

Public Document Pack



Health and Wellbeing Board

Wednesday, 28 March 2018 2.00 p.m.
The Halton Suite - Select Security
Stadium, Widnes

A handwritten signature in black ink, appearing to read 'David W R', written over a grey rectangular stamp area.

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 4th July 2018*

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

Part I

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HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 17 January 2018 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and N. Atkin, C. Carlin, P. Cook, S. Ellis, A. Fairclough, G. Ferguson, T. Hemming, T. Hill, A. McGee, E. O'Meara, I. Onyia, D. Parr, M. Pearson, C. Samosa, R. Strachan, D. Sweeney, I. Thompson, S Wallace-Bonner and S Yeoman.

Apologies for Absence: M. Larking, D. Parr, H. Patel

Absence declared on Council business: None

**ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD**

Action

HWB19 MINUTES OF LAST MEETING

The Minutes of the meeting held on 4th October 2017 having been circulated were signed as a correct record.

HWB20 WELL NORTH UPDATE - CHRIS CARLIN

The Board received a presentation from Chris Carlin, a representative of Halton CCG, who provided an outline of the work as part of the Well North funding programme. Well North was a partnership between Public Health England (PHE), The University of Manchester and Manchester Academic Health Science Centre; local authorities, NHS organisations, business (both big and small), community, voluntary and enterprise organisations.

The Well North principles were to:

- Address inequalities by improving the health of the poorest, fastest;
- Increase resilience at individual, household and community levels; and
- Reduce levels of worklessness.

The Board was advised that Well Halton was one of

ten regional “pathfinder” sites across the North and a place based approach had been adopted that built upon the unique nature of the Borough and capitalised on Halton’s many assets. Details of the unique projects which were being developed in various neighbourhoods, each being co-produced with the community, VCSE providers, agencies and private sector partners, were outlined in the report.

During the first year of the Well North Halton programme, the following five strategic goals had been set:-

- To create a Community Hub at Windmill Hill;
- Harness the reach of the Widnes Vikings Generate Positive Change;
- Identify and develop worldwide initiatives;
- Unit Halton Brook’s assets in a campus approach; and
- Create a social business hub in Runcorn Shopping City.

It was noted that as part of the second year of the funding programme it was agreed to continue with the five strategic goals and to expand the stem/science partnerships with Sci-Tech Daresbury and Catalyst Museum. The presentation also provided Members with an outline of how the budget had been allocated during the first year of funding.

Members were also invited to contact Chris Carlin in order to visit any of the sites which were included in the presentation.

RESOLVED: That the contents of the presentation and the review of the draft plan be noted.

HWB21 UPDATE ON DEVELOPMENTS IN HALTON ADULT MENTAL HEALTH SERVICES

The Board considered a report of the Director of Adult Social Services, which provided an update on some of the changes to service delivery that had been taking place in Halton in the past two years with regard to Halton Adult Mental Services. In 2015 a whole-scale review of the way in which mental health services were delivered across the footprint of the 5Boroughs Partnership NHS Trust was commissioned by the combined Clinical Commissioning Groups (CCG’s) covering Halton, St. Helens, Knowsley, Warrington and Wigan.

The Board was advised that the review produced a

set of recommendations covering five key areas and these themes and recommendations that came from them were largely accepted by the CCGs and their partner agencies. Consequently, work streams were set up to put the recommendations into place. In Halton it was reported that the following developments had taken place in mental health services during the past two years:-

- work had taken place locally to implement recommendations of the report in a way which created positive change for the people of Halton. The NHS Halton CCG, supported strongly by the Council, had led Task and Finish Groups with all key partners to establish clear, care pathways through the mental health system;
- within the North West Boroughs NHS Trust, there had been considerable local redesign;
- there had been some changes to the delivery of Social Care Services for people with mental health problems in the Borough; and
- the use of the Mental Health Resource Centre in Vine Street, Widnes had been redesigned;
- the Mental Health Outreach Team had been redesigned and positive results were being reported.

RESOLVED: That the report be noted.

HWB22 CQC LOCAL SYSTEM REVIEW OF HEALTH AND SOCIAL CARE IN HALTON

The Board considered a report of the Director of Adult Social Services, which provided an update on the Care and Quality Commission (CQC), Local System Review (LSR) of Health and Social Care in Halton. The review took place in August 2017 and examined how people moved between health and social care, including delayed transfers of care, with a particular focus on people of 65 years old in Halton. The review included an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of management resources. Although the review did not include mental health services or specialist commissioning specifically, they did look at the experiences of people living with dementia.

Members noted that the final report from the CQC

was published on 12th October following a Quality Summit which took place at the Stadium on the 11th October, which was attended by representatives from across partner agencies. The summary of the findings of the CGC review were set out in the report, together with the areas identified by CQC where they felt improvements could be made. As a system, Halton was required to submit a system-wide action plan to CQC by 9th November. Consequently, working collaboratively across our statutory partners and with support from Social Care Institute for Excellence, an associated Action Plan was developed in response to the issues highlighted within the report.

It was reported that progress against the actions outlined in the Action Plan would be monitored over the next few months by the Health and Wellbeing Board and Halton Borough Council's Management Team.

RESOLVED: That the report and associated appendices be noted.

HWB23 CARE QUALITY COMMISSION- LOCAL SYSTEM REVIEW ACTION PLAN (HEALTH AND WELLBEING BOARD ACTIONS)

The Board considered a report of the Director of Public Health, which provided an update on progress against actions from the CQC Action Plan relating to the Health and Wellbeing Board. During the summer 2017, CQC were commissioned by the Secretaries of State for Health and Communities and Local Government, to undertake a programme of target system reviews in 12 local authority areas; Halton was selected as the first area for one of these reviews. Following the publication of the review on 12th October 2017, an action plan, with a number of themes, was developed in response to issues highlighted in the report. Under the theme of Strategic Vision and Governance the following action was developed for the Health and Wellbeing Board:

Review role of Halton's Health and Wellbeing Board to ensure that there was enhanced challenge across the Health and Social Care system.

In order to respond to this action, a number of areas for development were identified to be presented to the Board. These were as follows:

- revised Membership (to include GP Federations). A copy of the revised membership list was included in

- the report;
- review Terms of Reference;
 - format of Future Meetings to include Board development;
 - performance Dashboard which would focus on the local system performance (to include Delayed Transfers of Care and the performance against the national standard for A and E) and highlight system risks.

RESOLVED: That

- (1) the contents of the report and associated documents be noted;
- (2) the proposed approach and revised Terms of Reference be agreed; and
- (3) update reports be brought to future meetings of the Board.

Director of Public Health

HWB24 PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided Members with the final version of the Pharmaceutical Needs Assessment (PNA) and a briefing on the results of the statutory 60-day consultation. Following the period of consultation, the Steering Group met on the 17th October 2017 and agreed that the PNA should be submitted to the Health and Wellbeing Board as the final version. The following next steps were proposed:-

- the PNA must be published no later than 1st April 2018;
- the attached version of the PNA was approved as the publication version;
- the PNA should be uploaded onto the Council's website;
- key stakeholders and the public would be advised accordingly; and
- the Steering Group would meet periodically to produce supplementary statements during the lifetime of the PNA.

RESOLVED: That

- (1) the PNA be approved for publication;
- (2) the Steering Group be delegated to deal with a

Director of Public Health

production of supplementary statements needed throughout the lifetime of the PNA;

- (3) the continuation of Healthy Living Pharmacies be supported;
- (4) the use of New Medicine Reviews and Medicine Management Reviews by pharmacists in Halton be supported; and
- (5) Pharmacists in their stewardship role on prescribing of antibiotics be supported.

HWB25 SAFEGUARDING ADULTS BOARD ANNUAL REPORT

The Board considered a report by the Independent Chair of the Halton Safeguarding Adults Board (SAB), which outlined the Annual Report 2016/17. The focus of work activity addressed SAB's priorities as identified from the 2015-2016 Annual Report, Performance Framework and Strategic Plan (2016-2018). In addition to acknowledging local and national safeguarding adults emerging issues/trends/policies throughout the year.

The report provided a summary analysis of the data gathered from both CCG and the Council Safeguarding Adults Collection and highlighted how this information informed the work priorities for 2017 – 2018. It was noted that the Halton Safeguarding Adults Board had agreed the three priority areas of work for the forthcoming year:-

- creating a safer place to live for all adults living in Halton (Safeguarding Prevention);
- providing the skills and knowledge to enable genuine care and understanding for adults at risk of harm (awareness raising and training);
- gaining a greater understanding of how mental health can impact adults at risk being protected and cared for in the best possible way (mental health).

These priorities would help shape the activity of SAB and SAB sub groups and key partners for 2017/2018 to enable the Board to continue to meet its strategic aims.

RESOLVED: That the report and associated Appendix be noted.

HWB26 ONE HALTON AND THE DEVELOPMENT OF AN ACCOUNTABLE CARE SYSTEM

The Board considered a report of the Chief Executive, which provided an update on One Halton and the Development of an Accountable Care System (ACS).

The Board was advised that an ACS was one in which several social and health care organisations provided all health and social care for a given population. There were three core elements to the system and significantly, the ACS would centre on the involvement of general practitioners in the network of providers delivering care along with local authorities and providers and commissioners of services.

In 2014/15 the Council committed to the development of an integrated model of health and social care, and agreed a shared vision – One Halton. The development of an ACS fits the original One Halton concept, delivering across the Halton Local Authority footprint. The revised Halton Accountable Care Strategic Vision, attached at Appendix 1, built on an initial commitment of partners to improve the delivery of health and social care provision. It was reported that to achieve the ACS, partners had established the One Halton Accountable Care system, with a memorandum of understanding and terms of reference, both of which were attached at Appendix 2 and 3 respectively. These documents underpinned the commitment to move towards the more integrated community based system, which reduced the demand on acute services and provided care closer to home.

At its meeting on 14th December 2017, the Executive Board endorsed the revised One Halton strategic vision and governance structure as described and approved the recommendations as highlighted in the report.

RESOLVED: That

- (1) the One Halton (ACS) Vision, be endorsed;
- (2) the memorandum of understanding for the One Halton Accountable Care System Board be agreed; and
- (3) the Terms of Reference for the One Halton Accountable Care System Board be agreed.

HWB27 DATES OF FUTURE MEETINGS

The following dates of future Health and Wellbeing Board Minutes were circulated to the Board:

The Board was provided with dates of future Board Meetings to 31st March 2019. All meetings were at 2pm in the Halton Stadium, Widnes.

RESOLVED: That the dates of future meetings be noted.

Meeting ended at 3.20 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 23 March 2018

REPORTING OFFICER: Chief Executive/Strategic Director, People

SUBJECT: Healthy New Town
Halton Hospital and Wellbeing Campus

PORTFOLIO: Health & Wellbeing

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

This report seeks to provide an update on the development of the Healthy New Town Halton Hospital and Wellbeing Campus

2.0 RECOMMENDATION: That

- 1) **Members note the current position on the development of the Healthy New Town Halton Hospital and Wellbeing Campus; and**
- 2) **Regular reports be provided to Members as the Healthy New Town Halton Hospital and Wellbeing Campus proposal is developed.**

3.0 SUPPORTING INFORMATION

- 3.1 Halton Healthy New Town is one of 10 demonstrator sites selected by NHS England but is unique in that it is the only site that has a hospital at its centre.

This gives an exciting opportunity to create a Halton Hospital and Wellbeing Campus at the very heart of Halton Lea, bringing together all of the elements required to deliver a badge-less, seamless Health and Social Care system for the people of Halton.

The Halton Hospital site is of such a configuration that it enables the delivery of the One Halton vision in a number of ways.

The aging Halton General Hospital will be demolished **but ONLY after the state-of-the-art Cheshire and Merseyside Treatment Centre has been extended, to accommodate services currently delivered in the General Hospital.**

The nature of the project is such that there will be no major service reconfiguration proposed, nor any interruption to current service delivery.

However by reconfiguring the land use the following can be achieved:

- Host multiple GPs/Primary Care Practitioners on site in a Medical Plaza

- Incorporate a Wellness Facility supporting rehabilitation and good physical and mental wellbeing for the community
- Create a bespoke imaging/diagnostics centre which could be directly accessed by primary care
- Dedicate the hospital to pure treatment/interventions since step-down/intermediate/rehab care would be delivered at –
 - Onsite Care Homes or at the Short Stay Rehabilitation Centre
- Create conferencing facilities for use by H&SC partners and the community
- Create a community centre comprising cafes, shops, etc.

After the creation of the Halton Hospital and Wellbeing Campus there would still be NHS land remaining to build

- dedicated housing for the elderly and Health and Social Care Key workers; and
- some independent housing which could be managed by HBC or housing associations

Master Planners have been engaged to explore all of the potential options for the entirety of Halton Lea, however the decisions about the Halton Hospital and Wellbeing Campus rest with the NHS as the landowner

They are committed to developing a state of the art facility to meet the needs of the current and future populations of Halton.

Local people, including staff and patients, are aware of the proposals to construct the Halton Hospital and Wellbeing Campus through a number of formal and informal engagement events, as well as through plans published both internally and externally.

This includes the production of

Halton Council's Masterplan for Halton Lea (in which a number of local Councillors have been involved); and

Halton Healthy New Town's Community Insights Report, which has had significant community and political input.

It is intended to continue the engagement programme throughout 2018 in conjunction with members, the public & our partners within the local health economy.

Following the Chief Executive's presentation at the recent Health PPB's the Leader has asked that as part of the on going engagement programme a further meeting be held to provide an opportunity for all Runcorn members to comment on the proposals and that future meetings be held with Runcorn members to keep them fully briefed and give them the opportunity to contribute to the development of the Healthy New Town proposals.

More information about the Halton Healthy New Town is available on the dedicated website: <http://www.healthynewtown.org.uk/>

Documents 1 and 2 attached show indicative images of the current proposals for the Healthy New Town Halton Hospital and Wellbeing Campus.

4.0 FINANCIAL IMPLICATIONS

- 4.1 A Bid for £40 million has been submitted to NHS England to support the development of the Halton Hospital and Wellbeing Campus.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

The Healthy New Town proposals will provide integrated, multi-disciplinary health and social care services for all families, and improve services specifically for children with learning difficulties and disabilities.

5.2 Employment, Learning & Skills in Halton

The Healthy New Town proposals will assist in the retention of existing and the creation of new employment opportunities Halton Lea.

5.3 A Healthy Halton

The Healthy New Town proposal will adhere to the One Halton vision and will be driven by the Health and Wellbeing Strategy and outcomes. Progress will be monitored by the Health and Wellbeing Board, and scrutinised by the Health PPB.

5.4 A Safer Halton

None.

5.5 Halton's Urban Renewal

The Healthy New Town proposals will assist in the regeneration of Halton Lea.

6.0 RISK ANALYSIS

- 6.1 Should the proposal not proceed the long term viability of the aging facilities on the Halton Hospital site may be at risk.
- 6.2 Should NHS funding not be available funding would need to be secured for other sources. If funding is not forthcoming this will put the project at risk.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The proposals will ensure the future delivery of health and social care is fair, sustainable and of high quality for residents of Halton.

8.0 REASON FOR DECISION

8.1 To ensure that the future delivery of health and social care is fair, sustainable and of high quality for residents of Halton.

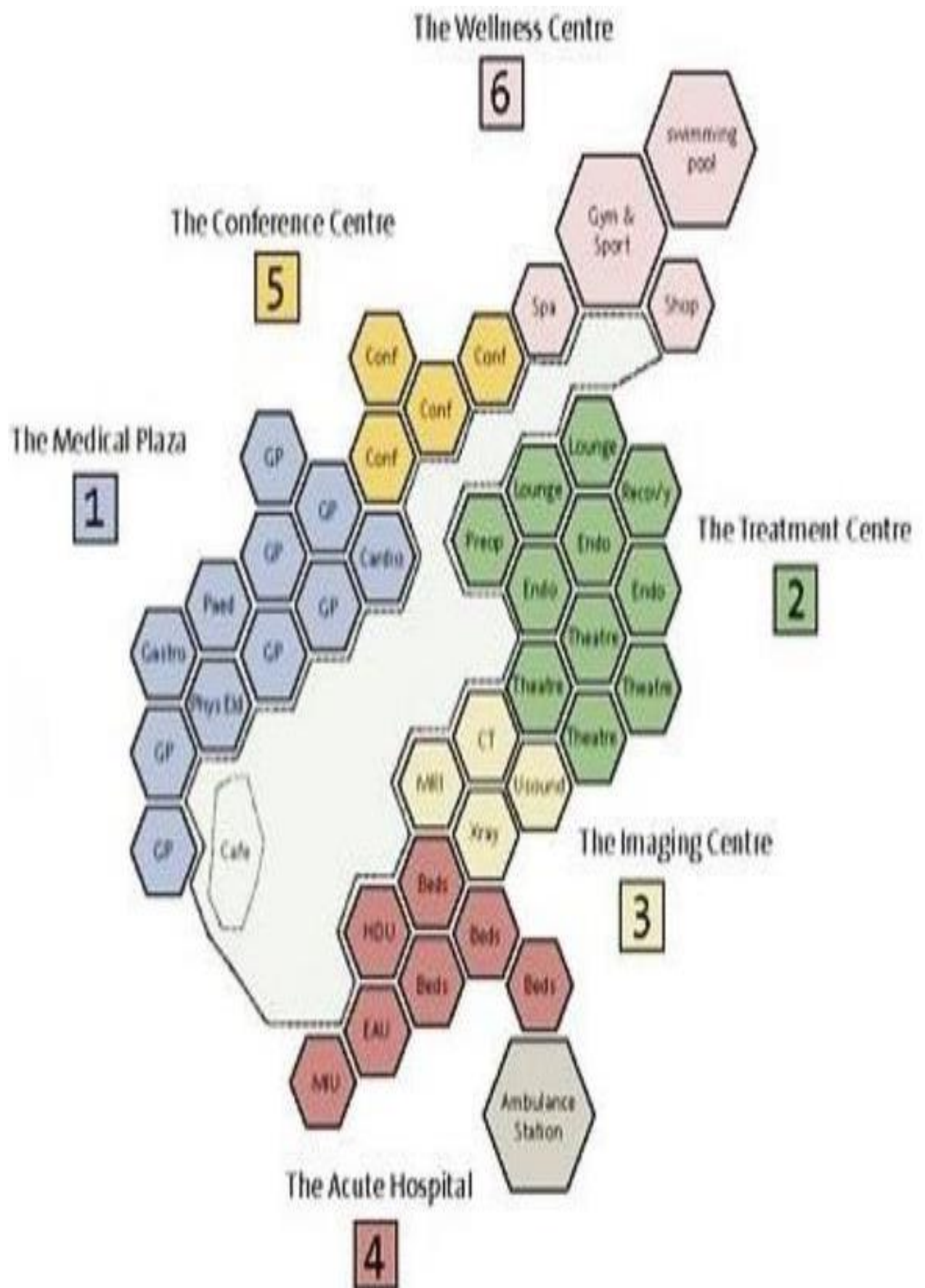
9.0 ALTERNATIVE OPTIONS

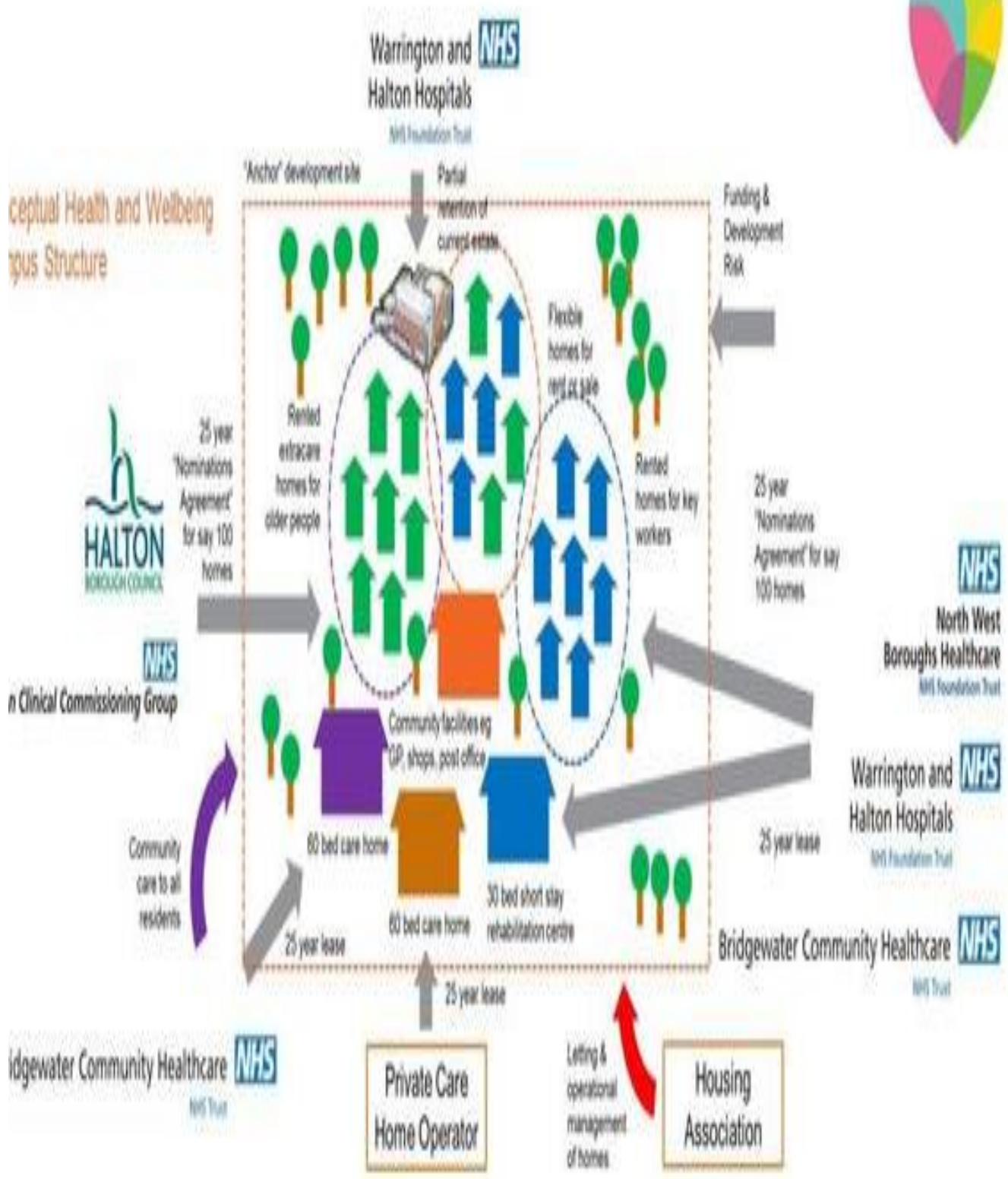
9.1 Should the proposals not proceed further consideration will need to be given to retaining, in their current condition, or upgrading the existing facilities at Halton Lea.

