cognitive impairments as a result of a stroke or an acquired brain injury. It is important to keep in mind that these conditions or illnesses do not in themselves mean that a person lacks the capacity to make a particular decision. The MCA is intended to be a provision that is enabling and supportive of people who lack capacity, not restricting or controlling of their lives. Although it clearly protects such people, it also aims to promote maximum involvement by people in decisions that affect them. Application of the MCA and the associated Code of Practice allows people to take appropriate action in individual cases and helps people to find solutions to difficult or uncertain situations. The MCA also applies to all those people who come into contact with people who may lack capacity. This includes (but is not limited to) family, friends and neighbours, professional health and social care and support staff, residential and nursing homes, lawyers and courts. It is important that registered professionals and other workers promote awareness of the MCA and are aware of their own responsibilities under it – See Sections 2.1 and 2.3.	*will' for a person aged 18 and over.* *This is not an exhaustive list and there may be other circumstances where capacity is determined. This will involve the same assessment process.* *Code of Practice, Chapter 2, page 20.* *Section 2.3 details how capacity is assessed by using a two-stage test.* *Appendix Four provide the structure, documentation and information required by staff working in the best interests of people lacking capacity.*
1.5	**The MCA Code of Practice** The MCA Code of Practice (CoP) is a comprehensive guidance documents intended for	

1.0	POLICY	*PRACTICE*
	use in conjunction with the legislation. The CoP provides additional information about how to put the MCA into practice. The MCA does not impose a legal duty on anyone to 'comply with the Code,' so it should be viewed by staff as best practice guidance. However, if a person **does not** follow the relevant guidance they must give a good reason why they have deviated from it. The MCA and the CoP should be seen together as a statement of best practice to be followed by staff in all matters. Hence any staff member working with an individual who has been assessed as 'lacking capacity' must act within the provisions of the Act and the CoP.	
1.6	**Interface with the Mental Health Act** There may be situations where the Mental Health Act 1983 (As amended by the 2007 Act) is the most appropriate legislation to apply to a person's care and treatment. It ensures that those with serious mental disorders receive care and treatment, even against their wishes. Here, decision-making capacity may be held but decisions made may not just be unwise but may be detrimental to the health and safety of the person or those around them, or pose a risk of this.	
1.6.1	The Mental Health Act (MHA) sets out circumstances when those with mental disorders can be: **a.** Detained in hospital for assessment or treatment; **b.** Detained and given treatment for their mental disorder without their consent; or **c.** Made subject to Guardianship or after-care under supervision to protect themselves or others.	*Where the MHA allows individuals to be treated for mental disorders, the MCA applies in the normal way to treatment for physical disorders. Healthcare staff may decide to focus initially on treating the mental disorder in the hope that capacity will be regained, so that a decision can be made about the physical disorder.*

1.0	POLICY	*PRACTICE*
	In general the MHA does not distinguish between those who have the capacity to make decisions and those who do not. Most people who lack capacity to make decisions about their treatment will never be affected by the MHA, even if they require treatment for a mental disorder. However there are situations where decision-makers must decide whether to use the MHA, MCA or both in order to meet the needs of individuals with mental ill health who lack capacity to make decisions about their own treatment. A key question for the decision-maker looking at the MHA is therefore whether no alternative solution is available under the MCA and the criteria under the MHA are genuinely met.	*The MHA and the MCA and their associated Codes of Practice as well as current case law should be taken into account in these situations.*
1.6.2	Before deciding whether to admit (to a hospital setting), treat and detain a compliant, incapacitated patient under the provisions of the MHA, consideration should be given as to: • Whether or not admission and treatment can be achieved under the application of the MCA/DOLS* regime instead, and whether that regime would be less restrictive than detention under the MHA. *It might be necessary to consider using the MHA rather than the MCA if: 1. The person cannot be provided with the care or treatment they need without being deprived of their liberty (and they do not meet the criteria for DoLS under the MCA). 2. The required treatment is not available under the MCA because the person has made an Advance Decision to refuse all or part of that treatment. Here, the MHA may annul the Advance Decision. 3. The person must be restrained in a way that is not allowed under the MCA. 4. It is not possible to assess/treat the person safely or effectively without the treatment being compulsory (i.e. the person could regain the capacity to consent, but on doing so might refuse to give consent). 5. The person lacks capacity to decide some elements of treatment, but has the capacity to refuse vital parts of it and have done so. 6. There is some other reason why the person might not get the treatment they need and they	*Practitioners do not have to apply to the Court of Protection to rule the MCA does not apply before using the MHA, The MHA always has precedence over the MCA. Similarly, if a practitioner believes that they can safely assess or treat a person under the MCA, they do not need to consider using the MHA.* *A person detained under the Mental Health Act (and Mental Health Code of Practice) needs to meet the specified criteria for detention. This sets out that they will be suffering a mental disorder of a nature or degree which warrants detention and/or treatment, and that the detention is in the interest of their own health and safety or with a view to the protection of others.*

1.0	POLICY	*PRACTICE*
	or others may suffer harm as a result. Section 5 of the MCA provides legal protection for those who care or treat someone lacking capacity, but in doing so they must follow the Act's principles and may only take action that is in the person's best interests. However, there is no protection under Section 5 for any actions that deprive a person of their liberty. Similarly, the MCA disallows giving treatment that is contrary to a valid and applicable Advance Decision to refuse treatment. None of these restrictions apply to treatment for mental disorder, though others do.	*This will also include the need to have an awareness of the Deprivation of Liberty Safeguards as outlined in Section 1.7.11.*
1.6.3	It is important for health and social staff who support certain client groups (for example, those with mental health problems, particularly those with severe and enduring mental ill health or older people) to have an understanding of the interface issues between the MCA and the MHA.	
1.7	**Definitions**	
1.7.1	**"*Advance Decisions*"** may be made by someone with capacity (over 18 years of age) who wishes to refuse specific treatment(s). An 'advance decision' will then apply at a future time should the person lose capacity. The treatment(s) which a person wishes to refuse must all be specified in the 'advance decision', including the circumstances in which the decision applies. Where a person wishes to make an advance decision to refuse life-sustaining treatment (sometimes known as a 'living will') the decision must be written down, signed by the person making the decision and witnessed (this will normally be a professional who would be in a position to confirm that capacity is held e.g. GP). An advance decision is legally binding, as long as it meets the necessary criteria (including being within the confines of what it can legally be used for) for it to be considered valid and applicable.	*See: Chapter 9, MCA Code of Practice.* *Also:* Halton Borough Council's Mental Capacity: Advance Planning – Policy Procedure and Practice, August 2016.
1.7.2	**"*Advance Statements*"** sets out a person's views,	

1.0	POLICY	*PRACTICE*
	wishes and preferences regarding their care and treatment in the future. They can cover details of how a person would like to be cared for, for example, at home, in a hospital, care home or hospice. They may cover what the person likes to do, for example, take a bath instead of a shower. They may also cover spiritual or religious beliefs the person would like reflected in their care. Unlike Advance Decisions these are not legally binding but serve as a set of clear instructions for family, friends or anyone involved in arranging care and treatment. By making an advance statement a person who may lose capacity at a future point is able to communicate their wishes and state their individual values.	
1.7.3	**"*Best Interests*"** is a core principle that underpins the MCA. It stresses that any act done or decision made on behalf of an individual who lacks capacity, must be done or made in their best interests. This principle covers all aspects of financial, personal welfare, health care decision-making and actions. The decision-maker must involve the person in the decision as fully as possible, making every attempt to communicate outcomes. Where capacity fluctuates they must consider whether the person may be able to make the decision for themselves at another time. Best interest involves not making decisions based on assumptions about the person, consideration of the circumstances of the decisions that need to be made and respect of any previously stated wishes, values or preferences.	*See: Chapter 5, MCA Code of Practice.*
1.7.4	***"Care Quality Commission (CQC)"*** is a non-departmental public body of the UK government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations – whether in hospitals, care homes or people's own homes. Part of the CQCs remit is to monitor use of the MCA and DoLS.	
1.7.5	**"*Carers*"** provide informal care and support to a person (partner, relative, friend or neighbour) who through illness or disability is unable to look after her/himself. The carer may be an adult, young	*Under the Care Act 2014 carers have a legal right to assessment of their own needs and may be entitled to*

1.0	POLICY	*PRACTICE*
	person or child. The role of a carer is not the same as someone who provides care professionally or through a voluntary organisation.	*support based on the impact of their caring role on their own life.*
1.7.6	**"*Children*"** – The MCA Code of Practice has provisions for dealing with cases where a person is deemed a child (under 16). This involves specific circumstances under which the Court of Protection can made decisions about those who are under 16 years of age and who lack capacity.	*See: Chapter 12, CA Code of Practice*
1.7.7	**"*Consent*"** is the voluntary and continuing permission of the person to the intervention or decision in question. It is based on an adequate knowledge and understanding of the purpose, nature, likely effects and risks of that intervention or decision, including the likelihood of success of that intervention and any alternatives to it. Permission given under any unfair or undue pressure is not consent.	
1.7.8	**"*Court Appointed Deputy (CAD)*"** - A CAD is appointed by the Court of Protection with legal authority to make decisions on behalf of an individual lacking capacity to do so themselves. They are often family members or friends, but can also be professionals such as solicitors or local authorities. The decision-making powers of a CAD may be defined in scope and duration by the Court of Protection.	
1.7.9	**"*Court of Protection*"** is a specialist court dealing with all issues relating to people who lack capacity to make specific decisions. It is responsible for dealing with contested decisions; determining the outcomes of disputes around enduring or lasting powers of attorney; appointing and monitoring CADs and/or trustees and making statutory wills. See Section 2.6.	
1.7.10	**"*Decision-Maker*"** - The individual who is responsible for deciding what is in the *best interests* of a person who lacks capacity and who makes a decision on their behalf. The decision maker can be a professional, family	

1.0	POLICY	*PRACTICE*
	member, carer or other. The decision-maker for different aspects of a person's life (their care, treatment or financial choices) may be the person who is appropriately skilled and knowledgeable and who best legally placed to make the decision. Any disputes on these matters can be settled by the Court of Protection. Decisions made on behalf of someone who lacks capacity can be made jointly between care professionals and family/friends, provided they are made in their *best interest*.	In the application of a DoLS this may be the 'Relevant Person's Representative' (RPR).
1.7.11	**"*Deprivation of Liberty Safeguards (DoLS)*"** provide a legal framework and right of appeal to ensure that adults lacking mental capacity are properly represented and not deprived of their liberty unless it is in their best interest. DoLS have been established to protect the rights of individuals who, for their own safety, need to be detained or subject to supervision and control in respect of their care and treatment. DoLS ensure that any decision taken to deprive someone of their liberty is made according to well-defined processes, thoroughly documented and carried out in consultation with specific authorities. They do not cover detention under the Mental Health Act.	*For definitions of roles and responsibilities under DoLs see: Halton Borough Council's Mental Capacity Act – Deprivation of Liberty Safeguards (DoLS) - Policy, Procedure and Practice - March 2016*
1.7.12	**"*Donor*"** – this is the individual who makes a Lasting Power of Authority (LPA) to appoint another person to manage their assets or to make personal welfare decisions (prior to October 2007 an Enduring Power of Attorney). The LPA will make decisions on behalf of the donor should they lose capacity at a future time.	
1.7.13	**"*Enduring Power of Attorney (EPA)*"** - This is a power of attorney created under the Enduring Powers of Attorney Act 1985 to deal with property and financial affairs. Existing EPAs made before this time continue to be valid.	
1.7.14	**"*Independent Mental Capacity Advocates (IMCA)*"** can be appointed (by a Local Authority or NHS body) to represent and support an individual who lacks capacity in situations where the person	

1.0	POLICY	*PRACTICE*
	has no one else to support them. IMCAs can also be taken on to support carers to understand and evaluate decisions that need to be made in someone's best interest. The IMCA role is a paid position. They provide independent and impartial information and guidance and represent the views and wishes of the person who lacks capacity.	
1.7.15	**"*Lasting Power of Attorney (LPA)*"** is a way of giving a trusted person decision-making responsibility where mental capacity may be lost at a later time. A *donor* can appoint an attorney or attorneys act on their behalf in matters relating to welfare, including healthcare, and/or financial dealings, such as their property or monitory affairs. An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. A donor can only make an LPA while they still have capacity.	*A donor must be over 18 years of age and have capacity at the time of appointing the Attorney.* *The making and registration process for a Lasting Power of Attorney can take around six weeks, during which time people can object to the registration of the LPA.* *An LPA for property and finance can be activated immediately; an LPA for welfare only triggers after the person loses capacity.*
1.7.16	**"*Managing Authority*"** - The person or body with management responsibility for the hospital, care home or sheltered housing accommodation in which a person is or may become deprived of their liberty.	
1.7.17	**"*Mediation*"** - This is a voluntary process undertaken to enable two or more parties to reach a mutually acceptable outcome. Parties who take part in mediation may be empowered by an independent mediator or facilitator to resolve the dispute themselves. Unresolved disputes regarding a person, who lacks capacity to make decisions for themselves, or in relation to whether capacity is held, can be taken to the Court of Protection.	*Disputes about the finances of a person who lacks capacity should usually be referred to the Office of the Public Guardian (OPG).*
1.7.18	**"*Mental capacity*"** broadly refers to the ability of an individual to make decisions and choices about specific elements of their life. This can include anything from meal choices through to decisions on health treatment. Different decisions require different levels of understanding and assessment of	

1.0	POLICY	*PRACTICE*
	whether capacity is held has to take this into account. The MCA and its CoP refer specifically to a person's capacity to make particular decisions at the time an assessment needs to be made. Any restrictions placed on a person lacking capacity must be lawfully made, proportionate and in the person's best interest. This may include decisions being made on their behalf, action being taken on their behalf or a deprivation of liberty.	
1.7.19	**"*Office of the Public Guardianship (OPG)*"** - The OPG: supervises CADs; keeps a register of deputies, LPA and EPAs; monitors attorneys; and investigates any complaints about attorneys or deputies.	
1.7.20	**"*Restraint*"** is using force or threatening to do so in order to stop someone doing something they are resisting. It is also defined as restricting a person's freedom of movement, whether they are resisting or not. The appropriate use of restraint always falls short of depriving a person of their liberty.	*See also: Restrictive Physical Interventions - Policy, Procedure and Practice - For Professionals Working With: Adults of all ages within a supported housing aspect of direct care services - January 2015.*
1.7.21	**"*Statutory Will*"** – If someone lacks the capacity to make a will it is possible for an interested party to apply to the Court of Protection to make a statutory will for that person. Someone with LPA, or a CAD, does not have the authority to make decisions on setting or changing a will. Statutory wills will normally be made on behalf of someone lacking capacity where no will exists. However, in some cases, where strong evidence exists to show that a will no longer represents the views and wishes of the person who lacks capacity, changes may be made by the Court of Protection.	*A will is a legal document that sets forth a person's wishes regarding the distribution of their property, possessions and financial assets. It may involve provisions for the care of children.*
1.7.22	***"Supervisory Body"*** – The Local Authority within which a person has 'ordinary residence' is responsible for conducting assessment for a standard DoLS authorisation.	*'Ordinary Residence' is normally determined by the geographical area the person lived immediately prior to entering the accommodation to which the*

