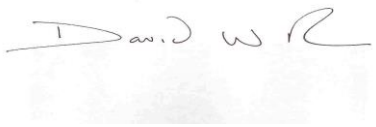
Public Document Pack

Health and Wellbeing Board

Wednesday, 5 July 2017 2.00 p.m.
The Halton Suite - Select Security Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 4 October 2017

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 29 March 2017 at Karalius Suite, Halton Stadium, Widnes

Present: Councillors T. McInerney, Polhill, Woolfall and Wright and G. Ferguson, S. Banks, E. Bragger, N. Bunce, P. Cooke, B Connell, S. Ellis, A. Fairclough, J. Fuller, T. Hill, D. King, M. Larking, E. O'Meara, C. Ogier, S. Semoff, R. Strachan, L. Taylor, S. Wallace-Bonner and A. Williamson

Apologies for Absence: M. Vasic, A. McIntyre, M. Pickup, S. Constable, D. Davies, D. Parr and S. Yeoman

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB26 MINUTES OF LAST MEETING

The Minutes of the meeting held on 18th January 2017 having been circulated were signed as a correct record.

On behalf of the Board, the Chair thanked Simon Banks, NHS Halton CCG for his contribution to the Board and wished him well in his new job.

HWB27 PRESENTATION - DEMENTIA UPDATE

The Board received a presentation from Jackie Fuller and Cheryl Ogier, both Admiral Nurse Practitioners for Five Borough's Partnership. Admiral Nurses were specialist dementia nurses who gave practical and emotional support to family carers, as well as the person with dementia. The team worked with the family carer as a primary client, providing families with the knowledge to understand the condition and its affects and the skills and tools to improve communication. They also provided emotional and psychological support to help family carers to continue to care for their family member.

The presentation provided examples of case studies, which included the outcomes, as a result of the support

provided by Admiral Nurses, for both the families and the person with dementia. In addition, Members of the Board were advised on how to access the Admiral Nurse Service.

The Board also received an update report on dementia diagnosis rates, services and priorities within Halton and future emerging issues. The dementia diagnosis rate target in Halton of 75% by March 2017 was set locally by NHS Halton Clinical Commissioning Group (CCG). In April 2016 Halton reached a diagnosis rate of 72%. Following on from this work had been carried out locally to focus efforts on improving diagnosis rates, including regular contact with GP practices by NHS Halton CCG to raise awareness of the Dementia Quality Toolkit.

On behalf of the Board, the Chair thanked the Admiral Nurse Practitioners for their informative presentation.

RESOLVED: That the report be noted.

HWB28 PRESENTATION - BOWEL CANCER SCREENING INTERVENTION

The Board considered a presentation from David King, Health Improvement Specialist – Advanced Halton Health Improvement Team, which provided an update on a research study undertaken around Bowel Cancer Screening in Halton. Bowel Cancer Screening was currently led by Public Health England but performance was monitored at local authority level. The presentation outlined details of the screening programme available every two years to all men and women aged 60 – 74 years. Currently, the Halton screening uptake was 52.2% with a North West average of 55.9% and a national average of 57.1%.

Mr King outlined to Members of the Board details on research he had undertaken to improve the Halton screening percentage across three GP practices. Through established links from health improvement work, two practices in Widnes and one in Runcorn were identified to take part in an 8 week intervention period. The intervention aimed to target non-responders to the screening invite by telephoning people once their GP practice was informed by the Regional Screening Hub. Within the three practices Health Improvement Trainers were given training to contact people who declined the original invitation. It was noted that 240 non responders were targeted and as a result of the telephone calls and an agreement with the regional screening hub, replacement kits were ordered directly from the practice. Results showed an average increase in

screening by almost 10% (9.7%) as a result of the intervention.

Members were also advised on work that had taken place to date following the research exercise. It was noted that a potential to expand the methodology across all GP practices would need extra resources to avoid an unequitable offer. To date, currently no funding had been identified to widen the offer. However, using existing resources, the practice of intervention had begun within five different GP practices for the next six months to build a business case further.

On behalf of the Board, the Chair thanked Mr King for the informative presentation.

RESOLVED: That the report be noted.

HWB29 INTEGRATED WELLNESS SERVICE ANNUAL REPORT

The Board considered a report of the Director of Public Health, which provided an update on the performance of the Integrated Wellness Service for the period January to December 2016, as detailed in the Annual Report. Halton's Integrated Wellness Service comprised Halton Health Improvement Team and Sure Start to Later Life and was an in house service within the Council. The team played a significant role in addressing the five priorities contained in Halton's Health and Wellbeing strategy (2015/2018) and worked with local clinicians and Health and Social care colleagues to deliver innovative, evidence based and measureable interventions such as breastfeeding support, stop smoking, healthy weight, falls prevention and access to low level early intervention and prevention services across the community.

It was reported that over the period the service had seen an upturn in people accessing all of the initiatives, with the service having engaged with in excess of 18,000 people across a range of programmes. Details of how the service would continue to develop and the range of initiatives proposed in 2017 were outlined in the Annual Report.

RESOLVED: That the report be noted.

HWB30 PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided an update on the Pharmaceutical Needs Assessment (PNA), including risks

associated with it and proposed local governance. The PNA was a statutory document that stated the pharmacy needs of the local population. This included dispensing services as well as public health and other services that pharmacies may provide. It was used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services.

It was proposed that the current framework developed across Merseyside would be used to produce the Halton PNA. This would ensure that, although each local authority PNA would be developed locally and differ according to the local area and population, it would continue to be in the same format which would make it easier to use and review. A Cheshire and Merseyside group of local authority PNA leads, the NHS England Pharmacy Contracts Team and representatives from the Local Pharmaceutical Committees had started to meet to discuss common elements of the PNA, both content and information gathering exercises.

The Board were asked to nominate Board level sponsors with responsibility for the PNA, with the management of the PNA being passed to the local Steering Group led by Public Health. The Steering Group would oversee the operational development and consultation for the PNA, reporting back to the Board for approval at strategic stages of the process, in line with the regulations. The next PNA must be published by the 1st April 2018.

The Board noted the financial risk associated with decisions based on information in the PNA which may open the Board up to Judicial Review.

RESOLVED: That

(1) Councillor Wright, Paul Cooke and Stuart Ellis be nominated as a Board level sponsor for the PNA;

(2) the financial risks associated with the PNA be logged through Halton Borough Council's Risk Assessment and Register process; and

(3) the establishment of a local steering group to oversee the PNA development process in line with the national regulations be noted. This group would report back to the Board on the draft before the statutory consultation began

and following this period detailing the Board's responses to feedback.

HWB31 HEALTH AND WELLBEING STRATEGY

The Board considered a final version of the One Halton Health and Wellbeing Strategy (2017/2022). The One Halton Health and Wellbeing Strategy was an overarching strategy to improve health in Halton. The new Strategy would build upon the successes of the previous strategy and outlined the key priorities which the Health and Wellbeing Board would focus on over the next five years. It had been developed using a partnership approach and was developed by a multi-agency steering group. The new Strategy provided:-

- An overview of One Halton;
- Principles of joint working;
- A joint vision, new priorities and how and why these were chosen
- An updated health and wellbeing profile for Halton;
- An outline of the progress made since 2013 and the challenges that remained;
- Examples of innovative work already being undertaken within Halton that took a place based approach, working with local people and using local assets e.g. Well North, Healthy New Towns; and
- How success would be measured.

The priorities for 2017-2022 of the One Halton Health and Wellbeing Strategy included:-

- Children and Young People: Improved levels of early child development;
- Generally Well: Increased levels of physical activity and healthy eating and reduction in harm from alcohol;
- Long term conditions: Reduction in levels of heart disease and stroke;
- Mental Health: Improved prevention, early detection and treatment;
- Cancer: Reduced level of premature death; and
- Older People: Improved quality of life.

RESOLVED: That the final version of the Strategy be approved and the development of Actions Plans for the identified priorities be supported.

Meeting ended at 3.40 p.m.

REPORT TO: Health & Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Halton Rapid Clinical Assessment Team

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To receive a presentation from Damian Nolan, Divisional Manager for Urgent Care on the development of Halton's Rapid Clinical Assessment Team (RCAT).

2.0 **RECOMMENDATION: That the Board the contents of the report and associated presentation be noted.**

3.0 **SUPPORTING INFORMATION**

3.1 Older people become unwell for a variety of complex reasons and sometimes require hospital attendance / admission for consultant led diagnostics and assessment.

3.2 Moving older people out of their home environment to hospital, particularly frail older people aged 75+, poses a number of significant issues and risks to their health and well-being including disorientation, confusion, falls, functional decline and risk of hospital acquired infection. Finding clinically suitable alternatives to hospital admission is important for this group.

3.3 The development of the RCAT service arose from an approach by a Care of the Elderly Consultant, Professor Bhowmick, to the medical team at Warrington and Halton Hospitals NHS Foundation Trust (WHHFT). Professor Bhowmick had developed, in 2 locations in Wales, a rapid assessment model for older people in the community who otherwise would be admitted to hospital for consultant assessment, diagnostics and review of non-life threatening illness.

From August 2015 to April 2016 a model was developed drawing on nursing resources in the Rapid Access and Rehabilitation Service (RARS) and Community Matrons.

3.4 The RCAT service commenced on the 4th April 2016.

GP led Primary Care Teams have the opportunity to refer to RCAT for an enhanced Rapid Clinical Assessment, including access to associated/necessary diagnostics, providing appropriate treatment to patients in their own home thus

helping to prevent hospital admissions in the frail/elderly population of Halton.

The referral criteria is as follows:-

- Age 75+. However the team are flexible and if a GP feels that a patient would benefit from an intervention irrespective of age, then they can contact the team to discuss this; and
- Not critically ill (e.g. Myocardial Infraction, stroke or severe sepsis etc.).

The service accepts referrals Monday to Friday 9am – 4pm and the aim is for the service to undertake an initial assessment within 2 hours

Access to rapid diagnostics runs through the existing access in the Urgent Care Centres (UCCs) and the departments at Halton, Warrington and Whiston hospitals.

3.5 From 4th April 2016 – 31st March 2017, 194 referrals have been made to the Service.

Of those referrals made, a total of 165 admissions where avoided during 2016/17.

For NHS Halton Clinical Commissioning Group, the average cost of an emergency attendance and admission via ambulance in 2015/16 was £2,786 (Age 75+).

Based on this figure, a total saving of £459,690 was made in hospital avoidance.

If this saving is then offset against the annual cost of the RCAT service, which is circa. £350k, then in 2016/17 a total saving of £109,690 was made.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Funding for the service is within the existing Pooled Budget between Halton Borough Council and NHS Halton Clinical Commissioning Group

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton**
The Service delivers improved access to healthcare for older adults within the community.

6.4 **A Safer Halton**
None identified

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

7.0 **RISK ANALYSIS**

7.1 The sustainability of the model moving forward remains a challenge and work is ongoing with the local Acute Trusts to explore options for securing the delivery of the service for the Borough.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no identified equality and diversity issues

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

9.1 None under the meaning of the Act.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Rapid Clinical Assessment Team (RCAT)

Mobile Medical Assessment Unit

Halton

Damian Nolan – Divisional Manager, Urgent Care

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

RCAT
The Challenge

‘I am ill. I’m in my own bed at home. Please treat me here’

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Case Study 1

D.J: 92 year old male, who lives alone, but has care provided by daughter.

Reasons for Referral

- Whilst walking at home, sudden onset of severe pain in right lower chest
- Blacked out and fell and banged head on door - Came around but had two more blackout episodes

Known Patient of

- Lymphoedema
- IHD
- Vitamin D deficiency
- Osteoporosis
- Glaucoma

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Case Study 1 (continued)

RCAT Diagnosis

- Probable PE
- Cellulitis right foot
- Postural Fall (42 mmHg)

RCAT Interventions

- ECG & Troponin – normal
- CTPA = No PE but a mass left lung
- Managed at home

Outcome on Discharge

- Recovered fully

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Case Study 2

J.H: 76 year old female, who lives with husband

Reasons for Referral

- 4 days SOB, with pain in right upper chest
- Cough; blood on two occasions
- May 2016 – Pneumonia (admitted to Hospital)
- SOB on exertion ever since

Known Patient of

- HTN
- LVSD
- Anxiety/depression
- Agoraphobia
- Gall stones

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Case Study 2 (continued)

RCAT Interventions

- Sub cut enoxaparin administered
- CTPA – next day: No Clots

RCAT Diagnosis

- Bronchogenic Carcinoma

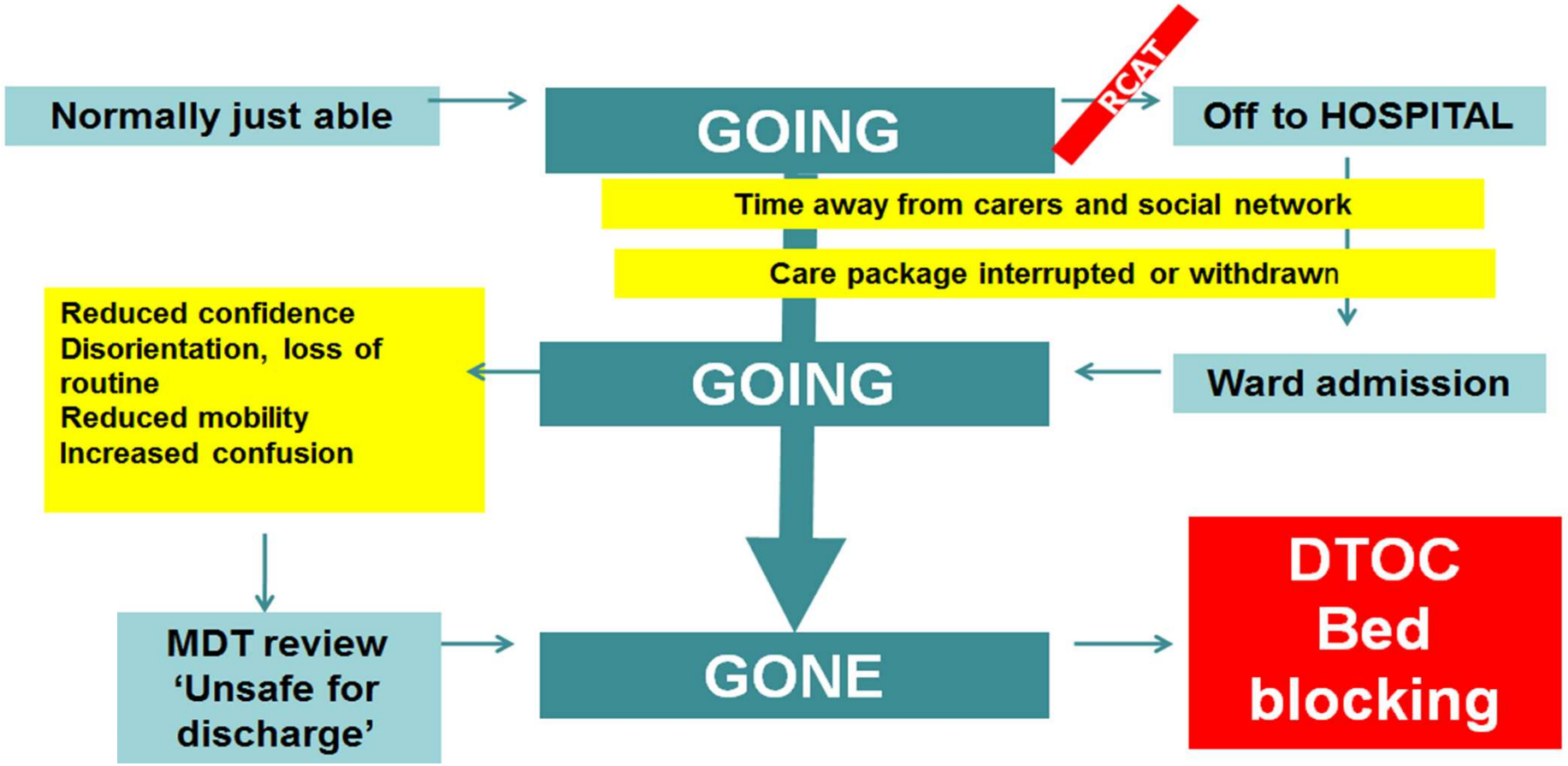
Outcome on Discharge

- Urgent referral to Respiratory Team

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

RCAT Earliest Intervention – The '3G' Syndrome



HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

RCAT

What We Did!!

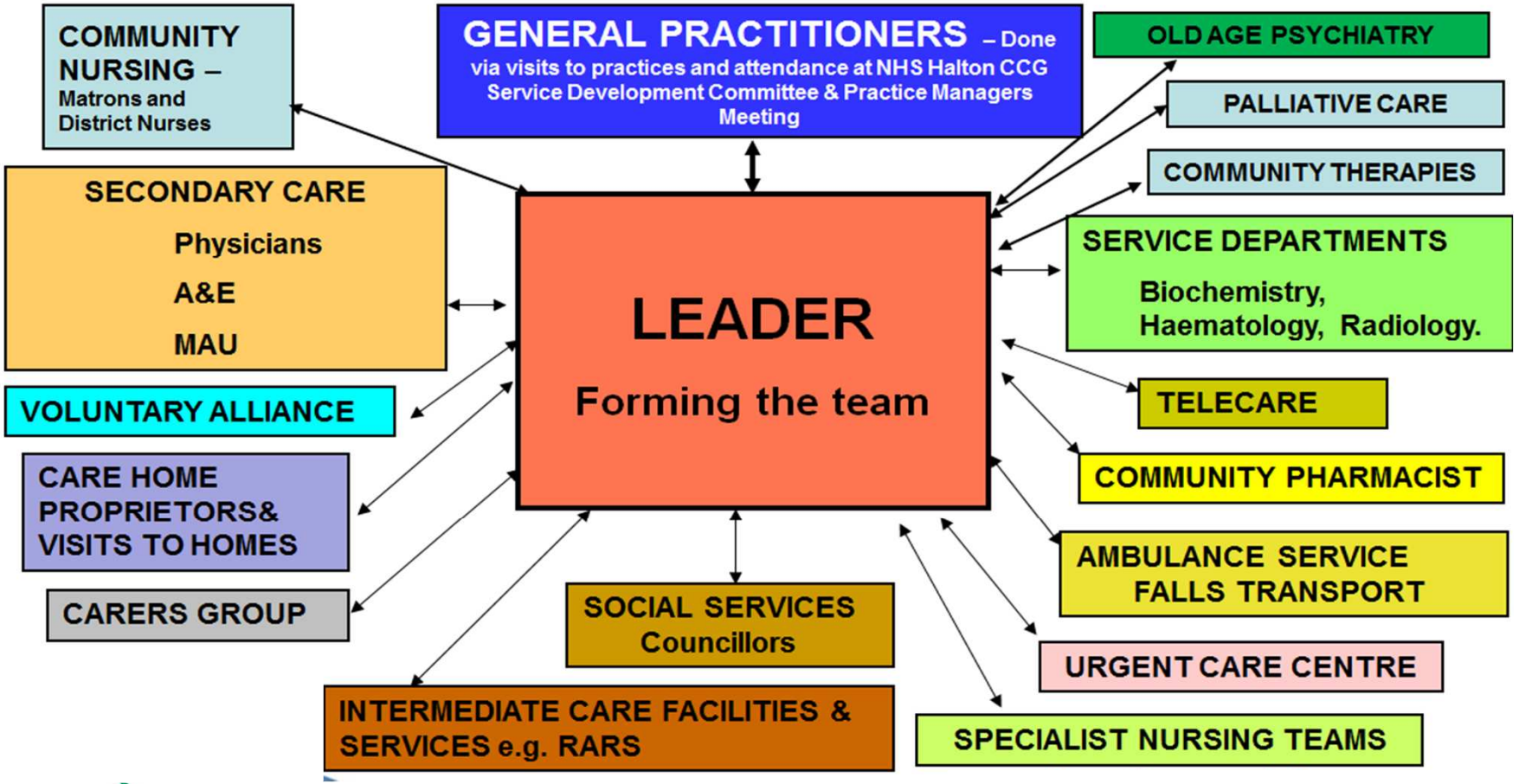
HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

How RCAT was Developed : Linking up Services



HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

RCAT: Mobile Medical Assessment Unit

VIRTUAL WARD

Resident in own home, care home or sheltered accommodation

Time Response
2 hours

Prevent Admission

Reduce DTOC

Prevent Premature Admission to Care Homes

REFERRING BODIES

GP led Primary Care Teams

Diagnostics

General Practitioner

RCAT

Nurse Assessors & Consultant

Communication between Patients and Carers

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

RCAT

Outcomes

HALTON BOROUGH COUNCIL

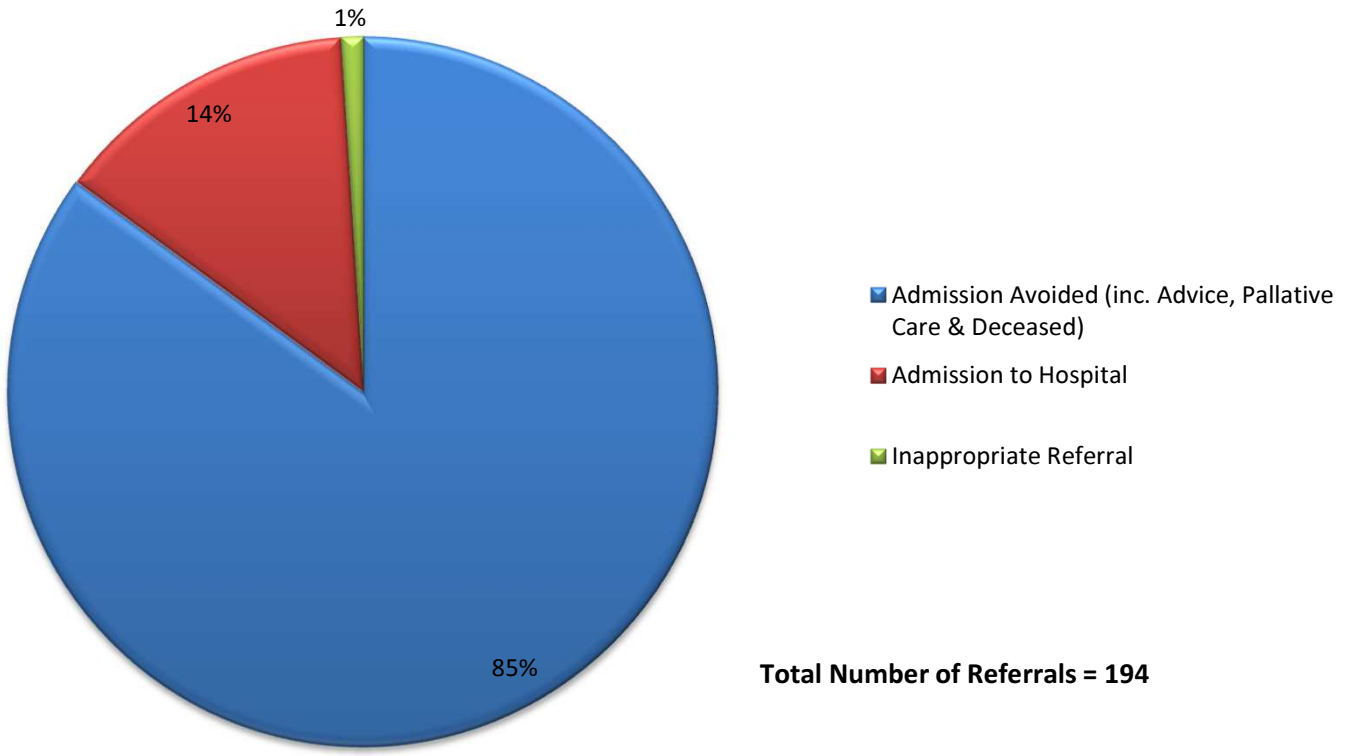
NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

RCAT Referrals April 2016 – March 2017

Outcome on Discharge



Total Number of Referrals = 194

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Feedback

'I was very privileged to receive this care, the Professor and his Team were wonderful and caring. Without them, the alternative would have been a spell in Hospital'
Patient

'Your service is gold'
Patient's relative

'Already, he has made a big impact on dozens of people, preventing numerous admissions'
Halton GP

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Questions

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

REPORT TO: Health and Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Maternal and infant mental health

WARDS: Borough Wide

1.0 PURPOSE OF THE REPORT

A presentation will be given to the Health and Wellbeing board members to provide them with an overview of the integrated work that is taking place in Halton to improve infant and maternal mental health and wellbeing.