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

Appendix I - Hexagon Diagram

Appendix 2 - Graphic Diagram





REPORT TO:	Health and Wellbeing Board
DATE:	28 th March 2018
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	One Halton Prevention Model and Framework Presentation
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 draft One Halton Prevention Framework and Model.

2.0 RECOMMENDATION: That

The contents of the presentation be noted and commented on.

3.0 SUPPORTING INFORMATION

One Halton seeks to bring the whole system together to deliver a place based, integrated, user friendly, prevention model. It will make the most of local talents and assets, services and providers and enable people to stay well and within reason manage their own health. This will improve our health outcomes so people live longer, healthier and happier lives. Aligned with this is a framework that outlines the models key principles and components. The Health and Wellbeing board will receive a presentation outlining the work that has taken place to develop the model and framework to date.

4.0 POLICY IMPLICATIONS

The Prevention Model and Framework will inform collaborative action for the Council, NHS, Social Care, Public Health and other key partners as appropriate.

5.0 FINANCIAL IMPLICATIONS

No additional funding required. However the model and framework will inform future activity and spending across the system.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

The best start in life is essential if children and young people are to have good physical, social and emotional health. A robust prevention framework and model will ensure this is embedded throughout the system.

6.2 Employment, Learning and Skills in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The prevention model and framework includes child development as a priority.

6.3 A Healthy 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

6.4 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.

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

Developing the Prevention Model and Framework does not present any obvious risk however, there are risks associated with the sustainability of the health system if we do not implement the model. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

Appendix 1 Halton Prevention Model and Framework 2018

Lead Officer: Eileen O'Meara

REPORT TO:	Health and Wellbeing Board
DATE:	27th March 2018
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	All-Age Autism Strategy
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on the new Halton All-Age Autism Strategy at the Appendix.

2.0 **RECOMMENDATION: That the Board:**

- i) **Note the contents of the report and associated appendices; and**
- ii) **Provide comment on the draft Strategy and its associated Delivery Plan.**

3.0 **SUPPORTING INFORMATION**

3.1 The current Autism Strategy was developed in 2012. Since then there has been a number of national publications relating to Autism including: Think Autism: fulfilling and rewarding lives, the strategy for adults with autism in England, update 2014; Statutory guidance for local authorities and NHS organisations to support implementation of the adult autism strategy (2015); and progress report on Think Autism (2016).

Halton also took part in the Autism Self-Assessment Framework (SAF) which was completed at the end of 2016.

3.2 In order to move forward with planning a new All-Age Autism Strategy, a working group was established in July 2017 with the following membership:

Patrick Frost – Principal Manager - CCW (Chair)
Maria Saville – Principal Manager – PBSS, HBC
Ami McNamee - Specialist Teaching Lead (HBC Education)
Sam Murtagh - Commissioning Manager (HBC Children's Services)
Catrin Williams - Community LD Team (North West Boroughs NHS Trust)
Jane Morris - Principal Manager, LD Nursing Team (HBC Adult

Social Care)

Jane Birchall-Smith - Community LD Team (North West Boroughs NHS Trust)

Lisa Birtles-Smith, Clinical Lead LD (Halton CCG)

Alison Sutch, Children's Complex Needs Nurse (Halton CCG)

Emma Sutton-Thompson, Practice Manager (HBC)

Natalie Johnson, Policy Officer (HBC)

3.3 Autism Questionnaire

As part of the initial consultation, the group devised a short questionnaire which was posted out to 230 adults identified from CareFirst as having a diagnosis of Autism, and also the survey has been disseminated within children's as follows:

- Brookfields School, the Resource Bases, Cavendish School and Ashley School, Parent Partnership and Assessment Co-ordinator for those with EHC Plans;
- Members of staff gave out to parents and to Mal Hampson at Halton Speak Out;
- In addition, the survey was added to the Local Offer in mid-September.

3.4 Draft Strategy

The group agreed that the main part of the strategy document would focus on the statutory guidance and Halton's position with specific areas (draft attached at Appendix 1). Contributions to the strategy were from a range of staff across HBC, HCCG and NW Boroughs NHS Trust.

The Delivery Plan has been developed jointly with service-users and stakeholders based on their experience of services and identifying areas for improvement. The Delivery Plan will be a "live" document that will drive priority areas for improvement forwards, ensure continuity and be led by a dedicated group, an Autism Action Alliance, which will be the first priority to establish, based on National guidance.

3.5 Consultation/Co-design of Delivery Plan

The consultation/co-design of the delivery plan has been undertaken by a combination of methods to suit different groups of people, including:

- Linking in with schools – parents coffee mornings;
- Experienced-based co-design event for Adults was held on 5th December 2017;

- Direct meetings with parent support groups – HAFS, ChAPS, Face to Face SCOPE;
- Linking in with IMPART (parent partnership);
- Involving Halton Speak Out.

Children’s representatives of the working group lead on the children’s side of the consultation/co-design.

A provider consultation event for adults was held on 10th January 2018 with other groups that are linked to Autism to identify actions to be included within the Delivery Plan.

This report was presented to the Health Policy and Performance Board on 27th February 2018.

4.0 POLICY IMPLICATIONS

- 4.1 An Autism Action Alliance will be established to take responsibility for moving the Autism-agenda forward, implementing and monitoring the Delivery Plan. This will be the first action on the Delivery Plan.

5.0 OTHER/FINANCIAL IMPLICATIONS

- 5.1 To ensure continuity of the Autism Strategy and Delivery Plan, the first priority is to establish Autism Action Alliance to lead on the implementation and monitoring of this. The Alliance would bring together different organisations, services and stakeholders and adults/children with autism and their families to set a clear direction for improved services.

6.0 IMPLICATIONS FOR THE COUNCIL’S PRIORITIES

- 6.1 **Children & Young People in Halton**
Developing an All-Age Autism Strategy aims to take a more joined-up and holistic approach to developing opportunities and realising potential for people with Autism at every stage of their lives.
- 6.2 **Employment, Learning & Skills in Halton**
None identified.
- 6.3 **A Healthy Halton**
National guidance states that an Adult Autism Strategy is a statutory requirement and there are certain criteria we should be implementing as a Local Authority and in partnership with other agencies. The development of an All-Age Autism Strategy goes

above and beyond this requirement.

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 It is vital that the needs of people with Autism in Halton are met. This is strengthened by National legislation detailing clear areas to be included and addressed.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

9.1 None identified.



DRAFT ONE HALTON ALL-AGE AUTISM STRATEGY 2018 - 2021 And DELIVERY PLAN

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Foreword

This new All-Age Autism Strategy in Halton aims to take a more joined-up and holistic approach to developing opportunities and realising potential for people with Autism at every stage in their lives. People with Autism are a valued part of the community of Halton and Halton Borough Council (HBC), NHS Halton Clinical Commissioning Group (CCG) and NW Boroughs Healthcare NHS Foundation Trust share a commitment to work together to improve the lives and opportunities for both children and adults with Autism in Halton.

We recognise that, although there are a lot of positives in the Autism services delivered in Halton, there are also areas that require more focus, especially around transition into adult services which we know can be a particularly difficult stage for young people. By joining together to develop an All-Age Autism Strategy, we are aiming for an ambitious approach, going above and beyond the national guidance.

The Strategy and the Delivery Plan set out our current position, the areas for improvement that we need to focus on over the next 3 years and the outcomes for individuals that we want to achieve. The Delivery Plan has been developed in conjunction with children and adults with Autism and their carers and families, along with the key providers of services within Halton. We would like to thank everyone who has been involved with the development of this Strategy and Delivery Plan, in particular people with Autism and their carers and families.

Rob Polhill

***Leader of the Council and
Chair of the Health and Wellbeing Board***

1.0 INTRODUCTION

1.1 National Context

In 2009 the Government implemented the first ever condition-specific legislation in England, the **Autism Act 2009**¹, demonstrating the importance that Parliament has attached to ensuring that the needs of people with autism are fully met.

In 2010, the original Adult Autism Strategy, *Fulfilling and Rewarding Lives*, was published.

During 2014, an updated Adult Autism Strategy was developed, **Think Autism** building on from the 2010 version, with a progress report on the implementation of **Think Autism** which was published in January 2016. The main vision in **Think Autism** is:

“All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them, they can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents”.

In March 2015, the Government produced updated statutory guidance for local authorities and NHS organisations to support the implementation of **Think Autism**. The guidance was revised following responses to a consultation “No Voice Unheard, No Right Ignored” which was a consultation for people with learning disabilities, autism and mental health conditions. It examined how people’s rights and choices can be strengthened. Halton’s strategy is based on this guidance, the national consultation and local consultation with adults and children who have autism and local organisations who are involved with people with autism.

Recent legislation has also provided for new duties for services for people with autism, including the **Care Act 2014** and the **Children and Families Act 2014**.

In 2014 the National Institute for Clinical Excellence (NICE) developed a quality standard on autism for adults and those under 18 which highlights how organisations can ensure they are delivering the best treatment and support for people with autism. The quality standard has 8 measurable statements to be used by organisations to improve the quality of care for those with autism. We have used these statements in our strategy and to contribute to shaping our Delivery Plan.

Implemented in September 2014, the Government published a new Special Educational Needs and Disability (SEND) code of practice for children and young people aged between 0 – 25 years and provides statutory guidance for organisations

¹ <http://www.legislation.gov.uk/ukpga/2009/15/contents>

that work with and support children and young people who have special educational needs or disabilities.

1.2 Local Context

Halton has a number of key local strategies and policy documents that are key drivers in areas of priority for health and social care. The documents include the following, which are all accessible on the HBC website at www.halton.gov.uk :

- One Halton Health and Wellbeing Strategy 2017 – 2022
- Halton Joint Strategic Needs Assessment (JSNA) 2017
- Pan Cheshire Local Safeguarding Children's Board Procedures 2017
- Adult Social Care Local Account 2015/16
- Safeguarding Adults in Halton: Interagency Policy, Procedures and Good Practice Guidance 2015 – 2018
- SEND Joint Commissioning Strategy 2017
- Children and Young People's Commissioning Strategy 2017-2020
- Children, Young People and Families Plan 2018 – 2021
- Halton Short Breaks Statement 2017

The One Halton Health and Wellbeing Strategy sets out the vision of the Halton Health and Wellbeing Board (HWBB) and states six different priorities for the borough for the time period the document is active. These priorities can be life-course and condition specific:

- Children and Young People (CYP): improved levels of early child development;
- Generally Well: increased levels of physical activity & 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.

Overview of Halton's population

The population of Halton, as of 2016, is older than that of England.² There is a greater proportion of the over-all Halton population aged 50-69 than England and, a much lower proportion of the population aged between 15 and 44. This emphasises the potential for an ageing population to impact upon the borough's working age population. Although there are currently a lot of people of working age in Halton, a lot are within 10-20 years of retirement age and so this may present issues with workforce population in the future.

The age breakdown of Halton's population is expected to change over the next two decades. The proportion of people over the age of 74 is expected to swell and the

² Halton's Joint Strategic Needs Assessment 2017

proportion of children and people of working age is expected to contract. This is the case nationally also, but is predicted to be emphasised more so locally. As of 2016 12.0% of Halton's population are aged 70 and above, whereas, in 2039 Halton's projected population aged over 70 will represent almost a fifth (19.6%) of the entire population of the area.

Estimated Prevalence of Autism in Halton

The Centre for Public Health, Liverpool John Moores University³ was commissioned by NHS England in 2016 to deliver this health needs assessment for learning disabilities and autism amongst adults and children for the nine Cheshire and Merseyside local authority areas. The report focuses on the health and wellbeing needs of adults and children with learning disabilities/autism.

The report provides some information on the estimated prevalence of autism amongst adults and children in each local area. Unfortunately, it is only possible to estimate because there are no definitive records held.

Estimated numbers are generated by applying national prevalence rates to local population data:



**Estimated numbers of children with ASD have been calculated by applying the prevalence rate of 1% reported by the National Autistic Society (2013) to local population projections (308 is the estimated number @ 2018 based on the 2012 population projections).*

***Estimated numbers of adults with ASD have been calculated using the national morbidity survey on autism in adults. This survey found the prevalence of ASD to be 1% of the adult population (Health and Social Care Information Centre, 2009) at a 1.8% rate amongst men and 0.2% amongst women. These prevalence rates have been applied to population estimates (2015) to give a predicted number of 855 adults with autism in Halton (760 males, 95 females).*

³ [Learning disabilities and autism: A health needs assessment for children and adults in Cheshire and Merseyside \(Centre for Public Health, Liverpool John Moores University, January 2016\)](#)

Establishing an accurate number of people with autism in Halton is extremely difficult because there is no register or exact count kept and this is the case across all areas. Records are held by local authorities in terms of the people they provide services to, schools will know how many of their pupils have autism and GPs and diagnostic services will hold their own records, but none of these datasets take account of those who are 'hidden' because they are not in contact with services or are not diagnosed.

A key action as part of the Delivery Plan will be to establish more accurate records of those with autism in Halton; this will depend on partnership working and data sharing, taking a systematic and co-ordinated approach across education, health and social care.

1.3 What is Autism?

Within Think Autism, the term autism is described as “an umbrella term for all autistic spectrum conditions, including Asperger Syndrome. Many people with autism also have related hidden impairments such as attention deficit hyperactivity disorder, dyspraxia, dyslexia, dyscalculia and language impairments as well as associated mental health conditions and linked impairments that may not be obvious to other people”.⁴

Autism is a lifelong condition that affects how a person communicates with and relates to other people. It also affects how a person makes sense of the world around them. The three main areas of difficulty, which all people with autism share, are known as the “triad of impairments”, which are:

- Social Communication - using and understanding verbal and non-verbal language, such as gestures, facial expressions and tone of voice;
- Social Interaction – recognising and understanding other people’s feelings and managing their own; and
- Social imagination – understanding and predicting other people’s intentions and behaviours and imagining situations outside their own routine.

1.4 The aim of this strategy

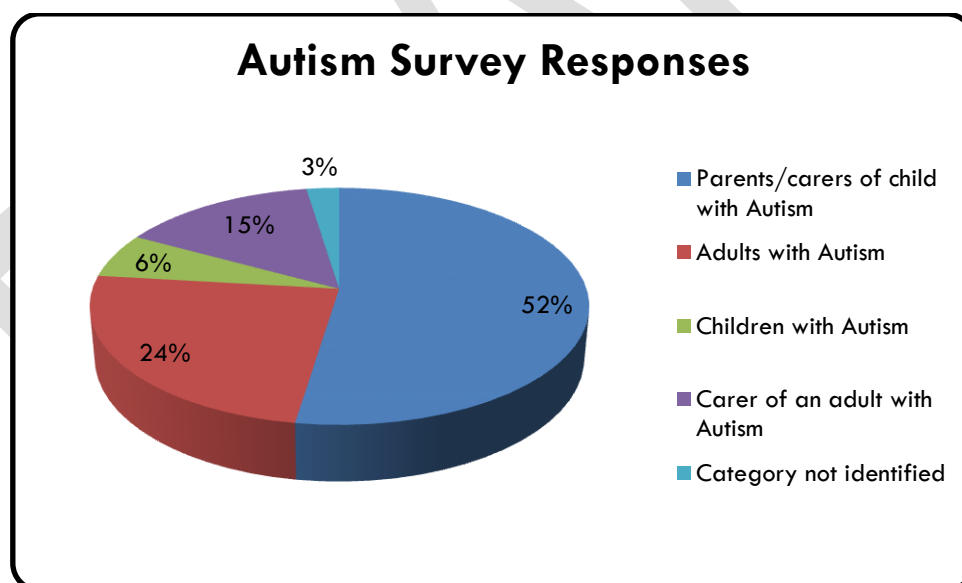
This is a high level strategy, designed to support people with autism in Halton, ensuring that services across Halton work in collaboration with key partners to move forward the priorities set out in **Think Autism**. The strategy aims to identify areas that require improvement, based on the views of adults and children with autism in Halton, and their carers and families, which link in to the national statutory guidance and national consultation.

⁴ New definitions of Autism are due out in early 2018 - <http://www.autism.org.uk/about/diagnosis/criteria-changes.aspx>

1.5 How the Delivery Plan was developed

At the end of this strategy there is a Delivery Plan which focusses on the areas for improvement. Halton are committed to working with people with autism and partner organisations in making improvements in this area. This has been a partnership approach between HBC, NHS Halton CCG, NW Boroughs Partnership, the independent and voluntary sector and people with autism and their carers/families. This has included:

- An initial easy-read survey sent by post to:
 - Adults with Autism/Asperger's
 - Headteachers at Brookfields Cavendish, Simms Cross, The Grange, St Peter and Paul schools to circulate to children with a diagnosis;
 - Local Offer;
 - Halton SEND Partnership information, advice and support service (SENDIASS);
 - Assessment Co-ordinators within SEN team;
 - SCOPE About Disability;
 - Halton Speak Out; and
 - Parents from children in Disabled Children's Services.
- The survey was also advertised on the Councils' Facebook and Twitter accounts



From the initial survey responses, the main two areas for improvement highlighted were:

- More places to socialise/more activities for people with Autism; and
- More support for young adults through transition.

Following the initial survey, we then held various consultation events across Halton to identify priorities and highlight areas for improvement including:

- Experienced-based consultation event with adults with autism at Runcorn Town Hall;
- Coffee mornings at schools;
- The Voice of Autism – Ashley High School; (see Appendix 1);
- Consultations with schools (see Appendix 2);
- Simms Cross Resource Base Questionnaire to Parents (see Appendix 3);
- A provider consultation event with key stakeholders.

EXPERIENCED-BASED CONSULTATION EVENT WITH ADULTS WITH AUTISM, RUNCORN TOWN HALL ON 5TH DECEMBER 2017

The event was facilitated by staff from Halton Borough Council and North West Boroughs Healthcare NHS Foundation Trust and was attended by adults with autism and their carers. Individuals had the opportunity to give their view of services based on their own experiences. The afternoon was filmed to be used to further improvements in autism services in Halton.



The discussions at the event were grouped into three key areas, which are displayed below along with the main points raised:

Discussion area	Key points
Autism services in Halton	<ul style="list-style-type: none"> • Good support is available. • Attendees reported getting the support they need when they need it. • There are no problems with the services that are in place although people feel there could be more support/services on offer. • Some services don't have specialist knowledge or experience of autism. • There is no dedicated autism group in Halton – the nearest is Liverpool or Manchester.

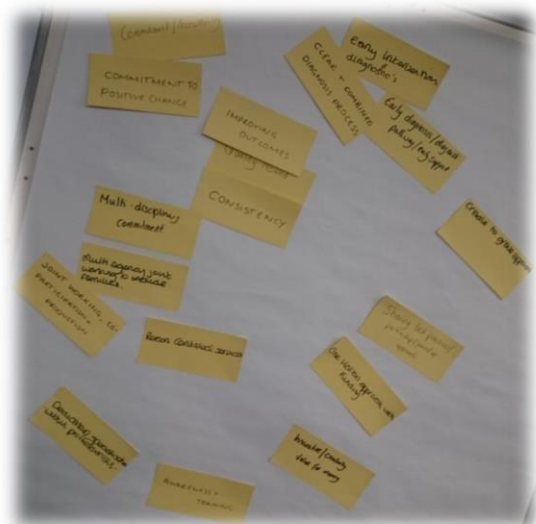
Discussion area	Key points
Relationships with people providing treatment and support	<ul style="list-style-type: none"> • Good relationships are established with individual members of staff who provide extra help and support which is appreciated (e.g. ring people for you). • Getting out and about helps – builds confidence and stops people being introverted about their condition. • Changes in Social Worker can sometimes cause stress and strain.
Experiences as a person diagnosed with autism	<ul style="list-style-type: none"> • Local services, e.g. shops/pubs, don't need to know about your condition. • The general public don't realise some of the issues associated with autism, e.g. clumsiness, and therefore may not understand behaviour to be related to the condition. • One attendee reported a bad experience with door staff in a local pub being unfriendly to everyone – once he told them about his condition they were okay with him. • There is the need to see things through the eyes of a person with autism to understand what they are going through. When people realise there is something different about you they can either be friendly or ostracise you.

