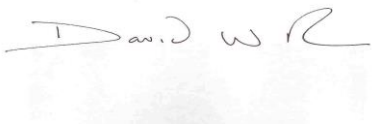
Public Document Pack

Health Policy and Performance Board

Tuesday, 19 September 2017 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

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

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 28 November 2017

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

Part I

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

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 20 June 2017 at the Council Chamber, Runcorn Town Hall

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

Apologies for Absence: Councillor Horabin

Absence declared on Council business: None

Officers present: S. Wallace-Bonner, A. Jones, D. Nolan, L. Wilson, H. Moir and P. Preston

Also in attendance: Councillor R. Hignett (in accordance with Standing Order no. 34), Dr. D. Lyon; L. Thompson; D. Sweeney; E. Alcock and G. O'Hare – NHS Halton CCG; and M. Huddart and M. Dunn – North West Ambulance Service

ITEMS DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HEA1 MINUTES

The Minutes of the meeting held on 7 February 2017 having been circulated were signed as a correct record.

HEA2 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA3 HEALTH AND WELLBEING BOARD MINUTES

The draft Health and Wellbeing Board minutes of the meeting held on 29 March 2017 were submitted to the Board for information.

HEA4 PERFORMANCE MANAGEMENT REPORTS, QUARTER 4 2016/17

The Board received the Performance Management Reports for Quarter 4 of 2016-17. Members were advised that the report introduced, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to

Health in Quarter 4, which included a description of factors which were affecting the service.

Members were requested to consider the progress and performance information and raise any questions or points for clarification and highlight any areas of interest or concern for reporting at future meetings of the Board.

RESOLVED: That the Quarter 4 priority based reports be received.

HEA5 NORTH WEST AMBULANCE SERVICE NHS TRUST: UPDATE

The Board received a presentation from North West Ambulance Service (NWAS) NHS Trust, updating them on the key issues arising from the Care Quality Commission's (CQC) inspection report published in January 2017, together with any specific issues for the Halton population when resources spent time out of area.

Members welcomed Michael Huddart, Head of Regulatory Compliance; and Matthew Dunn, Consultant Paramedic, who delivered the presentation on behalf of the Trust.

Resulting from the presentation the following points were made in response to Members' questions:

- Part of the recruitment procedure of Polish and Finnish paramedics included English Language testing; so all those recruited from these countries were fluent in the English Language;

- The difficulties in recruiting paramedics was a national issue and not unique to NWAS:

- The effect on recruitment from abroad following Brexit was unknown. It was noted that the recruitment of foreign nationals would not be long term and that the service needed to focus on the encouragement of a skilled workforce in this Country;

- Links with universities had been established to promote the need for paramedics and it was important that existing staff were supported with training and gaining qualifications as well;

- Within the recommendations there were 31 in the 'must do' category and these were being dealt with;

they were very complex however and it was difficult at this point to say how far along they were at the moment;

- The CQC would be carrying out another inspection in the future which would be unannounced;

- There was no improvement in Halton's emergency response times and the number of calls had increased.

RESOLVED: That the Board welcomes the presentation and notes the contents of the report.

HEA6 HOMELESSNESS SERVICE UPDATE

The Board received a report informing of the recent developments within the homelessness service, and to advise of recent legislative changes that would affect future homelessness and the demand for the service.

It was reported that the Housing Solutions Team had been proactively working with all client groups to reduce and prevent homelessness. The recent staffing issues were explained and it was noted that the Team would be back to full capacity by mid-November 2017.

Members were advised that the aim of the Housing Solutions Team was to assist and prevent people from becoming homeless in Halton. They also provided a community focussed and accessible service to ensure people knew where and how help could be sought if they were threatened with homelessness.

Members were referred to the table in paragraph 3.1.1 of the report which presented some key statistics taken from the statutory data report.

The report also included commentary on the following subjects:

- The Youth Officer;
- Homelessness database;
- Homelessness trends;
- Health and homelessness;
- Gypsy travellers;
- Syrian Refugee Programme;
- Supported Housing Accommodation;
- Local Policy Reviews (Gypsy Travellers; Youth Strategy; and the Homelessness Strategy; and

- Legislation (The Localism Act 2011 and the Homelessness Reduction Bill);

Following Members debate, the following responses to queries were made:

- Funding for the Syrian refugees was provided by the Home Office and support for refugees was provided by Refugee Action;

- The Board would receive further updates once the Homelessness Reduction Bill was introduced, which would be April 2018; however in the meantime further legislative guidance was expected in mid / late 2017, which would be provided to Members via updates;

- Councillor Ron Hignett, in attendance as the Portfolio Holder for Homelessness, wished to covey his thanks to the Housing Solutions Team for their hard work and dedication to the service; and

- Homelessness affected single people, couples and complete families for a variety of reasons.

RESOLVED: That Members note the report.

HEA7 NHS HALTON CLINICAL COMMISSIONING GROUP'S QUALITY REFERRAL PROGRAMME: IMPLEMENTATION OF A REFERRAL FACILITATION SYSTEM IN HALTON

The Board received a report that provided an update on the Halton Quality Referral Programme; namely the implementation of the Referral Facilitation System (RFS) as a key component of the programme. The report was presented by Dr David Lyon – Chair of the NHS Halton Clinical Commissioning Group (CCG).

It was reported that in October 2016, NHS Halton CCG's Governing Body approved an invest-to-save approach for the implementation of a RFS as part of the CCG Quality Referral Programme. This process facilitated the transfer of primary care referrals to secondary care via a secure electronic Integrated Care Gateway (IGC). The patient was then offered a choice of secondary care provision via use of the national e-referral system. The administration associated with e-referral was handled by the Referral Management Centre (RMC) which was provided by Midlands and Lancashire commissioning Support Unit (MLCSU).

The report went on to discuss phase 2 of the RFS implementation which was the introduction of a clinical triage process. Further it discussed patient communications and monitoring of the system and Members were referred to the diagrams in Appendices 1, 2 and 2 (a), which explained the current referral process, the referral facilitation process and the full referral facilitation process (including clinical triage and audit trail).

There were a number of drivers associated with the implementation of the RFS and these were also presented in the report and discussed by the Board.

Members queried the security of the IT systems in the NHS to be able to cope with the RFS. It was noted that all GP's would use the same system and all information would be stored in a 'cloud' so could not be lost. The *securenhs.net* system was robust and used nationally.

An update would be provided to the Board in approximately 6 months' time.

RESOLVED: The Board noted the update on the implementation of the RFS in Halton.

HEA8 GENERAL PRACTICE ALIGNMENT TO OLDER PEOPLE'S CARE HOMES

The Board received the outcome of the public consultation on the proposal to align General Practice to Older People's care Homes in Halton.

Members were reminded that at the Health Policy and Performance Board on 7 February 2017, the NHS Halton CCG's proposals to *Align GP's with Older People's Care Homes in Halton* were presented at the meeting, supported by Halton Borough Council. It was agreed at the meeting that the proposal amounted to substantial variation and Members therefore supported the consultation approach.

The consultation took place from 27 February 2017 to 22 May 2017 and the outcome of the consultation was appended to the report for Members information.

RESOLVED: The Board supports the alignment of GP Practice to Older People's Care homes in Halton.

HEA9 CLOSURE OF WINDMILL HILL MEDICAL CENTRE

The Policy and Performance Board was presented

with the reasons for the closure of Windmill Hill Medical Centre and the actions taken. The report was presented by Leigh Thompson – Director of Commissioning, NHS Halton CCG.

It was reported that in March 2017 NHS Halton Clinical Commissioning Group's (HCCG) Governing Body took the decision to close down Windmill Medical Centre on 31 March 2017, and to disperse the list. This followed the earlier decision to close the Windmill Hill branch surgery based in Widnes. It was noted that the practice was originally developed as part of the Equitable Access to Primary Care Programme and was being run by Liverpool Community Health (LHC), under a time limited Alternative Provider Medical Services (APMS) contract. Due to an organisational restructure at LCH there was no opportunity to extend the contract beyond its expiry date of 31 March 2017.

Members were advised that despite the decision to re-procure a GP practice at Windmill Hill, the CCG and Primary Care Team were unsuccessful in securing a new provider to take over the practice, despite extensive efforts and advertising both nationally and locally. This resulted in the CCG being left with no option other than to close the practice.

The report went on to discuss how the transfer of patients to alternative practices was managed using a Communication Handling Plan; setting a media protocol; and working with external stakeholders.

The Board was advised that the transfer of patients was a success with no problems reported. Mrs Thompson wished to convey her thanks, on behalf of the CCG, to the residents of Windmill Hill and others affected, as they had completely embraced the changes, which contributed to the success of this process.

The Board welcomed the report and the positive outcome for residents of Windmill Hill.

RESOLVED: That the Board noted the actions taken.

The Chair declared a Disclosable Other Interest in the following item as her son's partner works for a domiciliary care provider in Halton. She did not take part in the debate on this item.

HEA10 DOMICILIARY CARE/CARE HOMES – QUALITY: UPDATE

Members received an update which highlighted key issues with respect to Domiciliary Care and Care Homes locally.

By way of background it was stated that one of Halton Borough Council's priority was to ensure the provision of a range of good quality services to support adults requiring commissioned care in the Borough. The Care Act 2014 had put this on a statutory footing through a choice of diverse high quality services that promoted wellbeing.

As previously mentioned the care home market in Halton consisted of 26 registered care homes which provided 788 beds operated by 16 different providers. The capacity of these ranged from homes with 66 beds to smaller independent providers with 6 beds.

Members were advised that all care homes in Halton had now been rated by the Care Quality Commission (CQC) and the results of these were discussed in the report.

It was highlighted that the Council's Quality Assurance Team gathered intelligence and information on providers via quality and contract performance monitoring. They also operated an early warning system and Members were referred to the table in paragraph 3.9, which presented the Team's Care Home ratings for quarter 4 of 2016-17.

RESOLVED: That the report is noted.

HEA11 HALTON URGENT CARE CENTRES : UPDATE

The Board received an update on Halton's Urgent Care Centres (UCCs). Appended to the report was a list of clinical pathways in use at the UCCs.

The report presented information relating to:

- The utilisation of the UCCs for Runcorn and Widnes per month, from April 2014 to February 2017;
- The average waiting time at both Centres, from April 2014 to February 2017;
- Service user satisfaction;
- The impact of the UCCs on local hospitals; and
- Future developments.

Members wished to provide the following feedback on the UCCs :

- The reception areas, in some instances, were letting the service down;
- Patient confidentiality, perhaps due to the location of the receptions, was an issue;
- Patients were getting lost in the Health Care Resource Centre and missing their names being called; and
- Some patients had been turned away as early as 8pm with no alternative options provided to them.

It was confirmed that there was an out of hours GP (via booked appointment) at Halton Hospital in operation when the UCC was closed.

RESOLVED: That the Board notes the contents of the report and associated appendix.

HEA12 SCRUTINY TOPIC 17/18: HEALTH IMPROVEMENT TEAM (HITS)

The Board was provided with the details of the Health Improvement Team (HIT) Scrutiny Topic, as outlined in Appendix 1. Appendix 2 showed the schedule of meetings.

RESOLVED: That

1) the Board notes the report;
2) approves the Topic Brief outlined in Appendix 1; and
3) notes the Scrutiny Topic Working Group meeting schedule, with the invitation extended to all Members of the Board to attend.

HEA13 HEALTH POLICY AND PERFORMANCE BOARD ANNUAL REPORT : 2016/17

The Board received the Health Policy and Performance Board's Annual Report for April 2016 to March 2017.

It was noted that Members comments on the General Practice Alignment to Care homes paper presented at today's meeting, would be incorporated in the annual report.

The Chair wished to thank her Vice Chair and all Board Members and officers for their contributions over the past year.

RESOLVED: The Annual Report be noted.

Meeting ended at 8.25 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 19 September 2017

REPORTING OFFICER: Strategic Director, Enterprise Community & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

- Requires the disclosure of confidential or exempt information.

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Health Policy and Performance Board

DATE: 19 September 2017

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The draft minutes relating to the Health and Social Care Portfolio which have been considered by the Health and Wellbeing Board are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the draft minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 5 July 2017 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and N. Atkin, P. Cooke, D. Cooper, A. Fairclough, G. Ferguson, S. Johnson Griffiths, P. McLaren, A. McItyre, E. O'Meara, D. Nolan, D. Parr, H. Patel, M. Roberts, J. Rosser, S. Semoff, R. Strachan and P. Woods

Apologies for Absence: S. Ellis, Sally Yeoman, Tracey Hill and M. Larkin

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB1 MINUTES OF LAST MEETING

The Minutes of the meeting held on 29th March 2017 having been circulated were signed as a correct record.

HWB2 HALTON RAPID CLINICAL ASSESSMENT TEAM - PRESENTATION

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

It was noted that:

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

- the RCAT service commenced on 4th April 2016;
- GP led Primary Care Teams had the opportunity to refer to RCAT for an enhanced Rapid Clinical Assessment; and
- the service accepted referrals Monday to Friday 9am to 4pm and the aim was for the service to undertake an initial assessment within two hours.

The referral criteria was as follows:-

- Age 75+. However the team were flexible and if a GP felt that a patient would benefit from an intervention irrespective of age, then they could contact the team to discuss this; and

- Not critically ill (e.g. Myocardial Infraction, stroke or severe sepsis etc.).

It was reported that from the 4th April 2016 – 31st March 2017, 194 referrals had been made to the Service. Of those referrals made a total a total of 165 admissions were avoided during 2016/17. For NHS Halton Clinical Commissioning Group, the average cost of an emergency attendance and admission via ambulance in 2015/16 was £2,786 (age 75+). Based on this figure, a total saving of £459,690 was made in hospital avoidance. If this saving was then offset against the annual cost of the RCAT service, which was approximately £350,000, then in 2016/17 a total saving of £109,690 was made.

RESOLVED: That the presentation be noted.

HWB3 JOINT WORKING ON MATERNAL AND INFANT MENTAL HEALTH - PRESENTATION

The Board considered a presentation which provided Members with an overview of the integrated work taking place in Halton to improve infant and maternal mental health and wellbeing. Halton had received the 'Locality award for mental health inclusion' at the PIPUK (Parent infant partnership) infant mental health awards. The award was for the collaborative work that had taken place through the Halton Health in the Early Years group, on perinatal mental health, preparation for parenthood, and bonding and attachment. It was in recognition of the close working between the Bridgewater midwives, Family Nurses and Health visitors, and Children's centre staff, Health improvement team, Public Health and the CCG.

The Board considered a presentation which outlined

the work that was taking place to 'give every child the best start in life', by supporting mums mental health and building the relationship with the child.

RESOLVED: That the contents of the presentation be noted.

HWB4 JOINT LOCAL AREA INSPECTION OF SPECIAL EDUCATIONAL NEEDS AND DISABILITY FOR HALTON

The Board considered a report which provided an update on the outcome of the Joint Local Area Inspection of Special Educational Needs (SEN) and Disability for Halton. Between the 27th March and 31st March 2017, Ofsted and the Care Quality Commission conducted a joint inspection in Halton. As part of the inspection they:

- spoke to children and young people with special educational needs and/or disabilities, parents and carers, local authority and National Health Service (NHS) officers;
- visited a range of health and education providers including schools, Children's Centres, Early Years settings and Riverside College;
- considered a range of information about the performance of the local area including the local area's self-evaluation;
- met with the leads for health, social care and education in Halton; and
- reviewed performance data and evidence including the local offer and joint commissioning.

It was reported that the inspection focused on the following three areas:-

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

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

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

Members were advised that Ofsted had published the outcome of the inspection in a final letter on the 16th June and a copy had been previously circulated to Members of

the Board. The letter set out both the strengths of the local area and a number of areas for further development.

The report acknowledged what was working well, what needed to improve and emphasised the need for increased joint planning. Therefore, in order to respond to the areas for development and to further improve the outcomes for children and young people, NHS Halton Clinical Commissioning Group, the Local Authority, Impart (parent and carer organisation) and other partners were committed to working together to develop a local area joint Action Plan. Once developed the Action Plan would be monitored and reviewed by the SEN Strategic Partnership Board and a progress report would be provided to the Health and Wellbeing Board every six months.

RESOLVED: That

1) the outcome of the Joint Local Area SEND inspection be noted;

2) approval be given to the development of a Joint Action Plan to address the areas of development identified by the inspection; and

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

HWB5 REDUCING CHILD POVERTY AND IMPROVING LIFE CHANCES IN HALTON

The Board considered a report on the work of the Child and Family Poverty Strategic Group and how this fed into the Liverpool City Region co-ordinated approach to addressing child and family poverty.

In 2010 Halton, alongside other Liverpool City Region leaders, agreed to adopt a City Region wide approach to tackling issues relating to child and family poverty that would build on strong local and City Region partnerships. Subsequently, in 2011, the first Child Poverty and Life Chances Strategy for the Liverpool City Region was launched.

It was noted that whilst Halton was happy to adopt a joint strategic approach as part of the Liverpool City Region, it had agreed to develop its own Action Plan to underpin it. As a result, Halton's Child and Family Poverty Strategic Group had hosted a workshop on the 26th January to consider what should be included within Halton's Child

Poverty Action Plan and the outcomes from the workshop were detailed in the report.

It was proposed that the outcomes of the strategy and the Action Plan would be reported annually to the Children and Young People's Policy and Performance Board and the Liverpool City Region Child Poverty and Life Chances Commission.

RESOLVED: That the report be noted.

HWB6 FALLS UPDATE

The Board considered a report which provided an update on the Falls Service in Halton and the work undertaken to date in the line with the Halton Falls Strategy 2013 – 2018.

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

It was noted that to date many key actions identified in the plan had been fully implemented and although performance was still below the national average in a number of areas, there had been a significant decrease in the gap. The report highlighted progress against the Falls Strategy Action Plan within the following areas:

- Falls Pathways – Treatment/Prevention;
- Workforce training and awareness raising;
- Development of an awareness raising campaign with both the public and professionals;
- Improved partnership working and governance; and
- Impact on performance.

Members were advised that progress had been made in a number of areas in line with the following key priorities:

- to reduce emergency hospital admissions for injuries due to a fall (65+); and
- emergency hospital admissions due to fracture of neck or femur (65+).

However, it was reported that work needed to continue to close the gap and to reduce the numbers of people who fall in Halton. Therefore, a number of key recommendations which would support work in this area were outlined in the report.

RESOLVED: That the report be noted.

HWB7 PUBLIC HEALTH PROTECTION ANNUAL REPORT

The Board considered a copy of the Public Health Protection Annual Report 2016/17. The report provided an overview of the current health protection situation within Halton highlighting any on-going challenges or issues. The document enabled the Director of Public Health to provide assurance to the health and wellbeing board that the health of the residents of Halton was being protected in a proactive and effective way.

A copy of the Public Health Protection Annual Report 2016/17 had been previously circulated to the Board.

RESOLVED: That the report be noted.

HWB8 2016/17 PUBLIC HEALTH ANNUAL REPORT

The Board considered a report of the Director of Public Health, on the development of the Public Health Annual Report 2016/17. For the 2016/17 report the focus would be on the health of women and girls in Halton. The topic had been chosen to highlight key topics specific to female health and those issues local women and girls believed to be the most significant areas for their health.

The final version of the report would be presented to the Board in September 2017.

RESOLVED: That the Board

1) note the theme and areas of focus; and

2) raise awareness of the forthcoming report with their staff and elected Members.

HWB9 ADULT AND SOCIAL CARE ADDITIONAL FUNDING

The Board considered a report of the Director of Adult Social Services, which outlined the allocation of additional funding for Adult Social Care which was announced by the Chancellor in the Spring Budget. The additional funding was to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing the pressures on the NHS; including supporting more people to be discharged from hospital when they are ready and stabilising the social care provider market.

The report set out a number of recommendations on areas where this additional funding should be allocated, including cost and predicted outcomes.

RESOLVED: That the report be noted.

Meeting ended at 3.22 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 19th September 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Physician Associates

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 That the Board receive a presentation from Simon Constable, Medical Director, Warrington & Halton Hospitals NHS Foundation Trust, regarding the background to the development and use of Physician Associates within the Health Service.

2.0 **RECOMMENDATION: That the Board:**

i) Note the contents of the report and associated presentation

3.0 **SUPPORTING INFORMATION**

3.1 Physician Associates (PAs), or sometimes referred to as "Assistants", are typically life science graduates (with a pre-clinical degree) who go on and do a two year postgraduate diploma (clinical) course and take a national examination. This is undertaken over a five year period. Most basic medical qualifications (MB BS/MB ChB) take five years (formerly, two years pre-clinical and three years clinical) to complete.

To address the needs of the changing health service, not just the numbers of doctors, but also skill mix, working hours and 7-day service provision, there has been a national increase in the number of universities offering PA courses and most recently this has included the Universities of Manchester (in conjunction with Edge Hill) and Liverpool.

The Faculty of Physicians Associates (FPA) and the Royal College of Physicians (RCP) aim to ensure that the expansion of a new clinical workforce is done as safely as possible pending formal regulation, which requires a change in the law. The RCP wants to support high national standards of physician associate training, and to campaign for effective regulation. The RCP Council made this decision as it was seen as important to support, shape and understand the needs of the profession, in a manner that is complementary to the needs of physicians.

It also aligned with the RCP's aim to support the future clinical workforce as set out in the Future Hospital Commission report, published in 2013:

The roles of advanced nurse practitioner and physician's associate should be evaluated, developed and incorporated into the future clinical team in a role and at a level of responsibility appropriate to their competencies.

3.2 PAs are neither doctors nor autonomous medical practitioners in their own right; they are however trained in the medical model along the same lines as doctors. They work under the direct supervision of qualified doctors in virtually any clinical speciality and undoubtedly have a role to play in a truly multi-professional team that will see new and extended roles emerge in the coming years.

A feature of PAs which is unlike other roles is that generally this is a cohort of life-science graduates that would otherwise potentially be lost to the clinical workforce in the NHS, either through management training or through roles in industry. This is unlike the situation with nurses (or other allied health professionals) that move into extended clinical roles from another post that then typically creates a clinical vacancy that needs to be recruited to.

3.3 There is an outstanding issue of professional registration which means that currently PAs cannot prescribe or order ionising radiation, but this is likely to be addressed in the not-to-distant future and is being looked at by the Department of Health.

The Royal College of Physicians has a Faculty of Physician Associates and this is a source of further information if required.

https://www.rcplondon.ac.uk/news/faculty-physician-associates#2

At present there is a Physician Associate Managed Voluntary Register (PAMVR) housed at the Faculty of Physician Associates (FPA) which keeps details of physician associates who meet all the required standards. The Faculty of Physician Associates at the RCP, Health Education England and the higher education institutes involved in training physician associates continue to work towards regulation of the profession and the establishment of a statutory register.

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 sand its associated presentation 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 At present there is a Physician Associate Managed Voluntary Register (PAMVR) housed at the FPA which keeps details of physician associates who meet all the required standards. The PAMVR does not currently have force of law, so is 'voluntary' as its name suggests. However, the FPA strongly encourages all qualified physician associates to join the register, and all trusts and practices to ensure that the physician associates they employ are registered. To mitigate this risk all Employers are advised to check this at appointment and at yearly appraisals. This will help ensure that only those properly trained are able to practise as physician associates. While work towards statutory regulation is underway, the overall decision regarding the eventual registering body for physician associates will be made by the government. All UK-based physician associates are therefore strongly encouraged to join the PAMVR as it will form the initial list of physician associates to enter a statutory register when established.

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.

REPORT TO:	Health Policy & Performance Board
DATE:	19th September 2017
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Reviewing Local Health Policies – Procedures of Lower Clinical Priority
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a presentation in relation to the policy review and engagement exercise for the policies in relation to Procedures of Lower Clinical Priority.

2.0 **RECOMMENDATION: That the Board:**

i) Note the contents and the report and associated presentation.

3.0 **SUPPORTING INFORMATION**

3.1 Clinical Commissioning Groups (CCGs) in parts of Cheshire and Merseyside have been working together to develop a core set of Procedures of Lower Clinical Priority (PLCP) which are more consistent across the region.

PLCPs are routine procedures that have some clinical value, but only in certain circumstances, and so might not offer the best medical outcomes to patients - they are known to have medical benefit only in very specific situations or for a small group of people.

At the moment, the criteria for these procedures varies between areas, which can cause differences in availability for patients. Nationally, the NHS believes that by having a more standardised set of policies, which are more consistent across the region, we can deliver a more equal service for patients.

GPs and commissioning managers from the CCGs, along with colleagues from local authorities and public health, are working together to review more than a hundred policies to ensure they are making the best use of NHS resources, as well as aligning with the latest robust clinical evidence about the effectiveness of different treatments and national guidance. From this exercise, we now have a consistent set of policies which could apply to patients living in the seven CCG areas.

As a result, some of the criteria has been reviewed and may mean that fewer patients have access to these services, as their clinical circumstances will no longer meet with the evidence base for revised clinical eligibility for treatment. If a patient doesn't meet the criteria in the policy, but their GP or consultant believes that their circumstances are exceptional, an Individual Funding Request (IFR) for the procedure can be submitted.

As there are more than a hundred policies included in this regular review, engagement and consultation work will happen in batches, to allow for the appropriate level of engagement with key stakeholders and the public.

3.2 Feedback from the 12 week public survey, events and meetings responses will be provided w/c 30th November 2017. This will allow for feedback to be reviewed and taken into consideration in final decision making.

3.3 Communications and Engagement plan to be provided which outlines the targeted approach to each policy.

4.0 POLICY IMPLICATIONS

4.1 The proposed policy changes aim to bring current policies in line with the latest clinical guidance and make the best use of NHS resources.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any change will be within the current financial envelope. There is an expectation that there will be some financial savings made from the proposed changes, however this is not the key driver for change and proposed changes.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Children under 16 who may no longer have access to treatments or procedures based on cosmetic or psychological grounds. Targeted engagement with Alder Hey Clinicians, as part of policy development and survey responses has been carried out.

6.2 Employment, Learning & Skills in Halton

None identified

6.3 A Healthy Halton

Ensuring all procedures are clinically necessary and in line with the latest clinical guidance.

6.4 **A Safer Halton**

Ensuring all procedures are clinically necessary and in line with the latest clinical guidance

6.5 **Halton's Urban Renewal**

None Identified.

7.0 **RISK ANALYSIS**

7.1 The key issues have been logged on the project risk register and are continuously monitored, reviewed and in final decision making will be resolved.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 A phase 1 Equality Impact and Risk Assessment (EIRA) has been carried out for each policy which has been reviewed, as well as the communications and engagement plan itself. The EIRAs have informed the engagement plan, specifically were a protected class or minority may be more predominantly affected by an illness. The engagement specifically targets and addresses these cohorts of people.

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

9.1 None under the meaning of the Act.

REPORT TO: Health Policy & Performance Board

DATE: 19th September 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Stroke Update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update Members of the Board on Stroke Reconfiguration in Mid – Mersey.

2.0 **RECOMMENDATION:**

That Board Members understand the current position and note the contents of the report.

3.0 **SUPPORTING INFORMATION**

National Update

3.1 National Stroke Picture – 40% of stroke consultants posts are vacant – recruitment is an issue, especially in the North region. Locally, regionally and nationally recruitment drives have not been successful, international recruitment has yielded little response.

3.2 London has no stroke consultant vacancies, Salford – the largest Hyper-acute centre in England, taking around 1700 - 2000 patients per year has struggled to sustain their rota's and is currently 4 consultants down**.**

3.3 Professor Tony Rudd, lead for stroke is visiting all the poor performing stroke centres in England; Cheshire and Mersey have received no visits.

3.4 One of the latest treatments for stroke is a procedure called 'Mechanical Thrombectomy'. This is available at selective Neurological centres only. It is a treatment that only a small number of patients will require, around 3-5% of patients who have received stroke thrombolysis (clot busting drug) that has failed to remove clot. This equates to around 60-80 patients per year in whole of Cheshire and Mersey.

It is a specialist procedure and is therefore commissioned by specialist commissioners. The Walton Centre is the only centre in Cheshire and Mersey who currently deliver a limited 5day - Mon – Fri 8am-5pm Thrombectomy service. This service is limited as there are scarce numbers of interventional radiologists to perform the procedure, this is a national problem, in London for example, they are reducing the number of centres who provide Thrombectomy from 6 to 3 to provide a 24/7day sustainable service. Due to the speciality and small numbers of patients a regional (North West) service is being explored, as currently both Greater Manchester (Salford) or Lancs and South Cumbria (Preston) deliver limited 5 day service, like the Walton Centre.

Local Update

3.5 Phase 1 - all stroke patients requiring stroke thrombolysis being transferred to St Helens & Knowsley Trust (SHKT) 24/7 went live in March 2017. This equates to around an extra 100 patients being transferred to SHKT per year. To ensure that SHKT stroke service was able to carry on its gold standard stroke service a number of considerations needed addressing:

- Number of beds in the Hyper-acute stroke unit was increased by 2 and a further 4 in the rehabilitation ward.
- Stroke consultants (2 locum consultants) at Warrington Halton Hospital (WHH) are on the shared rota with SHKT sharing a 1:8 rota.
- St Helens Early Supported Discharge (ESD) Team was under resourced and St Helens patients had some time delays in being seen by the ESD team which led to longer length of stays in hospital, impact on ward beds and little if any ongoing community rehabilitation support following discharge from the team.

Example numbers of strokes patients transferred to SHKT:-

- Figures for May 2017 – number of referrals for stroke 213, of which 16 were from WHH, of these 16, 5 were diagnosed as stroke and 3 diagnosed as Trans ischemic Attacks (mini strokes). Others were mainly discharged following assessment, only one other was admitted for other care.

The patients stayed in SHKT for around 2-4 days, and then were either discharged home with Early Supported Discharge (ESD) or repatriated back to WHH stroke rehabilitation unit.

3.6 Patient and Public engagement sessions have been held across, Warrington, Halton and St Helens localities; they have been facilitated by the Clinical Commissioning Group's (CCG) communication and engagement teams in collaboration with the Stroke Association. Attendees at these events have been:

- Stroke survivors
- Relatives/carers
- Professionals from both Acute and Community services

3rd Organisations such as:

- Red Cross
- Health Watch
- Stroke clubs
- Halton Umbrella group

The public engagement process will be completed in September; so far the engagement process has shown a positive response from the Halton residents.

Many of the engagement sessions were supported by Dr Kidd (Stroke Consultant from WHH), Dr Hill (Stroke Consultant at SHKT) plus senior managers from both sites and Dave Sweeney (Interim Chief Officer Halton CCG). Dr David Lyons (Runcorn GP and NHS Halton CCG Chair) attended the Disability Awareness Day one of the many events utilised for raising awareness of the proposed changes to stroke services.

Stroke surveys have been disseminated at all events and so far. The main themes and questions raised via the survey and from the events are:

- Concern of loss of local services
- Concern of loss of community services
- Importance of patient choice for locality of rehab
- Access to community services and intermediate care
- Development of Intermediate care facilities with stroke specialist input.
- **Travelling concerns**
    - Cost of travel to new site
    - Ambulance – extra journeys
    - Car parking inadequate at SHKT
    - Transport and access over the Runcorn Bridge for people with disability-shuttlebus availability
- Finance - Tariff needs to follow patient
- Impact on Ambulance service
- Understanding of how 3rd sector organisations and their roles
- Capture community clinical services
- Bottlenecks how will patients be moved
- How does stroke pathway inter- relate to other pathways such as Neurology

Many of these concerns were answered on the day of the event. A full report with explanations will be ready in September following collation of surveys. Many attendees agreed with the change and some had received what they called excellent care in SHKT, but just wanted some greater understanding of reasons behind the changes.

3.7 A scoping out of ESD and community teams across Mid- Mersey highlighted a number of deficiencies in the services teams were providing, mainly the deficit in the St Helens team. NHS St Helens CCG have now resourced the team to provide a 6 day service with an expansion to provide 6 month community rehab if required.

WHH and Halton ESD Team have no Speech and Language Therapist in their teams, NHS Halton CCG have up-resourced their Community Speech and

Language team to aid the ESD team, WHH have been asked for some resource for this also.

