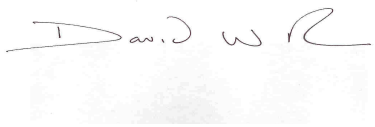
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 15 September 2009 6.30 p.m.
Civic Suite, Town Hall, Runcorn



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	**Labour**
Councillor Joan Lowe (Vice-Chairman)	**Labour**
Councillor Dave Austin	**Liberal Democrat**
Councillor Robert Gilligan	**Labour**
Councillor Trevor Higginson	**Liberal Democrat**
Councillor Margaret Horabin	**Labour**
Councillor Martha Lloyd Jones	**Labour**
Councillor Ged Philbin	**Labour**
Councillor Ernest Ratcliffe	**Liberal Democrat**
Councillor Geoffrey Swift	**Conservative**
Councillor Pamela Wallace	**Labour**
LINk Co-optee Vacancy	

Please contact Lynn Derbyshire on 0151 471 7389 or e-mail michelle.simpson@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 10 November 2009

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

Part I

(A) QUARTERLY MONITORING REPORTS | **211 - 268**

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 Services Policy & Performance Board

DATE: 15 September 2009

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 34(9).

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

- Requires the disclosure of confidential or exempt information.

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Healthy Halton Services Policy and Performance Board

DATE: 15 September 2009

REPORTING OFFICER: Chief Executive

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Executive Board and Executive Board Sub 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

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

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 16TH JULY 2009

EXB24 INTERMEDIATE CARE SERVICE WARRINGTON

The Board considered a report of the Strategic Director, Health and Community which provided details of the initial expression of interest submitted to Warrington Borough Council and Warrington PCT to deliver an integrated Intermediate Care Service and sought the Board's approval to progress the application and submit a formal tender.

The Board was advised that the Service would aim to:-

- Improve the ability of people to live independently through the provision of enabling and rehabilitation Intermediate Care services;

- Enable adults with physical and / or mental health impairment (but not adults with severe and enduring mental health), the Client Group, to participate fully in their local communities;

- Involve users of services, their significant others and the local community in the planning, development, monitoring and review of Intermediate Care services;

- Provide a robust performance management and clinical governance framework to ensure services meet the needs of the community, with regard to evidence based practice, best value and value for money; and

- Improve the range and mix of services for the Client Group and develop pathways that enable the appropriate and timely use of primary and secondary health care, social services, culture and leisure activities and voluntary sector services.

The Board was further advised that following the evaluation of the initial submission, the Authority in partnership with Health had been asked to take part in the next stage, the development of an outline solution which was appended to the report for information.

The outline solutions would be assessed and further dialogue would take place with organisations. A detailed solution would need to be

submitted in September 2009. The final submission of a formal tender would need to be made by 6th November 2009. If the Authority / Health Trust should be successful, notifications would be in December 2009 / January 2010 with a view to the service being delivered in April 2010.

Arising from the discussion the Board felt there was not sufficient financial information available with regard to long term funding and potential operational problems.

RESOLVED: That Halton Borough Council does not proceed with this application.

EXB25 NATIONAL SUPPORT TEAM FOR HEALTH INEQUALITIES

The Board considered a report of the Strategic Director, Health and Community which gave a progress update and action plan in response to the visit by the National Support Team (NST) for Health Inequalities in February 2009.

The Board was advised that in February 2009 the Health Inequalities National Support Team had assessed the position in St Helens and Halton and made a number of recommendations for improvement. The focus of the review was not on long term strategies but on immediate action which St Helens, Halton and the Primary Care Trust could take to dramatically reduce health inequalities within the next two years.

The Board was further advised that since the visit, a working group had been established and an action plan developed which was appended to the report for Members' consideration. Halton & St. Helens Council's had also agreed to lead on two of the main recommendations.

RESOLVED: That the Action Plan set out in Appendix 1 to the report be approved.

EXB26 WHISTON HOSPITAL – BURNS UNIT

The Board considered an urgent report of the Strategic Director, Health and Community which invited the Members to consider a proposal to establish a major burns unit in Manchester to the detriment of the existing unit at Whiston Hospital.

RESOLVED: That:

(1) This Council condemns the decision not to include Whiston Hospital on the short list for the major burns unit;

(2) This Council calls on the Secretary of State for Health to intervene and ensure that the provision of the Major Burns

Unit is maintained at Whiston Hospital without any of the facilities being downgraded;

(3) This Council is concerned that no proper business case has been developed or presented to the Council to support the recommendation to centralise a Burns Unit in Manchester;

(4) the Hospital will be left with significant financial problems as it now has a newly built Burns Unit with a PFI tariff to pay; and

If the Burns Unit is lost to Whiston, then other services will be lost including the services of leading burns specialists and facial reconstruction surgeons who are responsible for the reconstruction of facial features damaged by both cancer and burns.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 15 September 2009

REPORTING OFFICER: Chief Executive

SUBJECT: Specialist Strategic Partnership minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Health Specialist Strategic Partnership are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

Halton Strategic PARTNERSHIP

HALTON HEALTH PARTNERSHIP BOARD

MINUTES OF THE MEETING FROM

19 March 2009

Present : Fiona Johnstone (Chair)
Cllr Ellen Cargill
Glenda Cave
Melissa Critchley
Cllr Ann Gerrard
Dwayne Johnson
Diane Lloyd
Karen Tonge
Jane Trevor
Sue Wallace-Bonner
Jim Wilson

By invitation: Andrew Pannell

In Support: Elaine Skelland

		ACTION
1.	**Apologies** Lorraine Butcher, Chris Knights, Eugene Lavan, Tom McInerney	
2.	**Minutes of the previous meeting** These were agreed as a correct record.	
3.	**Matters Arising** **Child Poverty:** Information circulated by Glenda Cave. **Teenage Pregnancy**: Information circulated by Jane Trevor.	
4.	**Community Feedback** given by Karen Tonge: ▪ LINks launch on Friday 20 March at the Foundry. Current membership of 60 and decisions on structure and elections to take place. ▪ HVA have advertised for the new of post of Third Sector Lead Engagement Officer and it is hoped to have someone in place in early April. This role will encompass building on previous Health and Community Care Forum work, particularly in relation to developing sector networks and to improve communication, participation, consultation and engagement with voluntary sector groups. Also to provide baseline workforce information whilst continuing to initiate and capacity build groups. ▪ 20 Halton groups will appear in the commissioners catalogue being compiled by Debbie Dalby for PCT commissioners. ▪ HVA are taking a strong role in the NI 7 indicator in the LAA - an environment for a thriving third sector. Sessions to be held in the near future to discuss this and engagement with LSP partners to help achieve the targets. ▪ Halton Voluntary sector awards night proposed for June to celebrate	

	the work and achievements of volunteers and dedicated staff. Sponsors are being sought.	
5,	**Core Strategy - Spatial Planning** (To provide the partnership with details of the Core Strategy and how it can help us to deliver health outcomes) Andrew Pannell advised the group of the series of questions and appendices at the back of the report which highlight the amount of work already undertaken. He asked the group to look at Appendix 2 and to pass on any recommendations. It is hoped that the document will go to public consultation in October 2009 and any objections based on sound evidence. Liaison between Diane Lloyd and Andrew Pannell re involvement of the partnership. In response to Jim Wilson, Andrew Pannell confirmed that, as this document is a core strategy, it will be very detailed. Jim Wilson felt unsure how the partnership could feed into this document but felt it important to link with the PCT. Reference was made to the number of fast food outlets, alcohol and older council estates. Dwayne Johnson referred to Appendix 2 and the poor health of the disadvantaged. He referred to the improvements that have been made but highlighted the lack of change in aspirations which was leading to many young people leaving the area. In terms of response, Fiona Johnstone asked the group to: (a) discuss further with own organisations and (b) accept the opportunity as a health partnership to influence policy which will impact on health outcomes. Andrew Parnell confirmed that comments would be required before the end of June as a draft document will be taken to LSP Board in May. Fiona Johnstone asked the group to have discussions with own organisations and to email any policy points to Diane Lloyd. Fiona Johnstone thanked Andrew Pannell for his presentation.	
6.	**Performance Monitoring:** **Performance Management Report:** - Fiona Johnstone advised the group that performance management had been a significant issue raised during the workshops. The partnership agreed the actions contained within the Performance Management Report: ▪ all leads to complete the Quarter 3 return: ▪ proxy indicators to be identified by each programme lead: ▪ Quarter 4 return to be produced in a new format. **Quarter 3 Report:** Fiona Johnstone advised the group that a number of areas within the report were red and felt that some time should be spent on the report as it is the key focus for the group. It was agreed to discuss the report item by item. NI 18 (Adult participation in sport) - It was agreed that there is a need to develop proxy indicator reporting. Dwayne Johnson felt that the data appeared to be lower than anticipated. It was agreed to build proxy indicator and set up some aspirations for the Q4 report.	

	NI 39 (Alcohol-harm related hospital admissions) - Fiona Johnstone advised the group of the great deal of discussion held to ascertain how to monitor this indicator as there are significant levels of hospital admissions due to alcohol. She further added that the partnership needs to be aware of what is being commissioned to deliver on this indicator and if the interventions put in place are having an impact. NI 40 (Drug users in effective treatment) - Dwayne Johnson reported upon the unfairness of this target but also felt the need to be more effective in targeting this area. He referred to the hard core group and culture of drug taking in certain parts of Halton where a lot of work is being undertaken in prevention: huge campaigns, working with PCT and council, work in schools and high profile events with the police. Jane Trevor reported the new initiative for a group to undergo training to target 30/35 age group. Cllr Gerrard proposed targeting those areas where people are gathering to inject. Dwayne Johnson agreed to email figures to the partnership but felt there could be a move to amber next month. NI 53 (Prevalence of breastfeeding at 6-8 weeks from birth): Fiona Johnstone confirmed that this indicator is now amber with improvement and a possibility of this going to green. NI 56 (Obesity among primary school age children in Yr 6): Glenda Cave to check the data on this indicator. NI 112 (Under 18 conception rate): Fiona Johnstone reported that this situation is likely to worsen and actions have been identified following the recent NST visit. She added that this is an area which needs to be closely performance managed and is probably also being picked up in Children's and Young People's Partnership and that this must be recognised as a significant risk NI 115 (Substance misuse by young people): Data to be checked with Lorraine Crane as evidence required. NI 120 (All-age all cause mortality): Fiona Johnstone reported that there are some significant risks around this area and action plan s will be produced following the recent NST visit. NI 123 (16+ current smoking rate prevalence): Significant improvement expected in this area. NI 124 (People with long term condition….): Glenda Cave reported that this could possibly be removed from the LAA. NI 139 (People over 65……..): Awaiting outcome of discussions as to whether this will continue. NI 142 (No of vulnerable people….): Item green. NI 150 (Adults in contact with secondary mental health…….): Dwayne Johnson reported that this target had been renegotiated and can be set for 18 months to 2 years. He further added that this target will be extremely challenging in the current economic climate. Jane Trevor reported a 73% rise in job seekers with 248 redundancies recorded. Fiona Johnstone felt there had been a step forward in terms of quality of reporting. Finance Update: Glenda Cave had prepared a summary in terms of new commissioning proposals and had sought clarification on what the spend will be at the end of the year. Approval required to carry for to Q1/2 next year. Cllr Gerrard requested use of under spend on sporting projects and asked if the partnership could be informed sooner regarding any under spends. Fiona Johnstone felt that this highlighted the need to have a commissioning sub-group and also referred to the need to become more exacting regarding financial decisions.	**DJ** **GC**

Halton Strategic PARTNERSHIP

	Dignity funding now no longer required, therefore Glenda Cave to check on how this can be spent and also to check on SLA. Performance Monitoring Sub Group: Diane Lloyd felt that discussion was required regarding the appointment of a Chair for this group and the Commissioning Sub Group. Dwayne Johnson felt that someone from the Commissioning Team as Chair would be beneficial. Fiona Johnstone agreed to discuss this with Eugene Lavan. It was agreed that Fiona Johnstone would propose the membership for the groups and email this to partnership members who were asked to email Fiona Johnstone with any proposals for the Chairs of these groups. The Terms of Reference were agreed.	**FJ**
7.	**Community Strategy Refresh - Update** Diane Lloyd informed the group that there had been very little change to the strategy but that LAA indicators and local targets had been included and updated. This will be reviewed again next year with a new strategy by 2011. Melissa Critchley asked that dementia and old people's mental health be included. Fiona Johnstone felt that there is a need to look at the whole strategy as community engagement may come into this. Reference was made to the lack of communication to Ambition for Health Commissioning Plan. Fiona Johnstone agreed to check this with Diane Lloyd. Dwayne Johnson proposed the use of bullet points from Andrew Pannell's objectives.	**FJ/DL**
8.	**Ambition for Health Event (26 January 2009)** Fiona Johnstone advised the group that this item had been included for information and that the event reflected the results from the engagement process. Jim Wilson had been impressed with the attendees at the event.	
9.	**Away Day Feedback/Next Steps** Fiona Johnstone felt this session had been very useful. Cllr Gerrard asked if the group had the necessary expertise for alignment with LAAs. Dwayne Johnson felt that this could be resolved with correct membership for the Commissioning Group.	
10.	**AOB** Items for the agenda for the meeting on 21 May: ▪ Transport Study - consultant to be invited (Glenda Cave) ▪ NST Visit to be the main item (Dwayne Johnson) ▪ Proposals for WNF funding/ feedback from commissioning group (Diane Lloyd) ▪ CSP Update (Jim Wilson) Dwayne Johnson brought to the attention of the partnership the summit on Change4Life which focuses on changing lifestyles of younger people.	

Halton Strategic PARTNERSHIP

Action Summary – previous meetings

Reference	On Whom	Action	Status / Update

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 15th September 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Draft Joint Carers Commissioning Strategy 2009/12

WARDS: Boroughwide

1.0 PURPOSE OF REPORT

1.1 To present the Board with the draft Joint Carers Commissioning Strategy 2009/12 attached at Appendix 1

2.0 RECOMMENDATION: That the Healthy Halton Policy and Performance Board: -

1) Note contents of the Report
2) Comment on the draft Strategy and associated action plan

3.0 SUPPORTING INFORMATION

3.1 The Strategy builds upon the aims, objectives and activities outlined in the 2008/9 Carers Strategy, but has been written as a practical document, including an action plan, to support services in Halton move toward a more focused way of commissioning services for Carers over the next 3 years.

3.2 It has been developed as a result of research carried out in terms of other Local Authority plans and ongoing consultations and contributions from all stakeholders, including: -

- Local Implementation Team (LIT) Carer Sub Groups
- Carers (via a consultation event held on 12.2.09)
- Halton & St Helens NHS Trust
- Halton Carers Centre
- Voluntary Sector organisations
- Staff and managers from the Health & Community and Children & Young People's Directorate

3.3 The format of the commissioning strategy follows a similar one adopted with other Joint Commissioning Strategies within the Directorate and also takes account of the contents of the National Carers Strategy published in June 2008, by focusing commissioning intentions on: -

- Integrated and Personalised Services
- A Life of Their Own
- Income & Employment
- Health & Wellbeing
- Young Carers

3.4 The main objectives of this Commissioning Strategy is not only to move towards a process for the commissioning of services but it will continue to assist in the identification of hidden carers and improve information and access to support services. It should be noted that a balance will need to be achieved between commissioning and the work that continues to take place in supporting voluntary sector organisations e.g. Parkinson's Society, Connect etc to develop their services.

3.5 The LIT Carer Sub Groups and the multi agency Carers Strategy Group will undertake monitoring of the implementation of the Commissioning Strategy and associated action plan.

4.0 POLICY IMPLICATIONS

4.1 None specifically identified.

5.0 FINANCIAL IMPLICATIONS

6.5 Carers Services in the main are funded via the Carers Grant (details outlined in Commissioning Strategy) and the introduction of a Joint Commissioning Strategy is critical in ensuring that the Carers Grant continues to be ring fenced for use with carers as the Grant now forms part of the Area Based Grant. It should be noted that the Carers Grant funding is only available until the end March 2011 and consideration of funding arrangements past this date will need to be considered. Work will need to commence during 2009/10 on the development of a funding exit strategy outlining how the Commissioning Strategy could potentially be funded from April 2011; this could potentially look at alternative sources of funding from partner organisations or the redistribution of other funding available to the Local Authority.

5.2 **Carers Grant Allocation 2009/2010**

Halton Borough Council	£647,000
NHS Halton and St Helens PCT	£134,000

Carers Grant Allocation 2010/2011

Halton Borough Council	£687,000
NHS Halton and St Helens PCT	£268,000

5.3 As part of the National Carers Strategy the Department of Health (DoH) have allocated £150m to PCTs to support carers breaks in 2009/10 and 2010/11. Halton and St Helens PCT have ensured that these funds will be utlilised to support Carers and have ring fenced funds during 2009/10 and 20010/11 (details outlined in Commissioning Strategy). Discussions are currently taking place with the PCT as to how the funds would best be utilised.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

The strategy in relation to the future provision of Carers Services would benefit children and young people under 18 who have caring responsibilities, whose lives are often restricted in some way because they are supporting or taking responsibility for the care of a person who is ill or who has a disability etc.

6.2 **Employment, Learning and Skills in Halton**
The strategy would ensure opportunities for work, education and learning for Carers are maximised to their full potential.

6.3 **A Healthy Halton**
The strategy clearly demonstrates the Council's commitment, as a major stakeholder, in recognising the needs of Carers and in promoting their health and wellbeing within the Community.

6.4 **A Safer Halton**
None

6.6 **Halton's Urban Renewal**
None

7.0 RISK ANALYSIS

7.1 There continues to be an increase in the national and local agenda around carers particularly in light of the publication of the National Carers Strategy. The draft Strategy and associated action plan aims to address issues for carers in Halton in a structured way thus ensuring that, through working in partnership with Health, Voluntary Agencies and Carers that carer's needs can continue to be met.

7.2 The Directorate and it's partners recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community. We believe that in adopting this Strategy it will demonstrate our commitment to recognising, valuing and working with local carers in delivering effective services.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment (EIA) on the Strategy is currently being developed using the new corporate procedure, which is in the process of being drafted. Once the EIA is finalised it will be reviewed by the Health and Community Directorate Equalities Group.

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.

HALTON BOROUGH COUNCIL

NHS Halton and St Helens

JOINT COMMISSIONING STRATEGY FOR CARERS

2009 - 2012

Draft 13.08.09

CONTENTS

PREFACE

It is important that Carers have access to services based on recognition of their rights as individuals, choice in their daily lives and real opportunities to have a life of their own outside of the caring role.

The Joint Commissioning Strategy has been developed via ongoing consultations and contributions from stakeholders who provide services to carers as well as carers themselves. We have listened to what carers have told us about the help and support that they need and have responded by addressing the issues throughout the Strategy.

This Strategy is written as a practical document, including an action plan, to support services in Halton move towards a more focussed way of commissioning services over the next three years

We are committed to working jointly and in partnership with the voluntary sector within Halton, providing where possible an integrated response based on services which meet assessed needs and which are designed to improve lives and give new opportunities.

We are proud of what we have achieved for Carers within Halton since the production of the last Carers Strategy, but we also recognise the need for continual improvement and Halton Borough Council and NHS (National Health Service) Halton and St Helens, together with their partners have made a pledge to continually improve services and the quality of life for carers

We recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community and we believe that this Strategy demonstrates our commitment to recognising, valuing and working with local carers.

SECTION ONE: COMMISSIONING IN CONTEXT

INTRODUCTION

This document sets out the overarching strategy for the commissioning, design and delivery of services to people who are carers in Halton. The document stands alongside and complements the Corporate Plan for the Council, the Health and Community Directorate's Business Plan 2009-2012 and the NHS Halton and St Helens Primary Care Trust Plan. Halton Borough Council and NHS (National Health Service) Halton, jointly commissions services for Carers.

The Strategy outlines the vision, aims and fundamental values and principles underpinning the design and delivery of services to Carers and identifies the local and national drivers and influences that impact on its delivery. It aims to begin a process that outlines the commissioning intentions about the type, volume, quality and price of services that will be purchased and the activity needed to deliver those services. It also initiates exploration of how current supply can be changed, innovation encouraged and redundant or inefficient services decommissioned.

The Strategy attempts to help better business planning for current and prospective provider organisations. It aims to enhance and assure quality with regard to the provision of services to Carers and to demonstrate value for money.

WHAT IS COMMISSIONING?

Commissioning is about enhancing the quality of life of service users and their carers by:

- Having the vision and commitment to improve services.
- Connecting with the needs and aspirations of users and carers.
- Understanding demand and supply.
- Linking financial planning and service planning.
- Making relationships and working in partnership.

Commissioning should be based on:

- A common set of values that respect and encompass the full diversity of individual differences.
- An understanding of the needs and preferences of present and potential future service users and their carers.
- A comprehensive mapping of existing services.
- A vision of how local needs may be better met.
- A strategic framework for procuring all services within politically determined guidelines.
- A bringing together of all relevant data on finance, activity and outcomes.
- A continuous cycle of planning services, commissioning services, contracting services and revising or reviewing those services.

Definitions

Commissioning, procurement (or purchasing) and contracting are not the same activity despite the terms being used interchangeably.

Commissioning

The Audit commission describes commissioning, as **"the process of specifying, securing and monitoring services to meet individual needs both in the short and long term"**. Commissioning adopts a strategic approach to shaping the market for care to meet future needs.

Integrated Commissioning

Integrated commissioning is the ultimate aim of this Strategy and works at both a strategic and individual level.

Integrated strategic **(macro)** commissioning integrates the components of the commissioning process within 4 main functions:

- Information gathering (needs analysis and mapping of resources).
- Establishing policy and strategy for the investment and dis-investment of services.
- Developing good practice in service delivery.
- Research and evaluation

Care management **(micro)** commissioning involves:

- Identifying needs and priorities for the individual.
- Design of care package.
- Developing support arrangements.
- Monitoring and reviewing.

THE COUNCIL'S VISION

Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and a safer, stronger and more attractive neighbourhood.'

The Council has five strategic priorities for the Borough, which will help to build a better future for Halton:

- **A Healthy Halton**
- **Halton Urban Renewal**
- **Employment learning and skills in Halton**
- **Children & Young people in Halton**
- **A Safer Halton**

NHS HALTON AND ST HELENS

The NHS (National Health Service) established itself as a learning organisation which continuously strives to be Best in Class; and by working closely with patients and the public, local clinicians and our partners in our local economy, we aim to deliver an effective, proactive health service as well as providing leadership and support to enable improved health for local people.

NHS Halton and St Helens mission statement encapsulates this approach:

> *Our contribution to the wellbeing of the people we serve in Halton and St Helens is to enable them to have the best possible health and health care.*

NHS (National Health Service) Halton and St Helens currently spend approximately £520m on the commissioning and provision of services for local people. It is important that we make our investments wisely in line with local health needs, and that we target our resources to those whose needs are greatest, and design our services to reflect the different needs of our diverse population.

We have developed a strategic framework for action (our health strategy) – 'Ambition for Health', which outlines our comprehensive approach to improving health over the next five years. The ambitions are:

- **Improving health and wellbeing, and tackling inequalities in health**
- **Delivering effective and efficient health & related services that place the needs of patient at their core**

The strategy describes how we will make a difference by:

- **Supporting a healthy start in life**
- **Tackling the major killers through prevention**
- **Modernising services for specific disease groups**
- **Modernising services for vulnerable groups**
- **Improving access to services and facilities**
- **Strengthening disadvantaged communities**

HALTON'S VISION AND VALUES FOR CARERS
(This was developed as a part of the 2006 – 2008 Carers Strategy)

Vision

- Carers will be recognised and valued
- Carers will be supported and enabled to care as long as they wish to do so

- Carers will be enabled to have some regular time for themselves, free of their caring duties

- All agencies will work in partnership with carers to provide the help and services carers need

- All agencies will work together to plan and develop services for, and with, carers

- Information on issues of relevance to carers will be made available to carers, Statutory and voluntary agencies, and the wider community.

Values

The Local Authority, the Primary Care Trust, local health trusts, voluntary and independent sector agencies will continue to develop working in partnership to improve support for carers as part of mainstream community care and children's services. A pro-active approach will be taken to identify, accommodate and support diverse needs of the carer

- The major role played by carers in supporting people in the community who are frail, ill or disabled is recognised and valued

- Carers will be encouraged to identify themselves at the earliest possible stage, and will be empowered to ask for the service they require

- Carers will be involved in decision making about their needs and consulted about their preferences for services

- No carer will be compelled to care or to continue caring if they no longer feel able to do so * (*Please refer to paragraph below*)

- Former carers will be helped to access support to enable them to adjust to their new circumstances

- Service providers will ensure equity in the provision of support to carers, whatever the illness or disability of the person they are caring for

- Carers will continue to be involved in planning and determining the types of services available

- Carers will be invited to take part in the evaluation of services.

** In respect of children's services the values and visions may differ slightly as parents have a legal responsibility to their children, which adult carers do not have for the people that they care for. The role of the Children's Team within the Local Authority is to provide support to enable parents to continue to care for their children. The needs of the child are paramount and it is not usually in the child's best interests to live away from their family.*

WHO IS A CARER? / WHAT DO CARERS DO?

Who is a Carer?

A carer is someone who cares, unpaid, for a relative or friend who is unable to manage on his or her own because of illness, disability or frailty. The majority are unpaid **family carers**. Carers can be any age and come from all walks of life and backgrounds. More women are carers than men and they are more likely than male carers to care for someone with very demanding care needs and to care for a wider range of relatives.

A parent carer is a parent or guardian who is likely to provide more support than other parents because their child is ill or disabled. Parent carers will probably support their child for many months or years and this is likely to have a significant affect on the other children in the family. (*For more information please see Halton's Parenting Support Strategy 2007-2010, which addresses some of the more complex issues facing parents with disabled children*)

A young carer is someone under the age of 18 years who looks after another member of the family or close friend who is ill or disabled. They may be taking on the kind of responsibility that an adult would usually have. This may affect their education or social opportunities.

Caring relationships can be complex and family members may provide different types of care for each other in order to live independently in the community.

Within Halton, the following 'Definition of a Carer' is used:

Someone who provides regular and substantive care which goes over and above his or her usual role as a spouse / parent / family member. This may include people that do not necessarily live with the 'Cared For' person, but without the care that they provide it would be difficult for the 'Cared For' person to maintain a sense of independence.

What do carers do?

- Carers give practical, physical and emotional support to vulnerable people. They help the person they care for to deal with problems caused by short term or long-term illness or disability, mental distress or problems resulting from alcohol or substance misuse.
- Where the person being cared for no longer has the mental capacity to make a decision, the carer may be required to make decisions on their behalf.
- Carers may supervise someone to keep him or her safe.
- Caring responsibilities may vary over time and may be difficult to predict from day to day.

Anybody can become a carer, as a result of a sudden event such as an accident or this may be a gradual process when someone's physical or mental health slowly deteriorates.

THE NATIONAL CONTEXT

Many national Government policies and legislation influence local policy and the development, improvement and commissioning of services for carers. Some of these are outlined below:

- **The Carers (Recognition and Services) Act 1995**

- **The Carers and Disabled Children's Act 2000**
- **The Children's Act (1980)**
- **The Carers Equal Opportunities Act 2004**
- **Living Well with Dementia: A National Dementia Strategy (Feb 2009)**
- **The Mental Health Capacity Act (2005)**
- **The NHS and Community Care Act (1990)**
- **Quality Standards**
- **White Paper: Our Health, Our Care, Our Say**

(Further details of these policies and the legislation, can be found in Appendix 1.)

National Carers Strategy

The Government's new national strategy for Cares published on 10 June 2008 sets out their vision for supporting Carers over the next decade. it includes short-term commitments and identifies longer-term priorities. There is additional investment, primarily for extending planned breaks for carers and to help carers into work.

There is also an increased emphasis on joint agency working, and on the need for the National Health Service to more effectively engage with carers. The national strategy stresses the essential contribution of General Practitioner's in supporting carers and how this needs to be developed.

A survey of carers' health, released for the launch of this year's Carers Week, revealed that more than two-thirds of carers had been unable to find an opportunity to visit a GP about their own health due to time constraints and a general lack of flexibility to leave the house to attend appointments. Over two thirds said they felt that their health is worse because of their caring role, with 95 per cent of the 2,000 carers questioned saying that they regularly disguise the fact that their health is suffering in order to continue their caring responsibilities.

All carers need more support to be able to continue caring and to lead active lives as well. The new strategy is encouraging – there is additional investment; and a clear vision set out, which if delivered, would mean carers are treated with respect, have a degree of financial security, and receive quality advice and support from health, social care and other agencies. Carers would be treated as expert partners and there would be more choice and control over how they receive support.

The following diagram (on page 8) describes the ways in which the needs of the Carers can be effectively assessed

A WHOLE AREA APPROACH TO ASSESSING NEED

- The wheel shows the range of interventions needed to be sure of achieving the five Carers Strategy outcomes in an area.
- Which services deliver which interventions will vary greatly from area to area.
- The middle band shows that all interventions are built on three core approaches.
- It was felt that there should be one wheel for all groups of carers, but many ways of reaching and supporting excluded groups.

Challenges for excluded groups must be a key theme in developing this model.

Personalisation

On 17th January 2008, the Department of Health issued a Local Authority Circular entitled "Transforming Social Care". The Circular sets out information to support the transformation of social care signalled in … *Independence, Well-being and Choice* and re-enforced in … *Our Health, our care, our say: a new direction for community services.*

The Government approach to personalisation can be summarised as **"the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive".** This approach is one element of a wider cross-government strategy on independent living, due for publication in 2009.

The Government is clear that everyone who receives social care support in any setting, regardless of their level of need, will have **choice and control** over how this support is delivered. The intention is that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity.

Halton is in the process of developing the Personalisation agenda; through Self Directed Support and Personal Budgets

THE LOCAL CONTEXT

The challenges and opportunities facing Halton has led to the identification of a number of priorities for the Borough (outlined in the Community Strategy 2006-2011) and NHS Halton &St Helens Commissioning Strategic Plan (CSP) over the medium term with the overall aim of making it a better place to live and work. These include:-

- Improving health
- Improving the skills base in the borough
- Improving educational attainment across the borough
- Creating employment opportunities for all
- Tackling worklessness
- Tackling the low wage economy
- Improving environmental assets and how the borough looks
- Creating prosperity and equality of opportunity
- Reducing crime and anti-social behaviour
- Improving amenities for all age groups
- Furthering economic and urban regeneration
- Tackling contaminated land
- Creating opportunities/facilities/amenities for children and young people
- Supporting an ageing population
- Minimising waste/increasing recycling/bringing efficiencies in waste disposal
- Increasing focus on community engagement
- Running services efficiently

The Community Strategy provides an overarching framework through which the corporate, strategic and operational plans of all the partners can contribute. Halton's Local Area Agreement (LAA) 2008-11 builds on this overarching framework and provides a mechanism by which key elements of the strategy can be delivered over the next three years. It is an agreement between Central Government and the local authority and its partners about the priorities for the local area, expressed in a set of targets taken from an over National

Indicator set of 198 targets. The purpose of the LAA (Local Area Agreement) is to take the joint thinking of the Partnership enshrined in the Community Strategy, and make it happen through joint planning and delivery. Hence the five strategic themes detailed in the Community Strategy are mirrored in the LAA (Local Area Agreement).

The LAA (Local Area Agreement) will also seek to address the following issues:

- The physical, environmental and social problems resulting from Halton's industrial legacy, particularly from the chemical industries.

- Halton shares many of the social and economic problems more associated with its urban neighbours on Merseyside. The latest Index of Multiple of Deprivation (IMD) for 2006 shows that whilst the level of deprivation is improving Halton is still ranked 30th nationally.

- Health problems through a more discriminating approach is how services are delivered. We need to better concentrate on the wider determinants of health. We also need to target specific initiatives both geographically and demographically, especially recognising the needs of an increasingly ageing population.

- Social exclusion through a focus on responding to their full range of needs.

- The level of human capital and trends in economic growth may present problems for the future. This is particularly so given the district's poor performance in terms of social and environmental indicators, which may create difficulties attracting the best qualified people to the borough. Halton's performance on education and skills, and low levels of home ownership point to problems of inclusiveness, with groups of residents not sharing in the current levels of economic prosperity.

Given the above priorities, a key measure of whether service delivery has been transformed will be how far and how fast we can narrow the gap in outcomes for the most disadvantaged in Halton, as measured by comparison with both Halton and national averages.

SECTION TWO : NEEDS ANALYSIS

INTRODUCTION

The Health of Carers is a major influencing factor upon the health and welfare of the people receiving care, upon the carers themselves, and on the cost and shape of public services provided.

The changes in demography indicates that the "cared for" are living longer and that carers within Halton will have to care for much longer periods than in previous years often experiencing health problems as they get older themselves. To alleviate these pressures, the level of support commissioned/provided to carers needs to be enhanced and improved, as well as greater recognition being given to the pressures they face.

Halton has not been good in collecting demographic data around Carers and there are plans to address some of these gaps over the next 3 years, by targeting groups including Black and Minority, Ethnic Communities (BME), Lesbian, Gay, Bi-sexual and Transgender (LGBT) Mental Health and Gender of Carers.

POPULATION AND SOCIO ECONOMIC DATA

Halton is a largely urban area of 119,500 people. Its two biggest settlements are Widnes and Runcorn that face each other across the River Mersey, 10 miles upstream from Liverpool. The population of Halton was in decline for over a decade, but has recently started to increase. Between 1991 and 2002 the estimated Borough population decreased by 6,500 people from 124,800 to 118,300.

At present, Halton has a younger population than the national and regional averages. However, Halton mirrors the national picture of an ageing population, with projections indicating that the population of the Borough will age at a faster rate than the national average. In 1996 12.9% of the total population were aged 65 and over, by 2006 this had increased to nearly 14% and by 2015 this is projected to have increased to 17%, which could have a significant impact on the need for health and social care.

The population is predominantly white (98.8%) with relatively little variation between wards. However, in recent years, it has seen a small influx of Eastern European (Polish & Slovakian) migrants.

DEPRIVATION

Deprivation is a major determinant of health. Lower income levels often lead to poor levels of nutrition, poor housing conditions, and inequitable access to healthcare and other services.

Deprivation, measured using the English Index of Multiple Deprivation (IMD) 2007, ranks Halton as the 30th most deprived authority in England (a ranking of 1 indicates that an area is the most deprived). This is 3rd highest in Merseyside, behind Knowsley and Liverpool, and 10th highest in the North West : St Helens (47th), Wirral (60th) and Sefton (83rd) are way down the table compared to Halton.

The 2007 IMD shows that deprivation in Halton is widespread with 57,958 people (48% of the population) in Halton living in 'Super Output Areas' (SOA's) that are ranked within the most deprived 20% of areas in England.

In terms of Health and Disability, the IMD identifies 53 SOA's (Super Output Areas) that fall within the top 20% most health deprived nationally and that approximately 40,000 people (33% of the population) live in the top 4% most health deprived areas in England. At ward level, Windmill Hill is the most deprived area in terms of health. However, health deprivation is highest in an SOA (Super Output Areas) within Castlefields, ranked 32nd most deprived nationally.

Within Halton, the 21 wards were ranked as follows across each domain overall, with Windmill Hill the most deprived ward, and Birchfield the least deprived.

Wards Ranked within the IMD (Index of Multiple Deprivation)2007

Rank within Halton	**IMD 2007**
1	Windmill Hill
2	Halton Lea
3	Castlefields
4	Riverside
5	Norton South
6	Kingsway
7	Appleton
8	Halton Brook
9	Grange
10	Mersey
11	Ditton
12	Hough Green
13	Broadheath
14	Halton View
15	Norton North
16	Hale
17	Heath
18	Farnworth
19	Beechwood
20	Daresbury
21	Birchfield

(Source: Index of Multiple Deprivation 2007)

HEALTH

Health is also key determinant of a good quality of life and the first priority of Halton's Community Strategy states that 'statistics show that health standards in Halton are amongst the worst in the country and single it out as the aspect of life in the Borough in most urgent need of improvement'.

Halton remains relatively unhealthy, ranked 383rd out of 408 districts in the country, compared to 384th three years ago.

Average life expectancy in Halton was 76.1 years in 2003-05, compared to 77.7 years regionally and 78.7 years nationally. The figure for Halton has improved by 0.1 years since

2000-02, but the gap between it and the region and it and Great Britain has widened to 1.6 years and 2.6 years respectively. Life expectancy was relatively low among all comparator areas as it's linked to deprivation and low incomes. Only in Chester and Vale Royal do residents live longer than the national average. In all the other health indicators used in the production of the 'State of the Borough' audit, Halton performs below average. For example, Halton's mortality ratio in 2005 was 125 (Great Britain - 100), and its health index was 97.01 compared to Great Britain being 100, meaning its rank is little changed since 2004.

Health Deprivation Rank in Halton

Health Deprivation Rank within Halton	**IMD 2007**
1	Windmill Hill
2	Castlefields
3	Halton Lea
4	Riverside
5	Norton South
6	Halton Brook
7	*Kingsway*
8	Grange
9	*Appleton*
10	Ditton
11	*Mersey*
12	Hough Green
13	Broadheath
14	Halton View
15	Norton North
16	Heath
17	Farnworth
18	*Hale*
19	Beechwood
20	Daresbury
21	Birchfield

(Source: Index of Multiple Deprivation 2007)

CARERS - HEALTH

The Health of Carers is a major influencing factor upon the health and welfare of the people receiving care, upon the carers themselves and on the cost and shape of public services provided.

Data from this census shows that 13,500 of people in Halton provide formal or informal care, over 11% of the Halton population. National data (2001 Census) suggests that 11% of informal carers consider themselves to be in poor health, whilst in Halton the proportion appears to be higher, with 14% of all carers having felt that they were in poor health. Currently 10.85% of carers are receiving needs assessment or review and a specific carers' service, or advice and information. This clearly needs to be improved if threats to health and well-being are to be averted.

Number of Informal Carers within Halton

	All People	Good Health	Fairly Good Health	Not Good Health
1 to 19 hours – Provides care	7944	4858	2332	754
20 to 49 hours – Provides care	1891	937	645	309
50 or more hours – Provides care	3696	1429	1390	877
Total	**13531**	**7224**	**4367**	**1940**

Provision of Unpaid Care
(This table pertains to Carers and is not generic)

Wards	Number of Unpaid Carers	Proportion of Total Population	Halton Rank	Greater Merseyside Rank
Appleton	678	10.61	16	111
Beechwood	524	13.15	4	15
Birchfield	553	12.43	7	33
Broadheath	726	11.26	14	85
Castlefields	771	11.99	8	47
Daresbury	340	8.70	21	135
Ditton	799	12.79	6	23
Farnworth	760	12.86	5	20
Grange	796	11.60	9	67
Hale	264	13.91	2	4
Halton Brook	744	11.28	13	84
Halton Lea	739	11.52	10	71
Halton View	793	11.52	11	72
Heath	748	13.58	3	6
Hough Green	764	10.81	15	106
Kingsway	688	11.29	12	83
Mersey	645	10.49	17	117
Norton North	680	10.47	18	118
Norton South	721	9.98	19	125
Riverside	455	9.45	20	131
Windmill Hill	340	13.96	1	3
Total 13,531	**13,531**	**11.44**	**21 wards**	**138 wards**

(Source data; 2001 Census - Please note that the total number of 13,531 may not add up due to the rounding up process during the 2001 census)

Greater Merseyside Average **11.53**
North West Average **10.77**
England Average **10.03**

The percentage of people in Halton who provide unpaid care to others, usually a close relative, is 11.4%. This means that 13,528 people are providing care for someone. This figure ranks 5th highest in Greater Merseyside and 8th highest in the

North West. The Wards with the highest numbers of unpaid carers are Windmill Hill, Hale, Heath and Beechwood where the figures are above 13%.