PROVIDER CONSULTATION EVENT HELD AT THE STADIUM ON 10TH JANUARY 2018

The afternoon was facilitated by Helen Sanderson Associates and involved local providers of Autism services, including: Community Integrated Care (CiC), Cheshire Autism Practical Support (CHaPs), Halton Autistic Family Support (HAFS), Making Space and PossAbilities. There was also representation from HBC's Positive Behaviour Support Service (PBSS), Day Services, Disabled Children's Service and NHS Halton CCG's Children's Complex Needs Nurse.



The group identified **principles** that they felt should underpin this work.



Principles

- Commitment and Accountability for positive change;
- Multi-disciplinary working/joined-up working and sharing best practice;
- Person-centred services that focus on improving outcomes;
- Early Diagnosis pathway/early support;
- Awareness and training in Autism for all staff; and
- Quality – setting standards, innovative/creative value for money.



Discussions focussed on what is currently working well and what areas could be improved upon.

What is working?

Committed and professional services	Person-centred services – direct payments / personal budgets
Support for families, support groups	Person-centred planning
Accessible and flexible services	Variety of short break services and activities
Joint working / working together	Education – two schools are working
PBSS does work	Some commitment from services/providers

What needs to be improved?

Review pay for Personal Assistants	Process of diagnosis
Training	Funding services – pooling/multi-agency
Mental health	Child and Adolescent Mental Health Services (CAMHS)
Education still needs some improvement	If people or groups are good quality within an agency they can get broken up/moved on and the quality gets diluted but not replaced or passed on

Lack of specialist services – disparity in quality between and within agencies	Strategic/joint commissioning
PBSS needs more resources	Need more commitment to joint working
Attitudes and approaches – people not being listened to	Increased resources needed
Strive to become/develop more person-centred services	

It was stressed at the consultation event the importance of commitment and accountability for moving the Autism-agenda forward. The areas identified above have been translated into the Delivery Plan as actions that need to be improved. The Delivery Plan will be driven forward, monitored and implemented by an Autism “Board” which will be established as the first action on the Plan.

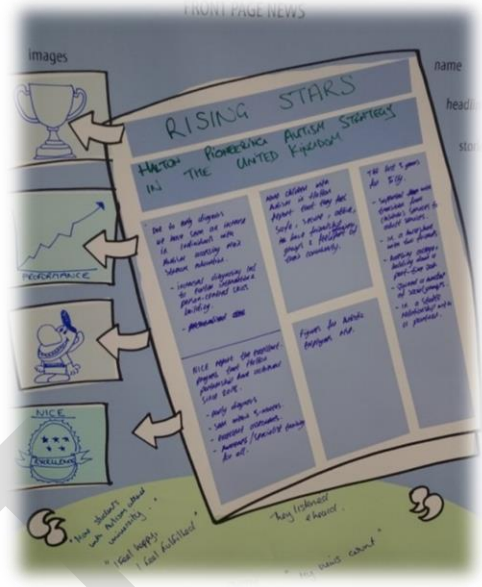
As a final exercise, providers identified what the newspapers could be reporting on in three years’ time, if everyone works together to make the improvements and stays fully committed to changing things for the better. Everyone in the room said they wanted to continue to support the Autism-agenda and work together on improving outcomes for people with Autism in Halton.

What Good Looks Like – below you can see the groups with their newspaper front pages



Name: Rising Stars

Headline: Halton pioneering Autism Strategy in the United Kingdom



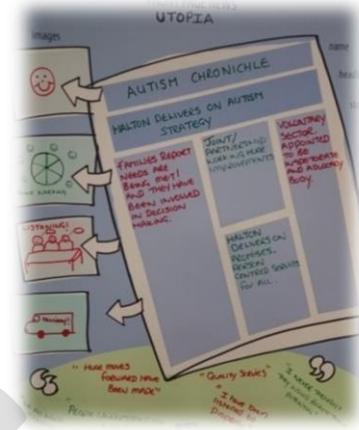
Stories:

<p>Due to early diagnosis we have seen an increase in individuals with autism accessing mainstream education.</p>	<p>More children with autism in Halton report that they feel safe, secure and active and have friendship groups and feel genuinely part of their community.</p>	<p>The last three years for Billy:</p> <ul style="list-style-type: none"> • Supported with transition from children’s services to adult services. • In a house with two friends. • Accessing college and holding down a part-time job. • Joined a number of social groups. • In a stable relationship with partner.
<p>Increased diagnosis led to earlier intervention and person centred skills building.</p>	<p>Figures for autistic employees rise.</p>	
<p>NICE report the excellent progress that Halton partnership has achieved since 2018.</p>		

Quotes:

“More students with autism attend university”
 “I feel fulfilled”
 “They listened and heard”
 “I feel happy”
 “My views count”

Name: Autism Chronicle
Headline: Halton delivers on Autism Strategy



Stories:

Families report needs are being met and they have been involved in decision making.	Joint partnership working huge improvements. Halton delivers on promises – person-centred services for all.	Voluntary sector appointed to be inspectorate and advocacy body.
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Quotes:

“Huge moves forward have been made” “People understand me now” “Quality services”
 “We all work together” “I have been listened to properly” “I never thought they would reach their potential”

Name: Halton News & Views
Headline: Halton Strategy hits success!



Stories:

Clear and consistent diagnosis pathways in place.	Joint funding available to provide appropriate services. Co-participating and co-production.	Improvements in person-centred planning.
Early support identified to improve outcomes and life opportunities.	People living the life they choose.	More training programmes in place for staff and professionals.

Quotes:

“Finally! We are listened to!” “I know what services I can access” “Diagnosis clear and guided”

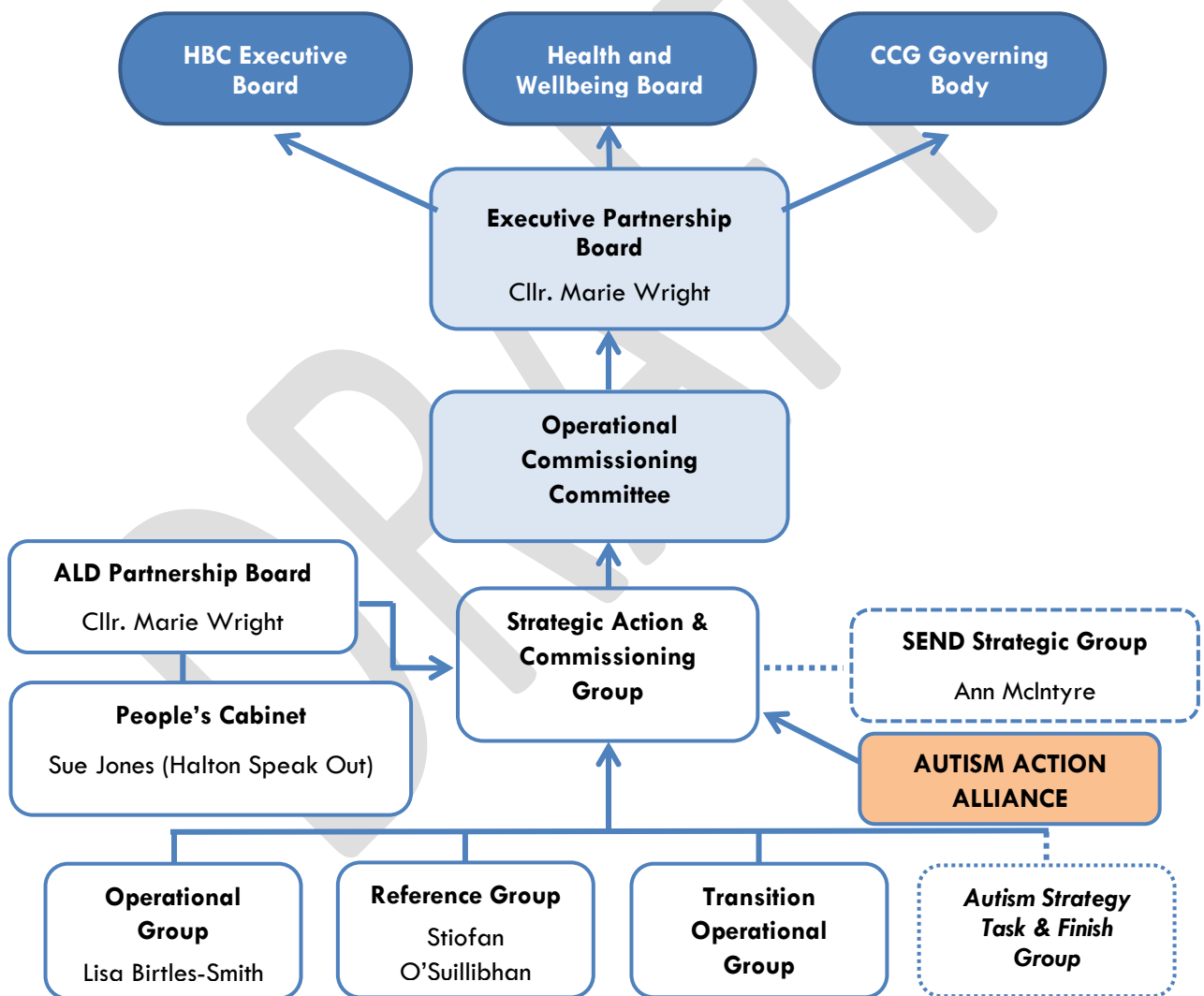
2.0 Strategic Objectives

Halton’s All-Age Autism Strategy provides a real opportunity for the needs of people with autism and their carers to be recognised and to ensure that they have the same opportunities as everyone else.

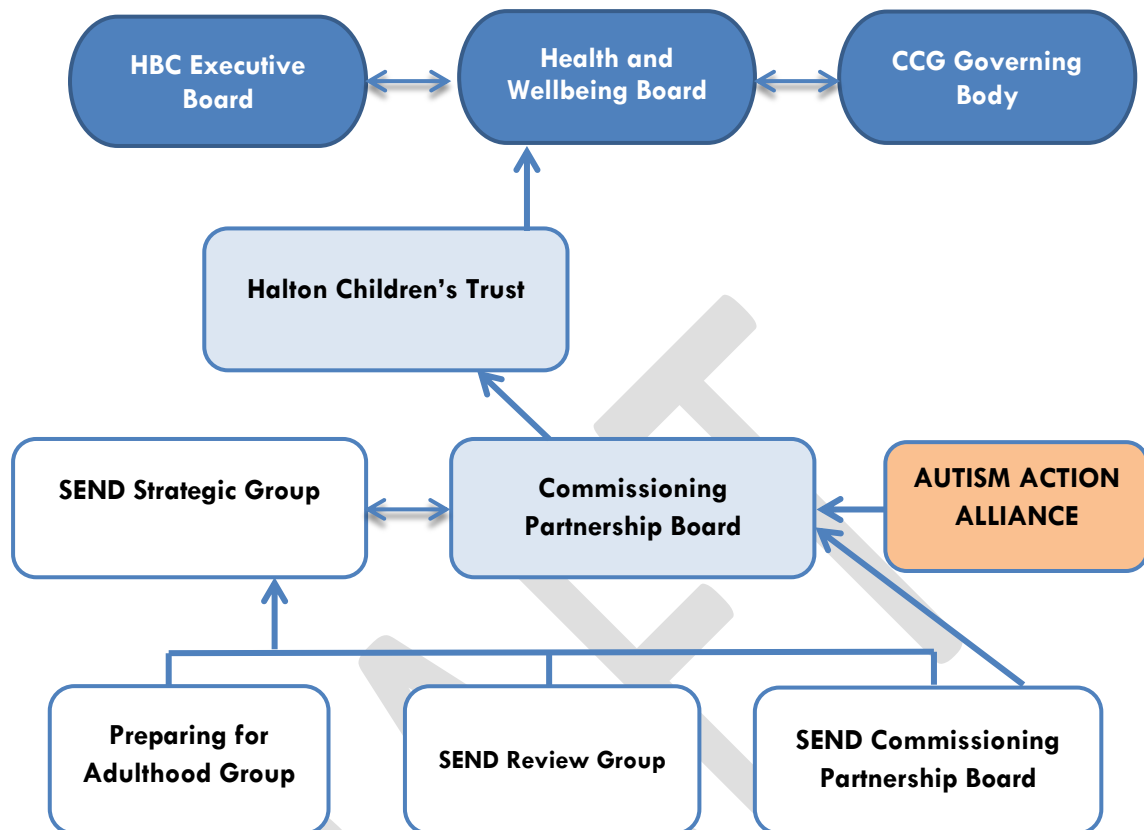
This strategy has been split into the strategic objectives based on the Department of Health’s (DH) statutory guidance *Think Autism*.

2.1 Local Planning and Leadership

Governance Structure – Learning Disability Services for Adults



Governance Structure – Children's Services



2.1.1 Identification and diagnosis of autism

Guidance from the DH states that while Local Authorities will lead commissioning for care and support services for people with autism, CCGs are expected to take the lead responsibility for the commissioning of diagnostic services to identify people with autism, and work with Local Authorities to provide post-diagnostic support for people with autism (regardless of whether they have an accompanying learning disability, other hidden impairments or a co-occurring mental health problem).

Adults

For adults with an identified Learning Disability (LD), a diagnostic assessment for autism can be accessed within LD services. However, should people with an LD be able to access generic Autism Diagnostic Services, then, under the principles of the Green Light Toolkit for Mental Health (National Development Team for Inclusion, 2012, 2013) reasonable adjustments should be made to enable this access. Halton Community LD Team follow the NW Boroughs Healthcare NHS Foundation Trust diagnostic pathway for LD and autism.

Referrals are accepted via the HBC hub or directly into the team and can be made by GP's, social workers, other professionals, carers or by self-referral. As part of the

referral process, a completed screening tool is required to ensure that the need for an assessment is clinically indicated and core areas of diagnostic presentation exist. The referral will then be discussed at the team meeting and, if appropriate, placed on the waiting list for an assessment. Within the team, assessments are completed using a range of tools including Autism Diagnostic Interview-Revised (ADI-R) and Autism Diagnostic Observation Schedule (ADOS) as recommended in the NICE guidance. As per NICE guidance on diagnosis, where possible a family member or carer is engaged to inform both current presentation and developmental history.

Following diagnosis, people with LD and autism receive multi-disciplinary support as required from the team. Clients accessing the LD service receive support based on clinical and presenting need, for those persons who receive a diagnosis the availability and access to the service will not change however, the diagnosis may provide additional information about need and provision of interventions.

For adults without a learning disability, autism diagnostic assessments can be accessed via the Adult Social Care (ASC) diagnostic service within NW Boroughs Healthcare NHS Foundation Trust. This service covers St Helens, Knowsley, Warrington and Halton boroughs and the assessments are funded by the CCGs. This service is currently based at Willis House, Whiston, L35 2YZ. Referrals can be made directly to the team and can be made by GP's, social workers, other professionals, carers or by self-referral. It is requested that an Autism-Spectrum Quotient – 10 items (AQ-10) screening self-assessment is completed with the referral and the team will then further explore suitability of an assessment. Within the team assessments are completed using a range of tools including Diagnostic Interview for Social and Communication Disorders (DISCO), ADI-R and ADOS. A report is then provided outlining the diagnostic decision and makes person centred recommendations. With the person's consent, this is shared with GP and relevant agencies. For those receiving a diagnosis of autism, the report outlines the statutory guidelines about assessment or reassessment of need and carers assessments that should follow a diagnosis of autism.

This is a diagnostic service only. Adults with autism who do not have a learning disability should access mainstream health services as and when they are needed. Mainstream services should make reasonable adjustments to support those accessing the service with autism. The Greenlight Toolkit outlines the reasonable adjustments that mainstream mental health services should implement to support people with autism.

Children

For Children in Halton, the Diagnostic Pathway is set out in a chart, which can be seen at Appendix 4. Feedback from the consultation events stressed that this is an area that requires evaluation. This will be an action on the Delivery Plan.

2.2 Transition from childhood to adulthood

Transition to adulthood is a crucial stage in the lives of all young people, and a time when those with autism may face particular challenges. Good transition support for children and young people with autism can have a profound impact on their ability to reach their potential, through access to further learning or training, employment and independent living opportunities. Co-operation between the relevant authorities is crucial if the person is to fulfil their potential. Local Authorities children's and adult services, children's health services and social care all need to play a part. Under the Children and Families Act 2014 Local Authorities have duties towards children and young people with autism and their families. There are also requirements that Local Authorities must meet under the Care Act 2014 as young people make their transition from children's services into adult services.

Recognising the importance of effective transition for people with disabilities and/or complex needs (including those with autism), Halton established a dedicated Transition Team early in 2017 alongside the development of a new multi-agency Transition Protocol for the period 2017-2020.

This approach ensures that legislative obligations are met and the transition process is joined up across education, health and social care with increased and targeted co-ordination and communication from all agencies starting from Year 9 (age 13/14) up to the age of 25 years or until an individual's appropriate transfer into generic adult services.

Throughout the transition process, there is a person-centred and outcome-focused approach with young people and their families/carers being fully involved in decision-making. They are supported, through a strengths-based approach, to be aspirational and reach their full potential in relation to education/employment, living independently, participating in society and being as healthy as possible in adult life.

2.2.1 Planning

The planning process for Transition will start in Year 9 (age 13/14) and at this point the Transition Team will become involved in planning for the transition to adult services, for young people with an Education, Health and Care Plan (EHCP) and a diagnosis of Autism.

The process will ensure that a young person has a named social worker, when required up until year 14 (age 18/19), who will attend all review meetings that are called by the school and the young person, their parents and carers or chosen representative, the school teacher, SEND representative, relevant health professionals, careers advisors and a person-centred facilitator.

In advance of the year 9 review, school will support the young person to complete the **'My Transition Plan'** document, which will be discussed during the review meeting and added to and updated as appropriate afterwards. The Transition Social Worker will support school staff with this process. The purpose of My Transition Plan is to capture the young person's aims and aspirations for the future, the options that may be available to them as they move towards adulthood and the care and support they may require.

To assist with transition planning, young people and their families should be referred to the [Preparing for Adulthood section of Halton's Local Offer](#), which provides information, support and advice across education, health and social care covering ages 0-25 years. In addition, the [Care and Support for You Portal](#) provides information, advice and signposting with regards to adult social care services (age 18+).

My Transition Plan sits alongside the EHC Plan and the Health Action Plan, which is initiated by the school nurse at year 9, as necessary. Some young people may also have an 'All About Me' book, which is produced by schools from year 7 onwards (schools are responsible for maintaining this). Each of these documents will be considered within the review and updated by the relevant professional as appropriate following the meeting. The Transition Social Worker, supported by the relevant school, takes responsibility for the My Transition Plan. The SEND Service has responsibility for the EHC Plan. Health staff in attendance at the review will give consideration to whether the young person needs any therapeutic involvement or if any further referrals need to be made.

In years 10 to 14 it is focussed on firming up the options when leaving statutory education. There should be taster sessions offered from the educational setting that the young person is looking to attend post-16 and these will be explored and confirmed by the current setting.

If leaving school or college (year 11/14), the young person's final School Health Review (to incorporate the Health Action Plan) should be completed by the school nurse or paediatrician and a copy given to the young person/their family and shared with their GP (if consent given). It should also be made available to adult services to inform future health needs.

The Social Worker will work with the young person in a variety of settings, whichever one is the most comfortable for the young person and their family. Future planning outside of education will also be discussed, future accommodation, employment, friendship and social opportunities and how much support they will require to ensure this is an achievable goal.

2.2.2 Transition protocol

The Protocol applies to children and young people between the ages of 14 and 25 who have disabilities and/or complex needs, including the following distinct groups:

- Those who have an EHC Plan (or a Statement of Special Educational Needs (SEN));
- Those who are likely to meet the eligibility criteria for adult social care services (in line with the Care Act 2014);
- Those with Continuing Healthcare needs;
- Those with complex needs (e.g. behaviours that challenge services, learning disabilities, severe autism, acute or chronic medical conditions);
- Those who would benefit from support in planning for adult life but do not have an EHC Plan/SEN (e.g. those with high-functioning autism or social/emotional/mental health difficulties/ill health);
- Carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood.

The Protocol provides professionals from across education, health and social care services who are involved in supporting young people through transition with information about what should happen and when, who has responsibility and how agencies should work together.