3.8 The Telemedicine service is being explored, with more information being available from September.

3.9 Phase 2 – this is where all acute strokes will move from WHH to SHKT for the 1st 72 hrs of care.

This will equate to another 300 patients being transferred across, so further work is being done to understand what this will look like and what needs to be done to ensure all patients continue to receive gold standard care.

Work being undertaken currently:-

- Finance – modelling of tariff and impact on both sites
- Further bed-modelling – need extra beds in Acute and rehab
- Recruitment of nursing and therapy staff
- Agreement for intermediate care beds in each locality to be utilised for stroke patients to reduce bed capacity and increase patient flow; these patients would be seen by stroke specialist ESD teams.
- Discharge planning and social workers – both pathway and recruitment
- SHKT to review department impacts such as Emergency department, orthoptics, vascular, radiology
- Repatriation process and policy
- Patient and Public consultation and engagement process –this will be determined following results of Phase one engagement.

4.0 POLICY IMPLICATIONS

4.1 Repatriation Policy for Phase 1 is yet to be finalised.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Finance and contracting discussions are underway to work out any changes to tariff or transfer of service.

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 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
- WHH – The substantive Stroke consultant has now left, leaving 2 locum stroke consultants. SHKT have got 1:8 rota including 2 locums. Medical Directors working on this now - taking stroke consultants off general medicine and geriatrician rotas
- Risk of SHKT Stroke scoring 'A' being impacted – due to not having enough beds so not getting to stroke ward in time. Reduced scanning capacity - not scanned in time frame
- Reduced therapy workforce
- Repatriation of patients back to WHH for extended stroke specialist rehab – poor process, no ring fenced beds.
- No formal access to Intermediate care beds for stroke patients in Halton or Knowsley. WHH utilise Padgate House with in-reach from ESD. NHS St Helens CCG have agreed to utilise Newton House with in-reach from ESD team. This is classed as an opportunity to reduce bed capacity and increase patient flow.
- Financial risks are yet to be determined for both sites and NWAS.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified, however both sites have undertaken Equality Impact Assessments.

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

9.1 None under the meaning of the Act.

REPORT TO: Health Policy & Performance Board

DATE: 19th September 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Medication Policy

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the new overarching Medication Policy (see appendix 1). The policy applies to Halton Borough Council adult social care services with responsibility for administering medication.

2.0 RECOMMENDATION:

RECOMMENDED: That the Board

1) **Note the contents of the report and associated appendices; and**
2) **Comments on the revised Policy.**

3.0 SUPPORTING INFORMATION

3.1 Halton's current Overarching Medication Policy (2014-17) and associated service specific procedures run until August 2017. It was therefore necessary to develop a new collection of documents; the Medicines Management Team within the CCG have led this work due to the technical knowledge required to appropriately advise services of safe and effective practice.

3.2 The new policy has been developed based on an example shared by Derby City Council and is in line with relevant legislation and guidance, including:

- The Care Act 2014;
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 12 (safe care and treatment);
- NICE guidelines;
- Royal Pharmaceutical Society guidance;

3.3 The policy outlines the Council's vision for medicines management in adult social care and describes its commitment to enable and safeguard the health, safety and wellbeing of service users and staff.

3.4 Currently in development to sit alongside this policy are a number of service specific Standard Operating Procedures (SOPs), which will set out exactly how the policy is implemented in each service area. These are being developed in close consultation with the following services:

- Adult Placement;
- Day Services;
- Oak Meadow (incl. reablement);
- Supported Housing Network.

3.5 With regards to commissioned services, there is an expectation that their policies, procedures and processes meet the standards set within this policy.

3.6 Once the policy and associated SOPs are finalised and approved, implementation within services will be supported through briefings and training with staff.

4.0 POLICY IMPLICATIONS

Implementation of the policy will ensure compliance with legislation and best practice in connection with medicines management in social care settings.

5.0 FINANCIAL IMPLICATIONS

None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

None

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

None

6.3 **A Healthy Halton**

Implementation of the revised policy and associated SOPs will ensure that the medication needs of those receiving support from the HBC services listed at 3.4 are properly and safely managed. The policy also offers an example of good practice, which will be shared with commissioned services in order to illustrate the expected standard.

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 RISK ANALYSIS

No risks identified.

8.0 EQUALITY AND DIVERSITY ISSUES

An Equality Impact Assessment (EIA) has been completed – copy attached at appendix 2. No negative impact was identified.

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

None under the meaning of the Act.

HALTON BOROUGH COUNCIL

NHS Halton Clinical Commissioning Group

Medication Policy

Adult Social Care

September 2017

Table of Contents

Information sheet

Service area	Adult Social Care
Developed by	Katherine O'Loughlin – Medicine Management Technician Zoe Mason – Medicine Management Pharmacist
Date effective from	September 2017
Review due	September 2020 Any key changes prior to this date will prompt a review.
Status: • Mandatory (all named staff must adhere to guidance) • Optional (procedures and practice can vary between teams)	Mandatory
Target audience	Halton Borough Council Services: • Adult Placement • Day Services • Oak Meadow (incl. reablement) • Supported Housing Network Commissioned Services
Date of committee/SMT decision	HBC People Directorate Adults Senior Management Team: 12.07.2017 Being presented at HBC Health Policy & Performance Board: 19/09/2017
Related document(s)	Associated service specific Standard Operating Procedures (SOPs)
Superseded document(s)	HBC Medication Policy 2014 – 2017
Equality Impact Assessment completed	02.06.2017

With thanks to Derby City Council for sharing their Medication Policy, from which this document has been developed.

Purpose of the policy

This policy outlines Halton Borough Council's vision for medicines management in social care. It also describes our commitment to enable and safeguard the health, safety and wellbeing of service users and staff.

People living with support from social care have the same rights as any other. Respect for the service user and their rights as an individual should be at the heart of the medication process. It should be assumed that every service user can self-medicate until assessment of the service user proves otherwise.

Medicines play an important part in helping service users remain independent. It is important that service users take their medicines as prescribed, and should always be encouraged to manage their own medication where this is possible and appropriate. This should be done through the use of medication assessments.

Treatment and care must be personalised, based on the individual's needs and preferences. Service users are all individuals and as such this policy must be applied with regard to the individual's beliefs, wishes, experience and ability. Staff should be aware of the individual's cultural background and other factors that impact on their lives and incorporate this into a person-centred approach to care.

As all medicines are potentially harmful it is important that staff who provide care are competent and confident about their role in medicine management. This policy intends to clarify for staff working in social care, the range of duties that can be undertaken in relation to medicines. It advises how these duties and tasks can be undertaken in accordance with best practice, legislation and national guidelines.

All staff have an important role to play in risk identification, assessment and management. To support staff in this, the Council tries to provide a fair and consistent working environment and does not seek to apportion blame. We hope this encourages a culture of openness and willingness to admit mistakes. Staff therefore are actively encouraged to report any situation where things have, or could have gone wrong. Information, training and support will be provided for any staff that finds themselves in such a situation. The Council wishes to learn from events and situations so that management processes can be continuously improved.

The policy has been written to reflect the duties of the Care Act 2014, particularly the promotion of people's wellbeing and to enable people to prevent and delay the need for more complex care and support.

The policy reflects the following:

- NICE good practice guidelines on 'Managing Medicines in Care Homes' (2014) 'Managing medicines for adults receiving social care in the community' (2017);
- The Royal Pharmaceutical Society's principles detailed within 'The handling of medicines in social care' that underpin safe handling of medicines in social care;
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 12 – Safe care and treatment.

Non-clinical staff in care homes, domiciliary care, supported living and day care settings will deal with matters relating to social care only. They are not responsible for making decisions

of a health-related nature. Medical advice must be sought from the service user's GP, other member of the primary care team, or any other relevant health care professional.

Non-clinical staff will not undertake invasive nursing procedures or other tasks that are defined as health-related and not social care. There may be exceptional circumstances when staff have received training and is deemed competent, in-line with guidance from this policy. This includes those tasks that family or carers might undertake having been shown and supervised by a health care professional. It must be made clear in the care plan which tasks non-clinical staff may undertake. This will only be undertaken with prior agreement with the commissioner.

In nursing homes, registered nurses must comply with the Nursing and Midwifery Code (2015). The Code outlines the professional standards that nurses and midwives must uphold in order to be registered to practice in the UK.

The Code can be used by registered nurses and midwives as a way of reinforcing their professionalism. Failure to comply with the Code may bring their fitness to practice into question.

Using the policy

Council services must follow this policy in conjunction with their service specific Standard Operating Procedures (SOPs).

Where the provider is not Halton Borough Council, the commissioned service provider will ensure their policies; procedures and processes meet the standards set within this Medication Policy.

This policy is divided into sections; all services must read and understand:

- Purpose of policy
- Legislation and best practice
- Principles
- Training and competency
- Essential practice for all providers

PLUS the section specific to the service they provide.

In the event of an issue being identified relating to medication that is not reflected in this policy, appropriate advice and guidance must be sought from an appropriate service manager, health professional, health and safety adviser, pharmacist, technician or out-of-hours service (such as the Urgent Care Centre or 111) who will take steps to clarify the situation.

Legislation and best practice

The Council is committed to meeting its obligations under:

- Care Act 2014
- Medicines Act 1968
- Misuse of Drugs Act 1971
- Health and Safety at Work etc. Act 1974
- The Mental Capacity Act 2005
- Management of Health and Safety at Work Regulations 1999
- Safeguarding Vulnerable Groups Act 2006
- Royal Pharmaceutical Society of Great Britain Handling of Medicines in Social Care 2007
- Care Quality Commission Regulations 2009
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12
- Skills for Care National Minimum Training Standards for Health Care
- Support Workers and Adult Social Care Workers in England 2013 (Qualification and Credit Framework Unit 80)
- Skills for Care Recommendations for CQC Providers – Medication Administration Training (standard 8) October 2014
- Care Certificate Standards 2015, Standard 13.5 Understanding medication and healthcare tasks 2015
- National Institute for Health and Care Excellence (NICE) Guideline, Managing Medicines in Care Homes March 2014 (SC1)
- National Institute for Health and Care Excellence (NICE) Guideline, Managing medicines for adults receiving social care in the community (NG67)
- Medicines and Healthcare products Regulatory Agency (MHRA)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(f) specifies that where equipment or medicines are supplied by the service provider, there are sufficient quantities of these to ensure the safety of service users and to meet their needs.

- Medicines must be available in necessary quantities at all times to prevent the risks associated with medicines that are not administered as prescribed. This includes those who manage their own medicines.
- Must have sufficient medication available in case of emergencies.
- Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times and kept in working order. They should be available when needed and within a reasonable time without posing a risk.
- Equipment, medicines and/or medical devices that are necessary to meet people's needs should be available when they are transferred between services or providers.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(g) the proper and safe management of medicines states that:

- Staff responsible for the management and administration of medication must be suitably trained and competent; this should be kept under review.
- Staff must follow policies and procedures about managing medicines, including those related to infection control.
- These policies and procedures should be in line with current legislation and guidance, addressing: supply and ordering, storage, dispensing and preparation, administration, disposal and recording.

The NICE guidance on Managing Medicines in Care Homes (SC1) provides recommendations for good practice on the systems and processes for managing medicines. The guidance is for people and organisations involved with managing medicines in care homes. It is anticipated that health and social care providers will need to work together to ensure that care home service users benefit from the good practice recommendations in this guideline. Areas covered are prescribing, handling and administering medicines and the provision of care or services relating to medicines in care homes.

The NICE guidance on Managing Medicines for adults receiving social care in the community (NG67) covers medicines support for adults (aged 18 and over) who are receiving social care in the community. It aims to ensure that people who receive social care are supported to take and look after their medicines effectively and safely at home. It gives advice on assessing if people need help with managing their medicines, who should provide medicines support and how health and social care staff should work together.

Principles of safe and appropriate handling of medicines (RPSGB, The Handling of Medicines in Social Care, 2007):

- Service users who use social care services have freedom of choice in relation to their provider of pharmaceutical care and services including dispensed medicines.
- Staff know which medicines each service user has and the social care service keeps a complete account of medicines.
- Staff who help service users with their medicines are competent.
- Medicines are given safely and correctly, and staff preserve the dignity and privacy of the individual when they give medicines to them.
- Medicines are available when the individual needs them and the care provider makes sure that unwanted medicines are disposed of safely.
- Medicines are stored safely.
- Social care service has access to advice from a pharmacist
- Medicines are used to cure or prevent disease, or to relieve symptoms, and not to punish or control behaviour.

Commissioner roles and responsibilities

As a Commissioner:

- The Council requires providers to ensure their policies; procedures and processes meet the standards set within the council's medication policy. This can be achieved by demonstrating the same standards within the provider's own policy.
- The Council will monitor provider organisations' management of medicines through the contracting arrangements and quality assurance monitoring visits.

- The Council requires all providers to comply with the council's incident reporting process for identifying, reporting, reviewing and learning from medication errors.

The Council requires all services to comply with the Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Good Practice Guidance.

Provider roles and responsibilities

As a Provider:

- The provider will ensure their medicines policy is in line with current legislation and the best available evidence. Where the Council is the service provider, this document and associated SOP's constitutes the Medication Policy.
- Where the provider is not Halton Borough Council, the commissioned service provider will ensure their policies; procedures and processes meet the standards set within this Medication Policy.
- All providers will ensure that all those involved in any element of medicines management are trained and assessed as competent in line with current national training standards, the requirements of the regulators and those of the service users.
- All providers will ensure that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines.
- Council run services will ensure that all medicines records and information complies with the council's Data Protection Policy (link available for Council staff). Where the provider is not the Council, the service provider will ensure that they comply with the Data Protection Act 1998 in line with internal policies.
- All providers will ensure that all medicines related errors or near misses are identified, reported, reviewed and investigated following guidance within this policy.
- All providers must ensure that they have a formal complaints process, which service users can access. For Halton Borough Council services, this must be done in accordance with the Adult Social Care Resolving Complaints and Improving Services Policy (link available for Council staff).
- All providers will ensure that medicines belonging to or prescribed for a service user are not used by other service users.
- All providers will ensure that all medicines administration records are up-to-date and accurate.

Principles

All care plans will identify whether, and at what level, the service user requires help to take their medicines.

All staff who administer medication will be responsible for ensuring medicines are administered strictly in accordance with the instructions of the prescriber.

Level 1: Self-Administration

Description of Level 1:

The Service user maintains responsibility for managing their medicines. The staff will always be working under the direction of the service user receiving care. This level of care includes service users who require:

- ***Help ordering and collecting prescriptions and advice on safe storage***
- ***Support with self-administration such as help opening containers at the request of the service user and when the staff has not been required to select the medication.***
- ***Occasional prompts/reminders to take medicines***

When supporting service users at Level 1 the staff must record and report any change in the service user's ability to manage their medication to their service manager.

At the point of access to social care, a medication assessment, which forms part of the care plan, must be carried out to assess the service user's ability to self-administer their medication. This process must ensure that the service user can take the correct dose of their medicines at the right time and in the right way. It must also ensure that the service user understands medicines must be kept safely and facilities are available for them to comply with this.

The assessor must determine who else may be involved. This must be done individually for each service user and must involve the service user and their family members, carers or care staff with the appropriate training and skills. Other health and social care practitioners must be involved as appropriate.

At all subsequent reviews of the service user's care plan, the person undertaking the review must check whether the service user's ability to self-administer their medication has changed and if so what adjustments need to be made to the medicines management arrangements.

Self-administration of medicines is not an 'all or nothing' situation. A service user can maintain control over their medicines via 'active participation' providing that staff can assist the service user in taking them.

Providers must ensure records are made and kept when service users are supplied with medicines for taking self-administration or when service users are reminded to take their medicines themselves.

For example:

- A service user who has suffered a stroke and is unable to manipulate containers may choose to retain custody of medicines and ask staff to assist at the time they choose to take the medicine.

- A service user may be able to safely manage external application of creams but may need staff help to administer tablets or other prescribed medication.

Staff undertaking assessments should liaise with the community pharmacist to ensure where possible, medicines are dispensed in a way that enables the service user to retain independence, for example: large print label, easy to open tops, Multi-Compartment Compliance Aids (MCAs) etc. (refer to 'Multi-Compartment Compliance Aids (MCAs)' section). Once assessments have taken place the responsibilities of the social care provider must be detailed in the service user's care plan.

Multi-Compartment Compliance Aids (MCAs)

There are increasing demands on GPs and community pharmacists to supply MCAs to assist patients to use their medicines correctly. The Royal Pharmaceutical Society (RPS) has published a report which includes guidance and recommendations for health and social care professionals. The report suggests, although MCAs may be of value to help some patients, they are not the best intervention for all patients and alternative options should be considered. Each service user's needs must be assessed on an individual basis by a pharmacist and any intervention must be tailored to the individuals' specific requirements.

Royal Pharmaceutical Society recommendations:

- In all cases, supply of MCAs under the Equality Act 2010 requirements should be on the basis that a Community Pharmacist considers it to be a reasonable adjustment.
- The decision to supply MCAs should only be made after taking all factors into consideration.
- The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to patients when there is not a specific need for a MCA.
- Service users who can safely self-administer their medicines should be encouraged to do so and where they are unable to do so, there must be appropriate training for carers so they are able to administer medicines from original packaging.
- Every patient identified as having medicines adherence issues should have a robust individual assessment to identify the best intervention based on their needs and the evidence currently available. This assessment should incorporate a clinical medication review, including reasons for non-adherence, medicines suitability and consideration of all possible options to support the individual.
- Where a service user's assessment indicates an MCA is the intervention of choice, it is important this is supported with the provision of information, appropriate counselling and follow up for the individual and the health or social care professional is aware of the legal, professional and practice considerations.

Levels 2 & 3: Supporting with medicines administration

Description of Level 2:

The service user is unable to take responsibility for their medicines, service users must agree to have the staff administer medication and consent must be documented in their personal care plan. If the service user is unable to give informed consent due to an assessed lack of mental capacity a best interests discussion must take place and be documented.

Description of Level 3:

Requirement is similar to Level 2. However Level 3 involves specialist techniques or invasive procedures, for example administration through a percutaneous endoscopic gastrostomy tube (PEG).

Level 3 can be performed by qualified and competent health care professionals or in exceptional circumstances, following an assessment by a healthcare professional (HCP), staff may be asked to administer medication at Level 3. This must only be done after staff have received training and competency assessment for the specific administration technique which will be on an individual basis by qualified health care professional.

Where appropriate, service users will receive relevant information about their medication so that an informed decision is made about their care.

Where service users are unable to self-medicate safely (level 1) , an assessment will be undertaken to determine the most appropriate method of supporting a service user, this could be by active participation or offering full support with administering medication.

Doses must not be varied or changed without written authority from a medical or non-medical prescriber involved in the service user's care. Such changes must be recorded on the Medication Administration Record (MAR) chart and in the service user's care plan.

Staff cannot action verbal instructions from a prescriber to change or initiate treatments for prescribed medicines. Written and signed confirmation, by safe haven fax/ secure email, must be received from the health professional before any alteration is made.

Social care staff will **not** assist service users to take medication, prescribed or non-prescribed, unless it is part of a comprehensive care plan (refer to 'Homely remedies' section).

In all care settings where it is agreed staff will administer medication (prescribed and non-prescribed) the medicines must be administered from the original package in which they were dispensed by the pharmacist or supplied by the manufacturer, adhering to the instruction on the label/ leaflet.

Medicines must never be 'secondary dispensed' i.e. taken out of their original container or package and put into another container for someone else to administer to the service user at a later time. In exceptional circumstances it may be appropriate to leave a dose out to support self-administration and when planned and authorised by a health professional.

For example: in domiciliary care, if it has been agreed with the service user and it is in the care plan, doses can be left out for that individual to take at a later time, e.g. sleeping tablet.

Medicines must only be given to the service user for whom they have been prescribed, labelled and supplied. They must not under any circumstance be given to other service users.

Staff must never alter pharmacy labels or stick pharmacy labels on to medication. If labels become detached or are illegible, the medicine in the container must not be given. Staff must inform the service manager or designated person. The service manager or designated person must seek the advice from a relevant HCP such as the supplying pharmacist, prescriber or if out-of-hours, advice from an out-of-hours service should be sought. This must take place immediately to ensure the service user does not go without their medication.

Crushing of tablets or the opening of capsules unless specified is not advocated, as it is an 'off licence' use of the medication. However with written authorisation from the prescriber and written guidance from a pharmacist, this is acceptable practice (refer to 'Off licence medication' and 'Covert medication' sections).

Medicines must not be forcibly given. This includes the crushing of tablets etc. into food or drinks in order to deceive (refer to 'Covert medication' section).

Medicines must never be used for social control or punishment.

In all care settings, staff must only assist with the administration of medicines when they have been trained and deemed competent to do the task. On-going refresher training must also be provided.

Training and competency

Staff will be encouraged to promote enablement where appropriate to allow service users to self-administer where possible. Or following an assessment, the service user will be supported with active participation or medication will be administered in a safe and correct manner by trained competent staff.

Service managers and staff must receive medication training preferably from an accredited learning provider; to ensure they are confident in handling and management of medication processes and procedures and to enable them to maintain the service user's health.

It is expected that staff who receive training will receive a certificate, a copy of this must be stored centrally within the service or at head office.

Service managers must ensure:

- The competence of their staff's ability to safely administer medication to service users.
- Staff who have completed approved training must be observed and supervised by a competent person before administering medication for the first time. This must be an occupationally competent person working for the provider and not the external trainer.
- Competency assessment should be direct observation or in exceptional circumstances questioning if it is not possible to demonstrate the task at that time e.g. how would support the service user if they had a medication which requires refrigerated storage?
- The initial assessment must be observed on 3 separate occasions, in order for competency to be signed off.
- The culture of their unit or organisation, values training and ensures that staff have a thorough understanding of the importance of medication to the health, safety and wellbeing of service users.
- Information in the medication policy is an integral part of service managers and team induction.
- All relevant staff undertake medicines training. This will involve theoretical based training but must also involve practical training and competency assessment in the place of work.
- All staff are confident and competent in their understanding of medication guidelines, protocols and procedures.
- Staff who lack confidence or whose competence is in doubt are supported through supervision and further training.
- Errors are investigated and consideration will be given to further training of staff (refer to 'Medicine errors and fair blame' section).
- Instruction is given on an individual basis from qualified health care professionals for tasks which constitute Level 3 medicines interventions that social care undertake for specific named service users e.g. administration of feeds via PEG tubes.
- Designated staff administer medicines only when they have had the necessary training and are assessed as competent.
- Additional training is provided to members of staff who require it in order to equip them with the skills and knowledge to effectively guide and support their team in the

safe handling of medication in the care setting. For example, service managers, supervisors etc. who need a higher level of knowledge than those they provide advice and guidance too.

- The care provider has a training matrix which is accurate, updated regularly, includes both training dates and competency assessment dates and has a way of alerting the service manager when staff training is nearing review.

Staff will:

- Receive training upon induction, regular refresher training and on-going competency assessments to ensure their competence.
- Receive an annual review of their knowledge, skills and competencies relating to managing and administering medicines. If there is a medicines related safety incident, this review may need to be more frequent.
- With regards to level 3 medicines administration staff will ensure they follow instruction from a qualified health care professional for specific named individuals and keep comprehensive records of the procedure undertaken.

Visiting Health Professionals will:

- Work to standards set by their professional body and ensure that they have the appropriate skills, knowledge and expertise in the safe use of medicines required to support service users living in the social care setting.

Training Standards:

- Skills for Care National Minimum Training Standards for Health Care Support Workers and Adult Social Care Workers in England 2013 (Qualification and Credit Framework Unit 80).
- Skills for Care Recommendations for CQC Providers – Medication Administration Training (standard 8) October 2014.
- Care Certificate Standards 2015. Standard 13.5 Understanding medication and healthcare tasks 2015.

Essential practice for all providers

In all situations, the following rules must be applied.

Providers must consider the following in a medicines administration process:

The 6 Rights of administration

1. **Right Service user**
    - Check service user name against the care plan, medication and (Medication Administration Record) MAR chart.
    - In care homes a recent photograph of the service user should be present to confirm identity.
    - In other care settings where a photograph is available it should be used to confirm identity.
    - If a photograph is not available intently must be verbally confirmed with the service user only, by asking them to state their name and date of birth.
    - Providers must ensure that medicines prescribed for a service user are not used by any other individual.
2. **Right Medicine**
    - Check service user's name against the medication label, MAR, packaging and contents (all must match).
    - Check strength is correct (Strength is the amount of drug in each dose form).
    - Check there have not been any recent changes to the medication.
    - Check the dosage instructions before giving medication.
    - Check the medication has not exceeded its expiry date.
    - Check for any additional labels and warnings.
3. **Right Route**
    - Check the way in which the medication is to be administered (e.g. oral, topical).
    - Staff may administer at level 3 when specified within the care plan and once they have received training and assessed as competent (refer to 'Training and competency' section).
4. **Right Dose**
    - Check the dose on both the MAR chart and medication label match (dose is the amount of medication to be given to the service user).
    - Ensure the dose has not already been administered by checking the MAR chart, if there is a discrepancy the service manager, key worker, or pharmacist must be consulted before the medication is given.
    - Record the actual amount given where a variable dose is administered (refer to 'The medication administration record (MAR)' section).

- Check that you have the right measuring device for liquid doses.

5. **Right Time**

- Check the administration time is clearly identified on the MAR chart and, or, the medication label. For example, '*Take one tablet in the morning'* clearly identifies when this medication is to be given. However *'take one tablet daily'* is open to interpretation, unless the dose column on the MAR chart is marked as to identify the time. If unsure contact the supplying pharmacy or service manager.
- Doses should be equally spaced throughout the day
- Check for any additional labels, warnings or specific instructions such as 'before food' or 'avoid grapefruit juice'.

6. **Right of the Service user to Refuse**

- The service user has the right not to take the medication (refer to 'Service user's right to refuse medication' section).

Do not give the medication if one or more of the above rights is incorrect.

Seek further guidance, initially from your service manager.

Dealing with medication is an important and high risk task. When staff are booking- in, checking or administering medication they must give it their full attention and should be free from all other responsibilities and directions at this time.

In the event of an untoward incident that colleagues cannot deal with, take a few seconds to lock the medication away; take the key with you and keep it on your person.

Service user's right to refuse medication

When an individual expresses a choice not to take a prescribed medication, the following actions must be taken:

- An entry must be made on the MAR and the staff must record the circumstances and reason why the service user has refused the medicine (if the service user will give a reason).
- The service manager or designated person must be informed, and they may seek further guidance from the prescriber, pharmacist or out-of-hours (the urgency will be dependent on the medication and the number of doses refused, refer to 'Time critical medication' section).
- A record of the decision made by the service user must be made in the service user's care plan.
- If the service user agrees; the carer, service manager or designated person must tell the prescriber about any on-going refusal and inform the supplying pharmacy to prevent further supply to the care home or person's own home.
- Medicines must **not** be forcibly given. This includes the crushing of tablets etc. into food or drinks in order to deceive (refer to 'Covert medication' section).

Before giving medication

- Inform the service user that their medication is due.
- Wash hands and any other utensils before use.
- Follow the 'six rights'.
- Use disposable non-latex gloves when appropriate, i.e. creams or cytotoxics. Providers must ensure that these are available for these purposes.
- Check for allergies detailed on the MAR chart. If no details provided on the MAR chart check the care plan, if not documented there check with GP surgery.
- Check verbally that the service user has not already taken or been given the medication.
- Check the dose has not already been administered by checking the MAR chart or if in an MCA that the medication is there. If there is a discrepancy staff must inform the service manager or designated person. The service manager or designated person must double check the discrepancy to establish if an error has occurred. If the service manager or designated person is unable to confirm if the medication has been administered or not, they must seek the advice from a relevant HCP such as the supplying pharmacist, prescriber or if out-of-hours, advice from an out-of-hours service should be sought. This must take place immediately to ensure the service user does not go without their medication.

When giving medicines

- Only administer medication the service user named on the label.
- Only administer medication from labelled bottles, containers or MCAs.
- Do not give medicines from unlabelled or illegibly labelled bottles, blister packs or containers.
- Do not transfer medication from their original containers. For example, removing the contents of a box resulting in separation from pharmacy label.
- Do not prepare medicines or drugs in advance of administration. Once prepared they must be given immediately or discarded.
- Do not leave medicines unattended for service users to take at a later time (unless agreed with prescriber, service user, it is risk assessed and clearly documented in the care plan).
- Do not handle medications directly when administering as far as is practicable.
- Do not give discoloured solutions, disfigured tablets or substances etc. These must be stored safely and returned to the pharmacist.
- Advice must be sought in the event that the medicine is unsuitable for use.

When administering liquids

- Shake the bottle by gently turning it upside down several times.
- When pouring, hold the bottle with its label on top so that the liquid falls away from the label.
- Pour into a measured dosage container appropriate for the volume of the drug to be given and appropriate to the requirements of the service user.
- Measuring devices include a graduated medicine cup, medicine spoons or an oral syringe with bottle adapter.

- When using a graduated medicine cup, ensure that the cup is placed on a flat surface and the liquid is poured into the cup and observed at eye level.
- If the medication is refused, the liquid medicine must never be poured back into the original bottle. It must be signed off as refused and disposed of safely (refer to the disposal section relevant to your specific service).

When applying external products

- Staff must wear disposable non-latex gloves when administering creams, ointments etc.
- If a service user is prescribed two or more external products for the same area, 15-30 minutes must be left between administering each product, unless directed otherwise by the prescriber.
- Corticosteroid creams and ointment need to be applied thinly; this will be stated on the label.
- When applying a moisturising cream or ointment these can be applied liberally.
- If instructions are unclear such as 'use as directed' staff must inform the service manager or designated person. The service manager or designated person must check if there is any written guidance on how to apply the external product available from the prescriber on record. If they are unable to confirm how to apply the external product they must seek the advice from a relevant healthcare professional such as the supplying pharmacist, prescriber or if out-of-hours, advice from an out-of-hours service should be sought. This must take place immediately to ensure the service user does not go without their medication.
- Information must be available to staff to know what the cream or ointment is for, where to apply, how much to apply and how long for.
- Apply creams and ointments to clean skin, and only to the area it has been prescribed for.
- The administration must be recorded.
- It is good practice to include a body map which indicates where the product should be applied.
- For external patches the site of application must be recorded and rotated in accordance with the manufacturer guidance and any instructions on the label. Take care not to touch the adhesive part of the patch.
- If a service user is prescribed two different eye drops to be administered at the same time 5-10 minutes must be left between administering each set of drops

'When required/PRN' medication

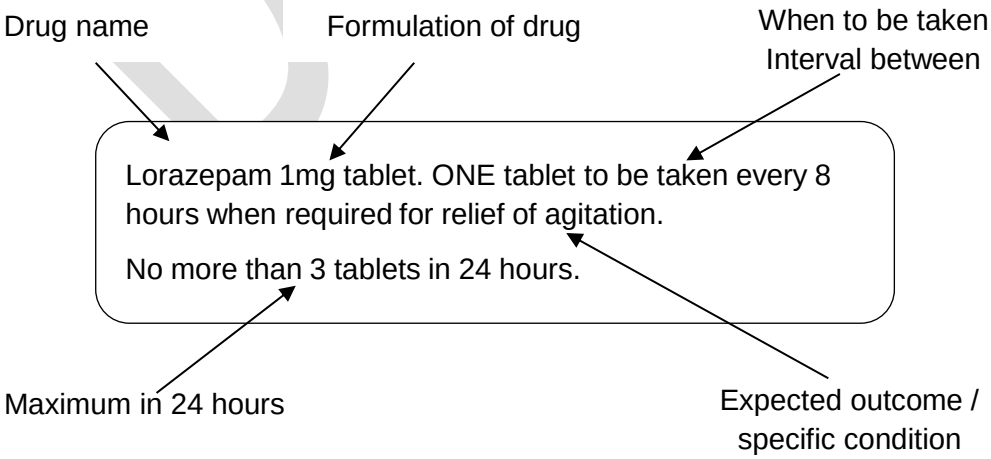
PRN is shorthand for an expression, rendered in Latin –"*Pro Re Nata*", which translates as "as need arises" and is used to communicate administration, is intended to be "as necessary" only.