National Top 4 illnesses reported by Carers

Mental Health of Carers	Physical Health of Carers
1 Anxiety	1 Stress
2 Depression	2 High Blood Pressure
3 Loss of Confidence	3 Heart Problems
4 Loss of Self Esteem	4 Strains

Number of People currently diagnosed with Dementia in Halton and the estimated costs to the local economy by 2025.

Borough	2008	Cost to economy	2025	Cost to economy
Halton	1061	£25,766,385.00	1613	£39,171,705.00

ECONOMY, INCOME AND EMPLOYMENT

Halton still has a relatively small economy, by national standards, but it has improved over the past 3 years as its ranking has climbed 8 places from 175th to 167th out of 408 British districts for economic scale. Other neighboring economies notably Chester, Vale Royal and Ellesmere Port have all slipped relatively in the same period. Out of 9 Merseyside and North Cheshire Authorities, seven have slipped and only Sefton (by 1 place) and Halton (8 places) improved. Not surprisingly, the economy of the sub-region is still dominated by Liverpool.

In terms of changes in employment, Halton performs well below the national average and is ranked 340th of all districts nationally, out of 408 districts. This is primarily because of Halton's dependence on the manufacturing sector and this sector has been affected most in falling numbers. Despite this, Halton's ranking is 40 places higher than it was 3 years ago. All the other Merseyside and North Cheshire comparators have seen their position decline over the same period.

Total employment in Halton decreased by 0.2 per cent during 1998 - 2005, well below the national increase of 9.1 per cent, and the North West regional increase of 7.1 per cent. Halton had the second lowest rate of change of all comparator areas with the exception of the Wirral. Knowsley, Chester and Middlesborough showed the most growth at 31.5 per cent, 11 per cent and 27.9 per cent increases in total employment between 1998 – 2005.

Halton still performs poorly with respect to the labour market, but its ranking out of 408 districts in the country has risen slightly from 364th to 357th by 2006 and the gap between it and the national average has narrowed.

The Borough performed better in terms of change in gross weekly earnings, with a 6.9 per cent increase in wages between 2005 - 2006. This was 4th highest in the comparator towns and better than the sub regional, regional and national increases.

Halton performs poorly in terms of skills and qualifications levels, ranked 370th out of 408 districts in the country, i.e. 38th worse in Great Britain. This is down from 342nd in 2004, illustrating that other LAs are outperforming Halton and overtaking it.

In summary the Borough's economy is relatively small (particularly compared to nearby, larger settlements such as Liverpool), but productivity is above average. Trends in economic change are a cause for concern however, when increases in general employment are undermined by declines in the manufacturing totals, which leave Halton with one of the worst positions in the country. In order to improve levels of growth, further improvements will be needed in the skills and qualifications base of the workforce.

The proportion of the resident population with at least a first degree – more important in a modern knowledge economy than ever before – is well below the national average. The number of people with no qualifications is falling, but not as much or as fast as elsewhere.

KEY MESSAGES FOR HEALTH AND SOCIAL CARE

- Windmill Hill (1st highest), Castlefields (8th highest) and Halton Lea (10th highest) are the three most deprived wards in Halton in terms of Health, it is realistic to assume that these three areas also house the highest number of Carers and that within that number, those Carers probably are sick or suffer with ill health. Birchfield, Daresbury and Beechwood are the three least deprived.
- Halton currently has a younger population than seen overall nationally but there is expected to be a sharp increase in Halton's older population in the next 15 years; which will have significant cost implications for Health and Social Care if preventative measures are not taken.
- Low-level investment will need to be considered, in order to address the growing number of people within Halton, that have been diagnosed with Dementia and the projected growth of numbers by 2025, which will ultimately present a financial burden on local services.
- The role of informal carers will become increasingly important and will need to be addressed through both this strategy and the local dementia strategy.
- Overall, the IMD (Index Multiple Deprivation) 2007 shows that there has been a slight improvement in Health Deprivation in Halton since 2004, but the gap has widened between the most and least deprived.
- 33% of Halton's population live in the top 4% most health deprived areas of the country.
- There is a strong correlation between Health deprivation and the following indicators when looking at Halton on a ward-by-ward basis:

    - Proportion of the population with a limiting long-term illness
    - Proportion of households claiming incapacity benefits
    - Housing tenure
    - Proportion of the population without access to cars or vans
    - Household income.

SECTION THREE: CONSULTATION

INTRODUCTION

In order to develop services that meet the needs of those who use those services, we need to consult with carers and other stakeholders to identify whether those needs are being met. This consultation process then informs the future commissioning of services. On-going consultation takes place with carers in Halton and specific consultation exercises/processes have been conducted/take place, as detailed below;

CARER CONSULTATION EVENTS

Halton continually makes itself aware of the priorities and key messages that have emerged from the Carer Consultation events over the last 2 years, some of these include:

- Developing systems for primary care services to strengthen a stronger link in the referral of carers at the point of a deterioration or diagnosis of the cared for persons condition.
- Increasing referrals between statutory services, social care services and non-statutory/voluntary services in order to provide options and choice in carer support.
- Providing Information – need for increased access and types of information
- Identifying hidden carers.
- Continuing to support carers for a transitional period once "caring comes to an end" by supporting carers through bereavement counselling, support groups, training and support into paid work or voluntary work and encouraging carers to "build a life of their own" after they cease to be carers.
- Including carers "voice" and influences in service development; through participation in Local Implementation Team (LIT) Sub groups for carers, Carers Forums and Carers Reference groups.
- Continuing to provide breaks and respite for carers in order for them to sustain their caring responsibilities and have a life of their own.
- The consultation events have also highlighted the disadvantage suffered by older carers who have had benefits stopped once they reach pensionable age – yet still continue to provide care.

CARERS' STRATEGY GROUP

The purpose of the Carers Strategy Group is to be responsible for the promotion of general carer issues across all sectors in Halton. The aim is to bring together the views of carers and statutory and voluntary agencies and to provide a focus for the development of health and well being for carers and those they care for.

Membership represents those organisations involved in the purpose of the group. Each representative brings their individual and organisational interests and experiences to the group. They contribute as fully as possible to the overall purpose and work of the group.

The Carers Strategy Group improves lines of communication and collaborative working between health, professionals and Carers in order to ensure that there are effective and appropriate services to Carers. The LIT Sub Groups for Carers feeds

into and from the Carers Strategy Group and have representatives from each team, including Mental Health, Adult Learning Disabilities, Physical and Sensory Disabilities, Drug and Alcohol Mis-use, Older People and Young Carers.

LOCAL IMPLEMENTATION TEAM (LIT) SUB GROUP (CARERS)

The purpose of the LIT Sub Groups (for Carers) is to oversee the performance and development of Adult Learning Disabilities Services, Physical and Sensory Disabilities Services, Mental Health Services, Drug and Alcohol Services and Older Peoples Services. In previous years the LIT Sub groups have been allocated carers grant funding and the members of the LIT Sub groups have allocated it out to teams/organisations for the provision of services.

It is the intention of Halton Borough Council to continue to devolve responsibilities as close to Carers as possible when shaping and developing services for Carers and the authority will be pro-active in encouraging and supporting carers to engage in the LIT Sub groups for Carers and the consultation events held across the borough.

The groups are responsible for providing feedback and making recommendations to the Carers Strategy Group. It is the intention of the LIT Sub groups to improve communication and collaborative working between health, professionals and Carers in order to ensure that there are effective and appropriate services to Carers. The LIT Sub Groups for Carers feeds into and from the Carers Strategy group and improves the lines of communication. The Carer representatives from each team, sit on the Carers Strategy Group.

There are current developments to establish a LIT Sub group for Young Carers. This will include representatives from service user groups, service providers and other stakeholders. Young adult carers will be given training and be allocated a mentor, so they are best able to participate in and contribute to, the LIT Sub groups and to enable them to share their views and opinions on current services and identify gaps in services. In order to include as many Young Carers as possible the LIT Sub group will operate at a time most convenient for young carers to attend. This group will take collective responsibility for allocating funds for young carers' breaks, with young carers' playing an active role in this process. This development will ensure Young Carers' issues feed directly in to the Carers' strategy group as a whole rather than being marginalised.

EQUAL OPPORTUNITIES SUB GROUP (CARERS)

The purpose of the Equal Opportunities Sub group is to be responsible for the promotion of "equality" of opportunity for "Carers" across Halton. The aim is to implement the Carers Equal Opportunities Act 2004 into local services by monitoring and raising awareness of agencies, individuals and partnerships. It is intended that this will impact on improved health and wellbeing for carers and those people that they care for. The group will be responsible for developing and reviewing the action plan and provide quarterly progress reports to the Carers Strategy Group.

CARERS REFERENCE GROUP

The role of the Carers Reference Group is to represent the "Voice of Carers" within Halton in discussions and in key partnerships with the local authority and other

service providers, relating to Carers issues, identifying gaps in services for Carers and to shape new or existing services for Carers. The Carers Reference group is overseen by a core membership. The Carers Reference Group is co-ordinated and "Chaired" by the Halton Carers Centre.

HALTON CARERS FORUM

The forum acts as the single voice of carers in Halton to influence and shape new and existing services, be involved in planning and monitoring of services; including action plans and policy development and to act as a consultation body for carers – ensuring that they are recognised as an equal partner by all members of local statutory and regional authorities including the Primary Care Trust. The Carers Forum holds regular events with guest speakers.

HALTON MENTAL HEALTH FORUM

The Mental Health forum acts as a conduit for the Voice of Carers (who look after people with mental health issues) and works in partnership with the Carers Reference group. They are represented on a number of strategic group meetings within the Borough, including the LIT and Sub LIT for Carers (Local Implementation Teams) regarding mental health.

CARERS SUPPORT GROUPS

The Halton Carers Centre organises two Carer Support Groups in Runcorn and Widnes who meet on a monthly basis. The aim of the groups is to provide a relaxing atmosphere where carers in Halton can talk about any issues or problems in their caring role, or just have a general chat over a coffee and a biscuit. The Carer Support Workers are on hand to provide information, support and advice.
The Mental Health team co-ordinates 3 Mental Health Support Groups across Widnes and Runcorn.

HALTON CARERS CENTRE

Halton Carers Centre is the first point of contact for unpaid carers of any age, caring for people with any condition in Halton. It provides information and advice via a drop-in service at the Carers Centre and/or telephone enquiries Monday – Friday. The Carers Centre is responsible for providing a wide range of services for carers including free training, bi-monthly newsletters, a wide range of leaflets, free day trips, holistic treatments, 2 Carers Support Groups, and self- referral to counselling services. The Centre also provides awareness presentations to professionals and other organisations in Halton in order to raise the profile of carers across the Borough.

LOCAL INVOLVEMENT NETWORK (LINk)

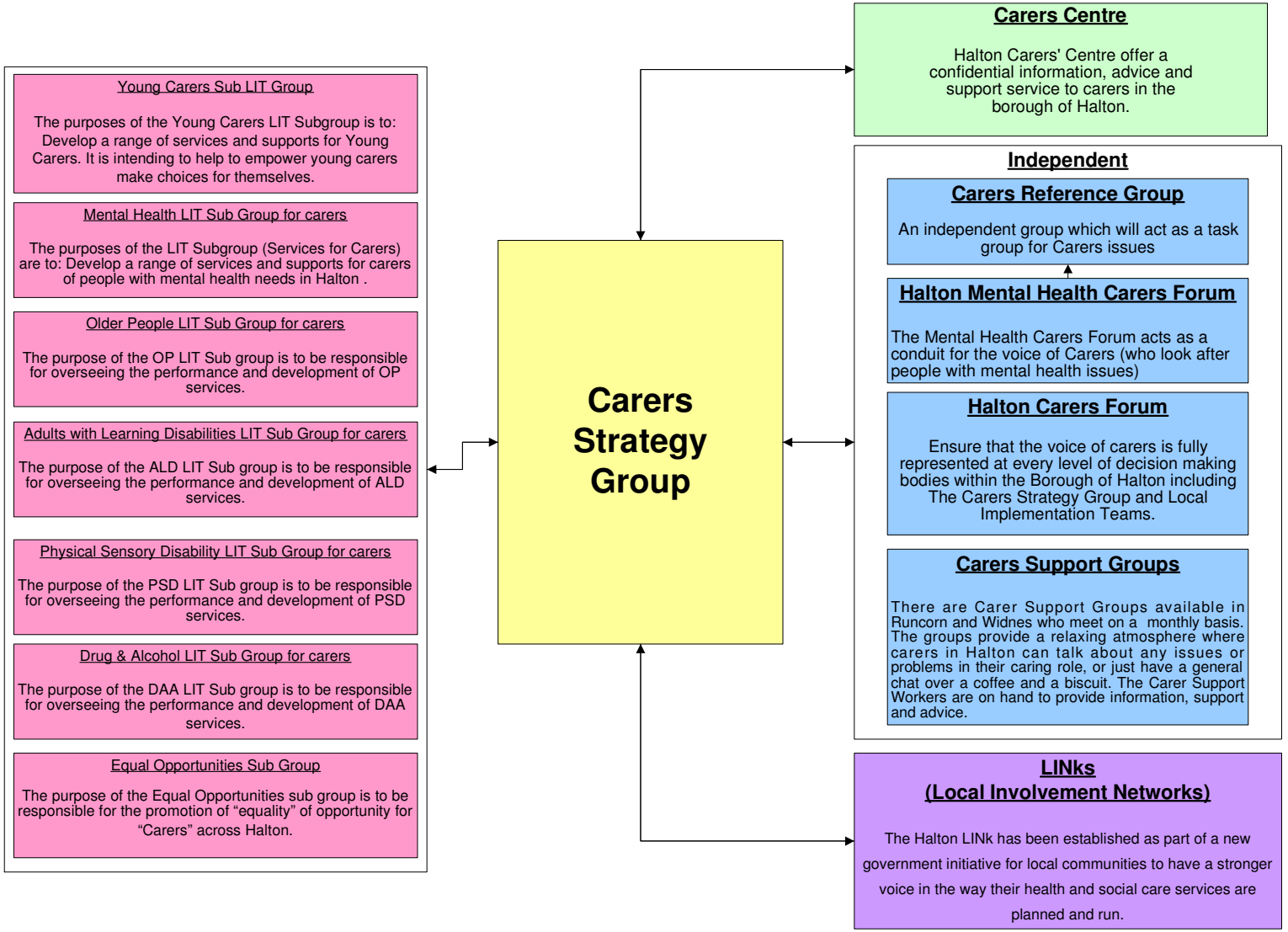
Halton LINk is a Government Initiative to enable communities to have a stronger voice in the way that Health and Social Care services are planned and run.

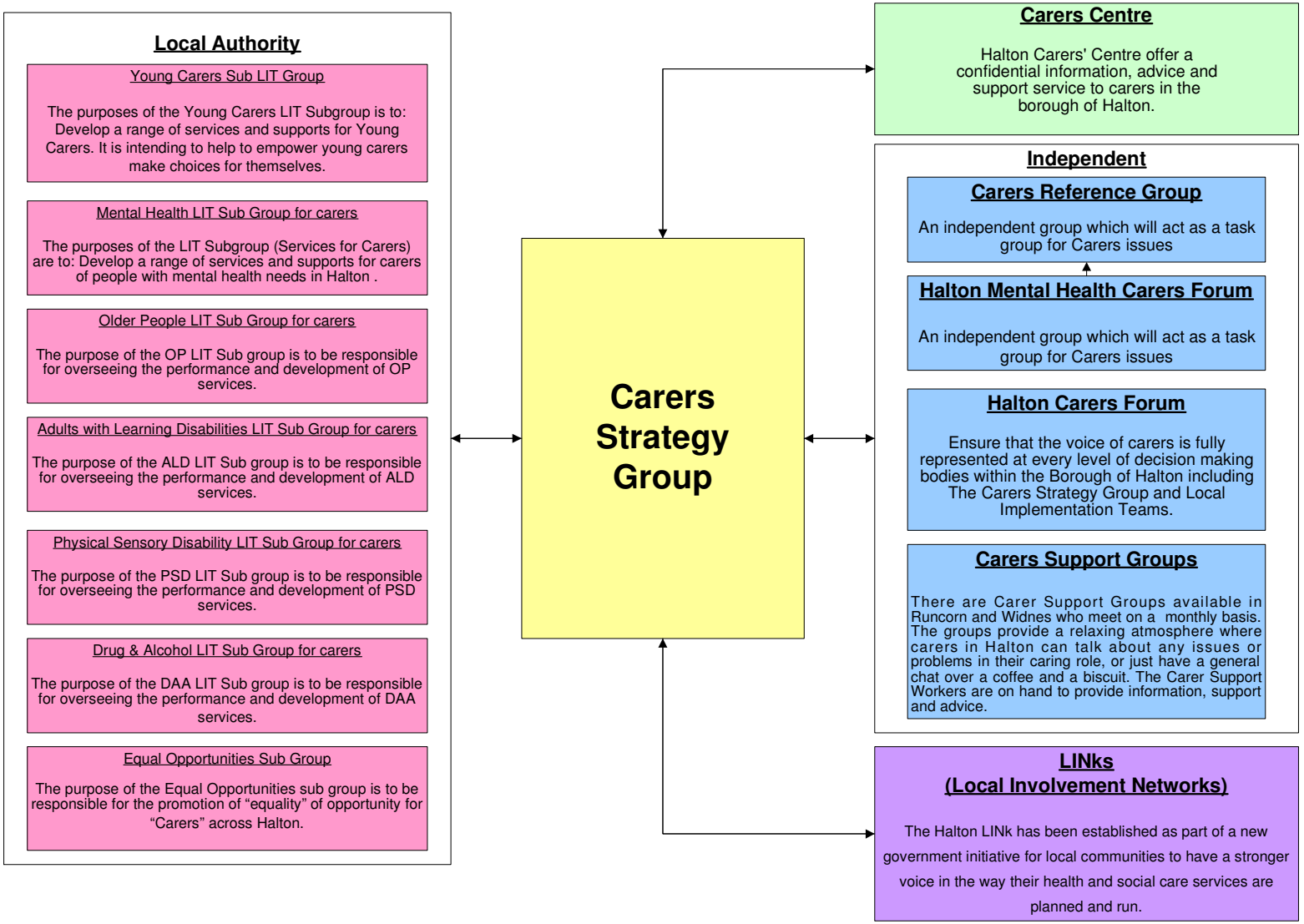
Run by local people and groups, the role of the Halton LINk is to promote involvement, to find out what people like and dislike about local services, monitor the care provider services and use LINk powers to hold services to account.

Halton LINk can;

- Ask by local people what they think about their health and social care services and a chance to suggest ideas to help improve services.
- Investigate specific issues of concern to communities
- Use its powers to hold providers and commissioners to account and get results
- Ask for information and get an answer within a specified amount of time
- Carry out checks to see if services are working well
- Make reports and recommendations and receive a response
- Refer issues to higher authorities, when service providers seem reluctant to accept findings and take appropriate action.

People in Halton can participate in the LINk as much or as little as they wish, from receiving information regularly to being involved in working groups, or being a Board member.


Young Carers Sub LIT Group
The purposes of the Young Carers LIT Subgroup is to: Develop a range of services and supports for Young Carers. It is intending to help to empower young carers make choices for themselves.
Mental Health LIT Sub Group for carers
The purposes of the LIT Subgroup (Services for Carers) are to: Develop a range of services and supports for carers of people with mental health needs in Halton .
Older People LIT Sub Group for carers
The purpose of the OP LIT Sub group is to be responsible for overseeing the performance and development of OP services.
Adults with Learning Disabilities LIT Sub Group for carers
The purpose of the ALD LIT Sub group is to be responsible for overseeing the performance and development of ALD services.
Physical Sensory Disability LIT Sub Group for carers
The purpose of the PSD LIT Sub group is to be responsible for overseeing the performance and development of PSD services.
Drug & Alcohol LIT Sub Group for carers
The purpose of the DAA LIT Sub group is to be responsible for overseeing the performance and development of DAA services.
Equal Opportunities Sub Group
The purpose of the Equal Opportunities sub group is to be responsible for the promotion of "equality" of opportunity for "Carers" across Halton.
Carers Strategy Group
Carers Centre
Halton Carers' Centre offer a confidential information, advice and support service to carers in the borough of Halton.
Independent
Carers Reference Group
An independent group which will act as a task group for Carers issues
Halton Mental Health Carers Forum
The Mental Health Carers Forum acts as a conduit for the voice of Carers (who look after people with mental health issues)
Halton Carers Forum
Ensure that the voice of carers is fully represented at every level of decision making bodies within the Borough of Halton including The Carers Strategy Group and Local Implementation Teams.
Carers Support Groups
There are Carer Support Groups available in Runcorn and Widnes who meet on a monthly basis. The groups provide a relaxing atmosphere where carers in Halton can talk about any issues or problems in their caring role, or just have a general chat over a coffee and a biscuit. The Carer Support Workers are on hand to provide information, support and advice.
LINks
(Local Involvement Networks)
The Halton LINk has been established as part of a new government initiative for local communities to have a stronger voice in the way their health and social care services are planned and run.


Local Authority
Young Carers Sub LIT Group
The purposes of the Young Carers LIT Subgroup is to: Develop a range of services and supports for Young Carers. It is intending to help to empower young carers make choices for themselves.
Mental Health LIT Sub Group for carers
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SECTION FOUR : CURRENT PROVISION OF SERVICES AND COMMISSIONING INTENTIONS

INTRODUCTION

The following sections describes the types of services that Halton provides under the following headings as listed in the National Carers Strategy (Integrated and Personalised Services, A Life of Their Own, Income and Employment, Health and Wellbeing and Young Carers)

As Halton moves towards the personalisation approach, it recognises that the way in which it has supported people before will have to evolve.

In order for carers to have more choice; stakeholders and carers will work to develop services and policies to help individuals best manage their own support packages. It has been acknowledged that colleagues across health and social care will also have to evolve in those new roles either directly within their own services or by referrals into other services. Halton has sometimes lacked choice of service options, in particular services that are able to provide respite breaks. This year we have managed to provide more carers breaks than previous years but are pro active in searching for more choice.

The Strategy is focussed primarily on adult carers but also accepts that the profile of younger family members needs to continue to be raised and recognised and that suitable service provision is put into place.

Work is also taking place between Adult and Children Services to ensure that the transitional process for children with disabilities entering adulthood is as smooth as possible.

INTEGRATED AND PERSONALISED SERVICES

The Government predicts that there will be 1.6 million more adults across England with a care need by 2020, that is a rise of 30%. Following the consultations that the Government carried out in 2007; they found that carers wanted to be acknowledged for their knowledge and skills and they wanted to be respected as expert carers. It is estimated that by 2041 there will be an increase of carers by 50%.

The Government has said that they need to prioritise the service provision to carers, which will enable them to continue in their caring role.

There is a need for services to work together more closely to provide a more tailored package of support to the carer. Carers stated that they wanted to have easier access into services and to have choice about whether they worked in addition to their caring role.

Existing Provision

Telecare; is a set of electronic sensors that is installed the cared for persons home that helps to make living at home safer. It is part of the community alarm service and does not use cameras. It is tailored to an individuals needs and its applications can vary from detecting excess smoke in the kitchen to floods in the bathroom. It can also tell if an area is too hot (cooker left on), or if the house is too cold (no heating on).

Just as important, Telecare can help us to know if you fall over or cannot get out of bed due to illness, and automatically contact a control centre for help.

Telecare can offer support for service users and carers as it can offer an alternative support for people to help them remain independent in their own home. This can often be an important addition for carers as it can give piece of mind for them that relatives with difficult conditions have support.

Carers Assessments; There are currently 6 specific Assessors who provide assessments for Carers. The Assessors work within the Physical and Sensory Disability team, Mental Health team, Adult Learning Disability team, Parents of Children with Disabilities and the Older Peoples team (Runcorn and Widnes). The aim of the Local Authority was to increase the numbers of Carers receiving a service as a result of undergoing an assessment. In 2007 the Local Authority recruited Carer Assessors to identify and engage previously hidden carers, to raise the profile of carers and to respond more quickly to requests from Carers, for an assessment. This has led to an increase carers receiving an assessment of their needs and accessing a service as a result of that assessment.

Direct Payments; are available from the local authority and offers support for carers. The Direct Payments team provides information and guidance on all aspects of receiving and managing Direct Payments including advice on how Direct Payments can increase independence, help with recruiting, selecting and employing staff (personal assistants), guidance and support on becoming an employer and employment law, access to training for personal assistants (to make sure they have the right skills), access to a payroll service to take away the worry of tax and national insurance calculations, information on insurance and health and safety issues and training on record keeping and managing your Direct Payment. Over the past couple of years the number of Carers who have accessed Direct Payments has increased from **440** carers during 2007/8 to **567** during 2008/09 and have used their payments for; domiciliary care, laundry costs, gardening help, caravan holidays, gym membership, theatre tickets, fuel costs and college courses.

Self-Directed Support; Halton is currently developing the required infrastructure to enable the personalised approach to be adopted and work effectively within the Borough. Halton's Vision Statement for Self Directed Support more commonly known as Personalisation is outlined below:

We believe all citizens of Halton, including people who require adult care services, should have the best possible quality of life. We want all people who use our service to have maximum choice, control and power over the support services they receive and we will strive to achieve this in partnership with people who use services, their families, care and local communities.

Our vision will be underpinned by a set of guiding principles set out below:

- We will enable people who use services to have the maximum choice over their lives - including the services they require - to achieve the best possible quality of life.
- People should be able to access the right services at the right time to meet their needs.
- People who use services and their carers will be treated with respect and dignity at all times, and assisted to make decisions themselves and to live their lives free from discrimination and harm.

- We will work in partnership with people who use services; their carers, families and representative groups to ensure we adhere to these principles and to enable them to shape the action we take to deliver person centred care services.
- We will work in partnership with other agencies – particularly those in health care and the voluntary sector – to deliver our vision.
- We will maximise the use of our resources in enabling people to have choice recognising that there will always be limits in the total sum of resources available.

Summary of Identified Needs

As part of the national strategy, the Government have outlined a number of priorities that they will work towards to support the development of Integrated and Personalised Services such as the personalisation agenda and this priority has also been identified by Carers within Halton, by identifying the need to have more control, flexibility and easy access to services that they need.

As such Halton has already commenced a number of projects that will support the reforming of services and processes to ensure a more flexible and personalised approach to services.

Commissioning Intentions

Carers Assessments; During 2008/9, there was an increase in the number of assessments undertaken that led to the Carers receiving a service. The work of the Carers Assessors will continue and it is anticipated that the levels of assessments undertaken during 2008/9 will continue from April 2009 onwards.

Direct Payments; Halton's intention is to continue to encourage Carers to utilise Direct Payments, which will enable carers to have increased choice about how they access the support and breaks they require.

Self Directed Support; Build upon the foundations of Direct Payments to ensure that carers are involved in the development of the infrastructure to support the personalisation agenda. As part of this project, work will be progressed during 2009/10 on the development of a self-assessment process for Carers and the people they care for.

NOTE : It is important to note that a challenge for Halton (as part of the personalisation agenda) will be supporting carers that provide regular and substantial care and who meet the "substantial or critical" within the Fair Access to Care criteria (FACS), yet avoid carers breaking down. Already it has been acknowledged that it is only by taking a preventative approach and taking early intervention measures that avoids the carer's situation deteriorating to a point of crisis. (See appendices for Adult and Children's Services FACS guidelines)

A LIFE OF THEIR OWN

Introduction

Many carers express feelings of isolation and frustration about the circumstances in which they have found themselves. Some family members become carers due to a deteriorating health condition and as the responsibilities gradually increase, they are often unprepared for the changes and learn as they go along to administer medication or carry out personal care, or understand complex medical terminology. Some carers admit they find it difficult to see themselves as carers and feel that the roles and duties that they carry out are all part of being a mother/brother/ wife/husband etc. A common theme amongst carers is the level of sacrifice and compromise within their own lives. In some circumstances this can lead to frustration and resentment, or even depression and/or hopelessness.

A way of ensuring that Carers within Halton have a life of their own is to ensure that specific services are available to give carers respite breaks, provide training, and offer employment opportunities.

Within Halton we have undertaken to define who is a carer and what access to breaks they can receive (See Appendix 3)

Existing Provision

- **Carers Centre**; First point of contact for Carers, providing information and advice via a drop in service and a telephone helpline Monday to Friday. The Carers Centre is responsible for providing the following services to Carers of any age, caring for people with any condition; A bi-monthly newsletter, breaks for carers including day trips, training and social events; offering holistic therapies and also first stage advocacy for Carers. The centre also provides awareness training to professionals within health and social care, and has a lead role in the Carers forum/Carers reference group.
- **Halton Leisure Cards**; are available free to carers that register at Halton Carers Centre and provide the carer with reduced admission charges to a wide range of services from swimming to museums and from reduced prices for theatre tickets to savings on DVD hire
- **Parkinson's Society**; provides a monthly social club with regular guest speakers offering support and information for service users and their carers, also one off day trips or events throughout the year.
- **Widnes and Runcorn Cancer Support Group**; includes carers in all its services, i.e. Advice, Information, Sign-Posting, Listening, Counselling, Complementary Therapies, Beauty Therapies, Art Workshops, Self-Help Groups, Respite Caravan Breaks, plus one off social events.
- **Lets Go Club**; offers a monthly social event and holidays for people who have suffered a stroke. They provide transport for people who without which would be unable to access the social events.
- **Halton Haven**; provides pamper days for carers who care for people with cancer or other life threatening illnesses.
- **Halton Happy Hearts**; provides tai chi classes, day trips and social events for people with heart conditions and their carers.
- **Runcorn and Frodsham District Mencap**; provides weekly social events for people with learning disabilities, enabling carers to access respite.
- **Liverpool Personal Service Society (PSS)**; offers a sitting service to people with dementia/alzheimers, enabling the carer to have a respite break.

- **Oakmeadow**; provides a day-care service for people with dementia.
- **Hope Inclusion Time Success (HITS)**; provides Young Carers assessments on behalf of the local authority. They provide information, support, social activities and groups for young carers up to the age of 16 years. A Young Adult Carers' service for Carers' aged 16-21 is also provided in partnership with the Carers' Centre.
- **Emergency Respite Service**; provides emergency respite for carers, where it is deemed that there may be a potential situation that would arise if the carer was incapacitated. This is accessed through the emergency card system and is available 24/7.
- **Halton People into Jobs;** Outreach service providing information, advice and guidance relating to employment, learning or enterprise. Pre-Employment support with all aspects of job search e.g. CV's, application forms, interview preparation, sign posting to training. Waged options, work experience etc. Financial assistance from carers' grant for carers moving into employment.

Summary of Identified Needs

Carers said that they are often restricted from freedom of choice in as much as they are unable to go on holiday when and where they want and that their days are often taken up by caring duties so are unable to do things spontaneously but have to "plan" even simple things like shopping or doctors appointments.

From the analysis of information obtained from the Consultation Event held in February 2009 there was a consensus amongst carers that they experienced '*rushing* or *clock watching'* and that they found it hard, if not impossible to relax due to their caring responsibilities.

Some carers felt frustrated that they were unable to pursue a satisfactory career and as result would feel that their finances suffered, there seemed little alternative to address the financial situation.

Commonly carers said that their social lives often suffered due to their role and that this varied from having no-one take care of the "cared for person" to there being a lack of places to go with the "cared for person" if they wanted to share an activity, to exhaustion from their responsibilities. Carers said that they lacked confidence which then impacted on them mixing with other people and compounded their isolation.

Carers have disclosed that transport has continued to be an issue for those people who have had to visit the cared for person over a long period of time, this is particularly pertinent for carers of people with mental health issues and people with dementia.

Commissioning Intentions

Continue to offer carers breaks through the funding of voluntary groups including;

- Halton Happy Hearts
- Alzheimer's Society
- Parkinson's Society
- Lets Go Club
- Runcorn and Frodsham District Mencap
- Halton Haven
- Halton Carers Centre

- HITS
- The Halton Leisure Cards

To fund additional voluntary groups in response to Carers feedback from the Carers Consultation held in February 2009, which includes;

- **Connect**; offers a weekly social club for people with learning/physical sensory difficulties allowing respite for the Carer or the opportunity for the Carer to be a part of the events. Connect's members choose the activities including; pool, table tennis, boccia, kurling, craft, bingo, disco, quiz, craft, music/singing workshops and daytrips – it's their decision. Connect also runs a football club for people with learning/physical disabilities.
- **Breathe Easy Halton**; offers support and information to those with lung complaints. Each month there is a meeting with a guest speaker. All are welcome. Social events and outings are held for the Cared and Carers.
- **HAFS**; provides monthly meetings including relaxation and massage therapy for carers, supervised trampolining and swimming sessions also general leisure and recreational activities. It offers carers breaks, including full advocacy service, helpline and reference library plus regular trips, outings and holidays.
- **A.C.E (Active Community Enterprise) Disco**; Set in St Basil' social club Hough Green on Thursday nights. Offers a disco & social evening throughout the year for people with learning disabilities.
- **Deafness Support**; provides support and respite breaks to young carers of deaf adults or siblings of deaf children.
- **Canal Boat Project**; offers a number of carers breaks and events which includes a 5 x day residential activity week in Barnsdon Dale, a canal boat residential and theatre visits for young carers.
- **Arch Initiatives**; provides one to one and group activities to young carers of with people alcohol or substance misuse.
- **Caring with Confidence**; is aimed towards improving support for carers aged 18 years and over by offering a course of sessions to develop carers knowledge and skills. Sessions are provided through the Halton Carers Centre.
- **Liverpool Personal Service Society (PSS)**; provides a sitting service for the cared for person, the PSS staff can either take the cared for person out for a break or can stay in the person's home; this enables the carer to have a period of respite. It has been agreed due to increased costs for the service, to put the contract out to tender; PSS have had a 3 month extended contract until a new service is contracted.

INCOME AND EMPLOYMENT

The Government's national strategy suggests a number of activities that may help to make combining paid work with care a real choice for as many carers as possible.

There are certain commitments to improve the support offered to carers by Jobcentre Plus as follows:

- Introducing a Care Partnership Manager in every Jobcentre Plus District.
- Introducing specialist training for Jobcentre Plus advisers who work with carers. This will better equip advisers to recognise and deal with the

needs of carers and enable them to assist carers with returning to/staying in work.

- Funding of replacement care for those who are participating in approved training. This will enable carers who are not in full time work to take full advantage of training opportunities/employment related programmes operated by Jobcentre Plus.
- Ensuring that eligible carers have access to appropriate employment programmes/provision.

Existing Provision

- **Halton People into Jobs**; are currently funded to provide training and support for Carers wishing to move into work or return to work
- **Community Bridge Building Service**; Workers can address and work with both carer and the cared for person. For example a carer could be referred for issues such as social isolation, which they may experience. The Bridge Builder team also provides services for the cared for person, which would then give the carer respite. When both the carer and cared for are referred to the service they would be allocated different 1-1 workers. The team can offer support into voluntary work, education and employment.
- **Employed Workers;** Within in Halton Borough Council Carers benefit from a number of policies/procedures that support flexible working.
- **Benefits Maximisation**; The Financial Services Team support each service user that in checking that they appear to be getting all the benefits that they are entitled to. If they consider that the service user may be entitled to more, then they refer the person onto the Welfare Benefits Team who are able to do a detailed benefits check and assist the service user to claim additional benefits where possible.

Summary of Identified Needs

At the carers consultation event some carers expressed a wish to pursue a career if they didn't have caring responsibilities/or to have the ability to combine the two, However Carers have fears with regards to being penalised on a financial level if they return to work.

The Carers consultation event highlighted inequality around people of pensionable age having carer's allowance/benefits stopped yet they continue to carry out the role of a carer – this may be an issue that Halton may decide to campaign on.

NOTE – The 'Make Work, Work' campaign addresses some of the issues that carers are faced with. 80% of carers are of working age and 3 million already combine work and care. 1 in 3 carers have said that they would return to work if the right support were available. If carers are forced to give up their jobs because of their caring responsibilities they can end up isolated and living in poverty.

Commissioning Intentions

To continue to fund and develop existing services;

- Halton People into Jobs
- Community Bridge Building Service
- Halton may support the Halton Carers Reference Group to consider the issue of inequality around areas of a pension-able age.

- To develop stronger working partnerships with Job Centre Plus, in order to provide better working opportunities for carers
    - Link into the 12 week training programme at Riverside College already planned to be delivered Autumn 2009
    - Carers to work with Jobcentre Plus to produce a leaflet explaining what the national strategy means locally
    - Establish a network of Carer Champions who have successfully combined work with caring responsibilities
    - Jobcentre Plus Care Partnership Manager to engage in discussions with Carer representative groups
    - Awareness raising for Jobcentre Plus advisers to take place to supplement formal training programmes to enable them to better understand the local issues
- Commission Halton Voluntary Action to co-ordinate the Volunteer Strategy for Halton Borough Council, which amongst other objectives will aim to provide additional volunteering opportunities for carers to gain work experience.
- Benefits Maximisation etc - Develop and distribute publicity leaflets to raise carer profile and inform carers about available services and benefits, within Halton. To link the development and distribution of leaflets to the Carers Promotional Strategy.

HEALTH AND WELLBEING

Introduction

There is clear evidence that carer's health often suffers or is neglected due to their caring responsibilities. During the consultation event carers reported that they often suffered with feelings of stress, anxiety and depression. There are also common ailments reported amongst carers such as; back injuries/strain due to lifting and moving the cared for person in their day to day lives.

During 2008 Healthy Halton Policy Performance Board carried out a scrutiny review around the Health of Carers with regards to them accessing Primary Care services. During this review carers reported a number of barriers when trying to access GP services, which potentially reduced the likelihood of them seeking health care when they most needed it, these barriers included;

- Difficulties in accessing flexible appointments at GP surgeries
- A lack of respect and/or understanding from some GP surgeries; carers felt that they could contribute to the cared for persons care and had a deeper understanding about the needs of the person that they cared for although "professionals" would sometimes dismiss or exclude them from the discussions and assessments
- In some circumstance carers said that when things went wrong they would be left to pick up the pieces.