2.0 RECOMMENDATION: That the contents of the presentation be noted.

3.0 SUPPORTING INFORMATION

Halton has received the 'Locality award for mental health inclusion' at the PIPUK (Parent infant partnership) infant mental health awards. The award was for the collaborative work that has taken place through the Halton Health in the Early Years group, on perinatal mental health, preparation for parenthood, and bonding and attachment. It was in recognition of the close working between the Bridgewater midwives, Family Nurses and Health visitors, and Children's centre staff, Health improvement team, Public health and the CCG. Over the last few years the 'Halton Health in the Early Years' group has worked hard to improve child development, with a focus on emotional health and is an example of good collaborative working.

The Health and Wellbeing board will receive a presentation outlining the work that is taking place to 'give every child the best start in life', by supporting mums mental health and building the relationship with the child.

4.0 POLICY IMPLICATIONS

Improving mental health and wellbeing is central to the development of local communities. It not only contributes to improving health, but has also been shown to increase an individual's ability to improve their education and employment opportunities, reduces social isolation and improves resilience.

5.0 FINANCIAL IMPLICATIONS

There are no additional financial implications from this presentation.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

The effects of depression on the mother, her infant and her family are well documented. "There was a significant association between maternal depression during the postnatal year and reduced quality of mother/child interaction for a significant period of time after the birth of the child" (Stern A, et al. 1991). Mothers with postnatal depression are likely to experience difficulties in relating to and caring for their babies.

Early intervention - at this stage of the child's development relating to perinatal mental health, bonding and attachment is essential to break the cycle of poverty, so enhancing life chances and reducing health inequalities for children and their families.

Parent relationships and early attachments are crucial to young children's ability to learn and develop cognitive, emotional and social capacity. It is in the interest of both child and society for attachment problems to be identified as early as possible.

6.2 Employment, Learning and Skills in Halton

Early identification and support to maternal mental health and improved infant attachment gives every child the best start in life. In the long term it impacts upon the child's social interactions, education and learning. Working to maximise maternal mental health will also support the mother to achieve education or employment goals.

6.3 A Healthy Halton

Having children can be a difficult time for families and mental health problems for mothers during pregnancy and the first year of their child's life are one of the most common complications of pregnancy, affecting between 15-20% of women. Early identification and treatment for families is important and evidence suggests that this has wide ranging implications on the future health of the family. There is also evidence that father can experience a greater risk of emotional health problems during this period.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**

None

7.0 RISK ANALYSIS

N/A for information only

8.0 EQUALITY AND DIVERSITY ISSUES

NONE

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

None under the meaning of the Act.'

REPORT TO: Health and Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Operational Director - Education, Inclusion and Provision

PORTFOLIO: Children, Young People and Families

SUBJECT: Joint Local Area Inspection of Special Educational Needs and Disability for Halton

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Board with the outcome of the Joint Local Area Inspection of Special Educational Needs and Disability for Halton and agree the arrangements for the development of a joint Local Area Action Plan.

2.0 RECOMMENDATION: That

(1) The outcome of the Joint Local Area SEND inspection is noted;

(2) Approval is given to the development of a Joint Action Plan to address the areas of development identified by the inspection; and

(3) a report on progress be submitted to the Board in six months.

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3.0 SUPPORTING INFORMATION

3.1 In May 2016 Ofsted and the Care Quality Commission commenced joint area inspections on the effectiveness of local areas in implementing the SEND reforms as set out in the Children and Families Act 2014. Under the inspection arrangements each local area would be inspected over a 5 year cycle.

3.2 Between 27th March and 31st March 2017 Ofsted and the Care Quality Commission conducted a joint inspection in Halton. They spoke to children and young people with special educational needs and/or disabilities, parents and carers, local authority and National Health Service (NHS) officers. They also visited a range of health and education providers including schools, Children's Centres, Early Years settings and Riverside College. Inspectors spoke to leaders, staff and governors about the implementation of the reports. In addition the inspectors considered a range of information about the performance of the local area including the local area's self-evaluation. Inspectors met with the leads for health, social care and education in Halton. Finally they reviewed performance data and evidence including the local offer and joint commissioning.

3.3 The inspection focused on the following three areas:

- The effectiveness of the local area in identifying children and young people's special educational needs and/or disabilities;
- The effectiveness of the local area in meeting the needs of children and young people who have special educational needs and/or disabilities; and
- The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and or/disabilities.

3.4 The final letter providing the outcome of the inspection was scheduled for publication in May 2017, however, due to political sensitivity Ofsted advised that it would not be issued until 9th June 2017 and that it would be published on 16th June 2017. Please see Appendix A for the full letter.

3.5 The inspection was led by one of Her Majesty's Inspectors from Ofsted, Jonathan Jones and his letter sets out both the strengths of the local area and a number of areas for further development. The main findings of the report include the following:

- The children and young people spoken to say they are happy and feel safe in school and college.

- Children and young people who have special educational needs and/or disabilities and are looked after receive effective support. The needs of these children and young people are well met as a result of early identification and appropriate and timely assessment.

- The achievement of children and young people shows secure signs of improvement across all key stages. Most rapid improvements can be seen in early years as a result of early identification and intervention.

- The work of the visual impairment services, audiology, teachers of the deaf and school nurses are strengths in the local area. The quality of the support and provision that these services offer makes a positive difference to children and young people.

- Young people in Halton are being prepared well for adulthood.

- The achievement of young people in post-16 provision is continuing to improve so as to be closer to the national average.

- The proportion of young adults in independent living and those in paid employment is much higher than the national average.

- Leaders work with children and young people is beginning to improve and there are some strong examples of co-production, for example, on short breaks.

- Leaders have an accurate understanding of what is working well and what needs to improve.

- The local area is on track to complete all transitions from statements of special educational needs to education, health and care (EHC) plans by March 2018.

- The majority of plans are completed within the expected 20 week timescale.

- Staff vacancies in a number of services impact negatively on the length of waiting times and the ability of services to meet the needs of children and young people.

- There is still some way to go until outcomes for children and young people area similar to national averages but there have been sustained improvements.

- The Action plan for the implementation of the strategy is not sufficiently robust. Joint plans and evaluations do not incorporate well enough aspects of health services and consideration is not always given to how actions will impact on outcomes for children and young people. The lack of sharp focus and joined-up thinking is also reflected in the quality of some EHC plans.

- Leaders do not have a thorough understanding of the range of parental views. A number of parents do not feel that there is transparency regarding identification, assessment and the rationale for decisions being made. Co-production is not firmly embedded and there is no shared understanding of how it should look in Halton.

- The local offer is extensive and up to date. Nonetheless, it is used by too few parents and some told inspectors they had never heard of it. A number of schools' websites do not provide the link to the local area's offer.

- There has been a sharp increase in the proportion of children and young people with social, emotional and mental health issues. This is increasing the number of children and young people who are persistently absent and/or being excluded from school. Leaders are working with schools and child and adolescent mental health services but it is too soon to see the impact on outcomes for these children and young people.

3.6 The report acknowledged that that there was an accurate understanding or what is working well and what needs to improve, however, emphasised the need for increased joint planning. Therefore, in order to respond to the areas for development and to further improve the outcomes for children and young people, NHS Halton Clinical Commissioning Group, the Local Authority, Impart (parent and carer organisation) and other partners are committed to working together to develop a local area joint Action Plan.

3.7 Once developed this Action Plan will be monitored and reviewed by the SEN Strategic Partnership Board and a progress report will be provided to the Health and Wellbeing Board every six months.

4.0 POLICY IMPLICATIONS

4.1 Health and Wellbeing Boards have a key role to play in supporting how the local area meets the needs of children and young people with special educational needs and disabilities

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Improve outcomes for children and young people with special educational needs and/ or disabilities

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

Improve education and employment opportunities for children and young people with SEND

6.3 **A Healthy Halton**

Support children and young people so that they can be as healthy as possible in adult life

6.4 **A Safer Halton**

Ensure children and young people with SEN feel safe

6.5 **Halton's Urban Renewal**

None.

7.0 Risk Analysis

7.1 The report identified that there was not a local understanding of the range of parental views. To respond to this area of development a detailed review of parental engagement will be commissioned.

8.1 Background Reports

Children and Families Act 2014

Special educational needs and disability code of practice: 0 to 25 years

The framework for the Inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities

Joint Local Area SEND Inspection in Halton 25th May 2017

Ofsted
Agora
6 Cumberland Place
Nottingham
NG1 6HJ

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted
lasend.support@ofsted.gov

25 May 2017

Mr Milorad Vasic
Strategic Director – People
Halton Borough Council
Municipal Building
Kingsway
Widnes
Cheshire
WA8 7QF

Simon Banks, Clinical Commissioning Group Chief Officer, Halton
Jan Snodden, Clinical Commissioning Group Accountable Officer
Ann McIntyre, Local area nominated officer

Dear Mr Vasic

Joint local area SEND inspection in Halton

Between 27 March and 31 March 2017, Ofsted and the Care Quality Commission (CQC), conducted a joint inspection of the local area of Halton to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of inspectors including an Ofsted Inspector and a children's services inspector from the Care Quality Commission (CQC).

Inspectors spoke with children and young people who have special educational needs and/or disabilities, parents and carers, and local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the disability and special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors met with leaders from the local area for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

This letter outlines our findings from the inspection, including some areas of strengths and areas for further improvement.

Main findings

- The local area is on track to complete all transitions from statements of special educational needs to education, health and care (EHC) plans by March 2018. The majority of plans are completed within the expected 20-week timescale.

However, staff vacancies in a number of services impact negatively on the length of waiting times and the ability of services to meet the needs of children and young people.

- Children and young people who have special educational needs and/or disabilities and are looked after receive effective support. The needs of these children and young people are well met as a result of early identification and appropriate and timely assessment.
- The achievement of children and young people shows secure signs of improvement across all key stages. Most rapid improvements can be seen in the early years as a result of early identification and intervention. There is still some way to go until outcomes for children and young people are similar to the national averages but there have been sustained improvements.
- Young people in Halton are being prepared well for adulthood. The achievement of young people in post-16 provision is continuing to improve so as to be closer to the national average. The proportion of young adults in independent living and those in paid employment is much higher than the national average.
- The work of visual impairment services, audiology, teachers of the deaf and school nurses are strengths of the local area. The quality of the support and provision that these services offer makes a positive difference to children and young people.
- The children and young people spoken to say they are happy and feel safe in school or college. They show a good understanding of how to stay safe, especially when online, and know who to speak to if they were to have any concerns or worries. Leaders have worked closely with schools and colleges to raise awareness and understanding of extremism and radicalisation.
- Leaders generally have an accurate understanding of what is working well and what needs to improve. This is included in the 'SEND Strategy for Halton'. However, the action plan for the implementation of the strategy is not sufficiently robust. Joint plans and evaluations do not incorporate well enough aspects of health services and consideration is not always given to how actions will impact on outcomes for children and young people. This lack of sharp focus and joined-up thinking is also reflected in the quality of some EHC plans.
- Leaders do not have a thorough understanding of the range of parental views. A number of parents do not feel that there is transparency regarding identification, assessment and the rationale for decisions being made. Co-production is not firmly embedded and there is no shared understanding of how it should look in Halton. Leaders' work with children and young people is beginning to improve and there are some strong examples of co-production, for example, on short breaks.
- The local offer is extensive and up to date. Nonetheless, it is used by too few parents and some told inspectors they had never heard of it. A number of schools' websites do not provide a link to the local area's offer.
- There has been a sharp increase in the proportion of children and young people with social, emotional and mental health (SEMH) issues. This is increasing the

number of children and young people who are persistently absent and/or being excluded from school. Leaders are working with schools and child and adolescent mental health services (CAMHS) but it is too soon to see the impact on outcomes for these children and young people.

The effectiveness of the local area in identifying children and young people's special educational needs and/or disabilities

Strengths

- The number of statements of special educational needs transitioning to EHC plans significantly increased in 2015/16. The local area is on track to transition all statements of special educational needs by March 2018.
- There has been a marked improvement in the timely completion of the initial health assessments for children looked after. This supports the early identification of needs when children become looked after.
- The uptake of the two-and-a-half-year integrated check has increased. Health assessments undertaken when children join Reception class, including vision and hearing checks, are achieved within timescales.
- Plans to broaden the reach of school health checks to Year 6 and mid-teens are encouraging. Children and young people who are electively home educated or those missing education are also offered access to the healthy child programme. This contributes positively to the early identification of needs.
- Plans completed by children's community nurses, including EHC plans, show good identification and awareness of the protected characteristics outlined in the Equality Act 2010.
- The integrated contact and referral team services (ICART) have greatly improved since Ofsted last inspected Halton in 2014. It is used as a 'one-stop shop', pointing professionals in the right direction in a timely manner. Professionals and users across the local area commented on the significant improvements in timeliness and appropriateness of the advice given in recent years. As a result, professionals are able to access the most suitable help and advice within a very short period of time.
- The virtual head works effectively with schools. By September 2017, all children looked after will have been assessed to address nurture needs and to support children and young people who are at risk of exclusion. Halton are proactive in supporting training towards the National Schools Nurture Award. This is helping to support better inclusion of children and young people looked after with social, emotional and mental health needs in mainstream schools.
- Bridgewater Community Health Care NHS Foundation Trust introduced one central point of contact so that requests for health information and care assessments can be dealt with more efficiently. This is shared with relevant services and contributes to more timely responses and a reduction in waiting times.

Areas for development

- Specialist provision in Halton to meet the needs of children and young people who have the most complex needs is at full capacity. This is slowing the rate of EHC plan completion within the 20-week timescale because of the challenge in securing alternative placements for these children and young people.
- Limited resources in the health visitor team have reduced the reach of four of the five mandated healthy child programme contacts. There is a prioritisation plan in place, supported by commissioners, whereby ante-natal and six to eight week checks follow a targeted, rather than a universal, approach. Although recruitment is underway, the reduced reach of these health checks limits the early identification of need.
- There is not a 'tell it once' culture across Halton, with parents and carers having to repeatedly tell the story of their child to different health services. This causes delays in children and young people being identified as in need of help and is a source of genuine frustration to parents and carers.
- Arrangements in health to ensure that information submitted for EHC plan assessments and plans is sufficient and of good quality are not robust. The way that this information is used and put into plans is inconsistent. In some cases, outcomes submitted by health staff were not the outcomes in final plans. This does not support effective planning for children and young people.

The effectiveness of the local area in meeting the needs of children and young people who have special educational needs and/or disabilities

Strengths

- Visual impairment services, audiology and teachers of the deaf provide effective support for children and young people. Services are timely and of good quality. Their work is making a positive difference to the lives and development of these children and young people. For example, the work of the teachers of the deaf ensures that teachers have the skills and strategies to fully engage children and young people who are deaf in learning alongside their peers.
- Parents welcome a recent initiative which involves weekly visits to their school by an ophthalmologist. Children are now able to have their eye tests and eye drops put in at school, where previously children had to go to a clinic appointment. This is less stressful for them and means they do not miss valuable learning time in school.
- The special educational needs and disabilities information and advice support service (SENDIASS) works effectively with young people as well as parents across the local area and is developing strong links with the local college. It supports a large number of young people, encouraging them and giving them confidence to have their voices heard.
- Parents are signposted to SENDIASS from the ICART team and also by school special educational needs coordinators (SENCos). SENDIASS have recently

engaged with 'Umbrella Halton', who offers support to newly arrived asylum seekers in the area. As a result, vulnerable children and young people who are new to the country receive early support and advice.

- Young people are involved in the allocation of grants of up to £10,000 to enable community organisations to develop new and different short-break opportunities. In response to parental requests, a new initiative to offer specialist swimming tuition for children and young people was scheduled to start in April 2017. This widens the leisure opportunities for children, young people and their families.
- The quality assurance arrangements for reviewing health assessments for children looked after in Halton are strong. Plans are holistic and support the improvement of children's health and well-being. Carers of children looked after indicate that they receive good, prompt support from occupational and speech and language therapists.
- The provision for short breaks is, in the opinion of those who use it, 'excellent'. This is a good example of provision not designed 'for' young people but 'by' young people. There are 122 personal budgets in place for short breaks which give families greater choice and control.
- The support offered by the local area special educational needs (SEN) consultants to SENCos in schools is of good quality. SENCos report that this support is helping to improve their practice and ensures that the needs of children and young people are better met. There are effective examples of sharing good practice among schools. Special schools, schools with a resourced provision base and the pupil referral unit are readily available to offer support and advice to their colleagues.
- School nurses provide additional support to children with medical conditions by helping settings to manage medical problems and provide training to school staff. When needs are identified, this collaborative approach supports children to have their health needs met in school so they can continue to access their education.
- Joint working between health settings and the early years settings which inspectors visited is well established. Each setting has a named contact from the health visiting team which supports the integration of the two-year-old checks.
- Parents and carers of children in the early years settings which inspectors visited were positive about the progress their children have made. Parents and carers also benefit from access to resources and additional support to meet the needs of their children, such as behavioural programmes.
- The youth justice service works closely with the local area to meet the needs of young people in custody and to ensure that they receive appropriate support while serving their sentences. There are smooth transitions to enable their reintegration into society.
- Parents and carers of children and young people who have special educational needs and/or disabilities value the contribution of the designated clinical officer

(DCO) and specialist nurse for children with complex care needs. Having access to a named person for SEND in the clinical commissioning group (CCG) supports a coordinated response by health services.

- Local area and CCG officers support initiatives such as 'Halton Speak' and 'Bright Sparks'. These initiatives give young people who have special educational needs and/or disabilities the confidence to make a difference to their lives and also work for the benefit of other young people in the area by being involved in decision-making. For example, 'Bright Sparks' has involved young people with a sexual health consultation and in improving the quality of short breaks.

Areas for development

- The protocol in place for sharing information between agencies is not robust or clear enough. This is impacting negatively on the assessment and meeting of children's needs in Halton.
- Parents believe that professionals do not routinely work well together to meet the needs of children and young people. To a user, the system can feel disjointed and the history of the child's circumstances and situation has to be retold too often.
- The extent of parental dissatisfaction among a number of parents is not fully appreciated by leaders. At its root cause is ineffective communication, which creates frustration. There is a willingness from parents to understand better the position of leaders' rationale for decisions but parents say that there needs to be more transparency. As a result, some parents and carers are unable to manage their own expectations, for example when waiting for health services.
- The awareness of the local offer among parents is variable, with a number of parents reporting that the first time they had ever heard of it was during the inspection. Work and training has been undertaken to establish 'Local Offer Ambassadors' with the aim of offering peer support to access the local offer. However, this service is not yet established and parents want to know who to contact if they need support to access information available on the website. A number of schools within the local area do not have a link to the local offer on their websites.
- There is no protocol in place to support the transfer of specialist equipment for children and young people once they move settings. This leads to duplication, where similar equipment is being purchased for use both at home and in school.
- A number of children and young people are waiting too long to be assessed and to have their needs reviewed in some health services. In occupational therapy (OT) the challenge of attracting and recruiting staff to include a specialist sensory OT, in addition to increased demand for the service, contribute to these delays.
- The local area recognises that there is more to do to develop and increase the uptake of personal health budgets beyond continuing healthcare. Broadening

this will support children and young people in Halton to have more choice in how their needs are met.