The transition timetable is outlined within the Protocol, which explains that Year 9 marks the start of the formal transition to adulthood process and it is at this point that the Transition Team will become involved in planning for the move to adult services. This is in line with the requirement under the Children & Families Act 2014 that every EHC Plan review from Year 9 onwards must have a focus on preparing for adulthood.

The Protocol also describes how, in line with the Care Act 2014, a transition assessment will be conducted for young people with care and support needs if they are likely to have needs when they reach age 18. Adult carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood are also entitled to a transition assessment.

2.3 Training of staff who provide services to children and adults with autism

NICE guidance states that all health and social care practitioners involved in working with, assessing, caring for and treating people with autism should have sufficient and appropriate training and competencies to deliver the actions and interventions that are required. NICE also state the importance of people with autism being involved in the delivery of training to health, social care and education practitioners.

2.3.1 Autism Awareness

Through a contract we have with the LD Training Alliance a two-day autism awareness training course is offered. This is to increase basic awareness of how people with autism present and effective support strategies that can be utilised. This is suitable for carers, support staff or professionals who require a basic understanding of autism or professionals who have limited prior knowledge of autism. All staff within Adult Social Care have access to this course.

The British Psychological Society (BPS) have autism modules via e-learning. Levels 1 and 2 are free, level 3 has a cost. The link to the modules can be accessed here: <https://beta.bps.org.uk/psychologists/professional-development/find-cpd>

SEN Service provides whole school staff awareness to schools and settings as required. Elklan for Verbal ASC is offered on a yearly basis for up to 20 staff delivered over three full days. The offer also includes nurseries with Early Years training and visits by autism specialist teachers and portage to settings who have received training. Ashley school, through the teaching school alliance also offers regular training.

The SEN Service also provides on at least an annual basis the York Intervention for parents and carers of young people on the autism spectrum training. This is a nine week training course which aims to support parents develop an understanding of autism and provide them with strategies to help manage behaviours that challenge. Sibling training and support is also provided by the SEN Service through Halton Young Carers on a regular basis. We are also intending to set up training for children and young people with autism based on what parents have asked for from the York Intervention.

Commissioned services such as Chatter Bug Speech and Language Therapy Service provides training for parents in areas such as; use of visual supports and use of PECs (Picture Exchange Communication System).

Brookfields Special School provides NAS Early Bird training for parents and carers of young children. The aim provides guidance and strategies to support children and encourages confidence building in supporting interaction and communication skills. Brookfields Special School also provides parents and carers of children at the school with training around visual supports and use of PECs.

The Graduated Approach

According to the SEND Code of Practice, schools and settings should support pupils with SEND including autism using an Assess, Plan, Do, Review process/approach.

The first step in supporting a child or young person with a diagnosis of autism is to ensure that high quality differentiated teaching targeted at the area of need is the first response to supporting a child with SEND including autism (SEND Code of

Practice, 2014 6.37). Within Halton, schools and settings should not delay in providing intervention and support for children with SEND, including autism and should deploy their own resources and provision targeted at the area of need in the first instance.

The Graduated Approach can be considered as a process where increasing levels of support are implemented, and referrals are made to advisory services as appropriate. Where schools and settings can evidence that they have followed the Graduated Approach and implemented the advice of external agencies, but the child has needs that are unmet, the next step in the Graduated Approach is to apply for support for Enhanced Provision.

Enhanced Provision allows schools and settings to supply evidence that a child or young person has needs that cannot be met within the school or setting's own resources. It also enables schools and settings to use funding flexibly for the benefit of the child or young person. Enhanced Provision is top up funding provided by the Local Authority to help meet the needs of the child or young person. This provision can take the form of training, equipment, specialist resources or additional adult support and it is the school or setting's responsibility to demonstrate this need and the rationale for this intervention and support. Enhanced Provision is time limited and will remain in place for one year.

2.4 Education, health and care plans

The DH Guidance states that the Children and Families Act 2014⁵ provides for a new SEND support system, covering education, health and social care. A key change within the Act is that it replaces SEND statements and Learning Difficulty Assessments (LDAs) with more co-ordinated EHC plans for children and young people aged 0 – 25 with the most complex needs. This brings parity of rights for those at school and at college. There is also continuity of support beyond 18 + up to 25 for a young person if they need it to achieve their desired education and training outcomes and to help prepare them for adulthood. EHC plans provide a much greater focus on long-term outcomes.

Not every child or young person with a diagnosis of autism will require an EHC Plan. All schools and settings are expected to follow the graduated approach as outlined above. Schools and settings are required to follow a process of assess, plan, do, review in response to any emerging SEND need including autism. Many children and young people with a diagnosis have their needs met at SEN support level within schools and do not require support beyond this. A minority of children and young people within Halton may require the support of an EHC Plan.

⁵ <http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

2.4.1 New school provision for children with autism

In Halton, we have a range of provision for children with a diagnosis of autism. Our aim is that many children and young people can have their needs met within their local mainstream schools so that they can access education within their own communities. In order to support schools to meet the needs of children and young people with autism, we offer a range of support and services including:

- Education Psychology Consultation;
- Specialist Teacher and advisor involvement;
- Outreach support from specialist settings;
- Speech and Language Therapy Service; and
- Training and support for schools and settings who support children and young people with autism.

Some children and young people with autism have needs that are exceptional and cannot be met within mainstream school. In order to support children who have needs that are beyond what a mainstream school can provide, there is a range of provision available including resource based and specialist provision.

In order to access this provision, children and young people's needs are assessed on an individual basis following an application for an EHC assessment.

Resource bases

Simms Cross School and The Grange School have resource base provision to meet the needs of children in Key Stage 1 and 2. Each base is staffed by a teacher and two teaching assistants. There is provision for 14 children with a diagnosis of autism to attend the bases. The resource bases have highly skilled and specialist staff who are able to support the needs of children with autism. The concept of the resource base enables children to continue to access some mainstream school experience and to learn alongside typically developing children whilst providing individualised, specialist support to meet the needs of the child. Historically, children were placed in the base following a request for Enhanced Provision. From September 2017, children admitted to the base will typically be allocated a place following an EHC assessment.

St Peter and Paul School and The Grange School have resource base provision for children with a diagnosis of autism in Key Stage 3 and 4. Each base has provision for seven children and are staffed with at least three members of staff. Staff within the resource base have received additional training in autism such as the three day Canterbury and Christchurch University course in 'Understanding autism in school – Certificate in Autism'.

Special School Provision

Halton has a range of special school provision designed to meet the needs of pupils with SEN including autism. Places to special schools are allocated through an EHC Plan assessment. Each one of Halton's special schools provides a carefully tailored curriculum designed to meet the needs of children with SEN.

Brookfields Special School is a National Autistic Society (NAS) accredited community school which provides education for primary aged children with severe and complex learning difficulties and autism. Outreach support for mainstream primary schools is also provided through Brookfields.

Chesnut Lodge Special School is a community special school providing education that caters for children with complex physical and medical needs between the ages of 2 and 16.

Ashley High School is an NAS accredited secondary provision for pupils with a diagnosis of autism or social communication difficulty. Pupils placed in Ashley High School are high functioning pupils who receive a similar curriculum to mainstream peers but due to their vulnerability require a smaller setting with specialist staff.

Cavendish High Academy is for secondary aged pupils between the ages of 11-19 with severe and complex learning difficulties, profound and multiple learning difficulties including those with autism.

For more information on any of Halton's schools, please see the Local Offer which provides more information on each of the schools and the support they offer: <https://localoffer.haltonchildrenstrust.co.uk/schools/>

2.4.2 Provision for students in further education

Riverside College provides a range of training and education from entry level to Higher Education. The Foundation Studies Department offer further education for students with learning difficulties and/or disabilities, social anxiety and autistic spectrum disorders, who are aged between 16-25 years. Students will have an individualised programme specifically tailored to meet their needs and aspirations to enable students to progress onto other courses and training, seek employment and increase skills for a more independence life. Students do not need an Education, Health and Care Plan to access this provision.

2.5 Transition to adult health services

Under the Children and Families Act 2014, CCGs must co-operate with local authorities to jointly commission services that will help meet the outcomes in EHC

plans. This should include supporting the transition between children and adult services.

The Halton Community LD Team sits within North West Boroughs Healthcare NHS Foundation Trust. The Halton Community LD Team is a multidisciplinary service that supports adults with a primary diagnosis of a learning disability who have difficulties accessing mainstream services *because of their learning disability*. If a person is not previously known to the team, first and foremost, information will be required as to the presence of a learning disability. This may be gathered via: a clinical interview with the person and/or their carers, a review of previous educational statements of SEN or professional health reports. Some people may require more in depth assessment to identify if they have a learning disability.

The Halton Community LD Team comprises: speech and language therapists, occupational therapists, physiotherapists, clinical psychologists, therapy assistants and a consultant psychiatrist. There is also a community matron for learning disabilities who sits within Bridgewater Community Healthcare NHS Foundation Trust and a team of LD nurses who sit within HBC.

Users of services receiving clinical support from learning disability services will have a learning disability and an unmet health need. People with a LD may also have a diagnosis of autism or require an assessment for autism. Users accessing these services receive support based on clinical and presenting need.

The team has good links with HBC's Social Services Transition Team and have provided guidance on indicators a person may meet criteria for having a LD, and therefore may require support from the specialist LD team. The team also meets regularly with health services in Woodview Child Development Centre to improve the identification of individuals requiring intensive support around transitioning from children's to adults services within specialist learning disabilities service input. Professionals from the team may attend ECH Plan meetings, where invited, for clients who are currently accessing the service.

For adults with autism who do not have a learning disability, health services would be accessed from mainstream teams. Mainstream services should make reasonable adjustments to support those people with autism accessing their service.

Halton's Local Offer has a wealth of information on preparing for adulthood and is under constant review. Work was undertaken with young people about transition, their understanding of it and what they wanted their adult life to be like. As a result a 'Vision' for Transition in Halton was proposed and consulted upon. Further consultation with a wider range of young people, families and professionals was undertaken and a Transition Action Plan is being developed by the Preparing for

Adulthood Task and Finish Group. This plan will encompass transition planning for all young people with SEND.

2.6 Preventative support and safeguarding

The Care Act 2014⁶ places a duty on local authorities to provide or arrange preventative services for people within their communities. LAs should ensure they are considering the needs of their local child, young person and adult population who have autism, including those who do not meet the eligibility threshold for care and support.

2.6.1 Access to information and signposting

DH guidance states that it is important that all people with autism, whatever their level of need, can easily access information in their local area about what support from peers, charities and other community groups is available.

In Halton we have our Local Offer website, which is an online resource available to everyone, in particular:

- Children and young people with SEN and/or Disabilities (SEND) from birth to 25 years;
- Parents/carers and families; and
- Practitioners and professionals.

By working closely with children, young people, parents, carers and professionals we have used their ideas and feedback to change the layout, content and information available on the Local Offer to ensure it is user-friendly, in an accessible format and easy to understand. The main 'home' page is set out in themed topic sections and from there information can be easily found in itemised drop-down boxes.

Halton SEND Partnership information advice and support service (SENDIASS) is Halton's statutory information advice and support service. The service delivers FREE and confidential independent, impartial advice, guidance and support to children, young people (0-25 years) and their families around SEN and/or disabilities, SEND. Access to support from Halton SEND Partnership is not dependant on a formal diagnosis of needs; the service covers initial concerns or identification of potential SEN or disabilities, through to ongoing support and provision.

Chapter 2 of the SEND Code sets out in detail the duties that rest on local authorities to ensure that information, advice and support is available to children and young people with SEN and disabilities, and their parents. The Code describes how such services should be provided (2.4), the principles that should be taken into account

⁶ <https://www.legislation.gov.uk/ukpga/2014/23/contents>

(2.8), who information, advice and support should be available to (2.9 – 2.16), and what services should be provided (2.17 – 2.23).

Effective information, advice and support will result in service users being able to navigate SEND processes (including education, health and social care), participate in decision making, and, where necessary, challenge service providers to ensure that the needs of children and young people with SEN and disabilities are identified, assessed, provided for and reviewed in accordance with the Children and Families Act 2014 and the SEND Code.

2.7 Reasonable Adjustments and Equality

DH guidance for Adults states that for many people with autism, mainstream public services can be hard to access. People with autism can have a number of sensory differences affecting all five senses that can impact on their lives in a number of ways including communication, socialising and living independently. All public sector organisations, including employers and providers of services are required to make reasonable adjustments to services with the aim of ensuring they are accessible to disabled people, including people with autism. People with autism have a right to access mainstream services just like anyone else.

For adults with autism who do not have a learning disability, health services would be accessed from mainstream teams. Mainstream services should make reasonable adjustments to support those people with autism accessing their service.

Adults with autism accessing health services should also have a hospital passport so that their personal information and preferences are clear to all staff.

2.8 Supporting people with complex needs

DH guidance for Adults states that people with autism who also have mental health conditions or behaviours viewed as challenging are entitled to get good quality safe care, whether at home, living in the community or in hospital. People should be assessed, treated and cared for in the community wherever possible. People should live in their own homes with support to live independently if that is the right model of care for them.

Local Government Association (LGA) and NHS England make some key recommendations for services for children, young people, adults and older people with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges. The guidance was produced in response to Action 19 of Transforming Care: A national response to Winterbourne View Hospital; and reaffirms a model of care which is known to represent best practice. NHS England

has also produced further guidance on models of care for intensive support services for people with learning disabilities and/or Autism.

Core principles that should be in place across all education, health and social care services accessed by all children and adults with a learning disability and/or Autism who may engage in behaviour that challenges include:

- Improved life quality;
- Reduction in prevalence and incidence of behaviours;
- Reduction in the number of people placed in restrictive placements e.g. Assessment and Treatment Unit (ATU), residential school etc.; and
- Reduction in the inappropriate use of medication, restraint and seclusion as behavioural intervention.

With reference to challenging behaviour several best practice recommendation are made:

- 1) Behaviour Support is based on an holistic assessment (incorporating Functional Assessment) of the context in which the behaviours occurs;
- 2) There is a written individual support plan;
- 3) The behaviour support plan includes: a description of behaviour that challenges; a summary of the reasons for this behaviour; proactive strategies and reactive strategies;
- 4) Monitoring and review arrangements; and
- 5) Implementation arrangements.

The PBSS provides such services. Individuals referred to the service are given a full Functional Assessment of behaviour, carried out by a Board Certified Behaviour Analyst (BCBA). From this a person centred intervention and Positive Behaviour Support plan is developed. Support is then provided by the service to implement the plan and monitor its effectiveness and progress. Once an individual has reached their behavioural objectives, which will include both challenging behaviour reduction targets and also improved quality of life indicators e.g. increase community access, then discharge processes will commence. Individuals are provided with a detailed exit and maintenance plan with a view to preventing procedural drift and a re-emergence of behaviours that challenge.

PBSS pick up referrals for those individuals with the most complex behavioural needs. A high number of individuals referred to PBSS have a diagnosis of Autism. Referrals are triaged in adult service by the Adult LD Nurse Team. Part of their role is to screen out any underlying health issues impacting upon the individuals' behaviour before progressing additional assessments/sign posting to specialist services e.g. PBSS. Individuals with Autism and a LD who engage in lower level behaviours are supported in adult services by the LD Nurse Team who also utilise a functional

assessment approach. Service users may also access support by Speech and Language Therapist (SALT), Psychology or Occupational Therapist (OT) as part of a Multi-Disciplinary Team (MDT) approach to challenging behaviour. In children's services behavioural support for lower intensity behaviours is offered by Woodview children's services or CAMHS where there is a mental health issue also.

PBSS also provide training to other mainstream services in Positive Behaviour Support. Training is offered with a view to skilling up services e.g. adult short break, to be better equipped to support people who can engage in behaviour that challenges services.

LGA and NHS England also recommend that an Active Support model of care is provided. Active Support is an evidence based approach to supporting increased meaningful activity. Halton has taken a strategic effort to utilise Active Support as a model of care across adult services e.g. all day service staff and supported housing staff have been given training in Active Support and adopt this model of care. PBSS also support Active Support training with independent service providers supporting individual's referred to the service.

For individuals sectioned under the Mental Health Act the Care and Treatment Review (CTR) protocol is followed. CTRs were developed as part of NHS England's commitment to improving the care of people with learning disabilities, autism or both in England with the aim of reducing admissions and unnecessarily lengthy stays in hospital and reducing health inequalities. CTRs are focussed on children, young people and adults who have learning disabilities, autism or both **and** who either have been or may be about to be admitted to a specialist mental health / learning disability hospital either in the NHS or in the independent sector. The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the care and treatment and differing support needs of the person and their families are met, and that barriers to progress are challenged and overcome.

Behaviour others may find challenging lessens with the right support and individuals benefit from personalised care and living in the community. It is important that those who support people with complex needs, whose behaviour may challenge or who may lack capacity should have a good understanding of supported decision-making, understand the principle that people would not be treated as lacking capacity simply because they make an unwise decision; should consider their wishes and feelings, and all health and social care organisations need to understand the principle of least restrictive care, identifying a range of interventions and seeking the least restrictive ones for people with autism.

For adults with autism and a LD who require admission to a mental health hospital setting, Byron Ward is based at Hollins Park Hospital in Warrington. This is within North West Boroughs Healthcare NHS Foundation trust.

Dynamic Support Database

The development of a Risk Register was referenced in the National Care & Treatment Review (CTR) protocol document to ensure there was support available to those individuals who may be at risk of admission to a Mental Health Inpatient unit. Across Cheshire & Merseyside the term 'Dynamic Support Database' is used rather than Risk Register. There is an agreed Standard Operating Framework, outlining agreed standards to be adhered to across the Cheshire & Merseyside Transforming Care Partnership⁷ footprint for the development and maintenance of Dynamic Support Database for adults (i.e. who are aged 18 years or over) with a diagnosed LD, who may also have an Autistic Spectrum Condition, who are registered with a GP within respective CCG areas, and who are currently clinically managed through the direct involvement of a local Specialist Community LD Team.

This is the web link for the accessible standard: <https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf>

2.9 Employment for adults with autism

Halton's Local Offer has a number of case studies on it that showcases where young people and adults have gained employment in the borough. One of the main outcomes for programmes within further education is to equip students with the skills to transition from college into employment.

A partnership between Halton Borough Council and Riverside College is piloting a Supported Internship Programme for 6 young adults who are gaining essential and valuable skills, essentially "on the job training" to seek employment. They are working as an employee of Halton Borough Council for between 3-4 days a week and go into Riverside College for 1 day a week. Riverside College provide a job coach for support in the workplace on a reducing scale with the intention that the natural workforce around the individual will be the ongoing support. The aim of the programme is for students to gain paid employment at the end of the programme. Riverside College are going to continue to offer Supported Internships in the future.

Recognising the value of Supported Internships, the Government, have committed to a further year of support in the form of a SEND Preparation for Employment Grant to increase the number of supported internships on offer in the borough and increase the number of employers who will give supported interns the work placement.

⁷ <http://www.cwp.nhs.uk/about-us/our-campaigns/transforming-care/>

2.10 Working with the Criminal Justice System

Under the Care Act 2014 (from April 2015) LAs must assess the care and support needs of adults (including those with Autism) who may have such needs in prisons or other forms of detention in their local areas, and meet those needs which are eligible; and work with prisons and other LAs to ensure that individuals in custody with care and support needs have continuity of care when moving to another custodial setting or where they are being released from prison and back into the community.

A needs assessment document produced by the Centre for Public Health at Liverpool John Moores University in Jan 2016⁸ suggest that the prevalence of ASD in CJS is higher than the prevalence of ASD in the general population however this conclusion is modified by the poor methodologies and biased samples used in the studies which formed part of Murphy and King's review (2014). Similarly the prevalence of offending in ASD populations are also difficult to interpret but suggest that adults with ASD commit the same or fewer offences than those in non-ASD populations.

The Youth Justice system differs from the adult system in that there is a statutory requirement to consider the welfare and wellbeing of the child, aged 10-17, as well as the need for public protection in any actions taken by the Police and Courts.

The 1998 Crime and Disorder Act requires the Chief Executive of the LA to ensure there is a multi-agency partnership in place including the Police, Probation, Health, Education and LA as well as other relevant partners. In Halton this is delivered in a wider partnership with Warrington, Cheshire West and Chester and Cheshire East councils who have formed Youth Justice Services to deal with children in contact with the Youth Justice system.

All children referred to the Youth Justice Service (YJS) in Halton have come to the attention of the Police and when circumstances of the child and or incident allows, the presumption is not to prosecute or utilise the formal Criminal courts system but to effect an appropriate out of Court disposal which generally means no impact in terms of a criminal record.

The primary model for Out-of-Court disposals is via the award winning (Howard league for Penal reform 2017) Divert programme which seeks to identify relevant issues within the child's experiences and address them without recourse to the formal court system wherever possible.

⁸ "Learning Disabilities and Autism: a health needs assessment for children and adults in Cheshire and Merseyside"

All children referred to the YJS whether via formal Court outcomes or by way of Out-of-Court disposal are assessed utilising a nationally credited assessment tool- AsetPlus - which includes issues of general and mental health. The Youth Justice Service refers those children with identified or suspected needs related to autism to the general service provision within Halton. YJS staff receive regular training to ensure they are up to date with a wide range of issues affecting children in the contact with the Police.

