**Health Policy & Performance Board Priority Based Report**

**Reporting Period:** Quarter 3: 1st October to 31st December 2016

## 1.0 Introduction

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

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

## 2.0 Key Developments

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

**Adult Social Care**

**Domiciliary Care**

We are about to launch the new domiciliary care tender process that will run from December 2016 to July 2017. This will see a significant change in service provision and will be supported by a reduction in the number of providers from the current level of 9 providers who cover a number of different zones, to a town based provision that will require one provider to operate in each town.

We have an agreement in principal for funding from the European Union to support delivering new technology solutions within the Domiciliary Care market. We are still working on the detail of how this funding could work and the parameters that the funders will be operating under.

**Mental Health Services:**

Review of the 5Boroughs Acute Care Pathway and Later Life and Memory Services (the Tony Ryan review): following the completion of the Tony Ryan review earlier in 2016, the CCG have been leading two local work streams which aim to redesign the delivery of services for people with mental health problems in the community. Two approaches are being taken:

- Prevention and early intervention: becoming involved with people at an earlier stage in their condition, to reduce the impact of the condition and potentially reduce the numbers of people who have to be referred thought to hospital-based mental health services
- Supporting the transfer of people's care from secondary to primary care services as their condition improves.

A successful multi-agency workshop was held in November 2016, to support the development of a model of service delivery to match these approaches and it is expected that this will be finalised in the next three months.

Additional work is taking place within the 5Boroughs on redesigning the support provided to people with complex needs and challenging behaviour, and the proposals for redesign of local inpatient services are out for formal public consultation.

**Community Bridge Builders**

- BB has worked with people with disabilities in a person centered way to find meaningful employment in their local community

  Voluntary work from April 2015

  219 people supported into voluntary work

  Paid Work/Permitted from April 2015

  47 people with Disabilities supported into Paid/Permitted work

**Learning Disability Nursing Team**

- There has been a significant increase in referrals and also the complexity of cases – thus increasing pressure on the team and increasing waiting times
- The team have recently completed SPACE training – preventing violence in the workplace and lone working. Pro-active approaches to conflict. The team have also completed first aid and personal safety training, along with 3 member s of the team recently completing a 2 day Autism awareness training.
- The team are continuing to look at completing sexual health training via the Family Planning Association; this is much needed due to the trend in referrals for this type of work.
- The team continue to provide men's and women's sexual health and relationship groups.
- The team are currently working with Susan Gallagher (Diabetes essential Lead) to work with people with Learning Disabilities accessing clinics with reasonable adjustments.
- We currently have a patient on Byron Ward, Hollins Park and we are offering weekly support.

**The Community Multi-Disciplinary Team Model**

A number of legislative and policy developments have contributed to the development of the community multi-disciplinary approach in Halton, further integrating health and social care in the borough.
The model for Community MDTs in Halton consists of staff from several different professional backgrounds, including GPs, Social Workers, Community Care Workers District Nurses, Social Care in Practice (SCiP) workers, Community Matrons, Continuing Health Care Nurses, and Wellbeing Officers, who are able to respond to people who require the help of more than one kind of professional. The MDT will work in an integrated way, aligned to GP practices.

The model works with four GP Hubs: Widnes North, Widnes South, Runcorn West and Runcorn East. Each Hub has clusters of GP surgeries. Each GP surgery has a single MDT, working with an identified GP patient population. A full report will be submitted to HPPB and Halton NHS Clinical Commissioning Group, Service Development Committee in early 2017.

Homelessness
The Syrian Refugee Programme is underway and Halton forms part of the Merseyside Sub Region. Collectively the 6 Merseyside Authorities have agreed to accommodate 510 refugees, with Halton taking 100 individuals. . The required procurement process has been completed and each authority has agreed what services will be commissioned. The Sub Region has appointed a LCR coordinator, who will work directly with the Merseyside Authorities and oversee the Vulnerable Person programme.

Gypsy Travellers
The new residential site officially opened November 2016, with occupancy at 75%. The Local Authority administered a phased allocation process and the final interviews will be held late January 2017.