- There is too much variability in the completion of annual health checks by general practitioners for those with learning disabilities aged 14 and over. This lack of consistency does not support an equitable approach to improving the outcomes of these young people.
- Bridgewater Community Health Care NHS Foundation Trust is not supporting staff to be able to write appropriate outcomes for children. As a consequence, the quality of outcomes for children in EHC plans is variable.
- The child development centre has developed a coordinated approach to support the children and young people they care for. This includes children and young people who have autistic spectrum conditions (ASC). However, input from CAMHS and educational psychology are not well established, which limits multidisciplinary decision-making and planning. Occupational therapy contributions can be delayed due to low capacity within the service.
- A number of children and young people are waiting too long to be assessed and to have their needs reviewed in some health services. Waiting times for ASC assessments exceed National Institute for Health and Care Excellence guidance. Parents can wait too long to receive the diagnosis that their children have attention deficit hyperactivity disorder. As a result, the much needed support is not received in a timely manner. In OT, the challenge of recruiting staff to include a commissioned specialist sensory occupational therapist, in addition to increased demand for the service, has contributed to delays.
- The alignment of EHC plans with child safeguarding plans is not sufficiently developed. Although these children are kept safe, professionals do not have all of the information they need to provide holistic support for these children and young people

The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities

Strengths

- The proportion of children who have special educational needs and/or disabilities and are achieving a good level of development in the early years is improving and moving closer to the national average. This is the result of increased early years support and identification; stronger effective working practices and training to enhance confidence, development and expertise of staff in schools.
- Although still below the national average, the proportion of pupils reaching the expected standard in the phonics check in Year 1 is improving.
- At key stage 2 and key stage 4, the progress made by children and young people who receive special educational needs support in English and mathematics is improving and moving closer to the national average. While progress measures are below average, the attainment of these pupils is similar to or above the national average for all pupils.

- The proportion of young people who progress into post-16 provision is high. The achievement of these young people is also improving and is close to the national average.
- The proportion of 18- to 25-year-olds in settled accommodation and paid employment is much higher than the national average. Opportunities are provided for young people to stay overnight in an independent flat. Young people are supported to plan and cook meals, go shopping and undertake routine household tasks. This enables them to be away from their parents and carers for the first time and supports their effective preparation for adulthood.
- The support to develop independent-travel training is well established. This enables a significant number of young people to travel independently, giving them greater social opportunities after school or college and at weekends. Young people and their parents view this positively.
- The proportion of young people who are not engaged in education, employment and training (NEET) is broadly similar to the national average. The tracking panel has been effective in quickly identifying young people who are at risk of becoming NEET and put into place multi-agency support. An example of the effectiveness of this provision is that there is only one young person with an EHC plan who is NEET in Halton.

Areas for development

- The majority of children and young people who are excluded in Halton have special educational needs and/or disabilities. For a number of pupils, a permanent exclusion has been the trigger for an education, health and care assessment. Some parents feel that a permanent exclusion for their child is the only way to access an assessment. The local area is providing effective support to manage challenging behaviours in schools via the pupil referral unit. As a result, an increasingly high demand is being placed on this provision.
- The proportion of children and young people who are persistently absent is increasing. Leaders have identified that this is as a result of the increasing prevalence of children and young people who have SEMH issues. Leaders are working with schools and settings on a number of initiatives to meet the needs of these children and young people but there is a shared concern that current demand is outweighing the support available.
- The tracking and monitoring of the achievement of specific groups within the special educational needs and/or disabilities population is not routinely carried out with sufficient rigour. For example, the achievement of the most able pupils who have special educational needs and/or disabilities and those who are in receipt of enhanced provision funding is not evident. The information is known at a pupil level and at a school level but the overview of how well these pupils are achieving across the local area is lacking.
- Written outcomes in EHC plans are not always clear. Of the examples seen, too many are written in a jargon-ridden manner which does not clearly set out what will be achieved. At times, the outcomes are generic, for example, 'Child Y will no longer need the services of the physiotherapist'; 'Child Z will engage with

the entire learning offer in school and transfer these skills.' Guidance about EHC plans from Bridgewater Community Health Care NHS Foundation Trust is not supporting health practitioners to write effective outcomes for children and young people.

- EHC plans are not currently signed off by health professionals when finalised. Although the specialist nurse scrutinises the plans, there is no evidence to indicate that healthcare professionals sign off the EHC plans as being fit for purpose.
- The action plan to implement the SEND strategy needs further development. It does not accurately identify the impact of actions and the difference they make to children and young people. The action plan does not include appropriate timescales for the completion of tasks. There is also an absence of improvement actions from health services, despite leaders knowing what still needs to be done.
- There is no consensus of what co-production in Halton should look like. This lack of consensus has impeded how well co-production happens across the local area. Leaders acknowledge that co-production is an area for development and are committed to new and more effective ways of working.
- Young people who have disabilities believe that there is a 'them and us' divide among their peers in Halton. They are appreciative of the initiatives which leaders support but want to see more being done at a strategic level.

Yours sincerely

Jonathan Jones
Her Majesty's Inspector

Ofsted	**Care Quality Commission**
Andrew Cook, Her Majesty's Inspector Regional Director, North West	Ursula Gallagher Deputy Chief Inspector, Primary Medical Services, Children Health and Justice
Jonathan Jones, Her Majesty's Inspector Lead Inspector	Elaine Croll CQC Inspector
Deborah Mason Ofsted Inspector	

cc: Department for Education
Clinical commissioning group
Director Public Health for the local area
Department of Health
NHS England

REPORT TO: Health and Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Children, Young People and Families

SUBJECT: Reducing Child Poverty and Improving Life Chances in Halton

WARDS: Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 This report is to update members of the work of Halton's Child and Family Poverty Strategic Group and how this feeds into the Liverpool City Region co-ordinated approach to addressing child and family poverty.

2.0 RECOMMENDATION: That the contents of this report be noted.

3.0 LIVERPOOL CITY REGION

3.1 Growing up in poverty can affect every area of a child's development and future life chances. We know that most disadvantaged children are less likely to achieve their academic potential, secure employment and gain a sense of future financial security. They are more likely to suffer from poor health, live in poor quality housing and unsafe environments.

3.2 In 2010 Halton alongside other Liverpool City Region (LCR) leaders agreed to adopt a City Region wide approach to tackling issues related to child and family poverty that would build on strong local and City Region partnerships.

3.3 In 2011 the first Child Poverty and Life Chances Strategy for the LCR was launched and subsequently in 2015. The vision set out in the strategy continues to represent our long term approach up to 2020, which was the national deadline to eradicate child poverty. Vision states that:

"Working together as City Region Partners we will reduce child and family poverty and maximise opportunities for children and young people in their life chances.

We will achieve this through a dual strategy which ensures an ever growing proportion of children and young people are ready for school and life whilst maximising family resources."

4.0 HALTON'S CHILD AND FAMILY POVERTY STRATEGIC GROUP

4.1 Given Halton are well represented on the LCR Child Poverty and Life Chances Commission by the portfolio holder for children and the Director of Public Health and have been key to developing the city wide strategy we are happy to adopt a joint strategic approach. In addition Local Authorities no longer have a statutory duty to complete a local child poverty strategy. We have, however, agreed we need to develop our own bespoke action plan to underpin it.

4.2 Halton's Child and Family Poverty Strategic Group hosted a morning workshop on 26th January attended by a range of stakeholders to consider what should be included in Halton's Child Poverty Action Plan. The group agreed to use the priorities for the Liverpool City Region as the basis of our action plan.
These are:

- Fair employment
- Birth and School readiness
- School interventions, pupil premium and NEETs (Not in Education Employment or Training)
- Health inequalities and lifestyle choices
- Transport and accessibility

4.3 Each table had a lead representing one of the priorities identified above who facilitated discussion with the aim of completing an exercise which aimed to ascertain the following:

1. What do we have in place now in Halton?
2. What do we need to focus on to improve things?
3. How can we work better with the Liverpool City Region (LCR)?

4.4 From the completed responses a paper was collated summarising the key areas/common themes against each of the priorities. These included:

PRIORITY AREA	KEY ISSUES
Fair Employment	a. Financial literacy in the community – can handle money b. Teach adults to understand their employment rights c. Use employed young people as role models d. Check childcare accessibility against adult learning and skills provision e. Look at supported internships for young people with learning difficulties
Birth and School Readiness	a. Integrated multiagency teams collocated b. Future use of Children's Centres – multigenerational?

	c. Increased focus on building parenting skills d. The system to develop an understanding of Early Years Pupil Promises and how we should spend it e. Complete an evidence review for what works with improved parenting and keeping children out of care.
School Interventions, Pupil Premiums and NEET	a. Financial literacy for children b. Mapping of availability of fresh food in deprived areas c. Ensuring all children entitled to free school meal get one d. Use social media to give young people information on training and jobs, interview techniques, CV writing, etc. e. Organise holiday meal clubs in deprived areas, tying in with big supermarkets
Health Inequalities and Lifestyle Choices	a. Training staff and voluntary sector to work with people on their lifestyle b. Digital access to health advice c. Scope opportunities for low cost/free sports opportunities d. Roll out pilot pregnancy and smoking Quit Buddy Stress Management Scheme e. Enabling children to make the right choice for secondary school meals
Transport and Accessibility	a. Increased communication on what concessionary fares, cheap tickets are available b. More children walking to school c. Increased awareness of cycle training for children

4.5 As a result the group are in the process of pulling together a SMART (specific, measurable, agreed upon, realistic and time-based.) action plan, which will feed into the LCR Child Poverty and Life Chances Strategy.

4.6 This Action Plan will be regularly monitored and evaluated for outcomes.

4.7 The outcomes of the strategy and action plan will be fed back on an annual basis to the Halton Children's and Young People's PPB and the LCR Child Poverty and Life Chances Commission.

5.0 FINANCIAL IMPLICATIONS

Reducing child and family poverty and improving life chances is a significant challenge for local authorities and Halton is no exception, particularly given the current economic climate and funding reductions. A City Region approach to addressing child and family poverty exploits economies of scale and also helps to share good practice.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

As a local authority we have a responsibility to ensure all children and young people, regardless of their circumstances, are supported to achieve their academic potential, secure employment and gain a sense of future financial security.

6.2 Employment, Learning and Skills in Halton

As a local authority we have a responsibility to ensure all children and young people, regardless of their circumstances, have access to a breath of education, training and employment opportunities.

6.3 A Healthy Halton

Children and young people who are living in poverty experience a number of issues that may impact on their physical and emotional health and wellbeing. These issues need to be addressed to reduce escalation into adult life acting as a barrier in achieving their academic potential and gaining successful employment.

6.4 A Safer Halton

We know that most children and young people living in poverty suffer from poor health, live in poor quality housing and unsafe environments. We need to work together to reduce the risk of children and young becoming involved in crime and also reduce their vulnerability to exploitation.

6.5 Halton's Urban Renewal

None identified

7.0 RISK ANALYSIS

The Liverpool City Region (LCR) like other Northern City Regions has been affected by the economic downturn of recent years with levels of unemployment and low wage growth. The Government's austerity programme has served to exacerbate the effects on the poorest families

in the City Region through reductions to benefits and tax credits and imposition of benefit sanctions, set against the ongoing squeeze on the cost of living.

Local Authorities no longer have a statutory duty to complete a local child poverty strategy, however to do nothing to help address this issue would be detrimental to the borough. This risk will be addressed through an efficient an effective action plan for Halton based on the priorities for the LCR. This action plan will feed into the Liverpool City Region Strategy.

Achieving an effective LCR Child and Family approach requires strong strategic leadership from a range of LCR partners. This has been addressed through the establishment of a LCR Child and Family Poverty Commission of which Halton is actively part of.

8.0 EQUALITY AND DIVERSITY ISSUES

Children and young people growing up and living in poverty can affect every area of a child's development and future life chances. Their needs may require a range of specific services.

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

Document	Place of Inspection	Contact Officer
Liverpool City Region Child Poverty and Life Chances Strategy 2015-18	Runcorn Town Hall	Eileen O'Meara
Child Poverty Act 2010	*http://www.legislation.gov.uk/ukpga/2010/9/contents*	Eileen O'Meara

REPORT TO: Health and Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Director of Adult Social Services

SUBJECT: Falls update

PORTFOLIO: Health and Wellbeing

WARDS: Borough wide

1.0 PURPOSE OF REPORT

1.1 To present the Health and Wellbeing Board with an update of the Falls Service in Halton and the work undertaken to date in line with the Halton Falls Strategy 2013 – 2018.

2.0 RECOMMENDATION: That the contents of the report be noted

3.0 SUPPORTING INFORMATION

3.1 The Halton Falls Strategy

3.1.1 In 2012 a review was undertaken to look at the falls service in Halton. This work was conducted by a multi-agency steering group and it became clear from very early on that services linked to falls were fragmented and there was no overarching vision. In addition to this fragmentation; overall performance was significantly worse than the national average, for example the hip fracture rate in people over 65 in Halton was 750 per 100,000, and the National average was 674 per 100,000. At this point it was agreed that a new falls strategy was required for Halton for the period 2013 – 2018.

The strategy focused on key objectives which included :

- To develop an integrated falls pathway for Halton
- To develop a prevention of falls pathway for Halton
- To develop a package of workforce training
- To develop an awareness raising campaign with both the public and professionals
- To improve partnership working across all agencies involved and improve governance arrangements to support falls.

3.1.2 The Falls Strategy was underpinned by a robust action plan which was agreed by all partners to drive the implementation of key objectives and to deliver evidence based, efficient, high quality services.

3.1.3 To date many key actions identified in the plan have been fully implemented and although performance is still below the national average in a number of areas there has been a significant decrease in the gap as illustrated in section 3 (performance). This links in with the key strategic priorities for falls prevention in Halton, which are to reduce:

- Emergency hospital admissions for injuries due to a fall (65+)
- Emergency hospital admissions due to fracture of neck of femur (65+)

3.2 **Progress against falls strategy action plan.**

3.2.1 ***Falls Pathways – Treatment/Prevention***

In order to develop an integrated falls pathway a multi-agency implementation group was established involving all key stakeholders and service user representatives. Access to treatment services and the patient journey was reviewed in order to streamline processes and to release capacity within the system. As an outcome of the review the FRAT (Falls Risk Assessment Tool) has been embedded into frontline practice across the Health and Social Care system including primary care (social workers, IAT, Complex care, hospital discharge teams, district nursing and intermediate care assessments) and is now part of the SAQ on Care First. To date there has been an increase in the usage of FRAT by at least 20%.

As a result of this work the number of people accessing the falls service has increased three-fold from 2011/2012 baseline (223 per annum to 750+ per annum). This number includes a rise in the number of people referred post fall from hospital into the falls prevention service.

The Falls Prevention Pathway has seen the development of the 'Age Well programme' which positions itself at both ends of the falls continuum i.e. as part of the treatment pathway for somebody who has fallen or as an initial entry point for those who are at risk of falling. The 'Age Well' programme currently delivers six classes per week on a rolling programme with a review every 15 weeks up to 45 weeks in total for each client. To date over 200 people have accessed the programme with 92% of clients showing improvements in strength, balance and gait at 3rd review. Recent developments have seen the integration of Sure Start to Later Life and SCIP workers at first & final review to address frailty & social engagement aspects for clients.

3.2.2 ***Workforce training and awareness raising***

As part of the 'Age Well Programme' a comprehensive package of training emerged from a successful 'Living Well' pilot in 2014/5. The pilot work focussed on skilling up community staff to use screening tools to identify people aged 75 + in the community at risk of memory

loss, falls or loneliness. Clinical pathways are used to identify the uptake of the screening.

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A wide range of teams were contacted across Halton particularly those who have front line community staff i.e. Wellbeing Enterprises, library services, domiciliary care, day care, residential care, local housing trusts, Bridge Builders, Age UK, Dementia Action Alliance members, SCIP workers & transport Services. To date over 80 delegates have been trained across 6 training sessions. 2 more are planned and booked up to end of July 2017.

3.2.3 ***Development of an awareness raising campaign with both the public and professionals***

As part of the 'Age Well' programme a campaign was developed to change public and professional perception of falls services including rebranding of promotional resources in line with recommendations by 'Later Life' training. Over the last three years numerous community wide events have been undertaken including three borough wide events to mark Falls Prevention Awareness week.

Over the last 12 months the 'Age Well' team have developed and delivered structured community awareness raising sessions to 24 community groups i.e. luncheon clubs, support groups etc., engaging 234 local residents.

3.2.4 ***Improved partnership working and governance***

Integral to the progression of this work has been the establishment of a partnership group which has adopted a multiagency approach to improving falls provision in Halton. The improvement of governance and reporting arrangements across this group has supported this agenda.

3.3 **Impact on Performance**

3.3.1 The tables in appendix 1 illustrate the Halton performance over a Six year period from 2010. Although the overall performance is above both the North West and the National average the gap is closing. The following are the headlines from the current performance:

- Emergency admissions rate for injurious falls in those aged 65+ (Appendix 1 table 1) have decreased in Halton by 22%, this compares to the National average which has seen an increase of 2% rise over the same period.
- Emergency admissions rate for injurious falls in males aged 65+ (table 2) have decreased in Halton by 27.6%, this compares to the National average which has seen an increase of 8.5% over the same period.
- Emergency admissions rate for injurious falls in females aged 65+

(table 3) have decreased in Halton by 18.5%, this compares to the National average which has seen an increase of 1.00% over the same period.

- Emergency hospital admissions rate for injurious falls for persons 65-79 (table 4) have decreased in Halton by 23.5% whereas they have reduced by 3% across England.
- Emergency hospital admissions rate due to fractured neck of femur 65+, (table 5) this measure does fluctuate as the actual numbers of fractures is relatively small; however the current rate is in line with the national average.
- Hip fractures in 80+ (tables 6) are also in line with national average, but they can also show some degree of fluctuation.

3.5 Summary and recommendations

In summary progress has been made in a number of areas in line with the key priorities to reduce emergency hospital admissions for injuries due to a fall (65+) and emergency hospital admissions due to fracture of neck of femur (65+). However work needs to continue to close the gap and to reduce the numbers of people who fall in Halton.

The following recommendations will support work in this area.

1. Continuation of the falls steering group with representation from all key partners from Halton Borough Council, Halton CCG, Secondary Care and Third Sector. Membership to also include residential and domiciliary care providers with the view to incorporating falls prevention into contracting arrangements for care providers moving forward.
2. Via the steering group review and update the falls action plan and monitor performance in order to drive continual improvement.
3. We will look into the potential for bone health to be included as part of the prevention element of the strategy. There is strong evidence that bone health and specific exercise programmes that improve balance, muscle strengthening and bone loading are effective interventions that need to start early to reduce the risk of falls in later life.
4. In partnership with the CCG look to explore the potential need for a “Fracture Liaison Service” in the future.
5. To continue to work across primary care to increase referrals into the falls prevention programme, particularly with practices with high incidence of falls.
6. As referrals increase and participation rates grow it is important that we identify suitable exit routes out of main stream services that continue to progress clients and allow maintenance of independence. Therefore a particular focus needs to be on the identification and involvement of external partners that can provide options to people exiting the service.
7. To continue to expand the health professional training in relation

to FRAT and to see where health professionals can intervene rather than referring to falls specialist nurse, thus releasing further capacity for more complex cases.

5.0 POLICY IMPLICATIONS

5.1 There are no policy implications.

6.0 RISK ANALYSIS

6.1 Continuation of services and implementation of recommendations are required to ensure continued improvement in falls performance to reduce the amount of people that fall in Halton year on year.