- PRN medication must be available when the service user requires it and be supported by clear prescriber directions in the form of written instructions.
- Written instructions must be in place for a specific named individual. Examples of written instructions include: explicit directions on a pharmacy label; explicit instructions contained in a letter, secure email or note from the prescriber.
- The need to administer PRN Medication must be reflected in the providers care plan.

- For PRN medication written instructions should detail:
  - Name of service user and prescriber details
  - Describe the medication and route of administration
  - The condition or indication for which the medication needs to be administered and what the medicine is expected to do.
  - Dose to be given
  - Maximum dosage per 24 hour period
  - Minimum time intervals between doses
  - Name of prescriber.
- The written instructions must be kept with the MAR charts.
- Staff administering and auditing MAR charts will need to monitor the administration of PRN and take action if continual administration is taking place seek advice from a health care professional as a medication review may be necessary.
- Appropriate storage and use-by dates must be regularly checked.
- The administration of PRN medication must be clearly recorded on the MAR chart with the actual dose and time administered.
- Prescribed PRN medication must only be given to the service user it is prescriber for.
- If a patient is taking PRN medication, it can be carried forward at the end of the month to the next month and does not have to be discarded providing:
  - The medication is still being prescribed by the doctor at the same dose and frequency
  - The medication is in an original pack and within its expiry date
  - The care provider will have to indicate the quantity of medication brought forward to enable a stock check to be carried out.

The care provider will have to consider how it handles repeat prescriptions for PRN medicines. If stock of medication is carried forward, they will need to ensure medication is not requested with regular repeat medications. This will enable a cost effective approach and reduce the wastage and costs of medicines.

Good practice pharmacy label highlighting specific instruction regarding PRN medication:



When the medication has been given

Complete the MAR chart for each individual service user as soon as the medication has been administered. Records must be completed before moving to the next service user. The record must include the following information:

- Exactly what was given (name, strength, dose and form of the medication).
- When it was given (time, date)
- Who administered the medication
- When more information is required a code should be used on the MAR chart and further information written on the back of the MAR chart. For example to explain when and why medicines were omitted or refused. Codes will differ between MAR charts however there must be a key which explains what each code means.

The Medication Administration Record (MAR)

Any involvement in a service user's medication (reminding, preparing, or assisting), must be clearly documented in the care plan and all administration recorded on a Medication Administration Record (MAR) chart. This document serves as a legal safeguard for service users and staff, should anyone be asked to justify their actions.

Quality Standard:

The Care Quality Commission's Essential Standards of Quality and Safety Outcome 9 (Regulation 13) Management of Medicines require providers to:

- Have arrangements in place for recording when it is not possible for a person to self-administer their medicines.
- Have records of when medicines are given to the person.

By doing so this ensures compliance with section 20 regulations of the Health and Social Care Act 2008.

General Principles:

- A MAR chart must be in place for the social care worker to refer to when involved in the administration of medication to a service user.
- A paper based or electronic MAR chart must be:
  - Legible
  - Signed by care staff when and where appropriate
  - Clear and accurate
  - Factual
  - Correctly dated
  - Completed as soon as possible after administration
  - Avoid jargon or abbreviations
  - Easily understood by the service user, family or carer
- MAR charts must be available for other HCP to view (when necessary/appropriate). If electronic MAR charts are used, providers will need to consider how they will manage this.
- The purpose of a medication administration record document is to enable staff (and service users if appropriate) to trace the use of a medicine (including prescribed creams, eye/ear drops and homely remedies) from the time it is requested to the time it is administered or destroyed.

- Details of the service user's allergy status must be detailed on the MAR chart; if no known allergy this must be stated. The service user's allergy status must have been clarified on admission into the care setting and detailed in their care plan and updated as appropriate.
- The MAR chart primarily acts as a source of information so that staff and appropriate professionals can identify who administered a certain dose and at what time. The care provider should keep a record of medicines administered by visiting health professionals on the service user's MAR chart.
- The records will be an aid to correct administration of medicines, although they do not necessarily ensure that a person has actually swallowed a dose that has been offered.
- Medication administration records also help ensure all staff are aware of the quantity of medication present and will reduce over ordering of repeat prescription medicines.
- Responsibility for providing MAR charts rests with the care provider.
- The use of eMAR (electronic MAR charts) is an acceptable alternative and individual arrangements with a community pharmacy will need to be agreed. Considerations must be made to ensure eMAR charts are available for other HCP to view (when necessary/appropriate).
- Care providers must ensure MAR charts are updated in a timely manner to reflect any changes in the service user's medication following written confirmation for the prescriber or when a new medication is supplied by the pharmacy.
- If a community pharmacy supply printed or eMAR charts, liaise with them if you require changes for the next monthly cycle.

General Process:

- In addition to checking the medicines delivered, the information on the MAR charts must be checked for accuracy. Ensuring that any medicine changes during the previous month are reflected on the new MAR chart. Ensure quantities of carried-over medicines are entered onto the new MAR chart.
- Any change to a prescription must be supported in writing before the next dose is given.
- After administration, the MAR chart must be completed with the signature/initials of the staff or the appropriate MAR code. There must NEVER be any gaps present on the MAR chart.
- If a medication is not given for any reason (e.g. not available, service user refuses medication, or health care professional advises not to give the dose), it must be marked using appropriate MAR code and a log must be made on the reverse of the MAR chart, detailing the date, reason why it was not given/ taken and the signature of the staff.
- Any changes in dosage or discontinuations of medication must be authorised by the prescriber either on the MAR chart or by a written letter or fax, stored with the MAR chart
- The completed MAR chart must then be retained in accordance with the organisations retention of records policy.

- The MAR chart must be used to record any prescribed medication as well as any homely remedies approved by a prescriber or pharmacist (refer to 'Homely remedies' section).
- Any PRN or variable doses must be clearly recorded on the MAR chart with the actual dose administered (e.g. one or two). The time of administration must also be recorded.
- A cross reference must be added to the service user's MAR chart when a medicine has a separate administration record. For example 'see Warfarin administration record'.

Secure email and safe haven fax

If the directions for administration are not clear, clarification must be requested. If the community pharmacist cannot help with clarification, the prescriber must be contacted to confirm the directions. This should be provided to the social care provider in writing. This can be sent via safe haven fax or secure email. A copy of the written confirmation must then be kept with the MAR chart.

Prescribers should avoid using the term 'as directed' but can be asked to clarify directions when necessary.

Handwritten MAR Chart

- There must be no delay in treatment if a MAR chart is not available.
- Procedures must be followed to ensure the administration of the medication can be recorded on a MAR chart as and when the medication is given.
- If a MAR chart cannot be supplied by the community pharmacy, we advise the following process is followed to ensure administration of the medication can be recorded on a MAR chart as and when the medication is given to the service user.

General process:

- A blank MAR chart should be obtained if no current MAR chart exists.
- The medication must be transcribed by a suitable trained and competent staff, exactly as it appears on the pharmacy label, ensuring the quantity, drug name, strength of medication, form of medication, the dose and any specific directions are clearly handwritten onto the MAR chart. Example of a transcribed label:

28 Aspirin dispersible 75mg tablets	➔ Quantity, drug name (full), strength, form
Take ONE daily	➔ Dose, how to take and how often
Take with or after food	➔ Additional instruction, caution or warning

- A date must also appear on the MAR chart making it clear when it was started.
- The MAR chart and medication to be administered must then be passed to a trained colleague for a second check to confirm all of the details are correct.
- Two signatures must appear next to the handwritten item and only when these two signatures are present, should this medication be administered. The signatures must NOT interfere or cause confusion with the details of the medicine.

- In social care settings where only one staff is present they should write the MAR chart, take a break and complete a different task, then recheck before administering medication or providers should ensure a second check is facilitated/available.

Expiry dates of medication

Every pharmaceutical product has an expiry date that is stated on the packaging, pharmaceutical products must not be used after their expiry date.

The use of the product past its expiry date may result in a lower active ingredient or changes to the product that may cause the service users discomfort or be a safety hazard due to microbial contamination or toxic changes to the products.

The opening date of short dated items such as: liquids, eye drops, creams and ointments must be recorded on the product when first opened and they must not be used after their expiry date. Medicines listed below must always have the date of opening written on the container (not outer box) and generally once opened should be replaced as follows (unless the medication states differently, see Patient Information Leaflet (PIL) or as advised by the pharmacy):

- Eye/Ear/Nose preparations after 28 days
- Cream/Ointment in large tubs (with no pump dispenser) after 28 days
- Cream/Ointment in tubes or pump dispensers after 3 months
- Oral liquid (in original packaging) after 6 months

Where staff are uncertain of the shelf-life of a particular medicine once opened, they must check the information supplied with the medicine or contact a pharmacist for advice.

Infection control best practice advice for the use of external preparations such as creams and ointments in all social care settings includes the requirement that:

- All creams should be used for a named service user only.
- Non-latex gloves must be worn when applying creams and ointments.
- Expiry dates should be checked at each use.
- Creams in pots should be discarded if they appear to be contaminated, you have any concerns about their appearance, or if the lid has been left off for an indeterminate period.

Time critical medication

Some medications are time critical; they must be given within a specific time frame as a delay in administration could pose a risk to the service user. For example: Parkinson medication, Antiepileptic agents, Insulin, Opiates, Antipsychotics (list it not exhaustive).

Where the prescriber has specified times on the directions these **must** be adhered to, if it is not possible to administer the medication at the specified time the service manager or designated person must be informed who must seek advice from the prescriber.

Some medications require a set amount of time between doses to be given safely. For example: Paracetamol requires at least 4 hours between doses and no more than 4 doses in

24 hours. If it is not possible to administer the medication with the required time gaps the manager must be informed who must seek advice from the prescriber.

Omitted medication

If a dosage of a regularly prescribed medication is intentionally omitted by staff administering the medication, for any reason e.g. not giving lactulose because the service user has developed diarrhoea, the following action must be taken:

- An entry must be made on the MAR chart.
- A record must be made in the service user's care plan.
- If medication is omitted frequently and/or repeatedly the service manager or designated person must be informed. Non-clinical staff must ensure they inform the service manager or designated person on the same day the medication is omitted. The service manager or designated person must seek advice from a relevant HCP if necessary.
- If the medication is time critical staff must inform the service manager or designated person. The service manager or designated person must seek the advice from a relevant HCP such as the supplying pharmacist, prescriber or if out-of-hours, advice from an out-of-hours service should be sought before intentionally omitting a dose.
- For medication which has been accidently omitted refer to 'Medicines errors and fair blame' section.

Adverse effects and allergies

Information about adverse effects of medicines that have been communicated by the prescriber or pharmacist to staff must be shared with all staff, as appropriate, and recorded on the service user's care plan and MAR chart.

If staff notices adverse effects then they must contact a HCP such as the pharmacist, prescriber or out-of-hours service to seek advice and report this to the service manager or designated person.

Sometimes an adverse effect will be an allergic reaction; some allergic reactions are extreme such as anaphylaxis. Severe allergic reactions are life-threatening and are a medical emergency which require immediate treatment. Symptoms include life-threatening airway and/or breathing difficulty/ rapid facial swelling. Blood pressure can drop rapidly causing dizziness/fainting, if an extreme allergic reaction occurs the staff must call 999 immediately.

Report any adverse effects of medicines to the Medicines and Healthcare products Regulatory Agency's via the Yellow Card Scheme.

https://yellowcard.mhra.gov.uk/

Problems with medication

Difficulties staff may encounter:

- Medication arriving in unlabelled or incorrectly labelled containers
- Medication labelled PRN (as required) where it is not clear what may trigger the requirement for the medication to be given.
- Dosage instructions are not explicit.

- Gaps on MAR charts (e.g. error by previous staff who did not sign after administration)
- A service user who refuses to take the medication
- A service user who does not take all the dispensed dose- spat out/spilt/ refused.
- Medication has run out or supply has been exhausted
- Medication is out-of-date
- Medication errors (refer to 'Medicines errors and fair blame' section).

This list is not exhaustive

- If there is a problem with a service user's medication and you are unsure, don't guess; inform your service manager or designated person who may need to seek advice from a relevant HCP such as the supplying pharmacist, prescriber or if out-of-hours, advice from an out-of-hours service. This should take place immediately to ensure the service user does not go without their medication.

Medicines errors and fair blame

If a medication error occurs or the correct procedures are not followed this could result in an error occurring or near miss, it must be reported to the service manager or designated person immediately. A medication administration incident form will need to be completed and acted upon to identify the cause and prevent the error recurring.

Examples of medication errors: wrong medications given, missed medications, dosage errors, timing errors, administration contrary to instruction (e.g. with food, instead of without).

If an error occurs:

- This must be reported to the service manager or designated person and if required, seek medical advice from a pharmacist, the service user's GP, out-of-hours, 111 or 999 depending on severity of error.
- Follow advice and instructions given.
- Inform the service user and/or nominated representative and their carer what has happened.
- Record the incident on the MAR chart detailing the error.

Staff who report errors immediately will be supported. All members of staff have an important role to play in risk identification, assessment and management. To support staff in this, a fair and consistent working environment must be provided that does not seek to apportion blame. This should encourage a culture of openness and willingness to admit mistakes. Staff are therefore actively encouraged to report any situation where things have, or could have gone wrong.

When errors are reported or identified, the appropriate service manager or designated person will undertake a fact-finding audit with the intention of ensuring remedial action.

Errors and near misses must be reviewed regularly to identify themes and trends and support staff who may require further medication training. All staff require refresher training annually but if there is a medicines related safety incident, this review may need to be more frequent.

If it is found from the investigation that staff have not followed guidelines and safe practice or have acted illegally, maliciously, negligently or recklessly in line with their duty of care, an investigatory interview may be undertaken in-line with disciplinary procedures.

Medicines-related incidents (safeguarding and care concerns) must be reported to the Integrated Adults Safeguarding Unit as per the threshold outlined within the Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Good Practice Guidance.

Halton's Safeguarding Unit can be contacted for advice on 0151 907 8306 or out-of-hours 0345 050 0148.

Providers must have a clear process for reporting medicines-related safeguarding incidents under local safeguarding processes and to the Care Quality Commission (CQC).

There is no requirement to notify CQC about all medicines errors, but a notification would be required if the cause or effect of a medicine error met the criteria to notify one of the following:

- A death
- An injury
- Abuse, or an allegation of abuse
- An incident reported to or investigated by the police
- Where relevant, you should make it clear that a medicine error was a known or possible cause or effect of these incidents or events being notified.

Reviewers of the medication incident will use the thresholds guidance contained within the Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Good Practice Guidance to identify the level of consequence and severity of the incident and subsequent actions that are required to be taken by the service manager or provider.

Medicines reconciliation and transfer between care settings

Reconciliation:

The service manager or the staff responsible for a resident's transfer into or out of a care setting must coordinate the accurate listing of the service user's medicines (medicines reconciliation) as part of a full needs assessment and care plan. They need to consider the resources needed to ensure that medicines reconciliation occurs in a timely manner.

Providers of health or social care services should ensure the following information is available for medicines reconciliation on the day that a service user transfers into or from a care setting:

- Service user's details, including full name, date of birth, NHS number, address and weight (where appropriate, for example, frail older individuals).
- CareFirst6 case file number (if available).
- GP's details.
- Details of other relevant contacts defined by the service user and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse, any persons with lasting power of attorney).
- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced.

- Medicines the service user is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known.
- Changes to medicines, including medicines started, stopped or dosage changed and reason for change if available.
- Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines).
- Other information, including when the medicine should be reviewed or monitored, and any support the service user needs to carry on taking the medicine (adherence support).
- What information has been given to the service user and/or family members or carers.
- Details of any recently omitted or refused medication.
- Details of when PRN medicines have been administered including dose and time.

Providers must ensure that the details of the person completing the medicines reconciliation (name, job title) and the date are recorded.

Providers must have a process in place for recording the transfer of information about service users medicines during shift handovers and when individuals move to and from care settings. For example, the medicines log/communication book can be used.

Errors in medication reconciliation must be recorded, reported and investigated (refer to 'Medicines error and fair blame' section)

Service user being transferred to hospital:

Effective communication between primary and secondary care is essential to ensure the correct information is transferred with the service user on admission and discharge from hospital.

The following should be provided upon admission:

- A copy of the current MAR chart including page numbers, for example page 1 of X.
- Details of service users allergies and reactions, if no known allergies this must be clearly stated.
- Other useful information to provide to the hospital when applicable include:
  - INR information
  - Date and site of most recent patch application
  - Recent weight
  - Due date of medication which is administered infrequently but on a regular basis, for example monthly or three monthly injections etc.
- Current medications in original containers, labelled with service user details and with clear expiry dates.
- Controlled drugs and medication in MCAs should **not** be provided unless they include 'time critical' medications (refer to 'Time critical medication' section).
- The medication and documents should be placed in a bag and labelled with the service users details to ensure all information and medications are kept together in one place.
- During the service users stay in hospital mark the MAR chart with the appropriate code (e.g. code H) to indicate in hospital.

- Do not re-order any repeat prescriptions for this service user as a review of the medication will take place in hospital and things may change.
- Contact the community pharmacy if repeat prescriptions have already been ordered, they may be able to return the prescriptions to the prescriber and prevent waste. If the medication still arrives you must remove them from the system, do not use and store safely within the medication room. This is because the medication that the service user returns from hospital with is the current medication regime to be followed.

Service user being transferred to other care setting:

- A copy of the current MAR chart including page numbers, for example page 1 of X.
- All current medications including blister packs, original containers, controlled drugs and topical medications must be sent with the service user.
- Details of service users allergies and reactions, if no known allergies this must be clearly stated.
- Other useful information to provide to the care setting when applicable include:
  - INR information
  - Date and site of most recent patch application
  - Recent weight
  - Due date of medication which is administered infrequently but on a regular basis, for example monthly or three monthly injections etc.
- The medications must be placed in a bag and labelled with the residents details to ensure all information and medications are kept together in one place.
- Where the transfer of medication involves controlled drugs provisions must be in place to ensure the correct legal processes are followed (refer to the controlled drug section relevant to your service).

Transferred from care setting with MAR chart:

- On arrival to the care setting, medications should arrive with a MAR chart.
- Contact GP surgery for up to date list of service user's medication.
- Check-in the medication on arrival against the MAR chart and the up to date medicine list from the GP surgery.
- Remember to check for any medication supplied from hospital clinic or specialists i.e. memory medication.
- Remove any medications that are either discontinued as per MAR chart and any medications that have been transferred with the service user but are not currently in use.
- If there are any discrepancies between the medication received and the MAR chart and the list provided by the GP surgery the service manager or designated person must be informed. The service manager or designated person **MUST** contact the previous care setting immediately.
- Do not ask the GP for a prescription in order to have medications packed into a MCA for ease of administration by staff.
- Place the medications in to the relevant system such as trolley/storage area that will be used.

- If there is uncertainty over who will be responsible for prescribing the future supplies of medicine you must clarify this in advance of the service user running out to prevent delay in treatment.
- Where the transfer of medication involves controlled drugs provisions must be in place to ensure the correct legal processes are followed (refer to the controlled drug section relevant to your service).

Transfer from care setting without a MAR chart:

- Contact the previous care setting to inform them that no MAR chart had been provided with the medications.
- Contact GP surgery for up to date list of service user's medication.
- Check-in the medication on arrival against the up to date medicine list from the GP surgery.
- Check for any medication supplied from hospital clinic or specialists, e.g. memory medication.
- If there are any discrepancies between the medication received and the list provided by the GP surgery you **MUST** contact the previous care setting immediately.
- Handwrite a new MAR chart (refer to 'Handwritten MAR chart' section).
- Place the medications in to the relevant system such as trolley/storage area that will be used.
- Place the handwritten MAR chart in the service users section of the MAR chart file.
- Do not reorder medications to be put in a MCA just for ease to replace dispensing from the original packs. Only reorder supply when stocks are running low.
- Re-order as per current medication regimen.
- Where the transfer of medication involves controlled drugs provisions must be in place to ensure the correct legal processes are followed (refer to the controlled drug section relevant to your service).

Transfer of care from hospital setting:

- It is very unlikely a hospital will provide a MAR chart on discharge however you should receive a discharge letter with the medication.
- If no discharge letter transferred with service user contact the hospital ward immediately
- Handwrite a new MAR chart – **DO NOT** amend a printed MAR chart that was in use prior to admission (refer to 'Handwritten MAR chart' section).
- Place the medications in to the relevant system such as trolley/storage area that will be used.
- Place the MAR chart in the service users section of the MAR chart file.
- Do not reorder medications to be put a MCA just for ease to replace dispensing from the original packs. Only reorder supply when stocks are running low.
- Re-order as per discharge letter and **NOT** an old repeat prescription prior to admission.

- Where the transfer of medication involves controlled drugs provisions must be in place to ensure the correct legal processes are followed (refer to the controlled drug section relevant to your service).

Medication review

- Health and social care practitioners should agree how often each resident should have a medication review. They should base this on the health and care needs of the resident.
- The frequency of planned medication reviews should be recorded in the resident's care plan.
- The interval between medication reviews should be no more than 1 year.
- Social care providers may need to prompt the service user to make an appointment or arrange an appointment on behalf of the service user for their medication review.

Homely remedies

- A homely remedy is a medicinal preparation used to treat minor ailments which can be bought over the counter and does not require a prescription.
- It is permitted that a small range of products may be kept in stock in a care service for individual service users for the treatment of minor ailments.
- If the resident self–administers the homely remedy a risk assessment would need to be completed and kept with their care plans.
- Where a care service provider offers service users treatments for minor ailments with homely remedies, advice from a HCP, such as a GP or pharmacist, should be taken for each service user in advance, or at the time of need. Advice should include:
  - Which medicinal product may be administered and for what indication it may be administered.
  - Which service users may be excluded from receiving specific homely remedies and the reason why, e.g. paracetamol is not given to a service user who is already prescribed paracetamol containing product.
  - The dose and frequency.
  - Maximum daily dose.
  - Duration of use before referring the service user to a GP.
- When seeking advice from the HCP the following must be discussed:
  - Past medical and drug history.
  - Any known allergies.
  - What the service user has used in the past for these particular symptoms
  - The service user is aware that the medicine is not prescribed
- If advice is taken in advance it should be clearly documented and reviewed periodically, especially if there are changes to prescribed medication. The record should identify which homely remedies are appropriate for an individual service user. This should be kept either with their care plans or with their current MAR chart.
- Homely remedies should be given for a limited period, usually 48 hours or the agreed period with prescriber/pharmacist.
- Homely remedies must only be administered for minor self-limiting ailments, which would not normally require consultation with a doctor. If in doubt advice can be sought from a pharmacist.

- It is the responsibility of the service manager, designated person or duty nurse to check the administration of a homely remedy is appropriate including checking that the service user has no potentially serious symptoms which require further medical intervention.
- If there is any uncertainty the prescriber or pharmacist must be consulted and the discussion documented.
- The service manager, designated person or duty nurse will regularly review and reassess the service user's response to the medication in line with advice and service user care plan.
- Further doses can be administered in accordance within the medicinal product's licence guidelines for a maximum of 48 hours or the agreed period with prescriber/pharmacist.
- If the symptoms persist a doctor must be contacted for advice on whether to continue treatment.
- Only the named preparation agreed by the prescriber or pharmacist may be administered without a prescription.
- Homely remedies should be stored in the same location as all other medication but designated clearly to show they are not patient specific.

Record keeping:

- The service manager, designated person or duty nurse must record the details of the assessment, homely remedy administered and outcome in the service user's care plan
- All administered doses of homely remedies must be recorded on the MAR chart as well as signing them out of the homely remedy stock book. Medication details should be handwritten onto the MAR chart with a second check from another carer or nurse.
- The homely remedy name, dose, date and time administered must be recorded on the MAR chart.
- A running total of homely remedies will be kept to enable processes to be audited.

Oral Anticoagulant therapy

Anticoagulant therapy includes medications such as warfarin, rivaroxaban, edoxaban, dabigatran and apixaban. These are use treat and prevent harmful blood clots in the body.

It is important that service users taking warfarin have their International normalised ratio (INR) checked by the anticoagulation clinic at regular intervals in line with National Patient Safety Agency guidance. The results of this test will be used to confirm the dose taken or to adjust if necessary.

General Principles:

- When anticoagulant treatment starts, the service user must be given verbal and written information from the prescriber or clinic, and this must be updated when necessary. The care workers must fully understand its contents.
- Social care providers should be prepared to produce records about blood tests when they request a prescription for warfarin or collect the medicine from a pharmacy on behalf of the service user.
- Doses of warfarin should be written as milligrams (mg). Warfarin tablets come in different strengths. If you confuse the number of tablets with mg, the service user

could get the wrong dose which would place the service user at risk of harm e.g. internal bleeding, stroke.

- All dose changes for warfarin must be confirmed in writing by the anticoagulation clinic.
- It is safe practice to attach the written confirmation of the warfarin dose, supplied by the clinic, to the MAR chart. Only accept a verbal message to change the dose in an emergency, and always ask for written confirmation as soon as possible.

General Process:

- Written instructions must be in place for the dose of warfarin to be administered.
- The warfarin dose must only be administered if clear written dosing instructions are provided.
- This may be in the form of a fax, yellow booklet, or letter from the anticoagulant clinic.

If a dose of warfarin has not yet been received from the anticoagulation clinic, the service manager or designated person must be contacted and they must then contact the clinic or practitioner for advice on appropriate action to be taken.

The maximum interval between INR checks of a service user is 12 weeks. Many service users will require more frequent INR checks, this is patient specific. Attendance for INR checks should be as instructed by the anticoagulation clinic.

Things to be aware of:

- Warfarin interacts with a number of other medications, additional blood tests may be necessary if the person has other medicines that interact with the anticoagulant.
- Warfarin interacts with a number of foods so a consistent diet should be eaten so that the effect of food does not vary too much.
- Staff supporting or administering warfarin to service users must fully understand the contents of the “National Patient Safety Agency Oral Anticoagulant Therapy Important information for patients” yellow booklet.
- Warfarin is regularly monitored to ensure appropriate doses are given. However staff should be aware of the signs and symptoms of bleeding and what to do if these occur.

Serious symptoms and signs of bleeding:

- Prolonged nose-bleeds (more than 10 minutes), blood in vomit, blood in sputum, passing blood in urine or faeces, passing black faeces, severe or spontaneous bruising, and unusual headaches.
- Bleeding might not be due to warfarin overdose but any of the above are experienced seek medical advice and request an urgent INR test.

Covert medication

Definition of Covert:

‘Covert’ is the term used when medicines are administered in a disguised format without the knowledge or consent of the service user.

The practice of offering medication covertly, for example in food or drink, must only be done using lawful practice as per the Mental Capacity Act (2005) and with appropriate documentation which clearly states the decision reached and the reasoning behind it.

All decisions about covert medication should be guided by the five core principles of the Mental Capacity Act (2005).

For further information and resources see the NHS Halton CCG 'Best Practice Guidance: Covert Administration of Medicines in Adult Health & Social Care Settings' document.

General Process:

The following points must be considered before administering a medicine covertly:

Necessity:

- Have all other administration options been considered for example: change of form to dispersible tablets or liquids, time of administration.
- Is the treatment essential, does it need to be given covertly?
- Practitioners should base their clinical decisions on an individual patient basis.

Capacity:

- Does the service user have the capacity to decide about medical treatment?
- The service user must have been assessed in accordance with the Mental Capacity Act 2005. This process must be relating to the specific task at the specific time and clearly documented.

Benefit:

- Treatment must be for the benefit of the service user and not to benefit others.
- Are there any potential risks or possible adverse effects that might be caused by administering the medicine covertly? Risk should not outweigh the clinical benefit, e.g. change in absorption or risk of service user tasting medicine and then refusing all food and drink.

Least restriction of freedom:

- Is the covert method the best way to achieve administration of medication?
- If medication is given covertly this must be detailed in their DoLS if one is already in place.
- A DoLS must be in place if any medication administered covertly alters mental state, mood or behaviour, and if it restricts a service user's freedom.
- Is the chosen method for covert administration the best way of administering medication to the service user and also causes the person the least distress?

Take the service user's past and present wishes into account:

- Has an Advance Statement been made? This may include specific instruction about life sustaining medication.
- It is important to take into account anything the service user may have said to family and friends or involve independent advocacy.

Consideration must also be made of ethical, cultural or religious beliefs. Consult others:

- Has there been full discussion within a multidisciplinary team (MDT) with expert pharmacy guidance? Example people involved in MDT: GP, later life and memory

service (LLAMS), pharmacist, carer, social worker, family or Independent Mental Capacity Advocate (IMCA).

Encourage the service user to use existing skills:

- Have all means of communication been explored?
- The service user should have every opportunity to understand the need for medical treatment and communicate decisions.

Registered service managers will ensure that:

- The use of covert administration must be included in the care plan once the MDT has decided it is in the service user's best interest. The decision must be communicated in writing and countersigned by all members of MDT.
- The proposed treatment and possible methods of administration have been discussed with a pharmacist who will need to consider the pharmaceutical stability of the medication in relation to the covert administration method proposed.
- Medicine must not be mixed in food or drink, crushed or opened without the written instruction from a pharmacist. Any person giving crushed tablets or opened capsules to a service user without directions and without making the appropriate checks could be held liable for any harm caused.
- The treatment plan should initially be subject to frequent review, on an individual service user basis, if the requirement for covert medication remains, full review must take place at least 3-monthly.
- The method of administration should be clearly recorded on the MAR chart and these directions accurately followed.

Safe handling of cytotoxic medication

Cytotoxic drugs describe a group of medicines that contain chemicals which are toxic to cells, preventing their replication or growth, and so are commonly used to treat cancer or other disorders such as psoriasis and rheumatoid arthritis. The toxicity of the cytotoxic drugs means that they can present significant risks to those who handle them.

General Principles:

- Occupational exposure can occur when preventative measures are inadequate.
- Exposure may be through skin contact, skin absorption, inhalation of aerosols or drug particles, ingestion and needle stick injuries (not relevant in the case of care staff), resulting from the following activities:
  - Drug preparation
  - Drug administration
  - Handling patient waste
  - Waste disposal
  - Cleaning spills

General Process:

- The risks must be identified. This needs to include identification of the cytotoxic drug that is being handled and the potential adverse effects on health. If you are unsure you **must** contact the community pharmacy.

- The groups of workers who may be at particular risk must be identified. For example, trainees, new and expectant mothers. Pregnant workers are especially at risk as some drugs could be harmful to the unborn child.
- The risk must be evaluated. The likelihood of the cytotoxic drug causing ill-health should be assessed. A decision should be made to determine whether existing precautions are adequate or whether more should be done.
- This risk assessment must be recorded and it is good practice to review the assessment periodically to ensure that precautions are still suitable.

The following measures must be considered:

Personal protective equipment (PPE)

PPE (gloves and disposable apron) must be provided and used wherever risks cannot be controlled in other ways. Staff must be trained in the correct use of PPE and it must be adequately maintained and stored. Women of child-bearing age who are being asked to administer cytotoxic medication must be informed of the fact that exposure to a cytotoxic may harm an unborn baby.

Dealing with spillages and contamination

Staff who are handling cytotoxics or contaminated waste must be familiar with clear procedures as advised by a pharmacist. Cytotoxic medication must **never** be crushed or broken and any spillages must be dealt with promptly. Staff and service users should wash hands thoroughly following the administration of oral cytotoxics.

Waste disposal

Procedures must be in place for the safe disposal of waste following the administration of cytotoxic medications. All relevant staff must be familiar with these procedures. Cytotoxic drugs must never be disposed of in an ordinary waste bin. Care homes with nursing provision will need to obtain a cytotoxic waste disposal bin from their waste contractor to dispose of oral cytotoxics. Care homes without nursing will need to return the oral cytotoxic tablets to the pharmacy for disposal. They should be put in a sealed container clearly marked with the drug name and 'for disposal'. It is important to consider that excreta (urine/faeces/sweat/etc.) from treated patients may contain unchanged cytotoxic drugs or active metabolites. The safe precautions regarding PPE and safe disposal must be followed when handling body fluids, faeces or contaminated clothes for up to seven days following the last dose.

Information, instruction and training

Staff handling cytotoxic drugs must be given appropriate information, instruction and training relevant to their work. Staff must be aware of the risks of working with cytotoxics and the necessary precautions.