**PUBLIC HEALTH**

**0 to 19 Healthy Child Pathway.**

Halton is developing a new service specification to commission an integrated 0 to 19 Healthy Child Pathway. This is being informed by a series of workshops that have taken place. It will include health visitors, school nurses, Family Nurse Partnership, and early help and support.

**World Mental Health Day**
Halton Borough Council celebrated World Mental Health Day on Monday 10 October with a conference and social event for residents and local professionals to inform and entertain. There were owls, dancers, bands and discussion groups.

The conference at Riverside College (Centre Stage, Kingsway) was attended by over 100 people and tied in with the theme of 'Building a Mentally Healthier Halton' - an ongoing theme for the Health Improvement Team.

150 local residents also attended the 'feel good' social event in the evening at The Studio in Lacey Street, Widnes. Performers included SJ Pure Dance, Hearts and Voices Choir and poet Clive Little.

The events were a partnership with Riverside College and The Studio, with support across local services and teams including health, education, housing and police, with the aim of finding ways to make people healthier and happier.

**Girls and Women's Health**

The Public Health England report 'Recent Trends in Life Expectancy at Older Ages' identified a potential risk of falling life expectancy trends in Halton amongst those aged 65 and over, with the changes being slightly more significant amongst females than males.

The World Health Organisation and the Chief Medical Officer Report in 2014 advocate a life course approach to women's health focusing on key priority areas; Child & Maternal Health, Mental Health, Cancer, Lifestyles, Violence and Reproductive/Sexual Health.

The public health services team are leading a girls and women's health work programme across the thematic areas Start Well, Live Well and Age Well. Since September 2016, there has been a review of public health intelligence, consultation with key stakeholders and community engagement via local radio, social media and one-to-one or group discussions. An engagement event with girls and women will be held on 24th January 2017 at Select Security Stadium, Widnes, 1.30pm to 4.30pm. Findings will support ongoing strategic development and commissioning plans. The 2016/17 Public Health Annual Report will focus on Girls and Women's Health in Halton.

## 3.0 Emerging Issues

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

**Adult Social Care**

**Mental Health Services:**

Social Work for Better Mental Health: this national programme has been designed to help local authorities to be clear about the roles and functions of social workers when they are working in integrated mental health services. Halton, jointly with Sefton Council, is one of the first implementers of this programme, which is sponsored by the Department of Health and the Chief Social Worker, and which will be rolled out throughout the country. The self-assessments have been completed and a final report is due to be written. This will then be used to refresh the partnership arrangement between Halton Borough Council and the 5BoroughsPartnership.

People with complex mental health conditions who are placed out of borough: a number of people complex mental health conditions have in recent years been placed by the health services in specialist placements some distance from Halton, either in private hospitals or specialist rehabilitation placements. Apart from the impact on the people themselves, who will find it hard to maintain their local links, there is often a high cost associated with these placements. The CCG, 5BoroughsPartnership and Borough Council are working together to develop local services and supports that can better meet the needs of this group of people, with the aim of supporting a number of them to return to the area.

Mental Health Serious Incidents: following a number of serious incidents in the summer of 2016, a number of processes are taking place to identify any lessons that can be learned and applied to service improvements. These processes are being overseen by a multiagency group which is considering the issues arising from each of the incidents.

The development of a progression policy, for Social Care Occupational Therapists, (SCOT) is underway which follows on from the work undertaken around the Social Work Progression Policy developed in 2015 and stems from a need for similar arrangements for Social Care Occupational Therapists (SCOTs).
Formal consultation begins in January 2017.

**PUBLIC HEALTH**

No emerging issues with Public Health.

## 4.0 Risk Control Measures

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

## 5.0 Progress against high priority equality actions

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

## 6.0 Performance Overview

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

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

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

***Prevention and Assessment Services*** **Key Objectives / milestones**

| Ref | Milestones | Q2 Progress |
|---|---|---|
| PA 1 | Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21, 25) March 2017** | ✓ |
| PA 1 | Integrate frontline services with community nursing (AOF 2, 4, & 21) **March 2017** | ✓ |

**Supporting Commentary**

**PA 1 - Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target**
Budget is monitored effectively, work is progressing to ensure the budget is balanced at the end of the year.