7.0 EQUALITY & DIVERSITY ISSUES

7.1 There are no Equality and Diversity issues.

Appendix 1

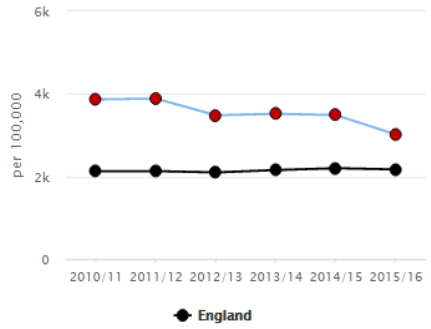
Emergency admissions for injuries due to falls in those aged 65+
Directly Age-Sex Standardised Rate per 100,000 population
Source: Public Health Outcomes Framework

Table 1

2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Persons) Halton

Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals | *Compared with benchmark* Better Similar Worse



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		625	3,865	3,560	4,189	2,516	2,126
2011/12		667	3,884	3,590	4,195	2,453	2,128
2012/13		624	3,480	3,210	3,768	2,376	2,097
2013/14		637	3,516	3,244	3,805	2,393	2,154
2014/15		649	3,484	3,217	3,768	2,547	2,199
2015/16		574	3,016	2,770	3,278	2,452	2,169

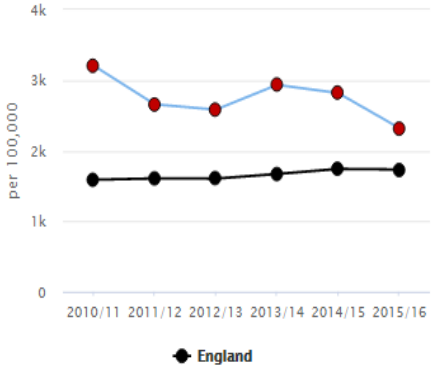
Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Table 2

2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Male) Halton

Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals | *Compared with benchmark* Better Similar Worse



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		201	3,207	2,737	3,729	1,915	1,587
2011/12		187	2,658	2,262	3,098	1,870	1,607
2012/13		195	2,582	2,209	2,997	1,851	1,604
2013/14		212	2,933	2,525	3,385	1,885	1,670
2014/15		216	2,817	2,430	3,246	2,057	1,742
2015/16		180	2,321	1,972	2,710	1,980	1,733

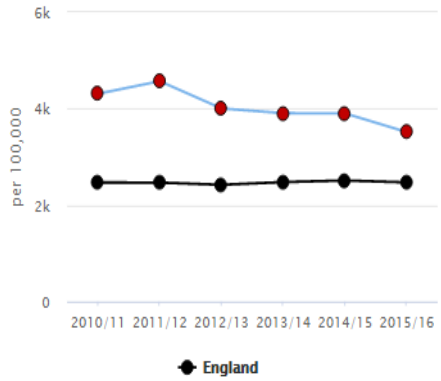
Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Table 3

2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Female) Halton

Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals | *Compared with benchmark* Better Similar Worse



Recent trend: –

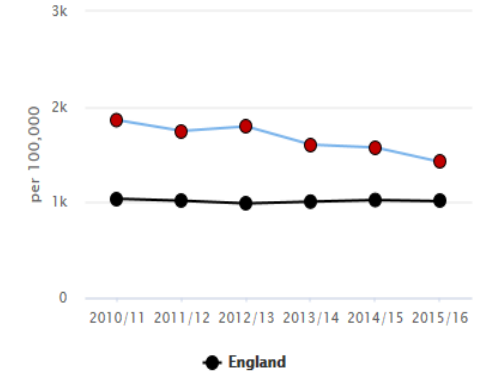
Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		424	4,309	3,905	4,743	2,885	2,470
2011/12		480	4,570	4,169	4,999	2,815	2,467
2012/13		429	4,005	3,634	4,404	2,708	2,421
2013/14		425	3,907	3,543	4,298	2,724	2,477
2014/15		433	3,903	3,542	4,290	2,874	2,510
2015/16		394	3,515	3,174	3,882	2,769	2,471

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Persons) Halton

Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		250	1,861	1,637	2,106	1,307	1,038
2011/12		240	1,747	1,533	1,983	1,236	1,017
2012/13		253	1,795	1,580	2,032	1,174	989
2013/14		239	1,604	1,406	1,823	1,164	1,007
2014/15		240	1,574	1,380	1,788	1,234	1,024
2015/16		223	1,424	1,241	1,627	1,206	1,012

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

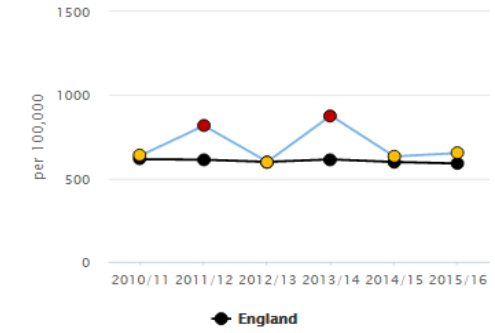
Emergency admissions for fractured neck of femur in those aged 65+
Directly Age-Sex Standardised Rate per 100,000 population
Source: Public Health Outcomes Framework

Table 5

4.14i - Hip fractures in people aged 65 and over (Persons) Halton

Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		107	637	520	773	623	615
2011/12		141	816	685	965	633	612
2012/13		107	600	491	727	625	599
2013/14		156	877	742	1,028	631	614
2014/15		120	632	522	758	629	599
2015/16		125	652	541	779	618	589

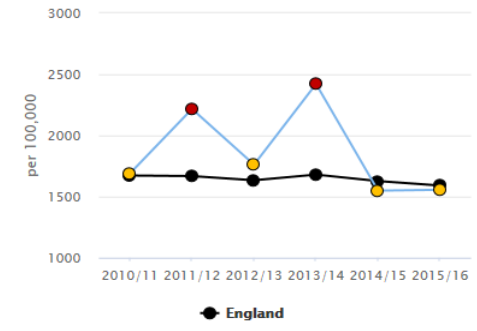
Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Table 6

4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Persons) Halton

Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		70	1,690	1,307	2,149	1,623	1,673
2011/12		96	2,217	1,788	2,716	1,684	1,668
2012/13		79	1,761	1,389	2,201	1,669	1,634
2013/14		105	2,421	1,974	2,938	1,680	1,680
2014/15		71	1,549	1,204	1,961	1,684	1,627
2015/16		71	1,556	1,209	1,970	1,619	1,591

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Falls Case Study

Appendix 2

A fall took away my confidence and I was frightened to go anywhere – now I've got my life back!

A Widnes lady said she went from a "busy, happy, family person" to a shell of herself after having a fall, until a GP put her in touch with the local Falls Prevention service delivered by HBC's Health Improvement Team.

Anne from Widnes told us "I had two and a half years of hell and was in and out of hospital. I had one fall, which then led to another and another as I became unsteady on my feet. No one seemed to know why I was falling or how they could help me. The injuries turned into other ailments and before I knew it I had lost all my confidence and didn't want to go anywhere. I stopped holidays, outings; anything that required me to walk anywhere, I was scared."

Anne's husband explained how they had been an active couple, always out and about and how he watched his wonderful wife disappear into someone unrecognisable. Then finally a GP put them in contact with the local Falls Service "Anne's GP told us about a Falls Prevention class that could help to build Anne's confidence on her feet and build her strength to help her become steady again"

This was the beginning of the future for Anne and Joe, Anne said "I finally feel like I am up and running again, I have met lovely new people and haven't had a fall since I joined the class. We have even booked a little coach holiday this summer. I have got my life back again, it's wonderful." Anne went on to say "I want everyone to know about the classes as they are brilliant, I am so grateful.

REPORT TO: Health and Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Public Health Protection Annual Report

WARDS: Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the Public Health Protection Annual report is to provide a clear overview of the current health protection situation within Halton highlighting any on-going challenges or issues. The document enables the Director of Public Health (DPH) to provide assurance to the health and well-being board (HWBB), that the health of the residents of Halton is being protected in a proactive and effective way.

2.0 RECOMMENDATION: That

1) the report be noted; and

2) members take the opportunity to raise questions or comments regarding the report.

3.0 SUPPORTING INFORMATION

3.1 Health protection is an essential part of achieving and maintaining good public health. It involves planning, surveillance and response to incidents and outbreaks. Health protection prevents and reduces the harm caused by communicable disease and minimises the health impact from environmental hazards such as chemicals and radiation. It also includes the delivery of major programmes such as national immunisation and screening programmes and the provision of health services to diagnose and treat infectious diseases.

3.2 The Health and Social Care Act 2012 states that Public Health teams, on behalf of Directors of Public Health are responsible for the local authority's contribution to health protection matters including responses to incidents and emergencies. Public Health England (PHE) is required to provide specialist support and have a complementary role to play.

3.3 The key roles necessary to provide effective health protection include:

- Planning and responding to incidents and emergencies
- Carrying out surveillance of communicable and notifiable diseases

- Reducing the negative impacts of communicable and non-communicable diseases including preventing infection and infectious diseases
- Minimising the health impact of environmental hazards
- Reducing premature mortality and morbidity by improving environmental sustainability

4.0 POLICY IMPLICATIONS

There are no significant policy implications with regard to this report.

5.0 FINANCIAL IMPLICATIONS

There are no financial implications as a result of this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

The remit of public health protection covers all population groups including children and young people. It also includes the provision and surveillance of childhood immunisations and vaccination to ensure children and young people are protected from vaccine preventable diseases such as Measles, Mumps and Rubella, Meningococcal disease and Human Papilloma Virus (HPV).

6.2 Employment, Learning and Skills in Halton

There are no significant implications for this priority

6.3 A Healthy Halton

The Public Health Protection Annual Report demonstrates action that is being taken to protect the health of Halton residents thereby directly contributing towards the Healthy Halton priority.

6.4 A Safer Halton

There are no significant implications for this priority

6.5 Halton's Urban Renewal

There are no significant implications for this priority.

7.0 RISK ANALYSIS

There are no direct risks as a result of this report, however, individual risk assessments are carried out as required for relevant priorities contained within the report.

8.0 EQUALITY AND DIVERSITY ISSUES

There are no equality or diversity issues resulting from this report.

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 Public Health Protection Annual Report 2016/17

Authors:

Sarah Johnson Griffiths – Consultant in Public Health

Diane Lloyd – Public Health Commissioning Manager and Programme Lead

Contents

Summary of Key Findings

- Halton has robust emergency planning arrangements
- TB incidence remains low in comparison to England
- Flu vaccination coverage for 2- 4 year olds and pregnant women is above England and the North West
- Flu vaccination coverage for the over 65s has decreased in recent years but is still higher than England
- MMR vaccination coverage for first dose is similar to England and for second dose is higher than England and similar to the North West
- HPV vaccination coverage in Halton (89.7%) is above England and the North West
- Hib/Men C vaccination rates remain high at 93.5% in spite of a slight reduction of 1.6% based on the previous year
- Childhood vaccinations remain around national targets but have seen a steady slow decline in recent years
- Uptake of the shingles vaccine in Halton has fallen from 50.9% in 2014/15 to 37.5% in 2015/16
- Breast screening in Halton is consistently above the North West but slightly below that of England
- Bowel screening rates are below that of the North West and England, however data for 2016 shows an increase on the previous year
- Cervical screening coverage rates in Halton are slightly below the North West and England and have seen a steady slow decline in recent years
- Abdominal Aortic Aneurysm screening in Halton has increased year on year since it was introduced in 2013
- HIV prevalence in Halton is low in comparison to national and regional trends
- Late diagnosis rates for HIV in Halton are significantly lower than England and the North West
- Since 2012, there has been a year on year decrease in Chlamydia screening rates in Halton, similar to the North West and England
- There were 26 cases of C. Difficile in 2016/17 (14 cases over trajectory)
- Latest data for MRSA for 2015/16 shows there was 1 case of MRSA

Purpose of this report

The purpose of this document is to provide a clear overview of the current health protection situation within Halton highlighting any on-going challenges or issues. The document enables the Director of Public Health (DPH) to provide assurance to the health and well-being board (HWBB) and the Executive Board Portfolio holder for Health and Wellbeing, that the health of the residents of Halton is being protected in a proactive and effective way.

Introduction

Health protection is an essential part of achieving and maintaining good public health. It involves planning, surveillance and response to incidents and outbreaks. Health protection prevents and reduces the harm caused by communicable diseases and minimises the health impact from environmental hazards such as chemicals and radiation. It also includes the delivery of major programmes such as national immunisation and screening programmes and the provision of health services to diagnose and treat infectious diseases.

The Health and Social Care Act 2012 defines the new health protection duty of Local Authorities (LAs). The Act states that Public Health teams, on behalf of Directors of Public Health are responsible for the local authority's contribution to health protection matters including responses to incidents and emergencies. Public Health England (PHE) is required to provide specialist support and have a complementary role to play. Both PHE and LA Public Health should work as a single unit when addressing health protection issues. NHS organisations including NHS England and our local Clinical Commissioning Group (CCG) have a legal responsibility under the NHS Act 2006 to mobilise resources to manage incidents and emergencies. They also have a legal duty to co-operate with LA Public Health teams in delivering health protection national and local priorities.

The key roles necessary to provide effective health protection include:

- Planning and responding to incidents and emergencies
- Carrying out surveillance of communicable and notifiable diseases
- Reducing the negative impacts of communicable and non-communicable diseases including preventing infection and infectious diseases
- Minimising the health impact of environmental hazards
- Reducing premature mortality and morbidity by improving environmental sustainability

Emergency Planning and major incident response

Background

Emergency planning and major incident response comprises actions that are taken to reduce the chances of emergencies occurring. If incidents do occur the response includes ensuring that the impact on residents and the environment is kept to a minimum. Emergency planning is guided by the Civil Contingencies Act 2004. The Act ensures that the organisations best placed to manage emergency response and recovery are at the heart of civil protection.

Current Situation

The 'Halton Borough Council Major Emergency Plan' implements the requirements of Local Authorities as Category: 1 Responders, under the provisions of the Civil Contingencies Act 2004. The purpose of the plan is to provide a framework for managing the council's response to a major emergency, which cannot be dealt with through normal procedures.

With effect from April 2013 NHS England, has taken over responsibility for the coordination and, if required, command and control, of NHS resources necessary for a multi-agency response to a MAJOR ACCIDENT at a COMAH site. This does not include the provision of public health advice – which is now provided by Public Health England (formerly the Health Protection Agency) and / or Halton Borough Council's Director of Public Health or the Scientific and Technical Advice Cell (STAC). NHS England will be involved in assisting with the cascading of any public health advice to healthcare professionals and members of the public.

Halton is part of the Cheshire Resilience Forum that is a Cheshire-wide working group covering the areas of Halton, Cheshire West, Cheshire East and Warrington. Halton also works across the wider regional footprint with the Regional Emergencies Division (formerly Government Office North West).

In 2016-2017 there were 9 Major Incidents (or Major Incident Standby) declaration for Halton incidents which required multi agency response, these include response due to Flood warnings, Severe Storm, roof collapse at an extra care establishment, fire in sheltered housing accommodation, Silver Jubilee bridge closures, industrial premises fire and a police related incident.

Recommendations

- Emergency planning groups should continue to meet regularly to monitor on-going activity and ensure they are aware of potential future risks/ scenarios which might occur and how these can be mitigated
- Halton Borough Council should continue to liaise with wider regional partnerships to use any available learning they have gained from incidents in other local areas

Air Quality

Background

Air pollution is defined as a mixture of gases and particles that have been emitted into the atmosphere by man-made processes. Air pollution is a local, regional and international problem caused by the emission of pollutants, which either directly or through chemical reactions in the atmosphere lead to negative impacts on human health and ecosystems. There are many sources of air pollution, including power stations, traffic, household heating, agriculture and industrial processes.

Generally, if you are in a good state of health, moderate air pollution levels are unlikely to have any lasting effects. People with existing lung or heart disease are generally more susceptible to the effects of air pollution and are likely to see effects at lower concentrations. However, higher levels or long term exposure to air pollution can lead to more serious symptoms and conditions, mainly affecting the respiratory and inflammatory systems, but also more serious conditions such as heart disease and cancer.

Current Situation

Air quality in Halton is assessed and monitored regularly in order to comply with UK and EU Air Quality legislation. Air Quality objectives have been achieved in Halton for all current pollutants with the exception of Nitrogen Dioxide.

A report on Air Quality in Halton in 2015 identified a number of recommendations for future action. As part of this Halton has identified two Air Quality Management Areas, both of them in Widnes, where levels of NO2 exceed the objective levels on more occasions than is permissible as part of the objective standards. The levels of NO2 are higher in these two areas as a result of higher town centre traffic activity. As a result of the declaration of Air Quality Management Areas, these areas are subject to additional measures and Halton Borough Council is working hard to ensure that the levels of NO2 in these areas fall to within

permitted levels. These activities include investigating traffic flow alterations and promoting alternative access to the town centre, cycling, walking etc.

National and European Air Quality Objectives are determined at levels to protect health. As Halton meets all these criteria (except in designated AQMAs) the air quality cannot be considered to be at levels poor enough to affect health.

Recommendations

- The Council will continue to implement and monitor the recommendations within the Air Quality report 2015
- As part of its core responsibilities the Council will continue to monitor air quality within Halton.

Communicable Disease

Background

Communicable diseases are diseases you can “catch” from someone or somewhere. They are spread from person to person, from an animal to a person or from the environment to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluids. Some people may use the words contagious or infectious when talking about communicable disease.

When diagnosed, some communicable diseases must be reported to Public Health England so that the data can be recorded and monitored. This enables PHE and local authority public health teams to work collectively to identify outbreaks, clusters of disease and trends over time which can contribute towards future planning and prevention.

The following provides an overview of some of the main notifiable diseases for Halton that were reported to Public Health England in 2016/17. It is important to note that some cases of food poisoning are not reported and are therefore not included in this data.

Food Poisoning

Background

Food poisoning is an illness caused by eating contaminated food. It's not usually serious and most people get better within a few days without treatment.

In most cases of food poisoning, the food is contaminated by bacteria, such as salmonella or Escherichia coli (E. coli), or a virus, such as the norovirus.

Certain types of food poisoning are, when detected, reported to Public Health England. These include:

Cryptosporidium

Cryptosporidium is a parasite (a tiny organism) that causes an infection called cryptosporidiosis affecting people and farm animals. Cryptosporidium is found in lakes, streams and rivers, untreated drinking water and sometimes in swimming pools.

Anyone can get cryptosporidiosis, but it is most common in children aged between one and five years. People who care for, or work with children are more at risk than others. For most people, the illness is unpleasant but self-limiting. However, it can be a serious illness in people who have immune systems that are not working properly.

Salmonella

There are more than 2,500 strains of salmonella bacteria. These live in the guts of domestic and wild animals including, chicken, cattle, pigs, hedgehogs, snakes and lizards.

Salmonella causes food poisoning. Foods such as eggs, chicken, pork and dairy produce can carry salmonellas. Fruit and vegetables can also become contaminated if they have been in contact with livestock, manure or untreated water. People preparing food should make sure that they wash their hands and clean kitchen equipment thoroughly to prevent the spread of salmonellas from meat to other foods in the kitchen. People can also become infected from contact with individuals with diarrhoea or from unwell animals.

Symptoms of diarrhoea, stomach cramps, nausea, vomiting and fever usually develop between 12 and 72 hours after becoming infected. Illness usually lasts from 4 to 7 days.

Campylobacter

In the UK, campylobacter bacteria are the most common cause of food poisoning. The bacteria are usually found on raw or undercooked meat (particularly poultry), unpasteurised milk and untreated water.

The incubation period (the time between eating contaminated food and the start of symptoms) for food poisoning caused by campylobacter is usually between two and five days. The symptoms usually last less than a week.

Escherichia coli 0157 (E Coli 0157)

Escherichia coli O157, is a bacterial infection that can cause severe stomach pain, bloody diarrhoea and kidney failure.

E. coli O157 is found in the gut and faeces of many animals, particularly cattle. It is an uncommon cause of gastroenteritis but can be caught by:

- Eating contaminated food (such as raw leafy vegetables or undercooked meat). Always wash all vegetables (including salad leaves) that will be eaten raw, unless they have been pre-prepared and are labelled 'ready to eat'. Washing may reduce the risk of infection, but will not eliminate any risk of infection completely.
- Touching infected animals or accidentally coming into contact with their faeces.
- Contact with people who have the illness, particularly if you do not wash your hands thoroughly after using the toilet or before handling food.
- Drinking water from inadequately treated water supplies.
- Swimming or playing in contaminated water, such as ponds or streams.

Symptoms include diarrhoea, stomach cramps and occasionally fever. About half of people with the infection will have bloody diarrhoea. People usually notice symptoms three to four days after they have been infected, but symptoms can start any time between one and 14 days afterwards. These symptoms can last up to two weeks.

A small number of people with E. coli O157 infection go on to develop a serious condition called haemolytic uraemic syndrome (HUS). This can sometimes lead to kidney failure and death, although this is rare. The risk of HUS is highest in children aged under five years. Some people become infected but don't develop symptoms.

Giardia lamblia

Giardiasis is an infection of the digestive system caused by tiny parasites called Giardia intestinalis (also known as Giardia lamblia, or Giardia duodenalis).

Symptoms include stomach cramps, nausea, bloating and indigestion.

Most people become infected with giardiasis by drinking water contaminated with the Giardia parasite, or through direct contact with an infected person.

The giardiasis infection can also be passed on if an infected person doesn't wash their hands properly after using the toilet, then handles food eaten by others. Food can also be contaminated if it is washed with infected water.

Listeria

Listeriosis is an infection that usually develops after eating food contaminated by listeria bacteria.

In most people, listeriosis is mild and causes symptoms including a high temperature (fever), vomiting and diarrhoea. These symptoms usually pass within three days without the need for treatment.

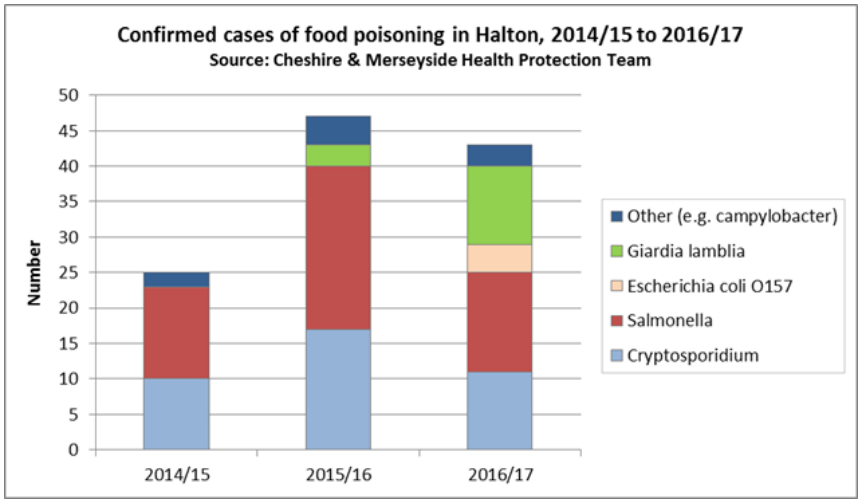
Listeria bacteria have been found in a range of chilled "ready-to-eat" foods, including pre-packed sandwiches, pate, butter, soft cheeses, cooked sliced meats and smoked salmon.

The bacteria may also be passed on through contact with the stools of infected animals or human carriers.

Current Situation

During 2016/17 a total of 43 cases of food poisoning were reported to Public Health England. This compares to 47 for 2015/16 and 25 for 2014/15.

The most common cause of food poisoning reported was Salmonella, followed by Cryptosporidium and Giardia. The Cryptosporidium cases were linked to an outbreak. In terms of Giardia, cases increased over 70% since the previous year, however these were sporadic and not linked to any particular cause.



Legionella

Legionnaires' disease is a serious lung infection caused by Legionella bacteria. Symptoms usually include flu- like such as mild headaches, muscle pain, high temperature, chills, tiredness, changes to your mental state, such as confusion.