At the Halton Carers Consultation in February 2009, carers reported that GP's rarely made referrals for them to access available carers services within Halton; they felt that they were in a prime position to inform carers about their rights and to signpost them, as soon as a "cared for persons" condition was either diagnosed or identified to have deteriorated.

Existing Provision

Enhanced GP services; Halton and St Helens Primary Care Trust introduced a new scheme for GP practices in December 2007 this included practices receiving payment to "identify carers, provide information and services to carers, having a named carer lead and to develop more flexible services, enabling carers to access healthcare for themselves".

In summary the aims of the scheme is to encourage GP practices to: -

- identify carers
- identify carers' health and support needs
- take account of carers' responsibilities when they access services in the practice
- identify, with carers, if they require a Social Services assessment, and making the referral
- refer carers to other services as appropriate
- provide appropriate information to help carers make informed choices about their own health and wellbeing, as well as that of the person they care for.
- to provide practices with some resource to enable the above.

Emergency Respite for Carers*;* An Emergency Respite for Carers service was set up in August 2008. This is accessed via an assessment with the local authority and it has been highlighted that there is a need to put a contingency plan into place in the event of an emergency and the carer is unable to be with the cared for person.

Carers have said that they often worried or felt anxious in case they got ill or had to attend a funeral at short notice and they were unable to arrange care for the cared for person. Some carers said that they had refused to go into hospital for care, as they had no-one to look after the cared for person; again, this demonstrates the responsibility and pressure that carers often feel which impacts on their own health.

Pamper and Holistic sessions; Halton Carers Centre have commissioned Riverside College to deliver a pamper and holistic sessions

Trips/breaks; As outlined earlier in this Section breaks/trips are organised via a number of organisations.

Commissioning Intentions

- Update the information available to carers in formats that are fully accessible to a range of carers across Halton including; Adults, young carers, people from black, minority ethnic communities (BME), gay and lesbian carers (LGBT). The information will be available in printed leaflets, newsletters, local publication (The World, Inside Halton) and on the Halton Borough Council website.

- Continue to offer emotional support through the funding of voluntary groups including Halton Happy Hearts, Alzheimer's Society, Parkinson's Society, Connect, Breathe Easy, Lets Go Club, Mencap, Halton Haven, Halton Carers Centre etc and work with them on the development of publicity materials

- Ensure that through training and information Halton Borough Council staff are aware of and respond to issues raised by Carers.

- The PCT to continue to offer GPs the Enhanced GP Service for Carers.

- Develop stronger partnership links with PCT.

- To pilot the "demonstrator sites across Liverpool, St Helens and Halton; in order to develop stronger referral Pathways for Carers.

- To continue to provide the Emergency Respite for Carers Service/Emergency Card and to carry out a service review.

YOUNG CARERS

Introduction

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. The care given may be practical, physical and/or emotional. 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. Underpinning guidance;

- The child or young person does not have to live with the person they care for.

- The term does not refer to young people under the age of 18 years who are caring for their own children.

- The term does not refer to young people under the age of 18 years who accept an age appropriate role in taking increasing responsibility for household tasks in homes with a disabled, sick or mentally ill parent.

- The impact of caring on a young person varies and it is important to assess needs on an individual basis."

We do not know the absolute figure for the number of young carers in the borough or the UK. Young carers are only known to agencies when they or their families chose to identify themselves. Therefore, the true extent of caring by children and young people is 'hidden'. The 2001 Census identified 175,000 young carers aged under 18 in the United Kingdom, 474 of whom are in Halton.

The aims of the Young Carers Strategy 2009 in summary are to raise awareness of and highlight the needs of young carers, to ensure all young carers have access to projects/services which can provide support for their emotional and personal needs, social and educational development and to encourage agencies to work towards supporting families to reduce the amount of inappropriate care that a child/young person provides to any family member. The strategy will also look at how services can best address the needs of young carers in families that fall under the "hidden harm" agenda, with specific reference to the development of working protocols between children's, adults (AMH and DAA services) and young carers services.

The agencies involved with delivering the Young Carers Strategy are aiming to achieve the position whereby young carers are seen as children first, by promoting inclusion and supporting them to be able to undertake educational and leisure activities with their peers. The aim is to ensure young carers are prioritised for access to universal services within the borough.

Children in a caring role should be supported to make choices about their life and feel confident that if they are not able or do not wish to provide the care, then the cared for person is not put at risk.

Existing Provision

Halton Young Carers Project is run by HITS specifically for young carers, it is important that this project whilst providing a valuable service should not be the only option for young carers, who should be encouraged to take part in activities with their peers who are not carers. Other statutory and 3rd Sector organisations also provide services which are available to young carers across the borough, offering activities and support on an individual and group basis. There needs to be clearer referral pathways and priority of access for young carers to these services.
Messages from Carers' consultation event 2009

Joined up working between Halton's Children's Services and Adults Services Departments must recognise the need to continue to work closely together to ensure families are assessed and their needs met holistically as outlined in The Children Act and National Service Framework for Children, Young People and Maternity Services. The family must be seen as a "whole" and their needs met accordingly, not addressed in isolation by the two departments and different social workers/care

managers. The care needs of the parent need to be assessed and met to prevent children providing care inappropriate to their age and capabilities.

This includes ensuring that the needs of all children with long-term social care needs in the transition from childhood to adults have been assessed and appropriately taken into account by Adults Services. Key aspects include young carers who at 18 will become adult carers and the need for all adult carers' services to retain awareness of child development and welfare issues in general and of child protection matters in particular.

Summary of Identified Needs

Young Carers reported that there was still a lack of suitable services for young people. Overall they felt that once they had accessed services at HITS, they were ok; but that referrals could sometimes be slow. Young Carers said that they felt there was a lack of choice/options for them, within Halton.

Although there are services in place for carers, there were reports at the consultation that lack of general information about available services; still stopped more carers accessing them. Those carers that had accessed the services available were satisfied with them.

- More responsive access into HITS
- Increased choice of activities and Young Carers breaks

Commissioning Intentions

To increase the choice of breaks accessible to young carers and includes the following;

- **Deafness Support**; this is a pilot scheme which will allow for young carers of deaf adults and siblings of deaf children to access a variety of short breaks throughout the year, they may be one off events or repeated events. Breaks may include tickets or entrance fees to Chester Zoo etc
- **Canal Boat Project**; Includes various breaks such as 5 x day residential with watersports, horse riding, picnics etc, a 3 x day canal boat residential for up to 8 young carers and a London 2 x day trip to include theatre to see Blood Brothers, sight seeing and a meal.
- **HITS**; will provide outings of local and regional interest to individual and groups of young carers. Carers will influence the type of event/break through consultation.
- **Arch Initiatives**; will offer one to one and group respite activities for young people aged between 0 – 19 years. The one to one sessions will enable the young carer to focus on specific issues that may face them with regards to being affected by their parents drinking or drug mis-use.
- **Halton Haven;** Will identify and provide individualised breaks for young carers based on their personal circumstances and may include holidays, theatre and cinema tickets and football matches.
- **HAFS**; To contribute to the development of facilities of the new teenagers room by providing equipment, which includes wide screen T.V, plus P.C. lap tops and games.

SECTION FIVE : PERFORMANCE AND FINANCE

PERFORMANCE ASSESSMENT

Halton Borough Council is currently rated as an 'Excellent' Authority and has a 3 Star Social Services rating and now a more challenging performance framework has been developed which requires councils to evidence a significant range of activities in order to achieve an adequate star rating.

NOTE: Areas where Councils will need evidence of supporting Carers/addressing their needs to even get an "adequate" performance now include:

- Good published information with opportunity to discuss with advisor where necessary
- Advocacy for Carers
- Rehabilitation recognising and supporting Carers needs
- Hospital Discharge processes recognising and supporting Carers needs
- End of Life Care
- Info re maintaining Carers health and well-being
- Inter agency coordination on the ground to support Carers and their families
- Support for families to avoid young Carers undertaking inappropriate care/ missing out on educational opportunities.
- Carers and their families being able to access community transport
- Independence Choice and Control for Carers (as well as service users)
- Carers access to leisure and community facilities
- Carers being involved in the work of voluntary organisations that support Carers
- A range of support services which are sensitive to Carers cultural needs
- A partnership approach to assessment (Carers recognised as expert partners in care)
- Named person to contact re the carers support plan and/or that of the person they look after
- Help to access Carer Direct Payments and Direct payments for the person they look after
- Carers involved in reviews (both their own and the person they look after)
- Sign posting Carers to appropriate services
- Carers enabled to understand their entitlement to service (and the entitlement for the person they look after)
- Carers helped to access work and training
- Working Carers helped to remain in work
- Workers appropriately trained
- Safeguarding Carers as well as service users
- Complaints processes which track outcomes/issues for Carers
- Help with financial information including benefits advice
- Demonstrating carer involvement and influence in our Strategic Planning and Commissioning Strategies

To achieve "performing well", Councils must be able to evidence most or all of the "adequate" characteristics and that:

- Carers are treated as expert partners and their quality of life is supported equally to those they care for.
- Carers report that their health and well-being needs and wishes are carefully taken into account.
- Carers have well-developed support and a greater than average range of options to choose from.
- Social care workers treat carers and families as partners. They have skills and knowledge to do this, even where needs are complex.
- Carers find that care and health workers are skilled in helping families who support people with more complex or intensive needs.
- Organisations led by people who use services and their carers are well supported and their views make a difference.
- Carers have specific opportunity to contribute and influence services.
- Carers have a copy of their support plan with a review date and contact.
- Carers are confident that making a complaint will not prejudice the support they receive.
- Carers can get personal advice about support options, and what the criteria on entitlement means for them.
- Carers have opportunities to combine work with caring. Many local employers recognise their needs and have flexible working conditions.
- Skilled advice helps many carers to maximise income available to them to reduce financial hardship caused by their caring role.
- Support schemes are flexible and help carers to work around individual employment and family needs and preferences
- Carers are provided with training opportunities to promote their skills and knowledge.
- Knowledge of population needs and the views of carers are comprehensive, and up to date.

The World Class Commissioning programme measures the PCT's performance against 3 domains; Outcomes, Competencies and Governance. *"The aim of world class commissioning, and therefore the ultimate test of its success, will be an improvement in health outcomes and a reduction in health inequalities"* Gary Belfield, Director of Commissioning, Department of Health.

NHS Halton & St Helens has recently been assessed for the second time, the result of which is an indication of progress in all three domains and the development of a Commissioning Strategic Plan (CSP) which sets out the case for action to improve health and tackle inequalities as well as the need to deliver effective services.

A key element in the CSP relates to young and adult carers, and outlines that:

- The PCT will ensure that work on the local carers agenda is linked to the work in both local authorities regarding the identification and support of carers to ensure that there is an assessment process to identify their health and emotional well-being needs, and pathways of support to meet their needs.

Work will be progressed during 2009/10 on the development of an appropriate Performance Framework to ensure that the Council and the PCT are appropriately positioned to respond effectively to the new performance requirements and this will include the development of an evaluation form. It is planned that the evaluation forms will be much more outcome based and will inform and influence the overall

development of service provision. It is intended to develop a system within the Assessment process; where Carers will be reviewed and the impact of the respite break or service intervention will be recorded. The focus on Carers health and well-being will be a priority and ways in which to reduce stress and maintain good health a clear target.

FINANCIAL ANALYSIS

Carers Grant 2008-2011

The carers grant is paid as part of the Area Based Grant. This is a non-ring fenced general grant. As such local authorities are able to determine locally how best to spend the Grant in order to deliver local and national priorities in their areas

Whilst there are no conditions attached to the Carers' Grant money for 2008/2011, the Care Quality Commission will continue to monitor the provision of services to support carers. The approach to carers set out in the Social Care Concordat 'Putting People First' should be reflected in the development of any services and policies.

As such the grant is currently utilized in the provision of services to carers. Outlined below are the details of planned spend during 2009/10 linked to the commissioning intentions outlined in section 4 of the strategy and identifies the number of carers that will be supported and breaks provided to those carers.

It should be noted that the Carers Grant is currently only available until March 2011 and it is unclear at the moment whether the Grant will continue past this date. It is anticipated that it would be unlikely that carers services could be funded within other resources currently available to the Local Authority. Therefore work will commence during 2009/10 on the development of a funding exit strategy outlining how the Commissioning Strategy could potentially be funded from April 2011; this could potentially look at alternative sources of funding from partner organisations or the redistribution of other funding available to the Local Authority.

2009/10 Carers Grant Allocation

Allocation for HBC	£647,000
Children Services Allocation (20%)	-£129,400
Total grant available for adult services	**£ 517,600**

NOTE: It should be noted that when figures are compared between service areas in terms of the numbers of breaks provided and the amount of grant allocated it does appear that in some areas there is some disparity across areas. This is due to the fact that some services/packages provided are more complex than others and therefore additional funds are required. This is kept under review by the Carer LIT Sub Groups, who are required to report on activity in terms of breaks provided/expenditure and outcomes for Carers to the Carers Strategy Group on a regular basis

FINANCIAL TABLES

Older People's Service
Carers Grant allocation in 2009/10 = £180,360

Organisation/Team/ Service	**Amount Allocated 2009/10**	**No. of Carers**	**No. of Breaks**
OPW	£39,621	150	1100
OPR	£39,621	150	1100
Oakmeadow	£25,686	26	1352
Let's Go Club	£5,500	95	1100
Halton Zipper Club	£1,000	25	784
Halton Haven	£1,000	50	100
Alzheimer's Society	£30,000	120	700
PSS	£7,932	12	299
New Service to be commissioned : One to one care/sitting service (July'09 onwards)	£30,000	**TBC**	**TBC**
TOTAL	**£180,360**	628	6535

Mental Health Service
Carers Grant allocation in 2009/10 = £32,000

Organisation/Team/ Service	**Amount Allocated 2009/10**	**No. of Carers**	**No. of Breaks**
MH Team	£26,000	100	900
Support Groups	£1,500	50	500
Training	£2,500	60	100
Contingency Fund (review Sept'09)	£2,000	N/A	N/A
TOTAL	**£32,000**	**210**	**1500**

ALD Services
Carers Grant allocation in 2009/10 = £40,726

Organisation/Team/ Service	**Amount Allocated 2009/10**	**No. of Carers**	**No. of Breaks**
ALD Team	£24,976	164	1000
Connect	£5,000	30	1580
Mencap	£5,400	156	3430
St Basil Discos	£350	30	1500
HAFS	£5,000	24	720
TOTAL	**£40,726**	**404**	**8230**

PSD Services
Carers Grant allocation in 2009/10 = £37,817

Organisation/Team/ Service	**Amount Allocated 2009/10**	**No. of Carers**	**No. of Breaks**
PSD Team	£22,000	102	747
Lets Go Club (swimming and sewing club)	£5,000	27	2280
Widnes and Runcorn Cancer Support Group	£5,000	80	1650
Breathe Easy Halton (BEH) Group	£1,420	10	30
Halton Happy Hearts	£1,500	70	2,000
Parkinson's Disease Society	£2,500	30	200
Contingency Fund (Review Sept'09)	£397	N/A	N/A
TOTAL	**£37,817**	**319**	**6907**

Young Carers Services
Carers Grant allocation in 2009/10 = £15,000

Organisation/Team/ Service	**Amount Allocated 2009/10**	**No. of Carers**	**No. of Breaks**
Deafness support	£1,000	10	40
Canal Boat Project	£4,000	10	50
Contingency Fund	£1,000	N/A	N/A
HITS	£3,000	11	50
ARCH Initiatives	£4,000	40	200
Halton Haven	£1,000	10	20
HAFSC	£1,000	11	122
TOTAL	**£15,000**	**92**	**482**

NOTE: No specific carers grant allocation has been provided to Carers of people with Drug and Alcohol problems, as it was agreed by the LIT Carers Sub Group for Drug and Alcohol that work would take place to ensure the better utilisation of Carers Services provided by Halton Carers Centre. This would be kept under review by the LIT Sub Group – Further details about the work of this group can be found on page 21 of this Strategy.

Generic Services
Carers Grant allocation in 2009/10 = £211,697

Organisation/Team/ Service	**Amount Allocated 2009/10**	**No. of Carers**	**No. of Breaks**
*Halton Carers centre - (HCC)	114,135	438	776
Emergency Respite	54,400	N/A	N/A

Service			
Publicity Materials	5,000	N/A	N/A
HCC – Complementary Therapy Service	13,000	250	1000
HCC – Carers Forum	9,162	800 - target members	460
HPIJ	16,000	40 – to be supported	N/A
TOTAL	**£211,697**	**1,528**	**2,236**

Halton & St Helens PCT contribute an additional £20k and the Children and Young People's Directorate contribute £30k to the infra structure and running costs of the Centre

PCT Carers Breaks Funding for 2009/10 and 10/11

Within the government's 10 year National Carers' Strategy published in 2008, one of the key commitments was the announcement that PCTs would receive £50m in 2009/10 and a further £100m in 2010/11 to provide breaks for Carers**.** This money has been given to the PCT as part of the total allocation and we will work in partnership with the council and third sector organisations to support breaks for carers.

2009/10	**£134K for Carers Breaks**
2010/11	**£268K for Carers Breaks**

SECTION SIX : IMPLEMENTING THE STRATEGY

INTRODUCTION

The strategic priorities and commissioning intentions outlined within this Joint Strategy will be closely monitored throughout the life of the Strategy via the Groups outlined in Section Three of this Strategy.

However, work will also take place to ensure that there is an appropriate infrastructure in place to implement the new strategy along with the development of an appropriate performance framework based on the action plan.

We will ensure that all carers services provided by the voluntary and statutory services are supported to set and deliver will set their individual targets on an annual basis and monitoring and performance feedback from those services will be provided on a quarterly basis through the Carers Strategy Group.

The feedback will include;

- Number of carers provided with a break
- Number of breaks provided
- The disability of the cared for person/connected team
- Age of carer
- Ethnicity of carer
- Number of assessments offered
- Outcomes for Carers

There is a particular emphasis on measurable outcomes for carers and this Strategy will demonstrate that Halton is in line with the best performing local authorities based on the national performance indicators.

There will be an annual review of carer services; which will include a Carer Consultation event and will contribute to the commissioning of future services and developments.

Carers will be encouraged to contribute their thoughts, opinions and experiences of carer services within Halton by joining Halton Carers Forum, Local Implementation Team (Sub groups for carers), Carers Reference groups and LINks, as well as steering groups and Service Development groups. It is essential that carers are involved in the development of services and monitor the performance and progress of those services.

JOINT COMMISSIONING STRATEGY ACTION PLAN

The Action Plan demonstrates how we will work towards the outcomes mentioned throughout the strategy. The National Carers Strategy has influenced the performance measures and local identified need. We have listed review dates and lead officers who will be responsible for/contribute to driving the aims forward and reporting on the outcomes.

Past records have demonstrated that we have exceeded targets/aims in certain areas; in particular we exceeded the number of assessments that were carried out in

2008/09. With this in mind, we will be pro-active in looking for opportunities to build upon our progress and update the action plan accordingly on an ongoing basis.

ACTION PLAN FOR 2009 – 2012
(To be reviewed annually)

*Adult Social Care Outcomes	Objective	Actions	Outputs/Outcomes	Links to National Carers' Strategy	Accountable Officer	Timescale
1. Improved Health & Emotional Wellbeing						
1.1	Carer Assessments	To provide assessments for carers; a) Halton Carers Centre (low threshold self assessments) b) Halton Borough Council c) Consideration to be given to FACS criteria in light of the Self Directed Support project	Increase numbers of carers that access an assessment and lead to provision of service/information or advice to ensure that their needs are being met.	• A life of their own • Income and Employment • Health and Wellbeing	Halton Carers Centre Manager Divisional Manager (Personalisation) Carers Assessors Carers Assessment Group	Ongoing – Review in November 2009
1.2	Department of Health Demonstrator Site	Partnership Bid to be to establish clear referral pathways and protocols for carers. To raise profile of carers issues and establish a more seamless service across Halton and St Helens	Increase numbers of carers accessing community based services and therefore reducing the deterioration of carer's health/conditions by providing information and services at an earlier stage.	• Health and Wellbeing	PCT Commissioning Manager (Community) Service Planning Manager Halton Carers Centre Manager	Ongoing – Review from Jan 2010 – Nov 2010
1.3	Complementary Therapy Service	Commission Halton Carers Centre to provide holistic therapies and	**250** carers having access for up to **1000** breaks in period	• Health and Wellbeing • A life of their	Halton Carers Centre Manager	Ongoing – Review quarterly

		pamper sessions, and trips	2009/10, leading to an improvement in health and wellbeing.	Own		
1.4	Promote Carer Issues	Distribute information through; newsletters, leaflets websites and face-to-face meetings.	Increase the numbers of previously hidden carers into services, resulting in more Carers within Halton, having increased knowledge about available services and their rights.	• A life of their own • Income and Employment • Health and Wellbeing	Carer Development Officer (in conjunction with all agencies and providers funded by the carer's grant and organisations including Primary Care Trust and Halton Borough Council)	Ongoing – Review in November 2009
1.5	Ensure that Halton & St Helens fully consider the needs of carers with the Development of Local Dementia Strategy	To provide clear direction of travel in relation to specialist services for people with dementia and their carers	Support the implementation of objective 7 from the National Dementia Strategy (see National Context – page 7)	• Health and Wellbeing	Joint Older People's Commissioning Manager	Ongoing
2. Improved Quality of Life						
2.1	Carer Participation	Increase involvement on groups: - a) LIT Sub Groups b) Carers Reference Group c) Carers Forum d) Personalisation	Commissioned services which meet the needs of the carer; and in which they monitor and evaluate throughout the year therefore	• Integrated and personalised services	Chairs of LIT Sub groups Halton Carers Centre Manager Divisional Manager	Ongoing – Review in November 2009

		Development Group	increasing the Carers voice and influence within service development		(Personalisation)	
2.2	Direct Payments	Assessors to offer and promote direct payments to those carers that wish to have more choice and flexibility in accessing services.	Increased choice and control for carers, ensuring that Carers have access to services, which offers more flexibility when Carers need it.	• Integrated and Personalised services • A Life of their own • Health and Wellbeing	Carers Assessors Direct Payments Team	Ongoing – Review in November 2009
2.3	Increased services for Young Carers	Halton Borough Council monitor the newly commissioned services suitable for young carers during the next carer's consultation	Young carers needs being met through increased flexibility and responsive services and which Carers have already influenced the commissioning of.	• A Life of Their Own • Integrated and Personalised Services	Young Carers Development Manager	Ongoing – Review in Jan 2010
2.4	Housing Support	Halton Borough Council to continue to include consideration for carers within their Housing Policy	Consideration being given to carers wishing to apply for housing	• Integrated and Personalised services	Housing Strategy Manager	Ongoing – Review in November 2009
2.5	Emergency Respite for Carers Service and Review	Opportunity to register for the Emergency Respite for Carers to those individuals where it is assessed as appropriate - Accessible through a Social Services Assessment for Carers.	Contingency plans for carers in case of an emergency reduce stress and anxiety	• A Life of Their Own • Health and Wellbeing	Divisional Manager (Intermediate Care) Service Development Officer (Carers)	Review – July 2009

2.6	Lifeline	Available for carers and the cared for – where it has been assessed as appropriate	Reduce stress and anxiety	• A Life of Their Own • Health and Wellbeing	Divisional Manager (Intermediate Care)	Review - October 2009
2.7	GP Enhanced Service for Carers	a) Available to carers within Halton - offers identification and a more flexible approach to carers needing to access primary care services. b) An annual audit to take place, which includes individuals from HBC, PCT and carers; to ensure that system is meeting the needs of carers and can shape future developments.	Increase carer's health and well-being and encourage carers to maintain their own health and to reduce long-term negative effects on carers.	• A Life of Their Own • Health and Wellbeing	PCT Commissioning Manager (Community)	Review - October 2009
2.8	Carers Breaks	To provide a range of breaks for Carers within Halton	To improve the quality of their lives by providing "time out" for Carers to focus on themselves and their own needs.	• A Life of Their Own • Health and Wellbeing	All agencies in receipt of Carers Grant funds	Review - quarterly
2.9	Leisure Cards	Halton Carers Centre to continue to issue Leisure Cards to carers who have registered with the Centre	To improve the quality of life to Carers within Halton and to offer the Carers chance to access flexible breaks when they most need	• A Life of Their Own • Health and Wellbeing	Halton Carers Centre Manager	Review - quarterly

			them.			
2.10	Develop a strategic approach to the distribution of Carer Information	Produce up to date Publicity Strategy 2009/12	To ensure that carers receive information and publicity to inform them about roles, responsibilities and expectations within their carer status, to indicate national and local developments and to outline services available within the borough for carers, better informing them about how they can influence and develop services within Halton.	• Leadership	Service Development Officer (Carers) /Carer Development Officer HBC	Review – September 2009
3. Making a Positive Contribution						
3.1	Defining a Carer	Review the definition and evaluate impact on fairer distribution of carers breaks	Carers having increased access to carer services. Carer services supporting the transition of change for carers	• A Life of Their Own	Service Development Officer (Carers)	June 2009

3.2	Carers' Day	To co-ordinate events and promote carers within Halton	Increase numbers of carers registering and accessing services within Halton	• A Life of Their Own • Income and Employment	Service Development Officer (Carers)/ Carers Development Officer	December 2009
3.3	Carers' Week	To co-ordinate events for carers and promote carer issues.	Increase numbers of carers registering and accessing services within Halton	• A Life of Their Own • Health and Wellbeing	Service Development Officer (Carers)/ Carers Development Officer	June 2009
3.4	Annual Carers Consultation Event	To set up an annual carers consultation.	a) To shape and develop services for carers and to review current services for carers. b) To increase numbers of carers that attended previous events	• Integrated and Personalised Services • Health and Wellbeing • A life of Their Own • Income and Employment • Young Carers	Service Development Officer (Carers)	January 2010
3.5	Promotional events and services	All partnership agencies to provide awareness raising presentations to raise the profile of carer's issues gathered through carer consultation events and feedback forms.	Improved services for carers by ensuring that staff understand the role of a Carer and the challenges that Carers face therefore being able to be more responsive and	• Integrated and Personalised Services • Health and Wellbeing • A life of Their Own • Income and Employment	Carers Development Officer (in conjunction with all agencies)	Review - August 2009

			receptive to Carers needs, when they access services.	• Young Carers		
3.6	Halton Carer Reference Group and Carers Forum	a) Carer involvement in the shaping and monitoring of carer services b) Participation in national survey	Services that will meet the needs of carers and enable services to be developed with a more transparent approach, therefore meeting the requests from Carers and ensuring a more equitable partnership within the development of those services.	• Integrated and Personalised Services • Health and Wellbeing • A life of Their Own • Income and Employment • Young Carers	Halton Carers Centre Manager	Review – November 2009
3.7	Continue to target "Hidden Carers"	a) Briefing sessions for staff teams across Halton. b) Continue to raise profile of Young Carers through Development of LIT Sub Group for YC and Continue presence in Other LIT Sub groups. c) Develop presentation to be delivered in schools and colleges	Increase numbers of Carers accessing services and therefore offer more Carers within Halton to receive the support and information that they need in order to maintain a life of their own and their health and wellbeing, as much as possible.	• Personalised Services • Health and Wellbeing • A life of Their Own • Income and Employment • Young Carers	Chair of Assessment Group and Sub LITS (Carers) for Local Authority, Carers Lead for PCT and Manager of Carers Centre and Carers Service Providers.	Review - December 2009

		in conjunction with other partnership agencies. d) Provide presentations to GP's, during their protected learning time. e) Re-establish Equal Opportunities Sub Group for Carers f) PCT to continue to commission Building Common Ground workshops				
4. Freedom from Discrimination & Harassment						
4.1	Religion, Culture and Ethnicity data collation can inform development of carer services (Ashley House, Halton Carers Centre – already collect this information)	All agencies/organisations to collect carer data	Carers from religious cultural, ethnic and/or minority community groups can receive services more suited to meet their needs – resulting in increased inclusion. Increase the numbers of people from BME communities	• Integrated and Personalised Services • A Life of Their Own • Health and Wellbeing	All Agencies Equal Opportunities Sub Group	Review quarterly – via Equal Opportunities Sub group

			accessing services			
4.2	Lesbian, Gay, Bisexual or Transsexual (LGBT) Carers	To carry out a consultation event (attend LGBT group) Primarily within Halton but otherwise consult group out of area if unable to contact Halton association	Increase numbers of LGBT carers registering for a service, and therefore being able to offer them the support and information that they need in order to continue in their caring role and to maintain their own health and wellbeing.	• Integrated and Personalised Services • A Life of Their Own • Health and Wellbeing	Service Development Officer (Cares)	Review quarterly – via Equal Opportunities Sub group
4.3	Equal Opportunities Sub Group for Carers	Re-establish group and set up women's day with Making Space. Establish women who are carers from Black, Minority or Ethnic (BME) Communities	Increase numbers of carers registering from BME communities and provide respite breaks to meet their needs, and to increase numbers of Carers within Halton that contribute to the development of suitable services.	• Integrated and Personalised Services • A Life of Their Own • Health and Wellbeing	Service Development Officer (Carers)/ Making Space BME workers	Review October 2009
5. Economic Well Being						
5.1	Opportunities to enter Training or Employment	Job Centre plus will be delivering a new government initiative, encouraging and supporting those carers	Carers having increased choice to improve their economic status and/or skills and	• Income and Employment • A Life of Their Own	Job Centre Plus	Review - September 2009

		that wish to return to work/training; to be given the opportunity to do so. Job Centre Plus will be working in partnership with Riverside College to deliver a 12 x week course for People with Substance mis-use problems and carers that wish to return to work or gain training.	knowledge base, contributing to increased choice about their own lives.			
5.2	Halton People into Jobs (HPIJ)	Halton People into Jobs, to provide training and support to carers wanting to return to work or to access training which will enable them to increase their potential to acquire work	Carers having increased choice to improve their economic status and/or skills and knowledge base in order to secure employment if they so wish	• Income and Employment • A Life of Their Own	HPIJ	Review - quarterly
5.3	Training to Staff and Other Professionals	Training to delivered by Carer Development Officer, Halton Borough Council and Halton Carers Centre staff in partnership to other professionals	Improve partnership working and communication between teams in order to provide a more seamless service for Carers, and to ensure that Carers receive a more supportive and	• Integrated and personalised services	Carer Development Officer Halton Carer Centre Manager	December - 2009

			efficient response from service providers.			
5.4	Halton Borough Council Community Bridge Building Service	To help carers and the cared for person access practical help and support.	Increase confidence of Carers and improve potential to increase economic well being	• A Life of their Own • Integrated and Personalised Services • Health and Wellbeing	Principal Manager (Bridge Building Service)	Review – September 2009
5.5	Halton Carers Centre	Provides a signposting and information service for carers who wish to find out more about their rights about benefits and support.	Increase numbers of carers accessing benefits and increasing economic wellbeing.	• A Life of Their Own • Integrated and Personalised Services. • Health and Wellbeing • Income and Employment	Halton Carers Centre Manager	Review - quarterly
5.6	Caring with Confidence	Provides training about the knowledge and essential skills required as a carer	To increase carers confidence about their caring skills and knowledge, in a safe and supportive learning environment.	• Health and Wellbeing • Income and Employment • A Life of their Own	Halton Carers Centre Manager	January 2010
5.7	Halton Welfare Benefits Team	Can provide advice and information about carer's financial positions	Increase numbers of carers who are informed about financial implications and more informed about making	• Income and Employment	Welfare Benefits Manager	December 2009

			changes.			
5.8	Flexible Working for Halton Borough Council Employees	Halton Borough Council continue to offer flexible working conditions, policies and practices for employees who have caring responsibilities.	Reduced stress in working conditions for HBC staff that have caring responsibilities, therefore helping them to maintain better health and wellbeing and to support their caring status where possible.	• A life of Their Own • Integrated and Personalised Services • Income and Employment • Health and Wellbeing	HBC's Flexible Working Group	Review – September 2009
5.9	Increase support resources for Parents with Disabled Children	Establish Support Group for Parents with Disabled Children	To increase information support and networking for parents with disabled children.	• A life of their own	Halton Carers Centre Manager	Review; July November and March
5.10	Maximise resources available to support delivery of Commissioning Strategy.	Develop of an exit strategy outlining how the Commissioning Strategy could potentially be funded from April 2011.	Use of resources will be efficient and effective; and will be targeted to meet identified commissioning priorities.	• Effective planning and use of resources will impact on the delivery of all targets	Carer Development Officer (in conjunction with all agencies and providers funded by the carer's grant and organisations including Primary Care Trust and Halton Borough Council)	Work to commence 2009/10- exit strategies to be complete by Sept 10.

- Where possible, linkages have been made with the current Adult Social Care Outcomes

Please note that the Action Plan will be reviewed and refreshed annually and that the deadlines, targets and priorities may changes according to National or Local directives and through identified need as a result of the annual Carers' Consultation events.

REFERENCES

1. A Community Strategy for a Sustainable Halton: 2006 – 2011
2. Halton Borough Council's 'It's all Happening in Halton' The Corporate Plan: 2006 – 2011
3. Parenting Support Strategy 2007-2010
3. The State of the Borough in Halton Report – 2008
4. Local Area Agreement 2008
5. Joint Strategic Needs Assessment (Health & Wellbeing) 2008
6. Young Carers - Is the harm still hidden? Best, Witton, Homayoun, Manning and Day – 2007

GLOSSARY OF TERMS

NHS National Health Service

PCT Primary Care Trust

GP General Practitioner

CSCI Commission for Social Care Inspection

IMD Index of multiple Deprivation

SOA's Super Output Areas

LIT Local Implementation Teams

FACS Fair Access to Care

HAFS Halton Autistic Family Support

LGBT Lesbian, Gay, Bisexual and Transgender

HITS Hope Inclusion, Time, Success

DAA Drug and Alcohol service

AMH Adult Mental Health team

DP Direct Payments

APPENDIX 1

The Carers (Recognition and Services) Act 1995

The Carers (Recognition and Services) Act 1995 was implemented in April 1995. Under this legislation:

- All carers of any age are given the right to request their own carers assessment
- The carers assessment looks at the ways in which the carer can be supported in their caring role
- The information from the carers assessment can be used to increase the services to the cared for person

The Carers and Disabled Children's Act 2000

The Carers and Disabled Children's Act 2000 was introduced in April 2001. Under this legislation:

- Unpaid carers over the age of 16 years who are caring for an adult have the right to request a separate assessment of their own needs. A carer may request his or her own carers assessment, even when the person they care for refuses their own assessment or support services
- People with parental responsibility for disabled children may also request a carers assessment
- Children's views are taken into account with the provision of service
- Local authorities have the power to provide services directly to carers to help maintain their health and safety and support them in their caring role
- Services to carers may be provided in a variety of ways, such as Direct Payments to carers

The Children's Act (1989)

This law states that the child's safety and wellbeing are the most important things and stresses the importance of helping families who are in need. Children in need are those that may not have the opportunities to achieve or develop fully without help from carers or support services.

The Carers Equal Opportunities Act 2004

This Act became law from 1st April 2005. The law has numerous positive effects for carers in Halton. It means that carers will:

- Be told about their rights to their own carers assessment
- Have their wishes to remain in, or return to work and education, taken into account when decisions are made about support given to the person they care for
- Have better information about opportunities for work, education, training and leisure
- Benefit from more emphasis on joint working between statutory services such Halton Social Services, the NHS Halton and St Helens and 5 Boroughs Partnership NHS Trust
- Carers will have equal access to services, advice and information and support regardless of gender, age, race, disability, religious beliefs and sexual orientation.

Benefits of the legislation include:

- More carers being able to continue in work or study whilst caring
- Increase the employability of carers who wish to return to work or study
- More opportunities for carers to have access to education, training and leisure services and lead to a more fulfilled life

Living well with Dementia: A National Dementia Strategy (Feb. 2009)

The aim of the Strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia.

Objective 7: of the Dementia Strategy identifies that family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' strategy are available for carers of people with dementia. This will include good quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

The Mental Capacity Act (2005)

The Mental Capacity Act applies to all individuals in England and Wales who are aged 16 and above and who lack capacity to make decisions. Hence everyone directly involved in the care of such individuals or employed in health and social care will be subject to the Act.

An individual demonstrably lacking capacity will need someone (often their carer) to make decisions on their behalf. The more important the decision the greater the likelihood that more people will be involved. An assessment must be made for each decision.

If an individual is shown to lack capacity then those acting on their behalf must do so in the 'best interests' of the person. It is important to ensure that 'best interests' actually represents the person's true wishes. Carers are often best placed to provide such information.

The NHS and Community Care Act (1990)

Means councils must involve families and carers when making plans for helping vulnerable people in the community

Quality Standards

The King's Fund, after extensive consultation with voluntary organisations, statutory bodies, social service departments and health authorities, published **Quality**

Standards for Local Carer Support Services in 2002. There are five quality standards, which include:

- Information
- Providing a break
- Emotional support
- Support that helps carers to care and maintain their own health
- Having a voice

White Paper: Our Health, Our Care, Our Say

The White Paper, published in January 2006, sets out the reforms intended to develop modern and convenient health and social care services. The White Paper acknowledges the vital role carers play. They provide a valued preventative service and it is imperative they and their families receive good quality, flexible and tailored support services in order to work and live their lives.

APPENDIX 2

Performance Framework

With effect from 1.4.09, the work of Commission for Social Care Inspection transferred to the new Care Quality Commission; which is the auditing body for the Local Authority.

At the CSCI (Commission Social Care Inspection) Carers Improvement Board in February 2009, Baroness Young the Chair of the Care Quality Commission and senior managers in CSCI (Commission Social Care Inspection) highlighted that the new outcomes and performance characteristics require a significant shift in focus - giving far greater emphasis to support for Carers than in the past and with a need to evidence outcomes for Carers. This is really very radical, making Carers everybody's business in a way that has never quite been the case before.

Appendix 3

Defining a Carer in Halton

A former carer within Halton can access carer's breaks and training from the Halton Carers' Centre for up to 12 months after they cease to be a carer through either bereavement or change of circumstances where the 'Cared For' person moves:

- into either a nursing home
- 24 hour residential setting
- their own tenancy
- a supported tenancy

Where the 'Cared For' person has gone into a residential setting or a nursing home, the Carer would have to demonstrate that they are continuing to provide care to the person which is in addition to the usual family relationship that they may have, i.e. they would need to be included in a Care Plan in order to continue to be recognised as a Carer and access carer breaks and training from the Halton Carers' Centre.