Reporting incidents

The spillage of any cytotoxic drug to which people could have been exposed must be reported on an incident report form and the service manager informed immediately.

Off licence medication

Definition of 'off licence':

Drugs may be used outside the terms of their product licence, e.g. a medication which is still being clinically trialled or for an indication not listed in the patient information leaflet. When a tablet is crushed or a capsule opened this can also be deemed “off licence” as the pharmaceutical company cannot then guarantee the quality, safety and efficacy of the medicinal product.

- Service users receiving “off licence” medication should be given sufficient information about the medicines prescribed, by the prescriber, so that they can make an informed decision.
- Prescribing unlicensed medicines may be necessary where:
  - There is no suitable licensed medicine that will meet the service user’s need
  - Or where a suitably licensed medicine that would meet the patient’s need is not available.
- The service user’s GP and/or pharmacist must be contacted to ensure that all other alternative forms of medication are explored before the decision is made to crush a tablet or open a capsule.
- In most cases there are alternative options to crushing tablets and opening capsules. For both service user and carer safety, these will often be more appropriate. It should be determined by the prescriber or pharmacist if there is a licensed liquid preparation available.
- If a GP or prescriber advises that a tablet should be crushed, this should be put it in writing, following advice from a pharmacist.
- A tablet can only be crushed or capsule opened with the written authorisation of the prescriber or formal directions on the label, for example ‘to be crushed and added to 10-20ml water’
- Tablets should not be broken in half unless scored
- Medication should generally be taken straight away.
- Medicine must not be mixed/placed in food or drink, crushed or opened without the written instruction to do so from a pharmacist. Any person giving crushed tablets or opened capsules to a service user without directions and without making the appropriate checks could be held liable for any harm caused.
- The written instructions must be kept with the MAR charts.
- When used “off licence” the manufacturer may assume no liability (or refuse to accept liability) for any ensuing harm that may come to the recipient.
- If the service user has swallowing difficulties this must be regularly assessed and appropriate action taken if there are any changes, with the potential of swapping back to tablets/ capsules. Speech and language team (SALT) can be contacted for advice on: 01928 593765.

Oxygen

Care settings are increasingly being asked to accommodate service users who use compressed oxygen gas. Oxygen is a prescribed item and must only be used as directed by the prescriber for the service user it is prescribed for. Oxygen rich compounds are highly flammable and as such oxygen represents a risk and action must be taken to safely control these risks.

Control Measures

Compressed oxygen cylinders should only be allowed on Council premises when absolutely necessary. If a service user requires personal oxygen, a suitable and sufficient risk assessment MUST be undertaken prior to use. It must be recorded and control measures introduced.

The results of the risk assessment, the control measures put in place and any relevant information must be communicated to staff and other relevant persons.

The prescriber should give specific instructions on oxygen use. The supplier should give advice on storage, valve operation etc. all staff using the apparatus should be deemed competent prior to usage.

Fire Risk

Materials burn much faster in oxygen than in air alone, it is therefore important that service users and staff supporting the service user:

- NEVER smoke or let anyone else smoke near them when using the oxygen equipment, this includes E-Cigarettes.
- NEVER charge an E-Cigarette or similar device close to them when using the oxygen equipment or near the equipment itself.
- NEVER use the oxygen equipment near an open fire or naked flames, such as matches, lighters, gas cookers or candles.
- NEVER use the oxygen near other heat sources such as electric or gas heaters or boilers.

Oxygen Saturation (Enrichment)

When oxygen equipment is turned on, oxygen can build up unnoticed on materials such as clothing, hair, fabrics, wood and paper. This can cause them to burn more easily if they catch fire. Because of this, service users and staff supporting the service user must:

- ALWAYS turn off oxygen equipment when they are not using it.
- ALWAYS use or store oxygen equipment in a well-ventilated area.
- NEVER place oxygen equipment near curtains or cover it with coats, blankets or other materials that may restrict the air circulation around it.
- NEVER leave the cannula or mask on the bed or chair when oxygen equipment is switched on.

Storage and Usage

Service users and staff supporting the service user must ALWAYS follow the advice given to them by the supplier about the safest place to store and use their oxygen equipment. It is important that they:

- ALWAYS ensure the oxygen equipment is stored in a well-ventilated area, kept upright, kept clean, dry and away from any sources of heat or fire e.g. convection heaters, gas or electric fires and cookers.
- NEVER store the oxygen equipment close to paint, oil, grease or any domestic heating gases.
- NEVER keep combustible materials near the oxygen equipment e.g. newspapers and magazines and other items that may burn easily.
- ALWAYS store full and empty cylinders separately.

- ALWAYS have warning signs posted in a prominent position, making the location of the oxygen cylinder(s) clearly visible when stored or in use.
- This information applies to all places where service users store or use their equipment, and when travelling with it.

Oils and Grease

- NEVER use oils or grease near oxygen equipment.
- NEVER use oil based creams such as Vaseline when using oxygen equipment.
- ONLY use water based soluble creams or products.
- ALWAYS make sure hands are clean when using their oxygen equipment.

Fire and Rescue Services

The details of oxygen storage and use must be shared with the local Fire and Rescue Service so that in the unlikely event of a fire, the Fire and Rescue Services know that oxygen equipment is at the address.

Managing personal and sensitive information

Supporting and managing medications as part of your social care role involves direct access to personal and sensitive information. Council run services will ensure that all medicines records and information complies with the council's Data Protection Policy (link available for Council staff). Where the provider is not the Council, the service provider will ensure that their internal policies comply with the Data Protection Act 1998.

Additional guidance

Time of administration:

- The time of administration must be carefully considered and be responsive to a service user's need and wishes. A personalised approach must be taken rather than focusing medication rounds based on meal times or driven by staff needs.
- Thought must be given to medicines which contain special administration directions. For example, take on an empty stomach.
- Thought must be given to location in which medicines are administered. For example, eye drops or inhalers may not be appropriate to be administered at the dining table.
- Thought must be given as to why the medication is being given as this may influence when it is administered. For example, a resident may choose to stay up to watch TV and go to bed at 11pm, therefor administering a sleeping tablet at 8pm would not be appropriate.

Additional consideration:

- Staff must never pass the medication on to another member of staff to give.
- Medication must never be prepared in advance of administration. You must always check that the service user is awake and ready to accept their medication.
- If a service user is not in their room or in the expected location they must be located and receive their medication, do not omit the dose.
- Staff must only sign the MAR chart if they have administered the medication or if they were required as a witness or second check.

Retention of records:

- On discharge from the service it is a requirement that records (including MAR charts) are retained for 3 years in a secure location as per the Data Protection Act.
- Controlled drug registers must be kept for a minimum period of 2 years after they have finished being used.

Death of a service user

As per advice within 'The handling of medicines in social care' (Royal Pharmaceutical Society), in the event of a death, all medication (including prescribed, homely remedy and topical preparations) must be retained for at least seven (7) days. The medication may be required for evidence by the Coroner as part of their on-going investigation.

Essential practice for care homes

NOTE: All staff working in a care home setting MUST also read 'Essential practice for all providers'

Service Manager Responsibilities

The service manager has overall responsibility for:

Ensuring compliance with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 12(2)(f) and 12(2)(g), the Royal Pharmaceutical Society's eight principles and the NICE guidelines on Managing Medicines in Care Homes.

Ensuring systems and procedures around medicines management are implemented and followed.

Determining the best system for supplying medicines to each service user based on their individual circumstances, with the aim of maximising independence where possible. The above can be achieved by monitoring and auditing the systems and procedures in place, which includes:

- Undertaking or overseeing the monthly process of ordering and booking in the prescribed medication supplied by the community pharmacy against those items ordered.
- Undertaking weekly audit of controlled drugs against the register.
- Carrying out monthly audits of the completed medication cycles on the MAR charts.
- Undertaking monthly audits of homely remedy stocks.
- Ensure all staff are competent and medication training is up-to-date.
- Carrying out annual medication competency assessments of all staff involved in administration of medication.
- Undertaking or overseeing the reporting of medication errors where the safeguarding threshold was not reached (care concern) and ensuring appropriate action is taken to prevent further errors occurring – evidencing the wider learning from the concern, to minimise the risk of it reoccurring in the future.
- Ensuring that every service user has a medication assessment and an individualised medication information sheet in place.
- Making a referral to safeguarding if the safeguarding threshold is reached.
- Reporting to CQC any untoward medicines related incident (refer to 'Medicines errors and fair blame' section).

Responsibilities delegated to staff

The service manager can delegate responsibilities and tasks to staff. The staff member is anyone deemed by service manager to be competent to carry out medicines management duties.

These staff will complete medication training prior to being given this responsibility (theoretical and practical competency assessment). The responsibilities of the staff on duty include:

- Assisting with the ordering of medicines.

- Assisting with the process of cross checking prescriptions against the original order to ensure discrepancies are identified before the prescriptions are sent to the pharmacy for dispensing.
- Assisting with the monthly process of booking in and checking of prescribed medication received from the community pharmacy against ordered items.
- Liaising with HCP where necessary.
- The safe storage and custody of medicines.
- Monitoring supplies and appropriate levels of stock of medicines including homely remedies.
- Medicines administration.
- Accurate record keeping.
- Regular review of assessments with service users to determine whether they are able to self- administer medicines.
- Continual checking of MAR charts after each round and if a gap is discovered report to service manager or designated person. The service manager or designated person must investigate the error, if required seek advice from a relevant HCP and report the error in accordance with the policy.
- Completion of medication incident report forms in accordance with the policy.
- Safely managing the disposal and return of medication (refer to 'Disposal of medication' section).

Ordering medicines

- Care home providers must ensure that at least two staff have the training and skills to order medicines. In exceptional circumstances ordering can be done by one staff.
- Care home providers must retain responsibility for ordering medicines from the GP practice and must not delegate this task to the supplying pharmacy.
- Check current stock levels of regular and PRN medication before ordering.
- The care home must maintain records of medicines requested in order to cross reference prescriptions and items received from the pharmacy.
- The care home must retain up-to-date records of current medication provided for each service user and ensure stock levels for each service user are kept at an appropriate level to avoid running out. Equally, medicines must not be stockpiled or over ordered.
- Protected time should be allowed for the ordering of medicines, in particular for the monthly order.
- The prescription produced by the surgery must be checked against the prescription request before it is sent to the community pharmacy to ensure there are no discrepancies.

Receipt of medicines

- Medication received from the pharmacy must be checked against the record held by the care home of items ordered to ensure all medicines ordered have been prescribed and supplied correctly.
- Protected time must be given to staff booking in medications, particularly the monthly cycle.

- Particular attention must be paid to controlled drugs and fridge items, which require processing first.
- All other medicines (prescribed and non-prescribed) brought into the home, from an alternative source i.e. those from the service user's home, discharge medicines from hospital, those brought from another care home or those brought in by friends/ relatives, must be recorded at the point of admission.
- This information must be obtained from the label on the medicine, not verbally from the service user or carer.
- If in doubt, or where there is any contradiction in dose or directions, consult the prescriber or community pharmacist
- When medicines received for a service user differs unexpectedly from medication received for the same service user in the past, the care home must check with the prescriber or pharmacist before giving the medicine.
- For respite and short-stay service users, this procedure must be undertaken at each admission.

Disposal of medication

When disposing of medicines and removing medicines, care home providers must have a process for the prompt disposal of:

- Unwanted medicines
- Expired medicines
- Medicines that exceed requirements (correct waste management within the care home should limit the quantity of items exceeding requirements)

Non-nursing care homes:

- Medicines that are no longer needed must be returned to the community pharmacy for disposal.

Nursing care homes:

- The waste must be consigned to a suitably authorised waste management facility

Disposal of sharps:

Disposal of sharps must be in a sharps bin.

- In residential homes service users who require a sharps bin should have one available on prescription (usually 1 litre capacity). When full, these sharps bins can be taken to specific locations within the borough for disposal.
- Visiting HCP who need to dispose of sharps may bring a sharps bin with them. The visiting HCP should make arrangements for disposal of any full sharps bins which they bring with them to use.
- In nursing homes large sharps bins may be available from their waste management company. Full sharps bins should be disposed of via the waste management company.

General Principles:

- Staff must never dispose of medication in domestic waste.
- Surplus, unwanted or expired medicines should not be stored in care settings.

- They cannot be used for anyone else. They should be disposed of as soon as possible.
- Disposal of medicines must be clearly documented (see below).
- Medicines for disposal should be stored in a tamper proof container within a cupboard until they are collected or taken to the pharmacy.
- Care home providers must have a medications returns record in place. The service manager or designated person is responsible for checking what is being returned and this must match the information in the returns record.
- The following information should be entered into the medications returns book:
  - Date of disposal
  - Name of service user
  - Name, strength, dose and form of medicine
  - Quantity being disposed
  - Reason for disposing of medication (e.g. dropped, refused)
  - Name and signature of the care home staff making the record
- Keep records of medicines (including controlled drugs) that have been disposed of, or are awaiting disposal.

The situations where medicines might need to be disposed of include:

- A service user's treatment is changed or discontinued- the remaining supplies of medication must be disposed of safely.
- A service user transfers to another care setting; they should take all of their medicines with them, unless they agree to dispose of any that are no longer needed.
- A service user has refused the medication.
- A service user passes away. The service user's medicines must be kept for seven days, in case the coroners or courts ask for them.

Storage

- A lockable drawer or similar facility must be provided for service users who self-medicate, this should be in their own room and the service user must hold the key to the storage area.
- Where medicines are administered these must be stored in a lockable medicine cupboard or trolley of solid construction. Medicines trollies must be secured to the wall or behind a locked door when not in use.
- Keys to the medicine cupboard and trolley must not be left in the vicinity of the cupboard but must remain in the possession of the designated person or person delegated with the responsibility of administering medicines.
- Keys to the medication storage areas must be kept separate from any general keys.
- Where facilities exist, medicine cupboards must be housed in the room that has been provided for use as a clinical room. The temperature of medication storage areas must not exceed 25 degrees centigrade. A daily record must be taken and if temperatures are found to be outside this range, the community pharmacist must be contacted for advice.
- Any specific storage needs indicated on the label e.g. storage in a cool place, must be followed.
- Any medicines required to be stored in a refrigerator should be held in a separate locked refrigerator used only for this purpose. The temperature of the fridge must be

monitored daily, using a max/ min thermometer (normal range is between 2 and 8 degrees centigrade). If temperatures are found to be outside this range, the community pharmacist must be contacted for advice. The refrigerator should be cleaned and defrosted regularly (refer to 'Cold storage of medicines' section).

- A separate fridge may not be necessary in a small care home unless there is a constant need to refrigerate medicines that a service user takes regularly, for example, insulin.
- For controlled drugs storage, refer to 'Controlled Drugs' section.
- When medicines are to be transported around the home it must be done in a secure manner for example: using a lockable medicines trolley. Staff must never leave the trolley unattended without ensuring that it is securely locked.

Cold storage of medicines

Some medicines require temperature controlled storage e.g. needs to be stored in a cool place or in a refrigerator. Medication requiring refrigerated storage usually requires a temperature between 2 and 8 degrees centigrade (specific temperature requirements should be detailed on products packaging). The maximum and minimum temperature of the fridge must be checked using a maximum and minimum thermometer (ensure the thermometer is reset once the reading has been taken). The temperature must be recorded daily, preferably in the morning before medicine has been administered, or at the same time each day. The temperature must be maintained between 2 and 8 degrees centigrade, if the fridge is found to be outside of the recommended range inform the service manager or designated person immediately.

The following action should be taken:

- Quarantine stock in a properly functioning fridge while advice is sought.
- If the fridge is faulty, attach a notice to the fridge clearly stating 'do not use'.
- Estimate how many hours the fridge has been out of range (you should have the reading from the previous day's check).
- Contact your regular pharmacy for advice or the manufacturer for individual product advice to establish if is it safe to continue to use the medication.
- If the pharmacy or manufacturer advice that it is safe to continue to use the medication but it is now deemed 'off licence' you must contact the prescriber to ask for their authorisation to use.
- If the pharmacy/manufacturer say that it is not safe to use the product or if the prescriber does not authorise the use of the product, a new prescription will be required. A prescription request and dispensing arrangements must be made to ensure the item is received and the service user does not miss a dose of their medication.
- Ensure that the stock which is no longer usable is disposed of promptly and safely.
- If the fridge is found to be faulty do not use the fridge until it is repaired to full working order.
- Remember to record the action taken on the fridge temperature record sheet.
- An incident form such as a care concern or safeguarding report may also be required.

Controlled Drugs

Definition of Controlled Drugs:

Controlled drugs (CDs) are those drugs defined in the Misuse of Drugs (Safe Custody) Regulations 1971, as 'dangerous or otherwise harmful drugs'. The regulations specify requirements for storage and record keeping. In order to meet legal requirements that govern controlled drugs, each care home and intermediate care establishment must be equipped with facilities for the safe storage of such drugs.

In domiciliary settings the additional requirements (as detailed below) are not required, there is no difference in the administration of CD's compared to other medications when the service user is in a domiciliary setting.

Self-administration of Controlled Drugs:

- The ability of a service user to self-administer their medication must be reviewed periodically and when the individual's circumstances change.
- Service users who self-administer and their medication includes CDs;
    - The CD must be stored in a locked non-portable cabinet or drawer in the service user's room, the service user must hold the key to the storage area.
    - If the care home is ordering and receiving the CDs on behalf of the service user a record must be made of the receipt, supply and disposal of the CD in the CD register.
    - If the service user is solely responsible for ordering and receipt of the CD there is no requirement to document this in the CD register.

Controlled Drugs administered by staff:

Storage:

- The structural requirements in relation to cabinets and rooms for the safe storage of controlled drugs must be met by Regulation 3(3) Schedule 2 of The Misuse of Drugs (Safe Custody) Regulations 1973.
- A controlled drugs cabinet must be present in every establishment.
- The controlled drugs cabinet key must be kept apart from the keys for other medicines.
- The key must be kept in the possession of the designated person or their deputy and must never be left in a drawer or suspended from a hook.
- The controlled drugs cabinet must never be removed from the premises.

Receipt of Controlled Drugs:

- The pharmacy supplier should inform you that a controlled drug has been dispensed and supplied. You should be asked to sign and complete a Controlled Drugs delivery note. A copy should be retained by the Pharmacist and a copy by the care home.
- A bound controlled drugs register must be present in every establishment.
- The Controlled Drugs must be booked into the CD register and locked away into the CD cabinet by two staff as soon as they arrive in the care home, recording the following information:
    - Date on which the drug arrived in the establishment
    - Name of service user requiring the drug

- Quantity received
- Form in which the medication has been received
- A separate page must be used for each service user and each strength even if the same drug is supplied
- Drug form must be specified at the top of each page
- The index of the register must be completed
- Two signatures of those booking in the drugs must be recorded
- The specific name of the supplier e.g. name and address of pharmacy. Please note the general entry of "received from pharmacy" is not acceptable.

Administering and recording:

- All procedures for general administration apply.
- Administration shall be by the designated person and witnessed by a second staff. The second member of staff must trained and competent in order to understand what they are checking.
- The witness must oversee the whole process and both staff are required to sign the controlled drug register. Only one signature is legally required on the MAR chart but it is deemed good practice to have two.
- Entries must be made when the dose is given. It must include the date, time, name of the resident, dose given, the signatures of the staff administering, a witness and the balance left in stock.

The controlled drugs register:

- No cancellation, obliteration or alteration must be made.
- Any corrections must be bracketed and linked to a note in the margin or footnote which is dated and signed by two members of staff.
- Entries must be made in indelible ink.
- The register must not be used for any other purpose.
- The register must be kept in a secure place at the establishment.
- A separate page must be used for each service user and drug and strength.
- Entries must be in chronological order with no missed pages or lines.
- The register must be a bound book with sequentially numbered pages and kept for two years from the date of the last entry.
- A running balance must be maintained. The balance of each drug must be checked regularly with the medication in stock. Stock checks of controlled drugs must be completed by two trained and qualified members of staff and documented in the controlled drug register.

Destruction of CD's and returning CD's to the pharmacy:

- In a home providing nursing care controlled drugs can be destroyed by two registered nurses using a suitable CD destruction kit which are available from the waste contractors or pharmacy.
- Records of destruction must be kept in the CD register, including, date the CDs were destroyed, amount destroyed and remaining balance with signatures of the nurse and witness.
- In all other homes CD's must be returned to the pharmacy for destruction.

- Return must be recorded in both the CD register and the 'returns' book showing:
  - Date CDs were returned to the pharmacy
  - The amount returned
  - The remaining balance with the signatures of the two people responsible (in CD register).
  - The signature and name of the person from the pharmacy to whom the CD was handed (in the returns book)

General Process:

- If a service user requires help to administer their controlled drug medication, this must be in their care plan.
- Where administration is by a visiting health professional, they must complete the entry on the MAR chart and in the controlled drugs book, witnessed by the responsible designated staff for that establishment.
- All controlled drugs will be marked with 'CD' on the original manufacturer's packaging, but not on the pharmacy labelling. If in doubt, seek advice from the supplying pharmacy.
- Some drugs are exempt from the storage regulations (e.g. Midazolam). However it is good practice to store it in a CD cupboard unless it is being used as rescue medication if in any doubt contact a pharmacist.
- The CD balance must be checked weekly as well as at each administration.

CD discrepancies:

When dealing with discrepancies, incidents and errors related to CDs. These must be reported immediately to the care home manager. Steps must be taken to establish what has happened.

Upon receipt of stock:

If a discrepancy is identified between what is expected and the supply received then the following steps should be taken**:**

- Enter the stock into the CD register indicating what was obtained, not what was requested.
- Contact the supplier as soon as possible to investigate and resolve the discrepancy.
- Store the CD separately in the CD cabinet awaiting collection.
- Arrange for the supplier to pick up the incorrect CD.
- When the stock is picked up, obtain a signed receipt from the person taking it away, and make an entry into the supplied section of the CD register.

If the CD received is deemed 'unfit' for use the following steps should be taken:

- Enter the medication received into the appropriate section of the CD register.
- Store the CD in the CD cabinet (ideally in a sealed bag marked 'Damaged Stock') until it is taken away.
- Inform the pharmacy that the stock received is 'unfit' for use, explaining the reason and arrange for the pharmacy to pick up the stock.
- When the stock is taken away, obtain a signed receipt from the person taking it away, and an entry must be made into the supplied section of the CD register.

Balance check:

If a discrepancy is identified between calculated stock figures (running balances) and actual stock the following steps should be taken:

- Check back through the entries for that drug and ensure that there has not been a bookkeeping or numerical error.
- Check the MAR chart and also any records of disposed medicines.
- If the discrepancy **can** be identified, record the outcome and make any corrections to the CD register with a signed and dated entry (this a retrospective entry) in the margin or at the bottom of the relevant page making reference to any supporting documentation that was used to resolve the discrepancy There must be no cancellation, obliteration or alteration of any entry in the CD register.
- If the discrepancy **cannot** be explained or rectified then the following must be informed:
  - CQC
  - The Area Team Controlled Drugs Accountable Officer (CDAO)
  - The Controlled Drug Liaison Officer (CDLO) at the police (contact details below).

Reporting to the CDAO:

Incidents, errors and near misses involving CDs as well as concerns about mishandling of CDs must be reported to the CDAO by using the CD website: www.cdreporting.co.uk .

Tip - You can save it as a favourite for easy access.

You will see the CD log on page. If you have not yet registered you can click on 'create an account' and complete the registration form.

Reporting to CDLO:

Our local CDLO is:
James Thompson(Controlled Drug Liaison Officer Cheshire Police)
Telephone: 01606 363611
Mobile: 07825 272503
Email: james.thompson3879@cheshire.pnn.police.uk

If you have any questions regarding Controlled Drugs you can:

- Contact your supplying Community Pharmacy
- Contact NHS Halton Care Home Medicines Management Support Team
- Contact Detective Constable James Thompson
  (Controlled Drug Liaison Officer Cheshire Police)
  Telephone: 01606 363611
  Mobile: 07825 272503
  Email: james.thompson3879@cheshire.pnn.police.uk

Additional guidance

Administering medicines

- A tabard (designated for use during the medication administration round) should be worn by the staff administering medication. The purpose is to alert others that medications are being administered, to help prevent and reduce interruptions occurring during the medication round. Healthcare professionals entering the establishment , staff and service users in the service should be made aware not to disturb a member of staff wearing the tabard unless in an emergency.

- Services may choose to use other systems to ensure the staff member administering medication is not disturbed; the system they choose must be robust.

Day trips and holidays

- When going out for the day or going on holiday, specific arrangements must be made for the period of the trip. The medicines are to be given to the service user or the person who will be caring for them during the day trip/holiday.
- The medication must be provided in its original pharmacy labelled bottles, containers and/or MCA.
- A photocopy of the MAR chart must be provided and a code (for example L) should be used on the original MAR chart to indicate the service user was on leave.
- The name, strength, and quantity of the medicine which is to leave the premises must be recorded and the medicines must be checked back in upon returning. Any discrepancies must be reported to the service manager or designated person who will need to investigate the incident and may need to seek medical advice. For example, a service user takes two co-codamol 30/500mg tablets per day. 28 tablets in the original container are taken out on a day trip for 6 hours, upon returning only 10 tablets remain when there should be 26.
- Where the designated or responsible person is accompanying the service user on the activity, they take responsibility for administering medication.
- Where they are not accompanying the service user, they must ensure the staff or any other adult who will be responsible for giving the medication has clear verbal and written instruction on what to do and signs for receipt and return of the medication. A suitable and sufficient risk assessment must also take place and be clearly documented.
- Where the service user is going on an activity organised by another organisation, the service manager must satisfy themselves the organisation has procedures in place to ensure the service user safely receives the correct medication. For example medicines policy, staff training, competency etc.

Day trips and holidays with controlled drugs

If the service user is going out with medication and it involves Controlled Drugs (CD) the care provider will need to ensure legal requirements are met.

Some care settings do not require additional legal storage or records for controlled drugs (refer to the controlled drug guidance specific to your service).

In care settings where additional legal requirements for controlled drugs are necessary, the service must ensure the following:

- A photocopy of the MAR chart must be provided and a code (for example L) should be used on the original MAR chart to indicate the service user was on leave.
- A record must be made in the CD register and witnessed by a second trained member of staff.
- A detailed record of who the CD was given to. For example, full name, company they work for, job title or relationship to service user etc.
- The person who takes the CD away should be asked to sign the CD register.
- The CD must be placed in a tamper proof bag or secure portable storage.
- The CD must be held by the designated person at all times.

- If the CD is not required during the trip/holiday and is returned to the service this must be checked, recorded in CD register and returned to the CD cupboard.
- If the CD is used during the trip/holiday this must be recorded on the MAR chart.
- Any discrepancies must be reported to the service manager or designated person who will need to investigate the incident and may need to seek medical and legal advice.

Essential practice for Day Services and Adult Placement

NOTE: All staff working in a Day Service or Adult Placement setting MUST also read 'Essential practice for all providers'

Self-administration

- Service users should be encouraged to retain responsibility for their own medicines while attending the service (where possible). This outcome should be decided through completion of a medication assessment tool.
- Service users who are assessed as being able to self-administer using an appropriate risk assessment tool, should be advised that the medication should be carried in a suitable container and kept safely on their person at all times if possible.

Administration of medicines

- Where service users are assessed as requiring assistance with administration of medication (level 2 or 3), the prescriber or pharmacist can be asked to assess whether an alternative preparation or pattern of administering the medicines can be used e.g. tablets being taken 2 or 3 times a day instead of 4 or giving the medicine at a different time of day to avoid having to give medicines in a day services setting.
- Where it is agreed staff are to assist service users with taking medication, the level of assistance must be clearly recorded, both on the assessment and in the care plan.
- Where a service user regularly attend day services (e.g. 4/5 days a week) and requires assistance with taking medication, the assessor/ care co-ordinator can liaise with the prescriber/ pharmacist to ascertain if they can provide separate supplies for day care.
- Where a service user attends the services less often e.g. once or twice a week the service user or carer must be asked to provide the medicines in its original pharmacy labelled bottles, containers and/or MCA.

Receipt of medicines

- The medication must be provided in its original pharmacy labelled bottles, containers and/or MCA.
- If there is any concern over the medication provided e.g. medication labels have become detached, labels are illegible, medication packaging has been tampered with, medication provided in a 'secondary dispensed' form, the medicine in the container must not be given. Staff must inform the service manager or designated person. The service manager or designated person must seek the advice from a relevant HCP such as the supplying pharmacist, prescriber or if out-of-hours, advice from an out-of-hours service must be sought. This must take place immediately to ensure the service user does not go without their medication.
- On admission to the service the medicines to be given to service users will be recorded on a MAR chart (refer to 'Handwritten MAR chart' section).
- On each attendance the medication being received must be checked against the records and the MAR must be re-written if the medication has been changed.
- This information must be obtained from the printed pharmacy label on the medicine and a recent copy of the patient summary records from the surgery, not from verbal instruction from service user/ carer.

- If the service user is on a PRN medicine the previous administration time and dose must be established to ensure the medication is not administered too soon which could result in an overdose.
- If in doubt, or where there is any contradiction, consult the pharmacist, prescriber if out-of-hours an out-of-hours service.

Storage

- To ensure safe storage of all medicines but also provide a person centred approach, each service user's storage requirements will be considered individually to determine the most appropriate storage solution. Considerations must be made to ensure others are not at risk such as other service users, visitors, family members, children and pets.
- If the service user self-administers and the medicines require safe storage this service user must be provided with a lockable cupboard or drawer and the service user must hold the key.
- Where medicines are to be administered by staff, the storage instructions on the packaging must be followed.
- When stored in a central location a lockable medicines cupboard should be used. The keys to the medicine cupboard must not be left in the vicinity of the cupboard but must remain in the possession of a designated member of staff.
- Where it is not possible to provide a lockable medicines cupboard, the medicines should be kept in a locked cupboard with each service user's supply of medicines being kept in a separate named container. The keys to the cupboard must not be left in the vicinity of the cupboard but must remain in the possession of a designated member of staff.
- A separate fridge may not be necessary in Day Services or Adult Placement unless there is a constant need to refrigerate medicines that a service user takes regularly, for example, insulin. Medication that requires storing in a refrigerator must be held in a separate, preferably secure, container to avoid cross contamination with foodstuffs.
- Care workers must check that the fridge appears to be working correctly if there are medicines stored in it.
- Staff must report to the service manager or designated person if the fridge appears to be defective. The service manager or designated person must contact a relevant HCP such as a pharmacist for advice.
- When storing medicines in an area accessible to others a risk assessment must be documented (even if stored in a separate secure container as this could be removed).

Medication leaving with the service user

This includes service users who are leaving temporally and those who are leaving for the last time.

- When the service user leaves the service a record of the medication which leaves with them must be made.
- A detailed record of who the medication was handed to must be made. For example, full name, company they work for, job title or relationship to service user etc.

- It is good practice to ask the person who the medication has been handed to, to sign the records for a clear audit trail.
- Information regarding the administration of any PRN items which has taken place at the Day Service or Adult placement service must be communicated to the service user or their representative.

Retaining Medicines in services (when service user not present)

- If medication is left at the premises when the service user is not present this must be stored securely and at the correct temperatures as indicated on the products packaging.
- The temperature of medication storage areas must not exceed 25 degrees centigrade. A daily record must be taken and if temperatures are found to be outside this range, the community pharmacist must be contacted for advice.
- Any specific storage needs indicated on the label e.g. storage in a cool place, must be followed.
- It is not recommended to retain Controlled Drugs or fridge items if the service user is not present as additional legal and safe storage requirements will be necessary.
- If the medicines stored are Controlled Drugs refer to 'Essential practice for care homes – Controlled Drugs' section.
- If the medication stored requires refrigerated storage refer to 'Essential practice for care homes – Cold storage of medicines' section).