Children detained by the Police prior to charge or Court appearance will be the responsibility of the Police during this period, but where detention is not required will be transferred to the LA for appropriate placement.

Children who receive a custodial outcome, whether sentenced or awaiting Court decisions, will receive a full health assessment and access to relevant services via the Institution in which they are placed, which can be anywhere in England or Wales as commissioned by the Youth Justice Board. The majority of children from Halton placed in a custodial setting will find themselves in Wetherby Young Offender Institution in Yorkshire. The YJS will retain case responsibility and will liaise with the child, family and home based services for the duration of the sentence in custody and upon release.

The wider YJS which covers the Cheshire Policing footprint and the four LA areas has access to specific speech and language services but these are currently unavailable in Halton.

At the age of 18, children transition to the adult criminal justice system and are expected to be transferred to the national Probation service for the remainder of any formal Court order.

The short **case study** below illustrates how the YJS Diversionary approach works in practice.

- 12 year old child arrested for six offences of criminal damage and one offence of assaulting a police officer.
- From the Police interview, it was clear that the child's level of difficulties were such that he struggled to comprehend the consequences of his actions i.e. recognise them as criminal acts.
- The case was referred to the Youth Justice award winning Divert scheme by police.



- The YJS triaged the referral and noted the child was known to children's services. YJS completed an assessment and liaison which included screening for SEN and disabilities through co-located CAMHS and Education specialists in YJS.
- YJS worked closely with the LA to advocate and help broker specialist education provision in Southport to support the child's identified needs.
- YJS contacted victims of offences who were happy for the matters to be dealt with by way of an out of court disposal.
- YJS and Police followed Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act⁹ guidance around joint decision-making for out of court disposals and made recommendation for the offences to be dealt with by way of an informal sanction called 'community resolution'.
- Outcome – the child was successfully diverted away from the formal criminal justice system and into appropriate support and intervention that would meet his needs, reduce risk of repeat offending and avoid harming his future life prospects with a formally recorded police caution or conviction.

⁹ <http://www.legislation.gov.uk/ukpga/2012/10/contents/enacted>

QUESTION	PUPIL RESPONSES
As an Autistic young person, what do you think is working for you in terms of your Autism?	<ul style="list-style-type: none"> • The school is autistic friendly and they are not like other schools • Small classes • Support • Having free time as a reward • No changes • My cards (visuals) • Stress relievers like sports, video games and music • Rewards for full credits in lessons • People understanding that I think differently to other people • Playing sports • Good/kind teachers • The help I am getting • Having fun in school, fun lessons • Science • Drawing • Being more mature • A mum that understands me • Money from government • My own room
What would make life easier for you at school?	<ul style="list-style-type: none"> • No loud noises, it hurts some people's ears • Not too much pressure on me to do my work • People accepting I am hyper sometimes • Having opportunities to calm down • Easy homework • Having special colours and drawing time • Time to think • Listening to my problems • To have a good morning at home so I take my good mood to school
What would make life easier for you at home?	<ul style="list-style-type: none"> • If I had more friends my age • When I bounce on my trampoline • Being allowed to go on my Xbox in the week • Not too much work • Building stuff on Minecraft • Letting me watch 'I'm a Celebrity' at the start and the end • No arguing, not talking at the wrong time • More mum and dad time • If we talked it out • Hit cushions • Personal space, relax time, a prize if I'm good on a Friday • To have a good day at school so I have a positive attitude at home
QUESTION	

	PUPIL RESPONSES
What does a good day look like for you?	<ul style="list-style-type: none"> • When I try to make the school better by being a Fire Marshall • Stress free and freedom of choice to do what I want, privacy • Reading, enjoyable lessons • When I don't get wound up by others • Getting full credits in lessons • Nice relaxed lessons with free time and Xbox at home • If my brain doesn't feel hard • More school drawing, looking at online images to draw • Getting no warnings • When I'm happy • Having fun, being with my parents, no one picking on me • Every day at school • Relaxing all day • Having a good morning at home so I enjoy myself at school
What does a bad day look like for you?	<ul style="list-style-type: none"> • When I get stressed out for certain reasons, when people annoy me I get angry • Friendships being broken • Two or more home-works a day • Being spoken to when I don't want to talk • When someone calls me a bad name (I would tell the teacher) • Change of timetable • Double lessons • When I get tired and mithered to death • Hard work, hard homework • Wednesday because of Science • Getting told off at school and at home • If I could not go to school • Getting told off because of my actions • When I'm unhappy • Being picked on, called names etc • People not letting me play football with them • Running out of sweets • When I get in trouble at home so I don't enjoy my day at school
Any other comments (continue over the page if necessary)	<ul style="list-style-type: none"> • I would like to go to other schools and make them aware of what Autism is and what the difficulties are • I would like a Halton Autistic football team • More DT as I think it is good to learn more about making stuff • Less pupils who are being annoying • Primary was 'hell' but I'm out of it

Consultation with Schools

Appendix 2

Thursday 9th November, 3.30pm-4.30pm at Ashley High School

Attended: RB Teacher Simms Cross, RB lead and SENCO, Simms Cross, RB Lead, St Peter and Paul's, Head teacher, Chesnut Lodge, DHT, Ashley, Assistant Head teacher, Ashley, Head of 6th Form and Autism Lead, Ashley, Infant base, The Grange, KS3 Base, The Grange, Practice Manager, Disabled Children's Service, Specialist Teacher.

- Welcome and introductions
- Overview/ aim of the strategy
We discussed briefly the aims and overview of the strategy and purpose behind it. Ami stressed the need to include and get the schools involved as key partners in the process. Ami thanked schools for sharing the questionnaire. We had a large response particularly from Brookfields.
- Parental and child/ young person feedback
We discussed the highlights from the feedback as shown on the next page. We also discussed the following training needs and support for parents:
 - York training is well established and attended but it is a lengthy course and not all parents can engage with this
 - Short courses that we could offer to all parents as a network of schools
 - Specific courses for parents e.g. sex and relationships, social media and internet use
 - Mental health and emotional wellbeing to support
- Further opportunities to gather pupil voice and consultation
 - Helping and supporting children to understand autism
 - Perhaps a video of children exploring what autism is and what it means which could be included on the local offer
 - Whether each school could appoint their own 'autism ambassadors' within the school to participate and work with schools and the community around understanding autism
 - Schools have agreed to have a discussion with pupils and share any further feedback.
- Inclusion of schools as stakeholders in the strategy

Schools welcomed the opportunity to network and wanted to continue to be involved in the strategy and any further opportunity to contribute.

- Any other business

Schools found the meeting helpful and have requested to meet again. The next meeting will take place on **Thursday 11th January at 3.45pm at Simms Cross, Widnes.**

The agenda will cover:

Emotional health and wellbeing for children with autism.

Schools will bring along and share resources and ideas they have developed to address emerging difficulties.

Ami to contact CAMHS and EP Service to see if there is any representation possible at this meeting.

Key themes from the feedback**Number of completed surveys received – 76**

30 received via Ami McNamee, the rest through the post

Adult with autism	19
Carer of an adult with autism	12
Child with autism	5
Parent/carers of a child with autism	38
Blank	2
Total	76

Autism	50
Asperger's	11
Blank	15
Total	76

Type of school

Mainstream	5
Special	39
Resource base	1
Blank	1
Total	46

Key themes emerging:

- Lack of post-diagnostic support
- Praise for some services

What schools and colleges can do better:

- Make mainstream schools more autism friendly
- Holiday periods particularly over 6 weeks can be difficult for parents
- Better links between health/ services and schools including services going into school
- Communication- parents can sometimes feel as though they are not fully included in school life
- Transport can be problematic for some children
- Some comments regarding change being too frequent

What else needs to change:

- More opportunity for social groups and activities
- Parents and CYP not always aware of service that are available to them
- Some concerns over transition to other services
- Consistency of staffing

SUMMARY OF SIMMS CROSS RESOURCE BASE QUESTIONNAIRE TO PARENTS

APPENDIX 3

13 questionnaires sent out, 10 returned.

	How does your child feel about school?
Enjoys/ happy	////////
Bad/a little bit good	/

Questions Asked	What are the challenges your child faces?		Any concerns regarding the support?		What is working well?		Any further support RB could offer?	
Responses	Handwriting	///	None	////////	Everything	//	None	////////
	Completing work	///	Changes in Base	//	1:1 Reading activities in RB	//	Continue Coffee Mornings	///
	Reading	//			1:1 writing activities In RB	/	Continue to inform parents	/
	Keeping his own behaviour under control	/			Staff’s approach and knowledge of child	// // //	Explain things in more details to parents with EAL.	/
	Homework	//			Daily Routine	/		
	Waking up	/			Incentives	// /		
	Hard work	/			Able to return to Base	//		
	Socialising/ Boundaries	//			Peer Massage	/		
	Anxiety	/			Golden Time	/		
	Independence	//						
	None	/						

Additional comments from parents

“Just to say thank you for all the help and understanding to date”, “The Resource Base staff are amazing”, “Brilliant education setting, I’m forever grateful”.
 “Thank you to all staff”, “I don’t think there is anything else the staff can do, you all do an amazing job”.
 “Thank you”.

CHILDREN'S SERVICES DIAGNOSTIC PATHWAY

APPENDIX 4

Referrals requiring multiple health services to a single point, one referral form.

Referral not indicating that universal support has been offered/taken-up.

Weekly Triage by small group 2-3 of below:
Advanced Nurse Practitioner (ANP), Child Paediatrician, Speech & Language Therapist, Occupational Therapist, Physio, Portage, Educational Psychologist, CAMHS, Orthoptist.

Referral accepted for Specialist Health Assessments. Group agree which professionals are to commence assessments and which may be later.
For medical assessment a child may be assessed by ANP/C Paediatrician (clinical decision by panel).
Where required, Admin/Assistant send leaflet/questionnaires to parents and schools, to obtain views of child in a range of settings.
Recommendation from Panel may be for some families to commence behaviour support via W Stratton/other courses as well as or instead of assessment.

Assessment commences (18 weeks RTT with appropriate combination of:
AHP assessments
ANP / Community Paediatrics assessment
History, Observation in Nursery / School
Parental/School questionnaires
Early years / Portage information (if involved)
CAMHS information (if known to service)
Ed Psychology, Specialist Teacher (if known to service)
Some assessments may be jointly conducted e.g. SLT + ANP, OT/PT, Additional Needs Nurse / Community Paediatrics.
Initial advice will be given to parents by assessors about managing presenting situation.

Support does not require medication / medical oversight

Continue the support with AHPs, Specialist Nurses/School /CAMHS/Education Psychology if involved. Discharge from Community Paediatrics back to GP.

Signposting to other sources of support

Some referrals may need to be signposted to universal early support such as Children's Centres /Health Visitor/School behaviour support/School Nurse support. Family to employ behaviour support strategies in school/at home. If universal provision implemented does not resolve the issue then Child can be referred back to specialist service. Some may need to be referred to Tier 2/3 CAMHS support if outside expertise of this group.

Multi professional panel meets to discuss assessment findings, by week 20 at latest. Group reviews all assessment findings and information provided by others and develop support plan (regardless of diagnosis)

Decision made:

1. If any further assessments are needed by ANP / Medical Staff
2. If ADOS needed
3. If other medical tests needed

Next actions:

- a. Support plan prepared for feedback
- b. Complete any further assessments identified
- c. Joint written report developed
- d. Agree which professionals to feedback to family
- e. Agree source of emotional support for family e.g. HV, SN, family member, Portage, Specialist Teacher, School.

CYP & Family Feedback Meeting

Meet with CYP & / or Family. Emphasis on 'support' not diagnosis
Feedback
a. Assessment findings
b. Support plan
c. Diagnosis if appropriate
d. Next steps - ongoing with some services, discharge from other services.



ONE HALTON ALL-AGE AUTISM STRATEGY

DELIVERY PLAN 2018 – 2019

1 LOCAL PLANNING AND LEADERSHIP					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
1.1	User-led delivery plan monitoring	Establish Local Autism Action Alliance as a sub group of the Learning Disability Partnership Board	May 2018	Patrick Frost, HBC	
1.2	Develop a local register of people diagnosed with Autism.	<p>GPs to continue to record when a person receives a diagnosis on the patient's record.</p> <p>Develop co-ordinated approach to gathering details of current and new diagnosis and updating register.</p>	September 2018	Lisa Birtles-Smith, NHS Halton CCG	

1 LOCAL PLANNING AND LEADERSHIP					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
1.3	Strategic/joint commissioning	Consider joint commissioning across the board (CCG/HBC Adults/HBC Children's) for any new or reviewed Autism services and undertake in a co-production manner.	March 2019	Sam Murtagh/Sheila McHale (Lisa Birtles-Smith)/HBC Commissioner	
		Report on current delivery of support linked to Autism from more generic commissioned services (link to 1.4).	May 2018	Sam Murtagh/Sheila McHale (Lisa Birtles-Smith)/HBC Commissioner	
		Links to local autism user group (as outlined at 6.3)			
1.4	More commitment to joint working and utilising good practice from others areas to improve services.	Review local area to ascertain areas of good practice.	March 2019	Members of the Autism Action Alliance.	
		Look at the viability of Autism-accredited services.	March 2019	Patrick Frost, HBC	

1	LOCAL PLANNING AND LEADERSHIP				
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
1.5	Identify external funding opportunities for Autism Services.	Review any external funding opportunities specific to Autism and work together as a multi-agency group on developing these funding opportunities.	March 2019	Emma Sutton-Thompson, HBC	
1.6	Promote new Strategy and raise awareness locally	Link in to World Autism Awareness Week from 26 th Mar to 2 nd April 2018	April 2018	Policy Team, HBC/Ami McNamee,	

2 TRAINING FOR STAFF					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
2.1	All staff across all agencies to be Autism-aware.	Develop and implement e-learning on Autism Awareness for all staff and increase access to LDTA autism training.	March 2019	Nicola Hallmark, HBC/Jane Birchall-Smith, /Lisa Birtles-Smith, CCG	
	Selected staff to be supported to be specialists (“autism champions”).	Identified staff to access further specialist training in Autism.	March 2019	Nicola Hallmark, HBC/Jane Birchall-Smith, /Lisa Birtles-Smith, CCG	

3 EDUCATION					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
3.1	Improved links between health services, social care and education.	Improved integration of Education, Health and Social Care within the EHC process.		Alison Sutch, CCG/Anita Parkinson, HBC/Tracey Coffey, HBC	
3.2	Support mainstream schools to develop 'Autism' and communication friendly settings	Schools and settings encouraged to develop their provision to meet the needs of CYP with Autism. Brookfields provide mainstream schools with Autism-friendly training as part of outreach support.	March 2019	Ami McNamee, HBC	
			Sept 2018		
		Schools and settings to demonstrate on their Local Offer SEN Information Report dates of their most recent Autism Awareness Training and how they have adapted their provision to meet the needs of CYP with Autism.	Sept 2018	Tracy Ryan, Local Offer	

3 EDUCATION					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
3.3	To improve the scope and range of post-diagnostic training opportunities for parents and carers.	York: Intervention and Support for Parents and Carers of children with Autism training offered on at least an annual basis to parents.	March 2019	Ami McNamee, HBC	
		Ensure that parents and carers receive information about the training through the post-diagnostic family feedback meeting.	March 2019	March 2019	
		Ensure details of any ChAPS training is cascaded through specialist Autism settings and through family feedback meetings at Woodview.	March 2019	Katrina Mardsen, Additional Needs Nursing, Woodview	
3.4	Increase knowledge of parents in Autism-related areas.	Commission specific training courses for parents, e.g. sex and relationships, social media and internet use.	March 2019	Ami McNamee, HBC to co-ordinate with individual schools.	

3 EDUCATION					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
3.5	Support schools to develop their provision to meet the emotional health and wellbeing of children and young people with Autism Increase support to parents and carers to meet the needs of CYP with Autism	Training and sharing of best practise for schools through half termly meetings. Ensure schools are to be aware of appropriate signposting, e.g. to GPs. Implementation of Nurture For Learning Vision across Halton to help schools, settings and services to meet the emotional health and wellbeing needs of all CYP and their families	January 2018 March 2018	Ami McNamee, HBC to coordinate along with Education Psychology Service “ “	
3.6	More opportunity for social groups and activities for children.	Liaise with other departments to promote social groups and activities for children.	March 2019	Anita Blakey, HBC	
3.7	Develop existing parent resource base meetings to ensure training needs are met.	Regular coffee mornings to support parents of children with Autism and opportunities for speakers.	May 2018	Ami McNamee, HBC	

4 SUPPORTING PEOPLE WITH MENTAL HEALTH NEEDS					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
4.1	Improved services for people with Autism and Mental Health needs	Review the services provided by CAMHS to ensure they are fit-for-purpose	March 2019	Sheila McHale, CCG/Alison Sutch, CCG	
4.2	Improved services for adults with autism and MH needs	Ensure all MH staff in ASC are Autism-aware (link to training above).	March 2019	Lindsay Smith, HBC	

5 SUPPORTING PEOPLE WITH COMPLEX NEEDS					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
5.1	The PBSS Service to be accessible to more of the population.	The following interim targets to establish if the PBSS Service should be extended or not and if it is what are the resource/financial implications.		Maria Saville, HBC/Sheila McHale, CCG	
		Identify existing behavioural services that currently meet the needs of individuals with Autism and no LD.		Maria Saville, HBC/Sheila McHale, CCG	
		Identify how many people would benefit from an expansion of PBSS eligibility.		Maria Saville, HBC/Sheila McHale, CCG	
		Identify the level of resource PBSS would need to meet this capacity.		Maria Saville, HBC/Sheila McHale, CCG	

6 AUTISM SERVICES					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
6.1	Improved process of diagnosis and information once diagnosed.	Review process of diagnosis for both Children and Adults.	March 2019	Lisa Birtles-Smith/Alison Sutch, CCG	
		Produce information pack/online information to give to people once diagnosed.	March 2019	Lisa Birtles-Smith/Alison Sutch, CCG	
6.2	Review specialist services and knowledge of staff in the Borough to ensure that the needs of people with autism are met adequately within Halton.	Mapping the gap in specialist and generic services/identifying good practice and look to jointly commission any that are required using person-centred approaches.	March 2019	Sam Murtagh/Sheila McHale (Lisa Birtles-Smith)/Adult Social Care Commissioner	
		Research the region to find good examples of day service provision for autistic adults that could be replicated in Halton.	March 2019	Sam Murtagh/Sheila McHale (Lisa Birtles-Smith)/Adult Social Care Commissioner	

6 AUTISM SERVICES					
REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
6.3	Establish local user group for people with Autism.	Research how groups in Manchester and Liverpool function and try to replicate locally.	March 2019	CHAPS/Patrick Frost, HBC	
		Establish terms of reference/membership following the research.	March 2019	CHAPS/Patrick Frost, HBC	
6.4	Ensure adequate short breaks provision in the borough to meet the needs of children with autism.	Review current short break provision for children with autism in the borough.	March 2019	Sam Murtagh, HBC	
6.5	Ensure children are at the centre of planning and children/parents/carers are fully able to contribute to the development of their transition plans.	Transition team to facilitate person-centred, strengths based approaches to the development of transition plans.	March 2019	Debbie O'Connor, HBC	

REPORT TO: Health & Wellbeing Board

DATE: 28th March 2018

REPORTING OFFICER: Sue Wallace Bonner - Director of Adult Social Services, Halton Borough Council

PORTFOLIO: Health & Wellbeing

SUBJECT: Care Quality Commission (CQC) - Local System Review (LSR) of Health & Social Care in Halton: Action Plan Update

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To receive an update on progress towards the actions included in the Action Plan developed following CQC's LSR of Health & Social Care in Halton.

2.0 RECOMMENDATION

RECOMMENDED: That the Board

(1) Note the contents of the report and associated appendix.

3.0 SUPPORTING INFORMATION

3.1 Following the presentation of the Final Report and Action Plan to the Board in January 2018 and the agreement that progress against the actions outlined in the Action Plan would be monitored via the Board, attached is the latest update available.

3.2 Updates have been sought from the individuals/organisations outlined in the Action Plan and those updates that have been received have been added to the Action Plan and highlighted in red, for ease of reference. NB. All previous updates received remain in the Action Plan.

4.0 POLICY IMPLICATIONS

4.1 None associated with this report.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None associated with this report.

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**
All issues outlined in this report and its associated appendix focuses directly on this priority.

6.4 **A Safer Halton**
None identified

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

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

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

9.1 None under the meaning of the Act.

Appendix 1

CQC's Local System Review of Halton – Action Plan: Update



Halton Clinical Commissioning Group



**CARE QUALITY COMMISSION
HALTON LOCAL SYSTEM REVIEW
(AUGUST 2017)**

ACTION PLAN



Background

Following the publication of the Care Quality Commission (CQC) Local Review of Health & Social Care Services in Halton report on 12th October 2017 (link: http://www.cqc.org.uk/sites/default/files/20171012_local_system_review_halton.pdf), this Action Plan has been developed in response to the issues highlighted within the report.