APPENDIX 4

ELIGIBILITY CRITERIA FOR CARERS OF ADULTS

Support will be provided if you are a carer and if:

Priority 1 **Critical**	**Priority 2** **Substantial**	**Priority 3** **Moderate**	**Priority 4** **Low**
You: • Are providing substantial amounts of essential care and are at immediate risk of collapse • Are at immediate risk of abuse • Are at high risk in regard to health and safety • Are no longer willing or not able to care and there is a high risk of the cared-for person entering hospital	***You:*** • Are providing substantial amounts of care and are at high risk of collapse • Are providing substantial amounts of care and without help the person cared for would need immediate care support • Are no longer willing or not able to provide care • Are at risk of abuse or risk with regard to health and safety	***You:*** • Are providing substantial amounts of personal care and without some assistance you may no longer be able to provide care • Are at some risk to your health/safety	***You:*** • Provide substantial amounts of care but experience limited difficulty in providing support to person cared for • Are at no risk with regard to health and safety

CHILDREN WITH DISABILITIES

NEEDS ASSESSMENT MATRIX

AND

ALLOCATION OF RESOURCES

Severity / Outcomes	LOW LEVEL OF NEED		MEDIUM LEVEL OF NEED		HIGH LEVEL OF NEED	
	☐		☐		✓	
Be Healthy: • Nature of disability • Dependency • Demand on Carer	Child needs routine medical checks only and requires no or minimal nursing care/support/treatment/		Child has unstable health and needs regular nursing care and support and/or complex medical care		Child has life limiting condition and requires daily nursing care and support and/or regular admissions to hospital	
	Child uses specialist equipment that does not require operational assistance		Child uses specialist equipment that needs operational assistance		Daily use of specialist equipment by child that needs operational assistance	
	Child has minimal therapy needs		Child has a planned programme of therapy		Child requires intense therapy programme	
	Child requires minimal help with personal care		Child needs daily support with basic self care functions e.g. eating, toileting, washing, dressing		Child is totally dependent on others for all basic self care functions e.g. eating, toileting, washing, dressing	
	Child is independently mobile		Child requires help with mobility and lifting		Child requires specialist aids for mobility	
	Child has some awareness of dangers and is able to function independently in the environment		Child has limited awareness of dangers and needs help to function in the environment		Child has no awareness of dangers and is dependent on others to function in the environment	
	Carer has no physical/mental health problems		Carer has some physical / mental health problems affecting ability to care		Carer has severe physical / mental health problems which have major implications for caring role	
	Low level of risk to health/safety of carer		Moderate level of risk to health/safety of carer		High level of risk to health/safety of carer	

Severity / Outcomes	LOW LEVEL OF NEED		MEDIUM LEVEL OF NEED		HIGH LEVEL OF NEED	
					✓	
Stay Safe: • Behaviour • Family dynamics • Support Networks • Environment	Child requires supervision in some circumstances		Child requires continual supervision throughout the day and occasionally at night		Child requires constant monitoring/supervision both during the day and at night	
	Behaviour is not a risk to self or others (including self harm) and requires minimal management		Behaviour is a moderate risk to self or others (including self harm) and requires some input to manage		Behaviour is a serious risk to self or others (including self harm) and requires structured behaviour management programme	
	No child protection issues		Child has been subject to Section 47 enquiries/Child in Need Plan		Child has a Child Protection Plan	
	Child is only person in household with disabilities		One other person with disabilities who needs some support in household		More than one other person in household with disabilities who needs some support	
	More than one carer		Sole carer but has a support network		Sole carer with no support network	
	There are no pressures in the family other than caring for child		There are some other pressures in the family		There are complex family problems e.g. domestic violence, frequent changes in household, substance misuse	
	Where the child lives is a safe environment		There is sometimes risk for the child because of the physical environment		Where the child lives is not safe because of the physical environment	

Severity / Outcomes	LOW LEVEL OF NEED		MEDIUM LEVEL OF NEED		HIGH LEVEL OF NEED	
	There is no risk of the child's placement breaking down		There is some risk of the child's placement breaking down		There is a high risk of the child's placement breaking down	
Enjoy and Achieve: • School • Hobbies	Child attends a unit in mainstream school, special school in the Borough or college		Child attends a special school in the borough with additional support or an out of borough placement		Child attends a complex needs out of borough placement with specialised package of support.	
	Child needs support to pursue interests and activities		Child needs 1 – 1 support to pursue inclusive interests and activities or requires specialised activities		Child can only purse specialised activities with support	
Make a Positive Contribution: • Risky Behaviour • Friendships • Communication	Child is confident and shows some understanding of risk situations		Child lacks confidence and is vulnerable to exploitation and bullying		Child has very limited understanding of risk situations and is extremely vulnerable	
	Child requires minimal support with communication		Child has significant communication difficulties		Child needs a skilled person to interpret communication	
	There are no difficulties in relationships with peers or siblings		There are stressful family relationships and/or some difficulties in relationships with peers		There is potentially harmful conflict with siblings and/or significant difficulties in relationships with peers	
	Child can adapt to different situations with support		Child needs to be prepared in advance for a change in routine		Child becomes extremely distressed following any small change to daily routine	

Severity / Outcomes	LOW LEVEL OF NEED		MEDIUM LEVEL OF NEED		HIGH LEVEL OF NEED	
					✓	
	Child able to express their views with support		Child needs specialist support in order to express their views		Child has extremely limited ability to express views even with support	
Economic Wellbeing: • Finance • Housing • Transport	The family are receiving all financial entitlements		The family needs to budget carefully to meet financial commitments		The family is on a low income and has financial problems	
	The family's accommodation is suitable and needs no adaptation		The family's accommodation is not totally suitable but does not need adaptation		The family's accommodation needs adaptation to meet the needs of the child	
	The child qualifies for low/medium rate DLA		The child qualifies for higher level DLA both for care and mobility		The child qualifies for higher level mobility DLA and needs a specially designed vehicle	
	The child will need support to continue in education, employment or training		The child will need individual support to continue in education, employment or training		The child will need a specialist adult care package	

SUMMARY

Overall Assessment of Need	Description	
Low	Need can be met by community based universal and/or preventive services	
Medium	Child would not have a reasonable standard of health and welfare due to a significant disability without the provision of specialist services	
High	Child has complex care needs requiring the input of specialist services	

ALLOCATION OF RESOURCES

Level of Need	Criteria, including risk factors	Desired outcomes of services	Examples of services **that might appropriately be provided at this level**
Low	1.Child needs routine medical checks only and requires no or minimal nursing care/support/ treatment 2.Child uses specialist equipment that does not require operational assistance 3. Child has minimal therapy needs 4. Child requires minimal help with personal care 5. Child is independently mobile 6.Child has some awareness of dangers and is able to function independently in the environment	Promotion of child's health Maintain a satisfactory level of personal care Safeguarding the child against abuse or neglect	1. Information about community facilities 2. Supported access to community facilities 3. Referral to community organisations for support in the home 4. Referral for occasional day and evening support within the community

Level of Need	Criteria, including risk factors	Desired outcomes of services	Examples of services **that might appropriately be provided at this level**
	7. Carer has no physical/mental health problems 8. Low level of risk to health/safety of carer 9. Child requires supervision in some circumstances 10. Behaviour is not a risk to self or others (including self harm) and requires minimal management 12. No child protection issues 13. Child is only person in household with disabilities 14. More than one carer 15. There are no pressures in the family other than caring for child 16. Where the child lives is a safe environment 17. There is no risk of the child's placement breaking down 18. Child attends a unit in mainstream school, special school in the Borough or College 19. Child needs support to pursue interests and activities 20. Child is confident and shows some understanding of risk situations 21. Child requires minimal support with communication 22. There are no difficulties in relationships with peers or siblings 23. Child can adapt to different situations with support 24. Child able to express their views with support 25. The family are receiving all financial entitlements 26. The family's accommodation is suitable and needs no adaptation 27. The child qualifies for low/medium rate DLA 28. The child will need support to continue in education, employment or training	Prevent breakdown of family or social networks Live in a safe home environment Promotion of social inclusion	5. Short term social work input on specific issues e.g. newly diagnosed, transition 6.Signposting to other agencies for advice regarding issues such as allowances, housing and carer support groups
Medium	1. Child has unstable health and needs regular nursing care and support and/or complex medical care 2. Child uses specialist equipment that needs operational assistance 3. Child has a planned programme of therapy		

Level of Need	Criteria, including risk factors	Desired outcomes of services	Examples of services **that might appropriately be provided at this level**
	4. Child needs daily support with basic self care functions e.g. eating, toileting, washing, dressing 5. Child requires help with mobility and lifting 6. Child has limited awareness of dangers and needs help to function in the environment 7. Carer has some physical / mental health problems affecting ability to care 8. Moderate level of risk to health/safety of carer 9. Child requires continual supervision throughout the day and occasionally at night 10. Behaviour is a moderate risk to self or others (including self harm) and requires some input to manage 12. Child has been subject to Section 47 enquiries/Child in Need Plan 13. One other person with disabilities who needs some support in household 14. Sole carer but has a support network 15. There are some other pressures in the family 16. There is sometimes risk for the child because of the physical environment 17. There is some risk of the child's placement breaking down 18. Child attends a special school in the borough with additional support or a specialised out of borough placement 19. Child needs 1 – 1 support to pursue inclusive interests and activities 20. Child lacks confidence and is vulnerable to exploitation and bullying 21. Child has significant communication difficulties 22. There are stressful family relationships and/or some difficulties in relationships with peers 23.Child needs to be prepared in advance for a change in routine 24 Child needs specialist support in order to express their views 25. The family needs to budget carefully to meet financial commitments 26. The family's accommodation is not totally suitable but does not need adaptation	Promotion of child's health Maintain a satisfactory level of personal care Safeguarding the child against abuse or neglect Support parents/carers in looking after child Prevent family breakdown or breakdown of social networks Live in a safe home environment Promotion of child's interests and social networks Promotion of social inclusion	1. Information about community facilities 2. Supported access to community facilities 3. Regular day and evening support within the community 4. Short term social work input on specific issues e.g. newly diagnosed; transition 5. Outreach support from Community Support Workers 6. Basic level direct payments 7. Occasional overnight stays up to 45 nights a year

Level of Need	Criteria, including risk factors	Desired outcomes of services	Examples of services **that might appropriately be provided at this level**
	27. The child qualifies for higher level DLA both for care and mobility 28. The child will need individual support to continue in education, employment or training		
High	1. Child has life limiting condition and requires daily nursing care and support and/or regular admissions to hospital 2. Daily use of specialist equipment by child that needs operational assistance 3. Child requires intense therapy programme 4. Child is dependent on others for all basic self care functions e.g. eating, toileting, washing, dressing 5. Child requires specialist aids for mobility 6. Child has no awareness of dangers and is dependent on others to function in the environment 7. Carer has severe physical / mental health problems which have major implications for caring role 8. High level of risk to health/safety of carer 9. Child requires constant monitoring/supervision both during the day and at night 10. Behaviour is a serious risk to self or others (including self harm) and requires structured behaviour management programme 12. Child has a Child Protection Plan 13. More than one other person in household with disabilities who needs some support 14. Sole carer with no support network 15. There are complex family problems e.g. domestic violence, frequent changes in household, substance misuse 16. Where the child lives is not safe because of the physical environment 17. There is a high risk of the child's placement breaking down 18. Child attends a complex needs out of borough placement with specialised package of support 19. Child can only purse specialised activities with support	Promotion of child's health Maintain a satisfactory level of personal care Safeguarding the child against abuse or neglect Support parents/carers in looking after child Prevent family breakdown or breakdown of social networks Live in a safe home environment	1. Information about

Level of Need	Criteria, including risk factors	Desired outcomes of services	Examples of services **that might appropriately be provided at this level**
	20. Child has very limited understanding of risk situations and is extremely vulnerable 21.Child needs a skilled or familiar person to interpret communication 22. There is potentially harmful conflict with siblings and/or significant difficulties in relationships with peers 23. Child becomes extremely distressed following any small change to daily routine 24. Child has extremely limited ability to express their views even with support 25. The family is on a low income and has financial problems 26. The family's accommodation needs adaptation to meet the needs of the child 27. The child qualifies for higher level mobility DLA and needs a specially designed vehicle 28. The child will need a specialist adult care package	Promotion of child's interests and social networks Promotion of social inclusion	community facilities 2. Frequent day and evening support within the community 3. Intensive individual social work support 4. Outreach support from Community Support Workers 5. Enhanced level direct payments 6. Regular overnight stays over 45 nights a year

Level of Need	Criteria, including risk factors	Desired outcomes of services	Examples of services **that might appropriately be provided at this level**
			In Exceptional **Circumstances:** 1.Foster placement 2. Residential placement

REPORT TO:	**Halton Health Policy and Performance Board**
DATE:	**15th September 2009**
REPORTING OFFICER:	**Strategic Director Health and Community**
SUBJECT:	**Older People's Commissioning Strategy**
WARDS:	**All**

1.0 PURPOSE OF THE REPORT

1.1 To present the Older People's Commissioning Strategy

2.0 RECOMMENDATIONS:

(1) Comment on the overall strategy

3.0 SUPPORTING INFORMATION

3.1 The new Older People's Commissioning Strategy builds on a previous strategy that covered 2004-2008. This new strategy aims to bring the plans for older people's services up to date and clearly identify the commissioning priorities for the next five years.

3.2 The commissioning strategy is important for two main reasons, it gives context for what we are intending in relation to commissioning and it also acts as a performance measure. This will enable us to monitor our progress against the actions and targets.

3.3 The lead arrangements for each partnership commissioning area are as follows

Commissioning Area	Lead Organisation
Older People (inc Intermediate Care)	**Local Authority**

3.4 Two consultation events involved a range of commissioning staff, providers, voluntary sector representatives, independent providers and service users and carers. In addition to these events a number of one-to-one meetings were carried out to ensure that a wide range of views were covered. The main themes of the commissioning strategy reflect the consultation that was completed.

3.5 The older people's commissioning strategy will work in conjunction with a range of other policy documents both nationally and locally to help shape services in the next three years. This strategy aims to improve the commissioning cycle within older people's services to help address and

improve the key areas identified in the strategy.

4.0 POLICY IMPLICATIONS

4.1 White Paper: Our Health, Our Care, Our Say

The White Paper, published in January 2006, sets out the reforms intended to develop modern and convenient health and social care services. The White Paper acknowledges the importance of joint commissioning and ensuring quality research, data and evidence to effectively procure the right services to meet the needs of an individual.

4.2 Personalisation

On 17th January 2008, the Department of Health issued a Local Authority Circular entitled "Transforming Social Care". The Circular sets out information to support the transformation of social care signalled in … *Independence, Well-being and Choice* and re-enforced in … *Our Health, our care, our say: a new direction for community services.*

4.3 Living well with dementia: A National Dementia Strategy (Feb. 2009)

The aim of the Strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia. This strategy should be a catalyst for a change in the way that people with dementia are viewed and cared for England.

4.4 THE LOCAL CONTEXT

The challenges and opportunities facing Halton has led to the identification of a number of priorities for the Borough (outlined in the Community Strategy 2006-2011) over the medium term with the overall aim of making it a better place to live and work.

Commissioning Strategy for Carers (Due Sept 09)

The Joint Commissioning Strategy has been developed via ongoing consultations and contributions from stakeholders who provide services to carers as well as carers themselves. We have listened to what carers have told us about the help and support that they need and have responded by addressing the issues throughout the Strategy.

Local Area Agreement

The Local Area Agreement (LAA) is the framework used to deliver Halton's vision as mentioned earlier. The LAA is a target based process that focuses on the five agreed priorities.

- **A Healthy Halton**

- **Halton Urban Renewal**
- **Employment learning and skills in Halton**
- **Children & Young people in Halton**
- **A Safer Halton**

Commissioning Strategic Plan

- This document was produced in 2008 by NHS Halton & St Helens and clearly outlines the need to change, the key priorities and the investment required to make a difference within the health equalities in Halton.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children and Young People in Halton

None

5.2 Employment, Learning and Skills in Halton

Within a number of the commissioning areas the targets for services will be linked to supporting vulnerable service users to access education, training and employment opportunities. This has been identified as a Local Area Agreement target (NI150) within Mental Health and is also an important part of stroke rehabilitation.

5.3 A Healthy Halton

Each of the service areas covered in the strategy is expected to clearly demonstrate a positive impact on the health and well-being of service users in Halton. This includes performance towards healthier lifestyles, better access, improved accommodation, dignity and improved mental health outcomes.

5.4 A Safer Halton

Contracts within this report will be able to support specific Local Area Agreement targets linked to information provision, satisfaction with services and overall perception of the area that they reside. These targets will be agreed as part of any revised contract and will be monitored through the relevant Commissioning Manager.

5.5 Halton's urban renewal

None

6.0 FINANCIAL IMPLICATIONS

6.1 Commissioning priorities for each of the service areas have been identified and work has begun to clearly identify the financial implications of individual pieces of work in the future. These final elements will be completed before submission to the Councils Executive Board.

6.2 One of the main implications that will need to be addressed will be the need to redesign existing services, not just create new services. This will take place across a range of service areas including mental health, prevention / early intervention and accommodation based provision.

7.0 RISK ANALYSIS

7.1 This strategy outlines the key risks and issues that commissioning faces in the next three years. If these areas are not addressed then the risk to health inequalities, economic burden, strain on frontline health and social care services would be extreme. The strategy sets out in the quality of life section a continuing shift toward improved lifestyle and an increase in preventative service provision.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The Older People's Commissioning Strategy addresses issues of equality and diversity for a range of service users. It ensures that access to services is not restricted because of age, mental health and well-being, limiting illness. It also considers alternative and diverse methods to address the needs of older people in Halton. Two key messages from the strategy relate to maintaining the dignity of all people accessing services and ensuring that nobody is discriminated on the grounds of age.

HALTON
BOROUGH COUNCIL

JOINT COMMISSIONING STRATEGY FOR OLDER PEOPLE

2009 - 2014

Draft

CONTENTS

Executive Summary

PRINCIPLES OF THIS STRATEGY

This document sets out the overarching strategy for the commissioning, design and delivery of services to older people in Halton. The document stands alongside and complements the Corporate Plan for the Council, the Health and Community Directorate's Business Plan 2009-2012 and the NHS Halton and St Helens Commissioning Strategic Plan.

The Strategy outlines the vision, aims and fundamental values and principles underpinning the design and delivery of services to Older People and identifies the local and national drivers and influences that impact on its delivery. It outlines the commissioning intentions relating to older people's services and will reference a range of specific strategies and documents that support in more detail particular workstreams.

The Strategy attempts to facilitate better business planning for current and prospective provider organisations. It aims to enhance and assure quality with regard to the provision of services to Carers and to demonstrate value for money.

This document covers older people's commissioning within Halton, however it needs to be considered and developed within our current priorities. The sections that follow are not exhaustive, but have been identified through stakeholder and service user feedback, as well as being both nationally and locally acknowledged as priority areas for older people's services.

It is also important to acknowledge that this strategy gives a clear overview and aims to set the direction of travel for commissioning over the next three years, this will be achieved through the initial action plan that forms part of this document. The action plan will be reviewed and updated on an annual basis through the Older People's Local Implementation Team, this will be described in the Governance Arrangements below.

The Older People's Local Implementation Team's has dignity at the heart of developments in the future and this strategy aims to use the dignity agenda when considering the commissioning intentions of services in Halton. The dignity challenge states:

- Have a zero tolerance to all forms of abuse
- Support people with the same respect you would want for yourself or a member of your family
- Treat each person as an individual by offering a personalised service
- Enable people to maintain the maximum possible level of independence, choice and control
- Listen and support people to express their needs and wants
- Respect people's right to privacy
- Ensure people feel able to complain without fear of retribution
- Engage with family members and carers as care partners
- Assist people to maintain confidence and a positive self-esteem
- Act to alleviate people's loneliness and isolation

Objectives for the next five years

There are five key areas that make up the priority areas that will see commissioning investment for the next five years. Each of these areas will be addressed in more detail in the full document and are summarised later in this section. The financial investment within commissioning will focus on:

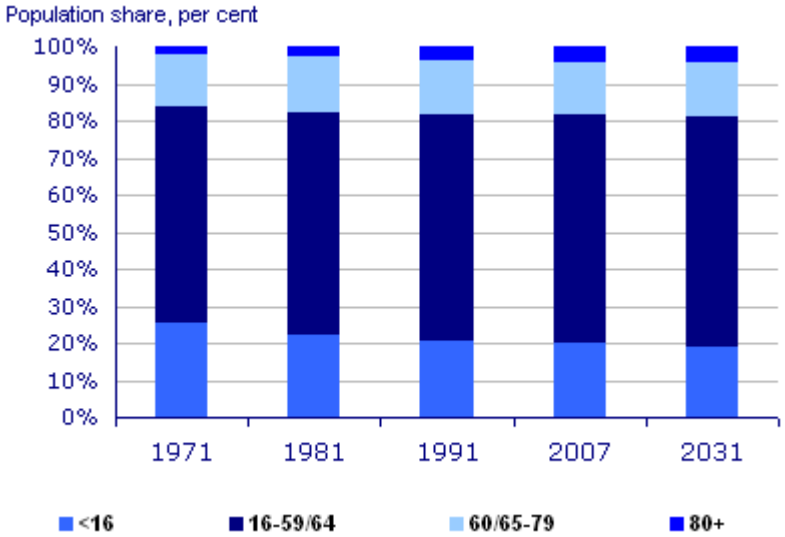
- The Development of Assessment, Care and Treatment Service (ACTS)
- Redesign of dementia services to ensure a shift from bed based investment to a greater proportion of community or prevention services
- Development of Psychological support for stroke survivors
- Increased specialist training linked to major illness and mental health (e.g. Stroke, depression, dementia etc.)
- Redesign of low-level information provision for older people's services
- Commissioning of additional extra care units

A number of additional commissioning priorities will emerge throughout the life of this strategy and many will only become apparent once completion of reviews and evaluation of existing services. Any newly commissioned, redesigned or continued service will have at it's heart all of the messages from the Dignity agenda. This will ensure that all services will be in a position to offer the highest level of quality for Older People in Halton.

The Issue facing older people

Ageing Population

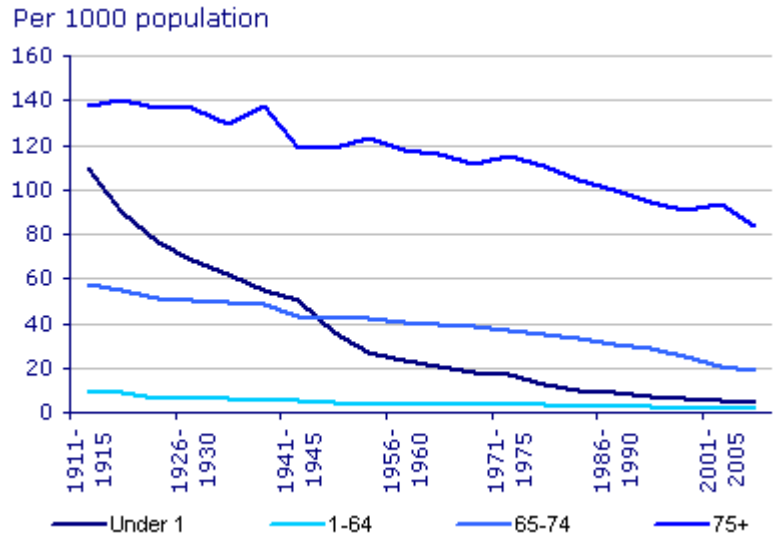
The percentage of the population aged under 16 has been declining since 1995 and this coupled with an ageing population has for the first time ever, seen the under 16 population drop below the percentage of the population of state pensionable age. Average growth in the population aged over state pensionable age between 1981 to 2007 was less than one per cent per year, however, between 2006 and 2007 the growth rate was nearly 2 per cent.



This growth is partly due to the number of women born in the immediate post World War Two baby boom who reached state pensionable age in 2007. These women were born in 1947, the men born in the same year will state pensionable age in 2012.

The fastest growing age group in the population are those aged 80 years and over who currently constitute 4.5 per cent of the total population. This age group has

increased from 2.8 per cent to 4.5 per cent between 1981 and 2007 and this trend is expected to continue over the coming decade. The reasons attributed to this increase include improvements in mortality at older ages over the second half of the 20th century.



The mortality rate in England and Wales for the population aged over 75 has fallen from 137 deaths per thousand in 1911 –1915, to 83 deaths per thousand in 2006 – 2007. The mortality rate for the population aged between 65 and 74 has declined by two thirds over the same period, from 57 to 19 deaths per thousand.

Although Halton is below the national mortality rate in the above age groups the trends are the same and the older population in Halton is expected to increase as follows.

Halton population aged 65 and over, in five year age bands, projected to 2025.

	2008	2010	2015	2020	2025
People aged 65-69	5,200	5,400	7,300	7,000	7,100
People aged 70-74	4,300	4,500	4,900	6,600	6,400
People aged 75 – 79	3,300	3,400	3,700	4,100	5,700
People aged 80 – 84	2,200	2,300	2,500	2,900	3,200
People aged 85 and over	1,800	1,800	2,100	2,500	3,100
Total Population 65 and over	**16,800**	**17,400**	**20,500**	**23,100**	**25,500**

- **Older People's Mental Health –**

Most older people in the UK have good mental health and well-being, but a significant minority have mental health symptoms that impact adversely upon their quality of life, increasing feelings of isolation or exclusion.

Truly person centred services and health promotion activities, by necessity, span a wide range of teams and services and we need to provide a vision for partnership working across Primary Care, Social Care and Specialist Services, Local Authority Housing, Statutory, Independent and Not for Profit sectors.

Most importantly, we need to explore working in partnership with the people who are experiencing our services – the clients, their family and carers. If our services are not known, used and trusted by our local population, we have failed.

- **Detection of Major Illnesses –**

Life expectancy at birth is a major indicator of overall health and whether the local population die younger than England as a whole. Life Expectancy is a key Government target: The national Public Service Agreement (PSA) for improving the health of the population aims:

- To increase the life expectancy at birth in England to 78.6 years for men and to 82.5 years for women by 2010 and;
- Reduce the inequalities in life expectancy at birth by 10% between the lowest fifth of local authority districts and the average for England by 2010.

Halton is a Local Authority district that experiences some of the poorest health, and thus are required to meet differential 'stretched' mortality targets to narrow the inequalities gap. An indicator of whether we are achieving this is to look at the gap between local life expectancy at birth and national figures. Life expectancy for both Males and Females has improved in Halton between 1991-1993 and 2004-2006 with Males living on average an extra 2.4 years and females living an extra 0.6 years.

- **Accommodation based services –**

Within the Joint older people's commissioning strategy we need to consider the accommodation needs of Older People. This relates to a range of provision including nursing, residential, extra-care housing, sheltered accommodation, registered social landlord and privately owned properties. As well as considering the mix of people supported to live in their own home compared to residential, we also need to consider an individuals needs in relation to being able to access services in the community and ensuring that no matter where older people live they are not subjected to social isolation, which could lead to a range of health and wellbeing problems.

Halton has a population of 118,208 and approximately 22,000 people over 60 of these 22,000 in excess of 8,100 are living alone, this represents 37% of people over 60. (*Source :Housing Needs Survey 2005)*

- **Quality of life –**

As life expectancy increases, the quality of life of older people is becoming a key policy concern both at a National and local level. However, there has been little research investigating the specific experiences, life circumstances and needs of older people.

One of the key issues to emerge is the importance of social groups, activities and networks in promoting and enhancing quality of life among older people. Also ensuring that older people are supported to remain engaged and an active part of society is vital to help maintain a high quality of life.

- **Personalisation –**

Personalisation means thinking about care and support services in an entirely different way. It means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about what, who, how and when they are supported to live their lives. It requires a significant transformation of adult social care so that all systems, processes, staff and services are geared up to put people first.

IMPLEMENTATION PLAN –

The implementation plan for the first year of this strategy is available through the Older People's Commissioning Manager for Halton or via the Older People's Local Implementation Team who will be accountable for the plan, this includes the refresh of the strategy and the development of a year 2 implementation plan.

SECTION ONE: COMMISSIONING IN CONTEXT

THE COUNCIL'S VISION

Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and a safer, stronger and more attractive neighbourhood.'

The Council has five strategic priorities for the Borough, which will help to build a better future for Halton:

- **A Healthy Halton**
- **Halton Urban Renewal**
- **Employment learning and skills in Halton**
- **Children & Young people in Halton**
- **A Safer Halton**

WHAT IS COMMISSIONING?

The audit commission's definition of commissioning states that it is:

"The process of specifying, securing and monitoring services to meet individual's needs both short and long term".

As such, it covers what might be viewed as the purchasing of services as well as a more strategic approach to shaping the market for complex health needs right through to early intervention and prevention services. Simply put, purchasing is the process by which services are obtained to meet the needs of service users and carers. However we must also consider the definition of procurement:

Procurement relates to the process of securing services and products that best meet the needs of service users and the local community for the time the specific needs exists. The corporate procurement strategy includes the expectation that the procurement of services will be based in three principles. Purchasing a service via a contract to meet the current need. Maintaining effective and up to date procurement procedures and ensuring that procurement meets the borough's key corporate objectives.

If commissioning is seen as providing strategic direction, then contracting can be defined as:

The management of the legal arrangements between the local authority and service provider agencies, which lay down the standards of the service, costs and the monitoring arrangements. As such it provides a quality assurance service to the local authority.

Strategic commissioning essentially integrates all the components of the commissioning process, described within four main functions:

- Information gathering (needs analysis and mapping of resources)

- Establishing policy and strategy for the investment and dis-investments of services
- Developing good service practice
- Research and evaluation.

This commissioning strategy will outline the six key priorities that have emerged from recent consultation, through the Joint Strategic Needs Assessment and through the Halton & St Helens NHS Commissioning Strategic Plan.

The aim of this strategy will be to outline the priorities clearly so that we can develop true Joint commissioning processes between all areas of the Local Authority, the Hospital Trusts, Halton & St Helens NHS, the voluntary sector, independent sector and service users and carers. The final point becoming ever more important as more people look to direct payments or individualised budgets as their preferred method of managing their life after retirement.

A MODEL OF COMMISSIONING

The Government White Paper, 'Our Health, Our Care, Our Say: Improving Community Health and Care Services' clearly outlines the importance of delivering change through joint commissioning with Primary Care Trusts, Local Authorities and Practice Based Commissioning clusters.

This will be the key vehicle for shaping services around needs and choices and ensuring a balance of provision from low (prevention) to high level (specialist Treatment) support.

Practice Based Commissioning has to be an integral part of the commissioning framework so that it can react to patient needs, but also plan longer-term developments for future commissioning priorities and service provision. The White paper emphasises that there must be a focus on local areas and outcomes rather than reorganisation. All commissioning organisations and providers need to improve the evidence base and the outcomes framework to support overall performance. The culture across the system has to continue to move to one of understanding what difference the service has made, not just how often has it been delivered.

There are a number of layers or types of commissioning – all of these methods can co-exist and the challenge within the current market is to adapt a system that allows us to utilise each layer to meet the needs of the local population. It is important to ensure that this is carried out whilst clearly adhering to the principles of World class commissioning as illustrated in fig 1

- Regional Procurement
- Local Central Commissioning – joint agency
- Local in-house commissioning – single agency
- Local neighbourhood commissioning – ' community pot' e.g Working Neighbourhood Fund etc.
- Local neighbourhood commissioning – e.g. Practice Based Commissioning
- Personal commissioning

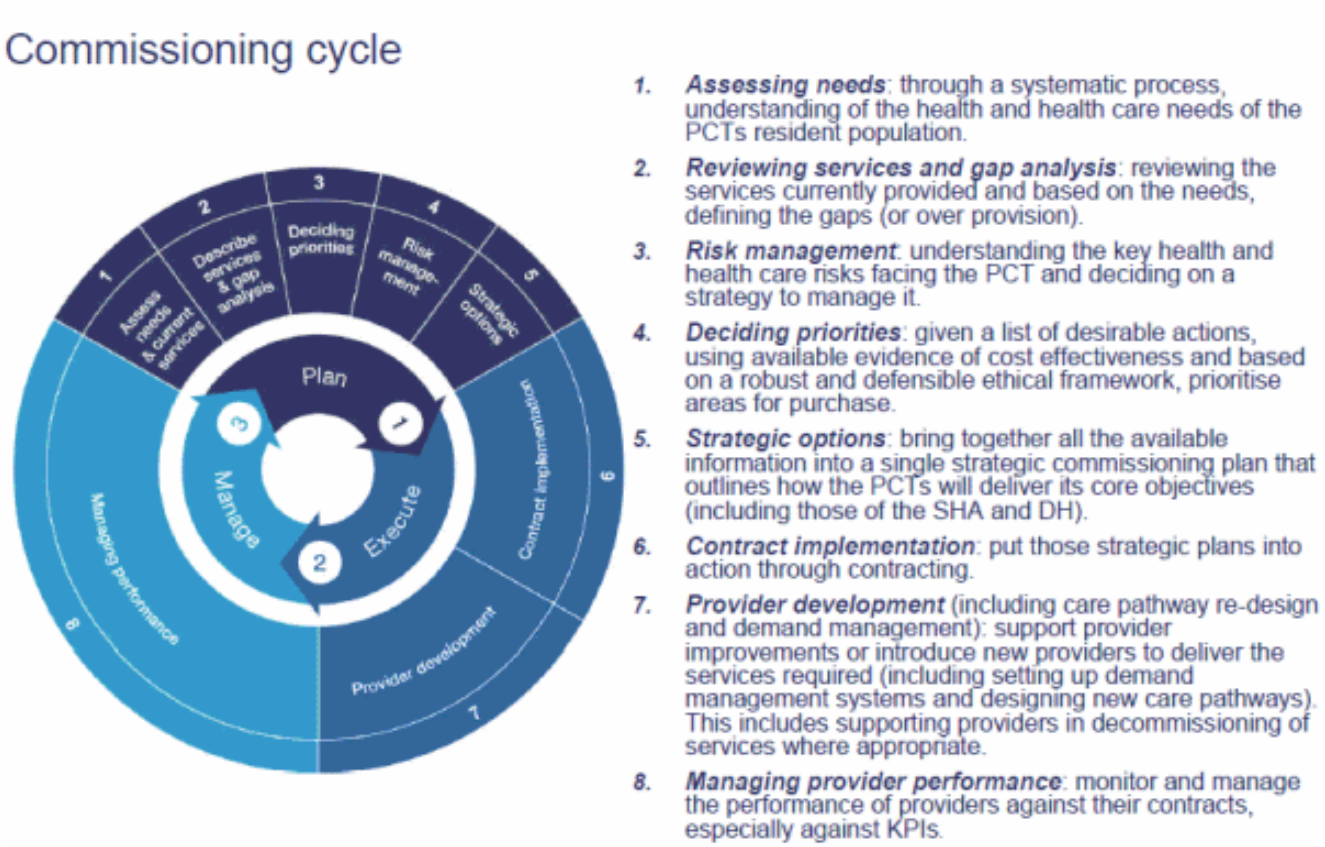
One of the driving forces at the local neighbourhood level is inequality of opportunity across service user or patient groups. It is clear that the drive to continue to develop and implement a clear prevention strategy, which is strongly supported in the White Paper, includes taking account of a wider group of citizens outside of traditional

social services. It begins to take account of the full needs of Older People, understanding that there is a need for access to health and acute services, but also that people want to access leisure, cultural and sporting activities. Older People still want to contribute to the economy through both paid and voluntary work and can offer huge knowledge, experience and are often highly skilled and motivated. Therefore commissioners need to adapt their individual plans and strategies and ensure that they are linked across health and social care and that all providers understand how they are contributing to all aims and objectives across the sector.

We will need to improve and work with those in Public Health to map incidence and need. The Joint Strategic Needs Assessment has already identified some of the obvious 'hotspots' that need to be addressed. This evidence will be linked to the Halton & St Helens NHS commissioning strategic plan that outlines seven priorities:

- Reducing harm from tobacco
- Reducing harm from alcohol
- Reducing harm from obesity
- Early detection of major illness (diabetes, heart disease, cancer, stroke etc.)
- Early detection of depression
- Quality of planned services (elective care)
- Quality of unplanned services (urgent care)

Fig 1



PARTNERSHIPS – MAKING A DIFFERENCE

Commissioners need to be responsive and, therefore, to enter into a more mature relationship with all providers. We must seek to maximise all the opportunities available by working with all service providers and partners to develop the highest quality of care.

This must include positive partnerships and working closely with voluntary, independent, community and faith groups across Halton. This approach will allow improved outcomes and a clearer understanding of each other's priorities and future direction.

These partnerships impact on a number of areas of commissioning from working with providers to assess the current capacity and quality of service, as well as identifying gaps in service. By using this level of intelligence we are able to understand what we need to commission more of and what needs to be decommissioned. This can and should go further by ensuring that every older person and carer in the borough has some method of having their voice heard so that we can get the true feelings and ideas of Halton residents. This will be described in more detail in section 3 – Consultation.

When developing meaningful partnerships we have to ensure that we consider both the strategic and operational implications. From a strategic point of view we have to ensure that all partners know all of the organisational objectives and how they link and which workstreams can be carried out jointly. Within Halton we can now operate within the remit of the section 75 partnership agreement that sets out to describe the lead commissioning agreements between the Local Authority and Halton & St Helens NHS as illustrated below:

"Each Partner retains Statutory responsibility for their functions carried out under the Commissioning Agreement. The vehicle for the delivery of such functions will be the LA ASC&H Commissioning Division for Older People, Learning Disabilities, Physical and Sensory Disabilities, Drugs and Alcohol and HIV aids. It will be the PCT Commissioning Division for Mental Health Services. Appendix 2 illustrates.

The lead arrangements for each partnership commissioning area are as follows:

Commissioning Area	*Lead Organisation*
Mental Health	*Halton and St Helens PCT*
Older People (inc Intermediate Care and older people's mental health)	***Local Authority***
*Alcohol and Substance Misuse**	*Local Authority*
Adult Learning Disability	*Local Authority*
Physical Disability	*Local Authority*
**The PCT will develop a joint PCT/LA role to support the commissioning of health outcomes for alcohol services*	

When we consider operational partnerships there are a number of elements to achieving success. Firstly the Local Authority, as lead commissioner for Older people's services, must demonstrate that the elements described under 1.1 earlier in this document are all working effectively to allow delivery of world-class commissioning.

COMMISSIONING OUTCOMES

The White Paper, 'Our Health, Our Care, Our Say: Improving Health and Care Services' consolidates the approach taken in the Green Paper ' Independence, Wellbeing and Choice' of theming together seven outcomes. These are:

1. Improved health and emotional wellbeing – health inequalities need to be addressed and are one of the main objectives of the Halton Health Partnership

2. Improved quality of life – people will be given the most appropriate support to help them remain independent and able to live at home.