Once bacteria begin to infect your lungs symptoms of pneumonia are also likely.

It usually takes six to seven days between getting the infection and the start of symptoms (known as the incubation period), although it can be any time from two to 19 days.

Around 90% of people with Legionnaires' disease make a full recovery after taking antibiotics. Legionnaires' disease can be particularly serious in people with pre-existing health conditions.

Current Situation

During 2016/17 there were 3 cases of Legionella in Halton. These were investigated and found to be sporadic with no obvious cause detected.

Hepatitis

Hepatitis is the term used to describe inflammation of the liver. It's usually the result of a viral infection or liver damage caused by drinking alcohol. There are several different types of hepatitis, most of which are outlined below.

Some types will pass without any serious problems, while others can be long-lasting (chronic) and cause scarring of the liver (cirrhosis) loss of liver function and, in some cases, liver cancer.

Hepatitis A

Hepatitis A is caused by the hepatitis A virus. It's usually caught by consuming food and drink contaminated with the faeces of an infected person and is most common in countries where sanitation is poor.

Hepatitis A usually passes within a few months, although it can occasionally be severe and even life-threatening. There's no specific treatment for it, other than to relieve symptoms such as pain, nausea and itching.

Hepatitis B

Hepatitis B is caused by the hepatitis B virus, which is spread in the blood of an infected person.

It's a common infection worldwide and is usually spread from infected pregnant women to their babies, or from child-to-child contact. In rare cases, it can be spread through unprotected sex and injecting drugs.

Hepatitis B is uncommon in the UK and most cases affect people who became infected while growing up in part of the world where the infection is more common, such as Southeast Asia and sub-Saharan Africa.

Most adults infected with hepatitis B are able to fight off the virus and fully recover from the infection within a couple of months.

However, most people infected as children develop a long-term infection. This is known as chronic hepatitis B and it can lead to cirrhosis and liver cancer. Antiviral medication can be used to treat it.

In the UK, vaccination against hepatitis B is recommended for people in high-risk groups, such as healthcare workers, people who inject drugs, men who have sex with men, and people travelling to parts of the world where the infection is more common.

Hepatitis C

Hepatitis C is caused by the hepatitis C virus and is the most common type of viral hepatitis in the UK. It's usually spread through blood-to-blood contact with an infected person.

In the UK, it's most commonly spread through sharing needles used to inject drugs. Poor healthcare practices and unsafe medical injections are the main way it’s spread outside the UK.

Hepatitis C often causes no noticeable symptoms, or only flu-like symptoms, so many people are unaware they're infected.

Around one in four people will fight off the infection and be free of the virus. In the remaining cases, it will stay in the body for many years. This is known as chronic hepatitis C and can cause cirrhosis and liver failure.

Chronic hepatitis C can be treated with very effective antiviral medications, but there's currently no vaccine available.

Current Situation

During 2016/17 there were a total of 6 cases of hepatitis within Halton. There were less than 5 confirmed cases of hepatitis in both 2014/15 and 2015/16.

Whooping Cough

Whooping cough, also called pertussis, is a highly contagious bacterial infection of the lungs and airways. It causes repeated coughing bouts that can last for two to three months or more, and can make babies and young children in particular very ill.

Whooping cough is spread in the droplets of the coughs or sneezes of someone with the infection.

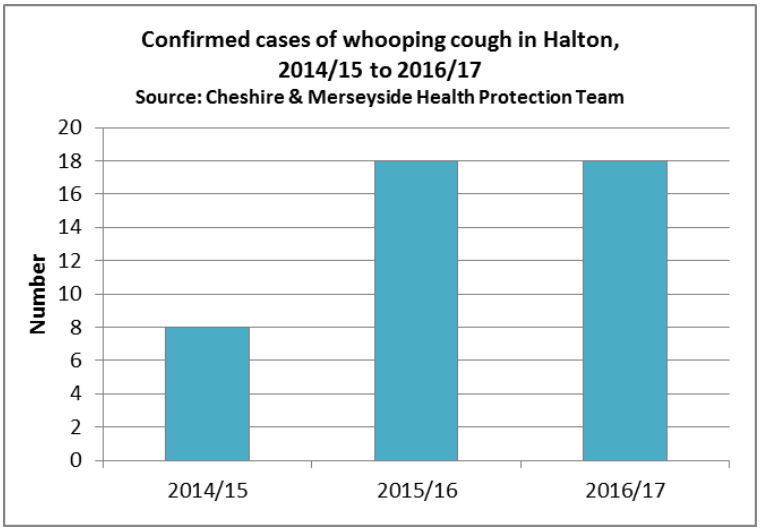
There are three routine vaccinations that can protect babies and children from whooping cough:

- The whooping cough vaccine in pregnancy – this can protect your baby during the first few weeks of life; the best time to have it is soon after the 20th week of your pregnancy
- The 5 in 1 vaccine – offered to babies at 8, 12 and 16 weeks of age
- The 4 in 1 pre-school booster – offered to children by 3 years and 4 months

These vaccines don't offer lifelong protection from whooping cough, but they can help stop children getting it when they're young and more vulnerable to the effects of the infection.

Current Situation

During 2016/17 there were 18 recorded cases of whooping cough in Halton. This figure was the same in the previous year but higher than that recorded in 2014/15 when only 8 were reported.



Dysentery

Dysentery is an infection of the intestines that causes diarrhoea containing blood or mucus.

Other symptoms of dysentery can include:

- painful stomach cramps
- Nausea or vomiting
- a fever of 38C (100.4F) or above

There are two types of dysentery:

- **bacillary dysentery or shigellosis** – caused by shigella bacteria; this is the most common type of dysentery in the UK
- **amoebic dysentery or amoebiasis** – caused by an amoeba (single-celled parasite) called Entamoeba histolytica, which is mainly found in tropical areas; this type of dysentery is usually picked up abroad

Current Situation

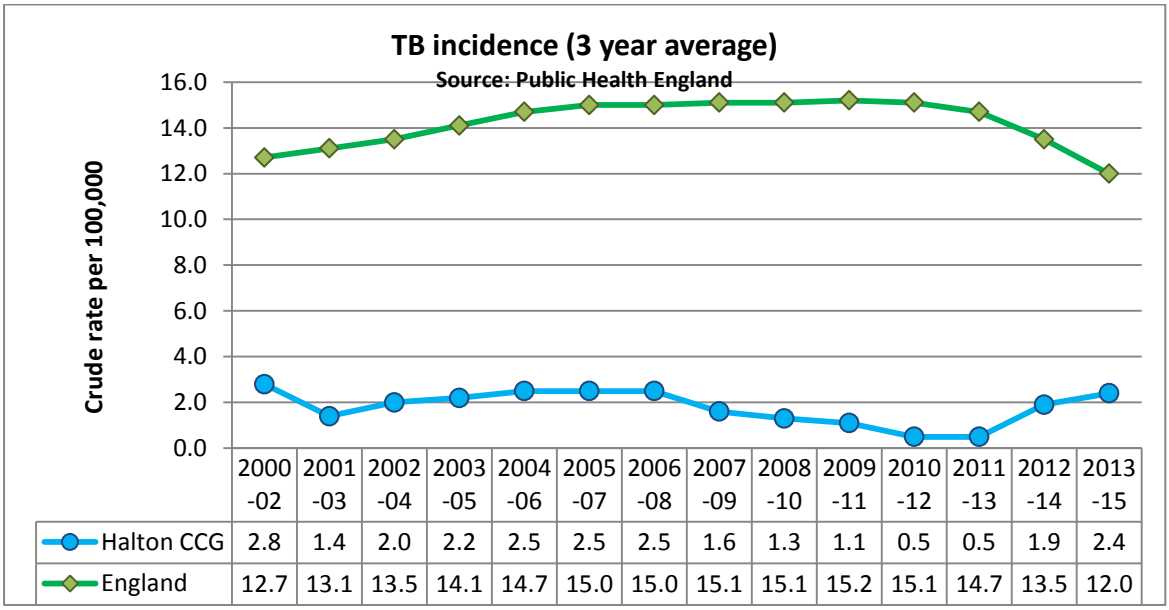
During 2016/ 17 there were 3 cases of dysentery in Halton. All of these were related to shigella bacteria.

Tuberculosis

Tuberculosis (TB) is a vaccine preventable disease caused by the bacteria belonging to the Mycobacterium tuberculosis complex. TB usually causes disease in the lungs (pulmonary), but can also affect other parts of the body (extra-pulmonary). Those most at risk are migrant populations and vulnerable groups, particularly the homeless.

Current Situation

The chart below illustrates that incidence rates for TB in Halton are low in comparison to England. This is largely to be expected due to Halton having lower than average numbers of at risk populations.



	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
Halton CCG	2.8	1.4	2.0	2.2	2.5	2.5	2.5	1.6	1.3	1.1	0.5	0.5	1.9	2.4
England	12.7	13.1	13.5	14.1	14.7	15.0	15.0	15.1	15.1	15.2	15.1	14.7	13.5	12.0

Recommendations

- Continue to monitor levels of communicable disease across all population groups and take effective action to prevent and control outbreaks as required
- Although TB incidence in Halton is low, continue to work with partner agencies to identify/ review at risk populations to ensure early diagnosis and treatment.

Seasonal Flu and Flu Vaccination

Background

Influenza (flu) is a viral infection affecting the lungs and the airways. The symptoms can appear very quickly and include a headache, fever, cough, sore throat and/ or aching muscles and joints. Flu occurs most often in winter in the UK and peaks between January and March.

The seasonal flu virus does not necessarily cause high mortality, but for some people flu can lead to complications including bacterial pneumonia, which can be life threatening especially to the elderly and those with underlying health conditions. In order to protect these vulnerable groups from seasonal flu, a national flu vaccination programme is offered. All those that fall within at risk groups are identified and offered the flu vaccination through their GP surgery. This is a national evidence based programme to help plan for the demand of flu.

Current Situation

Halton Borough Council does not have direct responsibility for delivering the seasonal flu vaccination programme, this responsibility lies with NHS England. The immunisation programme is delivered through general practitioners (GPs) in primary care. The Public Health team within the local authority, however, supports NHS England in the delivery of the programme by localising national plans to ensure effective targeting and prioritisation.

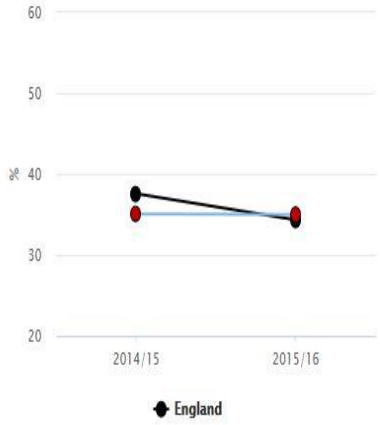
Halton also has a multi-agency Flu Planning Group which meets on a bi-monthly basis to co-ordinate the annual immunisation programme utilising local data and intelligence to enable effective planning. Lessons learnt from previous years also form an important part of this process.

The following charts show flu vaccination coverage for the main at risk groups in Halton compared to England.

3.03xviii - Population vaccination coverage - Flu (2-4 years old) Halton

Proportion - %

Export chart as image Show confidence intervals



Recent trend: –

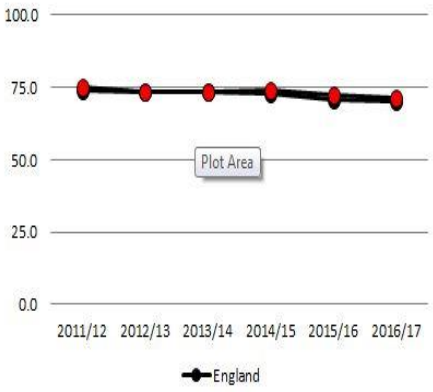
Benchmarking against goal: <40 | 40 to 65 | ≥65

Period		Count	Value	Lower CI	Upper CI	North West	England
2014/15		1,815	35.1	33.8	36.4	38.3*	37.6*
2015/16		1,694	35.0	33.7	36.4	34.4*	34.4*

Source:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/428972/Seasonal_Flu_GP_Patients_31Jan_LAs_acc.pdf

Population vaccination coverage - Flu (aged 65+) Halton

Proportion - %



Recent trend: ↓

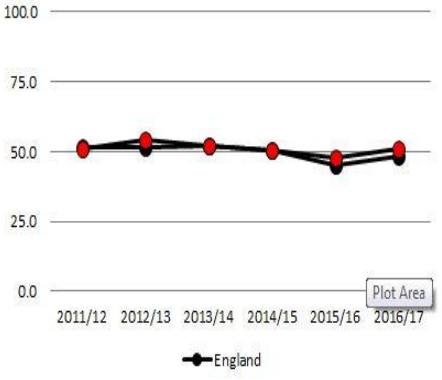
Benchmarking against goal: <75 | ≥75

Period		Count	Value	Lower CI	Upper CI	North West	England
2011/12		14,230	74.8	74.2	75.5	76.7	74.0
2012/13		14,641	73.6	73.0	74.2	75.8	73.4
2013/14		15,086	73.5	72.8	74.1	75.8	73.2
2014/15		15,549	73.8	73.2	74.4	75.4	72.7
2015/16		15,637	72.2	71.6	72.7	73.7	71.0
2016/17		15,487	71.5	70.9	72.1	72.9	70.5

Source: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-in-england-winter-season-2016-to-2017

Population vaccination coverage - Flu (at risk individuals) Halton

Proportion - %



Recent trend: ↓

Benchmarking against goal: <55 | ≥55

Period		Count	Value	Lower CI	Upper CI	North West	England
2011/12		7,723	51.2	50.4	52.0	55.3	51.6
2012/13		7,902	54.0	53.2	54.8	55.2	51.3
2013/14		7,569	51.9	51.1	52.7	56.5	52.3
2014/15		8,104	50.3	49.6	51.1	53.9	50.3
2015/16		8,789	47.6	46.9	48.3	49.0	45.1
2016/17		8,313	51.0	50.2	51.7	52.5	48.6

Source: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-in-england-winter-season-2016-to-2017

The data shows that although there was a slight decrease in 2015/16, uptake for 2-4 year olds is higher in Halton than both England and the North West. A similar trend is also observed for pregnant women where the latest data for 2016/17 shows that 50.6% of Halton women received the flu vaccination compared to 44.9% for England and 47.9% for the North West. Uptake for the under 65 at risk population is also higher than England but lower than the region as a whole.

Coverage for the over 65 population has decreased in recent years, which is similar to national and local trends. However, coverage in Halton (71.5%) is still higher than England (70.5%) but lower than the North West (72.9%).

Recommendations

- Continue to work with GP Practices to improve uptake in all population groups
- Enhanced intelligence of care home populations should be developed
- Continue to work across the wider Cheshire and Merseyside footprint to share communication plans
- Continue to utilise and promote the PHE social media campaign to promote uptake
- Promote and monitor uptake of staff flu vaccination schemes

Vaccine Preventable Diseases

Background

A number of vaccines are routinely offered through the NHS immunisation schedule in order to protect the young, older people and vulnerable groups from a range of infectious diseases. Vaccinations are carried out by a range of Primary Care professionals working in local communities, including GPs, Practice Nurses and School Nurses. The following provides an overview of the main vaccines offered and includes a brief analysis of uptake across Halton compared to the national and regional position.

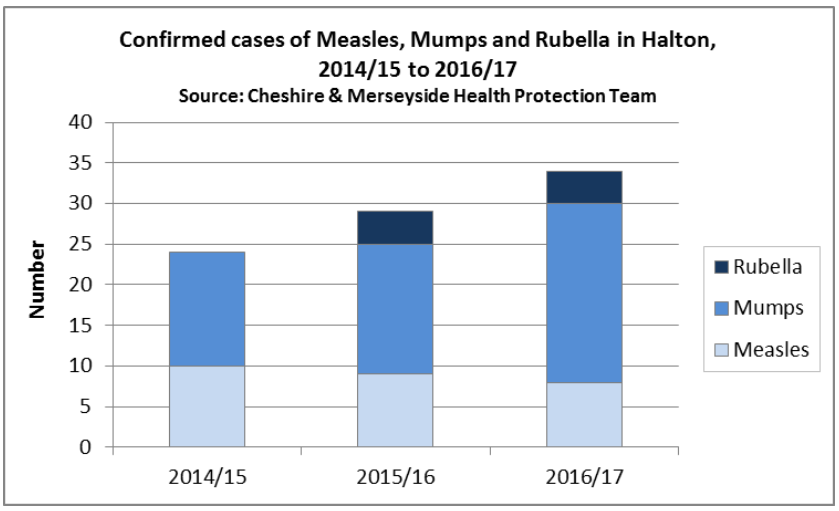
Measles, Mumps and Rubella (MMR)

MMR is a safe and effective combined vaccine that protects against three separate illnesses- measles, mumps and rubella (German measles) – in a single injection. The full course of MMR vaccination requires two doses. Measles, mumps and rubella are common, highly

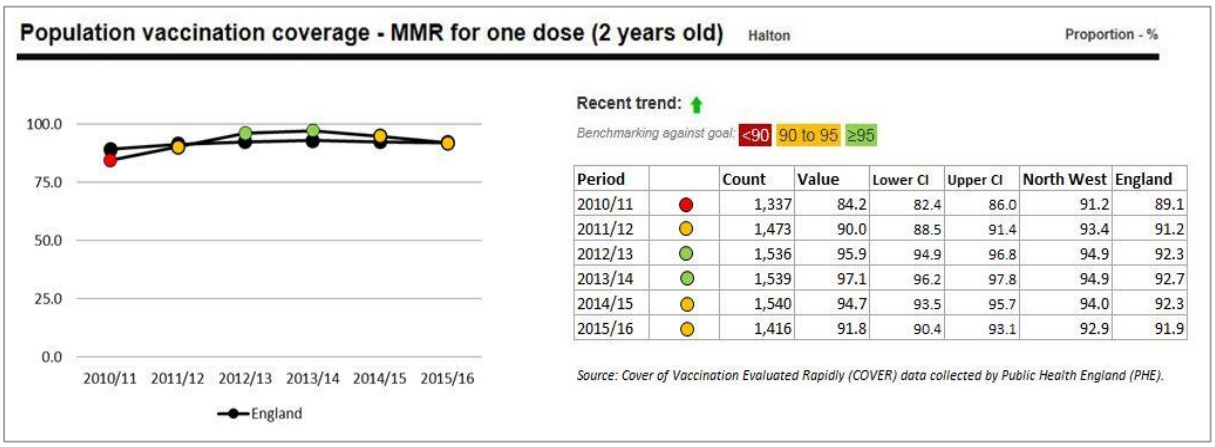
infectious conditions that can have serious, potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage. Since the MMR vaccine was introduced in 1998, fewer children have developed these serious conditions. However, outbreaks do happen with cases of measles in particular rising in recent years.

Current Situation

The following chart shows the number of recorded cases for Measles, Mumps and Rubella in Halton for the last three years. During 2016/17 there were 8 cases of Measles, 22 cases of Mumps and 4 cases of Rubella.

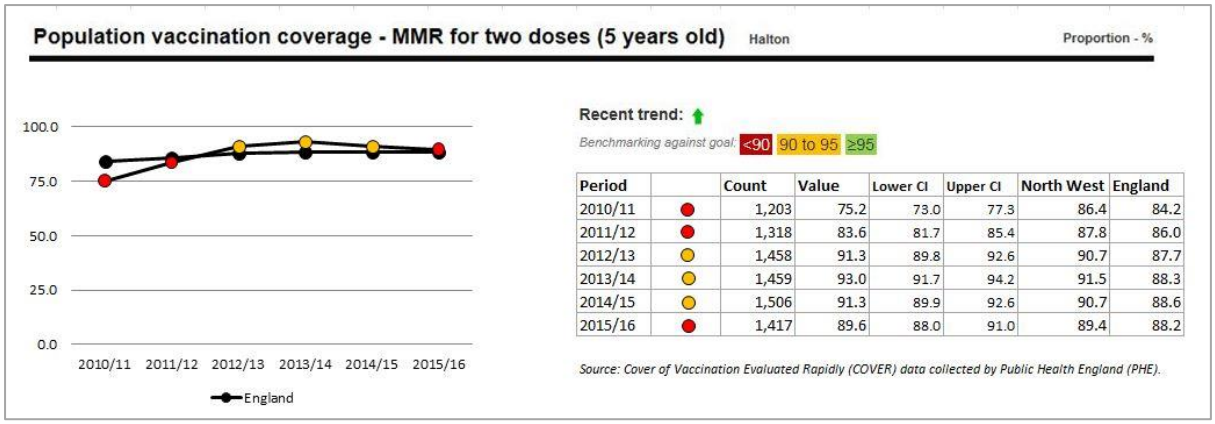


The latest data for MMR from 2015/16 shows that for the first dose (by 2 years old) Halton's uptake is similar to England and the North West. By the time the second dose is given at the age of 5 Halton is higher than the England average and similar to the North West.



Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		1,337	84.2	82.4	86.0	91.2	89.1
2011/12		1,473	90.0	88.5	91.4	93.4	91.2
2012/13		1,536	95.9	94.9	96.8	94.9	92.3
2013/14		1,539	97.1	96.2	97.8	94.9	92.7
2014/15		1,540	94.7	93.5	95.7	94.0	92.3
2015/16		1,416	91.8	90.4	93.1	92.9	91.9

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE).



