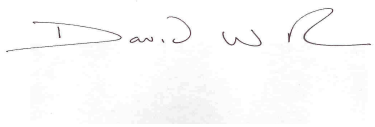
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 16 January 2007 6.30 p.m.
Civic Suite, Town Hall, Runcorn



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	Labour
Councillor Kath Loftus (Vice-Chairman)	Labour
Councillor Sue Blackmore	Liberal Democrat
Councillor Mike Hodgkinson	Liberal Democrat
Councillor Margaret Horabin	Labour
Councillor Diane Inch	Liberal Democrat
Councillor Harry Howard	Labour
Councillor Eddie Jones	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Geoffrey Swift	Conservative
Councillor Pamela Wallace	Labour
Mr Bob Bryant	Co-optee

Please contact Caroline Halpin on 0151 471 7394 or e-mail caroline.halpin@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 13 March 2007

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.

Agenda Item 3

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 16 January 2007

REPORTING OFFICER: Strategic Director, Corporate and Policy

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 33(5).

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(11) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for 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 submitted by 4.00 pm on the day prior to the meeting. At any 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 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 that 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 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

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

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 16 January 2007

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health Portfolio which have been considered by the Executive Board and Executive Board Sub since 12 September 2006 are attached at Appendix 1 for information.

1.2 The Minutes are submitted to inform the Policy and Performance Board of decisions taken in their area.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

None.

4.0 OTHER IMPLICATIONS

None.

6.0 RISK ANALYSIS

None.

7.0 EQUALITY AND DIVERSITY ISSUES

None.

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

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

APPENDIX 1

Extract of Executive Board and Executive Board Sub Committee Minutes Relevant to the Healthy Halton Policy and Performance Board

EXECUTIVE BOARD MEETING HELD ON 20 JULY 2006

HEALTH AND SOCIAL CARE PORTFOLIO

EXB22 Widnes Primary Care Estates Strategy

The Board considered a report of the Strategic Director – Health and Community which provided details of a response to the consultation on proposed changes to primary care practices in Widnes as detailed in the strategy "Improving Local Health Services".

The key aspects of Halton Primary Care Trusts' preferred options were outlined for the Board's consideration.

The Board raised a number of issues in relation to accessibility, parking facilities, nearest pharmacy locations, and the need for a more local service. It was noted that the principles of accessibility, equity and the reduction of inequalities needed be more clearly evidenced in the proposals and there would be potential difficulties should the proposals go ahead in their current form.

RESOLVED: That

(1) the proposals set out in the report be noted; and

(2) reassurances be sought from St. Helens and Halton PCT on the issues identified within the conclusions set out at section 4.0 of the report.

EXB23 5Boroughs Partnership NHS Trust Model of Care

The Board received a report providing Members with an assessment of the 5Boroughs Partnership Model of Care proposals, which highlighted the key issues for the Council to consider. The report outlined the proposals from "The Model of Care" including the key features of the proposals as follows:

- a change in emphasis of service delivery from treatment and maintenance to recovery and social inclusion;
- the development of Resource and Recovery Centres in each locality, which combined inpatient services with the new Crisis Resolution/Home Treatment service. This more intensive approach was intended to be much more flexible and needs-led; and
- delivery of a reduced but more focused range of day therapies which would provide Access and Advice Teams to act as gatekeepers to the new service. Tighter and more focused eligibility criteria would be developed which would determine the people who would be accepted by the service.

It was noted that there had been a meeting with the 5Boroughs Partnership, however it was felt that little progress had been made and a lot of work had to be done over the next six weeks in order to clarify and fully understand the proposals.

Members discussed the need for service users to be able return to the community to recover rather than having to live in hospitals and centres; what would be needed to make the model work; what resources we would have as a Council; and the possibility of training staff in order to look after clients from their homes.

RESOLVED: That

(1) the Council commission an independent person suitably qualified to review the 5Boroughs proposals; and

(2) a further report be presented to Executive Board on 7th September 2006.

EXECUTIVE BOARD MEETING HELD ON 21 SEPTEMBER 2006

HEALTH AND SOCIAL CARE PORTFOLIO

EXB34 Healthy Eating

The Board considered a report which outlined the findings of the Healthy Eating Topic Team and sought adoption of and action upon a number of recommendations. The Topic Team was jointly chaired by the Chairs of the Health and Life Chances Policy and

Performance Boards.

The aim of the Topic Team was to draw on evidence and advice from experts consulted by the Team and to concentrate on children and their families, and as a special case to include young people about to set up their own home for the first time.

The report set out a description of the Topic Team and other contributors, the approach taken and a list of recommendations.

Although there was a significant amount of information made available to the Team it became clear that there was no one overview or perspective on the current state of healthy eating in Halton. Many agencies, individuals and groups were involved in work to improve the diet of the Borough, particularly in relation to young people. However, no one group appeared to have the whole picture. As a result what should have been fairly easy questions to formulate answers to often proved more complex.

RESOLVED: That the recommendations be agreed and that progress with implementing the plan and its impact be monitored periodically by the Health PPB subject to funding being identified from the Council's budget setting process.

EXB35 5 Boroughs Partnership NHS Trust Model

At its meeting held on 20th July 2006 the Board considered a report which examined the model of care proposed and the early analysis undertaken by the Council and Halton PCT.

In general terms the view was that the model provided a sound platform to modernise mental health services based upon the model. However, the report highlighted significant concerns about the lack of information, quality of data supplied and uncertainties about the funding issues and invited the 5 Boroughs to respond to these issues. In addition, the Council agreed to commission an independent analysis of the proposals.

It was reported that Halton, Warrington and St. Helens Councils agreed to form a Statutory Joint Scrutiny Committee to scrutinise the proposals and had met on three occasions listening to the views of the 5 Boroughs and the 3 PCTs. A copy of the draft findings of the Joint Scrutiny Committee was circulated to Members of the Board. The concerns raised by the Joint Scrutiny Committee in essence were similar to those contained in the report undertaken by the independent consultant.

Since the report was presented, the 5 Boroughs had continued with their public consultation but at the same time extended the deadline for responses from key stakeholders to the 15th September 2006. The Chief Executive from the 5 Boroughs had agreed that Halton could formally respond after the meeting of the Executive Board on 21st September 2006. During the last two months a number of meetings had occurred with officers from the Council, representatives from Halton and St. Helens PCT and the 5 Boroughs Partnership. The report highlighted the processes and identified the responses to the Council's issues and concerns. In addition, a visit to Norfolk was undertaken by officers and PCT staff to compare the services.

Whilst the Council believed that the principles behind the proposed Model of Care were consistent with the commissioning strategies for Adults and Older People, which were agreed by the Council earlier in the year, there were some substantial risks in the transitition from the current model to the new model proposed. The consultant recommended that the Council supported the proposal on a conditional approval basis and explained why the alternative options were not supported.

In addition, the Joint Scrutiny Commission had made three recommendations, the key one being the model, in its present form, was not in the interest of health services in Halton, St. Helens, and Warrington. Also the Joint Scrutiny Committee had identified 12 factors which required addressing and invited the 5 Boroughs to respond to the issues raised in the report. The guidance on Joint Scrutiny required a response from the 5 Boroughs Partnership Trust within 28 days, a further meeting was therefore scheduled for 19th October.

Subsequently, it was reported that the 5 Boroughs had made some concessions during the consultation process and had now written to the Council's Chief Executive committing to a variety of issues, details of which were set out in the report. These concessions and commitments did move the partners closer together, however, the whole systems review may throw up a range of finer issues which would need to be resolved. St. Helens Council Executive Board had also discussed the proposals and their response was detailed in the report.

It was clear that the Trust needed to identify £7m to balance their budget and avoid over-trading in future years. As the whole system's review had not been undertaken, it was not possible to be entirely explicit of financial impact upon the Council. However, based upon our own analysis and through further clarification, the following

financial implications were confirmed:

- Housing and Flotation Support – Halton currently had 35 supported placements to meet the minimum supporting people requirements require an additional 10 units was required at an estimated cost of £210,000 per annum; and

- Community Teams – to meet the NHS policy guidance the assertive outreach team would need to fund two additional social workers at an estimated cost of £70,000 per year.

It was not possible to estimate anticipated costs upon:

(i) residential and nursing care costs;

(ii) out of area placements;

(iii) rehabilitation placements;

(iv) respite care;

(v) crisis houses (there were none in Halton);

(vi) other community care costs.

The conclusion, therefore, was that there would be significant financial implications for the Council, some of which were known, others which would require a more detailed financial analysis.

RESOLVED: That the Executive Board:

In principle, conditionally support the model subject to the recommendations made within the Council's Independent Consultant Report and the Joint Scrutiny Committee report being fully met and implemented.

EXECUTIVE BOARD MEETING HELD ON 2 NOVEMBER 2006

HEALTH AND SOCIAL CARE PORTFOLIO

EXB51 Consultation on Royal Liverpool Children's NHS Trust Application for Foundation Status

The Board considered a joint report of the Strategic Directors of Health and Community, and Children and Young People,

regarding key issues and concerns relating to the application for Foundation Status by the Royal Liverpool Children's NHS Trust.

It was reported that Foundation Trusts were to be at the cutting edge of a wider programme of public sector reform with the intention of offering more diversity and patient choice, enabling leadership, innovation and initiative to flourish as part of the local health economy and replacing central control from Whitehall with accountability to the local community. National debate was ongoing in this respect and implications and key questions were outlined within the report for the Board's consideration.

It was noted that the Trust had applied for Foundation Status under the Health and Social Care Act 2003 and, as the consultation period had ended on Monday, 23rd October 2006, a letter had been sent from the Health and Social Care, and Children and Young People, Portfolio Holders in response.

RESOLVED: That

(1) Halton Borough Council seeks clarity and reassurance as to what Foundation Status will actually mean for the residents and families of Halton in receipt of patient care;

(2) reassurance be sought that high cost and low caseload interventions will not be under threat in the context of a market driven by choice and competition;

(3) clarification should be sought as to whether the funding arrangements, assessment of need, nature of the workforce and the range of provision will change as a result of Foundation status;

(4) the Trust should make clear its policy on generating income;

(5) clarification should be sought with respect to the composition of the council of governors and the process for selecting representatives; and

(6) the impact of this policy (i.e. to foster innovation and change in acute hospitals) on the ability of Primary Care Trusts to invest in preventive, primary, community and intermediate care should be carefully monitored by the Healthy Halton Policy and Performance Board.

EXB52 Scrutiny and Commissioning Issues Across the Halton/St

Helens Footprint

The Board considered a report of the Strategic Director – Health and Community regarding the implications of the reconfigured Halton and St Helens Primary Care Trust (PCT) with respect to Halton Borough Council.

It was noted that the policy context arising from the White Paper was dominated by patient choice, Practice Based Commissioning, Payment by Results and the overriding requirement to achieve financial balance. The key issues that emerged from the policy context were outlined for consideration. It was noted that, within this context, PCTs were expected to act as a system intermediary. As such, their goal was to help customers achieve their objectives rather than those of the organisation itself. The Council would therefore need to consider its future joint commissioning arrangements with the PCT and build upon the work already established within the Children's Services Directorate.

In addition, information was provided in respect of the reconfiguration of the footprint for PCTs and the structure for the delivery of public health, as well as the arrangements for the scrutiny of health. It was noted that the reconfiguration of PCTs created an opportunity to review current arrangements, and opportunities for the development of health scrutiny were outlined.

RESOLVED: That

(1) the report be noted;

(2) a further report be received in 2007 on proposals to establish a Joint Public Health Unit; and

(3) the existing Scrutiny arrangements continue (but with the emphasis refined to take into account the points raised in 3.6.2 and 3.6.4 of the report).

EXB53 Transport Arrangements Post Reconfiguration of North Cheshire Hospitals Trust

The Board considered a report of the Strategic Director – Health and Community regarding transport between Halton and Warrington Hospitals, which had been prepared following a recommendation from the Healthy Halton Policy and Performance

Board (minute number HEA16 refers).

It was noted that recent developments, with a free bus service commencing from mid-November involving 11 journeys a day, had alleviated some of the issues highlighted by the Policy and Performance Board. However, a number of other issues relating to accessibility remained.