Essential practice for Supported Housing Network

NOTE: All staff working in a Supported Housing Network setting MUST also read 'Essential practices for all providers'

Storage in the service user's home or personal room (Level 1, 2 and 3 support)

Storage

- As part of the assessment process, the controls for the safety and storage of the medication will be identified.
- When the service user remains responsible for the medication they should be advised to store their medication in accordance with the instructions provided with the medication.
- Medicines should be stored within their own home or personal space when service users self-administer (level 1).
- Where it has been deemed that the service user is unable to take safe control or lacks capacity to manage their medication staff are responsible for the administration of medicines. Medicines must be stored safely and appropriately in accordance with the instructions provided. Other relatives, carers and health professionals should be informed where it is stored if appropriate.
- A separate fridge may not be necessary in supported housing network services, unless there is a constant need to refrigerate medicines that a service user takes regularly, for example, insulin. Medication that requires storing in a refrigerator must be held in a separate, preferably secure, container to avoid cross contamination with foodstuffs.
- Care workers who provide care must check that the fridge appears to be working correctly if there are medicines stored in it.
- Staff must report to the service manager or designated person if the fridge appears to be defective. The service manager or designated person must contact a relevant HCP such as a pharmacist for advice.
- When storing medicines in an area accessible to others a risk assessment must be documented (even if stored in a separate secure container as this could be removed).

Controlled drugs

Where medicines are stored in the service users own home or personal room additional legal requirements are not required. There are no differences in administration of these drugs compared to other drugs.

Return of Medication

- Any medication prescribed for the service user is their property and must never be removed by staff from the service user's home without first obtaining consent from the service user.
- Staff must never dispose of medication in domestic waste.

- Medication that is out-of-date or no longer used must be returned to the pharmacy, having consulted with the service manager and service user. This must be documented by the carer in the service user's file listing the medication disposed of.

Storage in a central location (Level 2 and 3 support)

When medication is stored in a central location in a Supporting Housing Network service these must be treated the same as medicines in a care home setting. Refer to the 'Essential practice for care homes' section for:

- Ordering medicines
- Receipt of medicines
- Disposal of medication
- Storage
- Cold storage of medicines
- Controlled Drugs (except the self-administration section)
- Additional guidance

Essential practice for domiciliary care settings

NOTE: All staff working in a domiciliary care setting MUST also read 'Essential practice for all providers'

Principles

- The support provided should enable the service user to maintain independence at home.
- The service users should be encouraged to manage their own medicines where appropriate and possible.
- Where there is no carer or other responsible adult willing and able to assist service users to take their medicines at home, or where the service user requests that informal carers are not to be involved in administration of their medication, domiciliary staff will undertake this task as part of an agreed care plan.

Ordering medicines

Responsibility for ordering medicines usually stays with the person and/or their family members. However, if it has been agreed that the care service provider is responsible, effective medicines management systems need to be in place.

- It must be agreed with the service user and/or their family members who will be responsible for ordering medicines, this information must be recorded in the service users care plan.
- When staff are responsible for ordering a service users medicines they must ensure that the correct amounts of the medicines ordered to ensure enough medicines are available without stock piling.
- When staff are responsible for ordering a person's medicines they must not delegate this task to the supplying pharmacist (or another provider).
- Service users have the right to choose which pharmacy or supplier provides their medicine.
- The service users care plan must detail who is responsible for ordering, collecting and dispensing the service users prescriptions.

Storage

- As part of the assessment process, controls for safety and storage of medication will be identified.
- When the service user remains responsible for the medication they should be advised to store their medication in accordance with the instructions provided with the medication.
- Where it has been deemed the service user is unable to take safe control or lacks capacity to manage their medication domiciliary assistants are responsible for the administration of medicines. Medicines must be stored safely and appropriately in accordance with the instructions provided. Other relatives, carers and health professionals should be informed where it is stored if appropriate.
- Medication that requires storing in a refrigerator must be held in a separate re-sealable container to avoid cross contamination with foodstuffs.

- Care workers who provide domiciliary care must check that the service user's fridge appears to be working correctly if there are medicines stored in it.
- Staff must report to service manager or designated person if fridge appears to be defective. The service manager or designated person must contact a relevant HCP such as a pharmacist for advice.

Return of Medication

- Any medication prescribed for the service user is their property and must never be removed by staff from the service user's home without first obtaining consent.
- Staff must never dispose of medication in domestic waste bins.
- Medication that is out-of-date or no longer used must be returned to the pharmacy, having consulted with the service manager and service user. This must be documented by the carer in the service user's file listing the medication disposed of.

Controlled drugs

In domiciliary settings additional legal requirements are not required. There are no differences in administration of these drugs compared to other drugs when the service user is in a domiciliary setting.

Role of the Pharmacist

Pharmacists are responsible for the supply of prescribed and non-prescribed medicines and appliances.

Pharmacists also provide advice to patients and carers on the proper use, storage and disposal of medicines and appliances. They are also able to offer advice on self-care, minor ailments, promotion of healthy lifestyles and signposting to other NHS/Social care services.

Community pharmacists keep computerised records of the medication they dispense. These records provide useful information and can indicate potential drug interactions. Pharmacies only have access to the records of medicines that they have previously dispensed. If a prescription is taken to a pharmacy that is not the service users “regular” pharmacy their computer records will not be as detailed and an interaction or allergy might not be identified during the dispensing process.

It is useful for the supplying community pharmacist to be informed of any admissions to hospital so that whilst in hospital, the dispensing of regular medications can be avoided and wastage can be prevented.

The pharmacist may need to liaise with the prescriber to clarify directions or doses of medication. Where the pharmacist is not able to do this the service manager or delegated member of staff will need to clarify the correct information with the prescriber.

NHS Halton CCG Medicines Management Team

Medicines management support, advice and guidance can be provided by the NHS Halton CCG Medicines Management team, their contact details are:

Zoe Mason – Care Home Pharmacist
NHS Halton CCG
Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD
Telephone: 01928 593452
Mobile: 07780 338984
Fax: 01928 593790
Email: zoe.mason2@haltonccg.nhs.uk

Katherine O’Loughlin – Medicines Management Technician
NHS Halton CCG
Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD
Telephone: 01928 593010
Mobile: 07876 651243
Email: Katherine.o’loughlin@haltonccg.nhs.uk

Glossary

Term	Explanation
Adverse effects	Is an undesired harmful effect resulting from a medication
Allergy	An allergy is the abnormal reaction of your immune system to a medication, food or product e.g. latex. Any medication — over-the-counter, prescription or herbal — is capable of inducing a drug allergy.
Confidential	Confidentiality is the right of an individual to have personal, identifiable medical information kept private
Controlled Drugs	Some medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs.
CQC	Care Quality Commission
Cytotoxic drug	Cytotoxic drugs are group of medicines that contain chemicals which are toxic to cells.
Designated person	A member of staff who the service manager has identified as being responsible and is trained and competent to support other staff when issues arise
Expiry date	The expiry date is the point in time when a pharmaceutical product is no longer within an acceptable condition to be considered effective.
HCP	Healthcare professional
Homely Remedy	Medicines for minor ailments that can be bought over the counter.
INR	International normalized ratio (INR) is a calculation made to test how fast the blood clots.
Invasive procedure	A procedure in which the body is penetrated or entered, e.g. by a tube or needle
MAR	Medication administration Record, used to record any involvement in a service user's medication.
MAR code	A letter used on the MAR chart to identify the reason why medication has not been administered e.g. R = refused, H = Hospital (codes may vary but there must be a key for the codes)

Term	Explanation
MCA	Multi compartment compliance aids refer to a range of medicines storage devices where medicines are removed from the original packaging and placed into compartments by a pharmacy. They are also referred to as blister backs or monitored dosage systems (MDS)
Medication review	A structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste"
Medicines Management	A person-centred approach to safe and effective medicines use, enabling people to obtain the best possible outcomes from their medicines
NG tube	Nasogastric intubation is a medical process involving the insertion of a plastic tube (nasogastric tube or NG tube) through the nose, past the throat, and down into the stomach. It is used for giving liquid food and medication.
Near miss	A near miss is an unplanned event that could threaten human safety or health but doesn't result in any harm.
NHS 111	111 is the NHS non-emergency number. It's fast, easy and free. Call 111 when you need medical help fast but it's not a 999 emergency.
NHS 999	Call 999 in a medical emergency – when someone is seriously ill or injured and their life is at risk.
NMP	Non-medical prescriber, is a health professional who is not a doctor, usually a registered nurse, pharmacist or other health professional who have undergone additional training to enable them to prescribe medicines when appropriate.
Out of Hours	These are services open outside the normal working hours of the GP surgery; these will include Runcorn Urgent Care Centre, Widnes Urgent Care Centre, extended G.P access and Urgent Care 24.
PEG	Percutaneous endoscopic gastrostomy. This is a flexible tube that goes through the abdominal wall directly into the stomach. It is used for giving liquid food and medication.
PIL	Every medicine pack includes a patient information leaflet (PIL), which provides information on using the medicine safely.

Term	Explanation
PRN/'As required' medicine	PRN is shorthand for an expression for "Pro Re Nata", which translates as "as need arises".
Safe haven fax/Secure email	Safe Haven procedures act as a safeguard for confidential information which enters or leaves the organisation, whether this is by fax, e-mail, post or other means
Secondary dispensing	Where medication is taken out of their original container or package and put into another container for someone else to administer to the service user at a later time. This activity is considered a high risk activity and must not take place.
Self-administering	The term self-administration of medicines means that the service user is responsible for storing and administering their own medicines
Service Manager	Nominated care manager or registered manager.
Short dated medication	Medication which has a shortened expiry date once opened.
Side effect	A usually undesirable effect of a medication or treatment
SPC	Summaries of Product Characteristics (SPCs) are a description of a medicinal product's properties and the conditions attached to its use.
Specialist administration technique	When medication is given by invasive procedure, additional specialist training and competency checks are required
Staff	A person who is employed by the care provider
The Council	For the purpose of this policy "The Council" refers to Halton Borough Council
Waste management	Ensuring that there are adequate amounts of medication available in order to meet the needs of the service user without overstocking.

EIA STAGE 1

EIA Ref		
Lead Officer	Name	**Natalie Johnson**
	Position	**Policy Officer, People Directorate (Adult Social Care)**
	Contact details	**0151 511 8909**

SECTION 1 –Context & Background

1.1 What is the title of the policy / practice?

Halton Borough Council Overarching Medication Policy

1.2 What is the current status of the policy / practice?

Existing Changed ✓ New

1.3 What are the principal aims and intended outcomes of the policy / practice?

The policy outlines the Council's vision for medicines management in social care and describes its commitment to enable and safeguard the health, safety and wellbeing of service users and staff.

1.4 Who has primary responsibility for delivering the policy / practice?

The policy applies to Halton Borough Council adult social care services with responsibility for administering medication. This includes the following services, which are supported to deliver the policy through service specific Standard Operating Procedures (SOPs):

- Adult Placement;
- Day Services;
- Oak Meadow (incl. reablement);
- Supported Housing Network.

1.5 Who are the main stakeholders?

Staff and services users within the services named above.

1.6 Who is the policy / practice intended to affect?

Residents Staff ✓ Specific Group(s) ✓ (add details below)

Those using the services to which the policy applies (detailed above).
Commissioned services are expected to have their own internal policies/procedures/ processes that reflect the standards set out within this policy.

1.7 Are there any other related policies / practices?

The service specific SOPs; this overarching policy together with the relevant service specific procedure will ensure proper medicines management within a range of social care settings.

SECTION 2 – Consideration of Impact

2.1 Relevance: – the Public Sector Equality Duty

Does this policy / practice / service have due regard to the need to: -

(a) Eliminate discrimination, harassment, victimisation and any other conflict that is prohibited by the Equality Act 2010
(b) Advance equality of opportunity between two persons who share a relevant protected characteristic
(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

Yes (✓) **No** ( )

State reasons below (please refer Appendix 1)

The policy supports services in the safe and effective management of the medication requirements of their service users who may be vulnerable due to disability or old age and as such require support from adult social care services.

2.2 Has data and information been used in determining the impact of the policy / procedure under review?

(for example research, surveys, complaints, consultation, monitoring data)

Equality Group(s)	N/A

Baseline data and information
Research into current legislation, regulations and good practice guidance.

2.3 On the basis of evidence, has the actual / potential impact of the policy/ practice been judged to be positive (+), neutral (=) or negative (-) for each of the equality groups and in what way? Is the level of impact judged to be high (H), medium ((M), or low (L)?

Protected Characteristic	Impact type +, =, -	Level H, M, L, -	Nature of impact
Age	**+**	**H**	The services that this policy applies to exist to support people who are vulnerable and require adult social care support because of old age or disability. This policy will ensure that whilst being supported by the service, their medication needs are supported in such a way that maintains their independence but also protects them from harm.
Disability	**+**	**H**	
Gender	**=**	**L**	
Race / ethnicity	**=**	**L**	
Religion / belief	**=**	**L**	
Sexual Orientation	**=**	**L**	
Transgender	**=**	**L**	
Marital status/ Civil Partnerships	**=**	**L**	
Pregnancy/Maternity	**=**	**L**	
In Halton two further vulnerable groups have been identified: -			
Carers	**=**	**L**	
Socio – economic disadvantage	**=**	**L**	

2.4 Does the policy/practice have any potential impact on safeguarding vulnerable people?

The policy sets out proper management of medication thus ensuring the safety of service users. It also describes how issues should be escalated through the Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Good Practice Guidance.

2.5 How will the impact of the policy / practice be monitored?

Regular competency checking of staff in administering medication. Reporting of medicines errors. Service audits and inspections.

2.6 Who will be responsible for monitoring?

Staff within affected service areas. Medicines Management Team. Quality Assurance Team.

2.7 If any negative impacts, or potential negative impacts, have been identified what mitigating actions will be put in place, thereby eliminating the need for a further Stage 2 assessment? Where none have been identified insert 'no further action required' in the first column.

Action & purpose / outcome	Priority	Timeframe	Lead Officer
No further action required	*(H, M, L)*		

2.8 Summary of stakeholders involved in this review

Name / Job Title	Organisation / representative of
Natalie Johnson, Policy Officer	Policy, Performance and Customer Care Team People Directorate (Adult Social Care)
Katherine Scragg, Care Home Medicines Management Technician	Medicines Management Team, NHS Halton Clinical Commissioning Group

2.9 Completion Statement

As the identified Lead Officer of this review I confirm that:- No negative impact has been identified for one or more equality groups and that a Stage 2 Assessment is not required.

Signed: N Johnson	**Date: 02.06.2017**

Completed EIAs should be sent to Corporate and Organisational Policy, to be given a unique reference number and for inclusion on the central register.

Appendix 1

Public Sector Equality Duty – EIA Checklist

The Equality Act s149 (the Public Sector Equality Duty) requires is that HBC has due regard to the need to:-

(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

These are matters that we must show we have taken into the reckoning in making decisions about the Council's functions. We therefore need evidence of the following:

1. We know about the duty
2. We have reflected on the duty
3. We have consulted those affected or likely to be affected
4. We have used relevant information already in the council's possession (surveys etc.)
5. \we have allowed adequate time for consultation with those affected and/or those who speak for those affected
6. We have allowed adequate time for earnest and genuine consideration of the information and views received
7. We have identified any adverse effects
8. We have sought to mitigate any adverse effects of decisions
9. We have identified principal options
10. Decision makers have not made up their mind in advance
11. We have considered all material considerations including our own financial situation, policy and strategy documents alongside along views received from consultees but have not applied those policies etc. In a rigid or unthinking way.

REPORT TO: Health Policy and Performance Board (PPB)

DATE: 19th September 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Blue Badge Policy, Procedure & Practice

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Health PPB with the revised Blue Badge Policy, Procedure & Practice (PPP) following comprehensive review (copy attached at appendix 1). To make the Board aware of two key issues that have arisen during the review process with regards to:

- Enforcing correct use and tackling potential abuse of the scheme;
- The eligibility requirements for organisational badges.

2.0 RECOMMENDATION:

RECOMMENDED: That the Board

1) Note the contents of the report and associated appendices; and
2) Comment on the revised Policy.

3.0 SUPPORTING INFORMATION

3.1 The Blue Badge Scheme helps disabled people with severe mobility problems to access goods and services by allowing them to park close to their destination, whether they are a driver or a passenger.

3.2 The scheme was introduced in 1971 under Section 21 of the Chronically Sick and Disabled Person's Act 1970. It was amended by the Disabled Persons' Parking Badges Act 2013 and the scheme as it currently stands is governed by the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000 (plus amendments).

3.3 The Department for Transport (DfT) is responsible for the legislation that sets out the framework for the scheme, which includes:

- The eligibility criteria;
- The maximum fee that local authorities can charge for issuing a badge;
- The period of issue of a badge;
- Grounds for refusing to issue a badge and for withdrawing a badge;
- Circumstances under which a badge should be returned to the issuing authority;
- The manner in which the badge should be displayed; and

- National concessions available to badge holders.

3.4 Local authorities are responsible for administering and enforcing the scheme. The DfT publish non-statutory guidance[1] to assist local authorities by sharing good practice. This guidance states that local authorities are *"responsible for determining and implementing administrative, assessment and enforcement procedures which they believe are in accordance with the governing legislation."*

3.5 The existing version of the Blue Badge PPP was produced in 2012 and last reviewed in 2014. The current review process has been comprehensive involving close consultation with Halton Direct Link and the Initial Assessment Team as both teams are responsible for dealing with badge applications. Legal Services have also been involved.

3.6 In summary, the following changes have been made to the policy:

- The policy section has been amended so that it makes reference to the DfT guidance rather than repeating it;
- Repetition between various sections of the document has been removed and the flow now follows the DfT guidance;
- The application forms have been amended to follow the model application form contained within the DfT guidance and are now included as separate appendices to the policy for ease of updating (the application forms are not attached with this report, as there are seven separate forms; however, they can be provided on request);
- The procedure sections detailing application, assessment and appeal processes have been made clearer with associated flow charts included as appendices;
- Appendices that are subject to frequent change for operational use (i.e. standard letters) have been removed as it is not necessary to include them within the PPP;
- The overall length of the document has been reduced from 115 pages to 28 pages (plus the application forms as separate appendices), making it easier to navigate.

3.7 In addition to the above, considerable work has taken place in connection with the issues surrounding enforcement and organisational badges. These issues are explained in more detail at 3.8 and 3.9.

3.8 **Enforcement of the scheme**

3.8.1 As part of reviewing the policy, it was felt that the enforcement procedures needed to be clearer and more robust. There is a range of information included within the DfT guidance regarding local authority enforcement powers. However, they are focussed on authorities with Parking Enforcement Officers, of which there are none in Halton. Instead, parking enforcement is the responsibility of Cheshire Police.

[1] The Blue Badge Scheme Local Authority Guidance (England), October 2014

3.8.2 Discussions were therefore held with Legal Services, Traffic Management and Cheshire Police along with HDL and IAT and a process for enforcement was agreed (detailed in section 2.15 of the policy). However, it should be noted that we are fairly limited in our enforcement powers, not least because parking restrictions are fairly minimal in Halton. Also, it is quite unlikely that badge misuse would proceed to prosecution as substantial evidence of the misuse would be required. Nonetheless, the policy now contains a clear process which is applicable to the local area.

3.9 **Organisational badges**

3.9.1 The DfT guidance states that *"an organisational badge may be issued to an organisation for use in a motor vehicle or vehicles when the vehicle or vehicles are to be used to carry disabled people who would themselves be eligible for a badge as specified in Section 4(2) of the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000. An organisation is defined in the 2000 Regulations as meaning an organisation concerned with the care of disabled persons to which a disabled person's badge may be issued in accordance with Section 21(4) of the Chronically Sick and Disabled Persons Act 1970."*

3.9.2 It further states that *"Local authorities will need to check whether the organisation in question:*

- *Cares for and transports disabled people who would themselves meet one or more of the eligibility criteria for an individual Blue Badge; and*
- *Has a clear need for an organisational badge rather than using the individual Blue Badges of people it is transporting."*

3.9.3 During the review process, a number of issues became apparent in terms of the content of the 2014 policy and the approval of previous organisational applications. As a result of these issues it has been necessary to strengthen the new policy with clearer details on which organisations are eligible, in order to ensure compliance with legislation and DfT guidance.

3.9.4 To assist with this process, a number of other local authorities within the North West were contacted and asked about how they deal with organisational applications (see appendix 2 for the questions and responses). Their responses reinforced our thinking that we simply need to be clearer within the policy about the organisational eligibility criteria, as described in the DfT guidance (see 3.9.2).

3.9.5 Therefore, the policy now makes it clear that to be eligible organisations must be *"concerned with the care of disabled people who would themselves be eligible for a badge"* and they must care for ***and*** transport such people and have a clear need for an organisational badge rather than using individual badges.

3.9.6 The new policy also makes it clear (see section 1.3 on page 7) that

the provision of care is the primary consideration and that in order to be eligible organisations will be required to evidence that they are registered with CQC or Ofsted as a provider of care to people with disabilities (who would be eligible for a badge individually). This is to ensure that only those organisations that are "concerned with the care of disabled people" are eligible for badges and those that simply provide assistance during transportation fall short of the criteria. We believe this to be in line with DfT expectations given that their guidance states:
"It is unlikely that taxi or private hire operators and community transport operators would be eligible for an organisational Blue Badge as they are not usually concerned with the care of disabled people…..Common examples of organisations that may be eligible include residential care homes, hospices or local authority social services departments…"

3.9.7 The tightening of the policy does mean that some organisations that currently have badges will no longer be eligible on renewal. To mitigate the negative impact of this change, it is suggested that all current organisational badge holders are made aware of the new policy immediately rather than finding out when their badge(s) expire. Some organisations have multiple badges, each of which may have a different expiry date so if such an organisation is no longer eligible they will lose their badges on a phased badge-by-badge basis. There are currently a total of 74 organisational badges across 20 organisations in Halton; it is anticipated that the majority of these organisations are eligible with less than five of them being unlikely to meet the eligibility criteria on renewal (these organisations currently hold approximately 50 of the organisational badges).

4.0 POLICY IMPLICATIONS

4.1 Approval of the revised policy will ensure that the Council is compliant with DfT guidance and regulations.

5.0 FINANCIAL IMPLICATIONS

None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES *(click here for list of priorities)*

6.1 **Children and Young People in Halton**
None

6.2 **Employment, Learning and Skills in Halton**
None

6.3 **A Healthy Halton**
The Blue Badge Scheme enables disabled people with severe mobility problems to access amenities within their community more easily. Ensuring that the scheme is properly administered in line with legislation

and guidance helps to maintain the robustness of the scheme, upholding the benefits of it for those who truly need it.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 RISK ANALYSIS

7.1 The changes to the policy in terms of organisational badges may result in some organisations that currently have badges no longer being eligible upon renewal. This is likely to be met with some dissatisfaction. However, the changes are required in order to ensure that local administration of the scheme complies with national guidance and legislation.

7.2 To mitigate the negative impact, it is suggested that organisations are notified in advance of their potential ineligibility upon renewal (as described at 3.9.7).

8.0 EQUALITY AND DIVERSITY ISSUES

An Equality Impact Assessment (EIA) has been completed – copy attached at appendix 3. No negative impact was identified.

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

None under the meaning of the Act.

HALTON BOROUGH COUNCIL

People Directorate

BLUE BADGE SCHEME

(Disabled Persons Parking Scheme)

Policy, Procedure and Practice

June 2017

CONTENTS

Appendices available as separate documents – Blue Badge application forms:

- Appendix 4 – Application for those who do not require further assessment (aged 3 and above)
- Appendix 5 – Application for those who are subject to further assessment (aged 3 and above)
- Appendix 6 – Application for a child under the age of 3 years
- Appendix 7 – Application for an organisational badge
- Appendix 8 – Fast-track application form (palliative care cases)
- Appendix 9 – Pre-assessed application form
- Appendix 10 – Renewal without further assessment application form

INFORMATION SHEET

Service area	Adult Social Care
Date effective from	June 2017
Responsible officer(s)	Policy Officer, People Directorate (Adults) Divisional Manager, Care Management Team Leader, Halton Direct Link
Date of review(s)	June 2019
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	Halton Direct Link (HDL) / Contact Centre Initial Assessment Team (IAT) Cheshire Police
Date of committee/SMT decision	To be added
Related document(s)	None
Superseded document(s)	Blue Badge Scheme (Disabled Persons' Parking Badge Scheme) Policy, Procedure & Practice March 2014
Equality Impact Assessment completed	10th February 2017

1.0	POLICY	*PRACTICE*
1.1	**Introduction** The Blue Badge Scheme (BBS) helps disabled people with severe mobility problems to access goods and services by allowing them to park close to their destination, whether they are a driver or a passenger. The Department for Transport (DfT) is responsible for the legislation behind the BBS, which sets out the following: • Eligibility criteria; • Maximum fee that can be charged for a badge; • How long badges can be issued for; • Grounds for refusal/withdrawal of a badge; • When a badge should be returned; • How the badge should be displayed; and • National concessions available to badge holders. Local authorities are responsible for day-to-day administration and enforcement of the BBS in line with the legislation; particularly, they must ensure that badges are only issued to residents who satisfy at least one of the eligibility criteria. The DfT publish non-statutory, good practice guidance to assist local authorities in ensuring that their administration, assessment and enforcement practices are: • Fair and consistent; • Customer-friendly and clear; • Timely and cost-effective; and • Resistant to abuse. In Halton, the BBS is administered by Halton Direct Link (HDL) and the Contact Centre with assessments being performed by the Initial Assessment Team (IAT) within the Care Management Division. There is also involvement from Cheshire Police in terms of tackling badge misuse.	*There is a range of information and guidance available on the Blue Badge section of the www.gov.uk website.* *The DfT Blue Badge Scheme Local Authority Guidance (England), October 2014 (from now on referred to as 'the DfT guidance') includes a full list of legislation relevant to the BBS (see Appendix B of the DfT guidance).* *See procedure section 2.1 for information on responsibilities.*
1.2	**Policy Aims** • Ensure that the BBS is administered consistently and fairly, in accordance with the DfT regulations and guidance; • Actively promote and raise awareness of the BBS in order to encourage disabled people to apply for and benefit from the Scheme; • Ensure that the BBS promotes equal opportunities by enabling disabled people to enjoy maximum mobility, access local facilities and play a full and active role in their communities; and • Work in partnership with the police and other local authorities to enforce the BBS and prevent fraud and abuse.	

1.0	POLICY	*PRACTICE*
1.3	**Eligibility Criteria** There are two ways a person can be eligible for a blue badge: ***Type 1: 'eligible <u>without</u> further assessment'*** People may be issued a badge without further assessment if they are aged over two years and meet one or more of the following descriptions: • Registered as severely sight impaired (**blind**); • In receipt of the **Higher Rate Mobility Component** (HRMC) of **Disability Living Allowance** (DLA)*; • Meet a **Moving Around** descriptor (receives eight points or more) for the **Mobility Component of Personal Independence Payment** (PIP)*; • In receipt of **War Pensioner's Mobility Supplement**; and/or • In receipt of a qualifying award under the **Armed Forces and Reserve Forces (Compensation) Scheme** (awarded a lump sum benefit at tariffs 1-8 and certified as having a permanent and substantial disability which causes inability or very considerable difficulty walking). *PIP is replacing DLA for people aged 16-64 on or after 8th April 2013 in a number of stages: • From April 2013 – new claimants in the North West and part of the North East of England as part of a controlled start period. • From June 2013 – new claimants in the remaining parts of Great Britain. • From October 2013 – certain DLA recipients to be invited to claim PIP (those reporting a change; those whose award expires; and young people reaching age 16 with the exception of those awarded DLA due to terminal illness). • From 2015 – the Department for Work and Pensions (DWP) will contact all other DLA recipients. ***Type 2: 'eligible <u>subject to</u> further assessment'*** People may be issued a badge after further assessment if they are aged over two years and meet one or both of the following descriptions: • Drives a vehicle regularly, has a **severe disability in both arms** and is unable to operate, or has considerable difficulty operating, all or some types of parking meter; and/or • Has a permanent and substantial disability that causes **inability to walk or very considerable difficulty in walking**.	*The DfT guidance states: "In no circumstances should a badge be issued to an applicant who does not meet one of the eligibility criteria set out in the legislation which governs the scheme. Badges should never be issued to people solely on the basis of their age."* ***Proof of entitlement under any of these descriptions <u>must</u> be provided – section 4.2 of the DfT guidance details exactly what forms of proof are acceptable.*** *Where possible, and in line with the Data Protection Act, local authorities are advised to access electronic records held by other departments/ agencies.* *It is anticipated that most people who qualify for a badge because they receive the HRMC of DLA will continue to qualify as they are likely to score eight points or more in the 'moving around' descriptor of PIP. There is some further guidance regarding the implications of PIP for Blue Badges on the www.gov.uk website.* *The Disabled Persons (Badges for Motor Vehicles) (England) (Amendment) (No. 2) Regulations 2011 prescribe that from 1st April 2012, the eligibility of those applying because of a permanent and substantial disability that causes inability to walk or very considerable difficulty in walking, must be confirmed by an **independent mobility assessor** (as defined by the Regulations, e.g.*

1.0	POLICY	*PRACTICE*
	Children under the age of three may be eligible for a badge if they meet one or both of the following descriptions: • Have a condition that means they must always be accompanied by bulky medical equipment which cannot be carried around with the child without great difficulty; and/or • Have a condition that means they must always be kept near a motor vehicle so that, if necessary, treatment for that condition can be given in the vehicle or the child can be taken quickly in the vehicle to a place where treatment can be given. **Organisational badges** may be issued as long as the organisation* in question meets the following criteria: • Cares for and transports disabled people who would themselves meet one or more of the eligibility criteria for an individual badge; • Has a clear need for an organisational badge rather than using the individual badges of the people it is transporting.	*physiotherapist or occupational therapist). Unless, that is, it is self-evident from the information that the applicant is either eligible or ineligible and an assessment would be of no further assistance. The assessor may be employed by the local authority but it should not be someone who has been involved in the applicant's care/treatment nor should it be the applicant's GP. Although, factual information from the GP/other medical professionals may be used as evidence to support decision-making.* **An 'organisation' is defined in the 2000 Regulations as meaning an organisation **concerned with the care of disabled persons** to which a disabled person's badge may be issued in accordance with section 21(4) of the Chronically Sick and Disabled Person's Act 1970.*
1.4	**Assessing eligibility of applicants subject to further assessment** The DfT guidance explains that eligibility under the 'subject to further assessment' criteria categories should be carefully assessed in order to maximise fairness and consistency across the country. Local authorities must record their procedures and the outcome of the assessment process in order to provide transparency for applicants and evidence of compliance with legislation/ guidance in the event of a complaint to the Local Government Ombudsman. The DfT guidance provides detailed information to assist local authorities in assessing eligibility under the various categories of applicant that are subject to further assessment. These are detailed below along with some key points to note, however, the relevant section of the DfT guidance should be consulted for further information and to ensure compliance: ***Assessing people with walking difficulties*** (See section 4.4 of the DfT guidance) • The applicant must have any permanent and substantial disability meaning they cannot walk or have very considerable difficulty walking. • Eligibility is not determined by the presence or absence	*An independent review of the BBS concluded that "intelligent use of independent mobility assessments in combination with initial cross-checking of existing council records and well-designed desk-based assessments (to filter out*

1.0	POLICY	*PRACTICE*
	of a particular condition. • It is the local authority's responsibility to determine whether the disability is permanent. Applicants should be reminded that they have a duty to return the badge should their mobility improve. • Applicants should be considered unable to walk if they cannot take a single step. • The factors to be taken into account in determining difficulty walking include – whether excessive pain and/or breathlessness are reported by the applicant when walking; the distance they are able to walk without experiencing pain/breathlessness; the speed at which they can walk; the length of time they can walk for; the manner in which they walk; their use of walking aids; their outdoor walking ability and whether the effort of walking presents a danger to the applicant's life or could lead to serious deterioration in health. ***Assessing people with a severe disability in both arms*** (See section 4.5 of the DfT guidance) • The applicant must drive regularly **and** have a severe disability in **both** arms **and** be unable to operate/have considerable difficulty operating all/some parking meters. • Applicants should only receive a badge if they meet **all three of the** conditions – only a small number of people are likely to qualify under this criterion. ***Assessing children under the age of three*** (See section 4.6 of the DfT guidance) • The types of equipment that might mean a child is eligible for a badge includes – ventilators, suction machines, feed pumps, parenteral equipment, syringe drivers, oxygen administration equipment, continuous oxygen saturation monitoring equipment, casts and associated medical equipment for the correction of hip dysplasia. • The types of condition that mean a child may need quick access to transport include children with tracheostomies, severe epilepsy/fitting or highly unstable diabetes and terminally ill children who can only access brief moments of outside life and need a quick route home. • The above lists are not exhaustive and each child application should be treated as a special case. • Medical assessments should not be necessary; a letter from the child's paediatrician confirming their condition and the equipment required is sufficient.	*those applicants who are 'self-evidently' eligible or ineligible) was the most cost-effective and robust method of assessing an applicant's eligibility under the 'subject to further assessment' walking criterion." (DfT guidance)*