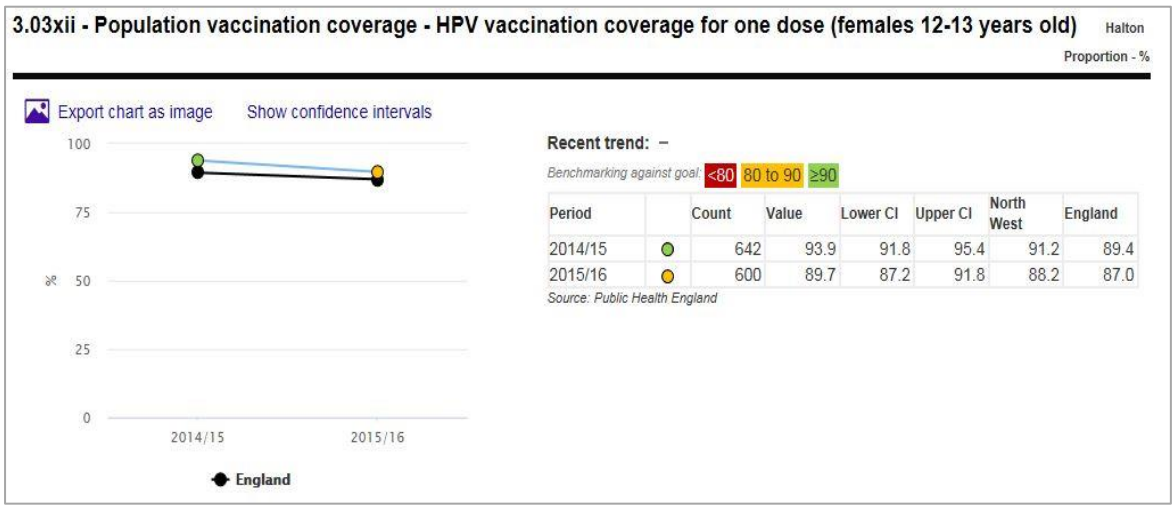
Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		1,203	75.2	73.0	77.3	86.4	84.2
2011/12		1,318	83.6	81.7	85.4	87.8	86.0
2012/13		1,458	91.3	89.8	92.6	90.7	87.7
2013/14		1,459	93.0	91.7	94.2	91.5	88.3
2014/15		1,506	91.3	89.9	92.6	90.7	88.6
2015/16		1,417	89.6	88.0	91.0	89.4	88.2

HPV

All girls aged 12 to 13 are offered the HPV (Human Papilloma Virus) vaccination as part of the NHS childhood vaccination programme. The vaccine protects against cervical cancer. It is usually given to girls in Year 8 across schools in England.

Current Situation

The percentage of girls being vaccinated against HPV in Halton in 2015/16 was 89.7 compared to 87% for England and 88.2% for the North West. However, the data also shows that Halton's percentage coverage dropped by 4.2% since the previous year a similar trend to that experienced both nationally and regionally. The national target for HPV is set at 90% and over.



Period		Count	Value	Lower CI	Upper CI	North West	England
2014/15		642	93.9	91.8	95.4	91.2	89.4
2015/16		600	89.7	87.2	91.8	88.2	87.0

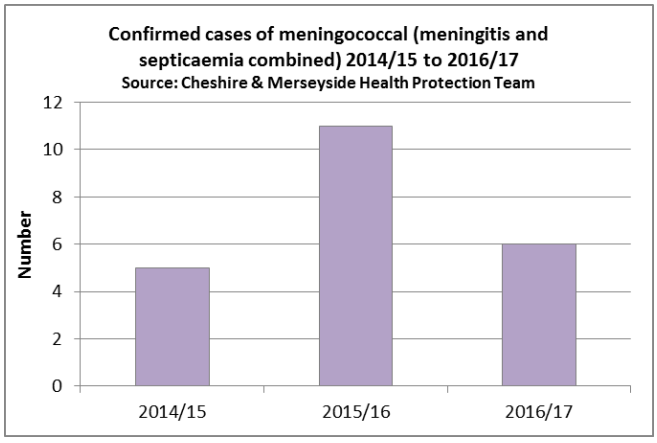
Meningococcal Disease

Meningococcal disease can affect all age groups, but the rates of disease are highest in children under 5 years of age, with the peak in babies under one year of age. There is a second peak in young people aged between 15 and 19. Babies are routinely offered the Men C vaccine as part of the vaccination programme at 3 months of age. A second dose of Men C is offered at 12 months in a combined vaccine with Haemophilus influenza b (Hib). Teenagers and first-time university students are offered Men C vaccination in a combined Men ACWY vaccine.

September 2015 saw the addition of the Men B vaccine being added to the childhood vaccination programme. The vaccine protects babies against infection from Meningococcal group B bacteria, which can cause Meningitis and septicaemia (blood poisoning), which are serious and potentially fatal illnesses. The vaccine is offered to babies aged 2 months, followed by a second dose at 4 months and a booster at 12 months.

Current Situation

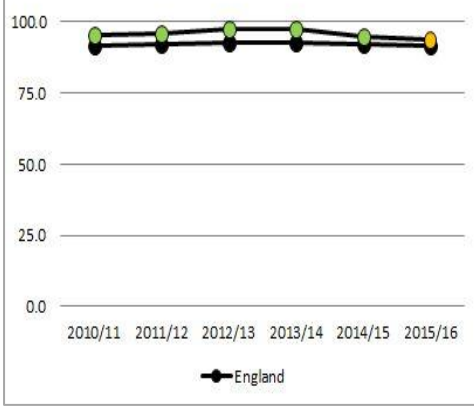
Over the past three years there were a total of 22 cases of Meningococcal infection in Halton, (9 cases of Meningococcal Meningitis and 13 cases of Meningococcal septicaemia).



Hib/ Men C vaccine uptake among 2 year olds in Halton remains high at 93.5% for 2015/16 but dropped by 1.6% based on the previous year. In spite of this, it still remains above England and the North West.

By age 5, uptake is above the 95% target (95.6%) and also exceeds England and the North West.

Population vaccination coverage - Hib / MenC booster (2 years old) Halton Proportion - %



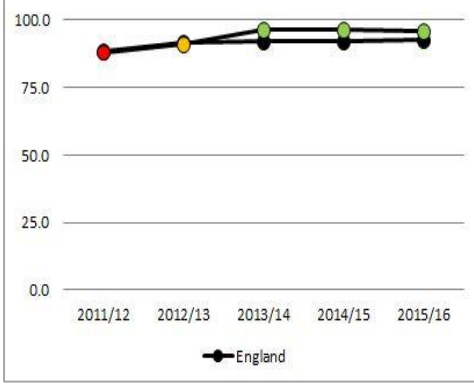
Recent trend:

Benchmarking against goal: <90 90 to 95 ≥95

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		1,515	95.5	94.3	96.4	93.3	91.6
2011/12		1,566	95.7	94.6	96.6	94.3	92.3
2012/13		1,564	97.7	96.8	98.3	94.9	92.7
2013/14		1,549	97.7	96.9	98.4	94.3	92.5
2014/15		1,546	95.1	93.9	96.0	93.2	92.1
2015/16		1,442	93.5	92.2	94.6	92.6	91.6

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE).

Population vaccination coverage - Hib / Men C booster (5 years old) Halton Proportion - %



Recent trend:

Benchmarking against goal: <90 90 to 95 ≥95

Period		Count	Value	Lower CI	Upper CI	North West	England
2011/12		1,385	87.9	86.2	89.4	89.2	88.6
2012/13		1,451	90.9	89.3	92.2	91.6	91.5
2013/14		1,508	96.2	95.1	97.0	92.8	91.9
2014/15		1,587	96.2	95.2	97.1	93.2	92.4
2015/16		1,512	95.6	94.5	96.5	93.9	92.6

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE).

Pneumococcal Infection

Pneumococcal infections are caused by the bacterium Streptococcus pneumoniae and can lead to pneumonia, septicaemia (a kind of blood poisoning) and meningitis. A Pneumococcal infection can affect anyone, however, some people need the pneumococcal vaccination because they are at higher risk of complications. These include:

- All children under the age of two
- Adults aged 65 or over
- Children and adults with certain long-term health conditions

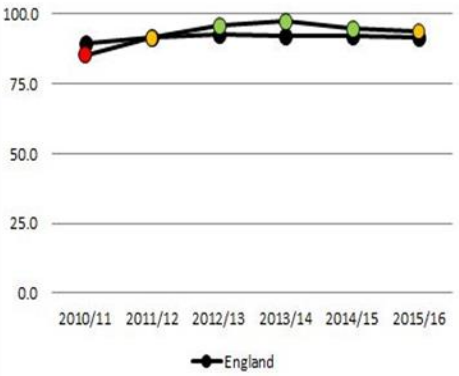
Children receive the Pneumococcal Conjugate Vaccine as three separate injections, at 8 weeks, 16 weeks and one year old. People over 65 only need a single pneumococcal vaccination, known as Pneumococcal Polysaccharide Vaccine (PPV) which will protect them

for life and those with a long-term health condition may need just a single one-off vaccination or five-yearly depending on their underlying health condition.

Current Situation

In recent years PCV vaccination coverage in Halton has remained consistently above the North West and England. Although a drop was observed in 2015/16 this remains consistent with national and regional trends. Coverage for the PPV vaccination for the over 65s is also above England but is currently slightly below the North West.

Population vaccination coverage - PCV booster Halton — Proportion - %



Recent trend: ↑

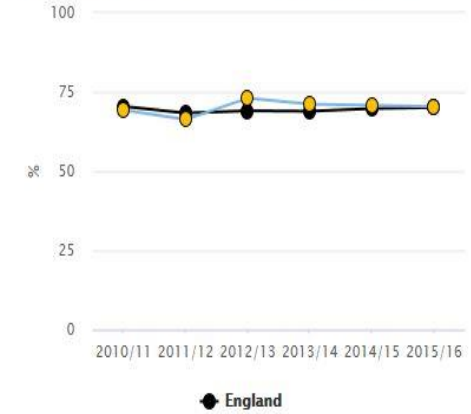
Benchmarking against goal: <90 | 90 to 95 | ≥95

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		1,355	85.4	83.6	87.0	91.2	89.3
2011/12		1,496	91.4	90.0	92.7	93.7	91.5
2012/13		1,536	95.9	94.9	96.8	94.8	92.5
2013/14		1,541	97.2	96.3	97.9	94.2	92.4
2014/15		1,544	95.0	93.8	95.9	93.3	92.2
2015/16		1,446	93.8	92.5	94.9	92.2	91.5

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE).

3.03xiii - Population vaccination coverage - PPV Halton — Proportion - %

Export chart as image Show confidence intervals



Recent trend: ↑

Benchmarking against goal: <65 | 65 to 75 | ≥75

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11		14,415	69.3	68.7	69.9	70.4*	70.5*
2011/12		12,006	66.3	65.6	67.0	69.3*	68.3*
2012/13		15,287	73.1	72.5	73.7	69.8*	69.1*
2013/14		12,386	71.2	70.5	71.8	69.7	68.9
2014/15		12,948	70.8	69.6	72.0	71.1	69.8
2015/16		14,825	70.4	69.8	71.0	71.7*	70.1

Source: Public Health England

Shingles

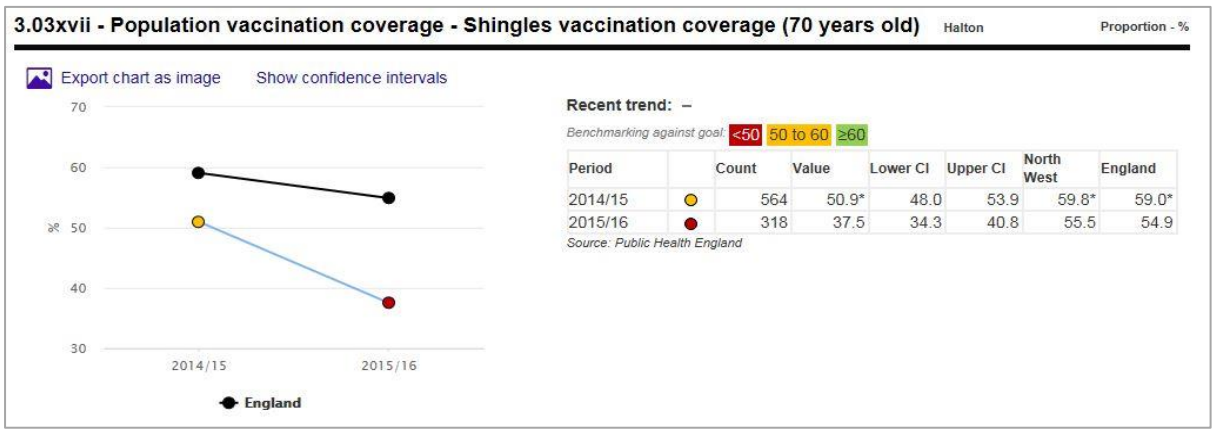
Shingles is a painful skin rash caused by the reactivation of the chickenpox virus in people who have previously had chickenpox. The shingles vaccine is given to people aged 70 or 78 years old on 1st September 2016. In addition, anyone who was eligible for the vaccine in the previous three years of the programme but missed out on their shingles vaccination remains eligible until their 80th birthday. This includes:

- People aged 71, 72 and 73 on 1st September 2016
- People aged 79 on 1st September 2016

The vaccine is expected to reduce the risk of getting shingles. For those who are unlucky enough to get the disease the symptoms are usually milder and the illness shorter.

Current Situation

Data for uptake of the shingles vaccine in Halton shows that since the vaccine was introduced, uptake has fallen from 50.9% in 2014/15 to 37.5% in 2015/16. The reasons behind this are unknown, however, these figures show that Halton is significantly below the North West and England.



Period		Count	Value	Lower CI	Upper CI	North West	England
2014/15		564	50.9*	48.0	53.9	59.8*	59.0*
2015/16		318	37.5	34.3	40.8	55.5	54.9

Recommendations

As the data shows Halton has good vaccination uptake in most areas, however, further work is needed to:

- Improve uptake of the Shingles vaccine in target groups by ensuring an effective strategy is developed to include communication across a range of settings including: front line professionals, primary care, community services and care homes
- Build on existing uptake rates in other vaccinations, aiming for 95% coverage and above in all areas of Halton

Screening Programmes

Background

Screening is a way of identifying apparently healthy people who may be at risk of a health problem, so that early treatment can be offered or information given to help them make informed decisions. In England, a range of screening programmes are available including breast, cervical and bowel cancer, diabetic eye screening and abdominal aortic aneurysm (a dangerous swelling in the aorta). Screening can lead to a reduction in late diagnosis and preventable deaths.

To maximise the benefits of the screening programme it is important that as many of the eligible population take up the offer of screening as possible. Screening rates can be affected by a number of factors including socioeconomic group, ethnicity, knowledge and service provision.

Breast Cancer Screening

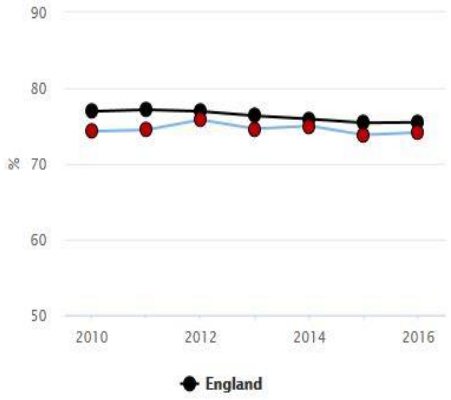
Breast screening is routinely offered to women aged 50- 70 years as part of the NHS screening programme. Women over 70 can self-refer.

Current Situation

The percentage coverage of breast screening in Halton is below the England average but is consistently above the North West. Whilst rates dropped in 2015 the latest data for 2016, shows an increase.

2.20i - Cancer screening coverage - breast cancer Halton Proportion - %

Export chart as image Show confidence intervals



Recent trend:

Period		Count	Value	Lower CI	Upper CI	North West	England
2010		9,840	74.3	73.5	75.0	75.6	76.9
2011		10,054	74.5	73.7	75.2	74.9	77.1
2012		10,448	75.8	75.1	76.5	74.9	76.9
2013		10,485	74.6	73.9	75.3	74.5	76.3
2014		10,736	75.0	74.3	75.7	73.4	75.9
2015		10,810	73.8	73.1	74.5	72.6	75.4
2016		11,137	74.1	73.4	74.8	72.2	75.5

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

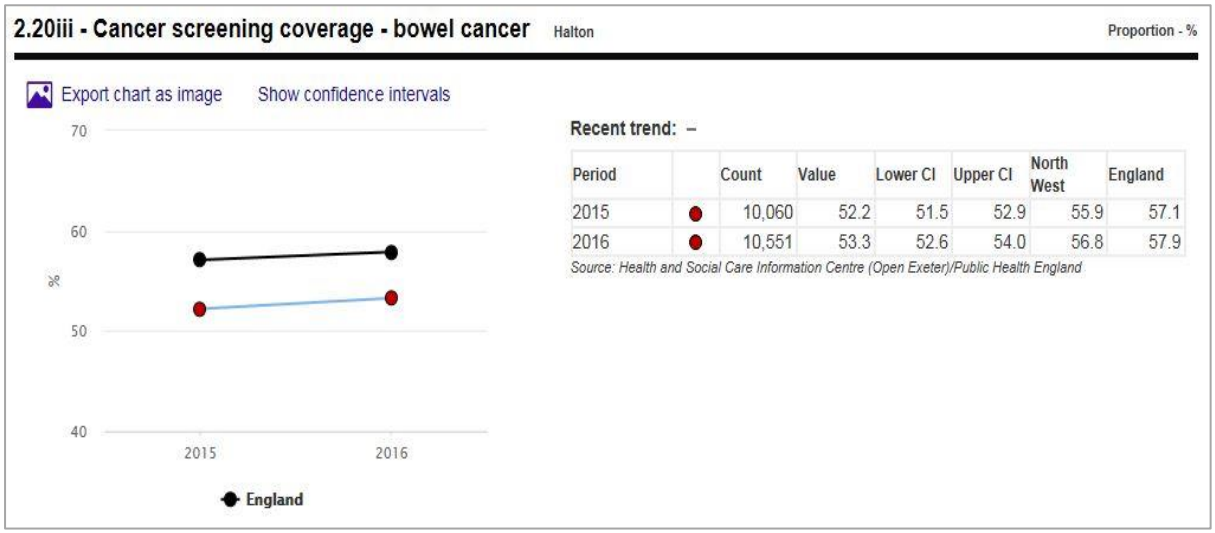
Bowel Screening

There are two types of screening for Bowel Cancer:

- A home testing kit is offered to men and women aged 60-74
- Bowel scope screening uses a thin, flexible tube with a tiny camera on the end to look at the large bowel. It is offered to men and women at the age of 55 in some parts of England.

Current Situation

In Halton, although screening rates for bowel cancer have improved in 2016, they are still below the England and North West. A new initiative has recently been introduced in Halton through primary care, whereby people are contacted by telephone to encourage them to return their bowel cancer testing kits. This also provides the opportunity to discuss any concerns the patient may have regarding the test. A pilot of the programme in 2016 proved successful within the trial group in increasing uptake.



Period		Count	Value	Lower CI	Upper CI	North West	England
2015		10,060	52.2	51.5	52.9	55.9	57.1
2016		10,551	53.3	52.6	54.0	56.8	57.9

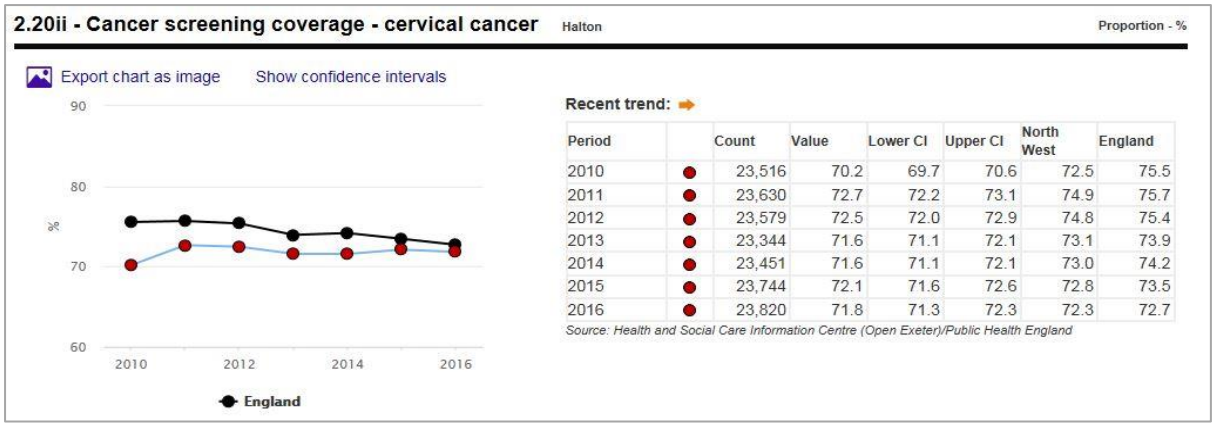
Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Cervical Screening

Cervical screening is offered to women aged 25- 64 to check the health of cells in the cervix. It is offered every three years for those aged 26-49, and every five years from the ages of 50-64.

Current Situation

Although rates for cervical cancer screening increased slightly in 2015 the latest data from 2016 shows a slight decrease. Halton's rate is slightly below the North West and 0.9% below that of England.