3. Making a positive contribution – people will be able to influence decisions that affect their lives as a member of their community and carers and volunteers will be able to support them

4. Choice and control – those with additional needs and who most dependent will have more control and a range of options wherever possible

5. Freedom from discrimination – those with additional needs will be protected and will be free from abuse and discrimination

6. Economic wellbeing – More people will move into socially inclusive engagement and employment

7. Personal dignity – the dignity of people with additional needs and those at the end of their lives will be promoted.

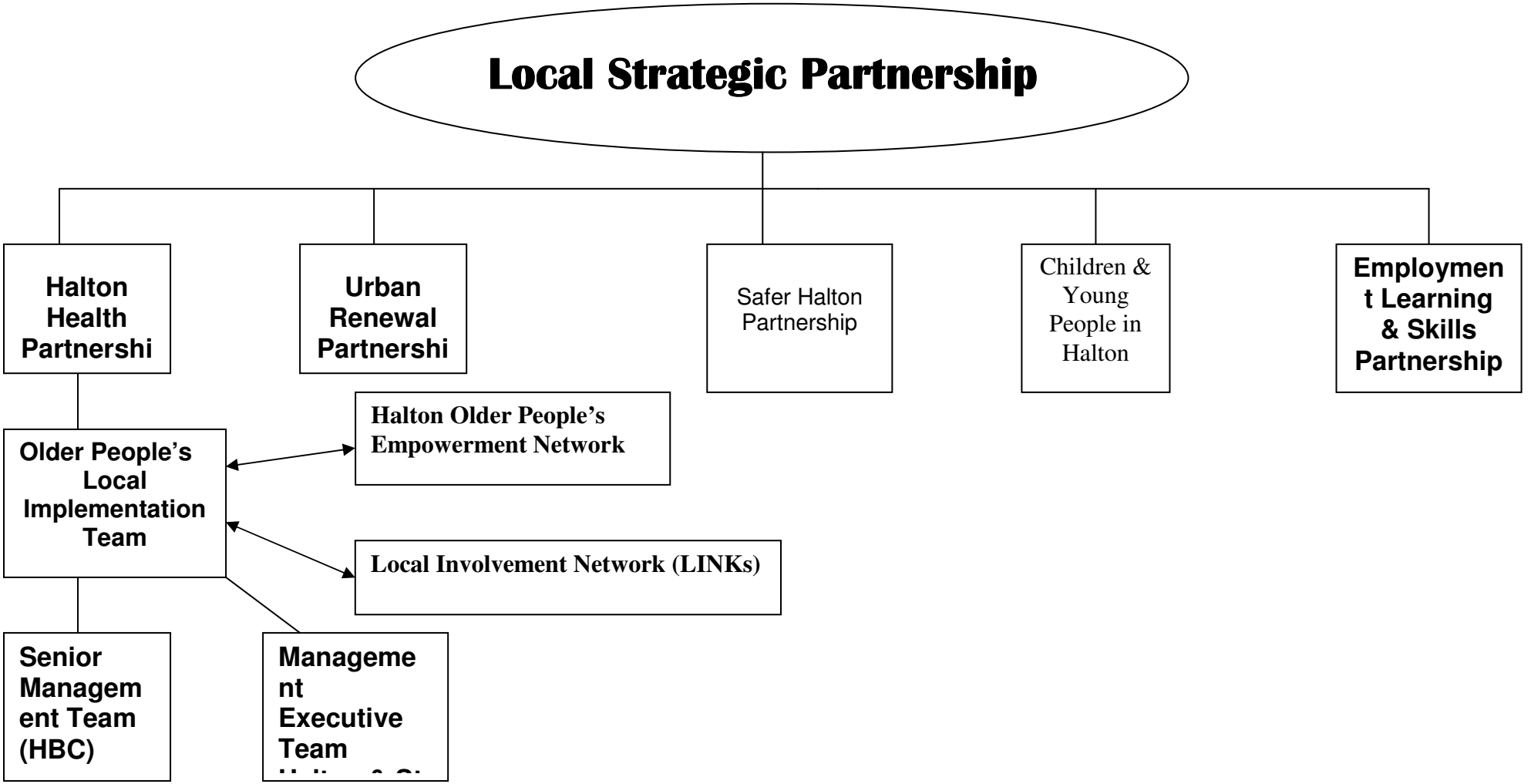
In order to achieve each outcome we need to develop a clear action plan that will identify the following:

- How we are going to commission strategically
- How we are going to commission locally
- How we are going to assist personal commissioning, and
- What we will ' decommission'

This action plan will be presented in section 7 of this strategy.

GOVERNANCE ARRANGEMENTS

The Older People's commissioning strategy is a joint document that sits across the Local Authority and NHS Halton & St Helens. This creates a range of complexities relating to the overall governance and implementation of the strategy.



The strategy sits alongside a number of key local and National documents as follows.

NATIONAL DRIVERS

White Paper: Our Health, Our Care, Our Say

The White Paper, published in January 2006, sets out the reforms intended to develop modern and convenient health and social care services. The White Paper acknowledges the importance of joint commissioning and ensuring quality research, data and evidence to effectively procure the right services to meet the needs of an individual.

Personalisation

On 17th January 2008, the Department of Health issued a Local Authority Circular entitled "Transforming Social Care". The Circular sets out information to support the transformation of social care signalled in … *Independence, Well-being and Choice* and re-enforced in … *Our Health, our care, our say: a new direction for community services.*

Living well with dementia: A National Dementia Strategy (Feb. 2009)

The aim of the Strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia. This strategy should be a catalyst for a change in the way that people with dementia are viewed and cared for England.

Framework for a fairer future – The Equality Bill (White Paper June 2008)

The above White Paper sets out some key messages relating to Equality, the vision for the paper is:
'Promoting equlity is essential for individuals to fulfil their potential, for the creation of a cohesive society and for a strong economy. A substantial body of equality legislation has been introduced over the last four decades, protecting millions of people from discrimination and promoting greater equality. But the legislation has become complex and hard to understand. The Bill will de-clutter and strengthen the law.'

Specifically in relation to age discrimination the Bill will contain powers to outlaw unjustifiable age discrimination by those providing goods, facilities and services in the future. To allow businesses and public authorities to prepare, and to make sure the law does not prevent justified differences in treatment for different age groups.

More information is available at:

http://www.equalityhumanrights.com/your-rights/age/

THE LOCAL CONTEXT

The challenges and opportunities facing Halton has led to the identification of a number of priorities for the Borough (outlined in the Community Strategy 2006-2011) over the medium term with the overall aim of making it a better place to live and work. These include:-

- Improving health
- Improving the skills base in the borough
- Improving educational attainment across the borough
- Creating employment opportunities for all
- Tackling worklessness
- Tackling the low wage economy
- Improving environmental assets and how the borough looks
- Creating prosperity and equality of opportunity
- Reducing crime and anti-social behaviour
- Improving amenities for all age groups
- Furthering economic and urban regeneration
- Tackling contaminated land
- Creating opportunities/facilities/amenities for children and young people
- Supporting an ageing population
- Minimising waste/increasing recycling/bringing efficiencies in waste disposal
- Increasing focus on community engagement
- Running services efficiently

The Community Strategy provides an overarching framework through which the corporate, strategic and operational plans of all the partners can contribute. Halton's Local Area Agreement (LAA) 2008-11 builds on this overarching framework and provides a mechanism by which key elements of the strategy can be delivered over the next three years. It is an agreement between Central Government and the local authority and its partners about the priorities for the local area, expressed in a set of targets taken from a National Indicator set of 198 targets. The purpose of the LAA is to take the joint thinking of the Partnership enshrined in the Community Strategy, and make it happen through joint planning and delivery. Hence the five strategic themes detailed in the Community Strategy are mirrored in the LAA.

Advancing Well Strategy (2008-2011)

The 'Advancing Well' Strategy aims to promote more independent living and reduce the social isolation often experienced by older people by working closely with all providers of services for older people. The success of the strategy will depend on positive joint action internally, between the various departments of the Council, and externally with other public and private organisations and with local voluntary and community sector groups. To do this, Halton is committed to providing strong community representation for its older people and a network of services through local partnerships. This involves close links with various organisations, such as, transport, job centres, colleges, health facilities, sport and other leisure facilities, housing and other organisations involved in the delivery of services for older people.

The Strategy will help to develop radical new approaches to the way in which we deliver services for older people. These involve promoting health, well-being, quality of life, equality and independence. Such diversity of approach lies at the very heart of all the Councils strategies.

Commissioning Strategy for Carers (Due Sept 09)

It is important that Carers have access to services based on recognition of their rights as individuals, choice in their daily lives and real opportunities to have a life of their own outside of the caring role.

The Joint Commissioning Strategy has been developed via ongoing consultations and contributions from stakeholders who provide services to carers as well as carers themselves. We have listened to what carers have told us about the help and support that they need and have responded by addressing the issues throughout the Strategy.

This Strategy is written as a practical document, including an action plan, to support services in Halton move towards a more focussed way of commissioning services over the next three years

We are committed to working jointly and in partnership with the voluntary sector within Halton, providing where possible an integrated response based on services which meet assessed needs and which are designed to improve lives and give new opportunities.

We are proud of what we have achieved for Carers within Halton since the production of the last Carers Strategy, but we also recognise the need for continual improvement and Halton Borough Council and Halton and St Helens Primary Care Trust, together with their partners have made a pledge to continually improve services and the quality of life for carers

We recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community and we believe that this Strategy demonstrates our commitment to recognising, valuing and working with local carers.

Local Area Agreement

The Local Area Agreement (LAA) is the framework used to deliver Halton's vision as mentioned earlier. The LAA is a target based process that focuses on the five agreed priorities.

- **A Healthy Halton**
- **Halton Urban Renewal**
- **Employment learning and skills in Halton**
- **Children & Young people in Halton**
- **A Safer Halton**

There are a range of specific targets contained within the Local Area Agreement that are appropriate for Older people's services and are covered in Appendix 1

Local Involvement Network (LINk)

The Halton LINk has been established as part of a new government initiative for local communities to have a stronger voice in the way their health and social care services are planned and run. Halton Voluntary Action has been appointed to act as the 'LINk Host' for the Halton LINk.

In July 2006, the Department of Health published plans to strengthen the ability for local communities to influence the care they get through LINks. Until now, one of the ways the NHS has listened to patients has been through Patient and Public Involvement in Health Forums (PPIF), but they ceased in March 2008.

Halton LINk will build on the work of the previous forums but membership will be open to everyone who lives in Halton, or anyone who uses health or social care services in Halton. The LINk will cover all publicly funded health and social care services in the area, no matter who provides them.

Commissioning Strategic Plan

This document was produced in 2008 by NHS Halton & St Helens and clearly outlines the need to change, the key priorities and the investment required to make a difference within the health equalities in Halton. The Commissioning Strategic Plan offers three key areas that Halton and St Helens suffer with:

- Economic Deprivation (within the worst 10%)
- Worklessness (21% with 11% of these people receiving incapacity benefits)
- Smoking, obesity and alcohol and drug misuse.

Each of these factors is a significant determinant of health. Taken together they largely explain why our population has comparatively poor health and significantly lower life expectancy, in particular due to high levels of heart disease and cancer. Our Joint Strategic Needs Assessment clearly shows the unequal impact these issues have within our local population and in comparison to the average health experience of the people of England. The vision is to improve the health of our local population and based upon this vision, six ambitions have been identified:

- Supporting a healthy start in life
- Reducing poor health resulting from preventable causes
- Supporting people with long term conditions
- Providing services to meet the needs of vulnerable people
- Making sure our local population has excellent access to services and facilities
- Playing our part in strengthening local communities

SECTION TWO : OLDER PEOPLE'S MENTAL HEALTH

INTRODUCTION

Most older people in the UK have good mental health and well-being, but a significant minority have mental health symptoms that impact adversely upon their quality of life, increasing feelings of isolation or exclusion.

Truly person centred services and health promotion activities, by necessity, span a wide range of teams and services and we need to provide a vision for partnership working across Primary Care, Social Care and Specialist Services, Local Authority Housing, Statutory, Independent and Not for Profit sectors.

Most importantly, we need to explore working in partnership with the people who are experiencing our services – the clients, their family and carers. If our services are not known, used and trusted by our local population, we have failed.

The number of people aged 65 years and over is expected to rise by nearly 60% in the next 25 years - from 9.6 million in 2005 to over 15 million in 2031. The percentage of the total population who are over 65 is predicted to rise from 16% to nearly 20% in 2031 and 26.6% in 2071 and the biggest growth in relative terms will be amongst the oldest old[1]

Everybody's Business suggested that mental health problems in older adults affect 40% of older people visiting their GP, 50% of General Hospital Inpatients and 60% of care home residents.

These mental health problems include depression, anxiety, delirium, dementia, schizophrenia, bipolar disorder and substance misuse.

Everybody's Business estimated that 60% of people over the age of 65 suffer from long-standing physical illnesses and, for them, mental health problems, particularly depression and dementia, are more common and have a worse outcome.

DEPRESSION[1]

It is believed that 25% of people over the age of 65 living in the community have symptoms of depression serious enough to warrant intervention, but only a third of them discuss it with their GPs, and only half of those get treatment, primarily medication. Symptoms of depression increase with age, affecting 40% of people aged 85 and over.

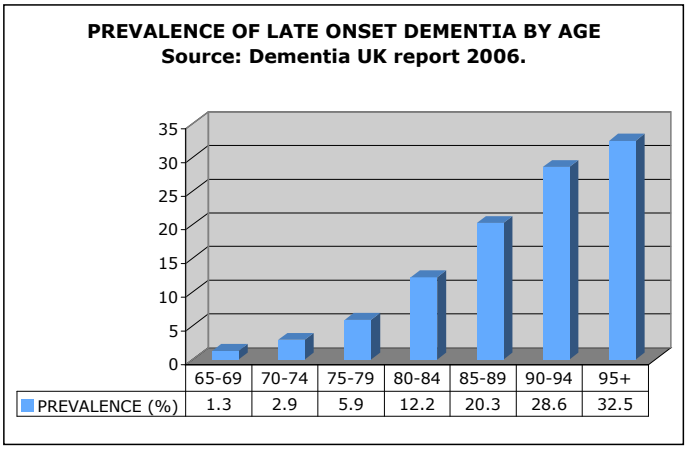
DEMENTIA[2]

Dementia UK estimate that we currently have 700,000 people in the UK with dementia, of which 15,000 have Early Onset Dementia and 11,500 are from black and minority ethnic groups.

[1] Help the Aged Demographic Statistics 2006.
[2] Source: Dementia UK Report 2006

We expect the number of people with dementia to increase to 940,000 in the next 15 years and to 1,735,087 over the next 45 years. These are increases of 38% and 154% respectively. Almost two thirds of people with dementia have Alzheimer's and a quarter have Vascular dementia or Mixed dementia.

The prevalence of both early onset and late onset dementia increases with age, approximately doubling every five years.



The severity of dementia increases with age: 13% of people aged over 65 have severe dementia but this increases to 23% for people over the age of 95. 60,000 deaths each years are directly attributed to Dementia

Approximately 56% of people in institutions aged 65 to 69 have dementia. This rises to 65% in those aged 95 and over.

80% of people living in Elderly Mentally Infirm Homes have dementia.
67% of people living in nursing homes have dementia
52% of people living in residential care homes have dementia

There are currently 1,061 people over 65 diagnosed with dementia in Halton. This is expected to increase to 1,683 by 2025.

The table below outlines the current level of people diagnosed with dementia in each of the four local areas, the projected number for 2025 and the estimated costs to each of the local economies.

	2008	Cost to economy	2025	Cost to economy
Halton	1061	£25,766,385.00	1613	£39,171,705.00
Knowsley	1424	£34,581,840.00	1908	£46,335,780.00
St Helens	1891	£45,922,935.00	2774	£67,366,590.00
Warrington	1983	£48,157,155.00	3142	£76,303,470.00
Total	**6359**	**£154,428,315.00**	**9437**	**£229,177,545.00**

The natural history of dementia, for example, means that a substantial proportion of those affected will develop challenging behaviour, including symptoms such as

depression, hallucinations and delusions. For the system as a whole to work for people with dementia and their carers, these services need to be effective and available. This means services in the community that work for older people with both functional and organic disorders and therefore a mixture of both.

50% of people with dementia suffer from depression[3]

17% of Older People with depression will develop dementia (alzheimers)[4]

20% to 30% of people who have had a stroke will develop dementia (multiple infarct dementia)[5]

70% of people who have had a stroke will develop depression during recovery

LOCAL DEMENTIA STRATEGY (due for publication Oct 2009)

Halton and St Helens Boroughs and Halton and St Helens NHS have drawn up a Joint Commissioning Strategy for dementia to address the objectives of the National Dementia Strategy (NDS) with a view to achieving the best possible local health and social care services for people with dementia and their carers.

The commissioning strategy is structured around the four thematic areas of the NDS: 'Raising Awareness', 'Early Diagnosis and Support', 'Living Well with Dementia' and 'Delivering the NDS'. In addition, it addresses key issues raised in a review in 2009 by the Halton Scrutiny Committee of services for younger adults with dementia.

There is currently a 'Cycle of Stigma' that prevents people seeking help and services from offering help. The strategy proposes a number of commissioning actions that are intended to break this cycle through a public health programme, a public information programme, and the provision of information to relevant groups of employers. These commissioning actions are not repeated in this document, but ensuring implementation will be the responsibility of the Older People's Commissioning Manager and the Older People's Local Implementation Team. This will be assisted by joint work with Childrens Services to ensure that non-stigmatising information is included in school curricula and through community engagement activities.

Currently only a small percentage of people with dementia ever receive a diagnosis and when they do it is usually in the latter stages of the illness. The commissioning of an Assessment Care and Treatment Services (ACTS) is proposed for each of the boroughs which will ensure that early and high quality assessment and support is available to all. This will include access to counselling and to a Dementia Care Advisor who will provide an enduring point of contact through time.
The 'Living Well with Dementia' set of objectives is focussed on improving current services such as home care, carer support, intermediate care, residential care and end of life care to ensure that they meet the needs of people with dementia and the needs of their carers. Current services have been mapped and evaluated against these six objectives and actions that will help to guide commissioning developments for each area of service have been defined.

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[3] Blazer,1980
[4] old age psychiatry;Rodda J, 2008
[5] Telemichi et al, 1992

KEY FINDINGS FROM NEEDS ANALYSIS

Using the Improving Access to Psychological therapies workforce tool, this provides an estimation of mental health morbidity for each PCT locality. It applies national data to establish the weekly prevalence of common mental health problems in Halton and St Helens. Using these figures the tools applies a number of assumptions concerning the impact of deprivation and the likely presentation and detection of common mental illnesses and provides an adjusted weekly prevalence for a number of disorders.

The assumptions are:

- Only 50% of people suffering from depression and/or anxiety will actually present in Primary Care.
- Only 50% of people presenting in Primary Care will actually be detected as having depression and/or anxiety
- The index of deprivation applied is specific to those with common mental health problems.
- Mixed anxiety and depression consists of 4 groups: -
    - Those treated as though they have depression
    - Those treated as though they have an anxiety disorder.
    - Those treated as though they have both anxiety and depression
    - Those with Post Traumatic Stress Disorder (PTSD) who form 22% of total with Mixed Anxiety and Depression
- The proportions of severity of depression are: -
    - Mild – 20%
    - Moderate – 40%
    - Severe – 40%

When we consider the above set of data we can clearly identify a range of gaps that we need to address. Only half of people present in primary care so specific work is required to reduce the stigma attached to mental health and support more people to visit their GP.

Detection and diagnosis rates are low and targeted training around all forms of mental health, particularly dementia is required to give GPs the support and expertise required to quickly and effectively help people in Halton.

Mental health can be particularly challenging for Older People as their circumstances can change significantly. Retirement, bereavement, loss of health, loss of mobility and isolation are all factors that have a huge impact on an individuals mental health and wellbeing and all of these areas need to be considered as we develop services now and in the future.

COMMISSIONING INTENTIONS

Halton is in the process of developing a range of specific workstreams that will begin to address some of the issues that have been raised above. The main developments are the completion and implementation of a local Halton & St Helens dementia strategy and an updated Older People's Mental Health Strategy. The aim of these documents is to clearly define the direction of travel and the commissioning priorities for the next three years.

The following are some of the main commissioning intentions from the two strategy documents:

- Development of Assessment, Care and Treatment Service (ACTS)
- Review existing provision of bereavement services in Halton
- Continue to work with adult mental health services to deliver consistent and efficient services for Older People in Halton
- Develop peer network service for Dementia.

PLANNED INVESTMENT

- Investment has already been agreed to continue to support the low-level dementia reading group.
- In addition the Working Neighbourhood Fund has agreed to commission a peer support network for people diagnosed with dementia. This will see an initial two-year pilot, which will incorporate a partnership between Age Concern and the Alzheimers Society.
- Business plans and service specifications have been developed for the Assessment, Care and Treatment Service and funding decisions will be made before September 2009.
- Investment is available from both the Local Authority and NHS Halton & St Helens to fund a training programme relating to dementia.

SECTION THREE : DETECTION OF MAJOR ILLNESSES

INTRODUCTION

Life expectancy at birth is a major indicator of overall health and whether the local population die younger than England as a whole. Life Expectancy is a key Government target: The national Public Service Agreement (PSA) for improving the health of the population aims:

- To increase the life expectancy at birth in England to 78.6 years for men and to 82.5 years for women by 2010 and;
- Reduce the inequalities in life expectancy at birth by 10% between the lowest fifth of local authority districts and the average for England by 2010.

Halton is a Local Authority district that experiences some of the poorest health, and thus are required to meet differential 'stretched' mortality targets to narrow the inequalities gap. An indicator of whether we are achieving this is to look at the gap between local life expectancy at birth and national figures. Life expectancy for both Males and Females has improved in Halton between 1991-1993 and 2004-2006 with Males living on average an extra 2.4 years and females living an extra 0.6 years.

The gap between England life expectancy and local life expectancy in 2004-06 shows a different picture with neither males nor females closing the gap (3.02 years and 3.15 years difference between Halton and England life expectancy respectively for males and females). Halton females have the third worst life expectancy in the country and males have the 6th worst life expectancy in the country.

Trends in Life Expectancy, 3 Year Rolling Averages

	Males	Females
Halton	74.3	78.4
St Helens	75.3	80.2
National	77.3	81.6

KEY FINDINGS FROM NEEDS ANALYSIS

A significant factor that contributes to the above figures is the early detection of major illness (Cardiovascular Disease, diabetes, respiratory, Cancer and Stroke). The NHS Halton & St Helens Commissioning Strategic plan outlines the Case for change and the vision / actions that are required to move forward the health inequalities agenda that is one of the top priorities in the borough.

The case for change outlines some of the key headlines for Halton and St Helens:

- Cancer mortality is 20% higher than the national average
- Cardiovascular Disease is 25% higher and Coronary Heart Disease 29%

- The three above account for 200 excess deaths compared to the National average.

- The success of current screening programmes for Breast, Cytology, Bowel cancer and Cardiovascular Disease demonstrates the value of early detection of ill health, both in terms of reducing mortality rates and in reducing the costs of treatment.

- The current total investment in early detection across Halton & St Helens is approximately £1.5m (this is <0.3% of total expenditure); this is disproportionate to the total spent on planned and urgent care. More investment is required upstream to reduce the costs of expensive treatments.

- In order to reduce the cancer mortality rates we need to extend the existing cancer screening programmes by lowering the age ranges and widening out to include other tumour groups.

- Stroke costs the NHS and the economy about £7 Billion per year: £2.8 Billion in direct costs to the NHS, £2.4 Billion of informal care costs (e.g. the costs of home nursing borne by patients' families) and £1.8 billion in income lost to productivity and disability. Outcomes in the UK compare poorly internationally, despite our services being among the most expensive with unnecessarily long lengths of stay and high levels of avoidable disability and mortality.

COMMISSIONING INTENTIONS

As mentioned in the key findings detection of major illnesses is an agreed element of the commissioning strategic plan. This document is the responsibility of NHS Halton & St Helens as the lead organisation on delivering an improvement against a number of targets. However, there is a need to work across all stakeholders and all services within the borough to support continued improvement. The following are some of the areas that will begin to address the health inequalities:

- **Leadership:** it is proposed that an executive director provides leadership supported by a bespoke project management team to oversee the commissioning, implementation and performance management of these programmes.

- **Screening / access to diagnostics and management plans:** the development of systematic health checks will involve inviting people for the following diagnostic tests in order to assess risk for major illness such as respiratory disease (COPD) Cardiovascular disease and diabetes. The tests provided will be; blood pressure test, full blood test (liver function, cholesterol), screening spirometry and CVD risk assessment.

- **Workforce development:** in order to develop a social marketing unit at the PCT, it has been estimated that a total of 10 whole time equivalent posts will be required. It is the intention for this to be a shared resource across the Primary Care Trust in order to deliver the objectives of this strategic plan.

- **Stroke services:** we need to redesign stroke services to ensure that we get the best out of the resources we currently use, and this should mean targeted

local investment. On the back of the National Stroke Strategy, Halton has completed a mapping exercise of existing local service provision to identify needs and gaps. This mapping exercise clearly identified three areas that needed more investment.

- **Communication support**
- **Psychological therapies**
- **Early supported discharge**
-

PLANNED INVESTMENT

- **Early detection services –** plan to increase the funding from current levels £1.5m to £5.7m in 2012/13.

- **Social Marketing –** the development of a social marketing team at the Primary Care Trust will be supported by significant investment reaching £1.5m by 2013. This intelligence will be used to inform robust strategies for improving the health of our local population across all priority areas.

- **Personalised risk management programmes -** biggest investment will be funding personal risk management programmes offered to patients as a result of their screening / diagnostic tests, this will include investment in leisure and lifestyle capacity, total investment will reach £9.5 million by 2013.

Early detection services investment plan

Investment	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Social Marketing Team	0.0	0.5	0.5	0.5	0.5
Social Marketing schemes	0.0	0.5	0.8	1.0	1.0
Screening management team	0.0	0.2	0.2	0.2	0.2
Screening (BP,FBT,Screening spiro,CVD risk)	0.0	0.8	1.8	3.4	3.4
Diagnostic test (Spiro, Echo, ECG)	0.0	0.1	0.3	0.5	0.5
Cancer screening (national programme)	0.0	0.8	0.9	1.0	1.1
Personalised plan management	0.0	0.1	0.1	0.1	0.1
Personalised risk mgt programme	0.0	1.8	4.6	9.5	9.5
Prescribing costs	0.0	0.8	1.5	2.2	2.7
Sub-Total	**0.0**	**5.6**	**10.7**	**18.4**	**19.0**
Benefits					
Reduced acute admissions	**0.0**	**-0.3**	**-0.8**	**-1.0**	**-1.0**
Total	**0.0**	**5.3**	**9.9**	**17.4**	**18.0**

- **Stroke** investment will be £85,000 in Halton over each of the three years beginning 2008/09. This local investment will be targeted on the three areas as mentioned in commissioning intentions.

SECTION FOUR : ACCOMMODATION

INTRODUCTION

Within the Joint older people's commissioning strategy we need to consider the accommodation needs of Older People. This relates to a range of provision including nursing, residential, extra-care housing, sheltered accommodation, registered social landlord and privately owned properties. As well as considering the mix of people supported to live in their own home compared to residential, we also need to consider an individuals needs in relation to being able to access services in the community and ensuring that no matter where older people live they are not subjected to social isolation, which could lead to a range of health and wellbeing problems.

Halton has a population of 118,208 and approximately 22,000 people over 60 of these 22,000 in excess of 8,100 are living alone, this represents 37% of people over 60. (*Source :Housing Needs Survey 2005)*

In addition to this the Joint Strategic Needs Assessment found that 48% of older person households contained a household member with a disability or limiting long term illness. Couple households were more likely to contain someone with a disability/limiting long-term illness (57%) than single person older households (43%). Not only is there a correlation between disability and limiting long-term illness with deprivation but also this relationship is stronger than for social isolation. There is thus an emerging picture of multiple negative effects on an older people's health and well being combined with deprivation. This means that the individuals' capacity to improve their health and well being is mitigated by the lack of economic and social resources to draw upon.

In the 2001 Census, 12.48% of people in Halton aged 65 and over were without central heating. The age group with the highest percentage are people aged 85 and over at 15.25%. These percentages are of particular concern given the concentration of people without central heating in areas of deprivation. It will be important for older people to be targeted as part of wider fuel poverty strategy given the combined effect of this age group being highly susceptible to the cold with rising fuels and limited financial resources.

Whilst the Housing Needs Survey collated information on household income, savings and benefits received, not all respondents were willing to answer questions relating to finances. Over half (58%) of older person households have less than £5,000 savings, rising to 67% of singles and falling to 46% of couples. Almost a fifth of couples and only 8% of singles have significant savings of over £30,000. Given the correlation between older people living in areas of deprivation and faced with increased risks to their health, this means they are also less likely to cope with unplanned events. Again early intervention, which prevents a problem escalating, will be key.

KEY FINDINGS FROM NEEDS ANALYSIS

EXTRA CARE HOUSING

The aim of the strategy for commissioning extra care services is to ensure that older people in Halton have access to a wider choice of care and support options that include extra care housing and service provision. The objectives for achieving this are:

- To meet the quantified projected need for extra care provision in Halton.
- To provide extra care housing models that are most appropriate to the Halton context.
- To make best use of existing resources in the borough
- To access capital funding through a combination of grants and other sources to enable the provision of new and or remodelled housing provision for extra care
- To work with partners and stakeholders to ensure a cohesive contribution to achieving the aims of the strategy and to ensure that it remains aligned to wider older people's strategy for the borough.

Halton currently has one extra care housing scheme providing 40 flats (37 one bed flats and three two beds) for a range of needs; the targets set for the service are 30% low dependency, 40% moderate dependency and 30% high dependency residents. The scheme has a lounge, restaurant, buggy store, therapy space, laundry, assisted bathing facilities and hairdressing room. It is owned by ECHG and managed by Halton Adult Services. Halton Adult Services also provide the care services.

Comparison of extra care units with other Boroughs

In comparing the number of extra care units with a sample of local authorities in the North West (using the same comparator authorities used in developing the Halton domiciliary care strategy), Halton has a similar number of units in proportion to the older population as Blackpool, but a significantly lower number than Warrington and Blackburn. See the table below. Information in this table includes extra care villages. It does not break down the figures into high, medium or low support needs or tenure.

Authority	Extra Care Units	Population (65+)*	Population (all)	% of people 65+	% of all people
Warrington	475	29,700	193,600	1.60%	0.25%
Blackpool	59	27,400	145,000	0.22%	0.04%
Blackburn	220	18,000	142,200	1.22%	0.15%
St Helens	318	29,300	177,800	1.09%	0.18%
Halton	40	16,500	118,900	0.24%	0.03%

RESIDENTIAL AND NURSING ACCOMMODATION

Key findings from needs analysis

The factors that impact on future demand for residential and nursing care includes:

- Long term funding for social care
- The Personalisation Agenda
- The Government's dementia care strategy
- Change of government
- Economic downturn, for example on recruitment problems in the sector, or the impact of rising unemployment on the communities and individuals ability to cope
- Assistive technology in the community and within care homes
- Breakthroughs in medical treatment of dementia
- The extent of funding and development of extra care housing
- Primary care commissioning and PCT funding of continuing care
- Demography

Older people aged 65 and over in local authority residential care, independent sector residential care, and nursing care.

	2008	2010	2015	2020	2025
Total number of older people in residential and nursing care during the year, purchased or provided by the CSSR	563	584	688	775	855

Source : (POPPI Tool)

The figures in the table above are an estimation based on population and trend data, they take into account the expected rise in the older population and the increase s in how long people live. However one of the key priorities for Halton is the continued support for people to remain independent in their own homes.

The last five years has seen a dramatic reduction in the number of older people who have moved into residential or nursing care in Halton and although there will be increasing pressures over the next fifteen years we can still anticipate rates below the National average. The continued development of Intermediate Care, Telecare, early intervention and prevention services will play an important role in reducing the level of increase in residential placements and support older people to remain independent in their own home.

Reclassified Description	2004/05	2005/06	2006/07	2007/08	2008/09
Community Care - SP	1.81%	1.46%	2.51%	2.01%	2.36%
Direct Payments	1.01%	1.00%	1.38%	1.79%	1.88%
Domiciliary Care	10.60%	11.74%	12.12%	13.67%	12.88%
Early Intervention/Prevention			3.57%	5.16%	6.99%
In-House Reablement & Intermediate Care	13.34%	12.92%	14.07%	14.26%	15.30%
Joint Equipment Service		0.70%	1.06%	0.81%	2.24%
Older Peoples Team & Hospital Team	8.52%	8.93%	8.55%	8.71%	10.40%
Residential & Nursing	64.72%	63.26%	56.75%	53.58%	47.96%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The table above clear demonstrates the shift in investment over the last five years in Halton. A 16% reduction in residential and nursing and more investment in community and prevention services. This trend is set to continue over the next three years.

COMMISSIONING INTENTIONS – extra care housing

- Current core need has been identified for 166 units of extra care housing provision. This will increase by an additional 48 units by 2017. In addition there is a current need for 11 units of extra care provision for older people with learning disabilities.
- Initially, the response to this need will be the development of four additional extra care schemes each providing forty to fifty units by 2013. There will be some take up by couples, which will increase the numbers of people benefiting from the service.
- Some of the places in the extra care services will be designated for low to medium support and the services will also be appropriate for older people with learning disabilities.
- Needs assessments should be revisited annually to update the analysis and will be undertaken through the Joint Strategic Needs Assessment.

- There is an equal demand for services in the two main centres of Halton, Runcorn and Widnes. It is proposed that as far as possible, depending on available sites, that the services should be located equally between the two towns.
- The location of individual schemes must be appropriate to the needs of older people.

All of the above commissioning intentions are subject to successful funding bids and availability of appropriate resources.

COMMISSIONING INTENTIONS – Residential care housing

The residential care strategy lays out a direction for commissioning residential and nursing care homes places for Halton citizens that is:

- Based on local, regional and national research
- Informed by consultations with key stakeholders
- Develop dignity in care workstream to support improvement in service quality
- Founded on values and effective working relationships with providers
- Designed to meet known forecast future demands
- Assessed related to service users presenting needs and their levels of dependency
- Flexible and outcome focused in it approach to procurement and contracting
- Joint with the PCT
- Offers a fair price to service providers within the resources available to the council
- Review the changes that have taken place in a number of residential homes linked to their re-registration to cover EMI nursing provision.

PLANNED INVESTMENT

Funding for extra care housing will be identified as business plans are progressed. In addition the development of extra care will be dependent on positive partnership working with providers, registered social landlords etc.

SECTION FIVE : QUALITY OF LIFE

INTRODUCTION

As life expectancy increases, the quality of life of older people is becoming a key policy concern both at a National and local level. However, there has been little research investigating the specific experiences, life circumstances and needs of older people.

One of the key issues to emerge is the importance of social groups, activities and networks in promoting and enhancing quality of life among older people. Also ensuring that older people are supported to remain engaged and an active part of society is vital to help maintain a high quality of life.

This is an important aspect of this strategy and each of the previous sections plays a part in ensuring people's maintained quality of life, but also all service areas should make sure that they do not reduce quality because of an individual's circumstances. For example if an older person moves into a residential home, but still wants to visit a local social group, leisure activity, church etc. they should still be encouraged and actively supported to do this. Too often an individuals health need becomes the priority at the expense of any aspirational or well-being requirements.

To achieve this we need to consider information provision, prevention, re-ablement and personalisation.

KEY FINDINGS FROM NEEDS ANALYSIS

Quality of life is often the most difficult area to collect meaningful evidence to support any case for change, but at the same time can be the most powerful in supporting an individual to remain independent and maintain the best possible quality of life. We often use case studies to tell the story rather than rely on data that can be difficult to quantify. Also when considering people's needs to maintain their own personal quality of life they are hugely diverse. One person might need support to visit a relative in hospital, whereas another might want to go for a pint each afternoon to the local pub.

Although this begins to present challenges to commissioners it also offers opportunities to be creative and look for ways to develop partnership working as well as learn from best practice in other areas.

INFORMATION PROVISION

'You don't know what you don't know' a quote from an older person attending the Older People's conference 2007. Although an obvious statement it clearly demonstrates the starting point when we consider low-level services that support an improved well-being or quality of life. Information is a vital component to ensure that local people have access to the services and facilities that they need and that they are receiving consistent quality.

In Halton there are already a range of services that support older people and their carers to get the information that they require.

- Sure Start to Later Life
- Halton Direct Link

- Age Concern Information service
- Age Concern Outreach service
- Community Bridge builders
- Reach for the Stars
- Health Trainers

Each of the above offers something different for an individual service user and it is clear that we already have in place a range of excellent services that offer a high quality to anyone accessing them, however there is still a need to develop a more co-ordinated approach to information, prevention and low-level support services. If we can implement a strategy to achieve this over the next two years we will be in a strong position to start shifting the resources required from high-level crisis intervention to moderate or low-level preventative services.

A review of the services above as part of an overall review of information provision will take place before the end of 2009/10 and will be supported by the development of a communication strategy for older people's services in Halton.

INTERGENERATIONAL WORK

Halton has only relatively recently embarked on a thematic focus of intergenerational activity, since April 2009. The approach is centred around positive activity to generate positive perceptions; building on what unites young and old, not what is problematic or divides.

We have already identified several catalysts of activity to generate and build community relations to support broader social capital across Halton.

The development of the first intergenerational conference clearly demonstrated the diversity of people within the local community who would like to be involved in intergenerational work in the future. Almost 200 local people attended the event across a range of ages, this has given us a base to start developing local engagement in planning future workstreams. By adopting an approach that utilises community development networks, voluntary sector; statutory organisations and community groups the spread of involvement will be diverse and far reaching. Future plans set out to utilise a community development approach to bring together a wide range of existing services to deliver creative activity and inspire community involvement and participation to generate social capital.

PREVENTION

Recent government publications clarify the intended direction that Local Government, National Health Services, Independent and voluntary sectors are expected to embark on. They also identify how this direction could be achieved within the current constraints of the local economy.

Local service users in Halton have an expectation that they should receive the highest quality services that are designed around local needs as well as being flexible enough to meet the aspirations of users and carers. In addition service users should always have a choice – even in essential services. This level of service provision should always be the aim of all commissioners and providers within Health, social care, independent and voluntary sector.

To achieve the aims and ambitions of the local population is not just the responsibility of the Local Authority as they are not the only provider of such services. There has to be a strong emphasis on partnership working and developing robust agreements that support and enhance the ability of staff and services to work quickly and effectively to address the needs of individual service users. There has to be within these agreements clear demonstrations on how we are going to achieve our aspirations, not a list of obstacles that will prevent development.

Partnership commissioning has been at the heart of ensuring that effective partnerships are in place to support the modernisation agenda. This can be clearly demonstrated through the development of the Section 75 Partnership Agreement that clearly identifies the processes and protocols expected from commissioning in all organisations. The agreement is important as it covers Halton & St Helens NHS, Halton Borough Council and St Helens Council.

In Halton we can draw on a significant service provision in relation to citizenship, inclusion and engagement and preventive low-level services.