RESOLVED: That the Council, in partnership with the Primary Care Trust and North Cheshire Hospital Trust, review the transport arrangements to and from Halton and Warrington hospitals

EXECUTIVE BOARD MEETING HELD ON 14 NOVEMBER 2006

HEALTH AND SOCIAL CARE PORTFOLIO

EXB60 Carers Strategy 2006 - 2008

The Board considered a report of the Strategic Director – Health and Community together with the draft Carers Strategy 2006/2008.

It was noted that all local authorities were required to provide a Carers Strategy, which identified the aims for delivering services to Carers. The Council would receive an annual ring-fenced grant 2006/07 and 2007/08 to support the Carers Services. In 2006/07 the grant was £490,000 and this was set to increase to £503,000 for 2007/08. The annual increase in carers grant reflected a growing importance placed by the Department of Health in supporting carers and it was expected that 15% of the overall scoring in assessing the performance of Adult Social Care within the Council would be against services for carers.

A stronger corporate approach to carers was required to meet national requirements as well as providing a Council-wide response to the needs of 13,528 carers in Halton. The Carers Strategy 2006/08 reflected the outcome of consultations undertaken and sought to build on, and develop, those aspects of services most valued by carers. An action plan had been drawn up to implement the Carers Strategy and this would be subject to a review in March 2007.

The Board considered hard-to-reach groups and the methods for identifying and helping them. It was noted that, for many, family GPs would be a mechanism to identify carers and sign post them to

the services available.

RESOLVED: That

(1) the Carers Strategy be noted; and

(2) the Strategy be approved.

EXECUTIVE BOARD SUB COMMITTEE HELD ON 21 SEPTMBER 2006

HEALTH AND SOCIAL CARE PORTFOLIO

EBS38 Appointee & Receivership Policy

The Appointee and Receivership Service was set up to assist those Council Service users who were unable or found it difficult to manage their own finances on a day to day basis, and those who had been assessed under the Vulnerable Adults criteria. It was believed that by removing the worry of dealing with their own finances, this would aid the recovery of the service user.

It was noted that at present the Council applied a 50% charge against interest to off set the running of the service. The existing arrangements within the Appointee and Receivership Policy had been formally reviewed, to include an increase in fee income to 100% of interest receivable.

In order to promote independence, as outlined in the White Paper, Our Health, Our Care, Our Say, the Appointee and Receivership Section was currently undertaking a research exercise to identify alternative ways for service users to be assisted with financial management through benchmarking against other neighbouring local authorities and incorporating the principles of activities across other North West support services.

It was recommended that a further report be brought back to the Sub-Committee in February 2007 for approval of any revisions to the policy for 2007/08 in the light of changes as outlined in the review, White Paper and Office of Public Guardian.

RESOLVED: That

(1) the revision of charges against interest within the Appointee and Receivership policy be approved; and

(2) a further report be submitted to the Sub-Committee in February 2007.

EXECUTIVE BOARD SUB COMMITTEE HELD ON 2 NOVEMBER 2006

HEALTH AND SOCIAL CARE PORTFOLIO

EBS40 Social Services Out of Hours Emergency Duty Team

At present the Social Services Out of Hours Service Emergency Duty Team (EDT) was provided through firstly a call reception and assessment service, which managed all the out of hours emergency calls for Halton's Social Services. This was delivered through a contract with Cheshire County Council at a cost of £115,000. Secondly, a front line contact service, to complete urgent assessments of need and risk consisting of daytime staff from Children's and Adults Services, who volunteer for an out of hours rota and receive enhanced payments. An additional £88,000 was allocated to the Budget for this purpose, making a total overall budget of £203,000.

The Sub-Committee was advised that there were significant problems with these arrangements, and as a result the service was not fit for purpose.

These problems stemmed from two key issues:

- the contract with Cheshire was significantly above the market value and the per capita expenditure on the service was much more than neighbouring authorities; and
- there were not enough volunteers to cover either of the rotas, and there were significant

gaps on these rotas. For Adult Services, over

50% of the rota could not be filled, whilst for

Children's Services this was approximately 35%.

The Contract with Cheshire required that they should cover for Halton if gaps arise, but this had been difficult to enforce.

Both Halton and St. Helens Borough Councils had separately reviewed their EDT Services and had concluded that a different service arrangement should be put in place. Officers of both authorities had met and had developed proposals, details of which were outlined in the report. These proposals had been supported in principle by the Senior Management Teams of both authorities.

It was proposed that Halton would pay St. Helens Borough Council £170,500 annually to manage the service for three years making a total of £510,000. The Sub-Committee was requested to consider waiving Contract Standing Order 3.1 – Relating to Contracts between £50,000 and £1m, on the grounds that there was only a very limited potential supply of the providers of EDT Services in the region. In addition, there would be a clear financial and operational benefit to the Council - a potential reduction in the overall budget of over £30,000 annually, allied to the delivery of a consistent service.

RESOLVED: That

(1) the proposals to develop a formal partnership between St. Helens and Halton Borough Councils for the delivery of the emergency out of hours social workers service as identified in the report be approved in principle; and

(2) the waiving of the Contracts Standing Order 3.1, be approved.

EXB41 Provision of short-term residential respite care for adults with learning disabilities

The Sub-Committee was advised that the need for short term residential respite care for adults with disabilities was met through an in-house resource at Moorfield Road, Widnes. This resource required modernisation in line with Valuing People. Halton PCT also had a residential resource that was accessed through the partnership working arrangements.

Currently the Bredon resource was closed whilst capital work was undertaken to enable reconfigured services to be delivered at this facility. Work would be completed by the end of 2006, and would include four fully accessible respite beds to meet the needs of those with severe physical disabilities as well as challenging behaviour.

The report proposed that the service based at Moorfield be closed and the new service based at Bredon be tendered out. In view of the significant budget pressures, the high cost of in-house provision and the Council's duty to ensure value for money and service delivery, it was proposed to transfer provision of care and support at Bredon to the independent sector through a process of competitive tendering. The proposed contract period was three years and the estimated value over this term, based on the independent sector English Average unit cost, uplifted to 2006/07 prices, was £1.03m. This represented a potential saving of £340,000 over the term of the contract.

It was noted that current staff at Moorfield would be eligible for transfer to the new providers of the respite services but currently there were insufficient vacancies within the supported housing network service to offer redeployment and it was likely that this would be an attractive alternative.

RESOLVED: That

(1) the proposal to tender for a 4 bed short stay unit based at Bredon be accepted;

(2) the proposal to close the 4 bedded unit at Moorfield be accepted; and

(3) further work would be undertaken in partnership with the Primary Care Trust to seek further investment in more innovative respite services rather than traditional bed based services.

EXB42 Long Term Procurement of Supporting People Services

On 19th September 2002, the Executive Board gave approval for the award of interim contracts to existing supported housing providers in order to afford protection to vulnerable people in receipt of services. The report proposed that the interim contract would be replaced by full Supporting People (SP) contracts, subject to the findings of a rigorous review to be conducted on each service which would evaluate value for money based on cost, strategic relevance and quality. In Halton there were 107 services for vulnerable

members of the community at an approximate cost of £8m per annum.

The Supporting People Service Reviews in Halton had been completed and in general services were found to be offering a fair to good service. The report highlighted the number of service improvements instigated by the Supporting People Team during the review process.

The Service Reviews also highlighted potential to reconfigure existing services in order to meet gaps in local needs and to improve value for money by reducing the cost of services. Initial discussions regarding the findings of the Supporting People Service Reviews had taken place with approximately one third of providers. These discussions had indicated a potential gross annual saving of approximately £700,000.

The report sought approval to extend interim contracts for a period of up to 12 months and to enter into full contracts, following a period of consultation with providers and subject to the following provisos:

- services were configured to meet an agreed local need;

- services were of good quality, reaching a minimum of level C against Supporting People Quality Assessment Framework and meeting all Quality and Performance Standards to the entire satisfaction of the Supporting People Commissioning Body;

- services were reviewed as offering Value for Money in terms of the quality and cost of the service; and

- expenditure could be met within existing budgets.

It was proposed that Standing Orders would be waived due to compliance with Standing Orders not being possible as:

(i) The SP Interim Contract set out an intention to enter into long term contracts subject to the satisfactory outcome at service review;

(ii) It would result in a clear financial detriment to the Council in that, a mass procurement exercise would be prohibitive in terms of cost and time;

(iii) it was not practicable as a mass procurement exercise could destabilise the provider market and place vulnerable people at

risk of loss of service;

(iv) an extension of the interim contract would allow officers additional time to undertake further value for money assessments, which would be used to inform negotiations with providers on reduced levels of funding; and

(v) an extension of the interim contract would afford the authority the flexibility not to renew contracts, should this prove necessary, to contain expenditure within budget.

RESOLVED: That

(1) in the exceptional circumstances detailed above, for the purpose of Standing Order 1.6, that Standing Orders 2.2 – 2.6, 2.8 – 2.13, 3.3 -3.6, be waived on this occasion because compliance would result in a clear financial detriment to the Council and would result in a market imbalance, placing vulnerable service users at risk of a loss of service;

(2) the Council extends interim Supporting People Contracts for a period of up to 12 months and enters into negotiations with existing service providers to ensure the continued provision of services to vulnerable service users, subject to the providers being able to demonstrate, to the entire satisfaction of the Supporting People Commissioning Body, that services are of good quality, are strategically relevant and offer value for money;

(3) Contract Standing Orders 2.2 – 2.6, 2.8 – 2.13, 3.3 – 3.6 are suspended to implement a retraction plan for the re-configuration of 24-hour Supported Living Services in order to minimise the risk of loss of service of some of the most vulnerable members of our community;

(4) delegated powers be approved to enable the Strategic Director, Health and Community, in conjunction with a Portfolio Holder for Community, to award contracts to existing providers subject to the conditions set out above on the varied terms set out under Sections 3.10 – 3.13 of the report;

(5) subsequent to the expiry of full Supporting People Contracts, granted under a waiver due to the exceptional circumstances set out in the report, Supporting People Services will be procured through a competitive tendering process; and

(6) the Strategic Director, Health and Community, in conjunction with the portfolio holder for Community, be authorised to take such action as may be necessary to implement the above recommendations

EXB43 Development of Short Term Pilots for Supporting People and Welfare Services

The Sub-Committee was advised that in 2003, Halton received a £8.5m ring-fenced grant for the provision of Supporting People (SP) Services. The grant had since been reduced each financial year. The Department of Communities and Local Government had confirmed the Council's levels grant up to 2007/08 and had confirmed that as an Excellent Authority, the Council retained the right to roll-forward any underspend.

However, the level of funding committed to the SP Programme on a national level had been the subject of considerable review since the programme was introduced in 2003. In October 2006 the Department of Communities and Local Government (DCLG) was expected to publish its plans for the long term funding arrangements for the programme. In addition to the risk to Halton of loss of funding, all Excellent Authorities faced the risk of loss of flexibility to roll-forward any underspend. DCLG had indicated an intention to require the return of underspend from 2008 onwards.

The on-going reduction in funding, coupled with concerns over the government's intention to introduce an SP distribution formula within the first two years of the programme, had lead to an effective freeze on the commissioning of any SP services. This restriction on the commissioning of new services and delays in the completion of on-going developments had lead to a year on year underspend on Halton's SP Programme Grant and subsequent concerns that Halton was failing to meet gaps in service identified in the SP Five-year Strategy and in meeting the Government's new preventative agenda for adults social care.

It was proposed that in order to maximise use of the grant and to ensure best use of resources for vulnerable members of the community, an expansion of services on a temporary basis, within the confirmed grant allocation up to the end of March 2008 be agreed.

Halton's SP underspend in 2005/06 was approximately £1.4m. This was rolled-forward into the 2006/07 budget which was also

currently projected to underspend by £1.4m. Bids had been invited for short-term funding of services to support vulnerable members of the community. Under the flexibility afforded to the Authority after achieving Excellent Status, bids were also invited for the provision of welfare services, which were only eligible for funding within the SP Grant conditions for Excellent Authorities. All services were to be viewed as pilots, attracting funding up to the end of March 2008. An outline of the services approved by Supporting People Boards and the indicative costs were set out in the report.