1.0	POLICY	*PRACTICE*
	Assessing organisational badge applications (See section 5.2 of the DfT guidance) • Ensure applications are genuine and necessary; it is for local authorities to make this judgement based on their local knowledge of the organisation concerned. • Residential care homes, hospices and local authority social services departments are common examples of eligible organisations. • It is unlikely that taxi/private hire/community transport operators will be eligible – such organisations should use the badge belonging to the individual they are transporting. • Organisations may be asked to provide the same type of information required by the Driver and Vehicle Licensing Agency (DVLA) for licensing a vehicle under the Disabled Passenger Vehicle (DPV) taxation class (for exemption from vehicle excise duty). To license a vehicle in the DPV taxation class, an organisation needs to make a signed declaration on the organisation's letter headed paper. The declaration for a badge application needs to say that they are an organisation concerned with the care of disabled people (who would met one or more of the eligibility criteria prescribed in the regulations that govern the Blue Badge scheme) and that they will be using the vehicle solely for the purpose of transporting those people. • Badges must be issued to the organisations not individual employees. • If there are only a small number of people eligible for a badge who would be transported by the organisation, it should be advised that the individuals themselves should apply for a badge rather than the organisation. • Organisations should be reminded, and should inform all of their employees, that if they use the badge to take advantage of the concessions when there are no passengers who are themselves eligible for a badge, they could face a fine of up to £1,000.	*It must be established that the applying organisation is in fact 'concerned with the care of disabled persons who would themselves be eligible for an individual badge.' It may be necessary for the assessing member of staff to conduct some research into the organisation in this respect (e.g. online, by speaking to other council departments or by visiting the organisation). The provision of 'care' is the primary consideration and it is a requirement that the organisation is registered with CQC or Ofsted as a provider of care to people with disabilities that meet the eligibility criteria for a badge.* *Although specialist vehicles, including those in the DPV taxation class (that are used solely for the purpose of transporting disabled people), are taken into account in the decision-making process, badges will not be granted purely on the basis of an organisation having specially adapted vehicle. Rather, an organisation must evidence that they meet the criteria outlined at 1.3 – they must <u>care for and transport</u> individuals who would themselves be eligible for a badge and they must have a <u>clear need for an organisational badge</u> rather than using the individual badges of the people being transported. Whilst the number of people cared for by the organisation who would themselves be eligible for a badge is taken into account when determining whether an organisational badge should be issued, this is not the only factor under consideration in deciding whether an organisation has a clear need for an organisational badge.*

1.0	POLICY	*PRACTICE*
1.5	**Unsuccessful applications** ***Grounds for refusal to issue a badge*** • The applicant holds or has held a badge and misuse has led to a conviction for an offence defined in regulations 2(3) and 2(4); or • The applicant fails to provide the local authority with adequate evidence of their eligibility, either as an individual or as an eligible organisation; or • The applicant fails to pay the fee chargeable for the issue of a badge (if a fee is required by the issuing authority); or • The local authority (i) has reasonable grounds for believing that the applicant is not the person they are claiming to be, or (ii) would permit another person to whom the badge was not issued to use the badge; or • The applicant fails to provide evidence of residency; or • The applicant already holds a valid badge issued by another issuing authority; or • A report from an independent mobility assessor confirming an applicant's eligibility has not been made available to that local authority in a form that is satisfactory to them. In accordance with DfT recommendations, all applicants who are refused a badge should be **informed in writing of the reasons for refusal**. This cannot simply be to say that they did not meet the eligibility criteria; a full explanation must be provided. Unsuccessful applicants must also be informed of the **appeals procedure** (see procedure section 2.13). The DfT guidance sets out two distinct ways in which a person may want to contact their local authority following an unsuccessful application: • They may wish to **request a review of the decision** if they feel their application was wrongly refused (i.e. an appeal); or • They may wish to **complain** if they feel unhappy about the manner/conduct of the staff members who handled their application or if they feel the process was unfair. If a review of the decision is required, this should be performed by someone who was not directly involved in the initial decision. The second point would be dealt with under the authority's standard complaints procedure; therefore, unsuccessful applicants should be informed of this and also reminded that they can also contact the Local Government Ombudsman.	*Regulation 8 of the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000 (SI 2000/ 682) (as amended by (SI 2011/2675))* *See procedure section 2.13 regarding the appeals process through which unsuccessful applicants in Halton can 'request a review of the decision'.* *Information on the Council's complaints procedures is available on the Council's website.*

1.0	POLICY	*PRACTICE*
1.6	**Successful applications** Successful applicants should be provided a copy of the DfT leaflet 'The Blue Badge Scheme: rights and responsibilities' along with their Blue Badge. There is a leaflet for individuals and one for organisations, both of which are available on the DfT website but will also be provided by The Blue Badge Improvement Service when the badge is sent. ***Badge issue fee*** The fee for individual and organisational badges is £10. ***Return of badges*** Badge holders must be advised that they are required to return their badge in the following situations: • The badge expires; • The badge holder is no longer eligible; • The organisation is no longer eligible or no longer exists; • If a replacement badge has been provided because the original was lost or stolen and the original is later found, it should be returned so it can be securely destroyed; • If the badge is damaged/faded making it illegible or meaning that it cannot be identified correctly or distinguished from a forgery; • The badge is no longer required (e.g. the holder has become confined to their house); • Another valid badge has been inadvertently issued by another authority; or • The badge holder dies. The badge remains the property of the issuing authority and they have the power to withdraw it in some circumstances. ***Period of issue*** Most badges must be issued for **three years**, with the following exceptions: • For children under the age of three, the badge should be issued for a maximum period ending on the day immediately following their third birthday; • Where entitlement for a badge is linked to an award of the Higher Rate of the Mobility Component of Disability Living Allowance, War Pensioner's Mobility Supplement or Personal Independence Payment, the period of issue should follow the period of receipt of that allowance if it is less than three years. (If any of those awards have been granted for a period longer than three years, the badge should still only be issued for the standard three-year period).	*Section 3.6 pf the DfT guidance sets the maximum fee at £10.* *Regulation 9 of the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000 (SI 2000/ 682)*

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	Renewal applications Renewal applications should be dealt with quickly and efficiently but offer an important opportunity to: • Confirm that those who were awarded a badge under the 'without further assessment' criteria are still receiving the qualifying benefits; if they are not, they may need to be assessed under the 'subject to further assessment' criteria; • Check that those who were awarded a badge under the 'subject to further assessment' criteria continue to meet that criteria; even if they have the same disability it is possible that their mobility may have improved; • Ensure that personal details are correct and that the badge is legible and displays an up-to-date photography; this will be the case for people who have a permanent disability that will not change, e.g. loss of limbs. Local authorities are able to determine their own methods for assessing eligibility at the point of renewal, in line with the regulations. If the initial application involved a robust independent mobility assessment, it may be possible to highlight applicants who have conditions that are unlikely to change and would therefore not require a further in-person assessment at renewal. ***Replacement badges*** A replacement badge can be issued if the original has been: • Lost; • Stolen (this should be reported to police and a crime reference number obtained); • Destroyed; or • Damaged to the point that it is illegible. The replacement badge should have the same expiry date as the original. The record of the original badge should be updated on the Blue Badge Improvement Service to show that it is no longer valid. If lost or stolen badges are later found after a replacement is issued, the original should be returned to the local authority so it can be destroyed. Damaged badges should also be returned to the local authority to be officially destroyed. The date and reason for issuing a replacement badge should always be recorded so that repeated cases can be monitored to pick up on possible cases of abuse. Replacement badges are chargeable.	*See Appendix H of the DfT guidance for some core principles of badge renewals.*

1.0	POLICY	*PRACTICE*
1.7	**Abuse/misuse** Below are some examples of how the badge scheme may be abused or misused. *By the badge holder:* • Parking in the wrong place/for longer than the time allowed; • Using a badge that is no longer valid, has been reported lost/stolen or is a copied version; • Allowing friends/relatives to use their badge whilst not transporting the badge holder; • Altering the details on the badge, e.g. the expiry date; and/or • Making a fraudulent application or using a badge that was obtained fraudulently. *By a third party:* • Using someone else's badge (with or without their knowledge) without their presence in the vehicle; • Using a badge belonging to someone who has died; • Using stolen/fake badges; and/or • Copying/altering or faking badges. It is important that all badge holders are made aware of their responsibilities and the consequences of badge misuse at the point of issue, in order to help ensure that instances of accidental misuse are prevented.	*The DfT's guidance leaflet 'The Blue Badge scheme: rights and responsibilities in England' is supplied with the badge.*
1.8	**Enforcement** The Blue Badge Scheme is susceptible to abuse given that badges can present substantial monetary value and any misuse of badges undermines the benefits of the scheme for disabled people. The DfT guidance offers comprehensive advice for local authorities in terms of how they can prevent/combat abuse (see section 7 of the guidance for further detail and procedure section 2.15 for information on local processes).	*There is a range of legislation that local authorities can use with flexibility to enforce the scheme and combat abuse in their area. Full details of the relevant legal powers and examples of their application are provided within the DfT guidance (see section 7).*

2.0	**PROCEDURE**	***PRACTICE***
2.1	**Responsibilities** For Halton Borough Council, Halton Direct Link (HDL) and the Contact Centre are responsible for administering the Blue Badge scheme, in particular: • Dealing with initial enquiries and issuing application packs; • Processing new/renewal applications from individuals/ organisations; • Sending any applications as appropriate to the Initial Assessment Team (IAT); • Checking that any medical information forms are fully completed before forwarding to the IAT; • Ensuring that applicants have provided all the required information/evidence; • Ordering badges and collecting fees; • Sending/receiving correspondence and dealing with queries about the scheme; and • Record keeping. The Initial Assessment Team (IAT) is responsible for: • Desk-Based Assessments (where required); • Independent Mobility Assessments (where required); • Any applications relating to a child under the age of three years; and • Any applications relating organisational badges. The Complex Care Teams provide assistance to the IAT as and when required. Cheshire Police are responsible for parking enforcement in Halton.	*HDL and the Contact Centre act as the initial point of contact for Blue Badge related enquiries. Any applications that require assessment are sent to the Initial Assessment Team (IAT) via email to (admin.CAS&IAT@halton.gov.uk). Admin staff monitor this email inbox on a daily basis and send applications/appeals to the relevant member of staff, as detailed within this policy and procedure.*
2.2	**Initial applications** Applicants must provide proof of their residence, which will be checked via Council Tax records and/or the Electoral Register (for individual applicants) before an application pack is issued. If the applicant is not resident in Halton, they must be referred to the relevant local authority. The DfT leaflet *'Can I get a Blue Badge?'* should be sent to anyone making an enquiry about the BBS. Applications can be made in person at HDL offices or by telephoning 0151 907 8309. HDL/Contact Centre staff will undertake a brief assessment to ensure that the correct application pack is completed at HDL or emailed/handed/posted to the applicant or their representative.	*See appendix 1 for a flow chart of the application process.* *See policy section 1.3 re eligibility criteria.*

2.0	**PROCEDURE**	***PRACTICE***
	Members of the public can also go to www.gov.uk in order to check eligibility and apply online for a Blue Badge; the application will then be sent to the relevant local authority for processing. There are a number of different application forms depending on who is applying for a badge: • Appendix 4 – Application for those who do not require further assessment (aged 3 and above) • Appendix 5 – Application for those who are subject to further assessment (aged 3 and above) • Appendix 6 – Application for a child under the age of 3 years • Appendix 7 – Application for an organisational badge • Appendix 8 – Fast-track application form (palliative care cases) • Appendix 9 – Pre-assessed application form • Appendix 10 – Renewal without further assessment application form **Note: all of the application forms (appendices 2 to 8) are available as separate, stand-alone documents, rather than being included at the end of this document.** Applications (complete or not) are recorded on the Blue Badge Improvement Service (BBIS) system, together with notes of any contact with the applicant (i.e. telephone calls, letters etc.) HDL/Contact Centre staff do not record information on CareFirst (the Council's client records system for social services), however, the IAT do load information relating to mobility assessments etc. onto this system.	
2.3	**Evidence required** *Proof of identification/address* In order to validate that the applicant is the person they claim to be and that they are resident in Halton, two forms of identification are required with all individual applications. If possible at least one form of identification should be photographic, for example, a bus pass, passport or new style driving licence. At least one form of identification should show the applicant's current address. Council Tax records and the Electoral Register will also be checked as additional verification. With regards to applications on behalf of children under the age of three, a copy of their birth or adoption certificate should be supplied.	

2.0	**PROCEDURE**	***PRACTICE***
	With regards to organisational applications, photographic identification is not required; however, the organisation's logo must be supplied with the application. *Proof of eligibility* The preceding policy section of this document outlines the eligibility criteria along with reference to the relevant section of the DfT guidance where the acceptable forms of proof of eligibility are outlined.	
2.4	**Eligible without further assessment applications** HDL/Contact Centre staff assess whether the applicant meets the *eligible without further assessment* criteria (i.e. if they are in receipt of the specified benefits) or whether medical information will be required to determine eligibility. Where applicants meet the eligible without further assessment criteria, the application is complete once photographs, proof of identification and other relevant evidence to support the application has been provided. The badge can then be ordered, subject to the payment of £10.	*See policy section 1.3 for the without further assessment eligibility criteria.*
2.5	**Eligible subject to further assessment applications** Where applicants apply under the *subject to further assessment criteria*, they should also be offered a referral to the Welfare Rights Service (0151 471 7448) to check their eligibility for qualifying benefits. For applications requiring further assessment, HDL staff will check the form to ensure that all relevant sections have been completed before forwarding to the IAT via the generic email address for a **desk-based assessment (DBA)**. If the DBA assessor needs to clarify any issue they can check CareFirst or contact the applicant directly. If the applicant has checked the permissions boxes on the application form, the assessor can contact the applicant's GP or any other accredited health professional indicated on the form. DBAs are usually carried out by a Community Care Worker (CCW). The application is reviewed against a scoring matrix. The CCW is able to consult with an Occupational Therapist (OT) throughout the DBA process. There are three possible outcomes of a DBA: 1. Approval; 2. Refusal; and 3. Independent Mobility Assessment (IMA) required.	*See policy section 1.4 re assessing eligibility of applicants subject to further assessment.* *See appendix 2 for a flow chart of the application process for individuals aged three and above who are subject to further assessment.*

2.0	**PROCEDURE**	***PRACTICE***
	Approval The IAT should notify HDL if the DBA has resulted in an approval score and HDL will then arrange for supply of the badge. *Refusal* The IAT should notify HDL if the DBA has resulted in a refusal score and HDL will then send a refusal letter to the applicant, which also outlines the appeals procedure (see section 2.13). The IAT must provide detailed reasons for refusal to HDL so that this information can be communicated to the applicant. *IMA required* If, following the DBA, it is decided that an IMA is required in order to gather further information prior to making an award decision the application will be referred to an OT. The applicant will be contacted to arrange a clinic appointment so that they OT can conduct the IMA (in exceptional circumstances, a home visit may be arranged). HDL should also be informed that an IMA is to be conducted. The IAT should notify HDL whether the IMA results in an approval or refusal and HDL will either arrange for the badge to be issued or send a refusal letter to the applicant which also outlines the appeals procedure (see section 2.13). The IAT must provide detailed reasons for refusal to HDL so that this information can be communicated to the applicant.	
2.6	**Child (under 3 years) applications** Child applications are 'subject to further assessment' against the criteria outlined in the DfT guidance. HDL will check the application form before forwarding it to the IAT along with other supporting information. An OT is responsible for deciding whether the criteria are met. If the application is approved, the IAT should notify HDL who will then arrange for the badge to be supplied. If the application is refused, the IAT should notify HDL who will then send a refusal letter. The IAT must provide detailed reasons for refusal to HDL so that this information can be communicated to the applicant.	*See policy section 1.4 re assessing eligibility of applicants subject to further assessment.*
2.7	**Organisational applications** Organisational applications are 'subject to further assessment'	*See policy section 1.4 re assessing eligibility of applicants subject to further assessment.*

2.0	PROCEDURE	*PRACTICE*
	against the criteria outlined in the DfT guidance. HDL will check the application form before forwarding it to the Advanced Occupational Therapist (Advanced OT) along with other supporting information. The Advanced OT is responsible for deciding whether the criteria are met. In doing this, it will be necessary to research the organisation concerned to understand the care provided, the type of clients (to establish if they have the required degree of immobility to be considered eligible for a badge as an individual) and the sort of transport provided and the vehicles used. It may also be necessary to visit the organisation concerned in some cases. If the application is approved, the Advanced OT should notify HDL who will then arrange for the badge to be supplied. If the application is refused, the Advanced OT should notify HDL who will then send a refusal letter. The Advanced OT must provide detailed reasons for refusal to HDL so that this information can be communicated to the applicant.	
2.8	**Fast-track applications** An application may be fast tracked if an applicant has a terminal illness that seriously affects their mobility. A fast-track application form (appendix 8) should be completed and signed by the relevant medical practitioner (e.g. GP/Palliative Care staff/Macmillan Nurse) and forwarded to HDL along with details of the individual's medical condition.	*Section 3.5 of the DfT guidance states that local authorities may wish to have a fast-track process for people who have a terminal illness that seriously affects their mobility, in order to make the final weeks of their life easier.*
2.9	**Pre-assessed applications** Whilst undertaking an assessment in an individual's home an OT or CCW may feel that the individual would meet the criteria for a Blue Badge without further assessment. In these cases they can fill out the pre-assessed application form (appendix 9) and leave a letter with the applicant, which explains that they will need to send in the payment and photographs. This removes the need for a further medical assessment.	
2.10	**Renewal applications** Applicants will be allowed to apply to renew their blue badge up to three months in advance of the expiry date on their existing badge. HDL will write to badge holders to notify them	*See policy section 1.6 re successful applications.*

2.0	PROCEDURE	*PRACTICE*
	that their badge is due for renewal. Renewal badges will not be issued more than seven days prior to the date of expiry on the old badge. Completion of a new application form is required in all cases. In cases where a previous assessment has confirmed that no further assessment will be necessary in the future, there is a shortened version of the application form (appendix 10). This can only be decided by an OT following an IMA and is usually only in cases of progressive neurological conditions. Organisational badge renewals are to be treated the same as new organisational applications.	
2.11	**Badge issue** Blue Badges for successful applicants who meet the necessary criteria are ordered via the BBIS system by HDL staff. Badges contain a gender specific serial number for parking enforcement purposes, which must be correctly assigned to the applicant (transsexual/transgender applicants should be regarded in the gender with which they identify). An up-to-date photograph must be submitted and digitally scanned onto the back of an individual badge unless the local authority is satisfied that the holder is not expected to live beyond six months from the date of issue. A £10 fee will be charged when an application is accepted to be processed, as a receipt number is requested by the badge ordering system. In cases where a further medical assessment is needed to establish eligibility, and an application is subsequently refused, a full refund will be made. The badges are delivered to the HDL office specified by the applicant. HDL contact applicants to advise that the badge has been delivered and is available for collection. Badges may only be collected within seven days of the expiry date of a current badge. A parking disc (time clock) is designed to be displayed with the Blue Badge when parking on yellow lines or in parking bays which are time limited and set to show the time of arrival by badge holders. A parking disc should be issued to new badge holders at the same time as their blue badge.	*See policy section 1.6 re successful applications.*

2.0	PROCEDURE	*PRACTICE*
	Only exceptionally, at the specific request of the applicant or their representative, may the badge be posted out. This would be via Royal Mail second class post (the same postal method through which badges are received at HDL). Postage would only be increased at the Council's discretion if there had been any particular problems in the standard process. In the case of postal applications, the applicant/organisation will be contacted when the badge is approved. Payment of the £10 fee is requested at that point. No badge will be issued without payment of the fee. To help prevent fraud, HDL staff must check that the person collecting the badge is the applicant by checking the badge photographs. Representatives collecting badges on behalf of applicants will be asked to provide the successful application notification letter and a form of photo identification from the applicant as authorisation (the requirement for such evidence is highlighted in the notification letter). An information letter and the DfT leaflet *'The Blue Badge Scheme: rights and responsibilities'* are provided to all successful applicants along with the badge. Parents/guardians of children under three are also issued with additional information on the qualifying criteria. Most badges are issued for three years, although there are exceptions where badges may be issued for a shorter period as explained in policy section 1.6.	
2.12	**Unsuccessful applications** The most common reason for an unsuccessful application is the applicant failing to provide adequate evidence of eligibility. For all unsuccessful applications, a letter must be sent to the applicant detailing the reasons for refusing to issue a badge. This letter must also provide information on the appeals procedure (see section 2.13). Any photographs which were provided must also be returned. A period of six months must elapse before an unsuccessful applicant may reapply, unless: • The applicant becomes eligible under the without further assessment criteria; and/or • There is a substantial change in the applicant's medical condition; and/or; • The applicant is able to provide evidence that was previously not forthcoming.	*See policy section 1.5 re the grounds for refusal of a badge.*

2.0	PROCEDURE	*PRACTICE*
2.13	**Appeals** Applicants have the right to appeal against the decision not to issue them with a badge within 28 days of the date of the decision letter. They must contact HDL/the Contact Centre to request an appeal. **Note that although the term 'appeal' is used, it is a review of the decision and every effort will be made to ensure that this is dealt with by someone who was not involved in the original decision.** Appeals and the resulting outcome should be logged on the BBIS system by HDL. Every attempt will be made to deal with appeals within 28 days of receipt. However, in some cases it may take longer than this for a decision to be reached (if an IMA is required, for example). ***Appeal following a DBA*** If an appeal is received following refusal to issue a badge after a DBA, an OT will review the DBA. In light of the information provided as part of the appeal they may decide to issue a badge or invite the applicant for an IMA, after which a badge may or may not be issued. In any case, the processes outlined at 2.5 should be followed. ***Appeal following an IMA*** Any appeal following an IMA will be reviewed by the Council's Advanced OT to ensure that all processes have been followed correctly. If the Advanced OT finds that processes and decision-making procedures have been followed correctly (e.g. there have been no errors etc.), a refusal letter should be sent explaining why the applicant is not eligible for a badge and HDL should also be notified. If the Advanced OT finds that processes/procedures have not been followed correctly, they may decide to overturn the original decision and issue a badge. In which case, they should advise HDL to follow the process outlined in section 2.5 regarding approval. In cases where the Advanced OT finds that processes have not been followed correctly, the issues should be discussed with relevant staff to ensure that a similar problem does not arise with future applications.	*See policy section 1.5 re unsuccessful applications.* *See appendix 3 for a flow chart of the appeal process.*

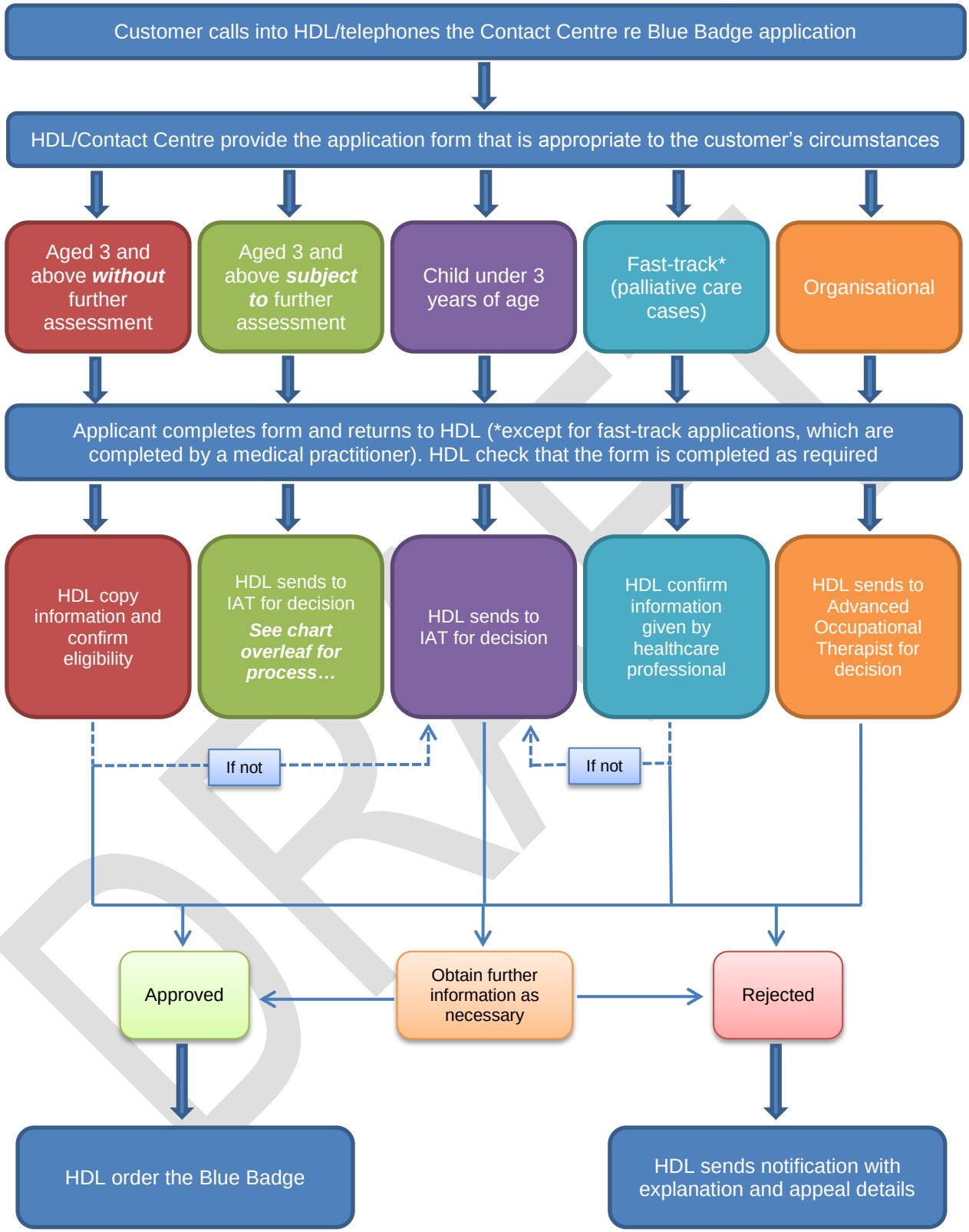
2.0	PROCEDURE	*PRACTICE*
	Appeals relating to organisational applications Appeals relating to organisational applications will be dealt with by the Divisional Manager with responsibility for the Blue Badge scheme. ***Appeals relating to applications for children under the age of three*** Appeals relating to applications for a child under the age of three will be dealt with by the Advanced OT. ***Complaints*** It must be noted that corporate complaints are entirely separate to appeals and may be made at any time relating to, for example, the behaviour/attitude of staff or processes not being followed but complaints **cannot** be made through this process against the actual decision. Applicants should be aware of their right to make a complaint they should also be advised that they can report any procedural irregularities/issues with their application to the Local Government Ombudsman.	*Information on the Council's complaints procedures is available on the Council's website.*
2.14	**Replacement badges** If a badge holder requires a replacement badge, they must contact HDL to request this. The reason for needing a replacement badge will be asked and recorded on the BBIS system. If the badge was stolen, the badge holder should be advised to report this to the Police and obtain an incident number. The badge holder will be advised to return the original badge, if it is later recovered so that it can be destroyed. Damaged badges must be returned to HDL at the same time the replacement badge is issued. There is a facility for members of the public to be able to report lost and stolen badges and any change of circumstances via www.gov.uk. Replacement badges will have an issue number on the front of the card next to the badge reference number. The expiry date shown on the replacement badge should be the same as the date that appeared on the original badge. The record of the original badge should be updated to show it is no longer valid. A £10 fee is charged for all replacement badges, irrespective of	*See policy section 1.6 re successful applications.* *The steps outlined in this section help to prevent potential abuse of the scheme.*

2.0	PROCEDURE	*PRACTICE*
	the reason for needing a replacement (e.g. loss, theft or damage).	
2.15	**Enforcement process** As outlined in policy section 1.7, there are a number of ways in which badges can be misused; it is therefore important to have processes in place to enforce correct use of the scheme and tackle potential abuse. The enforcement of parking restrictions in Halton is the responsibility of Cheshire Police (there are no civil parking enforcement arrangements in Halton). Penalty Charges are issued by the Police in Halton for any parking contravention (including a badge holder parking in the wrong place or parking with a valid badge but for too long). ***Preventing misuse*** Preventing abuse/misuse at the badge issue stage is an important element of the enforcement process; the procedures outlined in earlier sections of this document should be followed so as to ensure that: • The applicant's identity and address are checked and the badge is collected in person in order to prevent fraudulent applications; • Only those who are eligible for a badge are issued one and IMAs are used when eligibility is unclear; • Successful applicants are aware of, and understand, what constitutes correct use of their badge. ***Inspecting and retaining badges*** Police Constables and Police Community Support Officers (PCSOs) operating in Halton also conduct badge inspections on an ad-hoc basis in order to verify that the badge is being used by the correct person. Cheshire Police may contact the Council to establish further details about the badge holder and to check what information is held on the BBIS system. Badges are valid for use on a national level and, therefore, a badge issued in Halton may also be inspected in another local authority area (either by the police or other suitably authorised parking enforcement officer). A badge may be seized (by police in Halton or a parking enforcement officer in another area) if, upon inspection, there are reasonable grounds for believing that the badge: • Is a fake; • Has already been cancelled (because it was reported lost/stolen);	*See policy section 1.7 re abuse/misuse and 1.8 re enforcement.* *Section 7 of the DfT guidance outlines the wide-ranging legislation that is available for local authorities to use flexibly according to local circumstances and the specifics of each case of badge misuse.*

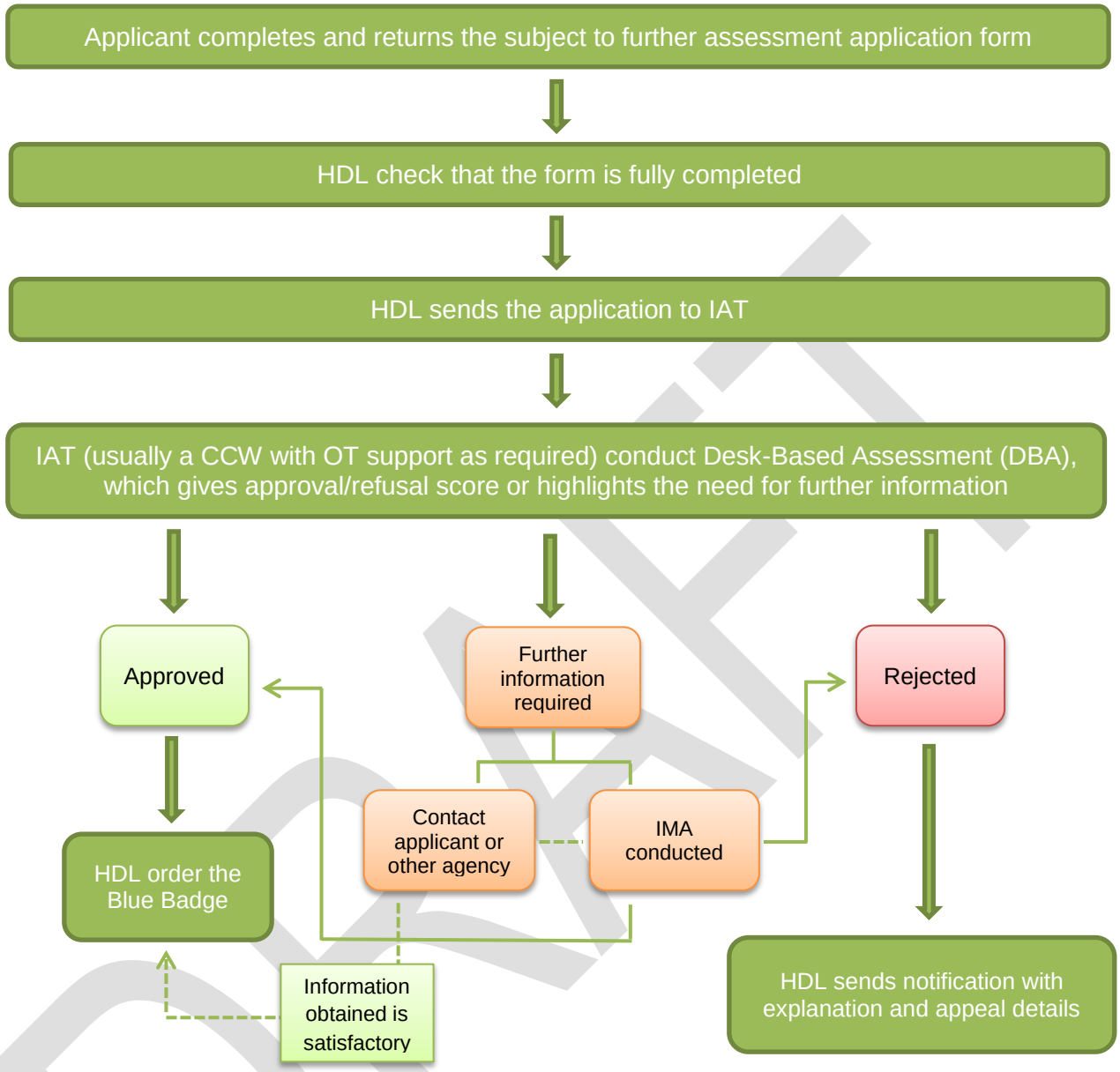
2.0	PROCEDURE	*PRACTICE*
	• Should have been returned to the issuing authority (for any of the reasons outlined in policy section 1.6); • Is being misused, which includes someone other than the holder using the badge without the badge holder being involved in the journey. Any badges that are seized (either within or outside Halton) are returned to Halton Borough Council as the issuing authority and HDL/Contact Centre staff will take action as necessary: • If seized under points 1-3 above, the badge would be destroyed; • If a valid badge is seized under point 4 above, it will normally be returned to the badge holder because the power to retain a badge is not the same as the power to permanently withdraw/confiscate a badge – the badge holder may not have known that the third party was using their badge. HDL/Contact Centre staff will contact the badge holder to advise that they need to collect their badge in person from one of the HDL Offices. They will be asked to explain the circumstances surrounding the alleged misuse and will be reminded of their rights and responsibilities under the scheme and what constitutes proper badge use. It is important to note that under Regulation 9(2) of the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000 a badge can be permanently withdrawn if a relevant conviction for misuse is obtained. **Halton Borough Council reserves the right to investigate and take such legal measures as deemed appropriate. This may be in conjunction with other agencies as necessary.** A relevant conviction requires that the non-badge holder is using the badge with the badge holder's knowledge; whilst this can be difficult to prove, local authorities are able to refuse to re-issue a badge if there are reasonable grounds for believing that the applicant would permit another person to use it (Regulation 8(2)(d)(ii)). Decisions to request that a badge is returned or not to renew a badge due to misuse must be taken by the Divisional Manager with responsibility for the Blue Badge Scheme. These are also the only circumstances under which an applicant can make an appeal to the Secretary of State for Transport. Where an appeal to the Secretary of State is unsuccessful, further appeal will be via the magistrate's court, whose decision is final.	