Citizenship, inclusion and engagement

- **Halton OPEN (Older People's Empowerment Network)** – an autonomous group of older people who meet to discuss the latest agenda for local service users and community. The group has an elected board of 15 members and has a wider membership of 654 that it consults with. There are also two members of Halton OPEN that sit on the Older People's Local Implementation Team and regularly feedback issues directly from the public.
- **Participation groups** – six groups offering primarily social interaction, but also offering older people an opportunity to feed into Halton OPEN and the Older People's Implementation Team. There are currently six participation groups that are supported by Age Concern, Windmill Hill, Halton Lodge, Hale Village, St George's Court, Castlefields and Bridgewater
- **Dignity Champions –** Newly formed and supported through the Older People's Local Implementation Team the Dignity Champions will report on the Dignity in Care agenda as part of the Local Area Agreement.
- **Area Forums –** available to all residents in Halton
- **Residents meetings** – Castlefields, Brookvale, Neighbourhood Management Areas, Halton Brook
- **Mental Health forum –** Peer network group for mental health service users that feeds directly into the Mental Health Local Implementation Team.
- **Halton Carers Forum –** direct support group for carers in Halton
- **Local Involvement Networks (LINKS)**

Prevention and minimum intervention

- **Befriending service –** a volunteer led service delivered through Age Concern that offers a regular visit to some of the most isolated older people in the borough. The service currently has in excess of 60 volunteers all carrying out a weekly or fortnightly visit.
- **Telefriending service** – A volunteer led service delivered through Age Concern that offers a regular phone call to older people who have some degree of social isolation or who are waiting until a befriending volunteer can be recruited. The service has three volunteers that support fifteen older people.

- **Home Safety checks** – The service is delivered through Age Concern and offers a comprehensive check into an older persons home. The service identifies risks in the area of fire, crime and falls and works with key stakeholders to make appropriate referrals. The service completes in excess of 300 checks per year.
- **Helping hand service** – A pilot service was delivered through Age Concern in 2008/09 offering low-level practical jobs for older people. The service is supported by volunteers and in the first year completed 200 small jobs. The service plans to expand during 2009/10 linked to the newly developed handyperson service.
- **Traders Register** – The register is available to all older people in the borough through Age Concern. It has a range of over 40 local traders registered and allows service users to access traders that are insured, must supply references and have been quality tested to give extra piece of mind. The service averages 100 enquiries per month.
- **Shopping service** – The service is provided through Red Cross and offers shopping for older people with limited mobility who have no other means of accessing their food requirements. The service is currently supporting 22 long-term clients and has capacity to support another 10 short-term clients.
- **Information service** – A signposting and low-level casework service that offers information to older people on any topic they require. The service has in excess of 500 enquiries per month and there has been a change into more people with higher needs or requiring some form of low-level advocacy.
- **Sure Start to Later Life** – A service delivered through Halton Borough Council, working in partnership. Four information officers offer a range of support to older people who have completed a low-level self-assessment of their needs.
- **Reach for the Stars** – Delivered through the Halton & St Helens Primary Care Trust the service offers volunteers who support older people into social activities. The service is designed to help people build confidence and access services that meet their short and long term needs. The service supports in excess of 350 older people per year.
- **Complimentary Therapies** – weekly community sessions that supports in excess of 200 older people each year.
- **Fresh Start** – is a weight management programme that is offered through the Healthy Living Programme via Halton & St Helens Primary Care Trust,
- **Fit to Dance** – the service offers three sessions at the Brindley, Ditton Community Centre and Murdishaw Community Centre. The service has supported 119 older people from April 2008 – Dec 2008.
- **Dance activities** – 14 additional dance groups accessible to Older People (8 in Runcorn, 6 in Widnes)
- **Recipe for Health –** A healthy eating programme delivered through the Healthy Living programme
- **Warden services** – Community based service offered through Halton Borough Council and linked to Intermediate Care.
- **Telecare –** Initial pilot service took place in 2006/07; the service has expanded dramatically and now has received mainstream funding.
- **Mens Health programme –** a pilot service that targets men accessing healthcare at an earlier point. The service is aimed at men who are 40+ and in its first year has already supported 95 men through health checks and 10 week taster sessions.
- **Arts –** a range of projects supporting the arts including: painting, camera group, 5 craft groups, cake decorating, and pottery.

- **Dementia reading group –** a pilot service that carries out poetry readings for people diagnosed with dementia. The service is carried out in two venues, one in the community and one within a residential care setting.

RE-ENABLEMENT AND INTERMEDIATE CARE

As commissioners we have to look toward prevention far more than treatment or crisis management. The population projections linked to health and lifestyle concerns point to major financial shortfalls for Health and social care in the future. The details in the section above show some of the targeted low-level work that is already being delivered in Halton, however it is important to acknowledge that alongside these services we must maintain and improve our higher level re-enablement services.

By ensuring that re-enablement, prevention and information work together we will be able to support all of an individuals needs and not just their priority health or social care need. Below is a menu of services already available in Halton.

Intensive time limited interventions

- **Intermediate Care Gold service**
- **Intermediate Care sub-acute unit**
- **Home from Hospital scheme** – service delivered by Red Cross and offers service users up to six weeks support for a range of low-level tasks once the service user has left Hospital.
- **Re-ablement service**
- **Dorset Gardens (Extra Care Housing)**
- **Sheltered housing**
- **Intermediate Care beds OakMeadow**
- **Rapid Access and Rehabilitation Service (RARS) –** aims to design **a** programme of activities to help people to live as independently as possible.
- **APEX falls exercise programme –** time limited exercise programme to support the mobility of people who have suffered or at risk of a fall.
- **Weight Management groups –** 13 separate weight programmes, some private and some provided through health (Runcorn x8, Widnes x5)

COMMISSIONING INTENTIONS

Halton is in the process of developing a range of specific workstreams that will begin to address some of the issues that have been raised above.

- Develop and implement prevention strategy

- Complete a communication strategy for older people's services

- Review existing information services to inform commissioning priorities and direction for the future.

- Develop outcome framework to collate evidence data for low-level services.

PLANNED INVESTMENT

Joint investment has been agreed through the Vulnerable Adults Taskforce for the next three years. This investment will be used to initially develop and then implement the prevention agenda. This work will be supported by external evaluation, the role of

this evaluation will be to demonstrate the impact and outcomes that have been experienced by the service user, the carer, the service, the Local Authority and NHS Halton & St Helens.

SECTION SIX : PERSONALISATION

Personalisation means thinking about care and support services in an entirely different way. It means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about what, who, how and when they are supported to live their lives. It requires a significant transformation of adult social care so that all systems, processes, staff and services are geared up to put people first.

The traditional service-led approach has often meant that people have not received the right help at the right time and have been unable to shape the kind of support they need. Personalisation is about giving people much more choice and control over their lives and goes well beyond simply giving personal budgets to people eligible for council or health funding. Personalisation means addressing the needs and aspirations of whole communities to ensure everyone has access to the right information, advice and advocacy to make good decisions about the support they need.

The Government approach to personalisation can be summarised as “the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and their services they receive”. This approach is one element of a wider cross-government strategy on independent living.

The Government is clear that everyone who receives social care support in any setting, regardless of their level of need, will have choice and control over how this support is delivered. The intention is that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity.

This means a common assessment of individual social care needs, emphasising the importance of self-assessment. The role of social workers will focus on advocacy and brokerage rather than assessment and gate keeping. This is a move from the model where the individual receives the care determined by a professional, to one where the individual is firmly at the centre, identifying what is important to them in delivering the care they need to be as independent as possible. This is called a ‘a person centred planning’ approach.

In the future, all individuals who are eligible for publicly-funded adult social care will have a personal budget. The budget will be clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being. Having an understanding of what is available will enable people to use resources flexibly and innovatively, no longer simply choosing from an existing menu, but shaping their own menu of support.

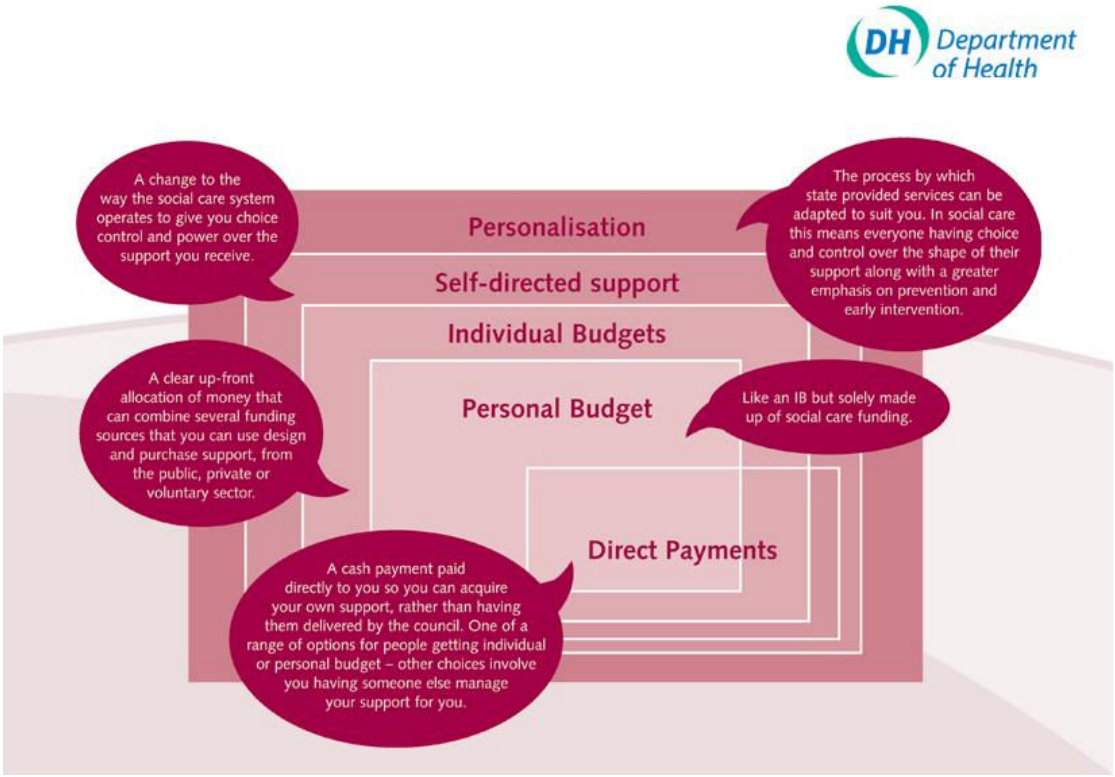
Progress to date

The Government has provided a Social Care Reform Grant to support the implementation of Personalisation.

A “Transforming Adult Social Care Change Board” (TASC) has been established to oversee the strategic planning and implementation of personalisation in Adult Social Care. This is chaired by the Strategic Director, Health & Community. Representatives from Corporate Services, NHS Halton & St Helens, users of social care services and

their carers all sit on the Board. In addition a Self Directed Support Group oversees dedicated work streams on Finance, Workforce, Commissioning and Outcomes.

Personalisation is a number one priority for the Department of Health. There are new targets that will accompany the Governments directives, but there is a clear expectation that by March 2011 significant change will have taken place. The Care Quality Commissioners already tracking progress on implementation. As such, Personalisation is probably one of the most significant policy developments since the implementation of the Community Care Act in 1993.



PERSONALISATION IMPLICATIONS FOR COMMISSIONING

- Ensuring the right balance of investment between different services- aggregated and disaggregated investments – as well as the appropriate balance between cost, quality and value for money to meet local needs.
- Shaping the market – so that high quality, flexible and responsive services are available for personal budget holders and self-funders
- Ensuring that people have access to information and advice to make good decisions about their care and support, however it is funded
- Finding new collaborative ways of working that support people actively to engage in the design, delivery and evaluation of services
- Developing local partnerships, particularly between health and social care, which produce a range of services for people to choose from and opportunities for social inclusion and community developments
- Commissioning prevention and well-being services – which promote the public good, but which would not be purchased by individuals, as well as some widely used services to more flexible specifications e.g. domiciliary care
- Ensuring all citizens have access to universal community services and resources such as transport and leisure activities.

SECTION SEVEN : REVIEW OF THE PREVIOUS OLDER PEOPLE'S COMMISSIONING STRATEGY

The Commissioning Strategy for Older People in Halton was published in 2004 and covered the period between 2004 – 2008. The strategy included a needs analysis and details of the current provision of service in Halton. From this data it went onto identify fifteen key recommendations that would form the basis of the implementation of the strategy. This section will look at how we have performed against some of these recommendations as well as considering some of the wider performances we have achieved over the previous four years.

Introduction

There have been a number of dimensions to the improvement journey within Halton, all of which have had to be in place to deliver sustainable improvement. These dimensions to improvement include:-

- Strategic Approach/Leadership
- Commissioning and Investment Strategy
- Meaningful Engagement
- Performance

These four key areas underpin the core outcomes contained in 'Our Health, Our Care, Our Say', and are integrated into the work undertaken by the Directorate and our partner agencies. These outcomes include: -

- Health and Well being
- Quality of Life
- Positive Contributions
- Choice and Control
- Discrimination and Harassment
- Economic Well Being
- Personal Dignity

Strategic Approach/Leadership

Joint working arrangements with NHS Halton & St Helens have developed strongly since 2005, with a whole system approach to promoting health, independence and well being. A number of new initiatives, such as a Sure Start to Later Life Scheme and links to the Bridge Building Scheme ensures people have increasing opportunities for an active and independent lifestyle. There is collaborative working with NHS Halton & St Helens in respect of services for Older People with Mental Health needs (fully integrated Community Mental Health Team, with single line management).

The development of an Advancing Well Strategy clearly recognises the impact that population ageing will have in the Borough and illustrates the need for raising the profile of Older People in the Borough. The Strategy is targeted at over 50s and is the first step in identifying the need for a major culture shift away from merely providing resource intensive high-level interventions toward low-level preventative services which promote social inclusion and positive mental health, thus reducing the need for some services.

Another element to the Advancing Well Strategy is to act as a tool that reaches across all Council Directorates as well as key partners and stakeholders. The Advancing Well Strategy has six key themes that cut across a range of service provision and aim to reflect the needs and aspirations of Older People. The six themes are: -

- **Transport** – Allowing Older People to Travel Safely and Access Services around the Borough
- **Employment & Education -** Enabling Older People to find Paid and Voluntary Work
- **Health** - Ensuring Older People are in Good Health Longer
- **Safe & Independent Living** - Supporting Older People to Live at Home in Comfort
- **Advocacy & Financial Services** – Providing Reliable and Easy Access to Financial and other Advice Relevant to Older People
- **Communication & Information** - Ensuring Older People are Involved in the Decision Making Processes relating to Local Services

The Halton Safer Homes Group is a multi-agency meeting, chaired by Cheshire Fire & Rescue Service, which works directly to implement key objectives from the Safer Halton Local Strategy Partnership. The Group has representatives from HBC, NHS Halton & St Helens, Police, Fire Service, Voluntary Sector and Community Groups.

There have been significant developments within Safeguarding Vulnerable Adults, as well as improved reporting, recording and training processes, there is also better working with Police and other organisations in ensuring relevant adherence to policies and procedures. Older People's Care Management now includes management of an Adult Protection Co-ordinator and oversight of the Older People's Community Mental Health Team employed within the 5 Boroughs Mental Health Trust.

Between 2004 and 2006, the Local Implementation Team (Older People) identified a number of prominent professionals and service users to undertake the role of 'Older People's Champion'. This role focused primarily on ensuring that the voice of Older People was heard and considered as part of the planning and implementation process. More recently the role of 'Older People's Champion' has been redefined to reflect the national agenda relating to personal dignity. 2009 has seen the appointment of a dignity co-ordinator to further improve the initial work started by the older people's champions.

Reviews of contracting and partnership arrangements have taken place and the completion of the section 75 partnership agreement along with the section 75 agreement for intermediate care clearly demonstrate the positive strides that have been made in the last four years.

There have been strong developments within Multi-Disciplinary Teams and although more still needs to be done particularly in relation to early intervention we have joint processes in place through, **Social Care in Practice**, **Rapid Access and Rehabilitation Service (RARS), Intermediate Care, Healthy Living Programme.**

One of the biggest areas of success over the last four years in Halton has been the reduction in placements in residential and nursing care. We saw a reduction of 36% over the period of 2003-04 – 2007-08. In addition to this reduction we have seen an increase in investment in Intermediate Care, which has resulted in positive outcomes

for service users in the community, to support many more older people to remain independent in their own homes and enjoying an improved quality of life. 2008/09 saw a joint agreement for funding between the Local Authority and Halton & St Helens NHS, this stability has subsequently allowed the service to develop and implement a Gold standard for Intermediate Care. It has also allowed for the newly opened sub-acute unit at the Halton General Hospital site in Runcorn.

Commissioning and Investment Strategy

Commissioning has developed widely rapidly and the post of joint Commissioning Manager for Older People now sits across Health and Social Care. The lead organisation for the post is the Local Authority, however it also sits within partnership commissioning in NHS Halton & St Helens. This allows the post to consider all aspects of commissioning and understand the key priorities across both organisations.

Significant commissioning achievements include:-

- Dorset Gardens Extra Care Scheme
- Dementia service
- Carers Breaks
- Sure Start to Later Life
- Lifeline and wardens development
- Meals service
- Re-tendering of domiciliary care contracts, including realignment of in house service to a short term service

In supporting this Change Strategy, a pool of change money was agreed, made up of £400k of NRF matched with £200k from both Social Care and NHS Halton & St Helens base budgets. This formed what is known as the Vulnerable Adults Taskforce Programme.

The Vulnerable Adults Taskforce Programme has been instrumental in commissioning a range of services that support well being, independence, health, leisure etc. These include the pilot Evercare service, Domiciliary Pharmacy, (both now mainstreamed by the PCT), low-level Podiatry, Telecare, Falls Service, Home Safety Checks, Traders Register, Shopping Service, Reach for the Stars. In addition the Local Authority is now working with partners to develop an outcome framework for the Local Area Agreement outcome 3 of the Healthier Communities and Older People block. This framework pulls together low-level activity across a wide range of areas, all targeted towards improving the health and well-being of local Older People.

One of the main criteria that the Vulnerable Adults Taskforce Programme is linked directly to emergency admissions, readmissions and length of stay. There have been a number of projects that have made a positive impact in this area including the Mental Health Liaison Nurse, Falls Service, Podiatry, Evercare and Telecare.

An improvement on 2005-06 is that the Community Warden and Telecare Service are fully integrated with the Falls pathway. This has effectively supported the preventative agenda and in many cases preventing the need for hospital admissions.

The Directorate has made significant advances in the use of assistive technology (e.g. door sensors to monitor wandering or fall detectors etc) to promote independence and choice.

Following the successful housing stock transfer the Lifeline and Wardens services were transferred to social care thus strengthening integration of care and support services.

Our first Extra Care Housing Scheme (in partnership with Riverside) opened on schedule in October 2006 (40 units at Dorset Gardens, Runcorn) to improve outcomes for people living independently in the Community. In-house home care are delivering the care, and developing a model of care provision, which meets the needs of an extra care facility. The Council continues to work with housing providers to develop Extra Care housing further and this is a key priority for the next five years.

There has been a particular focus on early prevention to reduce higher-level support services and signpost to non care managed support when necessary. This ensures people maintain their independence and quality of life. There has been extensive joint work in developing programmes/range of services to support vulnerable people to lead an active lifestyle and thus support the 'seven dimensions of independence'. Support has been given for programmes within the Healthy Living Programme including: -

- Reach for the Stars (programme to support older people into social activity),
- Health trainers,
- Participation groups and the Older People's Empowerment Network that allow local older people to have a voice and contribute to a number of formal bodies.
- Support for information provision through the development of Age Concern outreach information service and the Sure Start to Later Life project.

A comprehensive review of Care Management processes and systems has taken place, with all documentation redesigned to ensure need is identified consistently and risk managed appropriately.

An evaluation of the outcomes of intermediate care services was completed and led to the development of the Intermediate Care Gold service, which includes the new Intermediate Care unit at Halton Hospital. This service has consistently demonstrated an impact on reducing dependency, delays in hospitals and hospital admissions. Home care has moved to provide a 24/7 service and a specialist intensive domiciliary service for those with dementia is in operation

Joint working has been established with the Welfare Benefits Service and Fairer Charging Team thus leading to improved benefits maximisation and take up and timeliness of financial assessments.

There has been an increase in the use of Self Assessment in regards to helping individuals work out what equipment could help them remain independent. This self-assessment method as helped reduce the time it takes to get the equipment required and it has worked best for people who have less complex permanent disabilities.

Training and development remain as a key objective to support professional development. The Local Authority's Training Section has commissioned a number of events regarding Management Development. The first is a dual qualification consisting of the Institute of Leadership and Management (ILM) level 5 and the National Vocational Qualification (NVQ) in Management level 4 or 5, dependent on role within the organisation. In addition Halton Borough Council and Halton and St Helens NHS are currently attending a joint Management Development Programme, with a view to developing a joint approach across Halton.

Meaningful Engagement

The Council has a number of initiatives to enable Older People to engage in programmes to express their views with regard to service development, planning and review.

Improved engagement activities since 2005 include: -

- A consultation resulted in a change of provider for Community Meals;
- 123 responses from Older People in respect of the Advancing Well Strategy;
- Regular attendance from Halton's Older People Empowerment Network (OPEN) on the Local Implementation Team (LIT);
- More than 100 older people attended a recent annual conference
- Almost 200 people attending the first intergenerational conference in 2009.

The Older People's Empowerment Network (OPEN) is the main Older People's Group that acts as a focal point for gaining views and feeding them into key strategic planning groups like the Older People's Local Implementation Team. This was identified through the Vulnerable Adults Taskforce as an area for development (see Section on Commissioning & Investment Strategy). In addition, Older People have access to area forums, the Older People's conference and Age Concern's participation groups.

Although Halton OPEN set's it's own agenda based on the needs of local Older People they also react to local consultation topics and have offered support on: -

- Extra Care Housing
- Telecare
- Sure Start to Later Life
- Residential Care
- Carers issues
- Dementia Strategy

Each of the low-level Voluntary Services are supported to record Service User satisfaction as part of their contract or service level agreement. Questionnaires are a popular way of doing this, however we have also worked successfully to deliver the Older People's conference and the intergenerational conference, focus groups for the development of a men's health project and utilising technology for an event with Stroke Service Users and Carers, by operating an interactive question and answer session with data being illustrated as soon as the question had been answered. Service Users found this method of consultation particularly satisfying, as they were able to see that their views were being collected in a meaningful way.

One of the key themes that came directly from Older People at the 'Making a Difference' Conference in 2005, was information provision. Older People didn't know what was available or how to access it. This was mirrored in the recent intergenerational conference with over 90% of the requests for services already being available in the borough. This demonstrates that there is still much work to be completed in relation to communication and information provision.

A number of key services have been developed to help this process; Sure Start to Later Life, Reach for the Stars, Health Trainers and Age Concern Outreach information. In addition a directory of services is currently being developed to support even better information provision in the Borough.

There have been three successful Older People's conferences. Each conference is attended by in excess of 100 Older People and a range of professionals from all service areas. The conferences are an opportunity for local people to ask questions, understand progress in service delivery and contribute to future service developments. The conference was the starting place for the development of the Sure Start to Later Life project.

Halton Borough Council and Halton & St Helens NHS have undertaken a Joint Strategic Needs Assessment for Halton to identify the demographics of the borough as well as detailed analysis of the current picture in relation to performance, needs and gaps. The Joint Strategic Needs Assessment is a piece of work that needs to be completed on an annual basis. In relation to low-level services a mapping of existing services and service provision is currently being undertaken through the older people's working group that is chaired by the Operational Director, Cultural and Leisure Services. The mapping was completed during the Summer of 2009 and will now form part of the development of an early intervention strategy.

Performance

Commissioning and Investment Strategy describes some of the changes made, but have they improved outcomes? Performance for Social Care has traditionally been measured by DoH Performance Assessment Framework indicators, and below some of these are discussed. However these indicators have all significantly improved over the last 4 years supporting the achievement of a 3 star Social Services rating. Many of these are proxies for outcomes, and establish trends in performance across a system.

Rightly performance has increasingly been focussed on developing outcome measures. However we also have a journey and story to tell – this demonstrates some significant change with a dramatic increase in the number of older people supported at home alongside a decrease in long term residential and nursing placements. Standard output data is still provided and has been improved in relation to the consistency and frequency of collection, however the developments within outcome measures has seen a significant improvement in understanding the true impact of particular services. This has been demonstrated through the Vulnerable Adults Taskforce, which has begun the process of developing specific outcome data on the Mental Health Liaison Nurse service and the Falls clinic. We are currently working with partners to establish the impact of interventions in both areas on Hospital admissions, readmissions and length of stay. Although only in the initial stages it appears that both projects have made a significant impact on their key target areas.

The Council has been proactive in providing the opportunity for older people to take control of their own care. Halton is highly placed in the local authority league table for the use of direct payments. The Council is also promoting the use of telecare systems to help people live at home, in conjunction with the Halton Direct Link, 24-hour contact centre. Initiatives such as Halton Direct Link have led to an increase in the number of services accessed at a community level.

The number of adults and older people receiving Direct Payments as at 31st March 2009 (per 100,000 population) increased from 165 during 2005-06 to 283. This remains an area of very good performance and is higher than comparator Councils. (The main uptake was from older people, people with learning disabilities, people with sensory impairment, carers and black and minority ethnic groups).

The Council continued to improve on it's very good performance on the number of older people helped to live at home; from 111 during 2005-06 to 144 per 1,000 of the population aged 65 and over. This was higher than agreed target of 139.

Intensive homecare also increased (from 9.7 during 2005-06 to 11.1 per 1,000 of the population aged 65 and over). The estimated number of households who purchase intensive homecare through Direct Payments also increased (from 2.28 during 2005-06 to 3 per 1,000 of the population aged 65 and over) and performance exceeded the council planned target of 2.30.

There was a slight decrease from 74 during 2005-06 to 54 per 10,000 of the population aged 65 and over in the number of Older People admitted to residential and nursing care. This was in line with the plan and remains very good performance.

Development areas

The following points demonstrate where targets have been partially achieved, but still have some attached actions that need completion.

- The Older People's Local Implementation Team has maintained a high level of stability over the last five years. Chaired through the Local Authority and with a Primary Care Trust vice chair the Board has been able to operate as a fully functional multi-agency partnership board. It has been involved in modernisation, but there are still questions raised about the full impact and position the OP LIT has. The OP LIT only has direct commissioning control over a small budget (Vulnerable Adults Taskforce) and still struggles to fully influence other areas of work. **(See action 4,5, and 6 of the action plan)**

- Halton Older People's Empowerment Network (OPEN) remains the best source of consultation within the borough. The network provides a voice to local Older People who are able to sit as executive members on the OPEN board and be involved in conference's tackling local issues. Three members of Halton OPEN currently sit on the Older People's local Implementation Team and one member sits on the Stroke Core Strategy Group.

  The membership of Halton OPEN has now exceeded 600, but plans need to be developed to ensure that the full membership of the network is utilised and not just the executive committee members. **(See action 7 and 8 of the action plan)**

- The commissioning pot that is overseen by the Older People's Local Implementation Team (the Vulnerable Adults Taskforce) was fully audited in 2008. The Older People's Local Implementation Team does have some level of performance reporting mechanisms in place, but they are currently being redeveloped in line with the changes being made through the restructure of the board. **See Action 5 above.**

- In respect to links to the accommodation strategy this has been partially achieved, there is now a housing sub-group of the Older People's Local Implementation Team and this will need to be a priority when looking at Extra Care Housing, residential care, and developments in the Home Improvement Agency. It will also be vital in the current economic climate. **(See action 6 and 13 of the action plan)**

- The following strategies have been developed and are available to support this document:

  Advancing Well strategy
  Extra Care Housing
  Transport Plan
  Housing Strategy
  Commissioning Strategic Plan
  Carers Strategy
  Intermediate Care Gold Standard
  (See action 9, 10, 11, 12 and 13 of the action plan)

- The implementation of the Single Assessment Process has not been as successful as anticipated. Poor sign up and slow decision making have resulted in a deficiency in full coverage and this looks set to continue in the near future. An update and relaunch of the steering group is planned during 2009, this will include ensuring the correct membership of the meeting. **(See action 14 of the action plan)**

SECTION EIGHT : IMPLEMENTING THE STRATEGY

JOINT COMMISSIONING STRATEGY ACTION PLAN

No	Key Actions	Lead Responsibility	Links to local target	By When	Comments
1	To ensure service planning officers are clear in their role of supporting commissioning by provision of high quality evidence.	Older People's Commissioning Manager / Manager of Service Planning	NI7 – Environment for a thriving third sector A4H – Making a difference by providing services which meet the needs of vulnerable people A4H – Making a difference by making sure people have excellent access to services and facilities	Ongoing	Develop communication and reporting process between Commissioning and Service Planning. Ensure workplans are linked between both areas
2	Commissioning decisions are made based around the highest level of monitoring evidence that is available and that this be obtained through the contracts department and commissioners.	Older People's Commissioning Manager	NI5 – Overall satisfaction with the area. Links to all service specific NI targets.	Ongoing	Evidence reported to relevant reporting forums including the Halton health Partnership, Older People's Local Implementation Team etc.
3	There is enough capacity within the contracts team to fully support the commissioning requirements needed for effective commissioning of Older People's services.	Divisional Manager Planning & Commissioning		2010 -11	Reviewed under KPMG and Tribal review of Partnership commissioning. This will be dependent on future commissioning decisions.

4	Strengthen the Older People's local Implementation team to become more of a strategic commissioning body.	Chair Older People's Local Implementation Team	NI 7 – Environment for a thriving third sector. NI 124 – People with a long-term condition supported to be independent and in control of their condition. NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. A4H – to ensure that no-one experiences barriers to accessing good quality care and support because of their culture, ethnicity or sexuality. A4H – to ensure that all older people have the opportunity to enjoy a good quality of life.	Initial implementation Sept 2009 Low-level Review Sept 2010 Strategic review to be carried out in Sept 2011	New Terms of Reference in draft format at present. Need to strengthen membership as well as agreeing business priorities.
5	Improve reporting and performance frameworks of the Older People's Local Implementation Team.	Older People's Commissioning Manager	Links to internal team plan and World-Class commissioning intentions	Sept 2009 Review Sept 2010	Reporting process and performance framework to be completed

6	Develop Housing sub-group of the Older People's Local Implementation Team.	Divisional Manager Planning & Commissioning	NI124 – People with a long-term condition supported to be independent and in control of their condition. NI142 – Number of vulnerable people supported to maintain independent living	May 2009 set-up of meeting Extra care development 2010-2014	The newly formed group will need to be responsible for developments within Extra Care, the refresh of the Older People's accommodation strategy and linking in with the Dignity agenda across housing.
7	Implement commissioning links between Older People's Commissioning Manager and Halton Older People's Empowerment Network (OPEN)	Older People's Commissioning Manager and Chair of Halton OPEN	NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. A4H – To support communities to be engaged in the design and delivery of public services and solutions to improve the health and wellbeing of all our residents.	Ongoing	Commissioning manager to agree a method of reporting to and from Halton OPEN to improve engagement, consultation and service user involvement in planning.
8	Carry out audit of Halton OPEN members to develop an agreed database of what people's interests are and how they want to be involved.	Older People's Commissioning Manager and Chair of Halton OPEN	NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently.	End of 2009	Audit will target existing members of Halton OPEN to establish how people would like to be consulted and what where their areas of interest.

			A4H – To support communities to be engaged in the design and delivery of public services and solutions to improve the health and wellbeing of all our residents.		
9	Develop and implement a prevention strategy, which includes intergenerational initiatives.	Operational Director – Older People Operational Director – Cultural services	NI 7 – Environment for a thriving third sector. NI17 – Perceptions of anti-social behaviour NI120 – All-age all cause mortality NI124 – People with a long-term condition supported to be independent and in control of their condition NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. NI142 – Number of vulnerable people supported to maintain	End of 2009 for strategy Implementation plan Jan 2010 - 2013	Baseline audit has been completed and mapping of existing activity underway.

			independent living A4H – to ensure that all older people have the opportunity to enjoy a good quality of life.		
10	Complete development of a local stroke strategy	Head of Partnership Commissioning – NHS Halton & St Helens	NI124 – People with a long-term condition supported to be independent and in control of their condition NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. A4H – Making a difference by ensuring that when people do fall ill from some of the major diseases, they get the best care and support.	End of 2009 for strategy Implementation plan Jan 2010 - 2013	Mapping of service provision has been completed. Audit of existing performance against National Quality Markers is almost completed and will be repeated on an annual basis to demonstrate progress, gaps, good practice and deficiencies in service.
11	Complete the renewing of the Older People's Mental Health strategy	Older People's Commissioning Manager / Head of Partnership commissioning (NHS Halton & St Helens)	NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. NI150 – Adults in contact	Complete by March 2010	Work is underway in a number of areas to refresh the strategy, but will need to be completed after the proposed implementation of the Assessment Care and Treatment Service.

			with secondary mental health services in employment A4H – Making a difference by providing services, which meet the needs of vulnerable people.		
12	Produce a local dementia strategy	Older People's Commissioning Manager	NI124 – People with a long-term condition supported to be independent and in control of their condition NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. A4H – Making a difference by ensuring that when people do fall ill from some of the major diseases, they get the best care and support.	Strategy completed by Oct 2009 Implementation plan Jan 2010 - 2013	Project plan in place
13	Renew and update the older people's accommodation strategy.	Divisional Manager Planning & Commissioning	NI124 – People with a long-term condition supported to be independent and in control of their condition. NI142 – Number of	March 2011	

			vulnerable people supported to maintain independent living		
14	Ensure that objectives for implementation of Single Assessment Process are agreed and that the steering group takes joint ownership to oversee completion.	Single Assessment Process Co-ordinator			
15	In line with local needs projections and working in partnership with Halton & St Helens NHS, Registered Social Landlords, Private sector and Housing associations, develop business case and funding application to support Extra Care housing bid.	Divisional Manager Planning & Commissioning	NI124 – People with a long-term condition supported to be independent and in control of their condition. NI142 – Number of vulnerable people supported to maintain independent living	Ongoing Implementation 2010 - 2014	Draft plans currently being drawn up.
16	Increase and improve the effectiveness of the membership of Halton OPEN	Older People's Commissioning Manager and Chair of Halton OPEN	NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. A4H – To support communities to be engaged in the design and delivery of public services and solutions to improve the health and wellbeing of all our residents.	Ongoing	See action points 7 & 8

17	Explore the possibility of developing, with Halton OPEN, a mystery shopping service to measure the effectiveness of existing services in Halton.	Older People's Commissioning Manager and Chair of Halton OPEN	NI139 – People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently. A4H – To support communities to be engaged in the design and delivery of public services and solutions to improve the health and wellbeing of all our residents.	Ongoing	See action points 7 & 8

Appendix 1 - Local Area Agreement targets specific for Older People's Services.