RESOLVED: That

(1) in the exceptional circumstances detailed below, for the purpose of Standing Order 1.6, Standing Orders 3.3 – 3.6 be waived on this occasion. Compliance is not practicable for reasons of urgency, in that undertaking tender exercises would reduce the time available to spend the time limited funding on vulnerable members of our community and compliance would result in the Council having to forego a clearfinancial benefit, in that the Council could be required to return any under spent Supporting People Programme Grant from April 2008 onwards;

(2) delegated powers be approved to enable the Strategic Director, Health and Community, in conjunction with the Portfolio Holder for Community, to award short-term contracts to the parties listed in the report, at a cost not exceeding that listed and subject to the conditions set out in the report; and

(3) the Strategic Director, Health and Community, in conjunction with the Portfolio Holder for Community, be authorised to take such action as may be necessary to implement the recommendations as set out in the report; subject to further information on how the proposals regarding the appointment of the proposed three additional temporary Support Time and Recovery Workers could be developed without long term implications for the Council.

EXECUTIVE BOARD SUB COMMITTEE HELD ON 16 NOVEMBER 2006

HEALTH AND SOCIAL CARE PORTFOLIO

EXB 55 INDEPENDENT MENTAL CAPACITY ADVOCATE SERVICE

The Sub-Committee was advised that the Mental Capacity Act 2005 would come into force from March 2007 to protect vulnerable

people who were assessed as lacking capacity and, therefore were unable to make informed decisions. The Act required that all local authorities ensured the delivery of an independent Mental Capacity Advocate Service (IMCA) for all people assessed as lacking capacity, who had no family or friends to advocate on their behalf and/or in their best interests.

The Government had allocated funding to each Local Authority based on population size. For 2007/08 Halton had been allocated £18,868 of Mental Capacity Grant. In order to ensure the service was in place by 1st April 2007, all local authorities must begin the tender process as soon as possible.

It was noted that the low level of funding available would make it difficult to deliver an effective service commissioned by the Council alone as the allocated budget would not fund one full time advocate post. Therefore it was proposed to pool the resources available to Halton, Warrington St Helens and Knowsley (in total £97,897) to commission a service across the localities. The funding of a larger service would provide for greater flexibility in the delivery of the IMCA Service.

Warrington Borough Council had agreed to lead on the tendering process and contract award, in full consultation with representatives from all the other local authorities involved, who would also take part in the evaluation of the tenders.

RESOLVED: That

(1) the arrangements for a joint commissioning and tendering process for Independent Mental Capacity Services be agreed; and

(2) procurement of Standing Orders 2.2 – 2.6 and 2.8 – 2.14 be waived in light of the exceptional circumstances, namely that compliance with Standing Orders would result in the Council having to forego a clear financial or commercial benefit based on the price advantages likely to be achieved by pooled purchasing arrangements with St.Helens, Warrington and Knowsley.

EXECUTIVE BOARD SUB COMMITTEE HELD ON 16 NOVEMBER 2006

Health and Social Care Portfolio

EXB60 Intermediate Care Crisis Beds

The Sub-Committee considered a report which sought

authority to continue with the contract for two residential intermediate care crisis beds with Southern Cross/Highfield Health Care (Beechcroft Care Home), for up to six months, to suspend Contract Standing Orders, and approve delegated powers to enter into a contract without going out to competitive tender.

The Beechcroft Crisis beds were opened on 12th August 2005, these beds were an essential part of the service, and enabled the authority to manage more complex risk issues, negating the need to admit unnecessarily to more intensive services. The occupancy rate of these beds was 95%.

It was reported that compliance with Standing Orders was not practicable for reasons of no expressions of interest returned within timescales for the provision of this service. Expressions of interest had been requested twice. The existing contractor did express an interest verbally, however, due to administrative difficulties did not return a written expression of interest.

The request for waiver of Standing Orders was made to sustain this essential operational service, particularly over the winter period. The waiver was requested for a period of six months, to allow the time to again explore the market for the provision of these beds. Following the six month period, delegated authority was requested for the Operational Director (Older People) to award the contract, within the framework of Standing Orders, to 31st March 2008. If the waiver was not agreed, this could result in a decrease in service provision, particularly in Runcorn. This could result in an increase in admissions both to long term care and hospital, due to the lack of services in the community.

RESOLVED: That for the purposes of Standing Order 1.6c, that is if compliance is not practicable for the reason of the level of training support that has been provided within this environment and the need to continue to operate the service of two intermediate care crises beds in Runcorn, Procurement Standing Orders be waived in respect of the extension of the present contract with Southern Cross/Highfield Health Care (Beechcroft Care Home) for a period of up to six months from 31st December 2006.

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 16 January 2007

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: HITS Young Carers Service

WARD(s): Borough wide

1.0 PURPOSE OF REPORT

1.1 To provide information of the Young Carers Project delivered by HITS.

2.0 RECOMMENDATION: That the report be endorsed.

3.0 SUPPORTING INFORMATION

3.1 Young carers are children and young people under the age of 18 years who provide care to another family member who has a physical illness / disability; mental ill health; sensory disability or has a problematic use of drugs or alcohol.

3.2 The level of care they provide would usually be undertaken by an adult and as a result of this has a significant impact on their normal childhood.

3.3 HITS delivers a young carers programme as commissioned by Halton Children's Services. Current funding provides 1.5 workers and a proportion of management and is supported by 5 volunteers. The recent addition of a 0.5 young carers development worker is funded by NRF monies. The programme is placed within the Young Persons Support Team at HITS which enables worker support from other projects and easier access to and from other support programmes for the young people.

3.4 Currently 3 support groups are held weekly after school and although flexible, are divided by age. 5-10 year old meet on a Thursday, 9-12 year olds meet on a Tuesday and 12 years + meet on a Wednesday. The Wednesday group is run in partnership with Halton Youth Service who deliver the sessions supported by HITS volunteers. Individual support can be offered in response to assessed need and be provided by a paid worker or volunteer as appropriate.

3.5 Part of HITS' role is to identify and offer an assessment of need to young carers in Halton, the assessment has recently been brought

in line with the Common Assessment Framework document. Most recent figures from the 2001 Census suggest that there 474 young carers in the Borough, we are currently aware of approximately 200. In addition to raising awareness of young carers issues with professionals and agencies, a Young Carers Steering Group has been set up to explore developing a more coordinated approach to the provision of young carers services. It is recognised that there are agencies in addition to HITS that will identify young carers and may offer some support. Operating alongside this group is the young carers committee which is a group of young people who are who have experience of being a young carer. Their views will be fed into the steering group to assist in the development of services and access to them.

3.6 By providing a supportive environment, after school support and residential breaks from their caring role, young people are enabled to undertake typical age appropriate activities and develop relationships that contribute to positive emotional health.

4.0 POLICY IMPLICATIONS

4.1 Not applicable

5.0 OTHER IMPLICATIONS

5.1 Not applicable

6.0 EQUALITY AND DIVERSITY ISSUES

6.1 Although the number of young people from diverse backgrounds participating in the project are low, they are proportionately higher than Halton as a whole.

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

7.1 There are no background documents under the meaning of this Act.

REPORT TO:	Healthy Halton Policy and Performance Board
DATE:	16 January 2007
REPORTING OFFICER:	Strategic Director, Health & Community
SUBJECT:	Restrictive Physical Interventions Policy & Procedure
WARDS:	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide PPB with a draft Restrictive Physical Interventions Joint Policy and Procedure between the Health & Community Directorate and the Primary Care Trust for Adults with Learning Disabilities for comment.

2.0 RECOMMENDATION: That Members note and comment on the appended Policy and Procedure.

3.0 SUPPORTING INFORMATION

3.1 The Restrictive Physical Interventions Policy and Procedure has been developed to formalise current practices within health and social care for adults with learning disabilities and is, therefore, a joint policy for use by Council and PCT staff. It has been developed in line with the Department of Health's Guidance 'How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder' published in July 2002.

3.2 Stakeholder consultation has taken place on the draft, including Council and PCT staff working with this client group, service users and carers who may be affected by the Policy, Provider agencies, appropriate voluntary organisations, advocacy agencies, Adult Protection Committee members, Council and PCT health and safety officers and Council and PCT legal services.

3.3 Approval and endorsement of the Policy will also be sought from the PCT's Integrated Governance Committee.

4.0 POLICY IMPLICATIONS

4.1 None associated with this report.

5.0 OTHER IMPLICATIONS

5.1 Training

5.1.1 Associated training for the Policy and Procedure will be undertaken in two phases. Phase 1 will cover basic awareness and theory on restrictive physical interventions and challenging behaviour, an overview of the Policy and an outline of the Procedures. This will be covered in one session and will be provided in partnership with health colleagues to all appropriate staff working with adults with learning disabilities in both the Council and the PCT.

5.1.2 Those staff identified as needing practical training in Phase 1 will progress to Phase 2, a more intensive programme covering restrictive physical intervention techniques and relating them to the specific needs of those service users this Policy and Procedure will or may apply to, thus enabling staff to deliver such interventions. SPACE, a Warrington based organisation, have been commissioned to deliver this second Phase via the Joint Training Partnership on a 'train the trainer' basis.

5.2 Financial

5.2.1 The implementation and roll out of the Policy and Procedure will be achieved within budget, utilising both the Council's in-house Training Budget and Joint Training Partnership funds.

6.0 RISK ANALYSIS

6.1 None associated with this report.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None associated with this report.

Restrictive Physical Interventions

Joint Policy, Procedure and Practice for Adults with Learning Disabilities

2007-2010

Dwayne Johnson
Strategic Director
Health & Community Directorate
Halton Borough Council

Rebecca Burke-Sharples
Chief Executive
Halton & St Helen's Primary Care Trust

DRAFT 2.11.06

CONTENTS

INFORMATION SHEET

Service areas	Adults with Learning Disabilities
Date effective from	January 2007
Responsible officer(s)	• Margi Daw, Team Manager, ALD Specialist Community Team, Halton & St Helen's Primary Care Trust • Nigel Parker, Divisional Manager ALD Provider Services, Halton Borough Council
Date of review(s)	December 2009
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	All staff and provider agencies working in health and social care services with a responsibility for providing services to adults with learning disabilities.
Date of Committee decision	• HBC Health & Community Senior Management Team Oct 06 • PCT Integrated Governance Committee Oct 06 • PCT Allied Health & Other Professionals Group Nov 06
Related document(s)	• HBC Assessment & Care Management Manual for Adults & Older People • DoH Guidance on the protection of vulnerable adults 'No Secrets' • Halton's Inter-Agency Adult Protection Policy, Procedures & Guidance Manual • British Institute for Learning Disability (BILD) Easy Guide to Physical Interventions • BILD Carers' Guide to Physical Interventions and the Law
Superseded document(s)	None
File reference	

POLICY

1.1 INTRODUCTION

For some considerable time we have seen a change in our understanding of people with learning disabilities, with an emphasis on their rights as citizens to choice, independence, inclusion and dignity, as well as on their vulnerability to abuse and the denial of rights. It is, however, recognised that some people with learning disabilities do occasionally present aggressive or violent behaviours. In exceptional circumstances some people may occasionally require physical restraint or similar actions to prevent serious injury to themselves or to others, or damage to property.

Physical intervention refers to direct physical contact between one person and another or to physical contact mediated by an instrument or device. This Policy and Procedure is specifically concerned with restrictive physical interventions which involve the use of force to restrict movement or mobility or the use of force to disengage from dangerous or harmful physical contact initiated by people who access learning disability services.

This Policy and Procedure is issued jointly by Halton Borough Council (HBC) and Halton & St Helen's Primary Care Trust (PCT) and describes the context in which it is appropriate to use restrictive physical interventions with adults with learning disabilities and outlines procedures for responding to aggression and violence safely and effectively, and for the design, delivery, recording, monitoring and reviewing of the use of restrictive physical interventions. It, therefore, should be used in conjunction with assessment and care management procedures.

This document also includes good practice in the use of restrictive physical interventions and unacceptable practices that might expose people who access learning disability services or staff to risk of injury or psychological distress and covers all settings, including public places.

1.2 AIM OF THE POLICY

The aim of this Policy and Procedure is to ensure that restrictive physical interventions are used as infrequently as possible, that they are used in the best interests of people who access learning disability services, and that when they are used everything possible is done to prevent injury and maintain the individual's sense of dignity.