Period		Count	Value	Lower CI	Upper CI	North West	England
2010		23,516	70.2	69.7	70.6	72.5	75.5
2011		23,630	72.7	72.2	73.1	74.9	75.7
2012		23,579	72.5	72.0	72.9	74.8	75.4
2013		23,344	71.6	71.1	72.1	73.1	73.9
2014		23,451	71.6	71.1	72.1	73.0	74.2
2015		23,744	72.1	71.6	72.6	72.8	73.5
2016		23,820	71.8	71.3	72.3	72.3	72.7

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Abdominal Aortic Aneurysm (AAA) screening

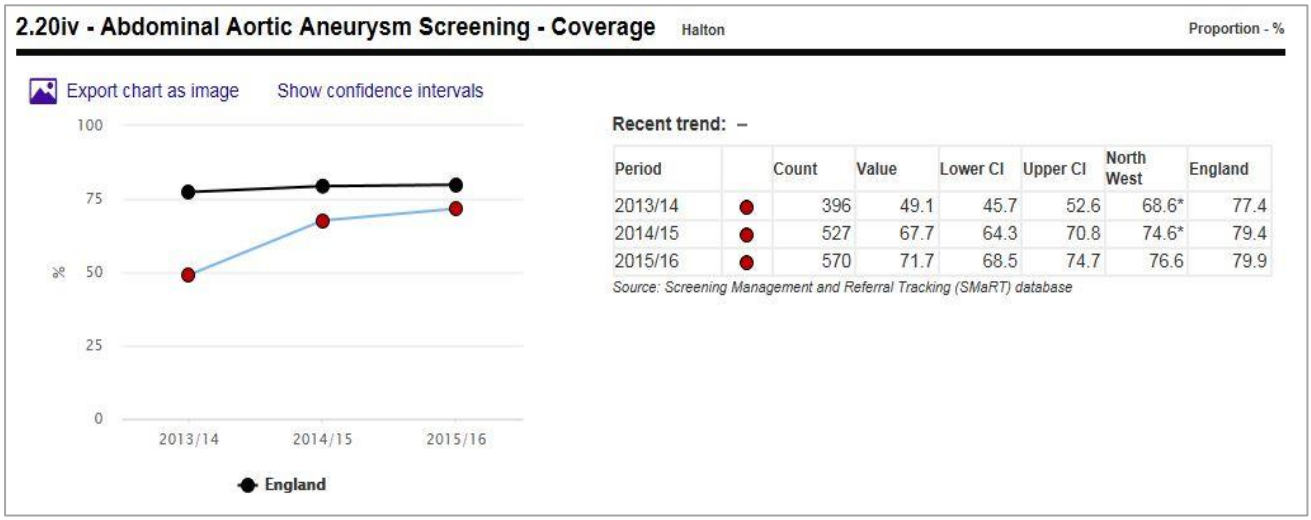
AAA screening is a way of detecting a dangerous swelling of the aorta- the main blood vessel that runs from the heart, down through the abdomen to the rest of the body.

This swelling is far more common in men aged over 65 than it is in women and younger men, so men over 65 are invited for screening in the year they turn 65. An AAA usually causes no symptoms, but if it bursts, it's extremely dangerous and usually fatal.

Screening involves a simple ultrasound scan of the stomach (abdomen) which takes about 10-15 minutes.

Current Situation

Since being introduced in 2013, uptake for AAA screening in Halton has increased year on year but still falls below both the North West and England.



Diabetic Retinopathy

Diabetic retinopathy is a complication of diabetes, caused by untreated high blood sugar levels. To minimise risk, people with diabetes should:

- Ensure they control their blood sugar levels, blood pressure and cholesterol
- Attend diabetic eye screening appointments- annual screening is offered to all people with diabetes aged 12 and over to pick up and treat any problems early on.

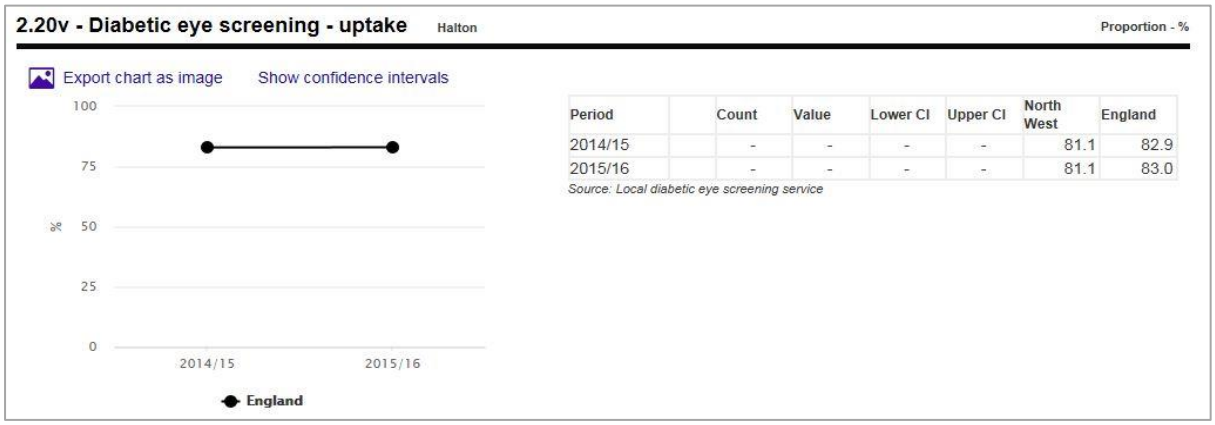
The screening test involves examining the back of the eyes and taking photographs. Depending on the results, patients may be asked to return for another appointment a year later, attend more regular appointments or discuss treatment options with a specialist.

Current Situation

Unfortunately, there are no specific Halton data for diabetic eye screening as the programme is managed as central hub services. The following tables however, show the latest quarterly data from the Cheshire and Merseyside immunisation report as well as national trends. This demonstrates that Cheshire and Central Mersey have the lowest level of uptake when compared to the North West and England as a whole.

3.1 Diabetic Eye Screening

3.1.i DE1 - Uptake of Digital Screening Encounter The proportion of those offered diabetic eye screening who attend a digital screening event.* *Target: Acceptable >=70%, Achievable>=80%*									
Screening Centre	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Trend
Cheshire	83.1%	79.3%	77.6%	76.9%	76.4%	76.8%	76.5%	75.9%	
Wirral	83.7%	83.9%	83.3%	83.4%	83.5%	83.8%	83.9%	83.9%	
Central Mersey	77%	76.8%	76.9%	78.4%	79.2%	79.2%	78.8%	79.8%	
Liverpool	83.5%	82.9%	83.0%	85.9%	88.0%	89.3%	91.2%	83.1%	
North Mersey	91.8%	91.4%	91.2%	91.8%	91.8%	92.0%	91.8%	91.7%	
North West	81.6%	80.8%	80.5%	81.1%	81.1%	81.3%	81.5%	81.1%	



Recommendations

- Build on existing improvements in bowel cancer and breast cancer screening
- Continue to build on the success of bowel cancer telephone pilot and roll out to more practices across Halton
- Maintain increase in AA screening to bring in line with North West and England average
- Examine ways to improve cervical cancer screening by identifying areas with low uptake

Sexually Transmitted Diseases

Sexual Health is an issue that concerns the majority of the population. The World Health Organisation defines sexual health along these main parameters:

- Enjoyment of sexual relations without exploitation, oppression or abuse
- Safe pregnancy and childbirth and avoidance of unintended pregnancies
- Absence and avoidance of sexually transmitted infections, including HIV

To ensure this can be achieved a comprehensive sexual health service is required, including health promotion campaigns and educational opportunities particularly for young people. In addition good surveillance of trends in key measures of sexual health such as sexually transmitted infections should be used to measure this. Within the Public Health Outcomes Framework the main areas of focus for sexual health are HIV and Chlamydia.

HIV

HIV is a virus that attacks the immune system, and weakens your ability to fight infections and disease. It's most commonly caught by having sex without a condom.

It can also be passed on by sharing infected needles and other injecting equipment, and from an HIV-positive mother to her child during pregnancy, birth and breastfeeding.

HIV stands for human immunodeficiency virus. The virus attacks the immune system, and weakens your ability to fight infections and disease.

There is no cure for HIV, but there are treatments to enable most people with the virus to live a long and healthy life, and to reduce the possibility of them passing on the virus to others.

AIDS is the final stage of HIV infection, when your body can no longer fight life-threatening infections. With early diagnosis and effective treatment, most people with HIV will not go on to develop AIDS (NHS Choices, 2017).

Current Situation

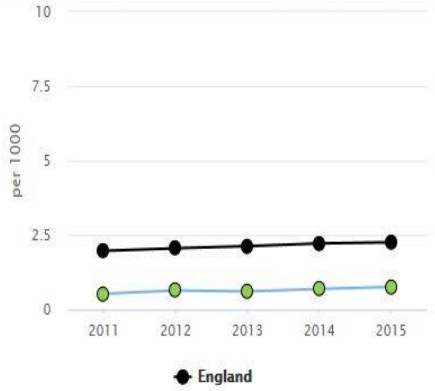
The following tables illustrate HIV diagnosed prevalence rates, testing uptake and late diagnosis.

The data shows that Halton's diagnosed prevalence rate is low in comparison to national and regional trends. HIV testing uptake however, is low particularly for women, where the rate dropped from 74.4% in 2014 to 37% in 2015.

Late diagnosis rates remain low in Halton at 12.5% for 2013-15 compared to 46.3% for the region as a whole and 40% for England.

HIV diagnosed prevalence rate / 1,000 aged 15-59 Halton — Crude rate - per 1000

Export chart as image | Show confidence intervals



Recent trend:

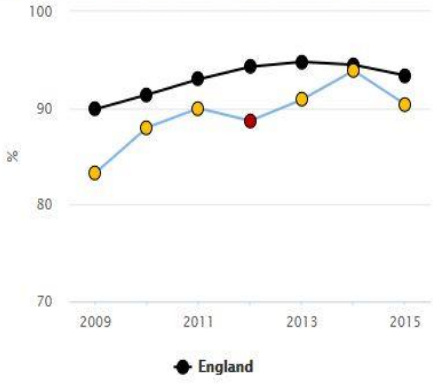
Benchmarking against goal: <2 | 2 to 5 | ≥5

Period		Count	Value	Lower CI	Upper CI	North West	England
2011		40	0.53	0.38	0.72	1.50	1.97
2012		48	0.64	0.48	0.85	1.57	2.06
2013		45	0.61	0.44	0.81	1.63	2.13
2014		51	0.69	0.51	0.91	1.71	2.22
2015		56	0.76	0.58	0.99	1.78	2.26

Source: Public Health England

HIV testing uptake, MSM (%) Halton — Proportion - %

Export chart as image | Show confidence intervals



Recent trend:

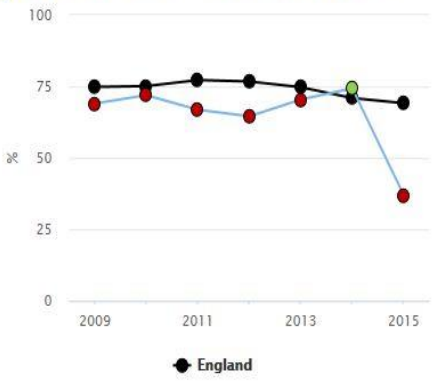
Period		Count	Value	Lower CI	Upper CI	North West	England
2009		65	83.3	73.2	90.8	90.0	89.9
2010		66	88.0	78.4	94.4	90.3	91.4
2011		90	90.0	82.4	95.1	91.0	93.0
2012		110	88.7	81.8	93.7	91.4	94.3
2013		130	90.9	85.0	95.1	92.3	94.8
2014		153	93.9	89.0	97.0	93.2	94.5
2015		150	90.4	84.8	94.4	93.5	93.4

Source: Public Health England

(MSM – Men who have sex with Men)

HIV testing uptake, women (%) Halton — Proportion - %

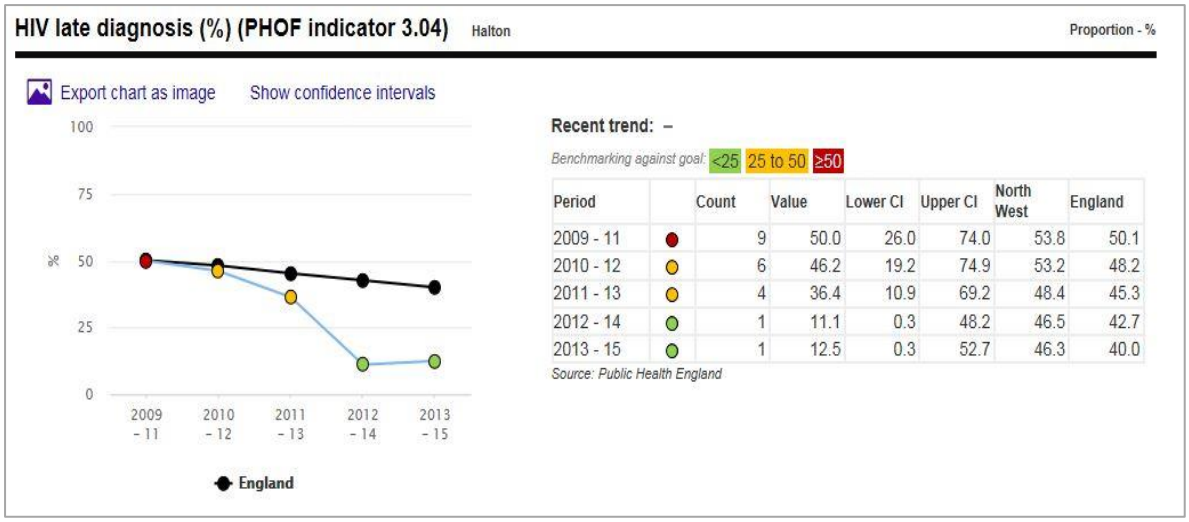
Export chart as image | Show confidence intervals



Recent trend:

Period		Count	Value	Lower CI	Upper CI	North West	England
2009		872	69.1	66.5	71.6	69.5	74.9
2010		757	72.0	69.2	74.7	69.2	75.2
2011		717	66.9	64.0	69.8	69.1	77.3
2012		677	64.6	61.6	67.5	68.2	76.8
2013		778	70.5	67.7	73.2	60.4	74.8
2014		720	74.4	71.5	77.1	52.3	71.0
2015		804	37.0	34.9	39.0	48.9	69.2

Source: Public Health England



Period		Count	Value	Lower CI	Upper CI	North West	England
2009 - 11		9	50.0	26.0	74.0	53.8	50.1
2010 - 12		6	46.2	19.2	74.9	53.2	48.2
2011 - 13		4	36.4	10.9	69.2	48.4	45.3
2012 - 14		1	11.1	0.3	48.2	46.5	42.7
2013 - 15		1	12.5	0.3	52.7	46.3	40.0

Chlamydia

Chlamydia is one of the most common sexually transmitted infections (STIs) in the UK.

It's passed on from one person to another through unprotected sex (sex without a condom) and is particularly common in sexually active teenagers and young adults.

In 2013, more than 200,000 people tested positive for chlamydia in England. Almost 7 in every 10 people diagnosed with the condition were under 25 years old.

Although chlamydia doesn't usually cause any symptoms and can normally be treated with a short course of antibiotics, it can be serious if it's not treated early on.

If left untreated, the infection can spread to other parts of the body and lead to long-term health problems, such as pelvic inflammatory disease (PID), epididymo-orchitis (inflammation of the testicles) and infertility. It can also sometimes cause reactive arthritis.

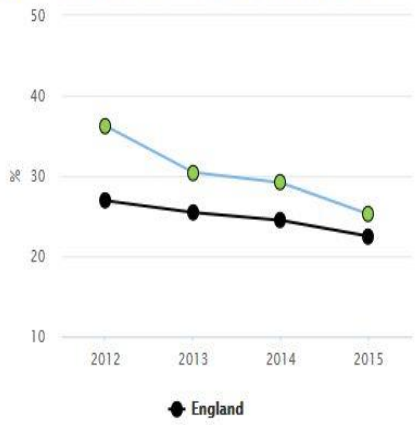
Current Situation

Since 2012, there has been a year on year decrease in the number of 15-24 year olds being screened for chlamydia. Although this is disappointing it is a reduction that has also been observed across the North West and England. In spite of this reduction in screening rates, Halton's rate still remains higher than England.

The data also shows that chlamydia detection rates in Halton for 15-24 year olds, reduced significantly between 2012 and 2014, although there was a slight increase during 2015.

Chlamydia proportion aged 15-24 screened Halton — Proportion - %

Export chart as image | Show confidence intervals



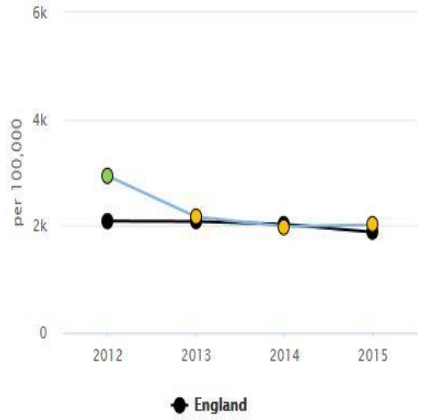
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2012		5,599	36.3	35.3	37.2	27.8	26.9
2013		4,639	30.5	29.6	31.4	25.5	25.5
2014		4,407	29.2	28.3	30.1	25.8	24.5
2015		3,816	25.3	24.5	26.1	25.5	22.5

Source: Public Health England

Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) Halton — Crude rate - per 100,000

Export chart as image | Show confidence intervals



Recent trend: –

Benchmarking against goal: <1,900 | 1,900 to 2,300 | ≥2,300

Period		Count	Value	Lower CI	Upper CI	North West	England
2012		454	2,940	2,676	3,223	2,361	2,095
2013		331	2,174	1,946	2,422	2,236	2,088
2014		301	1,993	1,774	2,231	2,354	2,035
2015		306	2,025	1,805	2,266	2,328	1,887

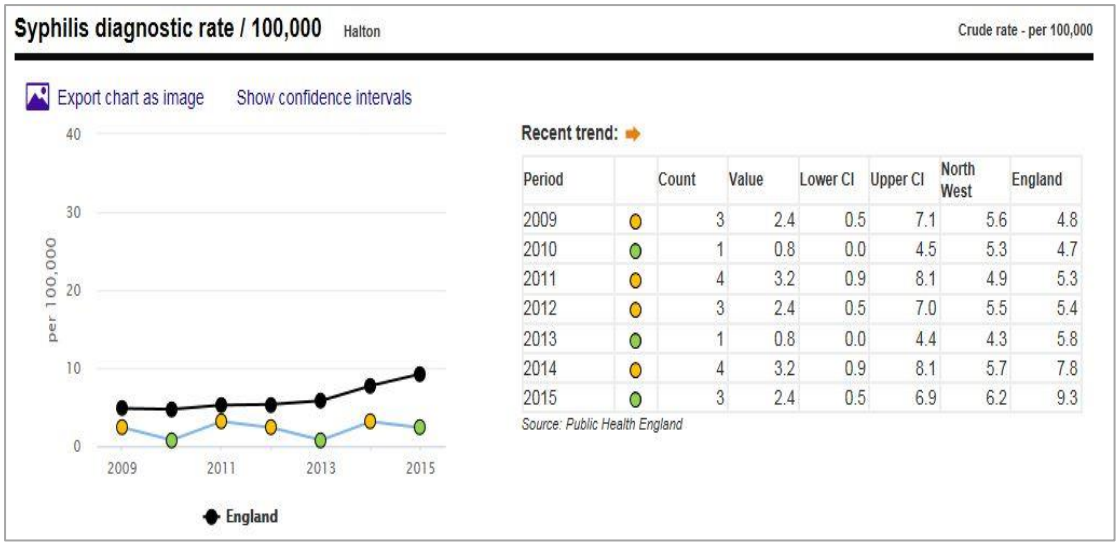
Source: Public Health England

Syphilis

Syphilis is a bacterial infection that's usually caught by having sex with someone who's infected. Those who think they may have syphilis should be tested and treated as soon as possible as it can lead to serious problems if it left untreated.

Current Situation

Cases of Syphilis in Halton are low with just 3 diagnosed cases in 2015. This is well below both the England and North West.



Period		Count	Value	Lower CI	Upper CI	North West	England
2009		3	2.4	0.5	7.1	5.6	4.8
2010		1	0.8	0.0	4.5	5.3	4.7
2011		4	3.2	0.9	8.1	4.9	5.3
2012		3	2.4	0.5	7.0	5.5	5.4
2013		1	0.8	0.0	4.4	4.3	5.8
2014		4	3.2	0.9	8.1	5.7	7.8
2015		3	2.4	0.5	6.9	6.2	9.3

Gonorrhoea

Gonorrhoea is a sexually transmitted infection caused by bacteria called Neisseria gonorrhoeae or gonococcus. It is easily passed between people through vaginal, oral or anal sex.

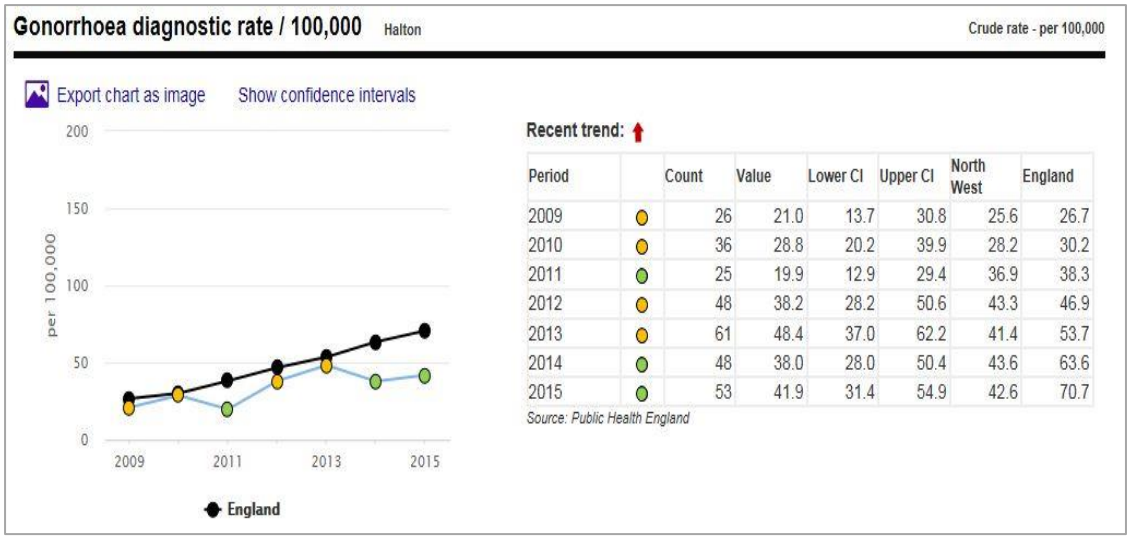
The bacteria can infect the cervix (entrance to the womb), the urethra (tube through which urine passes out of the body), the rectum, and less commonly the throat or eyes.