2.0	PROCEDURE	*PRACTICE*
	Reports of suspected misuse Members of the public are able to report suspected badge misuse to the Council; such information will be shared with Cheshire Police and the Council's Benefit Fraud section as appropriate and further investigation will take place. Following a report of misuse, the badge holder may be contacted and asked to present their badge for inspection by a Team Leader at one of the HDLs. This provides an opportunity to check whether the badge has been tampered with and to advise the badge holder of their responsibilities and encourage them to comply with them in the future. ***Recording badge misuse*** Accurate records of all badge seizures and reported incidences of (suspected) misuse must be maintained by HDL. Badge withdrawals or refusal to issue a badge due to misuse should be recorded on the BBIS system. Separate records of reported/suspected misuse are maintained internally in order to identify repeat incidences of misuse relating to the same badge holder. If more than one incident relating to an individual badge holder is recorded, a warning letter will be sent to the badge holder, advising that misuse is a criminal offence and if it continues, the badge may be revoked or not renewed upon expiry.	

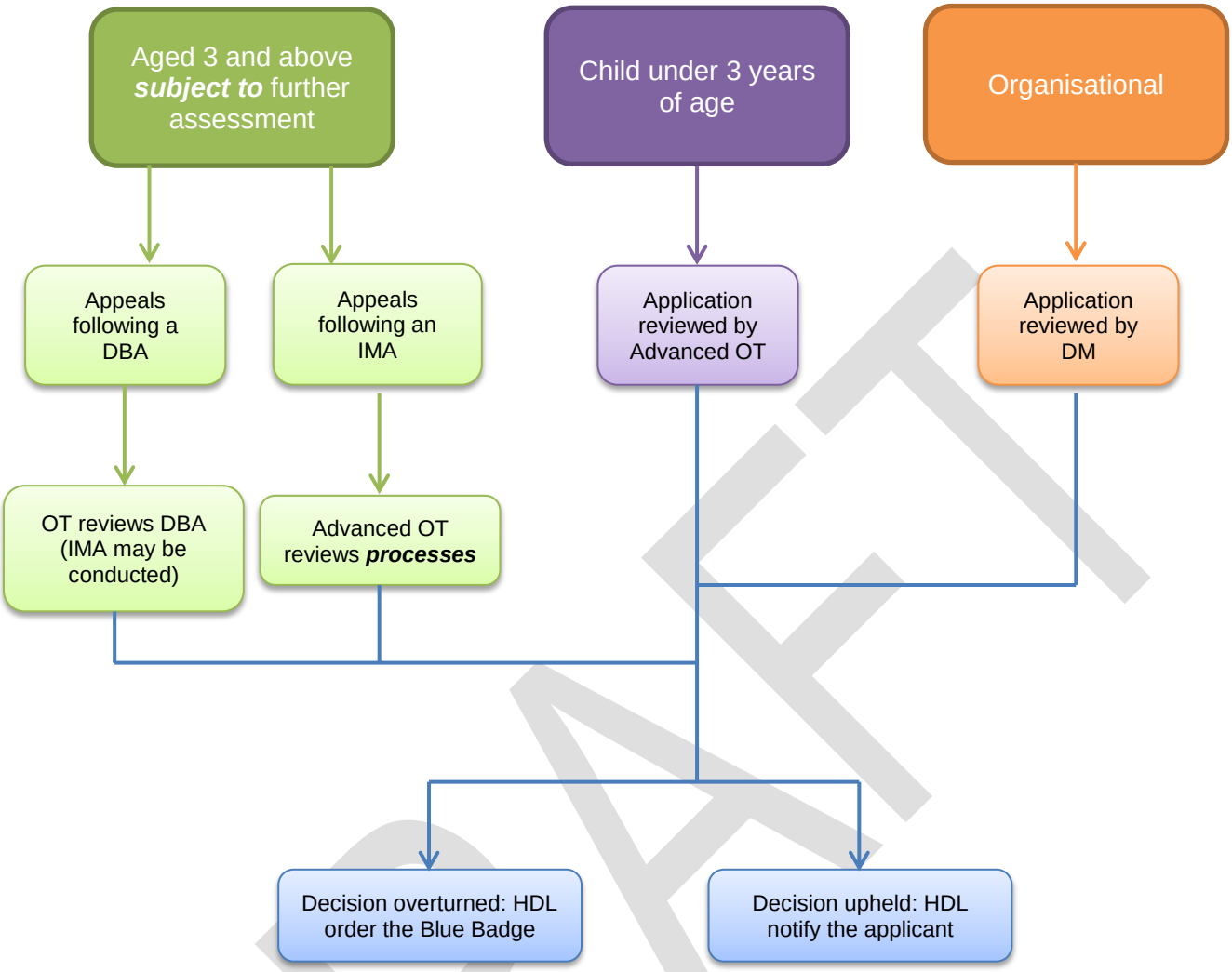
APPENDIX 1: Blue Badge application process flow chart



APPENDIX 2: Aged 3 and above subject to further assessment application process flow chart



APPENDIX 3: Appeals process flow chart



Appendix 2

Organisational Blue Badges – Research with Local Authorities

A number of questions were email to the following authorities (via their generic blue badge email addresses): **Cheshire West & Chester**, **Cheshire East**, **Warrington**, Liverpool, Knowsley, **Sefton**, Trafford, Bolton, Manchester, **Oldham**, **Blackburn**, Rochdale, Lancashire, Cumbria (those in **bold** are those who responded)

Have you developed specific local criteria to determine the types of organisations that are eligible for a badge, which goes over and above the information contained in the guidance?

Warrington	No we are faithful to the LA Guidance.
Oldham	No local policy regarding this currently exists.
Blackburn	We follow the DfT guidance to the letter! We don't have a 'local' policy for this; we refer organisations to the DfT criteria and will refuse applications if they do not match.
Sefton	All the applications now come to the OT Team for vetting and we have reduced our numbers considerably. We do use the Local Authority guidance and we have a separate form that we give out.
Cheshire West	We haven't developed specific Local criteria as we are familiar with organisations working in the community. We have worked with these organisations closely for many years so are familiar with their requirements. In addition when an Organisational badge comes in and if we are unfamiliar with the company we will look into the organisation to see who they are and what they do.

What do you consider constitutes providing 'care' when looking at whether the organisation *cares for and transports* those who would themselves be eligible for a badge? Is the care the primary consideration? Should it be a care provider such as a care home and as part of that care transport may be provided? Or would you consider that if a transport operator provides assistance boarding the vehicle and during the journey (e.g. provision of passenger assistants) that they are then providing 'care'?

Warrington	We are usually looking at care homes but those with residents who would themselves qualify for a Blue Badge. An example is we recently received an application for a home that had residents with learning disabilities – we researched the home online (including CQC reports etc.) and spoke to one of our social workers who had recently visited and she told us that none of the residents had mobility issues; it was mental health issues only. We refused the application. Another example is a supported living home for maximum 12 residents, mostly mental health and learning disabilities, some with mobility issues. We questioned the care provider and again one of our mental health team. We found that most were mental health/learning disability only and that those with mobility issues were in receipt of DLA or PIP. We refused the badge for the home and encouraged individual badges for those who needed them. The care provider reluctantly applied for the individual badges for their clients as they said it was time consuming and the organisational badge was an easier option for them. Care is our primary consideration and no, if a transport operator provides assistance we would not consider that to be 'care'. Again, we would encourage

	individual badge holders to use their badges.
Oldham	The organisations which have applied for blue badges have been those for care homes and day centres however as many of the people who are being transported already have badges anyway the number of organisational badges tends to be limited.
Blackburn	We have issued badges to Care Homes, special education services or Day Care services, such as our Welfare transport service, however we do not issue badges to community transport organisations as they are only providing a 'taxi service' and do not provide any care to the passenger. We advise CT organisations to encourage their users to apply for their own badge (if eligible) and then use it whilst travelling with the CT provider.
Sefton	We do not define 'Care' when looking at the provision of the Badge.
Cheshire West	We would use all the information provided on the application by the organisation applying. (Please see attached application) We would apply common sense, for example if it was an elderly care home they are going to have mobility concerns. They are going to need to be taken to appointments, as well as other necessary trips out to assist with their quality of life and the care they are given. We wouldn't consider a transport operator as any passengers they transport would be able to apply in their own right providing they met the necessary criteria. We would be looking more to award organisational Blue badges to Care providers like care homes, day care facilities where they are responsible for a larger number of disabled people. We apply the criteria set out in the Guidance document that you have quoted previously is so much that, " An organisational badge may be issued to organisations whose responsibility includes the **care and transportation** of disabled people who would themselves meet the eligibility criteria for a badge should they apply individually."

Are there any circumstances in which you would give badges to a private hire or community transport operator?

Warrington	No, they would only be transporting and not in their 'care'.
Oldham	Not unless this was proved to be essential.
Blackburn	None at all – the DfT criteria states that it is unlikely that they are eligible as they do not provide 'care services' to the passenger.
Sefton	We have historically given to our Community Transport Local providers although we have had less and less of late.
Cheshire West	We wouldn't award Blue Badges to private hire companies. With regards to community transport companies we would look at on an individual basis and would be looking to award when they regularly transport disabled people and not just on an ad-hoc basis.

Do you have any local authority fleet vehicles (e.g. those that provide transport specifically for disabled groups etc.) with blue badges?

Warrington	Yes, we do have approx. 8 fleet vehicles with Blue Badges. They have been issued specifically to a special needs school who have their own vehicles allocated for each key stage. The school, across each key stage, has a variety of mobile and non-mobile students with learning disabilities. The badges have been issued with guidelines for their use and are only used when a non-mobile pupil is present on one of the vehicles. At other times the vehicles are used without the badges. They sign the badge out to a driver when they know a non-mobile pupil is going to be present on the vehicle.
Oldham	No.
Blackburn	Yes, our Welfare transport fleet do have Blue Badges as the drivers also provide care to passengers and stay with them for the duration of their trip (including at the destination).
Cheshire West	We do not have any fleet vehicles that have been awarded an organisational badge.

Do you only give blue badges to organisations with vehicles that are registered in the DPV tax class (and are therefore tax exempt because they are used solely for transporting disabled people)? Or only to vehicles that have ramps/lifts etc.?

Warrington	No, we ask about DPV taxation class as part of the application process as that can play a part in our decision making. We also ask about adaptations but we don't make a decision just on the vehicle used.
Oldham	Applications are considered for all organisations however those issued tend to be for vehicles which are DPV tax class.
Blackburn	It is wholly dependent on what they do with the passenger (as detailed above). CT and Private Hire companies can be registered in the DPV tax class but are not eligible for a Blue Badge.
Sefton	The first thing we look at is whether the organisation has a DPV tax certificate and this must be provided. Although, as this does not necessarily prove the vehicle is adapted, we will also accept a photo displaying the disabled ramp etc.
Cheshire West	If the organisation passes in its own right for the care and transportation of disabled people then it would not matter what vehicle they use as the Blue badge will cover the organisation. In the majority of instances the care home will have a DPV and will also have lifts/ramps etc. but this is not the only basis we will award on.

How do you expect organisations to demonstrate that they will only use the badge when transporting people who would themselves be eligible for an individual badge? Do you expect them to know detailed information about the people they are transporting, such that they should be able to say whether or not they would be eligible for a badge as an individual?

Warrington	When we receive an application, we research the organisation to see what type of residents are likely to be in their care. We are very clear on why we are issuing a badge or not. There is an element of trust once the badge has been issued as the resource is not there to monitor the use of the badge(s).

Oldham	We issue very few of these and they have to be able to prove the type of people going to be transported however more usually it is easier to get the individuals to apply.
Blackburn	We ask the organisation to provide details of their passengers' disabilities and whether or not they would be eligible if they made a personal application. We do not do checks on this as we know the majority of organisations who apply for badges.
Cheshire West	We interrogate each organisational application and if necessary liaise with other local authority departments to gain an insight into the level of care and transportation provided. We also work closely with colleagues in the Fraud team to ensure ongoing enforcement is present in the authority. We would assume this as they would have specific experience in the their field and due to the genuine requirement of the Blue Badge and the inconvenience of having a badge removed from them it is unlikely they would apply fraudulently but again we find that by researching the companies we are able to match the disabilities that they cater for to the criteria that we would use to award Blue Badge on an individual basis. If information is lacking we will request further evidence and information in support of their application.

What sort of things do you look for in determining whether the organisation needs an organisational badge rather than using the individual badges of the people it is transporting?

Warrington	We are really keen for individual badge holders to use their badges rather than issue an organisational badge. We really question the applicant to be clear that we are issuing for the right reasons – we use the LA Guidance to help us ask the right questions. We want to know how many residents there are; how many have mobility problems and why do they not have their own badges? How old are the residents; is it an elderly care home? We look at the ration between mobile and non-mobile, if a low number of non-mobile, they should have their own badges.
Oldham	The size of the organisation, type of organisation, type of vehicle i.e. is it a suitable type of vehicle for transporting the individuals, how often the badge is likely to be used etc.
Blackburn	We ask the organisation to provide details of their passengers' disabilities and whether or not they would be eligible if they made a personal application. We do not do checks on this as we know the majority of organisations who apply for badges.
Sefton	We ask the question regarding how many eligible disabled individuals are in the organisation. We look at a minimum of 15. If there are less we encourage individual applications.
Cheshire West	We will Research the company requesting the badge in order to see what they need it for and the amounts of disabled people they are likely to transport. As previously advised, if necessary we liaise with service partners and council teams to understand the level of care provided.

Do you routinely visit organisations in assessing their applications? What questions are asked etc.?

Warrington	No, we don't routinely visit, however, I believe Liverpool City Council did visit each one, and this reduced the amount of badges issued.
Oldham	No as unfortunately there is no capacity with the team for carrying out any visits, it is all we can manage to keep up with the number of applications with the staff we have.
Blackburn	We do not visit organisations to assess their applications – most checks are done online to understand the organisation, their customers and their requirements.
Sefton	We do not have the capacity to visit the organisations.
Cheshire West	We don't feel the need as we work closely with our fraud team.

Cheshire East (telephone conversation with Liz Rimmer – 01270 371448 / liz.rimmer@cheshireeast.gov.uk)

- Don't have a Blue Badge Policy – just follow the DfT guidance
- Organisation must be concerned with the care of disabled people, which wouldn't include assisting onto/off the vehicles
- Cap of 20 badges per organisation – one organisation (David Lewis Centre) appealed but it was rejected and they were simply advised to manage their badges better

All LAs were asked to share a copy of their Blue Badge Policy; none of those who responded actually sent a copy. However, some are available online:
https://www.wirral.gov.uk/sites/default/files/all/Parking,%20roads%20and%20travel/parking/Blue%20badges%20and%20disabled%20parking/Wirral%20Blue%20Badge%20Policy.pdf

http://www.lancashire.gov.uk/media/897181/lcc-blue-badge-policy.pdf
Also, their web page (http://www.lancashire.gov.uk/roads-parking-and-travel/parking/blue-badges.aspx#organisation) states the following:

Organisational badges

Blue Badges for organisations may be issued to an organisation for use in a motor vehicle used solely for the purpose of transporting disabled people who would themselves be eligible for a badge. An organisation is defined as meaning an organisation concerned with the care of disabled persons to which a disabled person's badge may be issued.

You will be required to provide proof of any vehicle adaptations and Disabled Passenger Vehicle (DPV) excise exemption.

The rules about eligibility for a Blue Badge have changed considerably. Even if you have been issued with a Blue Badge in the past, this does not mean that you will be able to get one again.

EQUALITY IMPACT ASSESSMENT – STAGE 1

EIA Ref		
Lead Officer	Name	**Natalie Johnson**
	Position	**Policy Officer, People Directorate Policy Team (Adult Social Care)**
	Contact details	**0151 511 8909**

SECTION 1 –Context & Background

1.1 What is the title of the policy/practice/service?

Blue Badge Disabled Persons Parking Scheme Policy, Procedure & Practice

1.2 What is the current status of the policy/practice/service?

Existing		**Changed**	✓	**New**	

1.3 What are the principal aims and intended outcomes of the policy/ practice/service?

The Blue Badge Scheme (BBS) helps disabled people with severe mobility problems to access goods and services by allowing them to park close to their destination, whether they are a driver or a passenger. The policy aims to ensure that the scheme is administered consistently and fairly, in accordance with the Department for Transport regulations and guidance.

1.4 Who has primary responsibility for delivering the policy/practice/service?

Halton Direct Link (HDL) staff involved in administering the scheme and Occupational Therapists in the Initial Assessment Team (IAT) who are responsible for assessments.

1.5 Who are the main stakeholders?

Eligible disabled people who benefit from the scheme.

1.6 Who is the policy/practice/service intended to affect?

Residents		Staff		Specific Group(s) ✓ - (add details below)

Disabled people who are/may be eligible for a badge.

1.7 Are there any other related policies/practices/services?

No.

EQUALITY IMPACT ASSESSMENT – STAGE 1

SECTION 2 – Consideration of Impact

2.1 Relevance: – the Public Sector Equality Duty

Does this policy/practice/service show due regard to the need to: -

(a) Eliminate discrimination, harassment, victimisation and any other conflict that is prohibited by the Equality Act 2010
(b) Advance equality of opportunity between two persons who share a relevant protected characteristic
(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

Yes (✓) **No** ( )
State reasons below

The policy helps to ensure that disabled people with mobility problems are able to access goods and services by allowing them to park close to amenities.

2.2 Has data and information been used in determining the impact of the policy/practice/service (under review) on those with a protected characteristic?

Yes		No	✓

In "Yes" - please provide a brief summary of the principal findings / conclusions of this data/information/consultation.

If "No" – what further data/intelligence/consultation is (or will be) required to provide sufficient evidence of the impact on the protected characteristics.		
Information Source/Planned Activity	Timeframe	Lead Officer
N/A – this policy is in line with requirements under legislation and national guidance published by the Department for Transport.		

2.3 On the basis of evidence, has the actual / potential impact of the policy/ practice/service been judged to be positive (+), neutral (=) or negative (-) for each of the equality groups and in what way? And has the level of impact judged to be high (H), medium ((M), or Low (L)?

Protected Characteristic	Impact type +, =, -	Level H, M. L, -	Nature of impact
Age	+	M	This policy has a positive impact for disabled people as it
Disability	+	H	

Gender	=	L	outlines the local parking scheme (in line with national legislation/guidance) for allowing those with mobility problems to easily access amenities. Given that a large proportion of those with mobility problems will be in older age groups, there is also a positive impact on age.
Race / ethnicity	=	L	
Religion / belief	=	L	
Sexual Orientation	=	L	
Transgender	=	L	
Marital status/ Civil Partnerships	=	L	
Pregnancy/Maternity	=	L	
In Halton two further vulnerable groups have been identified: -			
Carers	+	M	Badges can be used for eligible disabled people when they are a passenger, therefore there is a positive impact for carers when accompanying the cared for person in accessing local services.
Socio – economic disadvantage	+	L	

2.4 How will the impact of the policy/practice/service be monitored?

Performance monitoring information is collected in line with DfT requirements.

2.5 Who will be responsible for monitoring?

HDL staff, Occupational Therapists in the Initial Assessment Team and the Principal Manager of the team.

2.6 If any *low to moderate negative* impacts, or potential *negative* impacts, have been identified, what mitigating actions will be put in place, thereby eliminating the need for a further Stage 2 assessment.

Where none have been identified insert 'no further action required' in the first column.

If any high impacts are identified – a Stage 2 assessment should automatically be completed.

Action & purpose / outcome	Priority	Timeframe	Lead Officer
No further action required	*(M, L)*		

2.7 Summary of stakeholders involved in this review

Job Title or Name	Organisation / representative of
Natalie Johnson, Policy	People Directorate Policy Team (Adult Social

EQUALITY IMPACT ASSESSMENT – STAGE 1

Officer	Care)

2.8 Completion Statement

As the identified Lead Officer of this review I confirm that:- No negative impact has been identified for one or more equality groups and that a Stage 2 Assessment is not required ☒

Signed: N Johnson	**Date: 10.02.2017**

Completed EIAs should be sent to Shelah Semoff, Enterprise, Community & Resources Directorate, to be given a unique reference number and for inclusion on the central register.

REPORT TO: Health Policy & Performance Board

DATE: 19th September 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports: Quarter 1 2017/18

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 1 of 2017/18. This includes a description of factors which are affecting the service.

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

i) Receive the Quarter 1 Priority Based report

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

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

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 1, 2017/18.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 1: 1st April to 30th June 2017

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the second quarter of 2017/18 for service areas within the remit of the Health Policy and Performance Board. These areas include:

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

2.0 Key Developments

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

Adult Social Care:

Review of the North West Boroughs Acute Care Pathway and Later Life and Memory Services

Following a whole-system review of the way in which the North West Boroughs' mental health services were delivered, a series of developments have taken place across the Trust footprint, to ensure safer and more effective service delivery. For Halton, this has meant the local authority, the North West Boroughs and NHS Halton Clinical Commissioning Group (CCG) working closely together to achieve the following changes:

- Changes to the provision of inpatient services in the borough, with the development of specialist inpatient resources outside Halton for people with dementia and older people with mental illnesses
- A local borough management structure has been developed, which can relate more closely to Halton strategic structures
- Work has been going on across the whole local system to develop clear care pathways to prevent mental health deterioration and reduce the need for people to access the specialist services provided by the North West Boroughs, and support more people to be maintained in their own communities
- Plans are being developed for people with extremely complex and multiple mental health needs, who may have been placed in expensive services many miles away, to be assessed and where appropriate provided with more suitable services closer to their own homes

Developing the use of the Mental Health Resource Centre in Vine Street, Widnes

This valuable specialist resource, owned by the Borough Council, has for some time been underused, after the previous tenants left, leaving the ground floor unoccupied. The Council, CCG and North West Boroughs are working closely together to redevelop the use of this facility, with each organisation committing capital funding to allow the development of a community-based assessment and crisis support service for people with mental health problems. The Council's Mental Health Outreach Team and Community Bridge Building Team are already based in the building, and this will allow the development of stronger links between mental health services and community support

services. The capital works have now been tendered out and it is hoped that the work will be completed by November 2017.

Redesign of Mental Health Social Work Services and Mental Health Outreach Team: Following an internal review of the Council's mental health social work service works, the decision has been taken to change the way in which it delivers care and support to people with mental health problems. From autumn 2017, social workers will no longer act as formal care co-ordinators within the North West Boroughs processes, and they will only be using the council's electronic case recording system. They will continue to work alongside North West Boroughs staff, and clear pathways will be developed to ensure that the same quality of service and response is delivered, so that people who use the services will not see any changes to the way their care is delivered. The social work role will be refocused, with a clear statement of roles and tasks, and this will allow social workers to focus more on early intervention and prevention.

The way in which the Mental Health Outreach Team delivers its services has also been reviewed, as part of the process of developing improved early intervention and prevention services for people in mental distress. The team will now be focusing on specific, time-limited (up to a year) interventions, tailored specifically to an individual's identified needs, and with measurable outcomes. This is an extension of the successful pilot into a small number of local GP practices which has taken place over the past two years, and which has delivered positive outcomes in preventing mental health deterioration. The service will be open to all people with mental health problems which are affecting their ability to cope independently in the community.

Care Management
We have invited Meridian to conduct a study of our Social Work provision across Assessment teams IAT, Complex Care, Widnes and Runcorn, as part our ongoing improvement process. Meridian is an international organisation specialising in process and efficiency improvement. They have extensive experience in the health and care sector and have worked throughout Ireland and the UK in the last 20 years assisting Boards, Trusts, Hospitals, Health and Care providers in service redesign, capacity planning and improving our client service.

The project is a year-long ongoing programme following on from an initial assessment period of 3 weeks. Meridian have provided a 10 week intensive programme roll out and will subsequently follow up throughout the year to ensure progress is being made.

Meridian work in a collaborative and inclusive way and we have the opportunity to shape new ways of working as a result of their input. Staff have been actively involved in a workload supervision exercise which has been extremely useful in getting us ready for some new, improved ways of working. Our primary aim is to ensure that we establish fairness and consistency in the allocation of workload for all staff.

Team managers have been working closely with Meridian to review the thresholds and procedures within the three Care Management teams; Complex Care Runcorn, Complex Care Widnes and the Initial Assessment Team. We have been particularly interested in reviewing the allocation process, Duty systems and our internal Panel processes. We seek to share good practice across the teams to implement a more consistent approach to these key activities. We believe that this will provide the best outcomes for our service users through increased consistency.

The focus on the work initially has been on improving management controls within our services to support us to more accurately be able to forecast, plan, assign and follow up work. We have focused on improving our productivity in relation to undertaking reviews so that we are able to make a transition to undertaking reviews on a 6 monthly rather than annual basis. We now produce weekly productivity reports using data already available to us to help us plan review work that needs to be allocated.

By bringing reviews forward we anticipate that this will enable us to identify and plan for changes in individuals needs more effectively thus preventing a crisis and reducing the risk of people presenting either to our services or primary/secondary care.

Public Health:

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

We are continuing to expand on a number of pilot initiatives that have proved very successful These include continuing to offer innovative approaches including stress management techniques and a quit buddy scheme to pregnant women to help them quit smoking. We are extenidng bowel screening follow up pilots to a nukber of other practices and have seen an increase in the numbers of people who return their sample kits to help identify bowel cancer screening earlier.

3.0 Emerging Issues

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

Adult Social Care:

Supported Housing Network
The pilot to review working practices, across the night time period within supported housing network is close to completion.

As part of the assessment the service has used an electronic system known as 'Just Checking' (http://www.justchecking.co.uk/media-toolkit/) to assist with the evaluation.
This is:

- A series of small, wireless sensors which are triggered as a person moves around their home. The sensor data is sent by the controller, via the mobile phone network, to the Just Checking web-server.
- Users log on to the Just Checking website, to view the chart of the activity.
- The system needs no other input. There is nothing to wear and no buttons to push.
- Installation is simple. You don't need a phone line or broadband. There are instructions with the kit and a telephone helpline.

The use of this technology has allowed the service to discriminate between periods of activity and inactivity and has formed a very useful platform for determining levels of need much more accurately. Consideration will now be given as to whether this tool can be used more widely including in the authority's commissioned external services.

Halton Women's Centre:
The Halton Women's Centre, based in a borough council building in Runcorn, was first commissioned in 2008, and has been managed and delivered since then by a Warrington-based charity, the Relationship Centre. The service is the only one of its kind in the North West, delivering arrange of services designed to improve the physical and mental health and wellbeing of local women. It is a highly respected and valuable service for women in the borough, which has achieved consistently positive outcomes.

Unfortunately, The Relationship Centre has had to close. However, given the importance of this service, the Council has taken over the management and running of the service, with the previous manager therefore being able to remain in post. A review of the current service and its potential for further development will be undertaken, and decisions will then be taken about the service's long-term future.

Blue Badge:
The Blue Badge Scheme helps disabled people with severe mobility problems to access goods and services by allowing them to park close to their destination, whether they are a driver or a passenger.

The scheme was introduced in 1971 under Section 21 of the Chronically Sick and Disabled Person's Act 1970. It was amended by the Disabled Persons' Parking Badges Act 2013 and the scheme as it currently stands is governed by the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000 (plus amendments).

A revised Blue Badge Policy, Procedure & Practice (PPP) following comprehensive review has now been completed.
Two key issues that have arisen during the review process with regards to:

- Enforcing correct use and tackling potential abuse of the scheme; and
- The eligibility requirements for organisational badges.

The draft Policy will be submitted to the September HPPB.

Public Health:

Halton continue to miss the 62 day referral to treatment cancer target, while this is seen as a local and a national; priority, the local cancer system needs to ensure we are alerting people to the dangers of missing appointments, as well as ensuring that we have a cancer referral and treatment system that provides the right level of accessibility and flexibility to meet the different needs of different people, including more complex cases.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2017/18 Directorate Business Plans.

5.0 Progress against high priority equality actions

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

6.0 Performance Overview

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

"Rate per population" vs "Percentage" to express data

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

Location	Rate per 100,000 population	Percent
Region A	338.0	0.34%
Region B	170.5	0.17%
Region C	225.6	0.23%

Adult Social Care

Key Objectives / milestones

Ref	Milestones	Q1 Progress
1A	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target	✓
1B	Integrate social services with community health services	✓
1C	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder.	✓
1D	Continue to implement the Local Dementia Strategy, to ensure effective services are in place.	✓
1E	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems.	✓
1F	The Homelessness strategy be kept under annual review to determine if any changes or updates are required.	✓

3A	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.	

Supporting Commentary

1a - Financial challenges remain. Processes in place for the monitoring of expenditure across the partnership

1b - An integrated MDT model is now developed and implemented via a series of workshops. Social Workers and District nurses have been grouped in alignments with GP Hubs with a series of workshops supporting the process.