Restrictive physical interventions should always be designed to achieve outcomes that reflect the best interests of users of learning disability services whose behaviour is of immediate concern and others affected by the behaviour requiring intervention. The decision to use a restrictive physical intervention must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing a restrictive physical intervention.

A restrictive physical intervention must also only employ a reasonable amount of force, that is, the minimum force needed to avert injury or damage to property, applied for the shortest period of time. It should only take place in the context of a person centred plan, functional analysis of the reasons for the behaviour and alongside positive approaches that address those reasons. Where possible, a restrictive physical intervention should be considered and agreed in advance as appropriate and only be an unplanned response where this is unavoidable.

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1.3 DEFINITIONS

Physical intervention refers to direct physical contact between one person and another or to physical contact mediated by an instrument or device.

There are different forms of physical intervention:

- **Restrictive** forms, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact; and
- **Non-restrictive** methods.

Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of people who access learning disability services and staff, and inevitably affects personal freedom and choice. For these reasons this policy is specifically concerned with the use of restrictive physical interventions, examples of which are given below.

Physical Intervention	**Bodily Contact**	**Mechanical**	**Environmental Change**
Restrictive	Holding a person's hands, arms, legs, head to prevent them hitting, kicking, biting, head-butting someone	Use of wheelchair belts to prevent free movement	Forcible seclusion or the use of locked doors
Non restrictive	Manual guidance, eg, to assist a person walking	Use of a protective helmet to prevent self injury or injury to others	Removal of the cause of distress, eg, adjusting temperature, light or background noise

Restrictive physical interventions can be employed to achieve a number of different outcomes:

- To break away or disengage from dangerous of harmful physical contact initiated by a person with learning disabilities.
- To separate the person from a 'trigger', eg, removing one person who responds to another with physical aggression.
- To protect a person with learning disabilities from a dangerous situation, eg, the hazards of a busy road.

Intervention can also be planned or unplanned:

- **Planned intervention** is when staff employ, where necessary, individual pre-arranged strategies and methods which are based upon a risk assessment and recorded in care plans.
- **Unplanned or emergency** use of force occurs in response to unforeseen events.

The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled and the nature of the harm they might cause. These adjustments have to be made at the time, taking due account of all the

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circumstances, including any known history of any other events involving the individual to be controlled. The minimum necessary force should be used and the techniques deployed should be those with which the staff involved are familiar and able to use safely and are described in the individual's care plan. Where possible, there should be careful planning of responses to individual adults known to be at risk of self-harm or of harming others.

Planned Intervention

Individual planned physical intervention strategies and methods should be:

- Agreed in advance by a multi-disciplinary team and an accredited physical interventions trainer working in consultation with the person with learning disabilities, his/her carer or advocate, based on a current risk assessment.
- Described in writing, informed by relevant specialist professionals and incorporated into other documentation which sets out a broader strategy for addressing the person's behavioural difficulties.
- Implemented only by staff who have undertaken appropriate training provided by an organisation accredited by BILD.
- Recorded in writing so that the method of physical intervention and the circumstances when it was employed can be monitored and, if necessary, investigated.

Where planned physical intervention strategies are in place for people who access learning disability services, they should be one component of a broader approach to behaviour management, treatment or therapy and subject to review.

Unplanned or Emergency Intervention

Unplanned or emergency intervention may be necessary when a person with learning disabilities behaves in an unexpected way. In such circumstances, members of staff retain their duty of care to the individual and any response must be proportionate to the circumstances. Staff should use the minimum force necessary to prevent injury and maintain safety, consistent with appropriate training they have received.

1.4 VALUES

This Policy promotes the following values:

- Restrictive physical interventions should only be used in the best interests of the person with learning disabilities whose behaviour is of immediate concern and for the protection of others who may be harmed by the behaviour requiring intervention.
- That all behaviour is meaningful, ie, challenging behaviour happens for reasons that need to be addressed by those around the person.
- People who access learning disability services should be treated fairly and with courtesy and respect.
- People who access learning disability services should be helped to make choices and be involved in making decisions which affect their lives.
- There should be experiences and opportunities for learning which are appropriate to the person's interests and abilities.
- The deliberate use of pain in the deployment of restrictive physical interventions will not be used or sanctioned.
- Staff should be trained and supported in adhering to the Policy and Procedure.

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1.5 LEGAL CONSIDERATIONS

Relevant Legislation

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
- Manual Handling Operations Regulations 1992
- Offences Against the Person Act 1861
- Human Rights Act 1998
- Local Authority Social Services Act 1970
- Care Standards Act 2000
- Mental Health Act 1983
- Mental Capacity Act 2005

Staff should only resort to a restrictive physical intervention after having tried first to defuse the situation. If such attempt fails, then intervention should only occur if and when the person with a learning disability presents a risk or imminent danger of (a) causing physical injury to themselves, staff or others; or (b) is causing damage to property.

Legal Implications

The use of a physical intervention may be construed in law as trespass to the person. There is a need for staff and managers to be aware of the potential legal implications of using restrictive physical interventions. Failure to follow instructions could result in liability for assault and battery, or more serious criminal offences if a person who accesses learning disability services incurs serious injuries as a consequence of the physical intervention, as well as a breach of the Human Rights Act 1998, in particular Articles 3, 5 and 8 as follows:

- Article 3, which states: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
- Article 5(1), which states: Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: The exceptions to the Article 5 right to liberty and security of person include where the interference is in order to secure the fulfilment of any obligation prescribed by law or where the interference is necessary to the lawful detention of persons…of unsound mind, alcoholics or drug addicts or vagrants.
- Article 8(1), which states: Everyone has the right to respect for his private and family life, his home and his correspondence. The exceptions to this right include where interference is in accordance with the law and is necessary in a democratic society in the interests of…public safety…for the prevention of disorder or crime…for the protection of health or morals, or for the protection of the rights and freedoms of others.

It is a criminal offence to use physical force or to threaten to use force unless the circumstances give rise to a ‘lawful excuse’ or justification for the use of force. Similarly it is an offence to lock an adult in a room without recourse to the law (even if they are not aware that they are locked in) except in an emergency when, for example, the use of a locked room as a temporary measure while seeking assistance would provide legal justification. Use of physical intervention may also give rise to an action in civil law for damages if it results in injury or psychological trauma to the person concerned.

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Under health and safety legislation, Halton Borough Council and Halton & St Helen's Primary Care Trust are responsible for the health, safety and welfare of its employees and the health and safety of persons not in employment, including people who access services and visitors. This requires us to assess risks to both our staff and service users arising from work activities, including the use of physical interventions. It also requires us to establish and monitor safe systems of work and ensure that staff are adequately trained and have access to appropriate information about the people they are working with who access services.

Defences

There are a number of defences which may be put forward to justify the actions of staff implementing physical interventions which could otherwise be viewed as unlawful under the civil or criminal law. These include:
Statutory Justification - Justification via legal statutes, eg, 'Sectioning' under the Mental Health Act- False Imprisonment.

Prevention of a Breach of the Peace - Actions could be justified if it could be shown that an individual was likely to cause harm to others or property or where harm was feared as a result of affray, riot, assault or other disturbances.

Duty of Care - A duty of care may exist where a vulnerable person is receiving care or support. More generally it may exist if the person A would be so closely and directly affected by the actions of person B, that B should reasonably consider this when deciding whether or not to act. Failure to observe a reasonable duty of care could be the basis for a legal action for neglect.

Providers of health and social care services owe a duty of care towards all people who access their services. The duty of care requires that reasonable measures are taken to prevent harm. Therefore, the use of locks or other security measures on outside doors to control visitor entry are permissible if the user of a service is supervised. It may be appropriate to employ restrictive physical intervention to prevent a significant risk of harm, for example:

- To prevent a person running toward a busy road.
- To prevent a person self-injuring.
- To prevent a person injuring another person.
- To prevent a person committing an offence.
- To ensure health is maintained via interventions, eg, blood tests.

Private Defence - An individual is entitled to take *reasonable* steps to protect themselves and others from injury caused by another person.

<u>Reasonable Action</u>

'Reasonable' means:

- "The person may use such force as is reasonable in the circumstances in the prevention of a crime." (Criminal Law Act, 1967)
- "Any restraint must be 'reasonable in the circumstances'. It must be the minimum necessary to deal with the harm that needs to be prevented". (Mental Health Act 1983 Code of Practice, par 18.11)

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What action is reasonable depends on:

- The scale of the threat to the person accessing the service and to others.
- The other options available for reducing the threat.
- The feasibility of carrying out the proposed actions.
- The likelihood of its success.
- The ability of the person accessing the service to give consent.

Reasonable Force

Any restrictive physical intervention should employ the minimum reasonable force and is legally defensible when it is required to prevent self-harming, injury to other service users, staff or individuals, damage to property, or an offence being committed. 'Reasonable force' should be determined with reference to all these circumstances, as well as:

- The seriousness of the incident.
- The relative risks arising from using a physical intervention compared with using other strategies.
- The age, cultural background, gender, stature and medical history of the person accessing the service.
- The application of gradually increasing or decreasing levels of force in response to the person's behaviour.

Therefore the reaction of staff to the behaviour of the person accessing the service must be in proportion to the harm threatened.

Examples

1. A person supported by the service strikes staff when his routine is interrupted. This behaviour ceases when people move out of striking range. It would not be reasonable to restrain this person, given that the consequences of his action can be avoided by other means. Meanwhile steps should be taken to ensure that the person's routines are interrupted as little as possible.

2. Someone sometimes head butts and kicks staff. If they withdraw she follows them. This happens mostly in the few days before her period. The attacks appear to be triggered by noise and activity by another person accessing the service. It would be good practice to ensure that this woman has access to appropriate advice and treatment for the pre-menstrual problem (which might extend to non-medical approaches such as massage and relaxation). It would also be sensible to reduce the sources of stress inducing noise and interference, for example by managing space and activities for the two individuals to avoid conflicts. It might still be reasonable to use a restraint procedure if she follows staff to attack them, and the blows cannot be blocked or deflected effectively.

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3. A man occasionally becomes agitated when out in community settings. The service has identified the conditions under which this is likely to occur, and is able to use this knowledge to keep the frequency of such episodes to a minimum, by avoiding trips when predisposing factors are evident, by planning trips carefully, and monitoring the situation for possible triggering events. Infrequently, despite these precautions, he becomes distressed and on these occasions has sometimes run off, putting himself and others in danger. On these occasions the use of physical restraint is a reasonable intervention, since its availability allows him to continue accessing community settings, while its application ensures safety. The preventative measures taken ensure that physical intervention is used infrequently. The man is aware of the possibility of using restraint on these occasions, and is comfortable with this.

1.6 PREVENTION OF CHALLENGING BEHAVIOUR

Challenging behaviour for the purpose of this Policy and Procedure is 'behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy or which is likely to seriously limit or delay access to and use of ordinary community facilities' (Emmerson 1987).

There are many reasons why a person with learning disabilities may have behaviours that are seen as challenging. They can often be prevented or reduced by the careful management of setting conditions, teaching of skills, enhancing the communication and interaction skills of carers and those accessing services and addressing physical health and well-being issues. Understanding of the reasons for an individual's behaviour and prevention by addressing those reasons therefore must be the fundamental objective.

Restrictive physical intervention is a reactive tactic. The pursuit of more pro-active intervention should always be the preferred option and so the use of restrictive physical interventions should be minimised by the adoption of primary and secondary preventative strategies.

Primary Prevention

The interaction between environmental setting conditions and personal setting conditions should be explored for each person who accesses learning disability services who presents a challenge. Setting conditions should be modified to reduce the likelihood of challenging behaviour occurring (primary prevention). Primary prevention focuses on prevention of the need to challenge, of the opportunity to challenge and of physical harm and is achieved by:

- Ensuring that the number of staff deployed and their level of competence corresponds to the needs of people accessing the service and the likelihood that physical interventions will be needed. Staff should not be left in vulnerable positions.
- Helping people who access learning disability services to avoid situations which are known to provoke violent or aggressive behaviour.
- Building positive interactions and communication environments.
- Care plans which are responsive to individual needs and include current information on risk assessment and management strategies.

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- Creating opportunities for individuals to engage in meaningful activities which include opportunities for choice and a sense of achievement.
- Developing staff expertise in working with individuals who present challenging behaviours.
- Talking to people with learning disabilities, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others, eg, having a living will. Some people may prefer withdrawal to a quiet area to an intervention which involves bodily contact.