1.0	POLICY	*PRACTICE*
		DoLS applies.
1.7.23	***"Wilful neglect"*** - The MCA covers definition of the criminal offences of ill-treatment and wilful neglect of a person who lacks capacity.	*A referral to the Police should be made for those in danger of immediate harm. Care Concerns are to be raised with Quality Assurance team and Safeguarding issues should be reported initially through the Contact Centre.*
1.7.24	**"*Young People*"** – The MCA defines this group of people as those aged between 16 and 17 years old. The MCA applies to those over 16 years of age with three exceptions: Only people aged 18 and over can make a Lasting Power of Attorney (LPA); Only people aged 18 and over can make an advance decision to refuse medical treatment; and the Court of Protection may only make a Statutory Will for a person aged18 and over.	*Deprivation of Liberty Safeguards (DoLS) have normally applied to those over 18 years of age. However in Birmingham v D (2016) a young person, aged 16, was voluntarily accommodated, with the consent of his parents, in circumstances that amounted to a Deprivation of Liberty, due to his lack of capacity to consent in person.* *This recent case could have implications for DoLS and their application to young people. Readers should be mindful of developments stemming from this judgement.*

2.0	**PROCEDURE**	***PRACTICE***
2.1	**Mental Capacity** Mental capacity is the ability to make a decision, ranging from something minor that affects daily life only, to a more significant decision with much wider implications. Everyone has the right to make decisions for themselves, provided they have the capacity to do so. The MCA sets out processes and principles for working with those who may lack capacity. Proactive application of the MCA ensures that people's care and treatment is appropriate, proportionate and not overly restrictive or controlling. Where a lack of capacity has been established the MCA provides a legal framework within which decisions can be made and actions can be taken on a person's behalf.	*Those who access the services and support offered through Halton Borough Council's Adult Social Care Services and associated commissioned functions may have impairments or disturbances of the mind or brain which will impact on their ability to make decisions.* *Capacity cannot be established merely by reference to:* • *Age;* • *Appearance;* • *Behaviour; or,* • *Diagnosis/condition.*
2.1.1	**The Principles of the MCA** The five principles of the Mental Capacity Act represent a benchmark for all those who interact with a person who may lack, or who does lack capacity to make their own decisions. Interaction made by employees of Halton Borough Council, partner agencies or commissioned services are made on a professional level and represent part of a supportive, empowering and protective relationship. The principles of the MCA deal with the challenge of protecting a person's choice and independence against the requirement to safeguard and their welfare and wellbeing. A person may make a decision that others consider unwise or wrong and may learn from their mistakes. Principles 1 – 3 account for this. People with disabilities or conditions that may impair their cognition must be allowed to do that same, if they have capacity to understand the risks associated with their decisions. On the other hand there is a clear need to protect against harm those most vulnerable in society. The Principles represent a clear	*This includes IMCA services.*

2.0	PROCEDURE	*PRACTICE*
	framework which delineates the divisions between these conflicting needs. Friends and family of a person who may or who does lack capacity are not bound by the principles, though would be well served to understand and apply them.	
2.1.2	**Principle 1:** "A person must be assumed to have capacity unless it is established that s/he lacks capacity" **(Mental Capacity Act, Section 1 (2))**.	*There must be clear documented proof (See Section 2.3 - Two-Stage Test) that a person lacks capacity about the particular decision they are being required to make.*
2.1.3	**Principle 2:** "A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success" **(Mental Capacity Act, Section 1 (3))**. This is a proactive duty on those who work with a person who may be thought to lack capacity to make a particular decision. The kind of support a person needs will depend on their circumstances. It may include: • Using a different form of communication (such as non-verbal communication). • Providing information in a more accessible form (such as photographs, drawing or other visual aids). • Treating a medical condition which may affect a person's capacity. • Having a structured programme to improve a person's capacity to make particular decisions. This principle aims to stop people being automatically labelled as lacking capacity to make particular decisions. If they play as big a role as possible in decision-making, this will help prevent	*People may require help to make or communicate a decision. This does not mean that they lack the capacity to make the decision.* *All possible steps must be taken to assist the person to make the decision. Where complex decisions are being taken, relating to a person's accommodation or treatment (including the giving of medication), these should be clearly described in the person's case notes, with a record of their success or failure and the reasons for this.* *Case notes must be signed and dated by the staff member concerned and should be specifically countersigned by the manager of the team/ service.*

2.0	PROCEDURE	*PRACTICE*
	unnecessary interventions in their lives.	
2.1.4	**Principle 3:** "A person is not to be treated as unable to make a decision merely because he makes an unwise decision" **(Mental Capacity Act, Section 1 (4)).** This can be one of the most difficult areas for families, carers and professionals alike. The Code of Practice (*page 24*) is clear, however: *"Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends, healthcare or social care staff are unhappy with a decision".* An unwise decision in itself may not indicate a lack of capacity. It may be a trigger for a fuller examination of the person's capacity to make a specific decision, or indeed of the information that person may need in order to come to a fully informed decision.	
2.1.5	**Principle 4:** "An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests" **(Mental Capacity Act, Section 1 (5))**. To ensure best interests are addressed throughout, the Code of Practice (*pages 65-66*) identifies a series of steps that should be taken by someone who is making a decision or taking an action. These should: • Encourage the person to be involved in making the decision. • Find out the person's views, past and present wishes, feelings, beliefs or values. • Avoid discrimination on the basis of age, appearance, gender, sexuality, religion or any other distinguishable	*This concept of 'Best Interests' applies whoever is making the decision and whether it is a minor or major one. It covers all aspects of financial, personal welfare and healthcare.*

2.0	PROCEDURE	*PRACTICE*
	trait, characteristic or belief. • Assess whether the person might regain capacity – and if so, consider whether the decision can be delayed. • Consult others, where practical and appropriate. • Avoid restricting the person's rights.	*This means that both principles of 'best interests' and 'least restrictive option' need to be applied each time a decision or action is made on behalf of a person lacking capacity.*
	• Where the decision concerns life-sustaining treatment, do not be motivated in any way by a desire to bring about the person's death, through assumptions about their quality of life.	*Find out if the person has previously made an Advance Decision that is specific to some aspect of their treatment.*
2.1.6	**Principle 5:** "Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action" **(Mental Capacity Act, Section 1 (6)).** This consideration – finding the least restrictive alternative, while continuing to consider the person's best interests – includes considering whether there is a need to act or make a decision at all.	
2.1.7	**Dignity and Candour** Dignity involves an innate right to be valued and respected. The principles and values of dignity within care are enshrined into law. All adults must be afforded the right to dignity and respect when using health and	*Following investigations into allegations of abuse against residents with learning difficulties and mental health conditions the Government commissioned: 'Transforming Care – A national response to*

2.0	PROCEDURE	*PRACTICE*
	social care services. The MCA and the Human Rights Act 2000 provide opportunities for people using services and their carers and advocates to challenge a paternalistic culture where professionals decide what is best for the people in their care. The ethics and values that underpin good practice in social care, such as autonomy, privacy and dignity are at the core of human rights legislation. There are ongoing tensions between adherence to these values and the need to protect people from abuse, neglect and harm. Abiding by the **Five Principles** of the MCA is fundamental to application of the law in practice. It may be reasonable to infringe a person's human rights if the action concerned is necessary, legitimate and proportionate. From 1 April 2015 all Care Quality Commission (CQC) registered providers became required to meet 'Regulation 20: Duty of Candour'. The Regulation focusses on the terms Openness, Transparency and Candour as vital measures for ensuring care and treatment is delivered safely and compassionately. It requires disclosure, as early as reasonably practicable, of any harm occurring within the course of care or treatment. For registered services the Duty of Candour is measured against existing 'Key Lines of Enquiry' within the CQC inspection process. Those services not regulated by CQC are expected to follow best practice in adopting the same values. Promoting a duty of candour is important in relation to mental capacity. It safeguards the welfare and wellbeing of those who may lack capacity to make choice about their care and treatment. It also supports protection against decisions being made for someone where capacity is held.	*Winterbourne View Hospital: Department of Health Review Final Report' (2012). The resulting proposal for a 'Model of Care' specifies dignity as a service principle and an outcome right for service users.* *The Francis Report also led to the instigation of Regulation 20: Duty of Candour:* *"The aim of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment.* *"It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.* *"Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body."* *(Care Quality Commission - Regulation 20: Duty of candour - Information for all providers:*

2.0	**PROCEDURE**	***PRACTICE***
		NHS bodies, adult social care, primary medical and dental care, and independent healthcare - March 2015)
2.2	**Referral process for those who may lack capacity** Anyone entering into, or currently in receipt of, Adult Social Care services through Halton Borough Council may have capacity issues. It is important that all Adult Social Care staff to have an understanding of the Mental Capacity Act and are able to recognise signs and symptoms of a loss of capacity. Also that they can identify care or treatment which may be unnecessarily restrictive or controlling, which may amount to an unlawful deprivation of liberty. Before a formal capacity assessment takes place all reasonable and practicable effort should be made to ensure that the person can make the decision for themselves. The MCA CoP says that a mental capacity assessment should be undertaken by the person who knows the person best and who feels confident in completing the assessment. In practice this will be a person who, in their course of employment in an adult social care capacity, has an established helping relationship with the person who may lack capacity. It is recognised that not all adult social care staff will feel confident and competent to undertake a capacity assessment. Within Halton Borough Council, where staff feel that a capacity assessment is warranted, they can make a referral to the Social Work teams under Care Management who will facilitate the process of assessment.	*See Section 2.8 regarding learning and development opportunities.* *This may involve presenting and communicating information in different ways; supporting the person to understand the decision; and putting them at ease, including making consideration of timing and location. There may also be a requirement to defer the decision to such a time as the person feels better able to make it.* *They should always have a level of understanding of capacity to the extent that they recognise capacity issues.* *Those staff members who know the person best and work with them on a regular basis will be involved in the assessment.*

2.0	**PROCEDURE**	***PRACTICE***
		Referral should initially be made to the Practice or Principal Managers within: • *Initial Assessment Team* • *Complex Care Runcorn* • *Complex Care Widnes* • *Adults with Learning Disabilities*
2.3 **2.3.1**	**Assessing Capacity and establishing Best Interest** **Assessment – The Two-Stage Test** Prior to the MCA assessment of capacity would have involved a referral to a psychiatrist. Now capacity assessment falls within the scope of all adult health and social care. This enables earlier decision-making and more effective use of resources. Capacity assessment can be facilitated by the Social Work teams within Care Management. This is particularly relevant where: • The decision that needs to be made is complex or has serious consequences. • An assessor concludes that a person lacks capacity, but the person wishes to challenge that decision. • Family, carers and/or professionals disagree about a person's capacity. • There is a conflict of interest between the assessor and the person being assessed. • The person being assessed is expressing different views to different people. • Somebody might challenge the person's capacity to make the decision, either at the time or later. • A person may have been abused but lacks the capacity to make decisions that will protect themselves. • A person repeatedly makes decisions that could put them at risk or could result in suffering or damage.	*Appendix One shows a Mental Capacity Assessment Flow Chart.* *Assessment of capacity should be made* ***at the time of the decision to be made.*** *All assessments and decisions are to be recorded on the CareFirst6 data management system.* *Where the person is receiving services from a multi-disciplinary team it will be the person who works most closely with the subject of the assessment who conducts the assessment, provided they are skilled and confident to undertake the assessment.*

2.0	**PROCEDURE**	***PRACTICE***
	Assessment of capacity involves a two-part test (examined in greater detail below). While taking account of the Principles of the Act (Section 2.1.1-2.1.6), this essentially asks two questions: 1. 'Does the person have impairment or disturbance in the functioning of the mind or brain?' 2. Where the answer to question one is 'yes', 'can the person make the relevant decision or not?' Part two of the assessment involves the assessor applying four further 'tests' to establish whether the person can: a) Understand the information relevant to the decision; b) Retain that information; c) Use or weigh that information as part of the process of making the decision; or d) Communicate his decision (whether by talking, using sign language or any other means).	*This first part of the assessment is often called the 'diagnostic' test for capacity. The second part is the 'functional' test.* *Where the answer to question one is 'no' then the person holds capacity.*
2.3.2	**Part 1: Establishing whether a person has either a temporary or permanent impairment of, or disturbance in the functioning of, their mind or brain.** Without this proof a person will not lack capacity under the terms of the MCA. The CoP (Page 44) gives examples of impairments or disturbances in the functioning of the brain or mind: • Conditions associated with some mental illnesses • Dementia • Significant learning disabilities • The long-term effects of brain damage • Physical or mental conditions leading to confusion, drowsiness or loss of consciousness • Delirium • Concussion	

2.0	PROCEDURE	*PRACTICE*
	• The symptoms of alcohol or drug use It should be stressed, though, that the issue is not the person's diagnosis, but their capacity to make a decision about a specific issue.	
2.3.3	**Part 2: Establishing whether the impairment or disturbance means that the person cannot make a specific decision when they need to.** As is clear from earlier sections, all possible and appropriate help and support must first be given to assist the person in making the decision. Part 2 only applies if all of this support has failed. This part involves four additional 'tests', the first three of which should be applied together – if a person cannot do any of these things they will be treated as unable to make a decision. The fourth can only apply to those people who cannot communicate their decisions in any way.	*Such a situation is uncommon and generally means the individual is unconscious, in a coma or has 'locked-in syndrome' where they are conscious but cannot move or speak at all.*
2.3.4	**Test 1: Understanding Information** No assessment of understanding should take place without being sure that the relevant information has been provided and in such a way that is most appropriate to helping the person to understand. This will be different to each person, should be tailored to their individual needs and documented appropriately. Communication (and documentation) must include: • The nature of the decision • The reason why the decision is needed • The likely consequences of making a decision or not making a decision	
2.3.5	**Test 2: Retaining Information** The information must stay in a person's mind long enough for them to be able to use it to make a valid decision. However, even if people can only retain information for a short time they should not automatically be assumed to lack capacity. Again it will depend on the decision in question and the tools that can be used to support a person.	*On asking the same questions after five minutes consistent responses should be given.*