The issues highlighted within the report have been reviewed and themed under the following headings:-

- Strategic Vision and Governance;
- Delayed Transfers of Care (including user experience);
- Key Actions for Winter 17/18
- Workforce;
- Market Capacity and Capability;
- Commissioning; and
- Patient Flow.

This Action Plan has been developed by the CQC Review Working Group, chaired by Sue Wallace-Bonner, the Director of Adult Social Services, Halton Borough Council and with representation from:-


- NHS Halton Clinical Commissioning Group (CCG)
 - Michelle Creed, Chief Nurse
- Halton Borough Council
 - Damian Nolan, Divisional Manager for Intermediate and Urgent Care
- Warrington & Halton Hospitals NHS Foundation Trust;
 - Lucy Cunliffe, Transformation and Delivery Manager
 - Neil Holland, Associate Director of Nursing
 - Jan Ross, Acting Chief Operating Officer
 - Jenny Farley, Deputy Director of Operations
- St Helens & Knowsley Teaching Hospitals NHS Trust;
 - Sue Redfern, Director of Nursing, Midwifery and Governance

- Ann Rosbotham-Williams, Assistant Director of Governance
- Northwest Boroughs Healthcare NHS Foundation Trust; and
 - Lindsey Maloney, Director of Operations
- Bridgewater Community Healthcare NHS Foundation Trust
 - Jacqui Tudor, Clinical Services Manager
 - Caroline Williams, Interim Director of Operations
 - Ian Senior, Assistant Director of Operations
 - Joanne Barnfield, Clinical Manager

The Group has been supported in its development by Hannah Miller, Senior Associate from the Social Care Institute for Excellence.

(Update - 21.2.18)

1. Strategic Vision & Governance

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
1.1	One Halton Accountable Care Strategic Vision to be signed off by Halton's Health & Wellbeing Board (HWBB).	Leigh Thompson	Ongoing	17.1.18	<p>The Strategic vision has already been signed off by the NHS Halton CCG and Halton Borough Council Executive Officers and will be formally presented to the HWBB on 17.1.18.</p> <p>Copy of Strategic Vision below:-</p>  <p>One Halton Draft Strategic Vision v6 (2</p>
1.5	Review role of Halton's HWBB to ensure that there is enhanced challenge across the Health and Social Care system.	Eileen O'Meara	9.11.17	Completed	<p>Proposal to be presented to the HWBB in January 2018 will include suggestions on:-</p> <ul style="list-style-type: none"> • Revised Membership (to include GP Federations) • Review of Terms of Reference • Format of Future Meetings – to include the sharing of learning across the local system (see Action 4.5). • Performance Dashboard which will focus on the local system performance (to included Delayed Transfers of Care and the performance against the national standard for A&E) and highlight system risks • Development sessions for the HWBB <p>Update (21.02.18) New TORs and Membership was agreed at the HWBB on 17.1.18 and work is progressing on developing and associated performance framework.</p>

2. Delayed Transfers of Care (inc. user experience)


Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
2.2	Ensure that the Home of Choice Policy within the Acute Trusts is appropriately applied	Jan Ross/ Amanda Farrell	1.04.17	31.3.18	<p>Both Trusts have a home of choice policy based on the Cheshire and Merseyside Home of Choice Policy and enforces this where choice is available. Work is ongoing to ensure this is used effectively and is being monitored through the contractual route by the lead commissioners.</p> <p>Both Trusts continue to work with staff teams to ensure this approach is embedded within Discharge Planning.</p> <p>Update – STH&K (21.02.18) STH&K have further discussed the policy internally with matrons, clinical directors and Integrated Discharge Team (IDT) to ensure that it is being consistently applied. This is tested twice weekly at the Complex Discharge Review meetings, where it is checked that letters are being issued as per policy. The Deputy Director of Operations and Performance supports Matrons, IDT and CDs by meeting with patients or families who are refusing to comply with policy (if they are having any difficulty) – but so far that has not been necessary.</p> <p>At the last MADE event a revised NHSE HOC policy for comment was circulated. This is a slightly simplified policy than the one – The policy has also been discussed by the AED delivery board to adopt and apply a consistent approach.</p>
2.3	Improve the length of time that patients are waiting for Intermediate Care Beds.	Damian Nolan	30.10.17	31.1.18	In addition to the work being undertaken as outlined below (see Action 6.1), the work taking place in respect of

					<p>the Intermediate Care Review (see Action 6.4) will address the issues associated with the length patients are waiting. Target LOS is 28 days.</p> <p>Update (21.02.18) As part of the IC Review a workshop is planned across stakeholders.</p>
2.4	Improve the length of time patients are waiting for a CHC assessment.	Anna Marie Jones	Ongoing	31.3.18	<p>There are no delays in respect to patients waiting for CHC assessments. Delays have been occurring in relation to the completion of a decision support tool (DST) within the 28 day timescale.</p> <p>A trajectory for improvement has been agreed with NHS England and will reach 80% within the financial year. This is monitored as part of the CHC improvement plan by NHS England.</p> <p>Update (21.02.18) At Q1 25%, at Q2 46.88% at Q3 on target to meet 80% trajectory by Q4</p>
2.5	Implement Trusted Assessors Model in Halton	Helen Moir	Ongoing	January 2018	As part of the Care Home Development Board work a number of care homes have agreed the employment of a shared Trusted Assessor to undertake a single assessment for care home placements. A Job Description has been completed and recruitment is underway.
2.6	Improve capacity and demand management within Domiciliary Care Provision.	Damian Nolan	1.9.17	31.3.18	The work taking place in respect of Domiciliary Care, as outlined in Actions 5.1, 5.2 demonstrate how current and future capacity and demand issues will be addressed and therefore contribute to the improvement of DTOCs.

					<p>Update (18.12.17) Reablement 1st model introduced on 5th December.</p> <p>Lead Dom Care provider has undertaken a proactive and ongoing recruitment campaign. Despite market pressures this has had a positive yield of quality candidates successfully completing the recruitment process. Moving forward, recruitment targets are being exceeded.</p> <p>Work progressing on sub-contracting arrangements between providers to support and strengthen local market capacity.</p> <p>Update (21.2.18) Work is on-going across Domiciliary Care providers and sub contracting arrangements are scheduled to be in place from 1st April 2018.</p> <p>A number of prioritised work streams are being progressed:-</p> <ul style="list-style-type: none"> • Embed practices across the Reablement 1st process; • Introduction of Single handled care; and • Medication management - Work is underway with pharmacies to look at the introduction of pre-printed MAR sheets across Domiciliary Care in order to reduce the risk of medication errors.
2.7	Some evidence of delays having a detrimental effect on individuals	Jan Ross	1.6.17	31.3.18	<p>Warrington and Halton NHS Foundation Trust have implemented red to green to identify delays in patient's journeys; these have been implemented across all medical wards and are discussed twice a day. Any issues are</p>

		Diane Stafford	Completed	Completed	<p>escalated to senior operational teams for help to unblock. Any patient who is medically fit and has a LoS of 10 days + over, are discussed at the weekly escalation meeting, attended by community, social and trust staff to look at discharge delays and see what can be put in place to ensure a safe and proactive discharge. All patients with a LoS of over 10 days are discussed in a weekly MDT, where appropriate additional therapy support is provided and all patients are monitored through Nursing assessments for any signs of deterioration in their condition due to a delayed discharge.</p> <p>St Helens and Knowsley Teaching Hospitals NHS Trust continue to monitor and assess patients who are experiencing delays to care, including delivery of maintenance therapy to ensure patients retain optimal function prior to discharge.</p> <p>Update – STH&K (21.02.18) Mechanisms in place to monitor delays; delays monitored on an ongoing basis. Currently twice weekly DTL (discharge tracking), monthly MADE and about to commence ECIP supported stranded patient reviews for non-social related LOS above 7 days.</p>
2.8	Improve the quality of discharge summaries provided, particularly in respect of medication	Jan Ross	1.6.17	31.3.18	<p>Warrington and Halton Hospitals NHS Foundation Trust have created a “medically fit for discharge” area on the patient administration system – Lorenzo. The Medically Fit for Discharge’ tab will populate with ‘live’ up to date discharge information. The discharge teams are then able to interrogate the numbers and use this to identify delays in discharge processes. This feeds the patient flow meetings and the Trust has also established task and finish groups for implementing improvements to the Trusts e-</p>

		Diane Stafford	1.11.17	31.12.17	<p>discharge processes. This is chaired by the Trusts Acting Medical Director Alex Crowe. All patients are given advice on discharge. The Medical Director is working closely with the divisions now that improvements in compliance with numbers of discharge summaries sent have improved. The quality of the summary is the focus and these will be audited on a bi monthly basis.</p> <p>St Helens and Knowsley Teaching Hospitals NHS Trust are undertaking an audit to confirm compliance with discharge checklists, including information for patients about take home medications and to identify areas for improvement. In addition, an audit will be completed on a sample of discharge summaries sent to GPs to review the quality of information provided regarding medications and to identify areas for improvement.</p> <p>Update – STH&K (21.02.18) Audit findings presented to January’s Patient Experience Council, with recommendations shared at February’s Ward Manager and Matron meeting. The standard operating procedure for ICE discharges and the ICE discharge manual were circulated to trainee doctors in November 2017 as a reminder of the requirements.</p>
2.9	Improve the information available to patients within the Discharge Lounges of the Acute Trusts	Neil Holland	1.10.17	31.3.18	<p>Warrington and Halton Hospitals NHS Foundation Trust is in the process of reviewing all materials provided to patients regarding discharge as part of the safe and proactive discharge CQUINN. This will include proactive management of TTOS and transport management as necessary.</p>
		Bongi Gbadebo	Ongoing	31.12.17	<p>St Helens and Knowsley Teaching Hospitals NHS Trust are reviewing the information available in Transfer Lounge,</p>

					<p>seeking the views of patients/carers on the quality and relevance of information available and will develop appropriate information to meet the identified needs of patients, including information leaflet about the purpose and function of the Transfer Lounge.</p> <p><u>Update – STH&K (21.02.18)</u> Trust Director of Transformation leading an ongoing initiative to improve communication and information sharing to patients and relatives relating to discharge. The project includes MDT sessions for ward staff and discharge teams, communication leaflets and focused attention to improving facilities within the Transfer Lounge</p>
2.10	Implement Halton’s IM&T Strategy to ensure that appropriate agencies are able to access the full range of patient data, as required, in order to expedite discharges from Hospital etc.	Emma Alcock	As per Strategy	As per Strategy	<p>Strategy attached here.</p>  <p>NHS Halton CCG IMT Strategy Final.pdf</p> <p>A number of actions form part of the strategy including the implementation of the following:</p> <ul style="list-style-type: none"> • EMIS Web into Halton Urgent Care Centres and HBC Adult Community Services; • Full Electronic Patient Record (EPR) system within St Helen’s and Knowsley Hospital Trust; • Warrington Shared Care Record Portal; • EMIS Viewers into HBC Social Care Services; and • End of Life Palliative Care Co-ordination System. <p><u>Update (21.02.18)</u></p> <ul style="list-style-type: none"> • EMIS implementation into Community Services and

					<p>Halton UCC's to take place between Q1 and Q3 2018/19. Engagement with services has commenced and EMIS configuration of templates and documents has commenced.</p> <ul style="list-style-type: none"> • EPR rollout in St Helens and Knowsley Trust underway. • Shared record portal procurement underway and supplier engagement commenced. • EMIS viewers installed onto Council PC's, data sharing agreement developed to support data sharing between primary and community services. • EPACC's system in place using the Medical Interoperability Gateway (MIG). End of life clinical need supporting the embedding of gold standard framework within GP practices.
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Update - 21.2.2019

3. Key Actions for Winter 2017/18

Action No.	Action Required	Responsible Officer	By When		Progress to date												
			Start	Finish													
3.1	To continue to meet the required targets in relation to DTOC	Sue Wallace-Bonner/ Michelle Creed	Completed	Completed	<p>A number of system changes are underway whilst these will make structural changes in the medium to long term additional actions are required to mitigate the impact of these changes during the winter whilst also managing seasonal pressures.</p> <p>Halton has seen some improvements in the number of delayed days over the summer months, August has seen an increase in the number of delayed days:</p> <p>The main reasons are patient or family choice and waiting further NHS care. Halton are still having difficulties with residential/nursing and domiciliary care capacity.</p> <table border="1"> <thead> <tr> <th></th> <th>July</th> <th>August</th> </tr> </thead> <tbody> <tr> <td>NHS</td> <td>256</td> <td>390</td> </tr> <tr> <td>SC</td> <td>69</td> <td>70</td> </tr> <tr> <td>Both</td> <td>0</td> <td>54</td> </tr> </tbody> </table> <p>Weekly/monthly monitoring will continue, with monthly reports to Chief Officers Management Team (HBC). The monitoring of DTOCs will also take place at a strategic level as outlined in section 2.1 of the Action Plan.</p> <p>Update (21.02.18) Clear processes in place for monitoring the level of DTOCs.</p>		July	August	NHS	256	390	SC	69	70	Both	0	54
	July	August															
NHS	256	390															
SC	69	70															
Both	0	54															

					Agency Responsible	Number of Delayed Days (October 2017)	Number of Delayed Days (November 2017)	Number of Delayed Days (Dec 2017)
					NHS	483	666	475
					Social Care	56	32	24
					Joint	24	14	12
					TOTALS	563	712	511
3.3	Identify opportunities for additional capacity over the winter period while in transition	Sue Wallace-Bonner/ Leigh Thompson	2.11.17	17.11.17	<p>A meeting has been arranged for the 9th November- CCG and LA to discuss options for:</p> <ul style="list-style-type: none"> • Additional health support for nursing homes • Feasibility to open a short-term unit • Feasibility of block purchasing additional care home beds for long- term placements <p>Update (21.02.18)</p> <p>Two nursing homes subgroup meetings have been held in December 2017/January 2018 with a further meeting planned for March 2018. Focus areas link in with the Care Home Development Group work streams to improve health in care homes:-</p> <ul style="list-style-type: none"> • Safer Staffing models (NHSE); • Development of a care home/nursing home MDT model; and • The role of registered nurses in care homes/nursing homes. <p>Both Acute Trusts have been awarded winter resilience funding. From Halton's perspective, STH&K are using some of the funds to recruit a number of Band 2 care assistants (22 in</p>			

					<p>total) to support the delivery of Reablement packages of care within the Borough. At this time work is progressing with the Trust to secure start dates for staff.</p> <p>WHH have used some of their funds to open 12 additional Intermediate Care beds on the Halton hospital site.</p>
3.5	Continue to sustain the current care home capacity	Sue Wallace-Bonner	Completed	Completed	<p>Continue to work across all care homes in Halton to prevent reductions in quality, which require suspension of placements. Led by HBC Quality Assurance Team, a group of health and social care professionals work proactively with homes identified as at risk of suspension of placements.</p> <p>Continue to work with providers to prevent closure of beds/homes. Monthly meetings are undertaken with all home care providers to ascertain their current sustainability and identify appropriate supports to ensure this is maintained.</p> <p>HBC have purchased a residential home and are in negotiations to purchase a nursing home with a provider who has declared their intention to cease operating the home.</p> <p>Update (21.02.18) Following the transfer of Millbrow Nursing home in Widnes on 11th December, work has taken place to improve the quality of provision and associated staffing levels. As such Millbrow opened to admissions on 18.1.18 and since then has made 9 admissions up to 22.2.18.</p>

4. Workforce

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
4.1	Develop system wide workforce strategy.	Leigh Thompson	Ongoing	TBC	Halton workforce strategy to be developed across health and social care as part of the Accountable Care System.
4.2	Develop Halton Social Care Workforce Strategy.	Sue Wallace-Bonner	9.11.17	April 2018	Initial meeting has been arranged. Desk top review of existing strategies commenced. HBC ASC undertaking corporate collaboration with Liverpool City Region re: Apprenticeship providers.
4.3	Organise Dementia Training for staff at the Halton Direct Links and ensure training for staff is provided on an ongoing basis to allow new staff to receive appropriate training, as and when required.	Damian Nolan	9.11.17	30.11.17	Update (21.02.18) Halton Direct Link (HDL) staff are undertaking Dementia Friends Awareness Training on 21 st and 28 th February, delivered by a local Dementia Friends Champion. It is anticipated that the whole team base (28 staff) will access the training across the two dates, and the manager will review who has 'missed' the training on the two dates above, due to leave etc. The Halton DAA Coordinator is currently looking at arranging an additional session open to any HBC front line staff during Dementia Action Week (May), which any HDL staff who were unable to attend the 2 dates above, will be able to access.
4.4	Additional Safeguarding training to be provided to A&E staff, as necessary and on an ongoing basis.	Rob Cooper – STH&K/ Jan Ross - WHH	9.11.17	31.3.18	HSAB developing a pilot programme of training to offer out on a multi-agency footprint. Also developing promotional learning materials in 7-minute briefings. To be delivered at team meetings and other appropriate forums within the Trusts. Update – STH&K (21.02.18) ED level 2 and ED paediatric safeguarding training is currently

					compliant @ Feb 18. Level 3 is still not compliant but is being addressed.
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(Update - 21.2.18)

5. Market Capacity & Capability


Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
5.1	Implement Transforming Domiciliary Care (TDC) Programme which aims to deliver modern and sustainable provision of domiciliary care for Halton's population.	Damian Nolan	Ongoing	1.4.19	<p>In line with project timescales, phase 1 of the TDC programme has been implemented i.e. Successful implementation of the new Domiciliary Care contract from 1.11.17. External support re: outcomes-based commissioning through Adams Consulting Partners Ltd.</p> <p>New Domiciliary Care model in place, in advance of winter 2017. Key aspects of the model to mitigate immediate capacity issues are as follows:</p> <ul style="list-style-type: none"> • Recruitment underway. 23 new recruits commencing. Average of 10 interviews per week. Recruitment drive to continue until March 2018. • Prime provider is offering rates of pay in excess of the living wage, enhancements for weekend working, pay travelling and training time. • Data analysis of existing utilisation of planned care provision is being undertaken. This is targeting reviews by social work teams and is releasing domiciliary care capacity. • Equipment that supports the management of manual handling by a single carer rather than two carers is being procured and staff being trained in its use. This will increase capacity. • Reduction in the number of providers is enabling a more focussed identification of issues with care provision. <p>Update (18.12.17) See update at 2.6 above.</p>

					<p>Single Handed Care - The implementation of single handed care in Halton is proposed in two phases:</p> <ul style="list-style-type: none"> • Phase One: New assessments suitable for single handed care • Phase Two: Conversions to single handed care at review stage, where appropriate. <p>NB. All cases considered for single handed care will be assessed against person-centred needs and where required a relevant risk assessment will be made</p> <p>The impact of the introduction of single handed care will be reviewed in 12 months' time. Funding has been agreed to purchase the required equipment to introduce Single Handed Care and roll out in respect to briefing teams and the need to assess for single handed care has begun (December 2017 onwards).</p> <p>Update (21.2.18) See update at 2.6 above. In addition in respect to Reablement 1st the Occupational Therapist role has been defined to support approach, including the introduction of joint functional assessments with Coordinators to identify needs, equipment etc on the first visit.</p> <p>A training programme for Single Handed Care, Train the Trainer has been identified.</p>
5.2	Implement Reablement First Approach.	Helen Moir	Ongoing	January 2018	A review of the current capacity model has released an additional 10% with a further 30% to be realised over the

					<p>next couple of months.</p> <p>Recruitment commenced November 2017 with a plan to increase the current capacity of the Service by 50%.</p> <p>Tunstall are currently working in partnership with HBC to review, develop and implement new technology and systems transformation across telehealthcare based on best practice. This preventative approach has been shown to deliver better outcomes at lower costs.</p> <p>Update (18.12.17) Reablement First introduced 5th December. Recruitment does continue to increase capacity further.</p> <p>Update (21.2.18) Work is currently underway with STH&K Trust to support recruitment across the Reablement Service (see comment at action point 3.3 above). Revised rotas and joint recruitment process is underway and it is anticipated that the first wave of staff will commence by the end of March 2018.</p>
5.3	Produce an updated Halton Market Position Statement (MPS).	Damian Nolan	Ongoing	31.3.18	<p>Review of current MPS commenced. This work will focus on:</p> <ul style="list-style-type: none"> • Determining the short, medium and long-term requirements for care provision across health and social care. • Co-producing the strategy with current providers, voluntary sector, people who use services and the local population.
5.4	Address issues of Care Home Market	Sue Wallace-	Ongoing	April 2018	The overall aim, as outlined with Halton's Better Care Fund