Secondary Prevention

Secondary prevention procedures should be developed to ensure that problematic episodes are properly managed with non-physical interventions before individuals become violent. Secondary prevention should focus on the active management of behaviour through the provision and promotion of alternative activities, positive and facilitative communication/interaction strategies, therapeutic intervention and the avoidance of contact. It involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing 'defusion' techniques to avert any further escalation.

Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of restrictive physical intervention at an early stage in the sequence may potentially be justified if it is clear that:

- Primary prevention has not been effective.
- The risks associated with not using a restrictive physical intervention are greater than the risks of using a restrictive physical intervention.
- Other appropriate methods, which do not involve restrictive physical interventions, have been tried without success.

All prevention strategies should be carefully selected and reviewed to ensure that they do not constrain opportunities or have an adverse effect on the welfare or the quality of life of people with learning disabilities (including those in close proximity to the incident), unnecessarily. In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are prescribed. This is likely to require a detailed risk assessment.

Devices which are required for a therapeutic purpose, such as wheelchairs and standing frames, may also restrict movement. Such devices should never be provided for the purpose of preventing problem behaviour, although in extreme circumstances they might be used to manage risks, as defined in Section 1.8. A decision to use therapeutic devices to prevent problem behaviour (for example, strapping someone into a wheelchair) must be agreed by a multi-disciplinary team in consultation with the individual concerned, their family and advocate, and recorded within their individual care plan.

Devices that are designed specifically to prevent problem behaviours should be considered a form of restrictive physical intervention, even if the individual does not resist the use of such devices. For example, arm splints or protective garments might be used to prevent self-injury. They should only be introduced after a multi-disciplinary assessment which includes consultation with the individual, their family and advocate, and after exploration of other options. If used, they should be selected carefully to impose the least restriction of

movement required to prevent harm while attempts should continue to be made to achieve the desired outcomes with less restrictive interventions. Such devices should only be used by carers who have received specific training in their usage. The rationale for using any devices and the circumstances in which they may be used must be clearly recorded within an individual's care plan. Their use should also be subject to a periodic review, with the outcomes of such reviews being recorded.

Example

A person supported by the service has mobility but cannot walk for longer distances and uses a wheelchair. He can become distressed in unfamiliar places but is usually ok once he has been to the same venue a couple of times. Staff leave him in the wheelchair in venues on first and second visits to minimise the risks of the behaviours he displays when distressed at the unfamiliarity. Once he is relaxed in that venue he is allowed to walk.

1.7 MEDICATION

In certain situations, the use of medication may be indicated as a method of managing extreme behaviour. Medication must only be administered upon medical advice and must only be used as a routine method of managing difficult behaviour where it is included within an individual's care plan and prescribed by a qualified medical practitioner.

The use of medication must comply with any regulations and should comply with national minimum standards issued under the Care Standards Act.

Under their duty of care, staff should not give tranquilisers to people with learning disabilities who have contra-indications. Contra-indications should always be recorded in the individual's care plan. Except in an emergency where there is a significant risk of personal injury or a serious risk of an offence being committed, rapid tranquilisation should not be used as a method of gaining control over individuals who display violent or aggressive behaviour.

Sometimes medical treatment is indicated for an underlying cause, eg, headache, sinus congestion, psychiatric disorders, pre-menstrual tension. Service providers must insist on high standards of diagnosis, treatment and monitoring, and support people accessing learning disability services to obtain appropriate health care. Where medication has been prescribed to control behaviour, referral to the Learning Disability Psychiatry service should be sought via the GP. Long term use of such medication should be avoided as there may be side effects and it often loses its effectiveness over time, therefore, use should be regularly reviewed.

In certain cases tranquilising medication, prescribed by a medical practitioner, is used as a short term expedient to reduce damage to the person or others. This should only be a temporary measure and such uses of 'chemical restraint' should be reviewed as for a physical intervention.

The PCT's Guidelines for the Covert Administration of Medicines (Disguising Medicines in Food and Drink) should also be referred to. These guidelines are specific to the care of adults who are deemed to lack the mental capacity to give informed consent to treatment with medication and are actively refusing medication. They should only be used when all

other options have been considered and when it is in the best interests of the patient.

Examples

1. Dr Jones is a GP and occasionally deals with patients who have learning disabilities and severely challenging behaviour. He is sometimes called upon to administer certain medication to his patients either as part of a long-term treatment programme as recommended by the Learning Disability Psychiatrist or as an emergency measure in order to deal with patients' challenging behaviours. Many of the patients lack capacity to consent to medical treatment.

   In any given circumstances, when consent is not given, treatment should only be given in the best interests of the patient and not the carer. Where medication has been prescribed, this should be reviewed by professionals and Carers involved with the person and the Learning Disability Psychiatrist on a regular basis.

2. Frank is a 30 year old man with Autism and severe learning disabilities. Urine tests and other symptoms have indicated that he may have developed diabetes. His GP requires a blood sample to make a definitive diagnosis. Frank is very anxious about being touched and despite attempts at desensitisation to needles refuses to allow bloods to be taken. It is agreed by all those involved in his care that he lacks the capacity to understand the consequences to his health of remaining untreated and that the risk to his health out-weighs the transient distress of the physical intervention required to obtain the sample. His GP agrees to prescribe a neuroleptic (tranquiliser) medication for Frank to be administered prior to the taking of bloods in order to minimise his distress.

1.8 RISK ASSESSMENT

Planned restrictive physical interventions should only be used as part of a holistic strategy when the risks of employing an intervention are judged to be lower than the risks of not doing so.

The use of force to restrict movement or mobility to break away from dangerous or harmful physical contact initiated by a person accessing the service will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to individuals, staff and others and pre-planning responses where possible.

Examples of physical intervention that might generally be considered low risk include:

- Members of staff taking reasonable measures to hold a person with learning disabilities to prevent him or her from hitting someone.
- A specially designed 'arm cuff' to prevent someone self-injuring.
- Accompanying a person who dislikes physical contact to a separate room for a few minutes where they can be continuously observed and supported.

Elevated levels of risk are associated with:

- The use of clothing or belts to restrict movement.

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- Holding someone who is lying on the floor or forcing them on to the floor.
- Any procedure which restricts breathing or impedes the airways.
- Seclusion where a person is forced to spend time alone in a room against their will.
- Extending or flexing the joints or putting pressure on the joints.
- Pressure on the neck, chest, abdomen or groin areas.

When the use of a restrictive physical intervention is sanctioned, it is important that appropriate steps are taken to minimise the risk to both staff and those accessing services and that a Level 2 Risk Assessment has been undertaken.

Among the main risks to people with learning disabilities are that a physical intervention could:

- Be used unnecessarily, that is when other less intrusive methods could achieve the desired outcome.
- Cause injury.
- Cause pain, distress or psychological trauma.
- Become routine, rather than exceptional methods of management.
- Increase the risk of abuse.
- Undermine the dignity of the staff or individual concerned or humiliate or degrade those involved.
- Create distrust and undermine personal relationships.

The main risks to staff include the following:

- As a result of applying a physical intervention they suffer injury.
- As a result of applying a physical intervention they experience distress or psychological trauma.
- The legal justification for the use of a physical intervention is challenged in the courts.
- Disciplinary action.

The main risks of not intervening include:

- Staff may be in breach of the duty of care (refer to Section 1.5, Legal Considerations).
- People accessing services, staff or others will be injured or abused.
- Serious damage to property will occur.
- The possibility of litigation in respect of these matters.

Whenever it is foreseeable that a person with learning disabilities might require a physical intervention, a Level 2 Risk Assessment should be carried out which identifies the benefits and risks associated with the application of different intervention techniques with the person concerned. Where the use of self-harm prevention devices is indicated, staff should be fully trained in their usage. This should always be recorded and incorporated with individual care plans. Where incidents are foreseeable, individuals should only be exposed to restrictive physical intervention techniques which are described in their individual records following a risk assessment.

In order to minimise risk and promote the well-being of people accessing learning disability services:

- Restrictive physical interventions should be employed using the minimum reasonable

force.
- Any single restrictive physical intervention should be employed for the minimum duration of time.
- For individuals, restrictive physical interventions should be sanctioned for the shortest period of time consistent with his or her best interests.
- Restrictive physical interventions should not cause pain.
- People accessing the service should have individual assessments to identify contra-indications of restrictive physical interventions before they are approved.
- People accessing the service who receive a physical intervention should be routinely assessed for signs of injury or psychological distress.

1.9 CAPACITY TO CONSENT

Capacity in the context of this Policy and Procedure is the right to express one's mind by determining what is the best or chosen course of action to be taken in a given situation. The Mental Capacity Act 2005 states that a person is unable to make a decision if he/she is unable:

(a) To understand the information relevant to the decision;
(b) To retain that information;
(c) To use or weigh that information as part of the process of making the decision; or
(d) To communicate his decision (whether by talking, using sign language or any other means.

It also states that:

- A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
- The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.
- The information relevant to a decision includes information about the reasonably foreseeable consequences of
  - Deciding one way or another; or
  - Failing to make the decision.

The level of capacity required depends on the seriousness or gravity of the decision needing to be taken and so capacity should be reviewed on an individual case-by-case basis.

This Policy/Procedure upholds the following principles from the Mental Capacity Act 2005:

- It should always be assumed that a person has capacity to make decisions unless there has been a formal assessment that shows that this is not the case
- People have the right to be supported to make their own decisions
- People should not be treated as lacking capacity merely because they have made an "unwise" decision
- Everything that is done for people without capacity should be done in their best interest.
- All decisions must be made in a way that is least restrictive of an individual's freedom.

Consent in relation to medical treatment is the voluntary and continuing permission of the person accessing the service to receive a particular treatment based on an adequate

knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it.

Consent should be sought and given by the person accessing the service before any restrictive physical intervention is employed and should be clearly noted in the person's individual care plan. A member of staff who employs such an intervention to a person who has not given consent or who has refused to give their consent could be liable under both civil and criminal law.

Where a person lacks capacity to consent, a 'best interest' procedure should be adopted whereby all those involved in the care of an individual agree that that person does not have capacity to consent and the most appropriate restrictive physical intervention to be deployed is agreed after weighing the potential benefit against the harm. The Mental Capacity Act 2005 establishes a checklist for establishing what is in the best interests of a person lacking capacity as criteria for taking actions or decision on that person's behalf.

An Independent Mental Capacity Act Advocate is entitled to be involved in discussions around planned restraint and best interest.

1.10 STAFF TRAINING

It is important for all staff who are expected to employ restrictive physical interventions to have effective training and support to enable them to do so. The nature and extent of the training will depend upon the characteristics of the people who may require a physical intervention, the behaviours they present and the responsibilities of individual members of staff. A training programme will be developed to support this.

Staff should only use methods of restrictive physical intervention for which they have received training. Specific techniques should be closely matched to the characteristics of individuals accessing the service and there should be a record of which staff are permitted to use different techniques. It is not appropriate for staff to modify the techniques they have been taught.

Individualised restrictive physical intervention is regarded as a structured intervention, akin to therapy, training or other treatment, and forms part of the overall care and support plan for the individual concerned. It will therefore be the responsibility of Managers and the Training Sections of both Halton Borough Council and Halton & St Helen's Primary Care Trust to ensure its availability and appropriateness via the Joint Training Partnership.

Training will be provided by trainers who are accredited under the BILD Code of Practice for Trainers in the Use of Physical Interventions to all relevant staff as part of the implementation of this Policy and Procedure. Staff should also be trained in relation to the Mental Capacity Act 2005.

Principles

- Where a potential need for physical intervention is identified, a referral will be made to the Specialist Community Team based at The Bridges who will arrange for an initial assessment that will identify whether or not physical intervention is actually required and what other interventions or approaches are, or should be, in place. Where physical intervention is required, appropriate training will be delivered within an agreed timescale. **A qualified professional with appropriate training and experience will be identified**

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to monitor the care and support plan.

- Training must encompass knowledge, skills and values. It must be documented, audited and regularly re-appraised for appropriateness and in accordance with up to date Government guidance.

- Arrangements will be agreed for staff to practice, review and update techniques learned.

- A record will be kept of all staff who have received training.