2.0	PROCEDURE	*PRACTICE*
2.3.6	**Test 3: Using and weighing up information** It is not just enough to be able to understand or retain information – a person must also be able to consider it to form an effective judgement, including an understanding of the consequences of the decision.	
2.3.7	**Test 4: Inability to communicate** A complete inability to communicate is rare. However, in these circumstances the MCA is clear that a person should be treated as if they are unable to make that decision. As with other aspects of capacity, all attempts should be made (and documented in the case file) to help the person to communicate.	
2.3.8	**Best Interest** A decision may be made on behalf of a person who has been assessed as lacking the capacity, provided it is in their 'best interest'. The MCA enshrines good practice into law. It encompasses a process to follow that enables those working with a person who lacks capacity to gather evidence and arrive at a decision which has taken account of all the circumstances, one which reflects the person's wishes and is taken in their best interest. Chapter 5 of the CoP sets out a Best Interest Checklist. Health and Social Care staff are involved in a variety of decisions for people who may lack or have difficult with capacity. Such decisions can vary along a continuum from simple or information such as 'what to wear and what to eat…' to complex and high-risk decisions involving 'serious medical treatment, adult protection, mental health and deprivation of liberty…' It is therefore important to identify the appropriate individual to make the decision and the level of decision-	*The CoP states that: "The term 'best interests' is not actually defined in the Act. This is because so many different types of decisions and actions are covered by the Act and so many different people and circumstances are affected by it."* *Appendix Two shows a Best Interests Flow Chart*

2.0	PROCEDURE	*PRACTICE*
	making that is required at the earliest stage possible. This will ensure that the level of professional involvement and any relevant safeguards match the importance of the decision to be made. In all cases the decision-maker must consult with 'relevant others' – including those with lasting power of attorney, IMCAs, carers, family members. Some decisions may require a 'Best Interest Meeting' to be convened. This is to ensure that all views are taken into account, for example, where someone has lasting power of attorney, where an IMCA is involved or where there needs to be a multi-agency approach to the decision or action being taken. This allows for all relevant information to be presented and the person's wishes, feeling, values and beliefs to be explored as part of the decision-making process.	*Halton Borough Council may convene such a meeting on behalf of a person lacking capacity, or may be invited to such a meeting as a partner agency.*
2.3.9	**Levels of decision-making** **Informal or simple:** These are decisions involving a person's daily routine. For example, where to go, what to wear, what to eat, what to buy. **Decision-maker** – the person's direct carer in consultation with family, friends and/or relevant others. **Recording procedures** – A brief note included in case notes and/or care plan. Record whichever decisions (if any) the person can make for themselves and what is known about their preferences (food, clothes, etc.) **Significant or formal:** These are long-term decisions such as care planning/review or decisions in relation to serious or long-term treatment. Care reviews held within a residential setting should be carried out formally with capacity assessment and Best Interest plans being documented.	

2.0	**PROCEDURE**	***PRACTICE***
	Decision-maker – an allocated key worker, such as a social worker, community nurse, or other professional…in consultation with relevant others (staff, family, friends, relevant others). Consideration should be given to instruction of IMCA services (if no other relevant person is identifiable). Also on whether to hold a best interest meeting to consult all parties. **Recording procedures** – In-line with Halton Borough Council policies care management data should be recorded on CareFirst6. **Complex or high risk:** This may include decisions involving long-term accommodation or serious medical treatment. Decisions where risks are high could be those around adult protection, and/or cases involving an 'Urgent Authorisation' for a Deprivation of Liberty. There may be a lack of consensus between those involved in the decision-making that requires a more formal approach to be taken to assessment, consultation and recording. Frequently the opinion of more than one professional will be involved and care-planning decisions will generally be within a multi-disciplinary context. **Decision-maker** – Allocated key worker, social worker, social care or health manager, doctor as part of a multi-disciplinary team and including a Best Interest Assessor and legal advisor if needed. **Recording procedures** – as above in significant/formal decisions. Additional reports, second opinions, legal advice may be required. Include a safeguarding plan if needed.	
2.4	**Local Governance Arrangements, Data Management and Performance Measures** As far as practicably possible all policies and procedures for the MCA and DoLS have been aligned to ensure that systems of delivery are consistent.	

2.0	PROCEDURE	*PRACTICE*
2.4.1	**MCA Steering Group** An MCA Steering Group, formed in 2006, meets twice a year, to focus on local delivery of the Act. The group has representation from: • Council services across Adult Social Care • Halton Borough Council Legal Services • NHS Halton and St Helens • The residential provider sector • The Halton and Warrington NHS • The local IMCA service The agenda for the group centres on: • Development of policies and procedures • Development and implementation of effective information • Training • Development of the IMCA Service	
2.4.2	**CareFirst6** Care records (adults and children's social services) are kept by Halton Borough Council on the data management system CareFirst6. Interactions and contact with service users should be appropriately recorded on CareFirst6. This includes keeping records on any assessments of capacity and best interest decisions made.	*Appendix Three and Four sets out the fields for completion on CareFirst6 for Mental Capacity Assessment and for Best Interest decision-making.*
2.4.3	**Performance requirements** Application of the MCA is a statutory requirements and Halton Borough Council is monitored and measured on its performance against the legislation. Accurate documentation of assessments, decisions and actions is vital to ensure that the	*Some fields on CareFirst6 will be mandatory – these are often the data areas which*

2.0	**PROCEDURE**	***PRACTICE***
	Authority can be held accountable for its activities and contact with service users who may lack capacity. Staff should, as part of their induction, become conversant and competent in their use of the CareFirst6 data management systems.	*relate to performance data requirements.*
2.5	**IMCA Services** Under the Care Act 2014, the right to independent advocacy was extended. The duty to employ advocacy services falls under the conditions that the individual has 'substantial difficulty' in being involved and has no other 'appropriate individual' to represent or support them. Independent advocacy can be appointed to support any stage of assessment, care and support planning, during safeguarding enquiries and reviews or appeals against eligibility decisions around access to service. The role of the IMCA is different from other forms of advocacy and should be recognised as such by all health and social care organisations. Their aim is to ensure that 'all practical and appropriate support' is given to assist the individual lacking capacity to be involved as much as possible in the decision. Those who lack capacity have the right to independent advocacy where they have no one else to represent them. In some instances, Independent Mental Capacity Advocates may also be commissioned to support a carer or deferred decision-maker. IMCA services may be employed where decisions need to be made which impact significantly on the person's life. These include decisions about a change in accommodation (short or long-term); a serious medical treatment; an adult protection procedure; or a case review.	*As stated in Section 1.7.14.* *The role of the IMCA can be divided into two parts:* • *The traditional advocacy role supporting and representing a person's wishes and feelings so that they are fully taken into account; and* • *The role of providing assistance for challenging the decision-maker when the person lacking capacity has no one else to do this on their behalf.*
2.5.1	An IMCA will establish contact with the person deemed to lack capacity to help support the decision-making process. They will take action to	***An IMCA does not make decisions or assess capacity. They provide advice, assistance and***

2.0	**PROCEDURE**	***PRACTICE***
2.5.2	help the person: • Express their wishes, feelings, beliefs and values; • Secure their rights; • Have their interests represented; • Access information and services; and • Explore choices and options IMCAs may work with service-users who have verbal communication difficulties. Where possible other means of communication should be explored, including the use of picture or signs. Occasionally no direct communication is possible, in which case the IMCA must elicit as much as possible from relevant records and other people who know or knew the person. IMCA services are paid, commissioned through the local authority or NHS. Services may be co-commissioned across a number of authorities. Each individual IMCA working for an IMCA service must be approved to undertake the role by the commissioning authority and hold relevant experience and training. The role typically involves the following: • Provide statutory advocacy. • Support and represent people who lack capacity to make decisions on specific issues. • Meet in private with the person they are supporting. • Access relevant health and social care records. • Provide support and representation, specifically while the decision is being made. • Act quickly, so that their report forms part of the decision-making. • Obtain and evaluate information.	***representation.*** *Before an IMCA is appointed they are subject to checks with the Disclosure and Barring Service (DBS).*

2.0	PROCEDURE	*PRACTICE*
	• Represent and support the person so they may participate as far as possible in any relevant decision. • Ascertain as far as possible, the person's beliefs, values, wishes and feelings. • Select alternative courses of action. • Obtain a further medical opinion, if deemed necessary. • Resolve disagreements about health care, treatment or social care. • Challenge or assist in challenging the decision-maker by using existing complaints procedures. The right to challenge applies both to decisions about lack of capacity and a person's best interests.	
2.5.3	An IMCA will also be required in the following situations where additional safeguards are important: • Decisions that may involve the provision of serious medical treatment, or the withholding or withdrawal of such treatment by the NHS, but not treatment regulated under Part 4 of the Mental Health Act. According to the MCA, NHS bodies are duty bound to instruct an IMCA when they are proposing to take a decision about 'serious medical treatment' or proposing that another organisation (a private hospital) carry out treatment on their behalf. This duty applies if, either the person lacks the capacity to make the decision themselves or there is no one (friends or family) available to consult about the decision. • Decisions (by an NHS body or Local Authority) to move a person into long-term care in a hospital (for more than 28 days) or care home (for more than 8 weeks). This applies where the accommodation or move is not a requirement of the Mental Health Act 1983. The IMCA role also applies where individuals being moved are self-funding with care being arranged by the local authority.	*An IMCA must be engaged to support the person who lacks capacity at the earliest possible stage. The only exception to this is in situations where an urgent decision is required. If this is the case, the decision-maker must involve an IMCA as soon as possible after an emergency decision is made, if:* • *The person is likely to stay in hospital for longer than 28 days; or* • *They will stay in other accommodation for longer than eight weeks.* *Where the person is detained or required to live in accommodation under the Mental Health Act, an IMCA will not be needed, since the safeguards under that Act will apply.*

2.0	PROCEDURE	*PRACTICE*
	• Decisions (by an NHS body or local LA) to move a person into a different hospital or care home. This applies where the current accommodation or move is not a requirement of the Mental Health Act 1983. Again, the IMCA role also applies where individuals being moved are self-funding with care being arranged by the local authority. • Local Authorities and NHS bodies may also involve an IMCA in a care review involving a change of accommodation. This applies where the individual has been in present accommodation for at least 13 weeks and the change in accommodation is being considered or arranged by the Local Authorities or NHS body.	
2.5.4	In undertaking this role, the IMCA will: • Be independent (impartial and objective) of the person making the decision. • Provide support for the person who lacks capacity. • Represent the person without capacity in discussions to work out whether the proposed decision is in the person's best interests. • Provide information to help work out what is in the person's best interests. • Raise questions or challenge decisions which appear not to be in the person's best interests. • Take responsibility for declaring any personal interest in a case and withdrawing from a referral to a person they have an established relationship with. Where the IMCA and the decision-maker(s) disagree, discussion and negotiation should be used to settle the disagreement. If this is not possible then the relevant complaints procedure (of the organisation employing the decision-maker) should be followed. Where no resolve can be sought the decision may be referred to the Court of Protection.	

2.0	**PROCEDURE**	***PRACTICE***
2.5.5	**IMCA – Safeguarding and Adult Protection:** Local Authorities and NHS bodies may also involve an IMCA in adult protection cases, where it is alleged the person is or has been abused by another, or is abusing or has abused another. This means that if they lack capacity, both victims and perpetrators can benefit from the support of the IMCA service**.** The involvement of an IMCA in such situations is a power rather than a duty. Local Authorities and NHS bodies which instruct an IMCA for adults at risk are legally required to give consideration to any representations made by the IMCA when making decisions concerning protective measures. Regulations allow IMCAs to make representations on any matter they feel is relevant to such decisions. For example they may raise concerns about the investigative process or the involvement of the police. IMCAs are required to produce a report for the person who instructs them. This should include representations regarding the proposed protective measures and any matters the IMCA feels are relevant.	*Where the person who instructed the IMCA is not the Safeguarding Manager (SM), SCIE recommend that a copy of the report is sent to the SM. Good practice is for the Safeguarding Manager to decide on the distribution of the report and not the IMCA. If asked for copies of the report the IMCA should direct the person to the SM.*
2.6	**The Court of Protection** The Court of Protection was created as a superior (specialist) court of record under the MCA. It has the same powers, rights, privileges and authority as the High Court. As such it can establish precedence and build up expertise in all matters related to the lack of capacity. As stated in Section 1.7.9 it was set up to deal with decision-making for adults (and some children) who may lack capacity to make decisions for themselves. It deals with decisions about finance and property but also about healthcare and personal welfare	*Prior to 2007 the Supreme Court of England and Wales dealt with matters of property and affairs of those who lacked capacity.* *Previous arrangements under the Supreme Court did not*

2.0	PROCEDURE	*PRACTICE*
	matters. It can appoint deputies to make decisions for people who lack capacity to make decisions for themselves. It is also used to decide whether an LPA (or EPA) is valid and where necessary, can remove deputies or attorneys who have failed to carry out their duties.	*deal with healthcare or personal welfare.*
2.6.1	It is expected that decisions are reached without referral to the Court, however it may be necessary to apply to the Court for: • Particularly difficult decisions. • Disagreements about capacity and best interest that cannot be resolved in any other way. • Situations which need ongoing decisions about an individual's personal welfare. • Contact issues with family where a restriction is being considered.	*Fees may be applicable to applications made to the Court of Protection.* *Application to the Court can come from any interested party, in accordance with the circumstances of the application. If a serious or major decision about treatment needs to be made then the application may come from the NHS Trust. It can also be from a family member as a means of settling a disagreement. The person being assessed can apply to the Court to challenge a decision that they lack capacity.*
	Within Halton Borough Council staff should refer matters of concern to their Divisional Manager, who will take advice from Legal Services prior to an application being made to the Court of Protection.	
	Informal discussions to resolve any disputes should always be made prior to escalation.	*Service users, carers, families and other interested parties should be made aware of Halton Borough Council's Adult Social Care Complaints Procedure as a means of resolving disputes.*
2.6.2	It will usually be necessary to refer matters to the Court relating to property and affairs (including financial matters) of a person who lacks capacity, unless: • Their only income is state benefits. • They have previously appointed a deputy as part of a LPA (or EPA).	
	The Court of Protection has powers to make decisions on specific issues such as serious	*If an individual disagrees with a ruling of the Court of*