**PA 1 - Integrate frontline services with community nursing**
A dedicated Steering Group with membership from Adult Social Care, Bridgewater Community NHS Trust, Halton NHS Clinical Commissioning Group and IT services from NHS and the HBC, have developed a model for Multi-Disciplinary Team working, to provide better communications and coordination of care across health and social care and improving outcomes for people with complex needs. Following development of system wide information sharing agreements and promising indications that Halton will receive regional NHS information technology grants that will make the joining together of information technology systems easier.

***Key Performance Indicators***

| Ref | Measure | 15/16 Actual | 16/17 Target | Q3 Actual | Q3 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| PA 2 | Percentage of VAA Assessments completed within 28 days | 85% (estimated - further data quality work ongoing to confirm this) | 85% | 84% | ✓ | ↑ |
| PA 6a | Percentage of items of equipment and adaptations delivered within 7 working days | 97% | 95% | 94% | ✓ | ↓ |
| PA 11 | Permanent Admissions to residential and nursing care homes per 100,000 population,65+ (ASCOF 2A1) *Better Care Fund performance metric* | 541.7% | 637.3 | 236.8 | N/A as no target | ↓ |
| PA 12 | Delayed transfers of care (delayed days) | 2475 | 236 per month | 1104.9 per 100,000 pop | ? | |

| Ref | Measure | 15/16 Actual | 16/17 Target | Q3 Actual | Q3 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| | from hospital (average per month) *Better Care Fund performance metric* | | | Total for Aug/Sep/Oct 2016<br><br>1438 (Delayed Days) | | |
| PA 14 | Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric* | 15231 V plan 16668 (Feb 16) | | 3398 Per 100,000 figure (all ages) | ? | |
| PA 15 | Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric* | 685.1 | TBC | N/A | N/A | N/A |
| PA 16 | Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B1) *Better Care Fund performance metric* | 63.3 | Data published for 15/16, figures have remained stable from 14/15.<br><br>This is an annual collection figures for 16/17 will be available late 2017 | | | |
| PA 20 | Do care and support services help to have a better quality of life? (ASC survey Q 2b) *Better Care Fund performance metric* | 93.3 | Data published for 15/16, figures have remained stable from previous years.<br><br>This is an annual collection figures for 16/17 will be available late 2017 | | | |

**Supporting Commentary**

**PA 2 - Percentage of VAA Assessments completed within 28 days**
We are on line to meet this target. We are a head of target compared to last years figures.

**PA 6a - Percentage of items of equipment and adaptations delivered within 7 working days**
This figure is slightly down on last years position but is on course to meet the target.

**PA 11 - Permanent Admissions to residential and nursing care homes per 100,000 population,65+**
Figure are until the end of Nov placed 51 compared to 81 people as of last year we are coming in as red which is positive for this particular target.

**PA 12 - Delayed transfers of care (delayed days) from hospital per 100,000 population**
The target is the number of days per month not a rate per 100,000 per population.

The number of delayed days is only available until October so a Q3 position would be August, September and Octobers figure.

We are above target. This is due to a small number of very long delays patients at 5BP.

**PA 14 - Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population**
The Q3 figure reported here is the latest available and covers the period (Aug to Oct 16) this number is based on 4422 non-elective admissions and a population of 130147. Non-elective admissions are above plan for the year by 1.9%, this has been attributed to increased admissions at Warrington hospital following the opening of the new ambulatory care unit, however an increase in admissions at Whiston has also been seen. This increase in admissions appears to indicate an increase in acuity of patients rather than increased demand as the number of Halton residents actually attending A&E at Warrington and Whiston has fallen

**PA 15 - Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+)**
The performance data is only being collected on an annual basis, the next date that data will be available is May 2017.