- Staff will receive attendance certificates as evidence of training.

- Procedures will be agreed for training staff who subsequently join a staff team that has received training.

- It is important that Managers encourage staff to feel confident about asking for support in situations where they feel vulnerable. Staff also need to feel supported when expressing their concerns about the practice of others.

- Staffed trained to carry out physical intervention need to receive regular refresher training, and the frequency of this will be identified by the trainer responsible in consultation with the manager of the staff.

- Newly appointed staff who indicate that they have received training will be required to provide evidence, in order assess it's suitability.

Independent Providers

Independent Sector service providers might arrange for their staff to be trained by other training providers. Those in roles that commission services (strategically or for individual people) and those whose roles have a professional advisory component have a responsibility to ensure that such training is appropriate. In seeking training, service providers are encouraged to consult the Training Sections of either Halton Borough Council or Halton & St Helen's Primary Care Trust and adhere to any training strategy/guidance issued to support this Policy and Procedure.

The list of accredited providers of Physical Intervention training, maintained by the British Institute for Learning Disability (BILD) allows confidence as to whether the training is likely to meet acceptable ethical and practice standards. However, a judgment would still need to be made as to whether the use of physical intervention was appropriate in any specific instance.

The BILD list of accredited training organisations is available at: www.bild.org.uk

PROCEDURE

2.1 DESIGNING INTERVENTIONS

Restrictive physical intervention should be sanctioned only when other less intrusive tactics have failed and there is a reasoned judgement from the direct carers that an assault or other behaviour likely to cause serious harm to the person accessing the service or others is likely to ensue.

Wherever possible, such interventions should be used in a way that are sensitive to and respect the cultural expectations of those accessing the service and their attitudes towards physical contact. Any restrictive physical intervention should avoid contact that might be misinterpreted as sexual.

In designing the intervention, the condition of the person accessing the service must be checked for the following, and medical advice sought before proceeding with restrictive physical intervention if any of the following contra-indications to the use of such an intervention are detected:

- A history of heart disease or other heart/circulatory problems, such as hemiplegia.
- A history of respiratory illness or other breathing difficulties.
- Recent fractures or surgery, a history of dislocated joints or osteoporosis.
- Spinal abnormalities
- Hypotonia (poor muscle tone)
- Implants, eg, spinal rods, gastrostomy tubes, hip replacements, pin and plates
- Down's syndrome (atlanto-axial joint instability)
- People taking anti-coagulant medicines

2.2 INCAPACITY TO CONSENT

Incapacity to consent to the use of a restrictive physical intervention applies to the greater proportion of clients this Policy is relevant to.

Consent should be sought and given by the person accessing the service before any restrictive physical intervention is employed and should be clearly noted in the person's individual care plan. A member of staff who employs such an intervention to a person who has not given consent or who has refused to give their consent could be liable under both civil and criminal law.

Where a person lacks capacity to consent, a 'best interest' procedure should be adopted whereby all those involved in the care of an individual agree that that person does not have capacity to consent and the most appropriate restrictive physical intervention to be deployed is agreed after weighing the potential benefit against the harm. This should be recorded using NHS Consent Form 4 (see Appendix 2) and retained as part of the individual's care plan and cross-referenced to the checklist established in the Mental Capacity Act 2005 (refer to Section 1.9).

An Independent Mental Capacity Act Advocate is entitled to be involved in discussions around planned restraint and best interest, therefore, consideration should be given as to whether an advocate would be beneficial for the service user and present.

The same process where consent is given should then be followed.

PROCEDURE

2.3 PLANNED USE OF RESTRICTIVE PHYSICAL INTERVENTIONS

In most circumstances, restrictive physical interventions will be planned and used in response to defined circumstance. Occasionally, it may be considered in the best interests of the person accessing the service to accept the possible use of a restrictive physical intervention as part of an activity that could not be introduced without accepting that reasonable force might be required, eg, taking bloods or other medical procedures. Similarly, staff might be sanctioned to use a restrictive physical intervention, if necessary, as part of an agreed strategy to help a person who is gradually learning to control their aggressive behaviour in public places.

Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of the restrictive physical intervention and to have this endorsed by a multi-disciplinary team which includes, where possible, the person's carer and/or advocate.

If it is foreseeable that a person accessing the service will require some form of restrictive physical intervention, for each individual there must be a written protocol which includes:

- A description of behaviour sequences and settings which may require a physical intervention response.
- The results of an assessment to determine any contra-indications for use of physical interventions.
- A risk assessment which balances the risk of using a restrictive physical intervention against the risk of not using a physical intervention.
- A record of the views of carers.
- A record of the views of the person accessing the service.
- A system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages.
- Previous methods which have been tried without success.
- A description of the specific physical intervention techniques which are sanctioned and the dates on which they will be reviewed.
- A list of staff who are judged competent to use these methods with this person, and their job titles.
- The ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

If there is a dispute regarding the appropriateness of the use of restrictive physical intervention for a particular individual between staff, carers, relatives, advocates or friends of the individual concerned, attempts should be made to resolve these. If agreement cannot be obtained then it may be necessary, and indeed obligatory, to obtain a ruling from the Court.

An up to date copy of the protocol containing the all of the above information must be included in the individual's care plan.

2.4 STAFF RESPONSIBILITIES

Physical restraint should not generally be attempted alone without support as most forms of restraint are designed for use by more than one person. Where non-physical methods have failed or the incident is of such significance to warrant immediate action and a decision is made to intervene physically staff should:

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- Make a visual check for items which could be used as weapons.
- Check for objects or furnishings on which people could injure themselves.
- The person responsible for co-ordinating intervention should nominate staff members to assist and allocate each a specific task.
- Any intervention should follow a gradient of control. Physical restraint should always be only the minimum necessary to contain the harm that needs to be prevented.
- Having a large number of staff grabbing at people can be counter-productive. Fewer but well briefed staff are likely to be more effective.
- If restraint is to be used, it will be employed swiftly and safely, and in the manner approved for that particular person.
- If limbs are to be held the joint should be avoided to reduce the chance of dislocations.
- If the person is being restrained on the floor and there are attempts at biting, the head may be held still.
- Where appropriate, continue to explain the reason for action and enlist support from the individual for voluntary control (eg, by calm encouragement to stay still) as soon as possible.
- Give control back to the individual as soon as possible.
- Any physical intervention means forcible control of one human being by another. Such action must be accounted for and as far as possible maintain the dignity of the individual.

Physical intervention will be terminated if the person shows signs of any of the following:

- Extreme distress
- Heart problems
- Breathing difficulties or very rapid breathing
- Seizures or convulsions
- Vomiting
- Choking
- Blue colouration of hands, feet, or other body parts (indicative of poor blood circulation)
- Mottling (paleness/yellowing of the skin), drowsiness or unconsciousness (indicative of restricted blood circulation)
- Painful swelling (could be indicative of bone fractures)

… and immediate medical attention will be sought.

Any restrictive physical intervention should be withdrawn slowly, in a measured way, eg, gradually lessening muscle tension, resting a hand instead of holding the individual, increasing the space between staff employing the intervention and the individual, reducing the number of staff involved, seeking verbal assurance that the person is alright and that they are calmer.

Prohibited Actions

- NEVER hold a person by the neck.
- Avoid excess weight being placed on any area.
- The stomach and neck should be avoided.
- Do not slap, kick or punch.
- There must be no application of pressure on airways.
- The genital area must be avoided.
- The deliberate use of pain to ensure compliance from the person being restrained, eg, by the use of wrist or arm locks, will not be sanctioned as acceptable practice.

PROCEDURE

- Other people who access learning disability services will not be asked to assist in any physical intervention. However, it may in some circumstances be appropriate to ask them to seek assistance, providing their physical safety is not put at risk by undertaking such an action. They may be prompted to leave the immediate area for their own physical and psychological protection.
- Deprivation of normal food or drink.

N.B. Employees breaching this Policy may be subject to disciplinary action, as would be the case for other breaches of Council and PCT policies.

Staff should be encouraged to report any incidents which give cause for concern to their line manager.

Where personal removal from a situation is not a viable option, staff have the right to take appropriate measures to defend themselves. The use of reasonable force sufficient to stop the assault and/or prevent injury to self or others continues to apply (see Section 1.5, Legal Considerations).

First Aid procedures should be employed as necessary by those responsible for implementation in the event of an injury or physical distress arising as a result of a physical intervention. Procedures following bites and other exposure to body fluids, as outlined in Appendix 1, should be adhered to.

Staff will always carry identity cards to show members of the public who may be concerned about practices.

Where there is an ongoing risk of behaviour that could damage the environment, making it unsafe, steps will be taken to make it safe, eg, repairs will be requested as a matter of urgency, polycarbonate glazing or protective film will be substituted for ordinary glass windows, etc.

2.5 EMERGENCY USE OF RESTRICTIVE PHYSICAL INTERVENTIONS

Emergency use of restrictive physical interventions may be required when people accessing the service behave in ways that have not been foreseen by a risk assessment. Injuries to staff and service users are more likely to occur when physical interventions are used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions might be needed.

An effective risk assessment procedure together with well-planned preventative strategies will help to keep emergency use of restrictive physical interventions to an absolute minimum. However, staff should be aware that in an emergency the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property.

Even in an emergency, the force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restrictive physical intervention in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (eg, injury or distress) will be less severe than the adverse consequences which might have occurred without the use of a physical intervention.

PROCEDURE

2.6 POST INCIDENT MANAGEMENT

Following an incident in which restrictive physical interventions are employed, both staff and those accessing services should be given separate opportunities to talk about what happened in a calm and safe environment. Interviews should only take place when those involved have recovered their composure. Post incident interviews should be designed to discover exactly what happened and the effects on the participants. They should not be used to apportion blame or to punish those involved. If there is any reason to suspect that a service user or a member of staff has experienced injury or severe distress following the use of a physical intervention they should receive prompt medical attention.

To help protect the interests of people accessing learning disability services who are exposed to restrictive physical interventions it is good practice to involve, wherever possible, carers and independent advocates in planning, monitoring and reviewing how and when they are used.

All service users and their carers should have access to complaints procedures within both Halton Borough Council and Halton & St Helen's Primary Care Trust. Information should therefore be given on complaints procedures by staff as required.

Following every incident of physical intervention, the following steps will be taken by the appropriate line manager.

1. Ensure immediate safety of all concerned, if this has not yet been done.

2. Review immediate options for staff and service user recovery. This includes those service users who might have been assaulted or threatened with assault by the person who received physical intervention and the service user who was the focus of the physical intervention.

3. In the case of injury determine what immediate action should be taken:
   - First Aid
   - Attendance at casualty or with GP or Occupational Health service.
   - Bites should be treated as potentially serious (see Appendix 1).

4. Debriefing, which involves going over the incident, avoiding any suggestion of blame, and acknowledging the feelings that the worker is experiencing.
   - Immediate care and concern shown by colleagues and managers is appreciated and can limit or even prevent longer term serious after effects.
   - Immediate actions may need to include looking after the person's belongings, contacting family or friends where necessary, or going off duty (within workplace, or home), and obtaining appropriate cover if required.
   - Any service users who have been involved (including having witnessed the incident) should also be debriefed.

5. Analysis of incident. Manager will need understanding of violence and aggression and their origin. Avoid the trap of individual blame (service user or staff).

6. Review options for prevention of further incidents and implement as appropriate.

7. Nominate staff for training if appropriate.

PROCEDURE

8. Ensure that:
   - Accident and incident report forms are completed.
   - An entry is made in the accident book.
   - Any obligations under Health and Safety legislation are met.

9. Review options for staff support and counselling.

2.7 RECORDING OF INCIDENTS

The use of a restrictive physical intervention, whether planned or unplanned (emergency) should always be recorded as quickly as practicable (within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. The written record should indicate:

- The names of staff and person accessing the service involved.
- The reason for using a physical intervention (rather than another strategy).
- The type of physical intervention employed.
- The date and duration of the physical intervention.
- Whether the service user or anyone else experienced injury or distress.
- If anyone did experience injury or distress, what action was taken?

The views of the service user(s) involved in the incident should also be recorded.

The contents of the incident book should be checked during each shift, by senior staff members on duty, checked regularly by the manager of the service and reviewed on a 3 monthly basis and appropriate action taken.