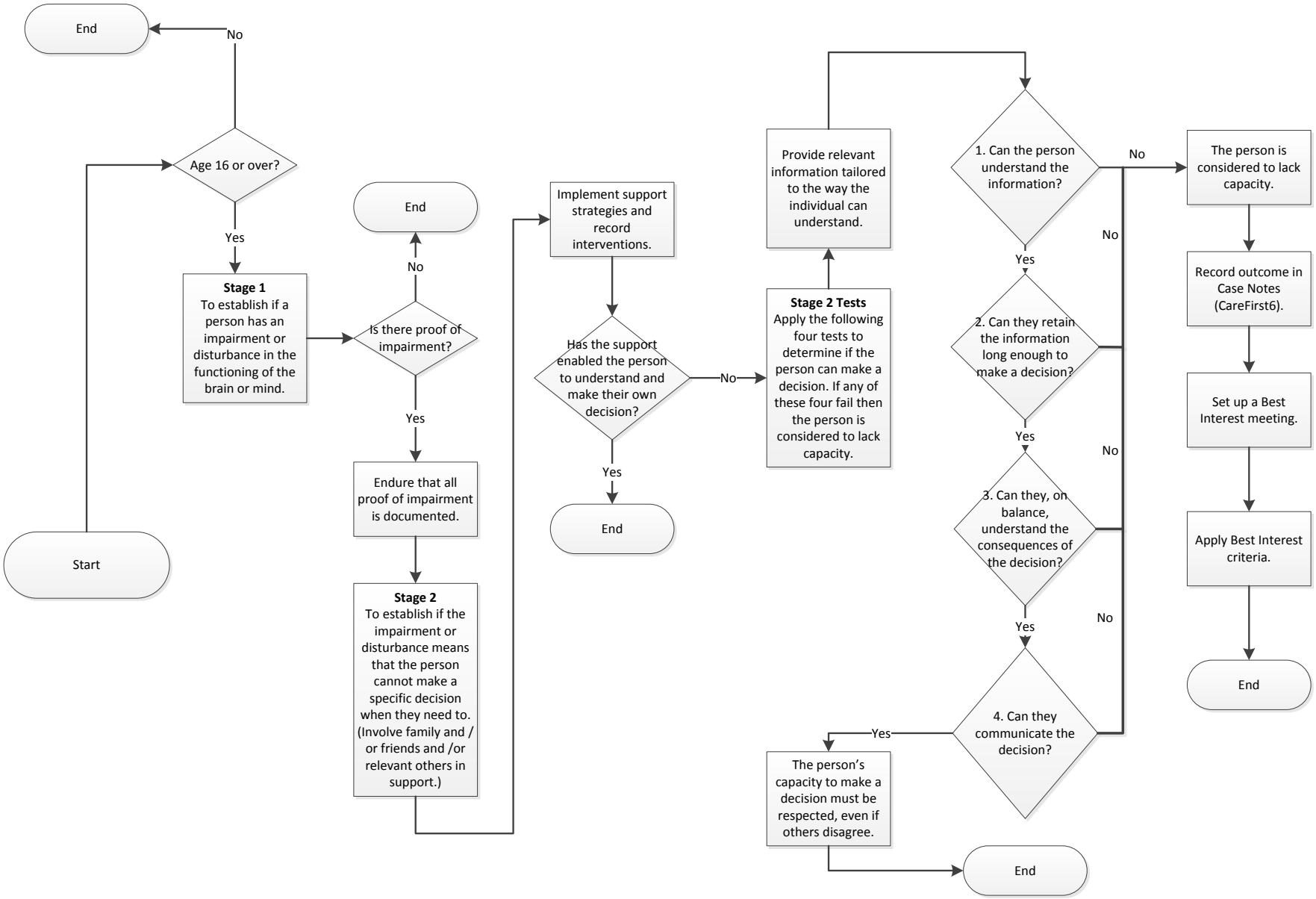
2.0	**PROCEDURE**	***PRACTICE***
	medical treatment. This includes: • Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration for people in a permanent vegetative state. • Cases involving organ or bone marrow donation by a person who lacks capacity to consent. • Cases involving non-therapeutic sterilisation of a person who lacks capacity to content to this. • All other cases where there is doubt or dispute about whether a particular treatment will be in a person's best interest.	*Protection they have the same right of appeal as they would with any High Court decision. Advice should be sought from a solicitor.*
2.7	**Supporting Carers** The Care Act 2014 provides statutory rights for carers to have their own care and support needs assessed and where eligible, provided for. This may be in situations where the carer finds the caring role has significant impact on their health or wellbeing. This right may be appropriate for those who undertake the role of attorney or guardian for a person who lacks capacity. Provision may include the right for an RPR (Relevant Person's Representative), within a DoLS arrangement, to access IMCA services in support of their role in representing the person who lacks capacity and has been deprived of their liberty.	*Carers are first point of contact would normally be through the IAT (Initial Assessment Team).* *Instigation of IMCA support for an RPR will be made via the Integrated Adult Safeguarding Unit (IASU).*
2.8	**Learning and Development Needs** All staff working in the fields of Health and Social Care should have a firm understanding of the MCA. A detailed local plan for meeting learning and development needs (in relation to MCA) has been devised with a range of training options and access points available to Council staff involved	*The Mental Capacity Act Learning Pathway (Appendix Five) has been developed to give clear direction on the*

2.0	**PROCEDURE**	***PRACTICE***
	with services users who may lack capacity. This ranges from general awareness and overview training, to much more specific issues required by those who assess capacity, to specialist training for Best Interest Assessors in DoLS arrangements.	*training requirements dependant on the level of interface with the service-user.*
2.9	**Further considerations**	
2.9.1	**Multi-agency/multi-disciplinary working**	
	The integration of health and social care was further embedded through legislative reform in the shape of the Care Act 2014. Increasingly multi-disciplinary working is being developed to assure the welfare and wellbeing of the service user in a holistic way. This requires Local Authority and NHS professionals working together, sometimes under pooled budgets or within integrated teams, to achieve defined outcomes.	
	Additionally, multi-agency working, across the public, private and voluntary sector is common-place. This allows for services to be delivered in innovative and cost-effective ways and also for greater choice for the service user.	
	Working in the best interest of the service user is paramount to multi-disciplinary and multi-agency working. Transparency of action and decision, in the form of effective and process-driven documentation, is essential to ensuring co-operation and consistency of practice.	
	Successful communication in multi-agency and multi-disciplinary working practice is also a key consideration to safeguarding. The protection of vulnerable adults, such as those who lack capacity to make decisions for themselves, is the responsibility of all agencies and organisations involved in the care and treatment of that person.	*All agencies and organisations should abide by data protection laws as well as taking account of their own policies and procedures in relation to information governance.*
2.9.2	**Fluctuating Capacity**	
	Certain conditions, illness or disability may leave a person with fluctuating, or temporary, capacity.	*Dementia poses a common dilemma in relation to*

2.0	PROCEDURE	*PRACTICE*
	This poses a difficulty for professionals involved in a person's care and treatment in ensuring that the Principles of the MCA are applied appropriately. Here, there may need to be a focus on 'decision specific' assessment of capacity. It is also permissible, where capacity fluctuates, to delay decisions, where time allows, and/or assessment of capacity. Documenting a decision made during a period of 'compos mentis', along with the person's wishes and feelings were they to lose capacity following the decision made, serves a useful purpose here. A Deprivation of Liberty Safeguard may be appropriate for someone who lacks capacity and needs to be under continuous supervision and control. However, where someone is likely regain capacity but there is evidence that they would object to admission and/or treatment the MHA needs be considered, providing they meet the criteria for detention under this Act. DoLS cannot be used if the patient is objecting to admissions and/or treatment and has the capacity to object.	*fluctuating capacity and assessment may need to be made on a decision-by-decision basis.* *Referral to the Court of Protection may be required where agreement cannot be reached in such cases.* *This may be setting specific dependant on what the admission is for and the treatment proposed.* *See also: DoLS Code of Practice.*
2.9.3	**Changes to legislation and the impact of Case Law** The reach of the MCA is immense and the balance it seeks to strike between protection and autonomy can be seen as precarious. Application of the MCA in practice presents philosophical, ethical and moral challenges which can be borne out in case law. More recently (2014) the Supreme Court judgement ("P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council") has widened the threshold for DoLS authorisation. Legislative reform to DoLS provision is currently under review by the Law Commission. The Care Act 2014 represents the most significant piece of legislative reform for adult social care in 60 years; it codifies various laws and sets out new	*This is evidence from the 'Bournewood' judgement and the subsequent incorporation of Deprivation of Liberty Safeguards in the MCA in 2009.* *Appropriate review will be made of relevant policies as required by legislative reform.*

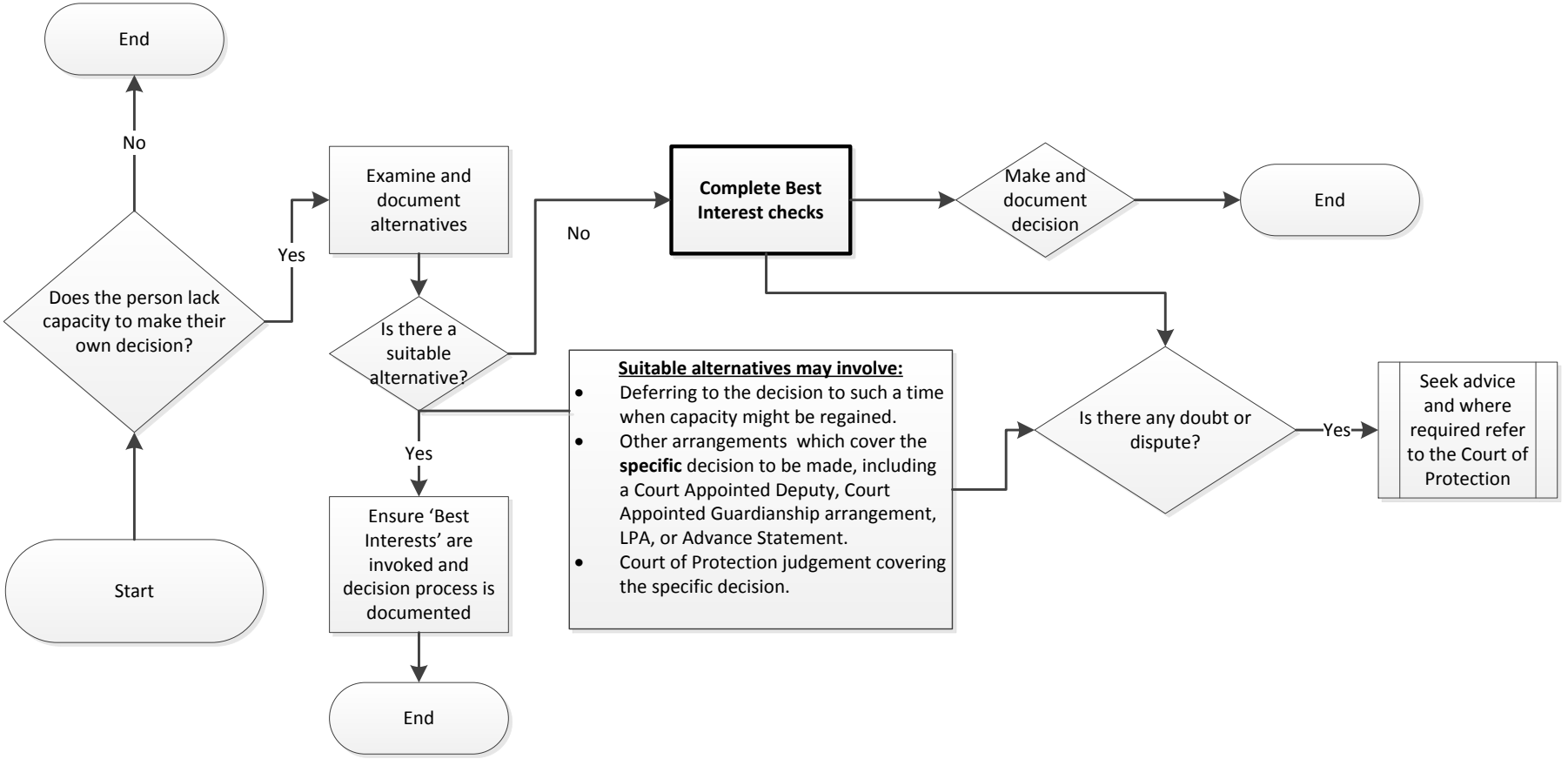
2.0	PROCEDURE	*PRACTICE*
	statutory requirements for Local Authorities. Areas which may impact on application of MCA provision and services include: • New rights for carers to be recognised in the same way as those they care for. • New safeguarding duties, guided by the principles of empowerment, prevention, proportionality, protection, partnership and accountability. • New duties to provide advocacy, including, where needed, for carers (including Relevant Person's Representatives in DoLS). • Definition and responsibility under the concept of 'ordinary residence'.	
	It is important for practitioners to remain conversant with changes to statute and judicial decisions, in the form of case law, which may impact on application of the MCA. This allows for effect, appropriate and evidence-based decision making to be applied in practice.	*This should be undertaken as part of continuing professional development (CPD) and cascaded to colleagues as appropriate.* *Major changes will be represented in policy reviews.*
2.9.4	**Limitations to the MCA** The MCA covers a range of decisions and actions which can be made or taken in a person's best interest. Where agreement cannot be reached about 'best interest' decisions may be referred to the Court of Protection. Some decisions are not included as they are considered so personal to the individual concerned, or are governed by other legislation. There are some decisions that automatically require a ruling from the Court of Protection.	*Sections 27-29 and 62 of the MCA set out the specific decisions which can never be made or actions which can never to carried out under the Act. 'Advance Decisions' may override the need to gain permissions from the Court of Protection provided they are legitimate.*

MENTAL CAPACITY ASSESSMENT FLOW CHART



APPENDIX TWO

BEST INTERESTS FLOW CHART



APPENDIX THREE

CareFirst6 Data Fields for Mental Capacity Assessment

Mental Capacity Assessment	
Form Details	
Form Start Date:	Worker Name:
Person Details	
Name:	CareFirst ID:
DoB/EDD:	Gender:
Address:	Tel No:

Important Information
Deciding that a person lacks capacity is a serious step. This pro-forma provides a means of structuring and documenting in a formal and clear way, the information required by those who are involved in assessing capacity.
Inc. staff working in health & social care (doctors, nurses, dentists, psychologists, psychiatrists, therapists, social workers, residential & care home managers, care staff, support workers) as well as carers, families, advocates & probation staff.
Assessing Capacity -- This needs to be integrated into the usual assessment procedures, care planning, reviews and monitoring. For some staff it will become part of the single assessment process (SAP).For others it may be part of reviews & monitoring
Unwise decision -- A person who has capacity can make an unwise decision. Hence, if an individual makes an unwise decision, this does not of itself indicate that they lack capacity.
Two-stage test -- The following two-stage test must be applied when assessing capacity. This pro-forma record provides the documentary evidence that it has been used.
1. Is there an impairment of, or disturbance in the functioning of the person's mind or brain? 2. If so, is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?
Please refer to Mental Capacity Act guidance. (See Mental Capacity Act guidance) Please refer to the Mental Health Act Procedures Manual.