**PA 16 - Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services**
Annual Collection

**PA 20 - Do care and support services help to have a better quality of life?**
Annual Collection

## ***Commissioning and Complex Care Services***

**Key Objectives / milestones**

| Ref | Milestones | Q2 Progress |
|---|---|---|
| CCC 1 | Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **March 2017** (AOF 4) | ✓ |
| CCC 1 | Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **March 2017** (AOF 4) | ✓ |
| CCC 1 | Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **March 2017** (AOF 4) | ✓ |
| CCC 1 | The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **March 2017** (AOF 4, AOF 18) | ✓ |
| CCC2 | Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **March 2017** (AOF 21) | ✓ |
| CCC3 | 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. **March 2017** (AOF 21 & 25) | ✓ |

**Supporting Commentary**

**CC1** - **Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder**

**CC1 - Continue to implement the Local Dementia Strategy, to ensure effective services are in place**

During Q3 Halton has contributed to the North West Dementia Perspectives State of the Region report, which makes a number of recommendations to facilitate quality through evidence based examples of good practice. These recommendations and the implications for Halton will be considered as part of the Dementia Delivery Group's refresh of the Dementia Delivery Plan in early 2017.

During Q3 Halton has supported the Department of Health Funded 'Beyond the Front Door' project, led by Life Story Network. A stakeholder workshop took place in December, the findings of which will contribute to the final project report and suite of resources to support professionals to raise awareness of and how to respond to specific transition points in people's care.

The Halton dementia diagnosis rate stands at 72%.

During Q3 the Halton Admiral Nurse Service continued to establish itself and work with partners to build caseloads. The service is delivering tailored support to approx. 90 cases with complex.

**CC1 - 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**

This work continues and is taking place alongside NHS Halton and the 5BoroughsPartnership. Two work-streams are developing proposed models for the delivery of early intervention and prevention services in mental health, and for services which support people who are recovering to be managed appropriately within primary care services. A final model is expected to be put forward early in 2017.

**CC1 - The Homelessness strategy be kept under annual review to determine if any changes or updates are required**

The annual homelessness strategy review event took place in December 2016 and was well attended. The action plan is presently being reviewed and will be updated to reflect key priorities.

The homelessness strategy is due to be fully reviewed June 2017 and consultation events with partners will be arranged. A five year action plan will be completed to determine the LA priorities and to ensure it reflects economical and legislative changes.

**CC2 – Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this**

Halton will be meeting with Warrington & Knowsley in February to explore the options for improving cooperation between the 3 Healthwatches.

**CC3 - 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.**

Work continues on the further alignment of system and services across Health and Adult Social Care in line with the associated project brief previously approved by Halton Borough Council, NHS and Halton Clinical Commissioning Group.

***Key Performance Indicators***

| Ref | Measure | 15/16 Actual | 16/17 Target | Q3 Actual | Q3 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| CCC 3 | Adults with mental health problems helped to live at home per 1,000 population | 3.21 | 3.00 | 3.35 | ✓ | ↑ |
| CCC 4 | The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6). | 0 | 0 | Figures not available | ✓ | Q3 Figures not available |
| CCC 5 | Number of households living in Temporary Accommodation (Previously NI 156, CCC 7). | 15 | 17 | Figures not available | ✓ | Q3 Figures not available |
| CCC 6 | 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 divided by the number of thousand households in the Borough) | 5.1 | 5.5 | Figures not available | ✓ | Q3 Figures not available |

**Supporting Commentary**

**CCC3 - Adults with mental health problems helped to live at home per 1,000 population**

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

**CCC4 - The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years**

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

The Authority will continue to strive to sustain a zero tolerance towards repeat

homelessness within the district and facilitate reconnection with neighbouring authorities.

**CCC5 - Number of households living in Temporary Accommodation**
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. There are established prevention measures in place which are fully utilised by the Housing Solutions team to ensure vulnerable clients are fully aware of the services and options available.

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

**CCC6 - 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 divided by the number of thousand households in the Borough)**
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 tea strives 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.

***Public Health***

**Key Objectives / milestones**

| Ref | Milestones | Q2 Progress |
|---|---|---|
| PH 01a | Work with PHE to ensure targets for HPV vaccinations are maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2017** | ✓ |
| PH 01b | Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2017** | ✓ |
| PH 01c | Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2017** | ✓ |
| 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. **March 2017** | ✓ |
| PH 02b | Maintain the Family Nurse Partnership programme **March 2017** | ✓ |

| | | |
|---|---|---|
| PH 02c | Facilitate the implementation of the infant feeding strategy action plan. **March 2017** | ✓ |
| PH 03a | Expansion of the Postural Stability Exercise Programme. **March 2017** | ✓ |
| PH 03b | Review and evaluate the performance of the integrated falls pathway. **March 2017** | ✓ |
| PH 04a | Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol. **March 2017** | ✓ |
| 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). **March 2017** | ✓ |
| PH 04c | Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support. **March 2017** | ✓ |
| 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).**March 2017** | ✓ |
| PH 05b | Implementation of the Suicide Action Plan. **March 2017** | ✓ |

**PH 01a** **Work with PHE to ensure targets for HPV vaccinations are maintained in light of national immunisation Schedule Changes and Service reorganisations**.