Recording will be used for a number of different purposes:

- Compliance with statutory requirements.
- Monitoring of service users' welfare.
- Informing risk assessment, management strategies and care plans.
- Monitoring the quality of the service.
- Monitoring staff performance and identifying supervision or training needs or outcomes.
- Contributing to service audit and evaluation.
- Updating medical records.

Records of incidents involving particular people with learning disabilities sometimes show that there are set patterns to their behaviour which, if unchecked, will lead to it becoming dangerous or exceptionally disruptive. In these circumstances, it might be necessary to use restrictive physical interventions at an early stage.

Other methods of recording behaviours may also be used to analyse setting and antecedents of behaviour as part of an ongoing assessment.

Where service users attempt to physically assault employees, then a violent incident report form should be completed – Halton's Violence at Work Policy and Accident/Incident Reporting procedures refer.

PROCEDURE

2.8 EMERGENCY REVIEW OF INTERVENTION

Restrictive physical interventions that have been designed and put in place will be reviewed as a matter of urgency in the following instances.

- When the intervention is being used more frequently than had been expected, or if the frequency of use is increasing over time.
- When staff report that agreed procedures do not enable them to effectively minimise harm.
- If injuries are sustained by the service user or staff in the course of employing the intervention.
- On any indication that interventions are not being carried out according to the agreed procedure.
- When new behavioural challenges develop (other than those that are the focus of the agreed intervention) which may also require the use of restrictive physical interventions.

2.9 AUDIT

Regular reports will be prepared by all agencies for care managers with copies to Service Managers. They will cover:

- Frequency of use of physical intervention.
- Number of staff trained, type of training received and details of upcoming training sessions.
- Injuries recorded (service user, staff, public).
- New cases where physical intervention is agreed.
- Cases where physical intervention is ongoing.
- Cases where physical intervention is requested but after assessment other strategies were used.

These reports are a basis for a review, not a review in themselves.

2.10 MANAGEMENT RESPONSIBILITIES

- Senior managers within the Borough Council, Primary Care Trust and provider agencies have the responsibility of developing, implementing and overseeing restrictive physical intervention policies and protocols.

- Senior managers will be responsible for ensuring that post-incident procedures and staff care and support procedures are adhered to.

- Employers and managers are responsible for the safety and well-being of staff and people accessing learning disability services.

- Employers and managers are responsible for ensuring that all appropriate staff are inducted in the policy and procedures contained within this document and receive training from accredited providers.

PROCEDURE

- Staff deployment, including agency and bank staff, should be organised to ensure that appropriately trained staff are available to respond to any incident that requires restrictive physical intervention.

- Senior managers have the responsibility of ensuring that all incidents arising out of the use of physical restraint are documented and acted upon accordingly.

- All people accessing learning disability services, their carers, families or friends must have recourse to a formal complaints procedure.

2.11 EXTERNAL ORGANISATIONS

External organisations serve residents of the Borough who are eligible for services provided by the Adults with Learning Disabilities Specialist Community Team. Work with individual people accessing learning disability services may indicate the need for restrictive physical interventions training. In these cases training can be negotiated with the Specialist Community Team, who will consult the Training Sections of either Halton Borough Council or Halton & St Helen's Primary Care Trust and adhere to any training strategy/guidance issued to support this Policy and Procedure.

Where restrictive physical intervention is agreed:

1. The trainers will satisfy themselves that the relevant pre-requisite assessment, interventions and staff training are in place.
2. An agreement will be written and signed by both parties identifying this as the way forward.
3. Monitoring arrangements will be identified as part of 2 above.

The same arrangement will extend to adult placement carers.

REFERENCES

- DoH Guidance for Restrictive Physical Interventions, How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder, July 2002.
- DoH Seeking Consent: Working With People With Learning Disabilities.
- Manchester Learning Disability Partnership, Policy on the Use of Physical Intervention, August 2003.
- British Institute for Learning Disability (BILD) Summary of Key Policy Principles on Physical Interventions.
- British Society for Disability and Oral Health, Principles on Intervention for People Unable to Comply with Routine Dental Care, April 2004.
- British Institute for Learning Disability (BILD) Carers' Guide to Physical Interventions and the Law.
- Surrey and Borders Partnership NHS Trust, Benchmark of Best Practice for Physical Interventions/Restraint, November 2005.
- Health & Safety Executive/Local Authorities Enforcement Liaison Committee, Circular 88/2, Violence at Work, October 2000
- Human Rights Act 1998
- Mental Capacity Act 2005
- Children's Residential Services Procedure for Safety Intervention
- Children's Residential Services Permitted Disciplinary Measures
- Halton PCT's Guidelines for the Covert Administration of Medicines (Disguising Medicines in Food and Drink), August 2006

APPENDIX 1

PROCEDURES FOLLOWING BITES AND OTHER EXPOSURE TO BODY FLUIDS.

These guidelines are in line with Halton & St Helen's Primary Care Trust's Infection Control policy on needle stick injury.

If you have any of the following injuries or exposure to body fluids:

1. Skin penetration injury (from bites that break the skin, bone fragments, needles, other medical instruments or unknown sharp objects).

2. Exposure of broken skin (abrasions, cuts, eczema, etc) to body fluids including blood, sputum, faeces, wound drainage and other moist body substances. (Note: skin that is not intact should be covered during personal care)

3. Exposure of mucous membranes including the eye to body fluids including blood, sputum, faeces, wound drainage and other moist body substances.

Then the following must be followed immediately:

- Wash the site with soap and water, without scrubbing.
- Irrigate mucous membranes (for example mouth, nose, ears, or eye) with large quantities of water as appropriate.
- Bleeding must be encouraged for puncture wounds (do not suck the wound).
- Report the incident to the person responsible for the work area (house, day centre, etc.). The responsible person should advise the Occupational Health Department at Hollins Park, Winwick, on 01925 664071.

For immediate advice contact Sue Wynne, Infection Control Nurse at Halton & St Helen's Primary Care Trust on 01928 593690, 9am-5pm.

Staff should attend Halton Hospital for minor injuries or the Accident and Emergency Department at Warrington Hospital if necessary.

Prevention

- Cover all cuts or breaks in your skin with waterproof dressings. Wear gloves if you are expecting to make contact with someone's body fluids.
- Wash hands carefully after every contact with body fluids.
- Seek advice from Occupational Health if you have eczema/dermatitis or other skin problems.
- Follow advice on positioning, stance, and prevention of violent incidents (where this has been given) to reduce likelihood of bites.

It is recommended that staff at risk of bites and other exposure to body fluids be immunised against Hepatitis B.

APPENDIX 2

ADDRESSES AND CONTACT NUMBERS

1. For more information on restrictive physical interventions contact:

The PCT's Adults with Learning Disabilities Specialist Community Team on 0151 4207619;
or
The Council's Social Work Team for Adults with Learning Disabilities on 0151 4955340
at
The Bridges Learning Centre
Crow Wood Health Park
Crow Wood Lane
Widnes
Cheshire
WA8 3LZ

Or visit Halton's adult protection website at www.halton.gov.uk/adultprotection

2. For more information on complaints procedures contact:

Customer Care Team
Health and Community Directorate
Halton Borough Council
Grosvenor House
Runcorn
Cheshire
WA7 2ED

Telephone number: 01928 704411
E-Mail: ssdcomplaints@halton.gov.uk
Or text 07775 765489

Or visit the Council's website at www.halton.gov.uk

Complaints and Claims Manager
Halton & St Helen's Primary Care Trust
Victoria House
The Holloway
Runcorn
Cheshire
WA7 4TH

Telephone number: 01928 593726
E-Mail: Debbie.fairclough@hsthpct.nhs.uk

3. For more information about the British Institute for Learning Disability visit their website at www.bild.org.uk

REPORT TO: Health Policy and Performance Board

DATE: 16 January 2007

REPORTING OFFICER: Strategic Director (Health and Community)

SUBJECT: Mental Capacity Act 2005

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 This report explains the provisions of the Mental Capacity Act 2005, and describes the regional and local processes to ensure effective implementation by April 2007.

2.0 RECOMMENDATION: that

1) **Members note the contents of this Report and the associated presentation**
2) **Members seek clarification on any issues**

3.0 SUPPORTING INFORMATION

3.1 **Context:**

3.1.1 The Mental Capacity Act received Royal Assent in April 2005, and is due to be fully implemented on 1st April 2007. It provides a statutory framework to empower and protect vulnerable people who cannot make their own decisions, and allows people to plan ahead to a time when they may lack capacity.

3.2 **National data**

3.2.1 Although there are no precise statistics about the number of people who may lack capacity in the country, the Mental Capacity Act Implementation Programme has estimated a range of 1 – 2 million, including some of the following:

- Over 700,000 people with dementia (rising to 840,000 by 2010)
- 145,000 people with severe learning disability and 1.2 million with mild to moderate learning disability
- 1% of the population with schizophrenia, 1% with bipolar disorder and 5% with serious or clinical depression at some stage in their lives
- 120,000 people living with the effects of a severe head injury

3.3 **Mental Capacity Act - provisions**

3.3.1 The Act makes clear:

- Who can take decisions
- In what circumstances the decisions can be made
- How people who take the decisions should go about it.

3.3.2 The Act is built on five key principles (Section 1):

- It should always be assumed that a person has capacity to make decisions unless there has been a formal assessment which shows that this is not the case
- People have the right to be supported to make their own decisions
- People should not be treated as lacking capacity merely because they have made an "unwise" decision
- Everything that is done for people without capacity should be done in their best interests
- All decisions must be made in a way that is least restrictive of an individual's freedom

3.3.3 Under the Act, it does not matter whether the impairment is temporary or permanent – the key principles still apply. Equally people cannot be deemed to lack capacity purely because of their age or appearance, or because they may act in a way which leads others to make unjustified assumptions about their capacity. A simple, clear test is provided by the Act for assessing capacity, based purely on a person's capacity to make decisions (Section 3). Crucially, any professional will now be able to make a decision about whether an individual has capacity to make a decision, although this will have to be based fully on the test contained within the Act, and any checklist in the Code of Practice. This is a radical change from current practice, where a medical practitioner – usually a psychiatrist – makes this judgement.

3.3.4 A checklist of factors within the Act is provided to ensure that each individual's best interests are promoted. Carers and families gain a right to be consulted and due consideration must be given to any wishes put in writing in advance by the person concerned.

3.3.5 Most importantly, the Act clarifies those circumstances where a person can provide care and treatment for someone who lacks capacity can do so without incurring legal liability (Section 5). This would include such things as giving medical treatment or using a person's money to buy something for them. In addition the Act considers issues of deprivation of liberty and restraint, to ensure that these are proportionate, considered and are the least restrictive option.

3.3.6 <u>Other provisions:</u>

- People will, under the Act, have the right to make advance decisions about whether to refuse treatment, should they lose capacity in the future
- There will be a new criminal offence of ill treatment and /or neglect of a person who lacks capacity

3.4 **Court of Protection and associated powers**

3.4.1 The Act replaces the existing Enduring Power of Attorney and Court of Protection receivers with two new provisions:

- Lasting Power of Attorney: where a person can be appointed to act if a person should lose capacity on the future. This role has been extended to include health and welfare functions
- Court-appointed deputies: who can take decisions on healthcare, welfare and financial matters, but will not be able to refuse consent to life-saving treatment

3.4.2 In addition, two new bodies are created or redefined:

- Court of Protection – will be the final arbiters on issues relating to capacity
- The Public Guardian, who will be the registering authority for Lasting Power of attorney and Court Appointed Deputies

3.4.3 It is expected that the Court of Protection will only deal with the most complex cases that cannot be otherwise resolved – all other cases should be dealt with at an early stage and as informally as possible. The MCA Implementation Programme has estimated that around 1500 cases annually will be referred to the Court of Protection, based on:

Local Authorities:	2 cases per annum	250
PCTs:	2 cases per Trust*	600
NHS Trusts:	2 cases per Trust	200
“Warring families”		450

3.5 **Independent Mental Capacity Advocates (IMCAs)**

3.5.1 The IMCA is a new position created by the Act, which includes a statutory right to advocacy for people who lack capacity and who have no families or friends to support them. The IMCA will make representations about the person’s wishes, feelings, beliefs and values, and bring to the attention of the decision-maker any other relevant information, and indeed will be able to challenge the decisions that are made. This is a very different and specialist model of advocacy, as the IMCA will have the right of access to case records and will be able to attend reviews and other meetings on behalf of the person without capacity. Any future IMCA service will need to deliver these enhanced and specialist functions.