Gonorrhoea can be easily diagnosed by testing a sample of discharge picked up using a swab. Testing a sample of urine can also be used to diagnose the condition in men.

It's important to get tested as soon as possible, because gonorrhoea can lead to more serious long-term health problems if it's not treated, including pelvic inflammatory disease in women, or infertility.

Current Situation

Nationally, there has been a steady increase in the rate of diagnosed Gonorrhoea cases, peaking at 70.7 per 100,000 in 2015. At a regional and local level rates have remained significantly lower with Halton's rate being 41.9 per 100,000 for 2015. Although this figure represents an increase on the previous year it is still on target.



Genital Warts

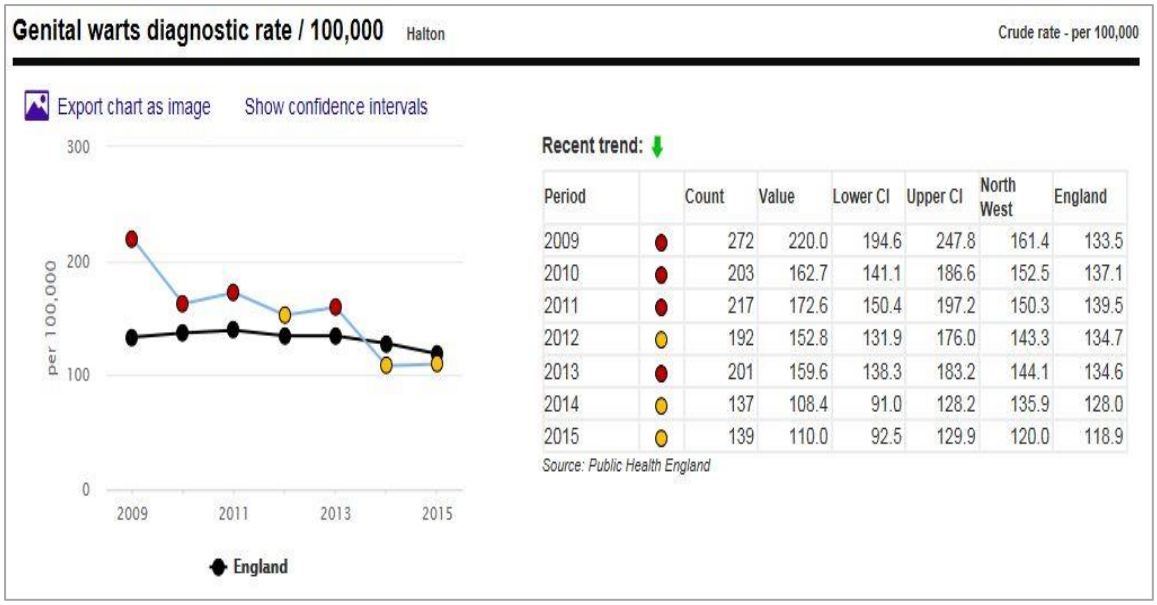
Genital warts are small fleshy growths, bumps or skin changes that appear on or around the genital or anal area.

Genital warts are very common. In England, they are the second most common type of sexually transmitted infection after chlamydia.

Genital warts are the result of a viral skin infection caused by the human papilloma virus (HPV). They are usually painless and do not pose a serious threat to health.

Current Situation

The diagnostic rate for genital warts in Halton is below both the England and North West rates. In spite of this difference rates have improved significantly since 2009 with the number of cases dropping by almost half. This data should however, be treated with caution as it only relates to diagnosed cases and therefore only represents those who have presented with the condition.



Period		Count	Value	Lower CI	Upper CI	North West	England
2009		272	220.0	194.6	247.8	161.4	133.5
2010		203	162.7	141.1	186.6	152.5	137.1
2011		217	172.6	150.4	197.2	150.3	139.5
2012		192	152.8	131.9	176.0	143.3	134.7
2013		201	159.6	138.3	183.2	144.1	134.6
2014		137	108.4	91.0	128.2	135.9	128.0
2015		139	110.0	92.5	129.9	120.0	118.9

Source: Public Health England

Genital Herpes

Genital herpes is a common infection caused by the herpes simplex virus (HSV). It causes painful blisters on the genitals and the surrounding areas.

As genital herpes can be passed to others through intimate sexual contact, it's often referred to as a sexually transmitted infection.

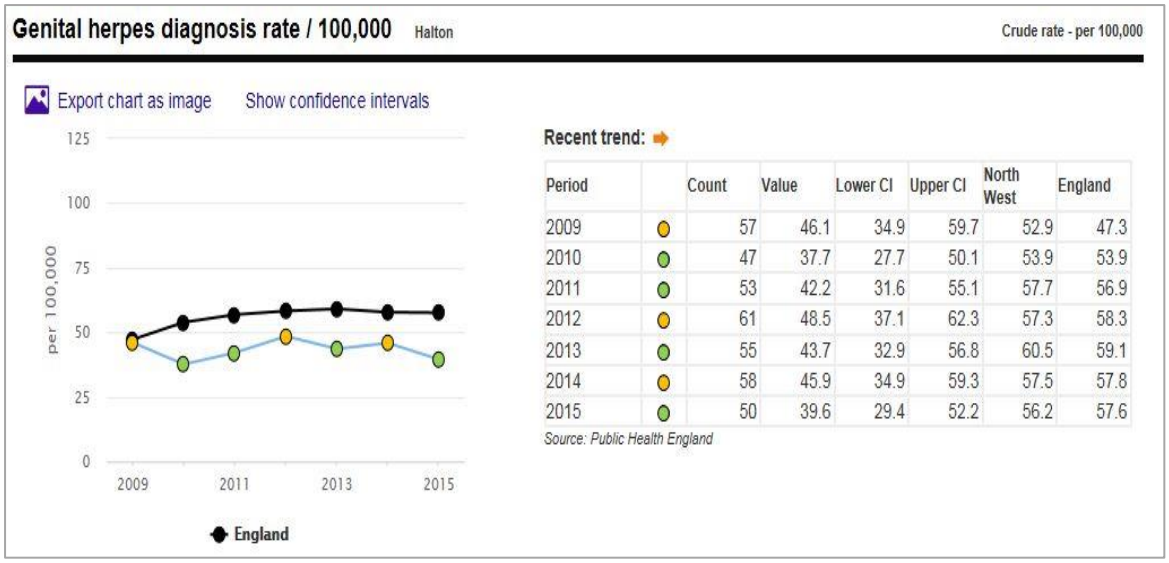
HSV can affect any mucous membrane (moist lining), such as those found in the mouth (cold sores).

Genital herpes is a chronic (long-term) condition. The virus remains in your body and can become active again. The average rate of recurrence is four to five times in the first two years after being infected. However, over time, it tends to become active less frequently and each outbreak becomes less severe.

Although there's no cure for genital herpes, the symptoms can usually be controlled using antiviral medicines.

Current Situation

Diagnosed cases of genital herpes have remained relatively low in Halton for a number of years and are significantly below rates for the North West and England. Since 2012, numbers have decreased year on year.



Recent trend:

Period		Count	Value	Lower CI	Upper CI	North West	England
2009		57	46.1	34.9	59.7	52.9	47.3
2010		47	37.7	27.7	50.1	53.9	53.9
2011		53	42.2	31.6	55.1	57.7	56.9
2012		61	48.5	37.1	62.3	57.3	58.3
2013		55	43.7	32.9	56.8	60.5	59.1
2014		58	45.9	34.9	59.3	57.5	57.8
2015		50	39.6	29.4	52.2	56.2	57.6

Source: Public Health England

Recommendations

- To continue to monitor STI levels and identify and take action following confirmation of confirmed outbreaks
- Continue to invest in preventative services which support keeping the levels of STIs down
- Look at ways of improving HIV testing uptake especially for women
- Continue to address low Chlamydia screening rates for 15-24 year olds

Healthcare Associated Infections (HCAIs)

Healthcare associated infections (HCAI) are infections that are acquired in hospital or as a result of healthcare interventions. They occur in hospitals and in the community and affect both patients and healthcare workers. It is estimated that 9% of all inpatients have an infection associated with their care in hospital.

Public Health England monitors the numbers of certain infections that occur in healthcare settings through routine surveillance programmes and advises how to prevent and control infection in establishments such as hospitals, care homes and schools. PHE also monitors the spread of antibiotic resistant infections and advises healthcare professionals about controlling antimicrobial resistance.

Two of the most common HCAI are Clostridium Difficile (C. Difficile) and Methicillin-resistant Staphylococcus Aureus (MRSA).

Current Situation

The Infection Control team for Halton during 2016/17 was hosted by Bridgewater Community NHS Trust and covers the three boroughs of Halton, Warrington and St. Helen's.

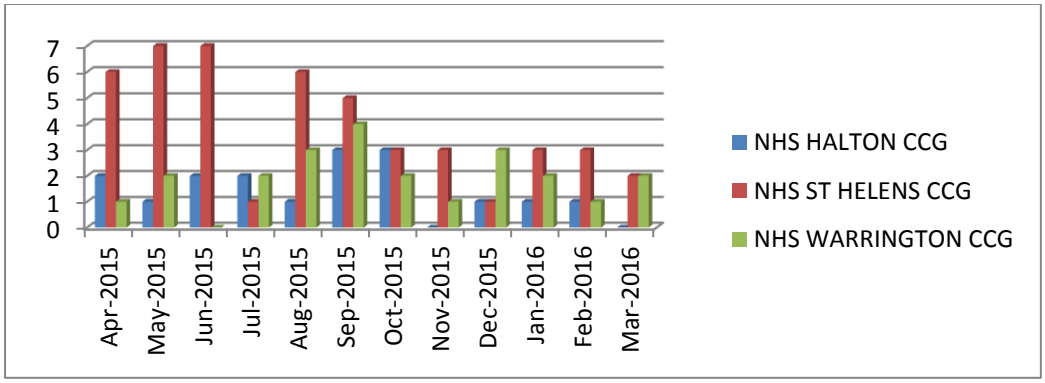
The Nurses continue to work hard to reduce the incidence of health care associated infections by promoting infection control principles across GP surgeries and care homes in the three boroughs. The nurses are involved in a variety of ways by training, audits, prudent prescribing of antibiotics and working closely with colleagues across the whole health economy.

The following graphs show the number of cases of C Difficile for 2015/16 and 2016/17.

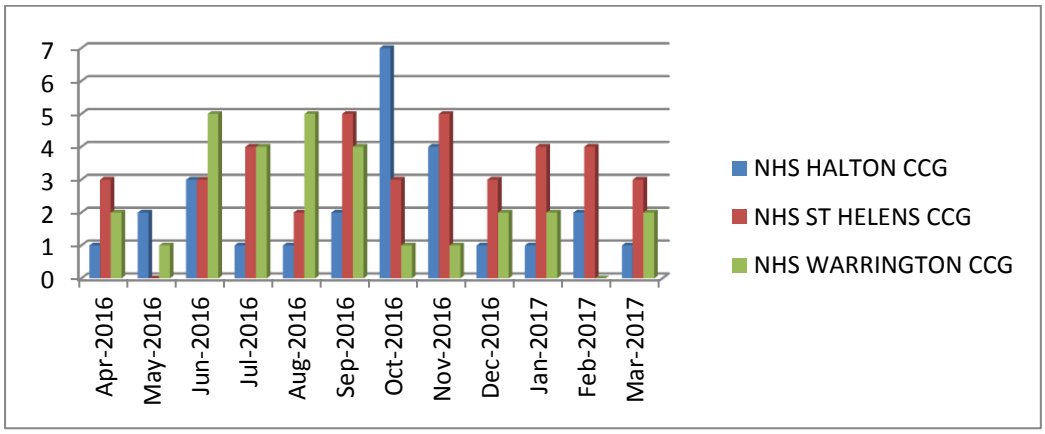
Clostridium difficile

Unfortunately, the Halton data indicates that the Department of Health, Clostridium difficile infection objectives for the year 2016-17 were fourteen cases over trajectory for this period. Root cause analysis of these cases show that many had pre-disposing factors, for example, were immuno- suppressed, had co-morbidities etc.

Clostridium Difficile 2015-2016



Clostridium Difficile 2016-2017



MRSA (Methicillin Resistant Staphylococcus Aureus)

Current Situation

The latest data for MRSA shows that in 2015/16 there was 1 case of bacteraemia (bacterial infection in the blood) in Halton. This case although community assigned, there had been hospital treatment before the patient was diagnosed and was readmitted following diagnosis. A route cause analysis is undertaken for every case of MRSA and in this instance, the Post Infection Review (PIR) identified some key recommendations for action.

- Discharge summary from the hospital to the care home should include details of -
- MRSA status indicating if patient is infected or colonised.
- Details of any suppression therapy that been given.
- Details of any antibiotics given and ongoing antibiotics.
- Details of any blood monitoring that is required as a result of antibiotics, including date of last blood test.

Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia
Rate per 100,000 CCG population

		2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Halton CCG	*Number*	6	5	7	2	0	0	1
	Rate per 100,000	4.8	4.0	5.6	1.6	0.0	0.0	0.8
England	*Rate per 100,000*	3.6	2.8	2.1	1.7	1.6	1.5	1.5

Source: Public Health England

Recommendations

- Continue to work closely with Three Boroughs Public Health Infection Control Team to support them to prevent, identify and treat HCAIs quickly and effectively.

Summary and Assurance

Overall, Halton has a robust health protection system which effectively monitors, controls and prevents population health issues. Health Protection is overseen through a multi-agency Health Protection Committee which meets quarterly and incorporates membership of all agencies involved with every aspect of health protection. Each member is accountable to the committee for and provides assurance to the committee regarding its area of responsibility.

Halton experiences many of the same challenges as its regional neighbours. For many indicators Halton outperforms England and the North West data, although there are a number of challenges that are faces with regards to the on-going protection of the health of the local population.

The health Protection committee has identified immunisation and screening programmes as a source of focus for the next year and will aim to reverse trends in reduction of uptake of childhood immunisations and aim to improve the uptake of cancer screening programmes.

The borough must continue to invest in and improve its health protection system in order to continue to address the recommendations set out within this report. The Council should also continue to work alongside local and regional partners to facilitate this work, monitor trends across the wider footprint, share learning and act collaboratively where required.

REPORT TO: Health and Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: 2016/17 Public Health Annual Report

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To advise the Board of the development of the 2017 Public Health Annual Report.

2.0 RECOMMENDATIONS: That the Board:

1. **Note the theme and areas of focus; and**
2. **Raise awareness of the forthcoming report with their staff and elected members.**

3.0 SUPPORTING INFORMATION

3.1 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.

3.2 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.

3.3 The Faculty of Public Health guidelines on DPH Annual Reports list the report aims as the following.

- Contribute to improving the health and well-being of local populations.
- Reduce health inequalities.
- Promote action for better health through measuring progress towards health targets.

- Assist with the planning and monitoring of local programmes and services that impact on health over time.

3.3 The PHAR is the Director of Public Health's independent, expert assessment of the health of the local population. Whilst the views and contributions of local partners have been taken into account, the assessment and recommendations made in the report are those held by the DPH and do not necessarily reflect the position of the employing and partner organisations.

3.4 Each year a theme is chosen for the PHAR. Therefore it does not encompass every issue of relevance but rather focuses on a particular issue or set of linked issues. These may cover one of the three work streams of public health practice (health improvement, health protection or healthcare public health), an over-arching theme, such as health inequalities, or a particular topic such as mental health or cancer.

3.5 For 2016-17 the Public Health Annual Report will focus on the health of women and girls in Halton. This topic has been chosen to highlight key topics pertinent to female health and issues local women and girls believe to be the most significant areas for their health.

3.6 The report will use a life-course approach through the following sections:

- Start Well – Maternity
- Start Well – Girls
- Live Well
- Age Well

3.7 Each chapter will cover the following areas:

- Summary of topic and why it is important
- What work has been or will be done

3.8 Summary of Chapter Content: -

Section	Chapter
Start Well – Maternity	Smoking in Pregnancy
	Mums' Mental Health
	Family Nurse Partnership
	Breast Feeding
Start Well – Girls	HPV (Human papilloma virus) Vaccination
	Mental Health
	Physical Activity
Live Well	Sexual Health
	Mental Health
	Cancer Screening
	Alcohol
	Wider Issues
Age Well	Warm Homes
	Social Isolation and Loneliness
	Falls
Recommendations - 2016/17 - Women and Girls' Health **Recommendations Update - 2015/16 - Assessing Needs and Taking Action**	

3.10 The final version report will be presented to the Health and Wellbeing Board in September 2017.

4.0 POLICY IMPLICATIONS

4.1 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.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The PHAR will highlight key topics for maternal health and children.

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 scams, 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 Developing the PHAR does not present any obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None

REPORT TO: Health & Wellbeing Board

DATE: 5th July 2017

REPORTING OFFICER: Director Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Adult Social Care Additional Funding

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform Health & Wellbeing Board of the allocation of additional funding for Adult Social Care.

2.0 **RECOMMENDATION**: **That the contents of the report be noted.**

3.0 **SUPPORTING INFORMATION**

3.1 In the spring budget the chancellor announced an additional £2 billion of new funding for councils in England over the next three years to spend on adult social care services. This will be broken down as £1 billion to be provided in 2017-18 with £674m in 2018-19 and £337m in 2019-20.

3.2 This has been recognised by the Directors of Adult Social Services as an important step towards closing the gap in Government funding for Adult Social Care, whilst we are waiting for the Green paper on future sustainability of the sector.

3.3 This additional funding is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing the pressures on the NHS- including supporting more people to be discharged from hospital when they are ready- and stabilising the social care provider market.

3.4 A small number of grant conditions have been applied, to ensure that the money is spent on adult social care services and supports improved performance at the health and social care interface.

3.5 The grant will be pooled into the Better Care Fund pooled budget, once agreement has been reached at the HWBB we will be in a position to allocate and spend funding immediately.

3.6 There is an expectation that allocation of this funding will result in a reduction in Delayed Transfers Of Care, a series of metrics will be developed by the DH and DCLG to assess improvements in patient flow

across the NHS and social care interface.

3.7 From May 2017, CQC will be undertaking targeted reviews in a small number of areas, for those areas identified as having the greatest challenge, to ensure rapid improvement.

3.8 Local Authorities and CCGs have a joint responsibility to implement each of the best practices set out in the High Impact Change Model for reducing delayed transfers of care, including agreements on the implementation of a trusted assessor model. However, it is clear in the guidance that councils are best placed to determine what is needed to maintain a diverse and sustainable market locally and ensure the funding reaches the social care frontline swiftly.

3.9 "Distinctive, Valued and personal" – Why Social Care matters: The next five years, has recently been published by the Association of Directors of Adult social Services. This document highlights the vision for adult services and how future funding should be directed to ensure the system is sustainable and supports individuals with care and support needs in the right place at the right time.

3.10 A number of pressure have been identified within our local system, as a direct result of reductions in available funding, including:

- Ability to manage increases in demand
- Domiciliary Care capacity and model of provision
- Care Homes- sustainability/risks from closures/model of provision
- Transfers of care from hospital- speed and availability of care
- Capacity and availability of Reablement packages.

4.0 **RECOMMENDATIONS:**

		Funding 2017-18	Outcomes
1	Reablement first approach on discharge from hospital- this should be an invest to save by reducing the reliance and availability of long term domiciliary care	£600k	*Improvement in a person's independence and quality of life *Reduction in the number of people delayed in hospital
2	Invest in transforming domiciliary care project	£400k	*Improvement in a person's independence and quality of life

			*Reduction in the number of people delayed in hospital
3	Development of improved technology offer/telecare/proactive response	£600k	*Improvement in a person's independence and quality of life
4	Further development of preventative options, including SSLL	£400k	*Improvement in a person's independence and quality of life
5	Develop a social care trusted assessor model	£50k	*Improvement on delayed transfers of care
6	Improve information provision within the hospital to support discharge choices/pathways	£50k	*Improved discharge pathways
7	Work with care home providers to develop an alternative commissioning/delivery model	£900k	* Training package developed and delivered * Framework for care- linked to staffing levels developed and delivered * develop a sector led improvement model

5.0 **POLICY IMPLICATIONS**

5.1 None identified.

6.0 **FINANCIAL IMPLICATIONS**

6.1 Additional funding- 2017/18 £2,974,314, which will reduce incrementally over the following 2 years, 2018/19 £1,827,114, 2019/20 £904,208, at which time we should receive the green paper on the future sustainability of the sector.

6.2 Due to the short term nature of this additional funding, a review of the outcomes and financial impact achieved will be completed at the end of year one and recommendations considered for years 2 and 3.

6.3 Section 151 officers will be required to complete returns to the DH in relation to the allocation of the grant.

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

7.1 **Children & Young People in Halton**

None identified.

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

None identified.

7.3 **A Healthy Halton**

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

7.4 **A Safer Halton**

None identified.

7.5 **Halton's Urban Renewal**

None identified.

8.0 **RISK ANALYSIS**

8.1 The recommendations for allocation of available funding has been considered, in light of the eight high impact changes, ADASS vision for future provision and our local areas of challenge; to ensure the biggest impacts and future sustainability of services.

8.2 An invest to save approach will be implemented to manage the risks in relation to non- recurrent funding.

8.3 Opportunities for collaborative working across the Liverpool City Region will be considered within the recommended projects.

9.0 **EQUALITY AND DIVERSITY ISSUES**

9.1 None identified.

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

None