Assessment
What is the decision?
Date(s) of previous Mental Capacity Assessment(s)
STATUS DATE CORRESPONDS TO THE DATE DECISION WAS MADE
Assigned To: Date: Activity Type: Child Visit? Child Seen Alone? Details:
Date of this Mental Capacity Assessment
STATUS DATE CORRESPONDS TO THE DATE THE DECISION WAS MADE. PROVIDE BRIEF DETAILS OF THE DECISION TO BE MADE AND THE OUTCOME OF THIS ASSESSMENT IN THE NOTES FIELD

Mental Capacity Assessment	
Name:	CareFirst ID:

Assigned To: Status: Status Date: Requested Date: Required by Date: Priority: Details:
Details of the person's Next of Kin
Relationship: Name: Address: Email: Phone: Notes:
Nearest relative (under the Mental Health Act)
Relationship: Name: Address: Email: Phone: Notes:
Details of the person with a Lasting/ Enduring Power of Attorney
Relationship: Name: Address: Email: Phone: Notes:
Details of the Independent Mental Capacity Advocate
Relationship: Name: Address: Email: Phone: Notes:

Mental Capacity Assessment	
Name:	CareFirst ID:

Details of the Court of Protection Deputy
Relationship: Name: Address: Email: Phone: Notes:
Details of the Supporting Clinician (if applicable)
Relationship: Name: Address: Email: Phone: Notes:
Details of other significant professional relationships
FOR EXAMPLE GP, CARE HOME STAFF, ETC…..
Name: Relationship: End Reason: Address: Email: Phone: Notes:

Examples of Impairment Conditions that are associated with Mental Capacity are:	
Dementia, significant learning disabilities, long term effects of brain damage, physical or mental conditions that cause confusion, drowsiness or loss of consciousness, delirium, concussion, symptoms of drug or alcohol abuse.	
In addition, there are a number of disease processes and conditions, which although temporary, can also affect capacity.	
Stage One	
Does the person have an impairment condition or disturbance in the functioning of their mind or brain?	
THE APPROPRIATE GUIDANCE SHOULD BE CONSULTED WHEN ESTABLISHING WHETHER THE PERSON HAS AN IMPAIRMENT CONDITION OR DISTURBANCE IN THE FUNCTIONING OF THEIR MIND OR BRAIN.	
If YES, provide details of all proof of impairment.	
WITHOUT PROOF A PERSON IS CONSIDERED TO HAVE CAPACITY UNDER THE ACT.	

Mental Capacity Assessment	
Name:	CareFirst ID:

If no, the assessment can be ended at this point – proceed to question 2.1.25	
Stage Two	
Obtain assistance from professionals and family members to establish that an impairment or disturbance means the person cannot make a specific decision when they need to.	
Family members and professionals can assist considerably by providing important background information. They can provide evidence to show that some temporary disease process or condition is affecting capacity.	
Such temporary infections or conditions may persist for 6 months or more, after which capacity may be regained with support.	
Provide details of those who are providing assistance and background information	
Include details of any temporary condition(s) that is affecting capacity	
Provide details of support strategies that will be implemented	
Has the implemented support worked?	
IF YES, THE PERSONS CAPACITY TO MAKE A DECISION MUST BE RESPECTED AND THE ASSESSMENT CAN BE ENDED - PROCEED TO QUESTION 2.1.25	
If NO, please provide details of why interventions / support have failed	
If support has failed then the following four tests must be carried out to determine if the person can make a decision and are crucial in demonstrating a lack of capacity.	
Information relevant to each of the tests must be tailored as far as possible to the way that the individual can understand and communicate. For example the use of pictures, signing, Braille, an interpreter.	
If any single test is failed, then the person is deemed not to have capacity.	
Test One	
Can the person understand the information relevant to the decision?	
IF NO, COMPLETE QUESTION 2.1.18 AND PROCEED TO QUESTION 2.1.25.	
Evidence of level of understanding of information relating to the decision	

Mental Capacity Assessment	
Name:	CareFirst ID:

Test Two	
Can the person retain the information?	
IT MUST STAY IN THEIR MEMORY LONG ENOUGH TO ENABLE THEM TO MAKE A VALID DECISION. IF NO, COMPLETE QUESTION 2.1.20 AND PROCEED TO QUESTION 2.1.25.	
Evidence of level of information retention concerning the decision	
Test Three	
Can the person use that information as part of the decision making process or appreciate the consequences of the decision in the sense that they can weigh its importance?	
IF NO, COMPLETE QUESTION 2.1.22 AND PROCEED TO QUESTION 2.1.25.	
Evidence of ability to weigh importance and consequences of decision	
Test Four	
Can the person communicate the decision, whether by talking, using sign language or any other means?	
ALL ATTEMPTS SHOULD BE MADE AND DOCUMENTED TO HELP THEM TO COMMUNICATE. IF NO, COMPLETE QUESTION 2.1.24 and proceed TO QUESTION 2.1.25.	
Evidence of ability to communicate decision	
Capacity Decision	
Does the person have the capacity to make the decision detailed in this document?	
If YES and the individual is found to have capacity to make a decision, then their decision must be respected and no further action is required. If NO, proceed to question 2.1.26. *THIS QUESTION IS MANDATORY*	
If capacity is found to be lacking, complete the Best Interest Decision process before deciding what is best for the person. Is a Best Interests Decision form required?	
HINT - SELECTING YES WILL ASSIGN A BEST INTEREST DECISION FORM TO YOU FOR COMPLETION	
Completion	
Completed by: Worker: Tel: Address:	Date:

APPENDIX FOUR

CareFirst6 Data Fields for Best Interest Decisions

Best Interests Decision

Form Details	
Form Start Date:	**Worker Name:**

Person Details	
Name:	**CareFirst ID:**
DoB/EDD:	**Gender:**
Address:	**Tel No:**

Important Information
This pro-forma provides a means of structuring and documenting the information required by those participating in making decisions and working in the best interests of adults lacking capacity.
This includes staff working in health and social care (doctors, nurses, dentists, psychologists, therapists, social workers, residential and care home managers, care staff, support workers) as well as carers, families and advocates.
Best Interests - When we make a decision on behalf of someone who lacks capacity, it must be the best one for that person, not us!
Least Restrictive Alternative - Different options and choices may be available. Before making the final choice all other less restrictive options for the person should be considered and where possible chosen.
The choice made should avoid placing unnecessary restrictions on the person's future opportunities, but still allow the original purpose of the decision to be made.
Please refer to Mental Capacity Act guidance. (See Mental Capacity Act guidance) Please refer to the Mental Health Act Procedures Manual. (See Mental Health Act Procedures Manual)

Best Interests Decision
What is the decision?
Date(s) of previous Mental Capacity Assessment(s)
Status date corresponds to the date the decision was made.
Assigned To: **Date:** **Activity Type:** **Child Visit?** **Child Seen Alone?** **Details:**

Best Interests Decision	
Name:	CareFirst ID:

Date(s) of previous Best Interest Decision(s)
STATUS DATE CORRESPONDS TO THE DATE THE DECISION WAS MADE.
Assigned To: **Date:** **Activity Type:** **Child Visit?** **Child Seen Alone?** **Details:**
Date of this Best Interests Decision B
STATUS DATE CORRESPONDS TO THE DATE THE DECISION WAS MADE. PROVIDE BRIEF DETAILS OF THE DECISION TO BE MADE AND OUTCOME OF THIS ASSESSMENT IN THE 'NOTES' FIELD
Assigned To: **Status:** **Status Date:** **Requested Date:** **Required by Date:** **Priority:** **Details:**
List all individuals attending the meeting and their current position:

	Name	**Position**	**Contact Number**	**Role/ Relation to Service User**
1				
2				
3				
4				
5				
6				

If the matrix above is full please continue in the text box below
If a person demonstrably retains capacity then their decision must be respected. If they lack capacity then evidence must be provided.
Provide details of the evidence gathered

Best Interests Decision	
Name:	CareFirst ID:

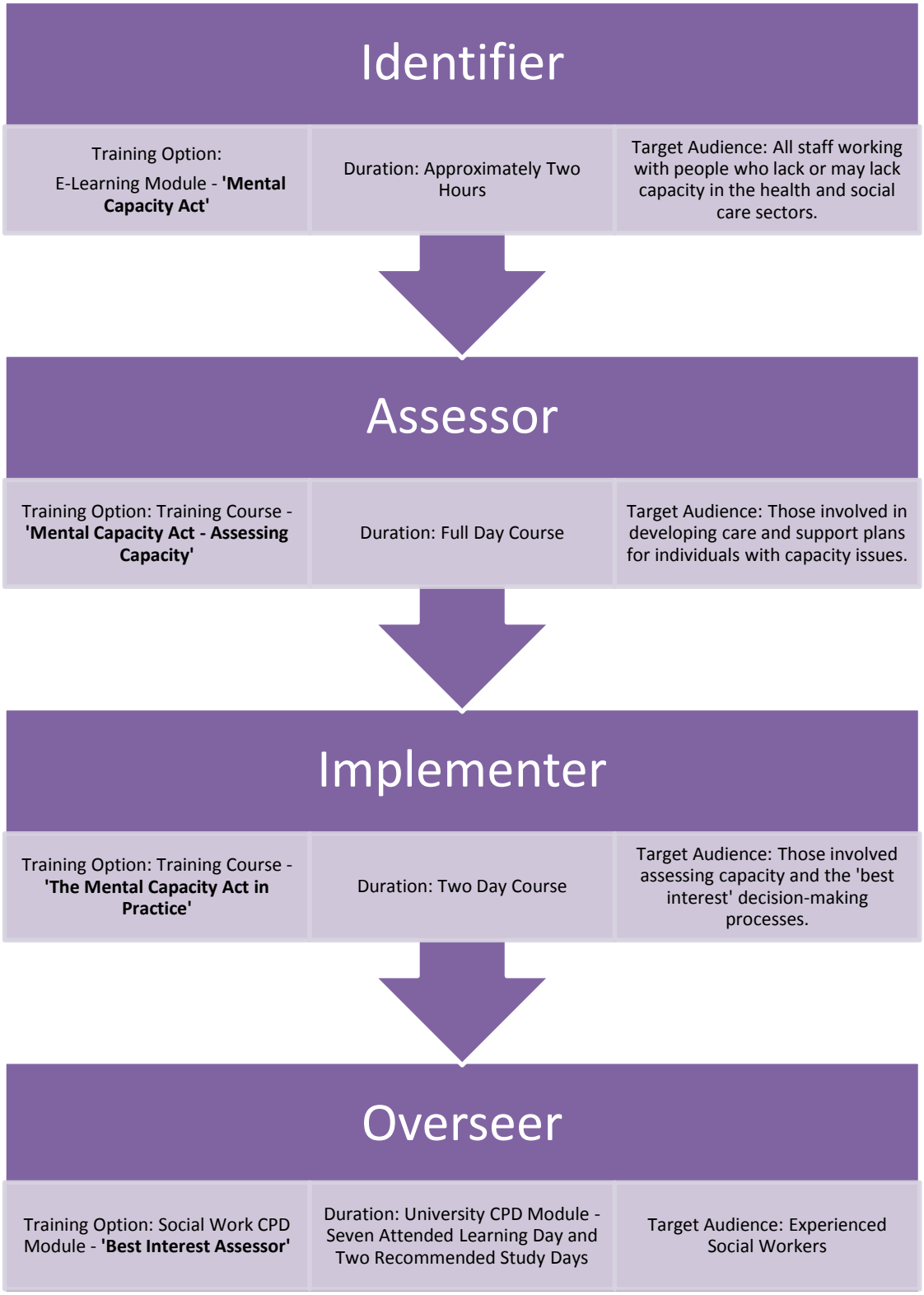
Provide evidence that potential alternatives to the decision to be made have been thoroughly examined and appropriately documented. If a suitable alternative is found this should be identified as such. If no alternative then go to 2.1.9.	
PROVIDE DETAILS OF THE LEAST RESTRICTIVE OPTIONS BELOW	
If the text box above is full please continue in the text box below	
Identify a suitable individual who is both willing and able to be consulted on behalf of the person. If no one suitable can be found from among friends and family then contact the Independent Mental Capacity Advocacy (IMCA) service, go to 2.1.10	
PROVIDE THEIR NAME AND CONTACT DETAILS BELOW	
Are there any arrangements with the Court of Protection (COP), relating to the decision? COP now cover issues of health and wellbeing, in addition to accommodation and finance.	
IF THERE IS, PLEASE FOLLOW COP GUIDANCE. IF NO SUCH ARRANGEMENTS IN PLACE, PLEASE GO TO 2.1.11 BELOW.	
Is the decision connected to the care and treatment of the person?	
IF NO, THEN SEEK ADVICE FROM THE PUBLIC GUARDIAN AND PROCEED TO QUESTION 2.1.16. IF YES, PROCEED TO QUESTION 2.1.12 AND CHECK FOR EVIDENCE OF AN ADVANCE STATEMENT (ALSO KNOWN AS: LIVING WILL, ADVANCE DECISION OR ADVANCE DIRECTIVE).	
Details of Advance Statement	
IF THERE IS NO RELEVANT ADVANCE STATEMENT, PLEASE CHECK IF THERE IS A LASTING POWER OF ATTORNEY AND PROCEED TO QUESTION 2.1.17.	
Is the Advance Statement in agreement with clinical judgement?	
If YES, please provide evidence below	
If NO, proceed to question 2.1.18 and complete 'Best Interest Checks'	
If YES to 2.1.13, are there any doubts about the Advance Statement?	
IF YES, PLEASE COMPLETE THE 'BEST INTERESTS CHECKS' - 2.1.8. IF NO, THEN THE ADVANCE DIRECTIVE THAT HAS BEEN MADE WHILE THE INDIVIDUAL WAS CAPABLE, IS LEGALLY BINDING.	
Is a decision needed from the COP?	
IF YES, PLEASE FOLLOW COP GUIDANCE AND END. IF NO, PROCEED TO QUESTION 2.1.17.	
Has a Lasting Power of Attorney (LPA) been identified?	
IF YES, THEN REFER TO INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) AND GO TO 'BEST INTEREST CHECKS' - QUESTION 2.1.18. IF NO, PROCEED DIRECTLY TO 'BEST INTEREST CHECKS' QUESTION 2.1.18.	