The throughput of clients accessing Halton Stop Smoking Service in April to September 2016 compared to the same period of 2015 - 2016 is showing an increase. This is against the national trend of services experiencing a reduction in their client throughput

The Halton Service quit rate for April to September 2016 has also increased by 11% compared to the same period in 2015. Again, historically this is against the national trend of services delivering lower quit rates when their throughput increases.

Halton's smoking prevalence at time of delivery for pregnant women has also reduced; by 4.8% in the period April to September 2016 compared to the same period of 2015.

**PH 01b** **Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%**.

No new data since last report.

In line with national trends we have seen a very slight decline over time in the uptake of both cervical and breast screening. Halton has worked very hard to identify and tackle the causes of low uptake espcially within the Bowel Screening programme. Wehave undrtake some local and regional work to increase participation and have begin to see a trend of increasing uptake in the Bowel Screneing programme. Halton continues to engage with partners, through the Memoradum of Understanding with the Cancer Task Group at Public Health England and Cheshire and Merseyside

authorities, to raise awareness and attendance across all screening programmes.

**PH 01c Ensure Referral to treatment targets are achieved and minimise all avoidable breaches.**

Individual breaches continue to be investigated alongside the trusts so that the root causes for the delays can be assessed and mitigated. Public Health and Halton CCG are currently working with Trusts to improve reporting and system wide assurances. This will also be a key focus within the development of a regional Cancer Alliance, and part of the STP approach going forward. 62 day targets continue to fluctuate and while patient choice is one reported factor, systems must be better equiped to manage choice

**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.**

Child development is a priority area for One Halton, and a working group is developing and refreshing an action plan. 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.

The CCG has invested in perinatal mental health, including training of health visitors and community staff to support mothers to bond with their baby and support parents experiencing perinatal mental illness (during pregnancy and immediately after birth). Perinatal pathways are in the process of being agreed, to improve consistency of care.

The new Parent Craft programme (Your Baby and You) is now available for all pregnant mothers. This has been developed and delivered in partnership with the Family Nurse Partnership, Health Visitors, Midwifery, children centres and our own breast feeding support team. Sessions are delivered in Runcorn Town Hall and Ditton Library on a weekly basis. The programme has recently been positively evaluated by families and demand is high.

**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 hosted its annual review event on December 16th, where families on the programme and partner agencies were invited to come along, learn more about Family Nurse Partnership and the journey that families have been on, and to reflect on progress over the last year.

**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.

**PH 03a Expansion of the Postural Stability Exercise Programme.**

Key activity this quarter:

- Currently delivering six Age Well exercise classes per week, three in both towns, level 1, 2 and 3 (level 1 being for most complex clients). Level 3 classes have become a maintenance class – 'Keep it Moving'. Classes work on a rolling programme with a review every 15 weeks up to 45 weeks in total.
- A total of 85 individual clients have attended and been supported through the service in quarter 3.
- The service is building stronger links with Sure Start to Later Life in an attempt to raise awareness of events and helping people to stay in touch with friends that they have made as part of the class.
- The service has been rebranded and is now called "Age Well exercise"

**PH 03b Review and evaluate the performance of the integrated falls pathway**.

The review of the falls pathway has been scoped and will be implemented over the remainder of the year. Initial work has focussed on the interaction between low-level services who support falls awareness and prevention. As a result a telephone health initial assessment will begin in the New Year which should reduce the number of assessment visits for clients and will help to improve the efficiency of the pathway.

**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). The Chief Medical Officer has updated the low risk weekly guidelines (men and women are advised not to regularly drink more than 14 units a week). Work has been undertaken to update resources and communicate this message to the public at community events across the borough.