Priority	***Indicators***	***Baseline (2007/08 unless specified otherwise)***	***Targets 2008/09***	***Targets 2009/10***	***Targets 2010/11***	***Lead partner (in bold) & supporting partners***
NI 5	Overall satisfaction with the area	Place survey indicator	TBC	TBC	TBC	HBC HVA PCT Police RSLs
NI 7	Environment for a thriving third sector	Place survey indicator	TBC	TBC	TBC	HVA HBC PCT Police
NI 8	Adult participation in sport	24% (2004)	27%	29%	30%	**LA** PCT Vol Sector
NI 15	Serious violent crime rate	Baseline 90 crimes recorded. 2% reduction target	2%	2%	2%	**Cheshire Constabulary & CDRP Partner agencies.**
NI 17	Perceptions of anti-social behaviour	Baseline 35% Target 27%	25%	23%	17%	**CDRP Partners / (Community Safety Team)**

Priority	*Indicators*	*Baseline (2007/08 unless specified otherwise)*	*Targets 2008/09*	*Targets 2009/10*	*Targets 2010/11*	*Lead partner (in bold) & supporting partners*
NI 30	Re-offending rate of prolific and priority offenders.	Baseline to be set by Home Office using JTrack system,.	TBC	TBC	TBC	**Cheshire Constabulary / Probation** & CDRP Partner Agencies / (Community Safety Team)
NI 32	Repeat incidents of domestic violence	For introduction in APACs in 2009/10 when coverage complete	-	-	-	Cheshire Constabulary & CDRP Partner Agencies
NI 33	Arson incidents	98.734 per 10,000 population	85.681 per 10,000 population	74.533 per 10,000 population	64.931 per 10,000 population	**Fire & Rescue Service**, Police + PCSOs, Youth Services, HBC, Schools, Businesses
NI 39	Alcohol-harm related hospital admission rates	2339.2	2428.1	2488	2521.2	**PCT** Hospital Trusts Mental Health Trusts LA / DAAT Police Schools Vol sector
NI 40	Drug users in effective treatment	New Indicator	TBC	TBC	TBC	CDRP

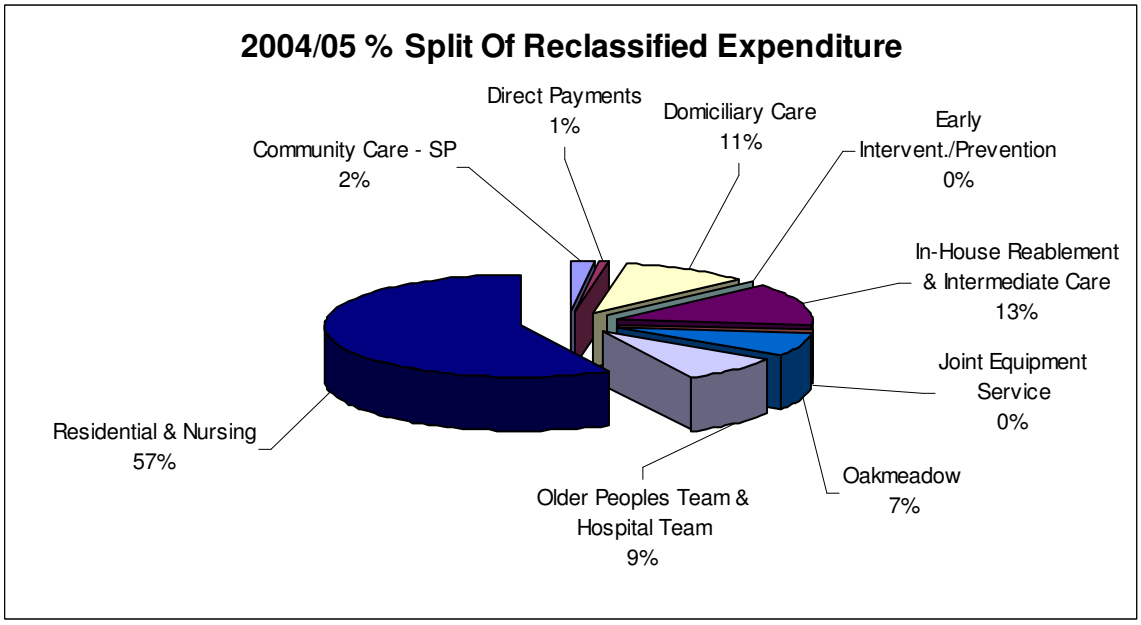
Priority	*Indicators*	*Baseline (2007/08 unless specified otherwise)*	*Targets 2008/09*	*Targets 2009/10*	*Targets 2010/11*	*Lead partner (in bold) & supporting partners*
NI 120	All-age all cause mortality	Males 805 Females 607	Males 780 Females 590	Males 755 Females 574	Males 731 Females 558	**PCT** LA Acute Trusts
NI 123	16+ current smoking rate prevalence	N/A (not calculated in this way before)	1038	1082	1128	**PCT** LA Acute Trusts Schools/colleges
NI 124.	People with a long-term condition supported to be independent and in control of their condition	N/A	TBC	TBC	TBC	**PCT/LA** Acute trusts Vol sector
NI 139	People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently	N/A	TBC	TBC	TBC	**LA** PCT Vol sector
NI 142	Number of vulnerable people supported to maintain independent living	94%	94.7%	95.3%	96%	**LA** PCT Cheshire Probation DAAT Vol sector Private sector

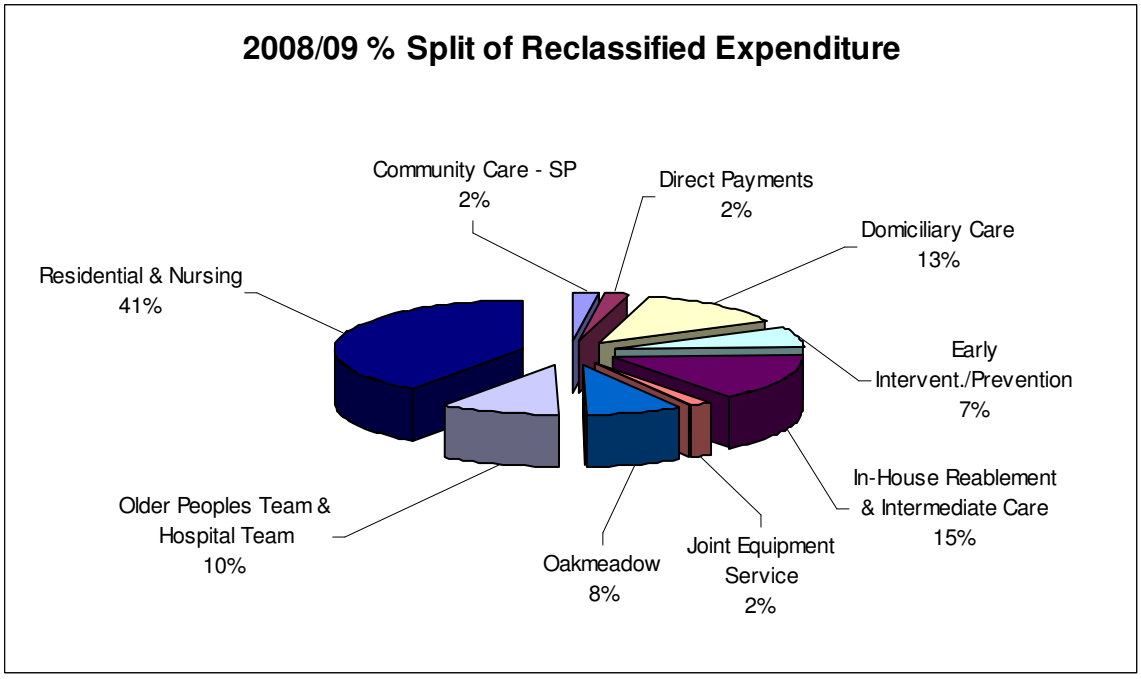
Priority	*Indicators*	*Baseline (2007/08 unless specified otherwise)*	*Targets 2008/09*	*Targets 2009/10*	*Targets 2010/11*	*Lead partner (in bold) & supporting partners*
NI 150	Adults in contact with secondary mental health services in employment	*N/A*	**TBC**	**TBC**	**TBC**	**LA** PCT Job Centre Plus
NI 153	Working age people claiming out of work benefits in the worst performing neighbourhoods					Job Centre Plus HBC
NI 154	Net additional homes provided	483 (estimate)	519	519	519	RSLs Housing Industry HBC
NI 173	People falling out of work and on to incapacity benefits					Job Centre Plus HBC
NI 175	Access to services and facilities by public transport walking and cycling					HBC Transport Operators Transport partnership
NI 175	LTP1A – Access to Whiston Hospital	29%	60%	60%	60%	

NI 175	LTP1B – Access to Warrington Hospital	0%	20%	30%	30%	

Appendix 2 –

Financial information





The pie charts above clearly demonstrate the shift that has already taken place in older people's services. This particularly shows the reduction in funding for residential and nursing provision that now only accounts for 41% of the overall budget compared to 56% four years ago. In addition early intervention now makes up 7% of the budget, whereas there was less than 1% provision four years ago.

Table 1 below shows the % change year on year for each of the descriptive areas. This again clearly demonstrates the financial increase in early intervention / prevention.

Table 1

Reclassified Description	2004/05	2005/06	2006/07	2007/08	2008/09
Community Care - SP	265,726	217,792	393,061	338,072	381,449
% Year on Year Change		***-18%***	***80%***	***-14%***	***13%***
Direct Payments	147,734	149,931	216,229	301,467	303,922
% Year on Year Change		***1%***	***44%***	***39%***	***1%***
Domiciliary Care	1,553,411	1,754,806	1,898,841	2,298,401	2,084,917
% Year on Year Change		***13%***	***8%***	***21%***	***-9%***
Early Intervention/Prevention			559,111	867,030	1,130,931
% Year on Year Change				***55%***	***30%***
In-House Reablement & Intermediate Care	1,955,835	1,930,607	2,205,538	2,398,189	2,477,298
% Year on Year Change		***-1%***	***14%***	***9%***	***3%***
Joint Equipment Service		104,094	166,286	135,927	362,090
% Year on Year Change			***60%***	***-18%***	***166%***
Oakmeadow	1,068,711	1,074,249	1,044,956	1,186,013	1,302,886
% Year on Year Change		***1%***	***-3%***	***13%***	***10%***
Older Peoples Team & Hospital Team	1,249,343	1,334,154	1,339,324	1,464,480	1,683,736
% Year on Year Change		***7%***	***0%***	***9%***	***15%***
Residential & Nursing	8,420,460	8,379,520	7,848,906	7,822,388	6,461,000
% Year on Year Change		***0%***	***-6%***	***0%***	***-17%***

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 15 September 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Developing a Comprehensive Community Learning Disabilities Services Infrastructure

1.0 PURPOSE OF REPORT

1.1 The four Boroughs of Halton, Knowsley, St Helens and Warrington, together with the NHS Knowsley, NHS Halton and St Helens and NHS Warrington, wish to develop a Model of Care to support the development of a comprehensive community based service infrastructure for adults with learning disabilities.

1.2 The objective is to transform the quality of care, service model and configuration of services for people with learning disabilities across the four boroughs. This is to be achieved through the development of a more effective range of community support services to enable people to remain at home and avoid hospital admissions and, where this is not possible, to provide a fair, personal, effective and safe in-patient service.

1.3 Commissioners wish to engage and consult with service users, carers, Learning Disability Partnership Boards and key stakeholders on this proposed model of care. This consultation process will occur through the months of August and September 2009.

2.0 RECOMMENDATION: That

Healthy Halton Policy and Performance Board members' are asked to note and comment on the following report.

3.0 SUPPORTING INFORMATION

3.1 In recent years community based services in the four boroughs have undergone significant change and development, accompanied by an apparent reduction in the requirement to use of the available in-patient hospital capacity. This transformation provides an opportunity to reflect on both the availability and quality of current in-patient provision and about the quantity and range of locally available community support services, particularly in relation to the capacity to respond to challenging behaviour.

3.2 Commissioners in the four boroughs believe that in the light of the changes in community focused services, and the reduction in use of in-patient services that it would be timely to refresh the model of care for specialist Learning Disability services, informed by current national strategy and good practice guidance, in order to see if further development of the local model of service would enable services for adult with learning disabilities to be further improved.

3.3 The Model of Care

The model of care presented below is founded on the principles enshrined in Valuing People[1] and re-affirmed in Valuing People Now[2] of 'Rights, Independent Living, Control and Inclusion', with services delivered in a person-centred way with a focus on enabling service users to access mainstream services including mainstream health services wherever possible. The model is intended also to promote the key objectives of Putting People First[3] and High Quality Care for All[4] which include encouraging choice and control, personalisation, health and well-being, prevention, early intervention, enablement, and delivering services as locally as possible. There is a significant focus on meeting the needs of people with challenging behaviour and this has taken its direction from the "Mansell report"[5]. The elements of the model concerned particularly with 'repatriation' from out of area placements have been informed by the Key Principles of 'Commissioning service close to home'.[6]

The model of care makes particular reference to:

- Principles and Practice
- Management Support and Commitment
- Workforce Development
- Transition Arrangements
- Community Services
- In-Patient Services
- Repatriation from Out of Area

Each of the elements of the model is presented in summary form

below.

The model is based on the premise that people with learning disabilities including people with challenging behaviour can lead fulfilling lives in the community supported by 'ordinary' learning disability services. They will sometimes have physical or mental health problems and should be supported to access mainstream health services. Where they need more specialist support, including specialist support arising from challenging behaviour they will have access to skilled support staff and where necessary the support of specialist professionals to assist assessment and help plan more effective support.

[1] Valuing People: A New Strategy for Learning Disability for the 21st Century (DH, 2001)

[1] Valuing People Now a new three year strategy for people with Learning Disabilities (DH, 2009)

[1] 'Putting People First: A Shared Vision and Commitment to the Transformation of Social Care' (DH, 2007)

[1] High Quality Care for All: NHS Next Stage Review final report (DH, 2008)

[1] Services for people with learning disabilities and challenging behaviour or mental health needs and challenging behaviour: The 'Mansell Report' (revised edition DH, 2007)

[1] 'Commissioning Service Close to Home' (DH, 2004)

3.4 Principles and Practice

Good quality learning disability services will have an approach based on strong community support services, planned around people in the environment that they are in, focussing on person-centred care, and looking at each individual's needs. This approach should be applied to all, including people with very complex needs. The service will be committed to achieving the outcomes of 'rights, inclusion, independence and choice', and to ensuring that it 'sticks with' individuals in spite of the difficulties experienced in meeting their needs.

3.5 Management Support and Commitment

Successful services are well organised and managed and deliver an individualised service through skilled staff. They will have a committed group of professional and front-line staff, working with the sustained support of senior policy-makers and managers, (Mansell 'Characteristics of exemplary services').

3.6 Workforce Development

Good services invest in training for the direct care staff of the service. Where services have accepted that people with complex needs and challenging behaviour should be a priority they will ensure that all staff are competent in working with them, and are equipped to understand the behaviour and to respond appropriately.

3.7 Transition Arrangements

Each area will have in place robust and sufficiently resourced transition arrangements. These will be consistent with the objectives of the current national policy and guidance and have the support of all of the relevant services for children and adults.

Young people with behaviour that challenges should be the subject of focused attention and support.

The arrangements will specify that no young person is placed in a distant residential school or other distant placements when their needs can be met effectively nearer to home. Commissioners will ensure that the necessary work is undertaken to build the capacity and confidence of local communities to support young people with more complex needs.

Effective transition support should be based on person-centred planning and partnership working and place young people's needs and aspirations at the centre of the transition process. This will help the processes of consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation.

3.8 Comprehensive Community Support

Comprehensive community support requires:

- An appropriately resourced Community Learning Disability Team
- Accessible specialist professional support
- Education, work and day opportunities
- The capacity to respond to crises 24 x 7
- Accessible resources to facilitate effective support for people with challenging behaviour
- Policies and protocols for the prevention of placement breakdown
- Respite / short breaks for carers of people with challenging behaviour
- Effective integration of the components of the service.

3.8.1 *Appropriately resourced CLDTs*

Effective community services should have at their core an integrated Community Learning Disabilities Team that is sufficiently and appropriately resourced to fulfil its role in meeting local needs including the capability to respond effectively to the needs of people with complex needs and challenging behaviour. Effective CLDTs will led to a greater level of admission avoidance and accelerated discharge from in patients services. Funding will be based on the principles of supporting individuals to live independent fulfilling lives, resources currently committed to in patient services should migrate to community services as activity migrates.

The workloads of the CLDTs will be carefully monitored, so that the impact of any change in in-patient capacity and of any refocusing of the use of in-patient services (such as focusing solely on meeting acute mental health needs) can be identified at an early stage and effectively managed.

3.8.2 *Accessible specialist professional support*

Where the CLDT is unable to meet all of the needs of an individual and requires additional specialist input this should be readily accessible.

The specialist service professionals such as psychiatrists, psychologists and speech and language therapists need to have the capability to respond effectively to the needs of people with complex needs and challenging behaviour and to respond in a timely fashion in situations of crisis including potential placement breakdown.
The specialist/Intensive Team professionals should work closely other community colleagues in a programme to repatriate people from out of area placements.

The CLDT will work to support Primary Care services in delivering high quality health services including health screening.

3.8.3 *Well-Integrated Community Services*

The various elements of community services for people with learning disabilities will operate more efficiently and effectively where there is good joint working, with a high level of co-operation and co-ordination, and where services share the same priorities. If this cannot be achieved within current structures consideration should be given to service redesign.

3.8.4 *Education, work and day opportunities*

People with learning disabilities, including people whose behaviour challenges should be able to access continued education, supported

employment and day opportunities, and this should positively contribute to the stability of community placements. Smaller scale and individually designed arrangements may be more appropriate for people with challenging behaviour.

3.8.5 *Crisis response capacity: 24 x7 access to advice and support*

When people are experiencing a crisis it is essential that the service can respond to their needs with appropriate and effective advice and support 24 hours a day, 7 days a week. As well as improving service accessibility and responsiveness this will positively impact on the number of out-of-hours admissions to in-patient units.

It would be consistent with current commissioning guidance to develop this service through investment in the existing mental health crisis response service. Linkage to services such as appropriate short break facilities and to the out of hours management system for local learning disability residential services could help to provide some flexible options to help to lessen immediate pressures and provide 'holding solutions' until the day-time services can resume responsibility (a wide range of 'options for respite' for meeting the needs of people in crisis can be found in Mansell p19). Where the person in crisis is in the 'core group' (see 'An Effective Response to Challenging Behaviour' below) they should have in place a well thought out contingency plan which should assist the effective management of the situation.

3.8.6 *Respite Care/Short Breaks*

Commissioners should ensure that opportunities for short breaks tailored to individual needs are available to every family supporting a person whose behaviour presents a challenge at home. Providing carers with a break when they are under pressure will prevent crises developing and help to prevent placements from breaking down. Where current services cannot meet these needs, additional and more robust respite services should be commissioned.

3.8.7 *A Placement Breakdown Pathway with Access to Intensive Support*

Preventing placement breakdown will reduce the demand for in-patient admissions and for out of area placements. There should be an agreed Placement Breakdown Pathway to which all providers are signed-up. This will emphasise the priority that is placed on the prevention of breakdown and put in place a system designed to provide early and effective support including access to levels of additional resources in accordance with the level of need.

3.8.8 *An Effective Response to challenging Behaviour*

- Learning disability services should give priority to people with challenging behaviour, they are the people with the greatest need for services and marked improvements can be achieved by quality services
- The adoption of a challenging behaviour policy will underpin this and ensure that there is a consistent response across all services. It should commit staff to 'sticking with service users' and resolving problems
- The group of people whose behaviour presents a serious challenge to services should be identified, and the services that are assessed as necessary to meet their needs developed, through a person centred planning process
- The plans should be clear about environmental risk factors, triggers, warning signs and contingency arrangements and ensure that back up resources can be made available to sustain arrangements through difficult periods, and that 'all the stops are pulled out'
- There should be access to specialists who are knowledgeable about challenging behaviour who can provide specific support with individuals and more general advice, information and training. The option of a specialist Challenging Behaviour Team to fulfil this function should be actively considered
- All staff working with people with learning disabilities should receive appropriate training in relation to challenging behaviour commensurate with their role

3.9 Reducing Distant Out of Area Placements

People should not be located in distant placements when local arrangements to meet their needs can be achieved. The repatriation of people from distant out of area placements will be assisted by:

- A specific 'repatriation' project in each borough
- Responsibility for managing the project clearly assigned
- An identified member of the CLDT responsible for each individual in a distant placement
- An agreed and manageable programme – the complexity of the task and the time demands involved in returning each individual may be very considerable
- Criteria for evaluating who should return – a small number of people may be appropriately placed
- Focused attention on achieving family / carer support
- Development of expertise and resources (e.g. 'transition houses'

as in the Oldham project) over time

- Monitoring the programme (as a key measure of service quality)

3.10 In-Patient Services

3.10.1 Commissioning good quality in-patient mental health services

- People with learning disabilities have the same right of access to mainstream mental health services as the rest of the population
- Mental health services that are commissioned need to have the appropriate skills to address the specific needs of people with learning disabilities
- Psychiatric hospital care should be based on short-term, highly focused assessment and treatment of mental illness through a small service offering very specifically defined, time-limited services

3.10.2 Effective management admissions and discharges

- It is important to effectively monitor and manage the use of the available capacity particularly if it is being reduced
- Commissioners should ensure that only appropriate admissions take place and that they follow an agreed admission / discharge pathway with clear admission criteria
- The CLDT should ensure that people are moved on from the units as soon as possible once they are fit for discharge
- Length of stay of patients should be formally monitored and if there appear to be impediments to a timely discharge resources should be identified as a priority to enable discharge to proceed
- Having access to appropriate accommodation is essential and a unit that includes a step-down facility may be particularly helpful in this regard.

3.11 Supported Accommodation and Residential/Nursing Home Care

- Decisions about where a person is to live need to be made on the basis of what is best for each individual
- Where people need to be supported other than with their families, supporting them in a home, (their own home or small residential home) near their family and friends will be the right decision
- Each authority needs to ensure that it has a range of appropriate accommodation options available to meet local needs and to make best use of the opportunities provided by personalisation to build flexible individualised models of support
- There may be particular complexities associated with the provision of appropriate local accommodation in relation to:
  - People returning from out of area

- Transition support for young people approaching adulthood who are in - or being considered for – an out of area placement
- Move on from hospital
- Placement breakdown / crisis support
- Step-down from forensic settings

Wherever possible the accommodation needs of people in any of these circumstances should be met within the above framework, however there may some people who need a period of relatively intensive support, together with focused rehabilitative work and the further development of skills to enable them to be able to successfully manage in the family home or in the locally available supported accommodation. Consideration should be given to commissioning small residential / nursing home facilities that can fulfil particular elements of this role in accordance with the particular gaps in current services and the particular needs of the local population in each borough.

3.12 Summary

Discussions with commissioners and local service managers, together with analysis of good practice in terms of national guidance and through service exemplars has provided the basis for the development of a model of care. The model of care is intended to facilitate the reduction in the numbers of individuals requiring admission to hospital and of distant out or area placements through local community infrastructure developments that are consistent with best practice and that will improve the service user and carer experience.

The key elements of the model of care are:

- A learning disability service that has strong leadership and is effectively managed with well trained and committed staff who have the capacity to respond effectively to challenging behaviour and to work with people through all levels of difficulty. A service that emphasises individualised services in the community achieved through person-centred planning.
- Transition services, in which there is good cooperation and coordination between services, which provide assured support into adulthood and through which people with complex needs and with behaviour that challenges, have their identified needs met through effective local arrangements.
- Comprehensive and well-integrated community support services, with well resourced CLDTs, that can readily access responsive specialist professionals. A service that can provide access to employment, education and day opportunities that have the flexibility to meet the needs of all service users including people

who challenge services. A 24 x 7 response to people in crisis giving them access to advice and support. A service that gives priority to meeting the needs of people who challenge and has policies, procedures and support structures to ensure that this can be achieved. Sufficient respite / short breaks arrangements that are able to meet the needs of people with challenging behaviour, and agreed pathways to prevent placement breakdown.

- A well-structured project to repatriate people from distant out of area placements.
- In-patient services that are focused on meeting the needs of people with learning disabilities that have a mental illness, that can provide skilled and appropriate support that is focused and time-limited, and with a well defined admission and discharge pathway. Length of stays monitored to assist the prevention of delays and resources made available to support discharge including the use of step-down arrangements.
- A range of appropriate supported local accommodation options designed around people's individual needs, together with small local units that can provide residential or nursing care to meet particular needs.

4.0 POLICY IMPLICATIONS

Specialist Services are currently commissioned from the 5Boroughs Partnership Trust. Halton has maintained a high number of people with learning disabilities in the community and therefore has consistently underutilised available beds. The model of care proposed would continue this direction of travel. It would also support the principles in Valuing People Now, which recognises that most people with learning disabilities should be supported within their communities.

5.0 FINANCIAL RESOURCE IMPLICATIONS

The Primary Care Trusts are the lead commissioners for specialised services while Local Authorities lead on the commissioning of Community services for people with learning disabilities. It would be expected that any disinvestment from specialised services would be reinvested in community services. The council and the Primary Care Trust have a strong partnership in this area and currently plan to establish a service in the community for people with challenging behaviour.

6.0 FURTHER IMPLICATIONS

7.0 OTHER IMPLICATIONS

8.0 RISK ANALYSIS

If the model is not adopted there is a risk that community services will not be strengthened, this in turn will lead to inappropriate use of inpatient services.

9.0 EQUALITY AND DIVERSITY ISSUES

The model proposed would promote the social inclusion of a group of Halton residents who often experience difficulty in accessing mainstream services.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 15 September 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Modernisation of Day Services

1.0 PURPOSE OF REPORT

1.1 To inform Policy and Performance Board (PPB) of the progress on the modernisation of Day Services and the outcome of recent consultation events.

2.0 RECOMMENDATION

RECOMMENDED: That

(1) The report be noted, and
(2) PPB supports the plan to continue to modernise the service.

3.0 SUPPORTING INFORMATION

3.1 Background

A report was taken to Executive Board on 4 June 2009 proposing a modernisation of Day Services and requesting permission to consult with all stakeholders about the future of these services. A comprehensive consultation plan was prepared and has since been updated and is attached at Appendix 1.

3.2 In February 2009 there were 58 people attending Bridgewater Day Centre on a regular basis. Some people attended for one day a week while others attended for up to three days per week. Some people had been attending Bridgewater Day Centre for many years. In some cases people began to attend when they left school, were first diagnosed or experienced the trauma that resulted in their disability. At the time there was an expectation that people would attend a day centre long-term and in some cases “for life”. This policy promoted dependency amongst service users and influenced staff practice. The advent of documents such as the White Paper.

3.3 Valuing People in 2001 and Putting People First in 2007 challenged traditional day service provision and advocated access to universal services for all. In addition, the developments of the Personalisation agenda really challenge Council’s into asking whether service users and carers will be prepared to use their Individual Budgets to attend

large Centres.

3.4 To begin the modernisation process the needs and requirements of the people attending Bridgewater Day Centre were identified. Following individual consultation and discussion they were subsequently linked to satellite units providing day activities in the community. The venues of the satellite units and the activities provided are listed in Box 1.

3.5 **Satellite sites and activities**

Box 1 shows the venues for the satellite units and activities offered.

Day	Time	Activity	Venue
Monday	10.00 - 16.00	Photography or craft work	Priory View Community Centre
	10.00 – 12.00 14.00 – 16.00	Exercise Drama	Upton Community Centre
Tuesday	10.00 – 12.00 14.00 – 16.00	Chess Group Boccha	Murdishaw Community Centre
Wednesday	10.00 – 12.00 14.00 – 16.00	Computer work Cooking/Healthy Eating	Upton Community Centre
	10.00 – 12.00 14.00 – 16.00	Cookery Skills Craft group/compute work	Independent Living Centre, Runcorn
Thursday	10.00 – 16.00	Interactive sports games/crafts	Priory View Community Centre
Friday	10.00 – 12.00 14.00 – 16.00	Tai Chi/Crafts Stained glass/sewing crafts	Churchill Hall, Runcorn
	10.00 - 12.00 1.00 - 4.00	Exercise Group Music & Dance or Craft/Indoor Bowls (alternate weeks)	Upton Community Centre
	10.00 – 12.00 14.00 – 16.00	Computers Boccha	Independent Living Centre
Every 4th Friday (pm)		Tea Dance (open to all)	Churchill Hall

3.6 Further sites are being identified. Additional days have been arranged at some existing venues, for example Churchill Hall. To begin with a group was meeting at Churchill Hall on a Friday and this proved to be very successful. Service users themselves now plan and run a Tea Dance once a month as part of the session. At the request of users and carers a further session at Churchill Hall has been arranged for Tuesdays. This coincides with the day when the street market is being held in Runcorn and this is a particular attraction to some of our service users.

3.7 A further venue currently being explored is the Murdishaw Community Centre. Initially the office space at the Community Centre, owned jointly by Riverside and LHT, was being used by a small number of service users to undertake IT activities. However,

this office was not big enough to accommodate many people. Other space within the building has now been vacated and is used allowing a larger group of people to attend and undertake other activities.

3.8 More recently, the room at the rear of the community centre, formally occupied by Children and Young People's Directorate, has been vacated and we are negotiating about using this room on a long term basis. The room will need some adaptation but would provide a flexible area and could accommodate a reasonable number of people.

3.9 Some of the satellite units need further adaptation to more fully meet the needs of disabled people. The limitations of some buildings, previously regarded as accessible for disabled people, have been identified by people actually trying to use the facilities and a list of recommended adaptations is being prepared. If this work is undertaken it will benefit the wider community now and in the future and not just the number of disabled people using social care services.

3.10 Staff and disabled people have been imaginative and resourceful in overcoming the challenges of integrating more fully into the wider community. Staff have solved problems in relation to equipment and transport for disabled people and one service user, for example, has agreed to use a manual wheelchair in one setting to ease access issues, reverting to a powered wheelchair when participating in activities on another day in a more spacious building.

3.11 **Consultation Plan**

3.11.1 **Day Service Staff**

Fortnightly consultation meetings with staff are now taking place and a team day for all staff was held in early August. The response from staff to the modernisation has been very positive. They were naturally concerned about their future job security. Although it is not possible to give any guarantees regarding the longer-term position it has never been the intention to cease providing day services, with an associated loss of job security, but rather to provide these services in different ways.

3.11.2 Staff are enjoying the flexibility of the satellite units and feel that they have got to know some of the service users more by providing the service in this way and have described it as "giving service users more of a voice especially people who are quiet". They have also noticed developments in terms of some users' independence and confidence. One user described how she now "enjoys shopping and meeting old friends and the tea dance". Another asked "When can I have another day in the community?"

3.11.3 Staff who are currently providing an outreach service, based at Bridgewater Day Centre have also been consulted with separately and the possibility of them joining the Mental Health Outreach Service is being explored. They recognise the advantages of the structure that this would bring to the service. They feel that being part of a bigger service will raise their profile.

3.12 **Service Users and Carers**

3.12.1 Individual visits by two members of staff to the homes of users and carers took place between mid June and the end of July. A total of fifty service users and thirty-two carers were interviewed and a questionnaire was completed with each individual.

Of the service users interviewed ninety per cent were positive about the changes. Comments made by them included:

"I enjoy Churchill Hall. It has a great atmosphere and I am looking forward to attending there on another day."

"Enjoy small groups in the community activities. More personal than large groups and you get to know people (staff) better.

3.12.3 The general consensus was that people are enjoying the social opportunities that community activities bring despite initial apprehensions. The commitment, professionalism and caring attitude of the Bridgewater staff was frequently referred to during the consultation. They are held in high esteem by users and carers alike.

3.13 People raised a range of other issues as part of the consultation interviews including the need to maintain friendship circles, lack of knowledge about carer assessments, the poor accessibility of some buildings and matters relating to transport.

3.14 **Consultation with interested bodies and individuals**

3.14.1 A meeting has taken place with a representative of the trade unions and the development was received positively. Key individuals in the community have also been interviewed and some of their concerns and anxieties addressed.

3.14.2 Halton and St Helens NHS have been contacted to identify formal mechanisms to consult with staff about the modernisation of day services. Some Health personnel have already been involved due to their membership of interested groups, such as the Older People's Local Implementation Team.

3.14.3 The Older People's Local Implementation Team has been briefed

and was encouraging about the developments in Day Services.

4.0 KEY ISSUES

4.1 Promoting Independence

The modernisation of day services has demonstrably increased the confidence of many service users. Some people, initially reluctant to try services in the community, are now requesting further sessions at the satellite venues and are socialising in each others homes in between sessions. Others who appeared more insular and reserved in the traditional day services setting have become more outgoing and have shared more about their personal circumstances, experience and skills within the smaller group settings. As stated earlier, we have traditionally caused people to be dependent on services and now have to enable these people to regain the confidence to use community facilities. Once they have achieved this some will feel able to make their own day activity arrangements either independently or through personalised budgets. New service users will be enabled to use community facilities from the start.

4.2 Community Centres

People living close to these centres are becoming more aware of the available facilities. Some users have started to visit the centres with neighbours for example, to use the café facilities at Murdishaw on a regular basis.

4.3 Accessible Environment

By using community facilities issues of accessibility have been identified and reported on. Longer-term, any improvements in the accessible environment as a result of this initiative will bring benefits to the wider community.

4.4 Personalisation

This initiative will give some people, previously dependent on traditional services, the confidence to participate in the personalisation agenda and to exercise greater choice in how they spend their time.

4.5 Bridgewater Day Centre

If it is recommended that, following the consultation, day services continue to be provided in satellite units in the community the future use of Bridgewater day centre will need to be considered.

5.0 PERFORMANCE

5.1 These developments are not directly impacting any reported

performance indicators but longer-term may influence people's confidence to consider personal budgets and arrange their own day activities.

6.0 FINANCIAL IMPLICATIONS

6.1 Due to staff changes at Bridgewater Day Centre it has been possible, within existing budget, to reduce the number of managerial posts and increase the use and number of front line staff to meet the demands of providing services in the community. In future, combining provision across all service areas, where appropriate may deliver further efficiencies. Any adaptations to buildings to improve accessibility will have resource implications although these improvements will bring about longer-term more general benefit to the community.

7.0 OTHER IMPLICATIONS

7.1 Options for the future use of Bridgewater Day Centre will need to be considered.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children & Young People in Halton

The potential closure of Bridgewater and the delivery of the service from community bases is a far more attractive proposition to younger service users in the Borough. It is noteable that no young people who have experienced transition access the building.

8.2 Employment, Learning and Skills in Halton

These proposals will increase the opportunities of service users seeking volunteering and employment .So far Cup Cake Caterers have been set up with service users from Bridgewater. The enterprise consists of some 8 service users who bake cakes and confections for sale at Country Garden outlets. These include, Norton Priory, Murdishaw Café and the buffet service. These service users no longer attend Bridgewater and will be in receipt of permitted earnings once their production levels can meet the bill. In other areas a stained glass project has been set up and photography classes all of which are underpinned by a desire to engage in activities with value to the individual and others. In addition, utilising the services provided by libraries provide further opportunities.

8.3 A Healthy Halton

It is difficult to evidence actual physical health improvements as a result of moving the service into the community but what is clear is

that those who have moved out are happier and more fulfilled – and this must have a positive impact on physical health

8.4 **A Safer Halton**

The movement out of the centre will have an impact on transport and Fleet Transport in particular. Close liaison with transport and ALD services to prevent doubling up is essential.

8.5 **Halton's Urban Renewal**

The existing centre or land could be considered for an Extra Care Housing facility.

9.0 RISK ANALYSIS

9.1 Not all stakeholders will support the modernisation plan. However, the process of consultation will enable them to express their concerns and for these to be addressed.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 The modernisation of day services will enable people to be more actively involved in community activities and will promote independence and confidence. Longer-term, these developments will help some users to participate fully in mainstream services bringing benefits for them and the wider community.

10.2 Any improvements in accessibility of the environment achieved as a result of this initiative, will benefit the wider community now and in the future.

10.3 An Equality Impact Assessment has been completed and circulated for further amendment. The draft document is attached at Appendix 2.

APPENDIX 1

HALTON BOROUGH COUNCIL

DAY SERVICES – CONSULTATION PLAN

Action	Process	Person Responsible	Timescale
Consult with users and carers	• Individual visits to service users and carers - complete matrix using ALD template • Meet with EC and CW to brief on process • Consult with users at satellite venues • Consult with Bridgewater Service User Committee • Consult with young people in transition from Children's to Adult Services	EC & CW RM/SO'S EC & CW RM/SO'S RM/SO'S	June/July 2009 5 June 2009 June/July 2009 Date to be arranged Date to be arranged
Consult with staff group about future development of day services	• Initial meeting with staff • Meet separately with staff not at initial meeting • Fortnightly briefing meetings • Staff supervision • Three weekly management meetings	RM RM RM PS RM/SO'S	26 May 2009 Asap From 5 June 2009 Ongoing Commenced 2008 and ongoing
Consult with Social Workers and other professionals	• Consult via team meetings and DMTs - OP LIT - PSD LIT	RM/SO'S	June 2009 June 2009

Action	Process	Person Responsible	Timescale
	• Consult with individuals and service provision groups: - Sue Lightfoot - Trade Unions - Transport - Bridge Builders - Sure Start to Later Life • Consult with councilors: - PPB - Ward councilors	 RM RM AW AW	 September 2009
Consult with Halton and St Helens PCT	• Contact Halton and St Helens PCT for advice re appropriate forums for consultation • Health personnel to be included in specific group consultations eg. PSD and OP LITs	RM RM	October 2009
Consult with specific interest groups and individuals	• Carers Centre: - Cieran Shanahan • Halton Disability Partnership: - Bob Bryan - Jimmy Awang - Norman Lloyd • Halton Open	SO'S SO'S RM/SO'S RM RM RM RM/SO'S	June/July 2009 June/July 2009 June/July 2009 June/July 2009 June/July 2009 June/July 2009
Report to Executive Board re. outcome of consultation	Report to Executive Board	RM/SO'S	October 2009

Action	Process	Person Responsible	Timescale
and recommendations			
Update SMT	Prepare interim reports to SMT	RM/SO'S	Monthly?

Key messages to be conveyed throughout consultation process:

- No loss of service
- No staff losses
- Programme of Change to be managed on a planned basis
- Existing service outdates in the light of development of personalisation
- Successful example of modernisation by modernisation of ALD services
- Need to further develop rehab service
- All new packages will be risk assessed

Key:
RM Ruth McDonogh
SO'S Stiofan O'Suillibhan
AW Audrey Williamson
PS Pete Smith
CW Cath Williams
EC Eileen Clarke

R McDonogh
Divisional Manager - ILS/OP
June 2009

EQUALITY IMPACT ASSESSMENT **SCREENING DOCUMENT**

Directorate	**Health and Community**	**Division**	Older People and Independent Living Services	**Person Responsible for Assessment**	Ruth McDonogh Divisional Manager Independent Living Services
Name of the Policy/Strategy	Modernisation of day services for disabled and older people	**Date of Assessment** August 2009		**Is this a New or Existing Policy?**	New strategy

1	What are the aims and objectives of the Policy / Strategy?	Aim: To promote independence and enable people to participate more fully in community activities and to exercise more choice and control over how they spend time. Objectives: • To identify, with service users and carers, preferred day activities; • To identify and assess the suitability of a range of satellite venues and pilot the use of these venues as alternatives to traditional building based day services; • To make recommendations to improve the accessibility of community venues to improve provision for the wider community; • To enable people to participate more fully in universal services; • To enable service user to gain or regain confidence to participate as members of the community; and • To help service users to prepare for the arrival of Individual Budgets.
2	What outcomes are wanted from the Policy / Strategy?	• Increased service user independence; • Increased social inclusion; • Increased use of universal services; • More accessible environment for all; and • Increased take up of Direct Payments and Individual Budgets.

3	Who is intended to benefit from the Policy / Strategy, and how?	Disabled people generally and specifically current users of Bridgewater Day Centre
4	Who are the main stakeholders in the Policy / Strategy?	Users of Bridgewater Day Centre and their carers, staff of Bridgewater Day Centre, other disabled people, care managers, Councillors, other professionals.
5	Who implements the Policy / Strategy and has responsibility for it?	Managers of day services and care management services.
6	Are there any associated Policies / Strategies or objectives?	Valuing People, Putting People First, Transforming Social Care, Personalisation agenda, day service strategies for other service user groups and Council priorities including: A healthy Halton, A safer Halton and Corporate effectiveness and business efficiency.

7	Could the Policy / Strategy have a differential impact (positive or negative) :			
		Yes	**No**	**Evidence**
a	On Racial Groups		**x**	Modernised service to be provided to all users regardless of racial group
b	Due to Gender		**x**	Ditto
c	Due to Disability	**x**		Although the strategy is initially aimed at enabling disabled people to use other than traditional day services and will therefore impact positively on them other

				community members who experience restrictions to access, for example, people with young children, will also benefit.
d	Due to Sexual Orientation		**x**	
e	Due to Age	**x**		Improvements in the accessibility of the environment will benefit people with young children and older people as well as disabled people.
f	Due to Religion		x	
8	Available statistical/qualitative information relevant to the Policy / Strategy and equality issues			23,780 people in Halton regard themselves as having a limiting long-term illness. The percentage of people enabled to live at home in Halton has risen from 82 per 1,000 population in 2002-03 to XX per 1,000 population in 2008-09. The percentage of people over 65 in Halton is set to rise by 56.6 per cent from 16,000 in 2007 to 26,000 in 2028.
9	Could the Policy / Strategy affect relations between different groups in the Borough?			The strategy will improve the relationship between disabled people and the wider community as they are enabled to participate more fully in community activities and are recognised for their skills and experience.
10	Could the Policy / Strategy damage relations between groups in the Borough and the Authority?			Some people, who are not familiar with disabled people taking an active role in the community, may take time to adjust to this development.

DECISION

Does the Policy / Strategy:	**Eliminate unlawful discrimination**	**Yes**	**x**	**No**	
	Promote equality of opportunity	**Yes**	**x**	**No**	
	Promote good relations between different groups in the community	**Yes**	**x**	**No**	
Impact Assessment: High / Low / None (delete as appropriate)					
Agreed By		**Date**			
Actions to Be Taken:					

		Yes	**No**
1	Collect more evidence		
2	Conduct formal consultations		
3	Reconsider Policy / Strategy		
4	Resubmit Policy / Strategy		
5	Adopt Policy / Strategy		
6	Make monitoring arrangements		
7	Publish assessment results		

Additional Comments:

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 15 September 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Halton and St Helens Social Services Emergency Duty Team

WARDS: All

1.0 **PURPOSE OF REPORT**

1.1 To update the Healthy Halton Policy & Performance Board on the Partnership arrangements for the delivery of the Emergency Duty Team (EDT) service across St Helens and Halton Councils.

1.2 To review and update the Partnership Agreement in line with the recommendations of a recent Audit Report.

2.0 **RECOMMENDATION**

i) That members of the Healthy Halton Policy & Performance Board note and comment on the report.