	Capacity & Sustainability.	Bonner			<p>Plan, is to sustain the level of Care Home beds within the Borough. This has resulted in the completion of HBC's purchase of a 23 bedded residential care home and discussions ongoing in respect to the purchase of a 44 bedded nursing home.</p> <p>Update (18.12.17) See update at 3.5 above.</p>
5.7	Ensure effective Medication practice in place in Care Homes.	Lucy Reid/ Katherine O'Loughlin	Ongoing	<p>Timelines</p> <p>Audit programme: ongoing</p> <p>Roll out of medicines policy to services: by 31.3.18</p> <p>Pilot training : start November 2017</p> <p>Roll out of full training programme: from 1.4.18</p>	<p>There is already a programme of audit of medicines management processes in local care homes – this will continue to be developed and delivered along with targeted support where incidents or issues are highlighted. This is led by the NHS Halton CCG Medicines Management team.</p> <p>A new overarching Medication Policy for the Borough Council's internal services has been completed and it is proposed that the principles within this will need to be adopted by all commissioned Care Homes by March 2018.</p> <p>The Medicines Management Team of NHS Halton CCG led the development of the policy due to the technical knowledge required to appropriately advise services of safe and effective practice.</p> <p>Work is progressing on the development of an associated training programme which will be delivered by the CCG medicines management team to care homes within the Borough. The training will start to be piloted end of 2017 with a view to rolling it out wider from April 2018.</p>

6. Commissioning

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
6.4	Complete system review of Intermediate Care (IC) Provision within Halton.	Damian Nolan	30.10.17	31.1.18	<p>Working group established.</p> <p>This review will address all aspects of provision including discharge planning processes and the promotion of services across the system to ensure a better understanding of what IC services are able to provide and workforce issues.</p>  <p>REVIEW OF INTERMEDIATE CARE</p> <p>Update (21.02.18) IC Review is progressing; see action point 2.3.</p>

7. Patient Flow

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
7.3	Address longer length of stay for emergency admissions in both acute trusts	Neil Holland	1.6.17	31.3.18	<p>Warrington and Halton NHS Foundation Trust have implemented red to green to identify delays in patient's journeys; these have been implemented across all medical wards and are discussed twice a day. Any issues are escalated to senior operational teams for help to unblock. The Trust is also working in conjunction with partners on discharge planning on day of admission, to ensure all relevant partners/agencies are involved in the transfer of care at discharge from the point of admission onwards. Any patient who is medically fit and has a LOS of 10 days + over, are discussed at the weekly escalation meeting, attended by community, social and trust staff to look at discharge delays and see what can be put in place to ensure a safe and proactive discharge. The Trust is also in the process of implementing MCAP (Making Care Appropriate for Patients) Patient Flow Decision Support Tool this year. The tool identifies patients that are clinically suitable for non-admission or discharge based on an objective analysis of the individual patient care service requirements, using evidence based clinical criteria.</p>
		Rob Cooper	Sept 2017	Ongoing	<p>St Helens and Knowsley Teaching Hospitals NHS Trust have clinically-led board rounds on inpatient wards 7/7; daily red/green principles in place with escalation to Matron for any daily delays. Daily Acute Medical Unit huddle with ED team is currently removing up to 3 patients from the bed list removing the need for an overnight stay. Task and finish group set up, discharge swim lanes agreed to improve access for all staff at ward level to the range of discharge options.</p>

					<p>IT support to enable next steps to roll out; identification of early morning discharges to support flow at ward level is in place, with on-going monitoring to improve performance; live Discharge Tracking List maintained to track and manage patients with complex discharge needs, escalating when blockages occur with weekday live inputs/updates from ward teams and IDT in place. Therapy inputs to be added by end of November; DTL meetings held twice weekly, resolving internal blocks and identifying external blocks for escalation to LA and CCG partners; monthly system-wide executive led multi-agency discharge event (MADE).</p> <p>Update (21.02.18) Clear mechanisms are in place and this is monitored on an ongoing basis</p>
7.6	Improve the Assessment/Discharge Plans in both Acute Trusts	<p>Neil Holland</p> <p>Diane Stafford</p>	<p>1.4.17</p> <p>1.11.17</p>	<p>1.4.18</p> <p>31.12.17</p>	<p>Warrington and Halton Hospitals NHS Foundation Trust is supporting discharge planning much earlier in the patient's journey, with a focus on the over 65 age group. They are working closely with partners to ensure good communication with the newly implemented check list; this will be audited monthly.</p> <p>St Helens and Knowsley Teaching Hospitals NHS Trust has commenced an audit to confirm compliance with admission/discharge checklists and identify areas for improvement.</p> <p>Update – STH&K (21.02.18) Audit findings presented to January's Patient Experience Council, with recommendations shared at February's Ward Manager and Matron meeting.</p>

7.7	Lower % 65+ still at home 91 days after discharge into Reablement versus comparators and decreasing	Sue Wallace-Bonner	30.10.17	April 2018	<p>Halton do have a lower proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services compared to comparator authorities. This does not equate to service users being admitted back into hospital. 2016/17 data shows the following:</p> <ul style="list-style-type: none"> • 61% at home • 23.5% in intermediate care services (step down or increased need) • 6% in long term residential care setting • 7% deceased • 2.5% in hospital <p>HBC have requested support from NW ADASS Sector Led Improvement Board with regards to how we report on this in the future.</p> <p><u>Update (21.02.18)</u> Following the unsuccessful circulation request for support to North West Performance Leads (NWPL), contact has been made directly with Stockport, Bury and Liverpool. There are some anomalies around Stockport's calculations and they were reluctant to divulge information and have requested this be raised as an agenda item at the NWPL (action requested).</p> <p>Discussion has taken place with Bury and Liverpool, both agree that inclusion of clients in intermediate beds, short term residential and those in residential care who are not permanently placed on day 91 can be included as being at home following discharge from hospital. This would increase Halton's 2016/17 figures to 84.5 per cent at home.</p>
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COMPLETED ACTIONS

(Update - 2.2.18)

1. Strategic Vision & Governance

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
1.2	Establish Accountable Care System Programme Board.	Leigh Thompson	Completed	Completed	<p>The Programme Board has been established and a Chair appointed (David Colin Thome). The first meeting of the Programme Board is scheduled for 23rd November.</p> <p>NB. As part of the ongoing development of the ACS, work will take place on the development of interagency/joint working and associated joint posts, associated governance arrangements and performance metrics.</p>
1.3	Ensure that there is a cohesive interface between and across Halton's Accountable Care System and the Cheshire and Merseyside STP.	David Parr	Completed	Completed	David Parr is the Executive for Halton Accountable Care System (ACS) within the Cheshire and Merseyside STP.
1.4	Establish Alliance LDS Joint Committee.	Dave Sweeney	Completed	Completed	<p>The Committee was established. It has been agreed that the Chair will be on a 6 month rotational basis. Initial chair of the Committee is Dave Sweeney. Three areas have been identified for initial focus as follows:</p> <ul style="list-style-type: none"> • Elective Care; • Mental Health; and • Urgent Care. <p>Update (15.12.17) First meeting took place on Wednesday 6th December 2017.</p>
1.6	CQC Local System Review Action Plan to be monitored, on an ongoing basis, by the HWBB.	Sue Wallace-Bonner	17.1.18	Completed	Action Plan to be presented to the next meeting of the HWBB on 17.1.18 and thereafter on a quarterly basis. Action Plan to also be monitored at the monthly joint Halton Borough Council/CCG Management Team meeting. System review of progress to be completed by February 2018

					<p><u>Update (18.12.17)</u> Report to be presented to HWBB 17.1.18 and then Action Plan to be monitored/updated on an ongoing basis.</p>
1.7	<p>Develop Winter Plan for the Halton System.</p> <ul style="list-style-type: none"> • Ensure Winter Plan communicated to Operational Staff. 	<p>Damian Nolan</p> <p>Damian Nolan</p>	<p>Completed</p> <p>Ongoing</p>	<p>Completed</p> <p>Completed</p>	<p>The Mid Mersey A&E Delivery Board has submitted the systems Winter Plan for 2017/18, in line with NHS England's timeframes. The Plan covers the Halton, Warrington, St Helens & Knowsley areas.</p> <p>Winter Plan being operationalised via the development/review of the Escalation Management System (EMS) Action Cards. Session planned with staff from across the local system on 16.11.17 to review Action Cards and test resilience of the system over winter. The Action Cards cover across health and social care organisations and will be cascaded within these by nominated leads.</p> <p><u>Update (18.12.17)</u> Session held with operational staff on 16.11.17. Update and use of EMS to be monitored on an ongoing basis.</p>

2. Delayed Transfers of Care (inc. user experience)


Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
2.1	Ongoing improvement to be made in the level of Delayed Transfers of Care (DTOCs).	System leaders and HWBB	Completed	Completed	<p>Delayed Transfers of Care and the associated actions to reduce these will be monitored at a strategic level via the Health and Wellbeing Board. There is a monthly report to the Chief Officers Management Team (HBC) including progress against the identified actions. Taking a collaborative approach, as a minimum, DTOCs are discussed weekly with the respective Trusts, with daily reports produced and considered at an operational level. In addition to monitoring at the Health and Wellbeing Board, monitoring of DTOCs, by senior leaders across the Mid Mersey area, takes places via the A&E Delivery Board.</p> <p>Current level of DTOC as at August is 514 (Target 425). This is due to :</p> <ul style="list-style-type: none"> • Patient or family choice; • Awaiting residential/nursing home placements/ awaiting further non-acute NHS care (including intermediate care); and • Arranging domiciliary care packages. <p>Below are some of the key actions in relation to these with further detail included in the sections identified.</p> <p>Update (18.12.17) DTOCs reported through to Chief Officers and Health and Wellbeing Board on an ongoing basis and are monitored closely by system leaders and the HWBB.</p>

3. Key Actions for Winter 2017/18

Action No.	Action Required	Responsible Officer	By When		Progress to date
			Start	Finish	
3.2	Implement additional capacity for this winter	Sue Wallace-Bonner	Completed	Completed	<p>9 additional block purchase beds commenced November 2017. Additional beds available for spot purchase identified daily. MDT support to improve support in care homes in place.</p> <p>Lead domiciliary care agency has recruited 23 people in 5 weeks, recruitment continues with an average of 10 interviews being completed per week. This will continue for the next four months. Agency also working with staffing agencies to supply capacity.</p>
3.4	Improve communications across the system	Sue Wallace-Bonner/ Leigh Thompson	1.11.17	Completed	<p>Reissue information to teams regarding the Halton discharge to assess pathway.</p> <p>Marketing campaign in respect of staying well in the winter and accessing appropriate health services commenced November 2017.</p> <p>System wide flu vaccination programme in place and inclusive of all health, social care and voluntary sector staff.</p>

5. Market Capacity & Capability

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
5.5	Develop plan to address the high level of admission/readmission rates to hospital from care homes.	Sarah Vickers	Completed	Completed	The Enhanced Care Provision to Older People's Care Homes in Halton Service (GP Alignment to Care Homes) was implemented on 1 st September. NB. Addressing admission and readmissions and links through to prevention initiatives is a key aspect of this service and will

					<p>be monitored via quarterly monitoring as outlined in the specification. The Care Home Development Group will monitor on a monthly basis.</p> <p>Copy of the Enhanced Care Provision to Older People's Care Homes in Halton Service Specification below is based on the best practice from national Vanguard:-</p>  <p>Enhanced Care Provision in Older Pec</p>
5.6	Review system of finding nursing home care placements where patient's discharge needs have substantially changed and therefore individuals cannot return to their original care home.	Damian Nolan	Completed	Completed	A review of the processes, in conjunction with the Discharge Teams, in place at both the Acute Trusts has taken place and identified enhanced escalation where issues are likely to occur.

6. Commissioning

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
6.1	Develop Joint Commissioning Strategy for Older People.	Sue Wallace-Bonner	Completed	Completed	<p>Following completion of the Joint Strategic Needs Assessment for Older People, work was completed on a gap analysis, the information from which was used to develop an overarching integrated Older People's Pathway to support Older People living and ageing well in Halton which is based on national good practice.</p> <p>This Pathway has been agreed across the Local System and Halton's Older People's Delivery Board, the membership of which is designed to be reflective of the local Adult Health</p>

					and Social Care economy whose role is to ensure that the Pathway continues to be fit for purpose.
6.2	Ensure that the monitoring of Primary Care within Halton is robust and fit for purpose.	Leigh Thompson	Completed	Completed	<p>As a delegated commissioner of General Medical Services the Primary Care Commissioning Committee (a subcommittee of the Governing Body) oversees the contracts, quality & performance of all GP practices. A Quarterly report is received by the committee outlining achievement against key performance and quality indicators.</p> <p>During 2017 the CCG Primary Care Team and GP Lead commenced Contract, Quality & Transformation visits to all practices. These visits have an agreed list of criteria for discussion which includes the local GP Quality Dashboard.</p> <p>For the range of additional contracts or enhanced services, which are over and above the national core contract, performance and quality are monitored as per the specification.</p> <p>There is a clear process in place for practices and the Primary Care Team to escalate any ad-hoc issues that may arise.</p>
6.3	Ensure that robust mechanisms are in place to monitor the provision in the Halton Intermediate Care Unit (B1).	Damian Nolan	Completed	Completed	<p>A new service specification has been implemented. Improved monitoring is in place.</p> <p>Weekly monitoring is being completed by the commissioner of this service. Regular reports are being made through to the Operational Commissioning Committee on a monthly basis.</p> <p>Following the CQC Review, a review of processes has taken</p>

					place at the Unit including discharge planning and the involvement of carers/families and of the managerial oversight of the Unit, has been undertaken by the Commissioner and Associate Director of Nursing from Warrington & Halton Hospitals NHS Foundation Trust. A new Matron is in place and the provision within the Unit is being monitored via the Length of Stay mechanisms within the wider Trust.
6.5	Ensure that there are robust mechanisms in place for the sharing of learning across the local system.	Michelle Creed	Completed	Completed	<p>NHS England Cheshire & Merseyside Quality Surveillance Group (QSG) receives monthly reports to highlight any areas of concern that may affect the quality, safety or patient experience of users of services. Deep dive focussed sessions are undertaken as required. CQC Local Area Review has been presented to the system partners (NHSE, CCG, LA, NHSI, CQC, HEE, Deanery, Healthwatch, PHE). Below outlines examples of processes in place.</p> <ul style="list-style-type: none"> • Serious incident learning event 25.10.17 on End of Life resulting from serious incident management. Root cause analysis is being undertaken and resultant action plan being developed. • Primary Care Safeguarding Leads learning event facilitated by Katherine Appleton, the LADO, on allegations against a healthcare and non-healthcare professional 26.9.17 • SAB Learning events on 01.09.17 and 08.09.17. These events were open to all HBC staff and staff from partner organisations to enable learning with regard two recent safeguarding reviews. The aim was to share the findings and learning around the Safeguarding Adults Review (SAR) and the Multi-Agency Review (MAR). The aim was

					<p>to ensure that partners had a greater understanding of:</p> <ul style="list-style-type: none"> ○ Safeguarding Adult Reviews and Multi-Agency Review and how and why they are undertaken ○ Managing risks ○ Understanding joint working ○ The learning and development points from a carers perspective ○ What the intended improvements in processes and practices are from these reviews <p>However these will be formally reported through to HWBB on an ongoing basis to allow for appropriate challenge etc. to take place (see Action 1.5).</p>
6.6	Complete gap analysis against the current Service Delivery Model for Halton's Urgent Care Centres (UCCs) and the newly published Urgent Treatment Centres (UTCs) Standards and develop recommendations for progressing the UTC development in Halton	Damian Nolan	Ongoing	Completed	<p>Attendances at the UCC's continue to increase. In July 2017 6,859 patients attended the centres and the proportion of UCC attendances to A&E attendances for NHS Halton CCG registered patients was 2.24:1.</p> <p>Recognising the need to build on the success of the UCCs the gap analysis, as outlined opposite, has commenced and initial work will be presented to the UCC Development & Monitoring Group on 22.11.17.</p> <p><u>Update (18.12.17)</u></p> <p>A gap analysis had been completed on both UCCs against the 27 UTC standards which included the issues that would need to be addressed to move the UCCs to UTCs; gap analysis has been shared at the UCC Development & Monitoring Group in November. Gap Analysis is now with the CCG for consideration. NB. The main gap is around bookable appointments and the interoperability needed with NHS111;</p>

					both UCCs are moving to using EMIS from October 2017, this will make the interoperability issues far more straight forward to resolve.
6.7	Undertake review of the Rapid Clinical Assessment Team (RCAT)	Damian Nolan	Ongoing	Completed	<p>Building on the work undertaken by the Liverpool School of Tropical Medicine, discussions to take place at the next Clinical Advisory Group on 8.11.17 regarding the future of RCAT and to agree an associated commissioning model.</p> <p>Revised Service Specification has already been drafted in advance of the meeting on the 8.11.17.</p> <p>Update (18.12.17) Unfortunately due to staffing issues the RCAT service has had to cease. However it is hoped that at some point in the near future the service will be able to start again.</p>

7. Patient Flow

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
7.1	Address the length of A&E Waiting Times at both Acute Trusts	Jan Ross	Completed	Completed	The performance of both Trusts in respect of the A&E standard is monitored through NHSi, NHSE, contract monitoring by the lead commissioners with strategic oversight through the A&E Delivery Board.
			Completed	Completed	Warrington and Halton NHS Foundation Trust actively manages its 4 hour target and has been achieving the NHSI trajectory. The trust has a patient flow board with 9 key work streams aimed at delivering 95% performance against the four hour standard. GP streaming has commenced in October 2017. All key actions related to four hour

		Rob Cooper	Completed	Completed	<p>performance are monitored internally.</p> <p>St Helens and Knowsley Teaching Hospitals NHS Trust – in addressing the length of A&E waiting times, the Trust has weekly meeting of Executive-led Transformation Group; live dashboard with real-time tracking of all patients; Mon-Fri in-reach frailty consultant into ED; GP streaming in Emergency Department has been in place since June 2017. Associated estates work is underway for co-located urgent care centre and recruitment commenced for Emergency Department Advanced Clinical Practitioners.</p> <p>Update (18.12.17) Clear mechanisms are in place and this is monitoring on an ongoing basis.</p>
7.2	Improve communication channels between the Hospital Discharge Teams and Domiciliary Care Providers	Damian Nolan	Completed	Completed	<p>Communication channels have improved with the introduction of a single Domiciliary Care provider in Halton.</p> <p>Improvements in the speed of discharges will be seen with the implementation of the Reablement First Approach (see Action 3.2)</p>
7.4	Improve managerial oversight of the Halton Intermediate Care Unit (B1).	Damian Nolan	Completed	Completed	See Action 6.3
7.5	Improve and closely monitor the average length of stay at the Halton Intermediate Care Unit (B1).	Damian Nolan	Completed	Completed	<p>As at the end of September 2017, average length of stay had reduced to 37 days. Target is 28 days.</p> <p>The average length of stay is monitored as part of the regular reports being made through to the Operational Commissioning Committee on a monthly basis.</p>

REPORT TO: Health & Wellbeing Board

DATE: 28 March 20118

REPORTING OFFICER: Chief Executive/Director of People

SUBJECT: One Halton

PORTFOLIO: Health & Wellbeing

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

This report seeks to provide an update on *One Halton*

2.0 RECOMMENDATION:

2.1 HWBB note the progress on One Halton.

2.2 HWBB support the better integration of health and social care services which is essential, and that additional investment in local services is badly needed.

2.3 HWBB receive further updates on the progress of One Halton

3.0 SUPPORTING INFORMATION

3.1 *One Halton* seeks to deliver a single fully integrated place based health, well being and social care system for the people of Halton, that has wellness at it's heart but also addresses the health and social care needs of the local community of Halton, where ever possible from within Halton and is easy to access, cost effective, of high quality and clinically robust.

One Halton, in short is

- The right care, in the right place, at the right time, from the right person and
- Helping people to help themselves stay well longer and get well quicker

3.2 Cheshire & Merseyside NHS (formally the STP) is, committed to the development of place based health and social care systems.

3.3. In 2014/15, Halton as a borough committed to the development of an integrated model of health and social care. The Council with its health partners developed the concept of One Halton, and agreed a shared vision:

“To improve the general health and wellbeing of the people of Halton, working together to provide the right level of treatment close to home, so that everyone in the borough can live longer, healthier and happier lives.”

- 3.4 At its meeting on the 14th December 2017 the Executive Board agreed to the further development of *One Halton*. Recent work with partners has focused on developing the *Vision for One Halton* and the principles and values by which the partnership will operate.

One Halton is place based, i.e., delivering across the Halton Local Authority footprint.

- 3.5 The **One Halton Strategic Vision** builds on the initial commitment of partners to improve the delivery of health and social care by ensuring:
- Services enable people to take more responsibility for their own health and wellbeing;
 - People stay well in their own homes and communities as far as possible; and
 - When complex care is required it should be timely and appropriate.

- 3.6 To progress *One Halton*, the Council and its partners have established the One Halton Accountable Care System Board (the Board)

- 3.7 The *One Halton* Accountable Care Programme Board is not a decision making body. It provides the forum by which the Council and its partners will provide system leadership and meaningful engagement in the development of the *One Halton*. The Board will provide oversight of any necessary work streams and report to the Halton Health and Well Being Board, a committee of the Council, that has the strategic responsibility for health and social care.

In respect of the future provision of any services, currently provided or commissioned by the Council (such as Children’s Services and Adult Services) decisions will be made by Executive Board.

The Halton Health PPB will provide scrutiny and oversight.

- 3.8 The Board has an independent chair, Dr David Colin-Thome. Membership of the Board is set out in the terms of reference.

For the Council the lead officer is the Strategic Director for People.

The Chief Executive is the senior responsible officer for the development of the ACS.