Best Interests Decision	
Name:	CareFirst ID:

Best Interest Checks	
Describe how the individual has been encouraged to participate	
Document the person's views and wishes	
Is capacity likely to be regained?	
PLEASE NOTE THAT 'N/A' STANDS FOR 'NOT ANSWERED' NOT 'NOT APPLICABLE'	
If YES, please provide details and document decision to delay	
If capacity is NOT likely to be regained, give details and list all individuals who have been consulted about the person's welfare	
Make a decision in the best interests of the person, using the least restrictive options available. Always encourage the person to participate - avoid restricting their rights and do not make assumptions about their quality of life.	
Document any information that may contribute to the person's Best Interests and any possible conflicts of interest	
Provide details of the decision that has been made and its likely outcome	
Will a further Best Interests Decision form need to be completed?	
HINT - SELECTING YES WILL GENERATE A BEST INTEREST DECISION FOR	
Completion	
Completed By: **Worker:** **Tel:** **Address:**	**Date:**

APPENDIX FIVE

Mental Capacity Act – Learning Pathway for Adult Social Care Staff



Identifier

E-learning chapters:

- Supporting people to make their own decisions
- Making day-to-day decisions about care and support
- Best Interest Decisions about day-to-day care and support
- Making more complex decisions
- More complex Best Interest Decision-making
- What to do when there is a disagreement
- Planning for the future
- A guide to the Deprivation of Liberty Safeguards
- Interface between the MCA and MHA

Accessing the Learning: The Council e-learning platform is situated on the 'Enable – Learning Pool' site which accessed through the intranet or via the Council's internet site. Contact Learning and Development regarding any access issues.

Assessor

Course objectives:

- To recognise the guiding principles of the Mental Capacity Act and understand why it is required
- To revisit the concept of 'duty of care' and how it relates to the Mental Capacity Act 2005, and Code of Practice
- To better appreciate person-centred care, and the need to deliver consistent and coherent, services which respect and protect Human Rights
- To be aware of the Agency documentation, check list, and to identify the relevant knowledge and skills required for assessing Best Interests decisions, in complex situations of competing demand
- To pinpoint the interface between the Mental Capacity Act 2005 and the Mental Health Act 2007
- To better develop strategies and skills in assessing and testing capacity, and ethical recording with the use of the agency pro forma

Accessing the Learning: This training course is available on the 'Corporate Learning and Development Calendar' and can be identified as a learning need in supervision discussions or as part of the EDR process. Where course dates are not available please contact Learning and Development.

Implementer

Course objectives:

- To examine capacity assessments in practice, considering when to assess, how to assess and what outcomes this will result in
- To take part in simulation assessment opportunities in a safe and developmental environment
- To explore the recording and reporting requirements involved in assessing capacity
- To be skilled in supporting people to make their own decisions, and recognising the IMCA role
- To recognise and response appropriately and with sensitivity to advance refusals and lasting powers of attorney
- To gain confidence in dispute resolutions skills resulting from conflict within the MCA process
- To understand the process and need for apply for Deprivation of Liberty Safeguards

Accessing the Learning: This training course is available on the 'Corporate Learning and Development Calendar' and can be identified as a learning need in supervision discussions or as part of the EDR process. Where course dates are not available please contact Learning and Development.

Overseer

Module Content:

The training will equip practitioners with the knowledge and skills necessary to undertake the role of the Best Interests Assessor under the Deprivation of Liberty Safeguards. The module teaching is underpinned by the key principles of the Mental Capacity Act 2005. It will also focus on human rights issues, and enable practitioners to develop their decision making skills in a range of complex practice situations.

Day	University Sessions
1	Introduction to the module and University systems Introduction to the Deprivation of Liberty Safeguards Human Rights Legislation
2	Mental Health Legislation ***Please note –AMHPs are not required to attend this session***
3	Mental Capacity Act 2005 and MCA Code of Practice Assessing capacity and best interests decision-making
4	DOLS Framework and Authorisation Process
5	Role and responsibilities of the Best Interests Assessor under DOLS Case Law
6	Practice Scenarios and documentation Input from practitioners
7	Case Scenarios and Assignment workshop

Accessing the Learning: This module is open to 'Experienced Social Workers', as set out in the 'Adult Social Care Social Work Progression Policy'. Applications should be made, in the first instance, through line management.

APPENDIX SIX

Quick Guide to: The Mental Capacity Act

The 5 Principles of the Mental Capacity Act:

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing capacity involves a two-stage test:

1. 'Does the person have impairment or a disturbance in the functioning of the mind or brain?'
2. 'Can the person make the relevant decision or not?' This is established by whether they can:
    a. Understand the information relevant to the decision,
    b. Retain that information,
    c. Use or weigh that information as part of the process of making the decision, or
    d. Communicate his decision (whether by talking, using sign language or any other means).

Where a lack of capacity is established **'Best Interest'** decisions may be made on behalf of a person. Best Interest involves consideration of all relevant circumstances, every possible and practicable effort to involve the person in the decision, taking account of the person's wishes and feelings, their values and beliefs, and consulting with their family, friends or relevant others.

Prior to losing capacity a person may appoint a deputy, under a **Lasting Power of Attorney**, to act on their behalf should they subsequently lose capacity.

Dispute about any decisions can be referred to the **Court of Protection** where no resolve can be reached informally.

A **Deprivation of Liberty Safeguard** arrangement may be made where a person lacks capacity to make decisions for themselves and it is in their best interest to detain them or make them subject to constant supervision and control. Deprivation of Liberty Safeguard can only be made according to well-defined processes.

A person suffering a mental health disorder may be detained under the **Mental Health Act** where it is in the interest of their own health and safety or with a view to the protection of others.

REPORT TO: Health Policy & Performance Board

DATE: 20th September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 1 2016/17

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 1 of 2016/17. This includes a description of factors which are affecting the service.

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

i) Receive the Quarter 1 Priority Based report

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

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

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 1, 2016/17.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no Equality and Diversity issues relating to this Report.

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

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 1: 1st April to 30th June 2016

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the first quarter of 2016/17 for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Adult Social Care (including housing operational areas)
- Public Health

2.0 Key Developments

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

Adult Social Care

Mental Health Services:

Review of the 5Boroughs Acute Care Pathway and Later Life and Memory Services: work continues across the mental health services in Halton to deliver the changes recommended by this review, which reported early in 2016. Two local workstreams are in place within the Borough; one is examining the pathways by which people can receive help and support at an early stage in the development of a mental health problem, whilst the other is developing clear pathways for people to "step down" from secondary care to primary care services. A third area of work is taking place across the whole of the 5Boroughs footprint, looking at developing a consistent approach to delivering care to people with personality disorders and complex and challenging lifestyles.

Direct Payments in Mental Health: people with mental health problems have for some time been one of the groups with the lowest uptake of direct payments, both within the borough and nationally. Following an internal review of this issue in Halton in 2015, Halton Disability Partnership has been commissioned to provide a small scale support service to people with mental health needs who might wish to take up the opportunity for a direct payment. Working with mental health services to raise awareness, and working with individuals with mental health needs to take up a direct payment, this has resulted in a small but significant increase of people using this service (from 23 to 31 people). Further work on redesign of the care pathways (see above) is expected to lead to a further increase in these figures.

Homelessness

Halton commissioned a supported hostel Brennan Lodge, which officially opened July 2015. The scheme offers 39 self-contained units for single vulnerable homelessness clients. The building is owned by Halton Housing Trust and the Salvation Army were commissioned to deliver the housing management support. Unfortunately, in November 2015 a number of management/safeguarding issues were identified, which, led to the service being suspended. A number of quality inspections were completed, however,

there was little improvement in the service delivery, and consequently, the decision to terminate the Salvation Army contract was approved.
The Salvation Army have been notified of the above decision and the contractual 3 month notice has been issued. Due to the demand for the supported housing scheme, the service will be re-procured. The procurement process is underway and it is anticipated that the new provider will take over the service by January 2017.

Peer Review
As part of the Gold Standard the Merseyside Sub Regional Homeless group registered for the peer review. Halton was due to be reviewed by St Helens early September 2015, however, due to work commitments; the reviewing Authority was forced to cancel. Halton is keen to progress with the Peer Review and it has been agreed that the Review will take place November 2016; the reviewing Authority is due to be confirmed.
Upon completion of the Peer Review, the Authority will then pursue registering for the Gold Standard and undertake the necessary assessment.

Syrian Vulnerable Person Resettlement Programme
Asylum seekers and refugees: in common with the other local authorities within the Liverpool City Region, Halton has made a commitment to participating in the asylum seeker and refugee dispersal programme, and to supporting a proportionate number of Syrian refugees through the Syrian Vulnerable Persons Resettlement scheme. The asylum seeker scheme is managed through a Home Office-appointed body, Serco. The Syrian refugee scheme is led by local authorities, working with its key strategic partners. A multi-agency forum is in place, to ensure a collective Halton response so that people new to this area receive a positive welcome and a smooth integration into local communities and services.

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

- The team are looking at implementing the Equalities Health Framework. This is a tool that is based on the determinants of health inequalities designed to help providers and people with Learning Disabilities understand the impact and effectiveness of services
- Meetings have been held with a number of GP practices across Halton to discuss Learning Disability Health Checks. Within the meetings, support from the Learning Disability nursing Team was discussed and how to attain greater attendance and completion of the Health Checks.
- A number of team members have recently attended training as part of transforming care. This training was to enable team members to take on the role of Clinical Advisor within CTR (Care and Treatment Review) meetings.
- A team member has been attending meetings regarding transforming care/risk register and to look at how the Nursing team will be part of this.
- Sexual health and Relationship work is a large part of the work that the team complete. The team are looking into attending a 4 or 5 day course run by the Family Planning Association in the near future to build on the knowledge within the team.
- Transition support has been offered as part of a multi professional approach to ensure the smooth transition to adult services for the young person and their family.

- Regular monitoring of patients discharged from the inpatient ward is undertaken by team members, in line with good practice, to ensure they settle in their new setting.
- Breast and testicular awareness sessions have been facilitated by the Nursing Team recently at the stadium in Widnes. The sessions proved to have a positive learning experience for the clients that attended.
- The team has recently been involved in a MDT meeting that has prevented the admission of a client to an in-patient unit.

There has been an admission to Byron unit and the team have attended CTR and MDT meetings for this client. The team continue to visit Byron on a regular basis and are part of an MDT approach to find the most suitable placement for this client.

Domiciliary Care

Significant consultation work has taken place to find the views of people who use domiciliary care in the borough. This information will go towards supporting the design of a new delivery model and will also form the detail for applying for external funding towards the end of 2016.

PUBLIC HEALTH

Mental Health Awareness week

Mental health awareness week in May was turned in to a Month across Haltin with a vacant unit within Runcorn Shopping Centre being transformed into a pop up shop which played host to a number of local services, signposting and music dance and a place to chat and find out. The Shop focussed on a different theme each week: general mental health; children and young people; dementia; and carers. The first week saw a footfall of 829 and an average of 250 a week for the remaining weeks. The services identified and intervened in 3 cases of crisis.

The programme was deemed a success and we are looking to identify is this is something that could be replicated or completed. It was recognise that it would be helpful to have more clinical services available amongst the relaxed signposting.

Caring Pub Launch

Halton Launched the Caring Pub Declaration a good practice guide for licensed premises, developed by Halton Borough Council in partnership with Cheshire Police and the local Pub and Club Watch. Pubs and clubs in Halton are pledging to help their customers stay safe and healthy.

The Declaration outlines the steps the pub will take to keep customers safe and healthy while visiting their premises, such as not selling alcohol to customers who have drunk too much and asking regulars to look out for older or more vulnerable customers so they arrive home safely. Many licensed premises in Halton have signed up to the Declaration, with more to follow, and are displaying it prominently to their customers.

Halton Community Alcohol Partnerships Launch

The Halton Community Alcohol Partnership (CAP) will raise awareness of the impact underage drinking has on the local community and reduce young people's access to alcohol by building on existing work already undertaken locally. The initiative sees Halton Borough Council, local services and businesses working together. An action plan of activities will aim to bring about sustainable improvements through education, intelligence-led enforcement and offering positive alternatives to young people that promote a healthy lifestyle.

3.0 Emerging Issues

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

Adult Social Care

Mental Health Services:

Social Work for Better Mental Health: Halton is an early implementer of this national programme, designed to make explicit the roles and tasks of social work within the mental health delivery system. The programme has been running for some months and a self-assessment has been completed. A report and action plan will shortly be produced, which will be used as a part of local service review and design.

PUBLIC HEALTH

Continued requirement to meet efficiency targets is likely to impact upon the delivery of some key programmes in the foreseeable future.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2016/17 Directorate Business Plans.

5.0 Progress against high priority equality actions

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

6.0 Performance Overview

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

"Rate per population" vs "Percentage" to express data
Four BCF KPIs are expressed as rates per population. "Rates per population" and "percentages" are both used to compare data but each expresses the same amount in a different way. A common guide used is that if a percent is less than 0.1 then a rate (e.g. per 100,000) is used. For example, permanent admissions to residential care expressed as a rate (50 admissions per or for every 100,000 people) makes more sense when comparing performance with other authorities rather than as a percentage (0.05%) which is quite a small number and could be somewhat confusing. More examples below:

Location	Rate per 100,000 population	Percent
Region A	338.0	0.34%

Region B	170.5	0.17%
Region C	225.6	0.23%

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q1 Progress
PA 1	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21, 25) March 2016.**	✓
PA 1	Implement the Care Act **(AOF 2,4,10, 21) March 2016.**	✓

Supporting Commentary

PA 1 Monitor effectiveness of Better Care Fund pooled budget:
The final submission for the national Better Care Fund pooled budget was agreed without conditions. The revised 3 year agreement between HBC and NHS HCCG commenced in April 2016.