3.5.2 In the North West region, Advocacy Matters – an advocacy service based in Warrington – are one of the nine national pilots for the new IMCA role, and cover the whole of Cheshire and Merseyside. These projects are running for twelve months from January 2006 and will be thoroughly evaluated.

3.6 **Funding:**

3.6.1 The funding allocation for all Local authorities has been clearly identified – using a complex formula - in LAC 2006 (15) for 2006/07, with provisional allocations for 2007/08, as follows:

2006/07

Training	Setting up IMCA	Total
£12,561	£6,273	£18,834

2007/08

Training	IMCA	General	Total
£12,561	£18,878	£11036	£42,475

3.7 Implementation Process

3.7.1 A national Programme Implementation Board has been set up, which includes representation from the ADSS, and oversees the national and regional implementation of the Act.

3.7.2 Regional leads to promote and support the implementation of the Act have been appointed by the Care Services Improvement Partnership (CSIP) – for the North West region the lead is Paul Greenwood. All Local Authorities were required to nominate a lead officer to deliver the Act – for Halton this is the Divisional Manager (Mental Health), and a Mental Capacity Act Implementation Network has been set up across the Region, involving all the lead officers.

3.7.3 It was strongly suggested by CSIP that a project team should be set up in each locality to deliver the Mental Capacity Act, and this has been the approach adopted in Halton. A project Steering Group has been established, and this is a formal subgroup of the Halton Adult Protection Committee. The Steering Group which consists of representation from:

- Halton Borough Council Health and Community Directorate
- Halton Borough Council Legal Services
- Halton and St Helens Primary Care Trust
- North Cheshire Hospitals

- Private sector domiciliary acre providers
- Private sector residential care providers

3.7.4 Engagement in the process is also being sought from representatives of the voluntary sector and the 5BoroughsPartnersship NHS Trust.

3.7.5 Four workstreams have been identified for the implementation project. These are in various stages of development, and are described more fully below.

3.7.6 Workstream 1: Training: clearly this is a complex piece of legislation and a substantial range of staff in all sectors will require training, although this will need to be at different levels according to their work roles. The prime responsibility for the delivery of training has been placed with the Local Authorities as leads – hence the allocations of training funds to the Local Authorities - although the expectation are that this training should be available to all sectors. To support local delivery, a range of training materials has been commissioned centrally by the Department of Health through the University of Central Lancashire, although this remains to be made fully available.

3.7.7 Five levels of staff – and their associated training needs – have been identified by the Department of Health:

Staff in acute hospitals:	Consent and advance decisions
Staff in mental health services:	Interface with Mental Health Act
Staff in care and nursing homes:	Best interests
Domiciliary care staff:	Best interests and consent
Research staff	

3.7.8 Each local area has been required to produce a local training plan, developed jointly with key partners – to identify the numbers of people requiring training in the area, the types of training they will require and the timescales in which it is to be delivered. This Plan has to be agreed by CSIP before the funds for 2007/08 will be released to the Local Authority.

3.7.9 A training subgroup has been established to deliver the training aspects of the project. The Training Plan has been developed with partners and has been submitted to CSIP – initial indications are that this has been favourably received. The subgroup will continue to meet to ensure effective delivery of the Plan.

3.7.10 Workstream 2: IMCA: as with training, the lead for this is with the Local Authorities, jointly with the Primary Care Trust, and the funding has been routed to the Local Authorities.

3.7.11 As indicated in paragraph 3.6.1 above, the financial allocations for the IMCA service for each area have been identified. However it is clear that this funding is relatively limited for what is intended to be a specialist service, and one which may require substantial input.

3.7.12 The advice from CSIP was that localities should consider economies arising from pooling the resource and this is the approach that has been taken locally. Following approval from the Executive Board in November 2006, Halton Borough Council has entered into an arrangement with St Helens, Warrington and Knowsley to develop this service jointly. This would give a pool of around £93,000. Warrington is leading the process on behalf of the other local authorities – a tender specification and service level agreement has been developed and the service is currently out for tender. A group consisting or representatives from each area – Halton's representative is the Joint Commissioning Manager for Mental Heath – is steering the process to ensure equitable use of the service by each area.

3.7.13 Workstream 3: Publicity and Information: this workstream will start in January 2007, and will consider the wider information needed by the general public about the Mental Capacity Act. It will ensure that material is made available in a variety of settings and in a range of formats, to make it accessible for all.

3.7.14 Workstream 4: Policies and Procedures: this will also start in January 2007. An overarching policy and procedure will need to be developed, but in addition each organisation will need to review its internal policies and procedures to ensure that they match with the requirements of the Act. This will be the responsibility of each organisation but a session will be held with them all to ensure both idea-sharing and a consistent approach. The overall progress will then be monitored through the Steering group.

3.7.15 Further issue: as with any Act of this nature, the key to effective delivery is the Code of Practice, which describes in detail all the processes that should take to support the Act. In this case Central Government has delayed in issuing the Code of Practice, and at the time of writing this Report it still is not available.

3.7.16 Despite this, Central Government still insists that the implementation date for the Act remains as 1st April 2007. This makes some of the key issues – training, for example, and the development of policies and procedures and publicity material – difficult to deliver within the timescales. This has been recognised by CSIP, which ahs made representations to Central Government about this issue.

4.0 POLICY IMPLICATIONS

4.1 In itself this process will deliver a key piece of national legislation and an overarching local policy will be developed to reflect this. However a substantial piece of work will also have to be done within the Borough Council to ensure that all internal policies and procedures are consistent with the Act.

5.0 OTHER IMPLICATIONS

5.1 **Financial Implications:** clearly there will be a financial implication to the delivery of the Act. Central Government has issued the funds identified in paragraph 3.6.1 and the implementation will have to be delivered within this financial framework. Assurances have been received that funding for the IMCA service will be carried through from year to year. The funding allocation includes an element for start-up costs and some ongoing expenses.

6.0 RISK ANALYSIS

6.1 There are two key risks to the successful delivery of this project:

- Engagement by key stakeholders
- Failure by Central Government to issue the Code of Practice in a timely way.

6.2 In terms of engagement, all key stakeholders have been contacted and have indicated their willingness to be involved. In some cases people will need to be drawn in for specific pieces of work only – such as training – and will not need to be part of the full Steering Group. The fact that the Steering Group is itself a subgroup of the Adult Protection Committee means that wider stakeholders are aware of the project and can engage as required.

6.3 The lack of a Code of Practice is a series problem for all areas. Locally we are able to continue with much of the initial preparatory work and general training, although more detailed training may need to be delivered in an intense burst nearer the implementation deadline.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The act applies equally to people who lack capacity from all groups, and the role of the IMCA is designed to support this. Local policies and procedures and publicity material will be written to ensure accessibility to all. An Equalities Impact Assessment will be completed.

REPORT: Healthy Halton Policy and Performance Board

DATE: 16 January 2007

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: Health Policy and Performance Board Work Programme 2007/8

WARDS: Boroughwide

1.0 PURPOSE AND CONTENT OF REPORT

1.1 This report is the first step in developing a work programme of Topics for the Board to examine in 2007/8. While the Board ultimately determines its own Topics, suggestions for Topics to be considered may also come from a variety of other sources in addition to Members of the Board themselves, including members of the Council's Executive, other non-Executive Members, officers, the public, partner and other organisations.

1.2 The key tasks for Board Members are:

- to suggest and gather Topic ideas on issues relevant to the Board's remit:
- to develop and prioritise a shortlist of possible Topics for examination in 2007/8, bearing in mind the Council's agreed selection criteria (copy attached):
- to decide on a work programme of 2 to 4 Topics to be undertaken in the next municipal year.

1.3 Members may also wish to monitor progress in delivering the 2006/7 work programme.

2.0 RECOMMENDED: that the Policy and Performance Board

(1) Consider and put forward its initial suggestions for Topics to be included in the Board's 2007/8 work programme

(2) Develop and informally consult on a shortlist of its own and others' 2007/8 Topic suggestions ahead of the Board's meeting on 13th March, bearing in mind the Council's Topic selection criteria

(3) Decide at its March 13th meeting on a work programme of 2 to 4 Topics to be examined in 2007/8.

3.0 SUPPORTING INFORMATION

(See Topic selection checklist attached)

OVERVIEW AND SCRUTINY WORK PROGRAMME

Topic Selection Checklist

This checklist leads the user through a reasoning process to identify a) why a topic should be explored and b) whether it makes sense to examine it through the overview and scrutiny process. More "yeses" indicate a stronger case for selecting the Topic.

#	CRITERION	Yes/No
Why? Evidence for why a topic should be explored and included in the work programme		
1	Is the Topic **directly aligned with and have significant implications for at least 1 of Halton's 5 strategic priorities & related objectives/PIs, and/or a key central government priority?**	
2	Does the Topic **address an identified need** or issue?	
3	Is there a **high level of public interest or concern about the Topic** e.g. apparent from consultation, complaints or the local press	
4	Has the Topic been **identified through performance monitoring** e.g. PIs indicating an area of poor performance with scope for improvement?	
5	Has the Topic been **raised as an issue requiring further examination through a review, inspection or assessment, or by the auditor?**	
6	Is the Topic area likely to have a **major impact on resources or be significantly affected by financial or other resource problems** e.g. a pattern of major overspending or persisting staffing difficulties that could undermine performance?	
7	Has some **recent development or change** created a need to look at the Topic e.g. new government guidance/legislation, or new research findings?	
8	Would there be **significant risks** to the organisation and the community **as a result of not examining this topic**?	

<u>Whether</u>? Reasons affecting whether it makes sense to examine an identified topic		
9	**Scope for impact** - Is the Topic something the Council can actually influence, directly or via its partners? Can we make a difference?	
10	**Outcomes –** Are there clear improvement outcomes (not specific answers) in mind from examining the Topic and are they likely to be achievable?	
11	**Cost: benefit** - are the benefits of working on the Topic likely to outweigh the costs, making investment of time & effort worthwhile?	
12	**Are PPBs the best way to add value** in this Topic area? Can they make a distinctive contribution?	
13	Does the organisation have the **capacity** to progress this Topic? (e.g. is it related to other review or work peaks that would place an unacceptable load on a particular officer or team?)	
14	Can PPBs contribute meaningfully given the **time** available?	

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 16 January 2007

REPORTING OFFICER: Strategic Director, Health and Community Directorate

SUBJECT: Health & Community Service Plans 2007-2010

WARD(s): Borough wide

1.0 PURPOSE OF REPORT

1.1 To provide Healthy Halton Policy and Performance Board with the Service Plans for the Health and Community Directorate 2007-2010.

2.0 RECOMMENDATION: That the Healthy Halton Policy and Performance Board comment on the reports.

3.0 SUPPORTING INFORMATION

3.1 As part of the business planning process each Directorate provides a plan for its services over a three-year period. Guidance on the format of the plans is provided for all of the Directorates to ensure consistency. The Service Plans are linked to the Council's Corporate Plan.

3.2 The primary purpose of Service Plans is to provide a clear statement on what individual services are planning to achieve and to show how this contributes towards achieving the corporate priorities of the Council. They are an essential tool for making key decisions about future service provision on a level of resources required. Additionally, the Service Plan is designed to enable the public, elective members and staff to monitor how well this part of the Council is performing to improving the quality of life for local people.

3.3 The service plans will be circulated in early January, as at the time of writing this report they are not yet completed in draft form. In addition the Plans will be tabled at the Healthy Halton Policy and Performance Board on 16th January, 2007.

4.0 FINANCIAL IMPLICATIONS

4.1 All Service Plans are expected to work within the budgetary framework.

5.0 POLICY IMPLICATIONS

5.1 Service Plans provide explanations of any policy implications to meet their objectives.

6.0 OTHER IMPLICATIONS

6.1 None.

7.0 RISK ANALYSIS

7.1 Risk analysis of meeting the objectives are contained with the Service Plans.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 It is expected that the Service Plans will ensure that services meets the needs of all members of the community.

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

9.1 There are no background documents under the meaning of this Act.