1c - A new all-age Autism Strategy is currently in development, with an anticipated implementation date of April 2018. A working group of key officers from across health and social care covering both adults and children's services has been established. The group is currently arranging some initial consultation in the form of a survey with children and adults with autism and their families/carers in order to highlight what is working well and where there are gaps in services or improvements to be made. This will be followed up with more in-depth consultation in the form of a focus group type event where those with autism and their families/carers will determine the priority areas for action as part of the new strategy.

1d - The Halton Dementia Strategy delivery plan has been refreshed with actions to undertake over the next 12months to 2 years. The refresh was based on consultation via a well-attended Halton Dementia Action Alliance event in March 2017. People living with dementia, cares, professionals and the voluntary and community sectors contributed.
Halton's dementia diagnosis rate is currently 72%, working towards a Halton CCG identified target of 75%.

The Admiral Nurse service continues to deliver its service to the most complex local dementia cares, currently supporting in the region of 100 cases.
Halton Dementia Action Alliance are coordinating a GP dementia awareness session, to meet demand from GP practices for the national Dementia Friends Awareness session and also training to meet the requirements of the NHS Tier 1 mandatory dementia awareness training. Halton DAA have secured the services (free of charge) of a specialist dementia nurse from The Countess of Chester Hospital who devised an NHS England and Alzheimer's Society accredited training session that incorporates both the Dementia Friends and NHS T1 training. The session will take place in Halton in September 2017, and places were offered to all GP practices, with 11 practices securing places for their clinical and non-clinical staff (53 candidate confirmed).

1e - Detailed work has been taking place between the Borough Council, the North West Boroughs and NHS Halton Clinical Commissioning Group to develop an improved range of services for local people with mental health problems. Specialist inpatient services have been developed for older people with dementia and other mental health problems; pathways to intervene at an earlier stage in a person's condition, and to support people to recover effectively, are being developed, and considerable work is taking place to ensure that the people with the most complex needs can be supported in local services.

1f - The homelessness strategy review is due to be completed by March 2018, to identify key priorities and objectives for a five year period. The consultation with partner agencies has been scheduled for September 2017, which will allow partners to identify and agree the key priorities to be incorporated within the five year action. The final version of the strategy will be submitted

to the relevant management boards January 2018 and will reflect economical and legislative changes to service delivery.

3a - This work aligns with the developing accountable care approach to the commissioning, contracting and performance of health and care provision in the borough

Key Performance Indicators

Older People:						
Ref	**Measure**	**16/17 Actual**	**17/18 Target**	**Q1**	**Current Progress**	**Direction of travel**
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric***	515.3	635	55.7	✓	↑
ASC 02	Delayed transfers of care (delayed days) from hospital per 100,000 population. ***Better Care Fund performance metric***	519	TBC	520		
ASC 03	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	3381	13,289	2211	✓	↑
ASC 04	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) ***Better Care Fund performance metric***	N/A	N/A	N/A	N/A as no target	N/A
ASC 05	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) ***Better Care Fund performance metric***	62.12%	65%	N/A	N/A	N/A
Adults with Learning and/or Physical Disabilities:						
ASC 06	Percentage of items of equipment and adaptations delivered within 7 working days	93%	96%	64%	N/A	N/A
ASC 07	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 1)	74%	78%	70%	✓	N/A

Ref	Measure	16/17 Actual	17/18 Target	Q1	Current Progress	Direction of travel
ASC 08	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 2) DP	44%	44%	35%	✓	N/A
ASC 09	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	86.90%	87%	86%	✓	↑
ASC 10	Proportion of adults with learning disabilities who are in Employment (ASCOF 1E)	6.9%	7%	5.5%	✓	↑
ASC 11	Out of Borough Placements – number of out of borough residential placements	32	30	N/A	N/A	N/A
People with a Mental Health Condition:						
ASC 12	Percentage of adults accessing Mental Health Services, who are in employment.	N/A	N/A	8.1%	N/A	N/A
ASC 13 (A)	Percentage of adults with a reported health condition of Dementia who are receipt of services.	52.86%	TBC	56.71%	N/A	N/A
ASC 13 (B)	Percentage of Carers who receive services, whose cared for person has a reported health condition of Dementia.	11.57%	TBC	14.75%	N/A	N/A
Homelessness:						
ASC 14	Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2002.	NA	500	95	✓	
ASC 15	Homeless Households dealt with under homelessness provisions of Housing Act 1996 and LA accepted statutory duty	NA	100	12	✓	
ASC 16	Number of households living in Temporary Accommodation	1	17	11	✓	↑
ASC 17	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number	6.62	6.00%	1.35	✓	↑

	divided by the number of thousand households in the Borough)					
Safeguarding:						
ASC 18	Percentage of VAA Assessments completed within 28 days	83.5%	88%	78%	✓	↑
ASC 19	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-learning, in the last 3-years (denominator front line staff only).	48%	56%	47%	✓	↑
ASC 20 (A)	DoLS – Urgent applications received, completed within 7 days.	73%	80%	NYA	NYA	New Measure
ASC 20 (B)	DoLS – Standard applications received completed within 21 days.	77%	80%	NYA	NYA	New Measure
ASC 21	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)	81.30%	82%	N/A	N/A	N/A
Carers:						
ASC 22	Proportion of Carers in receipt of Self Directed Support.	99.4	TBC	73.7%	✓	New Measure
ASC 23	*Carer reported Quality of Life (ASCOF 1D, (this figure is based on combined responses of several questions to give an average value. A higher value shows good performance)*	8.10%	9	N/A	N/A	N/A
ASC 24	*Overall satisfaction of carers with social services (ASCOF 3B)*	48.90%	50	N/A	N/A	N/A
ASC 25	The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C)	78.80%	80	N/A	N/A	N/A
ASC 26	Do care and support services help to have a better quality of life? (ASC survey Q 2b) ***Better Care Fund performance metric***	93.30%	93%	N/A	N/A	N/A

Supporting Commentary

Older People:

ASC 01 The current figure for Q1 is lower than for the same period last year at 74.3% which show less people are being admitted to residential / nursing care.

ASC 02 Delayed transfers of care (delayed days) from hospital per 100,000 population.
Better Care Fund performance metric

ASC 03 Q1 figure (per 100,000 all ages is 2886 actual admissions for the months of April and May only, Junes admissions are not available until the middle of August. The 2886 actual admissions compares favourably to the plan of 2962 and the same period last year of 2975

ASC 04 Data not currently available due to data issues with the CSU.
No refresh on data is available beyond 2015/16.

ASC 05 Annual collection only to be reported in Q4.

Adults with Learning and/or Physical Disabilities:

ASC 06 We have been unable to obtain the HICES data from Bridgewater Community healthcare NHS Foundation Trust since April 2017. Work continues to try and obtain it. .

ASC 07 There is no comparable data for the same period in 2016/17.

ASC 08 There is no comparable data for the same period in 2016/17.

ASC 09 We are on track to meet this target.

ASC 10 We are on track to meet this target.

ASC 11 Definitions and sources are to be agreed, figures will be available at Q2.

People with a Mental Health Condition:

ASC 12 New Measure, further details to be provided at Q2.

ASC 13 (A) New Measure

ASC 13 (B) Percentage of Carers who receive services, who's cared for person, has a reported health condition of Dementia.

Homelessness:

ASC 14 In accordance with the Homelessness legislation, all Local Housing Authorities must give proper consideration to all applications for housing Assistance. If they have reason to believe that an applicant may be homeless or threatened with homelessness, they must make inquiries to see whether they owe them any duty under Part 7 of the Housing 1996 Act.
The Local Authority anticipates a gradual increase in Homelessness. The figure identified for quarter one is generally low, due to identified client trends.

ASC 15 Part 7 of the 1996 Act sets out the powers and duties of housing authorities where people apply to them for assistance in obtaining accommodation. The 2002
The Local Authority has a statutory duty to provide both temporary and secure accommodation to clients accepted as statutory homeless. The figures are generally low, which is due to the high level of officer activity and initiatives to prevent

homelessness.

ASC 16 National and Local trends indicate a gradual Increase in homelessness, which will impact upon future service provision, including temporary accommodation placements.
The changes in the TA process and amended accommodation provider contracts, including the mainstay assessment, have had a positive impact upon the level of placements and positive move on process.
The Housing Solutions Team is community focused and promote a proactive approach to preventing homelessness.
The emphasis is focused on early intervention and empowerment to promote independent living and lifestyle change

ASC 17 The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention.
The officers now have a range of resources and options that are offered to vulnerable clients threatened with homelessness. The team strive to improve service provision across the district.
Due to the early intervention and proactive approach, the officers have continued to successfully reduce homelessness within the district.

Safeguarding:

ASC 18 At quarter 1 we are in a good position to achieve the target overall

ASC 19 If this figure is correct we are in a really good position to exceed last year's figures and meet the new target

ASC 20 (A) This is a new indicator. The majority of urgent requests are often inappropriate due to people being discharged from hospital during the assessment period

ASC 20 (B) The number of referrals is outstripping capacity. Action plan is addressing the backlog and a new prioritisation programme has been introduced to target the most in need

ASC 21 Annual collection only to be reported in Q4.

Carers:

ASC 22 New Measure

ASC 23 Annual collection only to be reported in Q4.

ASC 24 Annual collection only to be reported in Q4.

ASC 25 Annual collection only to be reported in Q4.

ASC 26 Annual collection only to be reported in Q4.

Public Health

Key Objectives / milestones

Ref	Milestones	Q1 Progress
PH 01a	Increase the uptake of smoking cessation services and successful quits among routine and manual workers and pregnant women	✗
PH 01b	Work with partners to increase uptake of the NHS cancer screening programmes (cervical, breast and bowel)	✓
PH 01c	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. AND/ OR Increase awareness among the local population on the early signs and symptoms of cancer.	✗
PH 02a	Facilitate the Healthy child programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years.	✓
PH 02b	Maintain the Family Nurse Partnership programme.	✓
PH 02c	Facilitate the implementation of the infant feeding strategy action plan	✓
PH 03a	Expansion of the Postural Stability Exercise Programme.	✓
PH 03b	Review and evaluate the performance of the integrated falls pathway.	✓
PH 04a	Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol	✓
PH 04b	Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA	✓
PH 04c	Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support	✓
PH 05a	Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions.	?
PH 05b	Implementation of the Suicide Action Plan.	✓

PH 01a Increase the uptake of smoking cessation services and successful quits among routine and manual workers and pregnant women

The throughput of clients accessing Halton Stop Smoking Service between April 2017 to June 2017 (Q1) compared to the same period in 2016 is showing a decrease from 255 to 216 so far. However, most Stop Smoking Services are experiencing a reduction in throughput at this time.

The quit data for Q1 is incomplete as 4 week outcomes for some clients are still outstanding due to the length of the programmme delivered over a 12 week period.

Halton's smoking prevalence at time of delivery for pregnant women (SATOD) indicates a reduction from 15% in Q1 2016/17 to 13% in Q1 2017/18.

Halton CCG has received £75,000 of funding from NHS England for use in this financial year (2017/18) to reduce maternal smoking rates. An action plan with focussed outcomes has been developed outlineing joint proposals for the use of this funding for evidence based effective interventions to reduce maternal smoking.

PH 01b Work with partners to increase uptake of the NHS cancer screening programmes (cervical, breast and bowel)

The 2 year Cheshire and Merseyside Cancer Screening Task force has now finished, though Halton is continuing to work alongside local partners within the Cancer Allinace, including the Prevention and Early Detection Boards, and within local LDS Cancer groups to ensure that there is a joint focus on imporvening cancer screening. We continue to work with local PHE Screening and Immunisation Team to develop practice specific plans to help identify were local practice performance may be below expected and develop targetted plans for improvement.

Uptake of breast and cervical cancer screening is increasing slightly againast a nationally decreasing trend. Local Bowel Cancer screening has seen a significant increase following local targetted activity to increase participation.

PH 01c Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. AND/ OR Increase awareness among the local population on the early signs and symptoms of cancer.

Referral to treatment targets were not met. Analysis of significant breaches suggest complex cases and diagnostic, alongside patient choice as a causal factor. National focus on improving 62 day target achievement by September 2018 and work across the Cancer Alliance should help improve patient flow and access to timely and appropriate diagnostics.

PH 02a Facilitate the Healthy child programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years.

The health child programme is being combined under one specifiction for children aged 0-19, (25 with special educational needs). The procument process for this new programme is under way. The specification will include health visiting, Family Nurse partnership, School Nursing, NCMP, Vision and hearing screening, and immunisations. The vaccination and Immunisation component of the programme is commissioned by NHS England. The new integrated specification should improve consistancy of approach, streamline services and improve efficiencies.

Child development is a priority area for being developed. The commissioned independent report into child development and the outcomes from the themed Ofsted visit have been used to form the framework for the action plan. Recently published school readiness data for 2015/16 shows a 7% improvement in Halton, narrowing the gap with England.

The Health Visiting Service is delivering all the new components of the national Healthy Child Programme, including assessing mothers' emotional health at 6-8 weeks and completing an integrated developmental check at 2-21/2. The early years setting and health visitors share the findings from the development checks to identify any areas of concern, so that services can collaboratively put in place a support package as required. A group is working to further develop the integrated check, improve data sharing and consistency of plans following the check.

PH 02b Maintain the Family Nurse Partnership programme.

Family Nurse Partnership is fully operational with a full caseload; it continues to work intensively with first time, teenage mothers and their families. The service works with some very complex cases and is building their multidisciplinary links across a wide range of agencies, to imrpove outcomes for these families. The service will be an intgegral part of the new 0-19 Service.

PH 02c Facilitate the implementation of the infant feeding strategy action plan

The implementation of the infant feeding action plan is underway, with oversight from the Halton Health in the Early Years group.

Breastfeeding support continues to be available across the borough in community and health settings. The infant feeding coordinator and children's centres are working towards achieving BFI (Unicef Baby Friendly Initiative) in the children's centres and are due to be inspected in the summer of 2017, alongside a Bridgewater inspection. This involves training children's centre staff, and auditing their practice.

The team continue to maintain baby welcome premises and are refreshing the Halton Early Years award, which encourages healthy living practices in early years settings, and includes breastfeeding. A Survey is underway to discuss dads attitudes towards breastfeeding, and what support they would like. Public health England has recently launched a national breastfeeding campaign, and the infant feeding team faciliated a Halton women to be in the press discussing her experiences, to try and raise the profile of breastfeeding locally.

PH 03a Expansion of the Postural Stability Exercise Programme.

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

PH 03b Review and evaluate the performance of the integrated falls pathway.
A review of the integrated falls pathway was undertaken via a multi-agency implementation group involving all key stakeholders and service user representatives. Access to treatment services and the patient journey has been reviewed in order to streamline processes and to release capacity within the system. As an outcome of the review the FRAT (Falls Risk Assessment Tool) has been embedded into frontline practice across the Health and Social Care system including primary care (social workers, IAT, Complex care, hospital discharge teams, district nursing and intermediate care assessments) and is now part of the SAQ on Care First. To date there has been an increase in the usage of FRAT by at least 20%.

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

PH 04a Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol

Good progress continues to be made in reducing the number of young people being admitted to hospital due to alcohol. Key activity includes:

- Delivery of alcohol education within local school settings (Healthitude, R U
- Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Delivery of community based alcohol activity.
- Delivering early identification and brief advice (alcohol IBA) training and
- resources for staff who work with children and young people).
- Running the Halton Community Alcohol Partnership which brings together partners to reduce underage drinking and associated antisocial behaviour.

Working closely with colleagues from Licensing, the Community Safety team, Trading Standards and Cheshire Police to ensure that the local licensing policy helps prevent underage sales and proxy purchasing.

PH 04b Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA

Work continues to raise awareness among the local community of safe drinking recommendations and to train staff in alcohol identification and brief advice (alcohol IBA).

PH 04c Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support

CGL continue to support individuals with alcohol misuse problems in Halton and support their recovery. During Q4, the service received 73 new referrals for alcohol only (50) or alcohol and non-opiate problems (23). Local data suggests that by the end of Q4 120 individuals were engaged in structured treatment where alcohol was the primary concern, and 78 were involved in post treatment recovery support. A further 46 clients were in receipt of support for non-opiate and alcohol problems. For Q4, 38.7% of individuals who have commenced extended brief interventions (EBI) have completed successfully.

PH 05a Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions.

A review of the mental hleath action lans is taking place for weach thematioc group and thes ewill be reviewed at the next Oversight group.

PH 05b Suicide action plan is being updated to reflect recent national progress and strategy changes. Training has been rolled out across partner agecies and Champs will be applying for regional suicide safe accreditaion within the near future.

Key Performance Indicators

Ref	Measure	16/17 Actual	17/18 Target	Q1	Current Progress	Direction of travel
PH LI 01	A good level of child development (% of eligible children achieving a good level of development at the	61.9% (2015/16)	65.0% (2016/17)	Annual data only	?	**N/A**

	end of reception)					
PH LI 02a	Adults achieving recommended levels of physical activity (% adults achieving 150+ minutes of physical activity)	48.5% (2015)	49.0% (2016)	Annual data only	?	**N/A**
PH LI 02b	Alcohol-related admission episodes – narrow definition (Directly Standardised Rate per 100,000 population)	841.7 (2015/16)	841.7 (2016/17)	Annual data only	?	**N/A**
PH LI 02c	Under-18 alcohol-specific admissions (crude rate per 100,000 population)	55.5 (2013/14-2015/16)	54.1 (2014/15-2016/17)	Currently Annual data	?	**N/A**
PH LI 03a	Smoking prevalence (% of adults who currently smoke)	16.6% (2016)	16.2% (2017)	Annual data only	?	**N/A**
PH LI 03b	Mortality from cardiovascular disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets*	92.0 (2016)	89.8 (2017)	85.5 (Apr '16 – Mar '17)	?	
PH LI 04a	Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)	341.5 (2015/16)	332.3 (2016/17)	Currently Annual data	?	**N/A**
PH LI 04b	Self-reported wellbeing: % of people with a low happiness score	12.7% (2015/16)	11.1% (2016/17)	Annual data only	?	**N/A**
PH LI 05	Mortality from all cancers at ages under 75 (Directly Standardised Rate, per 100,000 population) *Published data based on calendar year, please note year for targets*	177.2 (2016)	169.2 (2017)	184.1 (Apr '16 – Mar '17)	?	

PH LI 06ai	**Male** Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*	17.3 (2013-15)	17.6 (2014-16)	Annual data only	?	**N/A**
PH LI 06aii	**Female** Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*	18.8 (2013-15)	19.1 (2014-16)	Annual data only	?	**N/A**
PH LI 06b	Falls and injuries in the over 65s (Directly Standardised Rate, per 100,000 population; PHOF definition)	3016. (2015/16)	3000.5 (2016/17)	Currently Annual data	?	**N/A**
PH LI 06c	Flu vaccination at age 65+ (% of eligible adults aged 65+ who received the flu vaccine, GP registered population)	72.2% (2015/16)	75.0% (2016/17)	Annual data only	?	**N/A**

Supporting Commentary

PH LI 01 A good level of child development (% of eligible children achieving a good level of development at the end of reception)
New data not yet available but direction of travel shows significant improvements in Halton and narrowing the gap between Halton and England

PH LI 02a Adults achieving recommended levels of physical activity (% adults achieving 150+ minutes of physical activity)
No new data available but direction of travel suggests that more adults are undertaking greater levels of physical activity locally

PH LI 02b Alcohol-related admission episodes – narrow definition (Directly Standardised Rate per 100,000 population)
New data not available.

PH LI 02c Under-18 alcohol-specific admissions (crude rate per 100,000 population)
No new recent data but current annual data shows improvements.

PH LI 03a Smoking prevalence (% of adults who currently smoke)

Current data suggests a continues small improvement in the number of people who smoke in Halton

PH LI 03b Mortality from cardiovascular disease at ages under 75 (Directly Standardised Rate per 100,000 population) ***Published data based on calendar year, please note year for targets***
Currently achieving target, but too early in the year to state whether we will achieve target.

PH LI 04a Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)
Data not available to comment at the present time

PH LI 04b Self-reported wellbeing: % of people with a low happiness score
Data not available to comment at the present time

PH LI 05 Mortality from all cancers at ages under 75 (Directly Standardised Rate, per 100,000 population) ***Published data based on calendar year, please note year for targets***
Currently missing target, but too early in the year to state whether we will achieve target.

PH LI 06ai Male Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) ***Published data based on 3 calendar years, please note year for targets***
Data not available to comment at the present time

PH LI 06aii Female Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) ***Published data based on 3 calendar years, please note year for targets***
Data not available to comment at the present time

PH LI 06b Falls and injuries in the over 65s (Directly Standardised Rate, per 100,000 population; PHOF definition)
Data not available to comment at the present time

PH LI 06c Flu vaccination at age 65+ (% of eligible adults aged 65+ who received the flu vaccine, GP registered population)
Current data suggests a slow local annual decline in the number of people 65+ who take up the offer of seasonal flu vaccination. This reflects a regional and national pattern.

ADULT SOCIAL CARE DEPARTMENT

Revenue Budget as at 30TH June 2017

	Annual Budget	Budget To Date	Actual To Date	Variance To Date

	£'000	£'000	£'000	(Overspend) £'000
Expenditure				
Employees	13,881	3,402	3,319	83
Other Premises	326	98	101	(3)
Supplies & Services	1,074	171	176	(5)
Aids & Adaptations	113	28	34	(6)
Transport	201	43	37	6
Food Provision	140	26	28	(2)
Contracts & SLAs	525	178	184	(6)
Emergency Duty Team	95	19	17	2
Other Agency	624	99	96	3
Payments To Providers	1,468	412	416	(4)
Contribution To Complex Care Pool	20,646	3,038	3,207	(169)
Total Expenditure	**39,093**	**7,514**	**7,615**	**(101)**
Income				
Sales & Rents Income	-204	-156	-151	(5)
Fees & Charges	-740	-183	-142	(41)
Reimbursements & Grant Income	-1,102	-191	-198	7
Transfer From Reserves	-487	0	0	0
Capitalised Salaries	-111	0	0	0
Government Grant Income	-729	-161	-167	6
Total Income	**-3,373**	**-691**	**-658**	**(33)**
Net Operational Expenditure	**35,720**	**6,823**	**6,957**	**(134)**
Recharges				
Premises Support	516	129	129	0
Asset Charges	83	0	0	0
Central Support Services	3,352	844	844	0
Internal Recharge Income	-1,976	-596	-596	0
Transport Recharges	497	124	127	(3)
Net Total Recharges	**2,472**	**501**	**504**	**(3)**
Net Department Expenditure	**38,192**	**7,324**	**7,461**	**(137)**

Comments on the above figures:

In overall terms, the Net Department Expenditure for the first quarter of the financial year is £32,000 under budget profile, excluding the Complex Care Pool.

Employee costs are currently showing £83,000 under budget profile. This is due to savings being made on vacancies within the department. Some of these vacancies have been advertised and have been or are expected to be filled in the coming months. However, if not appointed to, the current underspend will continue to increase beyond this level.
The bulk of the staff savings are currently being made in the Care Management and Initial Assessment teams. These services are currently undergoing a review, with a view to realising permanent savings from currently vacant posts.

Fees & Charges income will struggle to achieve agreed budgets for the year. This is due to the Community Meals income target applied in 2016/17, and built into the 2017-18 base budget, which is not projected to be achieved. Estimates based on the first quarter's income indicate a net shortfall in the region of £90,000 for the full year.

Capital Projects as at 30th June 2017

	2017-18 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Upgrade PNC	34	6	6	28
ALD Bungalows	199	0	0	199
Bredon Reconfiguration	186	20	19	167
Grangeway Court Refurbishment	140	0	0	140
Vine Street Development	107	0	0	107
Purchase of 2 Adapted Properties	520	0	0	520
Total	1,186	26	25	1,161

Comments on the above figures:

The £34,000 funding relating to the upgrading of the PNC represents the unspent capital allocation carried forward from the previous financial year to enable the scheme's completion. The total scheme value was £100,000. It is expected that the scheme will be completed in quarter 2, within the remaining budget allocation.

Building work on the ALD Bungalows is expected to be completed within the 2017/18 budget year with spend to match allocation.

The Bredon Reconfiguration project is funded from previous year's Adult Social Care capital grant. Spend is anticipated to be within the capital allocation, and completed in 2017/18
The total scheme value was £356,000, the 2017/18 allocation of £186,000 represents the unspent funding carried forward from 2016/17, to allow the scheme's completion

Work to refurbish Grangeway Court will be completed in the 2017/18 financial year. At this stage in is anticipated that total expenditure will remain within the capital allocation.
The total scheme value was £343,000, the 2017/18 allocation of £140,000 represents the unspent funding carried forward from 2016/17, to allow the scheme's completion

The Vine Street Development project relates to the adaptation of the Mental Health Resource Centre in Widnes in order to better meet service user's needs. Work is currently being tendered, and construction is anticipated to commence in September.

The £520,000 capital allocation for the purchase of 2 adapted properties relates to funding received from the Department Of Health under the Housing & Technology for People with Learning Disabilities Capital Fund The funding is to be used for the purchase and adaptation of two properties to meet the particularly complex and unique needs of two service users. The scheme is anticipated to be completed it the latter part of this financial year.

COMPLEX CARE POOL

Revenue Budget as at 30th June 2017

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	4,040	808	714	94
End of Life	194	46	58	(12)
Sub Acute	1,734	382	378	4
Urgent Care Centres	815	3	3	0
Joint Equipment Store	616	39	32	7
CCG Contracts & SLA's	735	197	193	4
Carers Centre	359	90	90	0
Inglenook	121	0	0	0
Intermediate Care Beds	687	172	172	0
BCF Schemes	1,736	434	425	9
Additional Better Care Fund	2,974	0	0	0
Carers Breaks	434	80	80	0
Adult Social Care Services:				
Residential & Nursing Care	19,863	3,879	3,886	(7)
Domiciliary & Supported Living	13,016	2,272	2,413	(141)
Direct Payments	6,716	2,037	2,239	(202)
Day Care	410	46	70	(24)
Total Expenditure	54,450	10,485	10,753	(268)
Income				
Residential & Nursing Income	-5,214	-720	-721	1
Domiciliary Income	-1,867	-252	-240	(12)
Direct Payments Income	-308	-74	-77	3
BCF	-9,661	-2,415	-2,415	0
Improved Better Care Fund	-2,974	-744	-744	0
CCG Contribution to Pool	-12,968	-3,242	-3,242	0
ILF	-699	0	0	0
All other income	-113	0	0	0
Liability as per Joint Working Agreement	0	0	-107	107
Total Income	-33,804	-7,447	-7,546	99
Net Department Expenditure	**20,646**	**3,038**	**3,207**	**(169)**

Comments on the above figures:

The overall net budget for the Complex Care Pool budget is £276,000 over budget profile at the end of the first financial quarter, due in the main, to expenditure on adult social care packages of care being under pressure.

Expenditure on End of Life services is currently over budget profile by £12,000, the year-end position is expected to be approximately £48,000 over budget. This service has been a pressure on the budget for some time as the actual hours delivered exceed hours funded. This issue is currently being reviewed by HCCG.

The Adult Health and Social Care budget is currently £382,000 over budget profile and is analysed below:

Continuing Health Care and Joint Funded Care packages are exerting pressure on the budget as an increasing number of people are deemed eligible. These service users are also receiving care for longer periods of time than previously. A number of these care packages are transitionally funded placements which are not being assessed within the 28 day timescale and therefore if they are not deemed eligible for CHC there is a potential loss of income as HBC services are chargeable services. In addition to the above there are currently 35 Out of Borough CHC placements and 13 Joint Funded CHC placements which command a higher weekly price, on average they are 70% higher than placements within the borough. Expenditure against these budgets is currently £240,000 over budget profile and the anticipated year end position is expected to be circa £970,000.

Long term, out of area, mental health service users in hospitals have been brought back into the borough realising a significant saving for the health service, however to date no additional funding has been provided from HCCG to cover these costs although it has been agreed to joint fund the placements. Currently 6 service users have come out of hospital and the projected annual cost for these for 2017/18 is £211,678.

In 2016/17 the rate for Free Nursing Care was increased from £112 per week to £156.25. This has subsequently been reviewed by Department of Health and the rate from April 2017 has been set at £155.05. This remains another pressure on the pool budget as no additional funding has been provided from HCCG to meet the additional costs. There are currently 85 service users receiving FNC and the financial impact of the extra costs for these clients is £190,000 for 2017/18.

The number of clients receiving a service and the average cost of a care package is analysed below, by service type:

The total number of clients receiving a permanent residential care package has decreased slightly, from 599 clients in April to 588 clients in June. The average cost of a permanent residential package of care increased, in line with inflation, from £586 to £599 for the same period.

The total number of clients receiving a domiciliary package of care, increased by 1% during the first quarter of the financial year, from 788 clients in April to 796 clients in June. However, the average cost of a domiciliary care package remained more or less the same from £299 to £300 in the same period.

The total number of clients receiving a Direct Payment (DP) increased the most (2.6%) during the first quarter of the year, from 470 clients in April to 482 clients in June. The average cost of a DP package remained more or less the same from £323 in April to £324 in June. The number of clients receiving a DP is expected to increase further as 51 new referrals have been received into the service since April.

Contingency budget from the Better Care Fund has been utilised to offset some of the pressures mentioned above, however the anticipated forecast for the Adult Social Care budget is expected to be circa £1,300,000 over budget at year end. This will be partially offset by underspends in other areas of the budget. An action plan has already been implemented to look at reducing Continuing Health Care costs to bring the expenditure back in line with budget ensuring a balanced budget is achieved at year end.

Capital Projects as at 30th June 2017

	2017-18 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	899	150	110	789
Stair lifts (Adaptations Initiative)	200	50	27	173
RSL Adaptations (Joint Funding)	300	75	72	228
Madeline McKenna Residential Home	450	0	0	450
Total	**1,849**	**275**	**209**	**1,640**

Comments on the above figures:

Total capital funding consists of £1,504,000 Disabled Facilities Grant (DFG) allocation for 2017/18 and £345,000 DFG funding carried forward from 2016/17, to fund ongoing expenditure. The allocation of the funding between DFGs, Stair Lifts and RSL adaptations will be reviewed during the year, and may be reallocated between these projects depending on demand. It is anticipated, however, that total spend on these three projects can be contained within the overall capital allocation.

The £450,000 earmarked for the purchase of the Madeline McKenna residential home includes an allowance for the refurbishment of the premises

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 30 June 2017

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance to Date** (Overspend) £'000
Expenditure				
Employees	3,301	800	772	28
Premises	5	0	0	0
Supplies & Services	240	7	32	(25)
Contracts & SLA's	7,223	1,234	1,234	0
Transport	8	2	2	0
Agency	18	18	17	1
Total Expenditure	**10,795**	**2,061**	**2,057**	**4**
Income				
Sales Income	-19	0	0	0
Other Fees & Charges	-69	-13	-12	(1)
Government Grant	-10,454	-2,178	-2,178	0
Reimbursements & Grant Income	-69	-12	-12	0
Transfer from Reserves	-652	-30	-30	0
Total Income	**-11,263**	**-2,233**	**-2,232**	**(1)**
Net Operational Expenditure	**-468**	**-172**	**-175**	**3**
Recharges				
Premises Support	127	32	32	0
Central Support Services	739	185	185	0
Transport Recharges	20	5	7	(2)
Support Income	-30	-7	-7	0
Net Total Recharges	**856**	**215**	**217**	**(2)**
Net Department Expenditure	**388**	**43**	**42**	**1**

Comments on the above figures

In overall terms, the Net Department Expenditure for the first quarter of the financial year is £1,000 under budget profile.

Employee costs are currently £28,000 under budget profile. This is due to savings being made on vacancies within both of the Environmental, Public Health & Health Protection and Health & Wellbeing Divisions. Some of these vacancies have been advertised and are expected to be filled in the coming months. However if not appointed to, the current underspend will continue to increase beyond this level.

Expenditure on Supplies & Services is currently £25,000 over budget profile. This is due to legal costs relating to a Trading Standards case. This case is still ongoing & this will continue to be a budget pressure during 2017/18.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*

N/A	*Indicates that the measure cannot be compared to the same period last year.*