PA 1 Implement the Care Act:
Quarterly review continues to monitor activity in respect of the Care Act duties and responsibilities.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q1 Actual	Q1 Progress	Direction of travel
PA 2	Percentage of VAA Assessments completed within 28 days	85% (estimated - further data quality work ongoing to confirm this)	85%	18%	?	↓
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	97%	95%	83%	✓	↓
PA 11	Permanent Admissions to residential and nursing care homes per 100,000 population,65+ (ASCOF 2A1)	541.7%	Tbc	102.1%	✓	↓

Ref	Measure	15/16 Actual	16/17 Target	Q1 Actual	Q1 Progress	Direction of travel
	Better Care Fund performance metric					
PA 12	Delayed transfers of care (delayed days) from hospital per 100,000 population *Better Care Fund performance metric*	247 v target 236 (to January 2016)		419 v target 472 (to May 2016)		
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	15231 V plan 16668 (Feb 16)		3007 vs target of 2942 (YTD end May 2016)		
PA 15	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric*	685.1				
PA 16	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B1) *Better Care Fund performance metric*	63.3		N/A	N/A	N/A
PA 20	Do care and support services help to have a better quality of life? (ASC survey Q 2b) *Better Care Fund performance metric*	93.3	TBC	N/A	N/A	N/A

Supporting Commentary

PA 2 Percentage of VAA Assessments completed within 28 days:

There continues to be ongoing issues with data loading and the dates used when completing forms; we are however confident that safeguarding investigations are being completed within the 28 day timescales. The Performance Team are working closely with operational teams to rectify these issues.

PA 6a Percentage of items of equipment and adaptations delivered within 7 working days:

The direction of travel is less than that as of the same time in 15/16, this is due to missing information and should rectified for the next quarter.

PA 11 Permanent Admissions to residential and nursing care homes per 100,000 population, aged65+:
Figures for admissions to permanent residential and nursing care are based on 25 admissions at the end of Q1. This is a decreased from Q1 2015/16 which is the direction of travel we are aiming for.

PA 12 Delayed transfers of care (delayed days) from hospital per 100,000 population:
Figures up to January 2016.
This is no longer reported as days per 100,000 population, the values reported here are total number of days only. The target was comfortable met in April with just 181 days reported, however May saw 238 days. There has been a change in the predominant reason for delay and the main reason for delay is awaiting care home placement.
Target of 236 per month. Q1 419 total to May 2016 v target of 472.

PA 14 Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population:
The CCG has queried a large increase in the number of non-elective admissions witnessed at Warrington Hospital this year (+30%) this has not been seen in the number of A&E attendances and it believed that the new ambulatory care unit at Warrington hospital may be having an adverse impact on the number of non-elective admissions.

PA 15 Hospital re-admissions (within 28 days) where original admission was due to a fall, aged 65+:
Due to a change in the reporting of this we are not currently able to report re admissions on a quarterly basis. The next formal reporting will take place in April 2017. We are working to find a solution to this with CCG colleagues.

PA 16 Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services:
These figures are collected between 1st October and 31st December annually.

PA 20 Do care and support services help to have a better quality of life?:

We have exceeded the 15/16 target of 91%, in comparison to 14/15 figures, this indicator remains stable. Please note that this data has not yet been published. Publised data will be available September 2016 and may be subjec to change.

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q1 Progress
CCC 1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2016.** (AOF 4)	
CCC 1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2016.** (AOF 4)	✓
CCC 1	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2016.** (AOF 4)	✓
CCC 1	The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **Mar 2016.** (AOF 4, AOF 18)	✓

Key Performance Indicators

Supporting Commentary

CCC1 - Services / Support to children and adults with Autism:

CCC 1 Dementia Strategy:

During Q1 the Dementia Strategy Action Plan was almost completed. The outstanding actions will be carried forward and the Dementia Strategy Action Plan is scheduled for refresh during Q2.

During Q 1 the Post Diagnosis Community Pathway redesign was completed with the contract for the Prime Provider (Alzheimers Society) now in place.

Work is ongoing with the Later Life and Memory Service (LLAMS) Care Home Liaison team and primary care to undertake checks in residential homes for people who may have an undiagnosed dementia in order to maintain the local dementia diagnosis rate above 70%

During the quarter the Halton Dementia Action Alliance supported the Changing Minds campaign in Runcorn Shopping Centre, putting on a Dementia Week theme of events, stakeholder activity and information provision.

Work is onging by the Halton DAA to seek views of people living with dementia, and their carers and planning is underway for an Advanced Care Planning and end of life care event in Q 2.

HBC are supporting the Liverpool Dementia Action Alliance with the development of the

Department of Health 'Beyond the front door' research and report, by commissioners and other stakeholders contributing to the understanding of what the concept of 'home' means to people living with dementia, and how services can better support people at key transition points.

CCC 1 Mental Health:

Following the review of the Acute Care Pathway and the Later Life and Memory Services, a number of workstreams have been set up, both across the 5Boroughs and within the Halton area, to deliver the review's recommendations. The council is involved in each of these workstreams.

CCC 1 Homelessness Strategy:

The homelessness strategy 2014 – 2018 is an active document that captures future change, trends, and demands. The annual homelessness forum/consultation event is due to be held September 2016 to review the action plan, which will involve both statutory and voluntary agencies to determine the level of achievement and key priorities for next 12 months.

The main priorities identified for 2016/17 were Health and Homelessness, and Complex needs. A number of initiatives have been developed to improve the level of agency integration and service area provision. The focus will be around the key priorities, with additional emphasis placed upon achieving the objectives outlined within the St Mungo's report, which will be incorporated within the reviewed strategic action plan. The purpose of the review is to ensure that the working document is current and reflects legislative and economical change.

A Youth Strategy is also being developed to identity key service areas for young people. A consultation event was held mid-2016 and the CLG consultant is working directly with Halton to identify key objectives and good practice.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q1 Actual	Q1 Progress	Direction of travel
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	3.21	3.00	2.78	✓	↑
CCC 4	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6).	0	0	0	✓	↑
CCC 5	Number of households living in Temporary Accommodation	15	17	**5**	✓	↑

Ref	Measure	15/16 Actual	16/17 Target	Q1 Actual	Q1 Progress	Direction of travel
	(Previously NI 156, CCC 7).					

Supporting Commentary

CCC 3 Adults with mental health problems helped to live at home per 1,000 population:

This continues to be a challenging target, because a reconfiguration within the 5Boroughs reduced the numbers of people who could be counted in this cohort. The work to develop new care pathways into and out of long term care should increase the numbers however.

CCC 4 The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years:

The Authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients.

The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC 5 Number of households living in Temporary Accommodation:

Trends indicate a National and Local Increase in homelessness. This will have an impact upon future service provision, including temporary accommodation placements.

The changes in the TA process and amended accommodation provider contracts, including the mainstay assessment , has had a positive impact upon the level of placements

The Housing Solutions Team takes a proactive approach to preventing homelessness. There are established prevention measures in place and that the Housing Solutions team fully utilise, and continue to promote all service options available to clients.

The emphasis is focused on early intervention and empowerment to promote independent living and lifestyle change.

Public Health

Key Objectives / milestones

Ref	Milestones	Q1 Progress
PH 01	Work with PHE to ensure targets for HPV vaccination are	✓

	maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2016**	
PH 01	Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2016**	✓
PH 01	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2016**	✗
PH 02	Facilitate the *Early Life Stages* development which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2016**	✓
PH 02	Fully establish the Family Nurse Partnership programme **March 2016**	✓
PH 02	Facilitate the Halton Breastfeeding programme so that all mothers have access to breastfeeding-friendly premises and breastfeeding support from midwives and care support workers. Achieve UNICEF baby friendly stage 3 award **March 2016**	✓
PH 03	Development of new triage service between Rapid Access Rehabilitation Team and Falls Specialist Service. **March 2016**	✓
PH 03	New Voluntary sector pathway developed to support low-level intervention within falls in the borough. **March 2016**	✓
PH 04	Implement the Halton alcohol strategy action plan working with a range of partners in order to minimise the harm from alcohol and deliver on three interlinked outcomes: reducing alcohol-related health harms; reducing alcohol-related crime, antisocial behaviour and domestic abuse and establishing a diverse, vibrant and safe night-time economy. **March 2016**	✓
PH 04	Deliver a local education campaign to increase the awareness of the harm of drinking alcohol when pregnant or trying to conceive. **March 2016**	✓
PH 04	Hold a community conversation around alcohol – using an Inquiry approach based on the citizen's jury model of community engagement and ensure recommendations for action are acted upon by all local partners. **March 2016**	✓
PH 05	Successfully implement a new tier 2 Children and Young Peoples Emotional Health and Wellbeing Service. **March 2016**	✓
PH 05	Monitor and review the Mental Health Action plan under new Mental Health Governance structures. **March 2016**	✓
PH 05	Implementation of the Suicide Action Plan. **March 2016**	✓

Supporting Commentary

PH 01 HPV vaccinations:
No new data since last report.

Initial preliminary results show that first dose HPV vaccination are above 90% target for year, and dose 2 is already almost at target despite not being formerly reported until 2017. We will continue to engage with current school nurse providers to support high level delivery.

PH 01 Cancer Screening Programmes:
No new data since last report.
We continue to engage with all partners, to increase local uptake of cancer screening. The MOU with the Cancer Task group at PHE and Chewshire and Merseyside authorities is making progress and continues to undertake campaigns to raise awareness and attendance, including bowel screening campaigns,(in addition to local work),a nd breast screening collaborations. Other local work has iinvolved working with local pharmacies around breast screening call and recall, and making contact with people who had missed their appointment, re-engaging with them to book another screening appointment.

PH 01 Referral to treatment:
62 day breaches for referral to a cancer treatment are now being reported through the Halton System Resilience Group which includes the CCG and adult social care. Individual breaches by hospitals continue to be investigated and analysed so that the root causes for the delays can be assessed and mitigated. 62 day referral is currently below target and it is unlikely that Halton will achieve the 85% target (January 2016 data 79%). Public Health and CCG are currently working with Trusts to improve reporting and system wide assurance. A new Health and Wellbeing Cancer Action plan is being developed to address system wide issues which should help develop a system approach to reducing breaches

PH 02 Early Life Stages:
Facilitate the *Early Life Stages* development which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2016**

PH 02 Family Nurse Partnership programme:
The Health Visiting Service is delivering the additional components of the national Healthy Child Programme, including assessing the mothers emotional health at 6-8 weeks and completing and integrated developmental check at 2-21/2 , sharing the results with the early years setting to inform their assessment of the child, and services will collaboratively put in place a support package as required.

The BabyClear smoking cessation programme is underway to ensure women receive regular smoking cessation support throughout their pregnancy and all womens smoking during pregnancy is regularly monitored.

Public Health and the CCG have recruited a paediatrician, who will start working in April in the community. The aims of the pilot are to increase access to paediatric expertise within the community for families and importantly for health professionals. This will build knowledge and expertise, which has been shown elsewhere to improve patient care, and reduce attendance by families at A&E. A paediatrician has been recruited to the programme.

The CCG has invested in perinatal mental health, including training of health visitors and community staff to support mothers to bond with their baby and support mothers and fathers experiencing perinatal mental illness. Work to improve the perinatal pathway is also underway.

The report into child development in Halton has been completed and the final report is awaited.

Parent Craft
A Parentcraft programme (Your Baby and You) of 4 sessions has been designed, developed and implemented for pregnant Mums in Halton. The 4 sessions are:

- Session One : Nurturing the needs of your baby – delivered by Family Nurse Partnership
- Infant Feeding – delivered by HIT Infant Feeding Team
- Labour and Birth – delivered by Midwives
- Getting it right for you and your baby – delivered by Health visitors and Children's Centre staff

Parent Workshops

During April – June 2016, we have delivered 15 parent workshops, with a total of 81 parents attending. 12 of which were delivered in schools and the remaining 3 were delivered in nurseries

PH 02 Breastfeeding programme:

Breastfeeding support continues to be available across the borough in community and health settings. The infant feeding coordinator and children's centres are working towards achieving BFI in the children's centres.

Baby Welcome Award Data Jan – March 2016

During April – June 2016, we have renewed 132 settings and have awarded 1 new setting the Breastfeeding Friendly Award

National Breastfeeding Celebration Week in June 2016

As part of National Breastfeeding Celebration Week the focus was around the breastfeeding friendly venues with the aim of raising the profile of these instead of just focusing on the benefits of breastfeeding. We have creasted new business cards to support this (which has our contact details on for BF support as well as a QR code to access the most up to date list of BF friendly venues. We now also have an online map for families to find out where the venues are - http://hit.activehalton.co.uk/breast-feeding-venues/ which will make it easier to find venues close to where the families will be

PH 03 New triage service - Rapid Access Rehabilitation Team and Falls Specialist Service:

The triage service has been fully implemented and is showing considerable positive outcomes for individuals. A baseline review of this will be completed in October 2016.

PH 03 Voluntary sector pathway to support low-level intervention within falls:

Pathway is in place and is working well, there have been an increase in the number of referrals between organisations that has reduced waiting times for people accessing low-level services.

PH 04 Alcohol Strategy Action Plan:

Good progress continues to be made towards implementing the Halton alcohol strategy action plan. Key activity includes:

- Delivery of alcohol education within local school settings (Healthitude, R U Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Reviewing and updating the early identification and brief advice (alcohol IBA) training and resources across the lifecourse stages (pregnancy, children and young people, working age adults, older people).
- Reduce underage drinking and associated antisocial behaviour threough the launch of the Halton Community Alcohol Partnership.
- Working closely with colleagues from licensing, the community safety team, trading standards and Cheshire Police to ensure that the local licensing policy supports the alcohol harm reduction agenda, promoting more responsible approaches to the sale of alcohol e.g. theough the development of a "Caring Landlords Declaration"
- Working to influence government policy and initiatives around alcohol e.g. 50p minimum unit price for alcohol, restrictions of all alcohol marketing, public health as a fifth licensing objective.

PH 04 Education campaign around alcohol:
The 'please stop drinking mummy' FASD (Foetal Alcohol Syndrome) contiues to be promoted within the borough. The campaign has had positive feedback from both local women and midwives who have reported that it has helped them to discuss drinking habits with pregnant women.

In addition the Halton Health Improvement Team have delivered Making Every Contact Count (MECC) training to midwives, health visitors, Family Nurse Partnerships nurses and Breast Feeding Cooordinators to signpost and deliver advice on alcohol and Tobacco.

Hold a community conversation around alcohol – using an Inquiry approach based on the citizen's jury model of community engagement and ensure recommendations for action are acted upon by all local partners.

PH 04 Community conversation around alcohol:
The Inquiry group have developed recommendations for local action related to: alcohol education in schools and educating parents, alcohol licensing and promoting responsible retailing, alcohol advertising and education around alcohol especially awareness of alcohol units and recommended safe drinking levels. These were shared with local stakeholders at a well-attended launch event held in June. Local stakeholders will now support the group going forward in making these recommendations a reality. Members of the Inquiry group attended the local alcohol stratgey group to ensure their recommendations are taken forward locally.