- 3.9 Information about the general progress and emerging approach to *One Halton* is set out in Appendix 1

- 3.10 The Halton GP Federations and Bridgewater NHS Community Care Trust are leading on the development of a new “model of care”. The emerging thinking is set out in Appendix 2

4.0 FINANCIAL IMPLICATIONS

- 4.1 *One Halton* will be funded through existing resources. There will be project development costs but these are yet to be determined. Cheshire & Merseyside NHS have made available a Transition Fund to support the development of a place based health and care model. It is anticipated Halton will receive in the region of £100,000 in Transition Funding.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

One Halton will provide integrated, multi-disciplinary health and social care services for all families, and improve services specifically for children with learning difficulties and disabilities.

5.2 Employment, Learning & Skills in Halton

None.

5.3 A Healthy Halton

The One Halton work will be driven by the Health and Wellbeing Strategy and outcomes monitored by the Health and Wellbeing Board.

5.4 A Safer Halton

None.

5.5 Halton's Urban Renewal

None.

6.0 RISK ANALYSIS

- 6.1 Cheshire & Merseyside NHS England, through the Sustainability Transformation Programme, are committed to the development of place based health and social care. These do not necessarily require the inclusion of local authorities nor do they need to be confined to local authority boundaries.

- 6.2 The final version of *One Halton* and any associated new organisational arrangements, remain unclear but the potential impact on Council services and staff will be closely monitored and reported back to members

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 *One Halton* will operate fairly and transparently.

8.00 REASON FOR DECISION

8.1 To ensure that the future delivery of health and social care is fair, sustainable and of high quality for residents of Halton.

9.0 ALTERNATIVE OPTIONS

9.1 NHS England have signalled that accountable care systems will be the primary delivery model for health and social care. Halton Council can, however, choose not to be part of the development of *One Halton*. The development would relate purely to health care providers on their chosen footprint.

10.0

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

Appendix 1

Appendix 2

REPORT TO: Health and Well Being Board

DATE: 28th March 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO Health & Wellbeing

SUBJECT: Transforming Domiciliary Care

WARDS: Borough wide

1.0 **PURPOSE OF REPORT**

1.1 To inform the Board of the progress of Halton Borough Council's Transforming Domiciliary Care Programme

2.0 **RECOMMENDATION**

RECOMMENDED: That

(1) the report be noted

3.0 **Background**

3.1 Domiciliary Care describes the delivery of care and support services to people within their own homes. People who are assessed as eligible to receive this care can arrange this care themselves through a direct payment or request the council to commission this care for them. In Halton there are circa 800 older people and adults in receipt of this care commissioned directly by the council and equating to approximately 7000 hours of care delivery per week.

3.2 There are a range contractual methods that local authorities can commission and pay for these services and these vary across the region. Halton utilised a 'framework' approach whereby independent sector companies bid to provide an amount of 'block' hours in geographical areas and also provide additional 'spot' hours. Halton had 12 providers on this contract with a range of 15 – 150 people.

3.3 During winter 2015 and onwards it became increasingly difficult to provide care for a significant number of people (up to 65 at any one time) with demand exceeding supply. Work undertaken with the providers demonstrated that issues in relation to the recruitment and retention of staff as the key reason. Behind this was competition in the wider labour market and rates of pay; perception of care as a

career that lacked progression; insufficient volume of work for providers to enable investment in the borough.

3.4 In addition there has been a growing concern that the sector was focused too much on 'time and task' (the amount of time tasks were undertaken in) to the exclusion of 'outcomes' for people in receipt of services

3.5 Halton Borough Council undertook some preliminary work with key stakeholders including people in receipt of services and their families / carers to understand the wider issues and the key priorities for the recommissioning of these services. This work led to the 'Transforming Domiciliary Care' programme.

4.0 **Transforming Domiciliary Care Programme**

4.1 The programme has 3 main areas of focus; development of an outcomes approach; managing capacity and demand; improving the quality and safety of care delivery.

4.2 As the first stage of the programme Halton Borough Council have recommissioned the domiciliary care provision for the borough with a lead agency, Premier Care. This will enable a focus for investment in the borough and full engagement with the programme. This contract is for up to 7 years providing stability and security in this sector.

4.3 The programme is now developing key strands of work to support the key focus areas.

4.4 The 'Reablement First' approach will see all people who are identified as benefitting from and eligible for care undertaking a period of reablement through which their self-care abilities will be strengthened and longer term needs planned for. This approach brings together care staff, occupational and physiotherapy therapy and social care staff to devise and deliver the Reablement programme with the individual and their families / carers. Planning for the longer term will include Development of Outcomes Model. Staff training, development and career progression.

4.5 Capacity and Demand Management work includes: developing and utilising less labour intensive approaches to care and support such as use of technology and equipment; working with the community and voluntary sector to meet people's needs.

4.6 Quality and Safety of Care includes: medication management; training and development of staff; development of quality assurance mechanisms (internal and external); governance

5.0 Programme Structure

5.1 The Programme is governed by a Project Board that reports to the Senior Management Team of Adult Services. The board comprises membership from Premier Care, Adult Social Care Services, Age UK, Halton Open. Other agencies will be co-opted as required.

5.2 The Board meets monthly and has a series of working groups to deliver the project. This is also supported by an external reference group facilitated by Halton Open

6.0 POLICY IMPLICATIONS

6.1 None identified.

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

None identified.

7.4 A Safer Halton

The programme will support improvements in the care delivered for vulnerable adults.

7.5 Halton's Urban Renewal

None identified.

8.0 RISK ANALYSIS

8.1 None identified.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 None.

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

None.

REPORT TO:	Health and Wellbeing Board
DATE:	28 March 2018
REPORTING OFFICER:	Chief Executive
PORTFOLIO:	Physical Environment
SUBJECT:	Community Shop
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is;

- 1) To provide Members with details of the 'Community Shop' concept, and;
- 2) To provide Members with an update on the progress to develop a Community Shop in Halton and seek the Board endorsement to continue to progress such development.

2.0 RECOMMENDATION: That Board support the continued development of a Community Shop in Halton as outlined in this report.

3.0 SUPPORTING INFORMATION

3.1 At their meeting of 23rd March 2015, the ELS&C PPB received a report on 'Community Shop'. Members of the Board endorsed that further exploration be undertaken into the potential for a Community Shop to be established in Halton.

3.2 Community Shop is a Community Interest Company subsidiary of its parent company; Company Shop Ltd. Company Shop has been established for over 40 years, growing from a wholesale business supplying institutional outlets to become the UK's largest commercial redistributor of surplus food and products. It handles over 30,000 tonnes of surplus food product annually, providing retailers and manufacturers with a zero-to-landfill solution, where over 95% of food handled gets eaten. With a proud heritage and longstanding expertise in the execution and delivery of redistributing surplus goods, Company Shop is well placed to bring Community Shops to the UK in a sustainable and successful way.

3.3 In essence, Community Shop is a supermarket that has targeted membership to help tackle food poverty. The model provides fifteen job opportunities; twelve retail jobs for Halton residents, two mentors and one cook are created in the model. There are wider opportunities to support employment through skills development and linkages to the wider retail sector through food partner relationships.

4.0 COMMUNITY SHOP CONCEPT

- 4.1 Delivering surplus food for social good is the overall ethos of Community Shop. Community Shop ensures that quality branded food is available at discounted prices so that it can reach people who may need a helping hand to achieve financial independence. It seeks to provide a sustainable service that empowers people with limited financial resources to spend on food and not be reliant upon free hand-outs from 'Food Banks'.
- 4.2 By redistributing surpluses that exist in the food supply chain, and with the support of its parent company; Company Shop, Community Shop assists people on the cusp of food poverty to gain access to good, wholesome food at up to 70% less than normal retail prices. Key food partners within the supply chain include Tesco, Asda, Morrison's, Sainsbury's, The Co-Operative, Iceland, Marks & Spencer and many more. Product brands include a wide range of companies such as Nestle, Heinz, Premier Foods, Cadbury, Kenco, Kraft, Nisa and many more.
- 4.3 Surpluses can be caused by a whole host of reasons, from seasonal forecasting issues and labelling errors to a short shelf-life and many other things. Importantly though, unless they are redistributed, these surpluses would end up in landfill; the Community Shop approach prevents that from happening, ensuring that perfectly edible products are consumed by people who need them; Community Shop members. The money made from sales is then invested into their stores and the support services offered.
- 4.4 Similar models are already working well in Europe in the form of 'Social Supermarkets'. Company Shop is leading this area of work in the UK with four Community Shops now established in Goldthorpe, Athersley, Lambeth and Grimsby.
- 4.5 Not only will Community Shop offer a range of products at significantly reduced prices, but it will also provide an interactive programme of wider support available free of charge in the Community Hub (see section 6 below), from budgeting and debt advice to cookery classes.
- 4.6 Community Shops are supported by the supply logistics at Company Shops. Halton has been negotiating with Company Shop for the ambition to achieve a Community Shop in Halton for three years. Unfortunately, the logistics have not existed thus far to support a development in Halton however, Company Shop has opened in St Helen's in January 2018 and their strategic plan is to develop five Community Shops in the Liverpool City Region.

5.0 COMMUNITY SHOP MODEL

- 5.1 Community Shop limits membership to between 500 and 750 households and membership is for around six months; this is to deter dependency, maximise the impact that can be achieved for members through the Community Hub tailored support programme and to encourage movement of people to

education and employability.

- 5.2 Membership is typically restricted to those on a means tested benefit and directed towards residents living within agreed geographical areas.
- 5.3 Access to shops is controlled by Photo ID/Loyalty Card which limits the number of same type items that can be purchased at any one time. 'Point of Sale' software can monitor individual profiled spending patterns to ensure no abuse of the membership is undertaken.
- 5.4 Through providing access to discounted, wholesome food (alcohol and tobacco are not stocked), as well as access to extended services via its 'Community Hub', Community Shop will help members return to regular retail.
- 5.5 Partnership involvement is pivotal to the initiative. Joint working between partners such as the Local Authority, DWP, CCG, Public Health, and the CAB, for example, will enhance the initiative offer and its potential impacts. Financial commitments are required to support the delivery of a Community Shop and further detail is set out in Section 8 of this report.

6.0 COMMUNITY HUB

- 6.1 The 'Community Hub' is Community Shop's in-house dedicated extended service for members. It provides a range of programmes (free of charge) from CV writing skills to budgeting and debt advice, cookery classes to employability and skills training for individuals. There is an ambassador programme which supports community members in sharing the concept and supporting fellow residents thus generating a strong sense of community and building community resilience
- 6.2 Offering interactive group programmes daily to a pre-defined programme, as well as one-to-one programmes where required, Community Hub Mentors will work closely with members to help them on the road back to becoming main stream consumers. The Mentor offer is to all adults of the household not solely those who attend the supermarket for the shopping.
- 6.3 In addition to these extended services, The Hub will also serve a two-course lunch every day from 11am - 2pm, providing access to a low price home cooked warm meal each day. When the cookery classes are running "ingredient parcels" are provided that can be bought in-store to cook. Community Hub mentors will be in attendance at all cookery class sessions in a support capacity to the teaching staff and members. Menus and information on cooking and accessing ingredients will be made available every day, along with cookery classes taking place two days a week.
- 6.4 In Summary, under one roof a Community Shop:
 - Delivers a sustainable solution tackling the issue of food poverty
 - Targets those in the most deprived neighbourhoods
 - Creates employment and training opportunities
 - Reduces dependence on food bank hand outs

- Provides financial and debt advice
- Offers two-course low cost lunch
- Facilitates one to one contact with trained mentors
- Encourages members to become mainstream retail consumers
- Reduces the amount of food waste going to landfill

7.0 DEVELOPMENTS IN HALTON

- 7.1 The size of premises required for a Community Shop is approximately 3,000 to 4,000 square feet. The Council has been progressing the identification of potential premises with Community Shop over the last twelve months or so; supporting options appraisals and developing negotiations with potential premise owners. Community Shop has its own framework for identifying suitable locations and premises and after much consideration has identified Windmill Hill as a preferred location to explore further.
- 7.2 A feasibility study for an Integrated Health & Wellbeing Hub for Windmill Hill was commissioned by Big Local & Well Halton in September 2017 and is due to present a final report by the end of March 2018. Community Shop has asked to be included in the options for the site and a range of options are being refined at this interim stage.
- 7.3 The site is the existing Children's Centre, which would be remodelled and extended to accommodate co-location of the Children's Centre and Community Shop, as well as providing space for community activity and delivery of health related services.
- 7.4 The study was commissioned in response to community identified need for a quality accessible asset for Windmill Hill which would provide a central point of access and sense of place. The CCG have been keen to support developments for the estate which could contribute to supporting wellness for residents since the withdrawal of the GP surgery in 2017. The Children's Centre and Church site have been the main focus throughout the study; the tardy emergency of community shop provides an additional possibility of a key anchor tenant thus increases the viability of a project to attract capital funding to improve the asset.
- 7.5 Regardless of where a Community Shop might be located, all households across the borough who would qualify for membership to Community Shop will have the opportunity to become Members as part of a rolling programme that would target identified areas of need.
- 7.6 Community Shop are progressing plans to develop five Community Shops in the Liverpool City Region and are keen to work with Halton for the borough to be the first area to announce they are working towards opening one.
- 7.7 Representatives from Community Shop are attending a food poverty session at Westminster on the 17th April 2018 and wish to announce the joint work with Halton if endorsement to further develop the project is approved.

8.0 FINANCIAL IMPLICATIONS

- 8.1 Securing capital funding in a timely manner is key to enabling the project to be successfully delivered.
- 8.2 Funding for this scheme would need to come from a cocktail of grant funding sources as, at the present time, there are a limited number of large-scale funding streams for capital works to community buildings. Each funding stream comes with its own set of criteria on what and who can be funded, e.g. some will fund renovations and restorations as opposed to new builds.
- 8.3 In this case, funding would be likely to come from National Lottery, Landfill Tax Funds and Trusts and Foundations. At the present time Big Lottery Fund is closed for applications, but will re-launch its grant programmes in April 2018; at this point we will know whether they will reinstate their Community Buildings Programme. The Power to Change Trust may offer a source of funding as its remit is to support new and existing community businesses. 'Landfill' funders, including Biffa, Wren and Viridor, will consider amounts up to £100,000; however, some of these will not fund new builds, so that funding would need to be allocated to internal building 'fit out'. There are Trust funds, such as Esmee Fairbairn Foundation and Garfield Weston Foundation, which can award fairly substantial amounts of funding; further work would be required to consider which Trust funds would be the most suitable in relation to the project specification.
- 8.4 There is a possibility that some matched funding (capital) may be sought from the Council. However, as other funding sources are currently being explored, the extent of any Council matched funding is still unclear. If it were required a further report will be brought to this Board.
- 8.5 Consideration will also need to be given to who the applicant organisation will be, as this again will determine which funding streams can be applied to.

9.0 POLICY IMPLICATIONS

- 9.1 There are no new policy implications as a result of this report.

10.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

10.1 Children and Young People in Halton

The initiative is targeted at households in need of support, children & young people would benefit by virtue of the targeted approach offering membership to wards experiencing child poverty.

10.2 Employment, Learning & Skills in Halton

The model provides direct employment opportunities for 15 members of staff. There would be opportunities to support linkages to further employment

across the retail and logistics partners linking into Halton Employment Partnership (HEP). The mentoring programme focusses on skills development and employability.

10.3 **A Healthy Halton**

Access to low cost food provision, including fresh produce, will improve the quality of food intake. The mentoring programme that goes alongside the shopping offer will increase knowledge and practice of healthy eating for the scheme participants and their households.

10.4 **A Safer Halton**

A sense of community and community connectedness reduces residents' fears of crime where they live. They are likely to feel a stronger sense of belonging and safety in an environment where the communities know each other, are active and there are established links to other stakeholders like police, housing, community wardens, etc. Community Shop can engender this approach in the Community Hub.

10.5 **Halton's Urban Renewal**

A Community Shop would be an asset within the Borough and provide a targeted retail offer.

11.0 **RISK ANALYSIS**

11.1 Community Shop provides the opportunity to address food poverty, work intensely with individuals to support building skills and employability prospects, create employment opportunities and overall positively impact on health and wellbeing. The risk is not pursuing the opportunity to work with Community Shop to bring these benefits to Halton.

12.0 **EQUALITY & DIVERSITY ISSUES**

12.1 This initiative targets the most financially disadvantaged residents in Halton's Community. Poverty and inequality are often elements of a complex set of circumstances which present exclusion. This initiative aims to tackle poverty and generate improved life chances for disadvantaged members of our local community.

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

Document	Place of Inspection	Contact Officer
Employment, Learning & Skills and Community Policy & Performance Board Report 23 rd March 2015 - Community Shop	Municipal Building Kingsway Widnes	Angela Scott

REPORT TO:	Health and Wellbeing Board
DATE:	28 March 2018
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Support for Key Governmental Action on Obesity
WARDS:	Borough-wide

1.0 PURPOSE OF THE REPORT

- 1.1 To provide members of the Board with some background information on new options to tackle obesity.

2.0 RECOMMENDATION: That the Board note the contents of the report and supports the three key areas for government action.

3.0 SUPPORTING INFORMATION

- 3.1 The Council notes that obesity is a major public health concern with the majority of adults in England being overweight or obese and a more than a third of our 10 to 11 years old being overweight or obese.

It is estimated that obesity is responsible for more than 30,000 deaths each year. Being overweight or obese increases the risk of a wide range of diseases including Type 2 diabetes, hypertension, cardiovascular disease and many cancers. It also negatively affects quality of life and mental wellbeing.

No one is 'immune' to obesity, but some people are more likely to become overweight or obese than others. Factors of income, social deprivation and ethnicity all have an important impact on the likelihood of person becoming obese. Data from the National Child Measurement Programme shows that obesity levels in the most deprived 10% of children is approximately double that of the least deprived 10%.

Obesity places a huge strain on health and social care as well as having a broader impact on economic development. The estimated annual cost of obesity in England is around £32.5 billion and if no action is taken these costs will increase.

We recognise that the causes of obesity are complex. Environmental, physiological and behavioural factors all interrelate and play their part in influencing the prevalence of obesity. This is why at a local level Halton has a wide range of activities to tackle obesity. This includes providing an integrated healthy lifestyle and wellness programme, having health

promoting planning policies and our 0 to 19 service working with schools to be health promoting.

However, we feel more needs to be done by national government to support the efforts of local areas and we call upon the Government to lead on three areas of action:

3.2 Implement the Food Revolution actions

Food Revolution is a campaign committed to inspiring real, meaningful, positive change in the way children access, consume and understand food.

Working with medical experts and professionals Food Revolution has created a six-point plan for action which they believe governments across the world should be working towards as a priority.

We welcome that the UK government has implemented the first action, which is the introduction of a sugary drink tax, but strongly advocate that the government also acts upon the other 5 actions which includes sugar reformulation on all products and clearer labelling of products.

3.3 Tackle Food Poverty

An affordable healthy diet is vital for good health. However, we know many people, due rising food prices, low wages and reductions in benefits, have an insufficient income to buy healthy food. This 'food poverty' trap results in families cutting back on fresh fruit and vegetables and buying cheap, sweet, fatty, salty, or processed foods that need little cooking.

This results in poorer people having worse diets, greater levels of obesity and poorer health. Across the Halton region many families are living in poverty and there is high demand on food banks.

Whilst there is considerable work across the Liverpool City Region (LCR) to tackle poverty, illustrated in the commitment set out in The LCR Child Poverty and Life Chances Strategy, more needs to be done nationally. We call upon the UK government as the world's sixth largest economy to do more to end food poverty. Food banks should not become a substitute for an effective welfare system and fair work which includes earning a living wage.

3.4 Introduce a fairer and greater obesity focus of the use of sugar levy funding

We welcome the government's sugary drinks levy with the money raised to improve PE and sport for primary-aged pupils to encourage healthy and active lifestyles.

The funding is to be allocated directly to primary schools, based on the number of pupils in years 1 to 6. There is no adjustment for deprivation. We believe to make the greatest impact the funding should be weighted to those with greatest health needs. The National Child Measurement Programme figures show it is the areas with greater deprivation which have a comparably higher proportion of children who are obese, compared to areas in the least deprived areas. If the funding was allocated direct to Local Authorities, rather than to individual schools, there would be greater potential to ensure resources were utilised to meet the needs across the local area.

Furthermore as obesity is influenced by both energy expended and energy consumed to tackle obesity we would like to see the criteria for this funding to also include activities which will help children and families make healthier food and drink choices.

In conclusion we strongly believe that more needs to be done on a national level to address the public health issue of obesity.

4.0 POLICY IMPLICATIONS

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

5.0 FINANCIAL IMPLICATIONS

Funding from the sugary drinks levy should be weighted according to those with greatest health need.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Reducing levels of overweight and obese children is a key priority for Halton.

6.2 Employment, Learning and Skills in Halton

N/A

6.3 A Healthy Halton

Supporting healthy eating, tackling fuel poverty and tackling inequalities are central to the One Halton Health and Wellbeing Strategy.

6.4 A Safer Halton

None specified.

6.5 Halton's Urban Renewal

None specified.

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.