**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 the last 12 months to September 2016, a total of 283 individuals underwent alcohol treatment. A further 98 individuals underwent treatment for alcohol and drug misuse (alcohol and non-opiate drugs).

Performance continues to be good, with outcomes remaining higher than the national figures:

- Successful alcohol treatment completion rate was 41% locally, compared to 38% nationally (Oct 2015 to Sept 2016).
- Individuals leaving alcohol treatment successfully and not returning within 6 months was 92% locally, compared to 91% nationally (Oct 2015 to Sept 2016).

**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).**

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

A review of the Mental Health Strategy and refresh of high level indicators based on new national policy drivers has been completed and approved by the Mental Health Oversight Group. This is currently being taken to the subgroups for a refresh of the individual action plans required to achieve the objectives.

**PH 05b Implementation of the Suicide Action Plan.**

The action plan continues to be overseen by the Halton Suicide Partnership group.

Activity towards becoming a Suicide Safer Community is underway and a series of training programmes have been rolled out to multiple partners and agencies acorss a multi disciplinary footprint.

***Key Performance Indicators***

| Ref | Measure | 15/16 Actual | 16/17 Target | Q3 | Current Progress | Direction of travel |
|---|---|---|---|---|---|---|
| PH LI 01 | Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population<br><br>*Published data based on calendar year, please note year for targets.* | 167.0<br><br>*(2015)* | 176.0<br><br>*(2016)* | 163.7<br><br>*(Q4 2015 – Q3 2016)* | ✓ | ↑ |
| PH LI 02 | A good level of child development | 54.7%<br><br>*(2014/15)* | 54.6%<br><br>*(2015/16)* | 61.9%<br><br>*(2015/16)* | ✓ | ↑ |
| PH LI 03 | Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition). | 3360.0<br><br>*(2014/15)* | 3294.1<br><br>*(2015/16)* | Annual data only | ? | ↑ |
| PH LI 04 | Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population | 767.2<br><br>*(2014/15)* | 808.4 | 834.85<br><br>*Q2 2015/16 – Q1 2016/17* | ? | ↑ |
| PH LI 05 | Under 18 alcohol-specific admissions Crude Rate, per 100,000 population | 51.0<br><br>*(12/13 to 14/15)* | 55.0 | Annual data only | ? | N / A |
| PH LI 06 | Self-reported wellbeing: % of people with a low happiness score | 11.8%<br><br>*(2014/15)* | 12.4% | Annual data only | ? | ↑ |

**Supporting Commentary**

**PH LI 01 Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population**
Data used is rolling annual, based on calendar year of date of death registered.
The rate has seen an improvement up to September 2016 and is on track to hit the 2016 target.

**PH LI 02 A good level of child development**
This indicator has seen an improvement in 2015/16, narrowing the gap between Halton and England.

**PH LI 03 Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition)**
Data used is annual, published data. 2015/16 data is not yet available.

This will remain the case until a solid source of local data can be attained.

**PH LI 04 Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population**
Although an increase was seen between 2014/15 and 2015/16, the provisional quarterly rate to Q1 2016/17 shows a slight decrease.

**PH LI 05 Under 18 alcohol-specific admissions Crude Rate, per 100,000 population**
No update from previous quarter available

**PH LI 06 Self-reported wellbeing: % of people with a low happiness score**
No update from previous quarter available. This is based on annual published survey data for Halton residents calculated from the question "Overall, how happy did you feel yesterday?" Respondents answer on a scale of 0 (not at all happy) to 10 (completely happy) and this indicator is a percentage that scored 0-4.

# APPENDIX 1 – Financial Statements

Financial Statements are not currently available, however will be circulated in an updated report for PPB.

**ADULT SOCIAL SERVICES & PREVENTION AND ASSESSMENT DEPARTMENT**

**Comments on the above figures:**

**Comments on the above figures:**

**COMPLEX CARE POOL**

**Comments on the above figures:**

**Comments on the above figures:**

**COMMISSIONING & COMPLEX DEPARTMENT**

**Comments on the above figures**

**Comments on the above figures**.

**PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT**

**Comments on the above figures:**

**Comments on the above figures**.

# 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.* |