PH 05 Children and Young People Health and Wellbeing Service:
Five Boroughs NHS trust have been jointly commissioned by the CCG and Public Health to deliver the tier 2 children and young people's mental health service. This service has now been in place since July 2015 and as well as providing the targeted mental health service, work will include mental health and wellbeing training for staff working with children and young people, such as schools, school based face-to-face work and an online counselling service.

Additional funding has been secured through the CCG for the provision of a schools liason worker and also a Youth Offender Service worker specifically to work to build capacity, knowledge and access to emotional health and wellbeing suport.

Utilising transformational monies the CCG has established a grants scheme to ensure the outcomes of the Future in Mind report can be realised in Halton. Activities funded have included: Perinatal mental health training; Youth engagement ; and the development of Apps and other technology to support this important agenda.

PH 05 Mental Health Action plan:
The action plan and activity reports from sub groups are reviewed at the Mental Health Oversight Board.

A refresh of the mental Hleath action plans, and suggested high level indicators is due to begin shortly to reflect additional strategic direction guided by the 5 year foreward view for mental health , which will be completed by October 2016

PH 05 Suicide Action Plan:
Good progress is being made towards implementing the Suicide strategy action plan. This work is being overseen by the Halton suicide prevention partnership.
Key developments include:

- Working towards Halton being a suicide safer community
  This area is developing and should be completed by early 2017
- Developing a local multi-agency suicide awareness campaign plan
  Area is in debvelopment
- Developing a local training plan to deliver suicide awareness training for community

members, local community groups and key professionals who interact with known groups at high risk of suicide

This is underway and a training package is rolled and being constantly reviewed.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q1	Current Progress	Direction of travel
PH LI 01	Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population *Published data based on calendar year, please note year for targets.*	179.8 *(2014)*	185.6 *(2015)*	169.2 *(2015)*	✓	↑
PH LI 02	A good level of child development	46% (2013/14)	56.7%	54.7% (2014/15)	N / A	↑
PH LI 03	Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition).	3237.6 *(2014/15)*	3263.9	2904.1 (Oct 14 – Sep 15)	✓	↑
PH LI 04	Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population	767.2 (2014/15)	808.4	820.4 Provisional (Q4 15/16)	✗	↓
PH LI 05	Under 18 alcohol-specific admissions Crude Rate, per 100,000 population	51.0 (12/13 to 14/15)	55.0	Annual data only	?	N / A
PH LI 06	Self-reported wellbeing: % of people with a low happiness score	12.1% (2013/14)	11.10%	11.8% (2014/15)	?	↑

Supporting Commentary

PH LI 01 Mortality from all cancers at ages under 75:
No update from previous quarter available.

PH LI 02 Child development:
No update from previous quarter available.

PH LI 03 Falls and injuries in the over 65s:

No update from previous quarter available.

PH LI 04 Alcohol related admissions:
Provisional alcohol related admission data have shown an increase since last quarter. This trend is reflected across the region and work is being undertaken via the Halton alcohol strategy to reverse this trend (as outlined in section above).

PH LI 05 Under 18 alcohol-specific admissions:
No update from previous quarter available**.**

PH LI 06 Self-reported wellbeing:
No update from previous quarter available.

APPENDIX 1 – Financial Statements

ADULT SOCIAL SERVICES & PREVENTION AND ASSESSMENT DEPARTMENT

Revenue Budget as at 30th June 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	7,694	1,833	1,805	28
Other Premises	80	14	15	(1)
Supplies & Services	342	117	113	4
Aids & Adaptations	113	9	9	0
Transport	18	2	3	(1)
Food Provision	28	4	4	0
Other Agency	23	3	0	3
	2,224	0	0	0
Transfer to Reserves				
Contribution to Complex Care Pool	17,761	2,937	2,934	3
Total Expenditure	**28,283**	**4,919**	**4,883**	**36**
Income				
Fees & Charges	-306	-77	-75	(2)
Reimbursements & Grant Income	-209	-81	-80	(1)
Transfer from Reserves	-2,464	-18	-18	0
Capital Salaries	-111	-28	-28	0
Government Grant Income	-86	-49	-49	0
Total Income	**-3,176**	**-253**	**-250**	**(3)**
Net Operational Expenditure	**25,107**	**4,666**	**4,633**	**33**
Recharges				
Premises Support	389	93	93	0
Central Support Services	1,874	441	441	0
Internal Recharge Income	-1,677	-381	-381	0
Transport Recharges	29	7	6	1
Net Total Recharges	**615**	**160**	**159**	**1**
Net Department Expenditure	**25,722**	**4,826**	**4,792**	**34**

Comments on the above figures:

In overall terms, the Net Department Expenditure for the first quarter of the financial year is £31,000 under budget profile excluding the Complex Care Pool.

Employee costs are currently showing £28,000 under budget profile. This is due to savings being made on vacancies within the department. Some of these vacancies have been advertised and have been or are expected to be filled in the coming months and therefore it is not anticipated that the same level of variance continue for the remainder of the financial year.

At this stage in the financial year, it is anticipated that spend will be to budget at year-end.

Capital Projects as at 30th June 2016

	2016-17 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Upgrade PNC (Telehealthcare Lifeline System)	100	11	11	89
Community Meals Oven	10	0	0	10
Total	**110**	**11**	**11**	**99**

Comments on the above figures:

Work is ongoing with the PNC upgrade. Hardware has been purchased and the contractor is liaising with the council to start the build. Completion is expected within the next six months.

The purchase of the Community Meals oven is expected to take place within the financial year, with spend to match the capital allocation.

COMPLEX CARE POOL

Revenue Budget as at 30th June 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	4,196	505	424	81
End of Life	192	48	57	(9)
Sub Acute	1,727	5	4	1
Urgent Care Centres	815	50	47	3
Joint Equipment Store	615	115	100	15
Contracts & SLA's	987	316	288	28
Intermediate Care Beds	596	149	178	(29)
BCF Schemes	1754	424	424	0
Adult Care:				
Residential & Nursing Care	21,387	4,270	4,005	265
Domiciliary & Supported Living	9,678	2,075	2,327	(252)
Direct Payments	5,033	1,642	1,866	(224)
Day Care	434	65	58	7
Frailty Pathway	155	0	0	0
Contingency	518	0	0	0
Total Expenditure	48,087	9,664	9,778	(114)
Income				
Residential & Nursing Income	-5,059	-777	-914	137
Community Care Income	-1,840	-283	-235	(48)
Direct Payments Income	-253	-51	-83	32
BCF	-9,491	-2,373	-2,373	0
CCG Contribution to Pool	-12,846	-3,211	-3,211	0
Other CCG income	-114	-32	-28	(4)
ILF Grant	-723	0	0	0
Total Income	-30,326	-6,727	-6,844	117
Net Department Expenditure	**17,761**	**2,937**	**2,934**	**3**

Comments on the above figures:

The overall net department budget is £3k under budget profile at the end of the first financial quarter.

Intermediate Care Services includes spend for the Therapy & Nursing Teams, Rapid Access Rehabilitation and Reablement. There are currently a few staff vacancies in this area and some contracts have been renegotiated hence the underspend.

Intermediate Care Beds includes payments for 6 extra beds. As these beds become vacant they will no longer be used in Intermediate care so spend should reduce in year.

The Adult Care budget is currently £83k over budget profile.

The total number of clients receiving a residential care package decreased by 1.9% during the first quarter of the financial year, from 592 clients in April to 581 clients in June. However, the average cost of a residential package of care increased from £557 to £561 for the same period.

The total number of clients receiving a domiciliary package of care reduced by 2.8% during the first quarter, from 807 clients in April to 785 clients in June. However, the average cost of a domiciliary care package increased from £235 to £242 in the same period.

The total number of clients receiving a Direct Payment increased 8.6% during the first quarter, from 444 clients in April to 482 clients in June. The average cost of a DP package reduced from £271 to £253 for the same period.

Work is ongoing to realign the Adult Care budget in line with projected spend.

A number of high cost packages of care are included in the forecast, including Continuing Healthcare, which continues to be a pressure. Although we are anticipating a balanced budget at year end, this could change if new high cost packages appear. Therefore, as this budget is volatile in nature, it will be closely monitored.

Capital Projects as at 30th June 2016

	2016-17 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	788	140	114	674
Stair lifts (Adaptations Initiative)	157	75	86	71
RSL Adaptations (Joint Funding)	140	50	62	78
Madeline McKenna Residential Home	450	0	0	450
Total	**1,535**	**265**	**262**	**1,273**

Comments on the above figures:

Total capital funding consists of £1,378,000 Disabled Facilities Grant (DFG) for 2016/17, and £157,000 DFG funding carried forward from 2015/16, to fund ongoing expenditure. The allocation of the funding between DFGs, Stair Lifts and RSL adaptations will be reviewed during the year, and may be reallocated between these projects depending on demand. It is anticipated, however, that total spend on these three projects can be contained within the overall capital allocation.

The £450,000 earmarked for the purchase of the Madeline McKenna residential home includes an allowance for the refurbishment of the premises. It is anticipated that the purchase will take place in the second quarter of the financial year.

COMMISSIONING & COMPLEX DEPARTMENT

Revenue Budget as at 30 June 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance to Date** (Overspend) £'000
Expenditure				
Employees	6,418	1,576	1,524	52
Other Premises	243	71	81	(10)
Supplies & Services	342	86	86	0
Other Agency Costs	618	66	66	0
Transport	187	47	37	10
Carer's Breaks	429	93	91	2
Contracts & SLAs	151	23	21	2
Emergency Duty Team	94	23	22	1
Payments To Providers	3,149	482	482	0
Total Expenditure	**11,631**	**2,467**	**2,410**	**57**
Income				
Sales & Rents Income	-198	-99	-102	3
Fees & Charges Income	-290	-41	-35	(6)
Reimbursements & Other Grant Income	-492	0	0	0
CCG Contribution To Service	-340	-75	-53	(22)
Transfer From Reserves	-1,351	0	0	0
Total Income	**-2,671**	**-215**	**-190**	**-25**
Net Operational Expenditure	**8,960**	**2,252**	**2,220**	**32**
Recharges				
Premises Support	236	59	59	0
Transport	393	98	114	(16)
Central Support Services	1,090	264	264	0
Internal Recharge Income	-649	-140	-140	0
Net Total Recharges	**1,070**	**281**	**297**	**(16)**
Net Department Expenditure	**10,030**	**2,533**	**2,517**	**16**

Comments on the above figures

Net departmental expenditure is currently £16,000 below budget profile at the end of the first quarter of the financial year.

Employee costs are currently £52,000 below budget profile. This results from savings made on vacant posts above the targeted staff savings level of £300,000. The majority of these savings are currently being made within Day Services and Mental Health Services. These posts are currently in the process of being recruited to, and it is not anticipated that the level of savings above target will continue for the remainder of the financial year.

Premises expenditure is currently running above budget profile by £10,000. This budget will be monitored carefully during the year, given that the winter months will bring additional pressures on utility costs, and remedial action will be taken if necessary to ensure a balanced budget at year-end.

Whilst there is currently spend below budget on external transport costs, this is more than offset by spend above profile on internally recharged costs for transport costs. This situation will be monitored closely during the year with the aim of preventing an overall overspend.

Income is less than anticipated at budget setting time.. Whilst the minor variances between sales and rents and fees and charges are expected to balance out by year-end. the income received from the Clinical Commissioning Group remains a concern. This income relates to Continuing Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user's care packages. The shortfall is currently projected to be £90,000 for the year.

At this stage in the financial year, it is anticipated that spend will be to budget at year-end.

Capital Projects as at 30 June 2016

Capital Expenditure	2016/17 Capital Allocation £'000	Allocation to Date £'000	Actual Spend £'000	Total Allocation Remaining £'000
ALD Bungalows	299	0	0	299
Social Care Capital Grant	356	0	0	356
Grangeway Court Refurbishment	343	172	172	171
Community Capacity Grant	57	0	0	57
Total Capital Expenditure	**1,055**	**172**	**172**	**883**

Comments on the above figures.

Building work on the ALD Bungalows is expected to be completed within the financial year, with spend to match allocation.

The Social Care Capital grant consists of funding which was received in the 2015/16 financial year, and has been earmarked for the intended reconfiguration of Bredon hostel.

Work to refurbish Grangeway Court is currently underway, and it is expected that the works will be completed in the first half of the financial year. At this stage in is anticipated that total expenditure will remain within the capital allocation.

The Community Capacity Grant allocation represents unspent grant funding from previous financial years, which is available to fund new capital projects, or augment existing capital allocations.

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 30th June 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	3,385	818	779	39
Supplies & Services	273	27	26	1
Other Agency	21	21	16	5
Contracts & SLA's	7,556	1,324	1,322	2
Total Expenditure	**11,235**	**2,190**	**2,143**	**47**
Income				
Other Fees & Charges	-57	-16	-14	(2)
Sales Income	-44	-44	-44	0
Reimbursements & Grant Income	-166	-121	-121	0
Government Grant	-10,718	0	0	0
Transfer from Reserves	-500	0	0	0
Total Income	**-11,485**	**-181**	**-179**	**(2)**
Net Operational Expenditure	**-250**	**2,009**	**1,964**	**45**
Recharges				
Premises Support	162	40	40	0
Central Support Services	592	113	113	0
Transport Recharges	18	5	4	1
Support Income	-64	0	0	0
Net Total Recharges	**708**	**158**	**157**	**0**
Net Department Expenditure	**458**	**2,167**	**2,121**	**46**

Comments on the above figures:

In overall terms, the Net Department Expenditure for the first quarter of the financial year is £46,000 under budget profile.

Employee costs are currently £39,000 under budget profile. This is due to savings being made on vacancies within both of the Environmental, Public Health & Health Protection and Public Health Divisions. Some of these vacancies have been advertised and are expected to be filled in the coming months. However if not appointed to, the current underspend will continue to increase beyond this level.

Capital Project as at 30 June 2016

Capital Expenditure	2016/17 Capital Allocation £'000	Allocation to Date £'000	Actual Spend £'000	Total Allocation Remaining £'000
Halton Recovery & Wellbeing Project	45	0	0	45
Total Capital Expenditure	**45**	**0**	**0**	**45**

Comments on the above figures.

Work is underway on the physical refurbishment of the Halton Recovery Hub in line with the grant application. The work is expected to completed during July 2016.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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