3.0 **SUPPORTING INFORMATION**

3.1 Following approval by both St Helens and Halton Executive Committees, a joint Emergency Duty Team became operational in October 2007 under a three year Partnership Arrangement. The EDT provides an emergency social care service for adults and children who are deemed vulnerable and are at immediate risk or require immediate statutory support.

3.2 The EDT is located in Halton Borough Council's Contact Centre at Catalyst House, Widnes. The Team consists of an EDT Manager, 6 Full Time Social Workers and a Part Time Administrative Officer. It operates outside normal working hours. Under the terms of the Partnership Agreement, all staff are directly employed by St Helens Council, whilst all infrastructure for the service is supplied by Halton Borough Council

3.3 The budget for 2008/09 is £391,499 and is funded on a 50:50 shared basis between St Helens Council and Halton Borough Council.

3.4 <u>Governance and Partnership Agreement</u>

3.4.1 Before the EDT service was in place, a Steering Group was set up, consisting of senior officers from both Councils, to drive forward all

developments, and a full Partnership Agreement was developed. At the point that the new service began, Steering Group became the full Partnership Board.

3.4.2 The Partnership Board has met regularly in line with the Partnership Agreement, with responsibility for chairing the board being shared between Senior Officers from both Councils on an annual rota. The Board reviews management information, the budget, service delivery, areas for development and any issues that impact on the service. A Performance Management Framework has been also developed and the Board considers statistical information at each meeting. This framework is to be taken forward through 2009/10 with the development and piloting of an outcomes-based framework, which will build on pure statistical information to give a fuller picture of the effectiveness of the service.

3.4.3 An Operational Group has also been established, and reports to the Board. Again, the role of chairing this Group has been shared across Service/Divisional Managers from both Councils, mirroring the arrangements for the Partnership Board.

3.5 Audit Report

3.5.1 In the autumn of 2008, the Internal Audit Departments of both Councils undertook a joint audit of the EDT service. The Audit report confirms that this is a positive partnership and that examples of good practice should be shared across both councils. It also recommended that:

- there is a need to develop an ICT strategy for the service
- the Information Sharing Strategy should be updated and further developed
- value for money should be promoted at all times
- further arrangements for Business Continuity and Risk Management should be developed
- the development of an annual operation plan for the service that would be monitored by the Board. This would replace the requirement for a separate annual service plan for this service. The Action Plan has been agreed by the Partnership Board attached as ***Appendix 2***.

3.6 Service Delivery

3.6.1 It is important to note that the data presented to the Board can only provide a flavour of the activity that is undertaken. Statistical data regarding numbers of referrals in any area does not reflect the workload for the team. One mental health assessment or one child protection investigation can take many hours but will be recorded as one referral. Similarly several phone calls for advice can be completed in a short time but each will be recorded as a single referral.

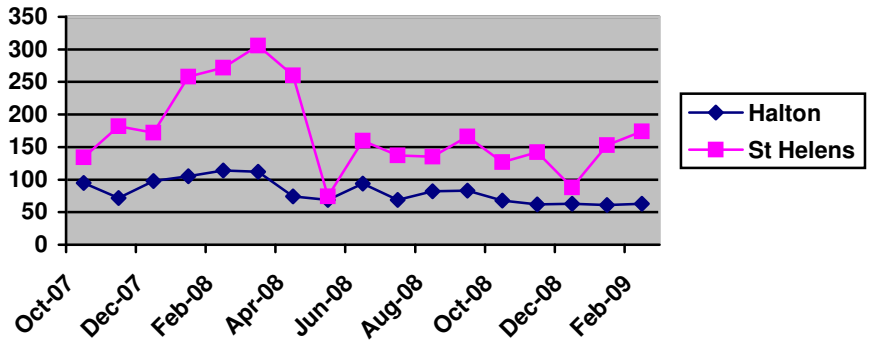
3.6.2 Accurate data collection has been one of the key challenges for this new

team, and was initially slow in being developed because the service was new to professionals and families, the team was managing with some difficult IT arrangements and there was limited administration capacity. The Board now believes that the information being gathered during the last 6 months is a truer and perhaps more accurate reflection of activity. By the end of 2009/10 the information gathered will be more robust and informative of EDT activity.

3.6.3 Children and Families Referrals

3.6.3.1 Table 1 (below) shows a significant variance in the early months in children's referrals to EDT from St Helens and Halton. One reason may be that the criteria for the new service were much tighter than that previously provided by the old EDT service in St Helens; this required some adjustment by day time staff in St Helens and the EDT team itself. As a result, further clarification was provided to staff in respect of the role and function of EDT, and alternative arrangements were put in place to ensure the EDT were managing referrals that fit the criteria for this service. There now appears to be a more consistent trend regarding numbers of children's referrals though it is likely that St Helens will continue to generate more children's referrals to EDT than will Halton.

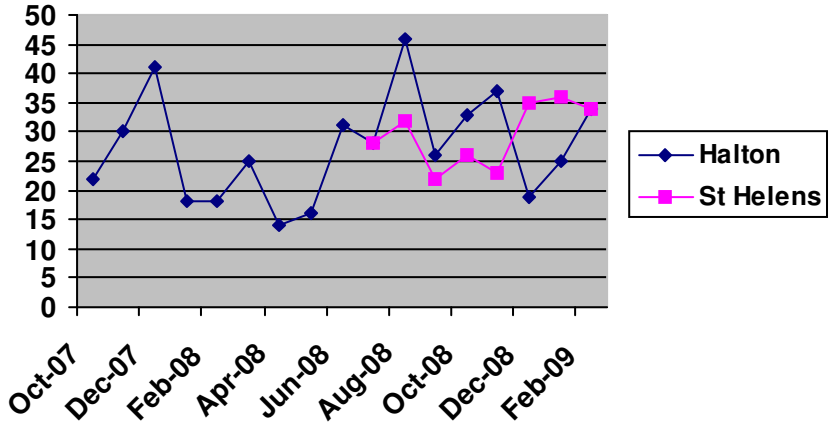
Table 1. Children & Families Referrals



3.6.4 Adults Services

3.6.4.1 For Adults Services, data capture for St Helens has only been possible since June 2008, because of difficulties with the IT system; the effective period for comparison is therefore much less. Table 2 shows the pattern of activity data for Adults Services (excluding mental health services), and again highlights discrepancies in referrals between St Helens and Halton, with this time a greater number of referrals coming form Halton. This is still being investigated, but is thought to relate partly to a number of referrals from a particular residential learning disabilities setting in Halton, which the service is now aware of and is managing differently.

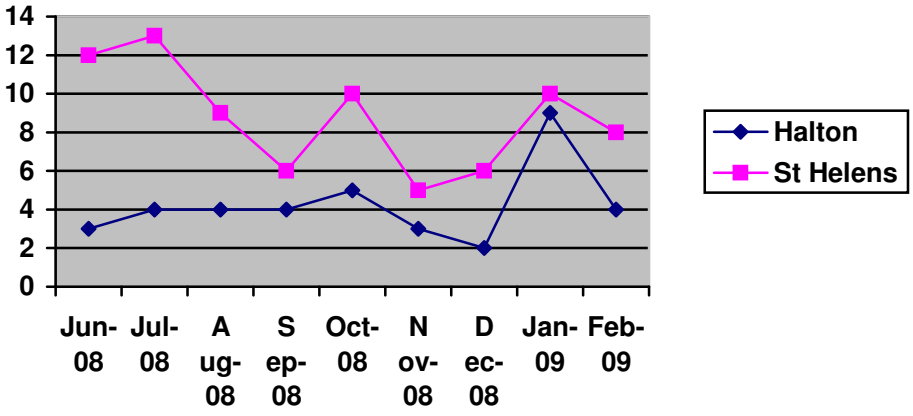
Table 2. Adult Referrals



3.6.5 Mental Health Services

3.6.5.1 Table 3 refers to the number of people referred for assessment for admission to hospital under the 1983 Mental Health Act. It shows a higher rate of referrals from St Helens than Halton, and at one stage this rate was substantially higher. This was investigated and appears to have related to particular practices in case management in daytime services in St Helens. As a result, these practices were modified and the referral rate in St Helens has reduced.

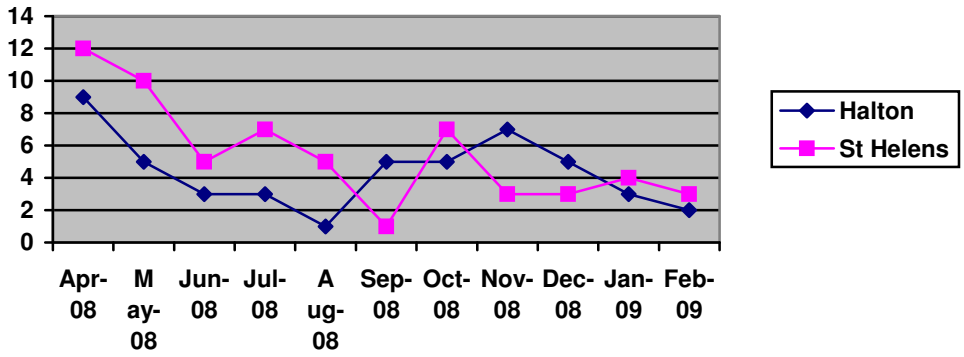
Table 3 Mental Health Referrals



3.6.6. Police and Criminal Evidence Act Referrals (PACE)

3.6.6.1 Under the Police and Criminal Evidence Act, there is a duty on Local Authorities to provide an "Appropriate Adult" to provide support, in the absence of a suitable family member or friend, to a child/young person or vulnerable adult who has been arrested and is being interviewed or charged. Table 4 shows the PACE referrals for Halton and St Helens, which are largely the same.

Table 4 Appropriate Adult Referrals

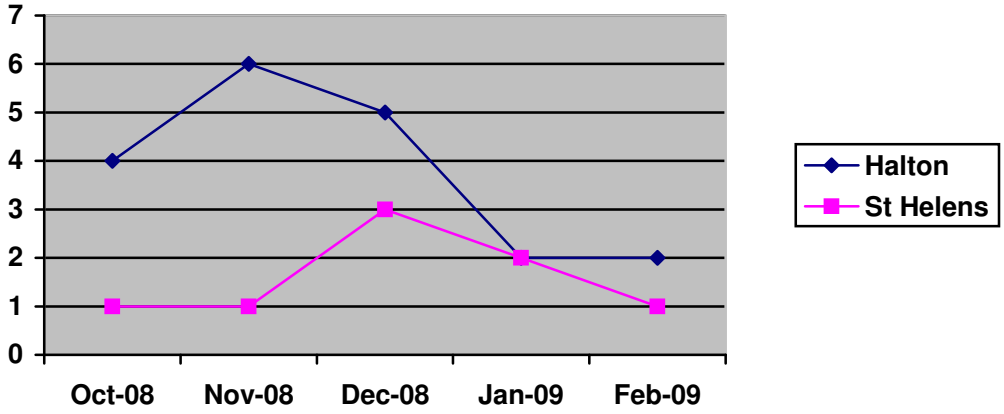


3.6.6.2 Appropriate Adult work may not be large in numbers but can take up a significant amount of EDT time. Many hours can be spent in a police station by EDT providing this service and can have a negative impact on other aspects of service delivery. The Board monitors this carefully and other options are being considered to manage this part of the out of hours service better.

3.6.7 Homelessness

3.6.7.1 Although the numbers of Homeless people referred into this service is relatively small it is important that an out of hours service is provided. EDT has been able to offer this provision across both Boroughs and this is an area that is being developed further. The activity data are in Table 5.

Table 5 Homelessness Referrals



3.7 Key Operational Issues

3.7.1 **Staffing:** the staffing establishment is explained in paragraph 3.2. This fulfils basic requirements but pressures have arisen because of long-term sickness, and the requirement for staff to undertake the complex training required to be approved to complete Mental Health Act assessments. Through the use of alternative arrangements, which have included the use of sessional staff drawn from daytime services, the service has continued

successfully. These additional costs have been contained within the allocated budget.

3.7.2 **IT systems and procedures:** there has been substantial co-operation between the IT services of both Councils, and this is to be applauded. For the EDT service, the initial complications of operating IT systems tailored to each Council, plus a manual back-up system, proved considerable. As the service has been developed, some of these issues have been resolved, but the need for an ICT strategy for the service remains. This was highlighted by the Internal audit report and will be considered further by the Partnership Board. The ideal solution would be for a single system covering both Authorities, but this would be both complex and financially prohibitive.

3.7.3 **Location:** the team is based at the Contact Centre in Widnes and this has worked well. It has had a number of benefits and has been instrumental in being able to present the team as a professional and identifiable team within both Boroughs. The audit reports comments on this arrangement and makes recommendations regarding the call handling arrangements, which will be actioned and monitored by the Board.

3.7.4 **Publicity and information:** as a part of the development of the service, a substantial piece of work had to take place to inform the general public and all key stakeholders about the changes. Information was placed in free newspapers, fliers were sent to a range of stakeholders, websites for both Councils were updated, and the team manager spent considerable time visiting the services that were most likely to make referrals to the new EDT. Overall, this rigorous approach meant that the changeover to the new service took place smoothly and without disruption.

3.8 Learning Points

3.8.1 **General:** there have been many benefits from the implementation of this partnership arrangement, and also many learning points that can and should be shared both for this service specifically, and for partnerships of this nature in general. These are summarised in the following paragraphs.

3.8.2 **Preparation:** before the service began, extensive planning and preparation took place, at both strategic and an operational levels. The team manager and service manager from Halton worked together to develop the policies and procedures that would be required for the service delivery. Meetings were held with staff and other professionals in both boroughs to raise awareness and clarify roles and responsibilities of the service prior to its implementation in October 2007. This preparatory work was essential and meant that the service was operational from the start.

3.8.2 **IT issues:** the complexities of the IT issues were underestimated. It was initially believed that as both Boroughs used the same software (CareFirst), then this would be simple to manage. The reality was

different. Each Council used a different version of the same software and there were differences between the adults and children's systems that were used. Staff have had to operate with four different systems; this has been a challenge and has meant that a great deal of time has been spent on learning and using the systems. Over time, changes have been made to the systems, including the implementation of a completely new IT system for Children's' services in St Helens, and improvements have occurred. However this continues to be a problem and one that if we were to embark on another partnership arrangement would warrant much more consideration.

3.8.3 **Staffing:** the specification for six staff was very tight, especially for this service. EDT staff must be very experienced, flexible, and trained in both children and adult areas of social work. There are few experienced staff who are qualified to deal with both service areas. As the service continues to become more specialised, the ability to recruit to this specification of staff becomes more difficult. The Partnership Board will need to consider future staffing arrangements/requirements and how this might impact on the development of the partnership. In addition, the initial expectation had been that two EDT social workers would train to fulfil duties under the Mental Health Act (see para 3.7.1), but the impact on the service of this detailed training is such that only one person at a time can be released for this purpose. In consequence, daytime staff are called upon more frequently to support the service.

3.8.4 **Budget:** the initial budget only provided for staffing costs, without any additional allocation for such things as training, printing and contingencies. It became quickly clear that this would require very careful monitoring, but it was a positive feature that the nature of the partnership arrangement meant that the concerns could be shared effectively across the two Councils. It is however essential to ensure that the budget in any partnership arrangement is fit for purpose.

3.8.5 Out of a potentially difficult situation some creative arrangements have been put in place, and the service has been able to agree some new income for the service. There has been additional finance from children's services in both Councils for family support. Additional finance has also been secured for the Homeless service provided to both councils. On the basis of this, consideration is being given to further income generation for other out of hours services provided, and there are future possibilities of widening the Partnership to cover a neighbouring borough. It is however essential to ensure that the budget in any partnership arrangement is fit for purpose.

3.8.6 **Cultural differences:** one of the issues the team and the Board have had to manage has been the cultural differences between **and** within the two Councils. Decision making arrangements have been similar in many respects, but on occasions differences have needed to be managed and respected.

3.8.7 Operationally, there were some initial concerns that staff used to working in one Borough would be operating in unknown geographical territory, and practical support and time to get to know the Boroughs were provided in the early days. This has not proved to be as problematic as first envisaged, and other staff who might have to work outside can learn from this. Thresholds for work have sometimes been different but this has also been helpful, as services have learned from each other. This has undoubtedly been helpful to staff and beneficial to service users.

3.8.8 **Sharing of good practice:** this has been an important positive that has arisen from the Partnership. There has been mutual respect and support at all times between the two Councils; as an example, supervision and mentoring for the team manager has been provided by staff in both Halton and St Helens. The sharing of practice, procedures, advice and support has extended to daytime services and this has certainly been made easier as a result of the Partnership arrangements.

3.8.9 **Service Delivery:** overall, the view from staff in both Councils who refer into the team on behalf of service users is that the new EDT provides a professional service that is valued by them and by service users. This is important and needs to be built on.

3.8.10 **Data collection:** before the service was established, a significant amount of data was collected from existing services, in order to be able to predict future demand. The design and structure of the EDT service was built upon this. Some of this data has proved flawed – for example, the expected rate of calls into the Call Centre – and this imposed some initial strains on the service. However this has been managed through both the Partnership Board and the Operational Group, and the service has continued to operate successfully. The importance of accurate and detailed information for a project such as this cannot be underestimated, however.

3.9 Previous Approval/Consultation

3.9.1 Prior to the Partnership Agreement being approved there was a great deal of consultation at every level in both Councils. Following the implementation of the Partnership there has been ongoing consultation with staff from both Councils, other professionals from a range of agencies and also a survey of service user views was undertaken. The survey feedback was limited in terms of responses but overall was positive.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 Financial

The current service is relatively inexpensive in that it provides cover out of hours 365 days a year including all bank holidays. The alternative arrangements would be to revert to previous arrangements for EDT, which were as expensive, in fact the current arrangements meant there has been a saving for each Council. Each Council has different arrangements for funding EDT but together there is a 50:50 split in respect of the overall budget of £391,499.

6.0 OTHER IMPLICATIONS

6.1 Human Resources
The staff are employed by St Helens Council.

Land and Property
The office accommodation is provided by Halton Council.

Legal Implications
The service enables both Councils to meet statutory obligations for all vulnerable residents of both boroughs.

7.0 RISK ANALYSIS

7.1 Risk to Service Users – The new service provides an emergency service to the most vulnerable people in both Boroughs. The service can only provide **emergency cover** but without the service some people would be at risk. It is therefore not an option for either Council not to have in place an arrangement for out of hours social work provision.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This team provides emergency services to all residents of Halton and St Helens.

Appendix 2

St. Helens Council

DRAFT

Audit Report 2008/09

Children and Adults Emergency Duty Team

Contents

Draft Report Distribution

Chris Williams	Senior Assistant Director, Children and Families	Children and Young People Services – St Helens Council
Barry Fitzgerald	Acting Assistant Director, Care Management	Adult Social Care and Health – St Helens Council
Audrey Williamson	Operational Director, Adults of Working Age	Health & Community – Halton Borough Council
Nigel Moorhouse	Divisional Manager, Children in Need	Children & Young People – Halton Borough Council

Date	March 2009	
Contact Officer	Barbara Aspinall	Lesley Boyle
E-mail	BarbaraAspinall@sthelens.gov.uk	Lesley.boyle@halton.gov.uk
Telephone	(01744) 456148	0303 333 7303 ext 2167

St. Helens Council

EXECUTIVE SUMMARY

Partnerships

Children and Adults Emergency Duty Team

Scope

To review the joint arrangements for the Emergency Duty Team (EDT) and provide assurance that appropriate governance, staffing and operational procedures and controls are in place. The audit was undertaken in conjunction with Halton Borough Council's Internal Audit Team.

Background

Following approval by both St Helens and Halton Executive Committees, a joint Emergency Duty Team became operational in October 2007 under a three year Partnership Arrangement. The EDT is located in Halton Borough Council's Contact Centre at Catalyst House, Widnes. The Team consists of an EDT Manager, 6 Full Time Social Workers and a Part Time Administrative Officer and all staff are directly employed by St Helens Council.

The EDT provides an emergency service for adults and children who are deemed vulnerable and are at immediate risk. Operating hours are 17.00 to 09.00 Monday to Friday and 48 hour cover over Saturday and Sunday.

The budget for 2008/09 is £391,499 and is funded on a 50:50 basis between St Helens Council and Halton Borough Council.

Audit Opinion

In our opinion, based on sample testing, review of documentation and discussion with officers, the control environment as currently designed and operated provides adequate assurance that the risks reviewed in this audit are being managed to an acceptable level**.**

Key Issues

Governance

In the main, sound governance arrangements are in place. However, there is scope for improvement as follows:-

- ✓ There should be an annual formal review of the service so that each Council can ensure that the partnership arrangement continues to be the preferred option for service delivery.

- ✓ As specified within the Constitution and Partnership Agreement, quarterly performance monitoring reports should be provided to both Councils. Each member Council should then report performance to Senior Officers and Members through their governance framework.
- ✓ Risk management processes could be improved by developing a risk register which should be subject to periodic review by the Board.
- ✓ The partnership should develop ways to demonstrate that the current arrangements provide value for money.

Agreed Action

Actions to address the recommendations are contained in the Action Plan which has been agreed with the Partnership Management Board.

INTERNAL AUDIT REPORT

CHILDREN AND ADULTS EMERGENCY DUTY TEAM

1.0 Objectives

To ensure that the following control objectives are being achieved within an appropriate control framework:-

1. Appropriate governance, performance monitoring and reporting arrangements are in place and operating effectively
2. Staff are utilised effectively and suitable employee controls are in place
3. Appropriate policies and procedures have been developed and complied with to ensure the service operates within an agreed framework
4. The IT infrastructure meets the business needs of the service and is sustainable.

2.0 Conclusions & Recommendations

2.1 Control Objective – Appropriate governance and performance monitoring and reporting arrangements are in place and operating effectively

Partnership Management Board

The EDT is governed by a Management Board, which consists of representatives from Adults, Childrens and Youth Offending Services from both Councils. Terms of Reference for the Board had not been documented but this was addressed during our review, with draft Terms of Reference agreed by the Board in January 2009. From a review of Board minutes we confirmed that meetings have been held monthly since the Service started and have been well attended. Actions arising from matters discussed are documented and responsible persons identified. These actions are followed up at subsequent meetings.

An Operational Group was set up in January 2008, with representatives from all the relevant services from both Councils, including Information Technology Officers and representatives from the Halton Contact Centre. Draft Terms of Reference were drawn up in February 2008 for approval by the Board, however this has been overlooked. During our review the draft Terms of Reference were submitted to and agreed by the Board in December 2008. The Operational Group has dealt with policy and procedure documents, processes for the collection of data for performance monitoring and IT issues. We noted that minutes of the Operational Group were not being presented at Board meetings. Members of the Board had identified this at their meeting in November 2008 and requested minutes to be presented from December 2008.

Constitution and Partnership Agreement

A Constitution and Partnership Agreement is in place which outlines the function of the EDT, the constitution and frequency of meetings, and arrangements for accountability, funding and termination of the Partnership. The Agreement has been signed by both parties.

When the Partnership was approved by both Councils in 2007, it was agreed that it would be a three year arrangement. However, the Constitution and Partnership Agreement is not dated and does not specify the period of the Agreement. In addition, there is no provision in the Agreement for a review of the arrangements during the period of the Partnership to ensure that they remain relevant and appropriate.

Performance Monitoring and Reporting

The Constitution and Partnership Agreement provides for a quarterly performance monitoring report to Halton and St Helens and outlines areas to be reported to Members. However, although the Operational Director, Halton and Senior Assistant Director, St Helens indicated that they both report EDT issues to their respective Senior Management Teams, there have been no formal reports to either Council.

A Performance Monitoring Framework has been documented and agreed by the Board, which outlines outcomes to be delivered by the EDT. The measuring of these outcomes is to be achieved through customer quality assurance surveys and statistical data regarding the number and type of referrals, completed assessments and intervention outcomes. The St Helens Adult, Social Care and Health Performance Management Team has carried out a customer survey and reported findings to the Board in September 2008. Due to the low number of responses, there was limited feedback from this exercise; however, a recommendation was made regarding the method for future, ongoing customer surveys. To date there have been no further surveys.

The EDT Manager has provided statistical information in monthly reports to the Board, however, due to different IT systems being utilised, there have been problems collecting all required data in a consistent format for both Councils. Steps are being taken by the EDT Manager to address these issues with Halton IT.

Although the EDT service is included at a strategic level within both Council's Service Plans, there is no detailed operational plan for the Team to implement or monitor actions for ongoing improvement of the Service.

Budget reports are provided to and reviewed regularly by the EDT Manager and the budget position is reported and discussed at each Management Board meeting. At the time of this review, expenditure was within budget.

Risk Management

There are opportunities for the Partnership to develop and improve its risk management processes. The EDT manager presents a report on the operation of the service over the previous period raising relevant issues, many of which are, in effect, the risks that the service is facing on a day to day basis. However, this process does

not represent the robust and overarching risk management process that the Board should be engaging in.

A more formal process would enable the Partnership to effectively manage strategic decisions, service planning and delivery and achieve its overall objectives. This should start with the identification, analysis, control and timely monitoring of risks by the Board.

Value for Money

One of the functions of the Board, as detailed in the Partnership's Constitution and Agreement, is to look for ways in which the efficiency, economy and effectiveness of the partnership arrangements might be improved. Also, in the Use of Resources, key lines of enquiry, Councils are required to regularly review their partnership working to demonstrate that they are providing effective outcomes and value for money. There are opportunities for the Partnership to further develop mechanisms to demonstrate that the EDT service provides value for money.

To demonstrate value for money the service first needs to identify all its operational costs regardless of how they are being met. The funding arrangements for the Partnership are detailed in the Partnership agreement which states that funding to meet the EDT budget will be split 50-50 between Halton and St Helens Councils. However the budget does not include all costs incurred on the service delivery. Elements are provided 'in kind' by the respective Councils. Although this is the agreement, these costs should be identified and included in the operational costs of the service. The total operational costs can then be used for comparison purposes and further analysis to demonstrate value for money.

Also the EDT now provides an 'out of hours' service for the Homelessness Service for both Halton and St Helens, and the 'appropriate adult' role for the Youth Offending service. Again, the costs of providing these additional elements should be known and included in the value for money equation. Consideration could also be given to recharging the respective services.

Also, if there are opportunities for providing an 'out of hours' service for neighbouring councils, then all costs should be known to ensure a realistic contribution is made by future participating Councils.

Information Sharing Agreement

Information Sharing Agreements were recommended to be established between agencies to facilitate effective and legitimate information sharing practices. These agreements are tiered to reflect the level at which they operate. For example:-

Tier One - To be agreed on a regional basis between Chief Executives of the respective agencies to demonstrate their willingness to the principle of sharing information.

Tier Two - Between specific partners and operational areas, signed by operational line management of those areas and details types of information to be shared.

Tier three & four – Directly connected to a specific operational area and details what and when information will be shared.

In line with best practice a Tier 2 Information Sharing agreement should be established specifically for this Partnership. Within the 'Accountability' section of the EDT Constitution and Partnership Agreement there is reference to the Board's

responsibility to ensure a Tier 2 Information Sharing agreement is in place. However, the Board has taken legal advice and guidance, the outcome of which it was agreed that only a Tier 1 agreement was required, which has been signed at a regional level. The Board should amend paragraph 17 (e) to reflect this decision.

Recommendations

1. The Constitution and Partnership Agreement should include the agreed period and duration of the Partnership.

2. The Constitution and Partnership Agreement should include review arrangements. There should be an annual, formal review of the service so that each Council can ensure that the partnership arrangement continues to be the preferred option for service delivery.

3. In accordance with the Constitution and Partnership Agreement, quarterly performance monitor reports should be provided to both Councils. Each member Council should then report performance to Senior Officers and Members through its governance framework.

4. The Board should ensure that performance targets and outcomes are reported in accordance with the agreed Performance Management Framework.

5. An annual operational plan should be introduced to include actions for improvement and development of the Service.

6. A more formal risk management process should be developed by the Board allowing strategic risks to be identified and appropriate controls developed to mitigate those risks. The risk register as recommended in Halton Borough Council's draft Code of Practice for Partnership Working could be utilized to evidence this process. The identified risks should be monitored on regular basis by the Board.

7. The Partnership needs to develop ways to demonstrate that it is not only providing an effective service but also providing value for money. An understanding of costs is needed to assess whether or not the Partnership is providing value for money. This information can assist in future decisions regarding the potential to expand the service. This should form part of the annual review of the partnership agreement as detailed in recommendation 2.

8. In line with best practice it is recommended that a Tier 2 Information Sharing Agreement is developed specifically for service delivery under this Partnership. Following legal advice and if the Partnership is satisfied that the Tier 1 Information Sharing Agreement satisfies the governance arrangements around information sharing practices required for the operation of the Partnership, then paragraph 17 (e) on the partnership agreements should be amended to that effect.

2.2 **Control Objective – Staff are utilised effectively and suitable employee controls are in place**

Sample testing confirmed that suitable employee controls are in place with regard to management of the work rota, recording staff attendance and compliance with sickness absence, supervision and appraisal procedures. Quality control checks on operational procedures are carried out by the EDT Manager through a sample of case reviews during Supervision and a monthly sample review of random cases extracted from the computer systems. From a sample review of annual leave request forms it was identified that leave had not always been signed as authorised by the EDT Manager. The requirement for this authorisation was discussed with the EDT Manager.

A six weekly employee work rota has been in place since the Partnership started in October 2007. This rota is based on 6 full-time Social Workers in post and provides an element of cover for sickness and annual leave. The rota is effective but is only intended to cover short-term absences. However, since the partnership arrangement started, one Social Worker has been on long-term sickness absence, followed by a secondment. This has resulted in the EDT Manager and two relief Social Workers covering shifts and payment is based on their standard pay rather than a flat rate. In addition, one of the full-time Social Workers and the two relief Social Workers are not qualified as Approved Mental Health Practitioners (AMHP). As AMHP cover is required on shift this has resulted in additional standby duties for the EDT Manager and other members of the Team.

These staffing issues and associated budget implications have been regularly reported to the Management Board and with the assistance of the CYPS HR Manager, St Helens Council, options have been considered. At the time of our review, one of the Social Workers had given notice to resign from her employment. Therefore an interim revised rota was being considered for implementation in March 2009 which would be based on four full-time Social Workers, with efforts being made to recruit to the vacant post and a number of sessional Social Workers to provide cover as and when required.

2.3 Control Objective – Appropriate policies and procedures have been developed and complied with to ensure the service operates within an agreed framework.

Occupational risk assessments

The EDT has a comprehensive suite of policies, procedures and guidance which provides for a robust framework in which the Team can safely operate. Through sample testing it was evident that the team are carrying out their core function in terms of dealing with calls, recording of assessments and the hand-over process to the day-time duty teams was secure. Hard copies of policies and procedure documents are widely available within the office and copies are e-mailed to each member of the team for reference.

Included within the procedures are a number of risk assessments for specific events, e.g. dangerous dogs, lone working. It was noted that an occupational risk assessment had not been undertaken, specifically in relation to the risk of stress. The EDT manager has agreed to raise this issue with St Helen's Human Resources Section, which provides the HR support for the team.

Halton Direct Link Contact Centre Advisors

There is an agreed protocol between the Halton Direct Link Contact Centre Customer Service Advisors and the EDT team. This is regularly reviewed by the Contact Centre Manager and the EDT Manager. Through discussions with the EDT Manager it was evident that there were some issues about the consistency and quality of information being collected and recorded from the caller, by the HDL advisors. It was agreed that this issue could be addressed by further training.

Cross Authority Procedures

Due to the partnership arrangement the EDT Manager is able to obtain a good overview of the individual professional care practice and procedures operating within both Councils. This provides a useful mechanism to identify where certain practices prove to be more effective and can drive service improvements in the less effective areas. Therefore this overview provides an added benefit and should be demonstrated and celebrated as the 'added value' that the Partnership provides.

Recommendations

9. A stress risk assessment should be undertaken for the EDT and issues identified should be addressed and monitored regularly.

10. Refresher training for the HDL advisors should be provided to ensure the information that is collected from the caller is accurate, comprehensive and meeting the right quality standards for the EDT team. This could be scheduled with the training requirements for the pending implementation of Carefirst 6 in Halton.

11. The benefits of partnership working by sharing good practice across both Councils should be clearly demonstrated and held up as a success of the Partnership.

2.4 Control Objective – The IT infrastructure meets the business needs of the service and is sustainable**.**

ICT Strategy

The EDT is supported by a complex IT infrastructure. EDT staff are required to be proficient in accessing both St Helens care systems and Halton Borough Council's care systems, which vary dependent on the client group. Despite the complexities, the IT systems currently meet the existing business needs.

However, looking into the future, it is unlikely that systems will become more integrated. This may not be seen as a problem. For example, Halton is implementing Carefirst 6 and Careassess whereas St Helens are moving away from Careassess and adopting Liquidlogic. As each Council makes its own strategic decisions for future developments in their respective ICT infrastructures, the EDT service needs to have its own ICT strategic plan to future-proof service delivery and plan for any essential developments that may be required to overcome any incompatibility issues. Also, this

ICT plan could inform any future potential partners to enable them to evaluate their ability to integrate or adapt their own systems if they wished to join the partnership.

EDT - Business Continuity Plan (BCP)

Through discussions with the EDT Manager we identified that there have been a few occasions when, due to IT system failure in the main, the Team has put its BCP in operation. This has included temporarily returning to a paper-based system with success.

Currently there are three business continuity plans that are relevant to the EDT service. There is a HR business continuity plan which covers staffing issues; the Halton Direct Link Contact Centre's BCP makes reference to the EDT systems; Health and Community Directorate's BCP also includes the EDT but makes reference to the previous Cheshire County Council contracted service.

Due to BCP for the EDT being referenced in three separate documents, this could lead to confusion at a time when absolute clarity is required.

There should be one BCP for the EDT which should contain plans for all three areas i.e. staffing, systems and IT failure. This would provide one reference point in the event of a major incident occurring.

Laptop Encryption

The EDT staff have a laptop each which they take home after midnight whilst they carry out the remainder of their shift. These laptops are not encrypted which presents a risk that sensitive or personal information could be compromised if they were lost or stolen. It is not usual practice to save client information on the hard drive however, supervision notes and other sensitive data may be contained on the hard drives.

Recommendations

12. The EDT Partnership Board should develop its own ICT Strategy to provide a plan of how the EDT IT infrastructure will adapt as both Councils follow their own Strategic ICT plans. This will assist in the sustainability of the partnership and allow future potential partners to evaluate their ability to integrate or adapt their own systems.

13. The BCP for the EDT should be brought together in one document.

14. The implications of data on the laptop being unencrypted should be assessed and appropriate arrangements made to ensure that personal or sensitive data is not compromised.

3.0 Action Plan

Emergency Duty Team

Rec. No.	Recommendation	Responsible Officer	Agreed Action and Date of Implementation	Actual Date of Implementation
1	The Constitution and Partnership Agreement should include the agreed period and duration of the Partnership	Senior Assistant Director, CYPS, (St Helens)	Partnership Agreement to be amended and recirculated to Board and Directors identifying dates of partnership and dates for review. June 2009	
2	The Constitution and Partnership Agreement should include review arrangements. There should be an annual, formal review of the service so that each Council can ensure that the partnership arrangement continues to be the preferred option for service delivery.	Senior Assistant Director, CYPS, (St Helens), Operational Director (Halton)	Partnership to be reviewed at September Board with approval by each Council in line with change in Chairing arrangements in October. October 2009	
3	In accordance with the Constitution and Partnership Agreement, quarterly performance monitor reports should be provided to both Councils. Each member Council should then report performance to Senior Officers and Members through their governance framework.	Senior Assistant Director, CYPS, (St Helens), Operational Director (Halton)	Report to be completed each quarter. First report to include summary report for Oct 07 to February 2009.	May 2009
4	The Board should ensure that performance targets and outcomes are reported in accordance with the agreed Performance Management Framework.	Acting Service Manager (St Helens)/ EDT Manager	Current performance report to be incorporated into a reviewed Performance Framework. October 2009.	

5	An annual operational plan should be introduced to include actions for improvement and development of the Service.	Chair of the Operational Group	Operational Plan to be completed and presented to the Board by September 2009 and to be commenced from 1 October 2009.	
6	A more formal risk management process should be developed by the Board allowing strategic risks to be identified and appropriate controls developed to mitigate those risks. The risk register as recommended in Halton Borough Council's draft Code of Practice for Partnership Working could be utilized to evidence this process. The identified risks should be monitored on regular basis by the Board.	EDT Manager	Risk Register and Business Continuity Management Plans reviewed and updated.	April 2009
7	The Partnership needs to develop ways to demonstrate that it is not only providing an effective service but also providing value for money. An understanding of costs is needed to assess whether or not the Partnership is providing value for money. This information can assist in future decisions regarding the potential to expand the service. This should form part of the annual review of the partnership agreement as detailed in recommendation.	Finance Officers (St Helens & Halton)	Full costings exercise to be completed and inform practice. Ongoing partnership agreements. September 2009	
8	In line with best practice it is recommended that a Tier 2 Information Sharing Agreement is developed specifically of service delivery under this Partnership. Following legal advice and if the Partnership is satisfied that the Tier 1 Information Sharing Agreement satisfies the governance arrangements around information sharing practices required for the operation of the Partnership, then paragraph 17 (e) on the partnership agreements should be amended to that effect.	Group Solicitor (Halton)/ System Information Management Officer (St Helens)	Tier 2 information sharing agreement for EDT to be developed, led by information from both Councils. August 2009	
9	A stress risk assessment is undertaken for the EDT and any issues identified should be addressed and monitored regularly.	Acting Service Manager (St Helens)/ EDT Manager	Risk assessment to be completed via the appraisal process. June 2009	
10	Refresher training for the Halton Direct Link advisors should be	Divisional	Refresher training to be provided	

	provided to ensure the information that is collected from the caller accurate, comprehensive and meeting the right quality standards for the EDT team. This could be scheduled with the training requirements for the implementation of Carefirst 6 in Halton.	Manager (Halton)/ EDT Manager	by September 2009	
11	The benefits of partnership working by sharing good practice across both Councils should be clearly demonstrated and held up as one of the successes of the Partnership.	Senior Assistant Director, CYPS, (St Helens), Operational Director (Halton)	To be detailed in report to Chief Officers and Members (Cross referenced to Rec No 3) June 2009	
12	The EDT Partnership Board should develop their own ICT Strategy to provide a plan of how the EDT IT infrastructure will adapt as both Council's follow their own Strategic ICT plans. This will assist in the sustainability of the partnership and allow future potential partners to evaluate their ability to integrate or adapt their own systems.	Senior Assistant Director, CYPS, (St Helens), Operational Director (Halton)/ ICT Strategy Officers (St Helens & Halton)	Strategy for EDT to be completed and approved by both Councils. January 2010.	
13	The Business Continuity Plan for the EDT should be brought together in one document.	Acting Service Manager (St Helens)/ EDT Manager	Business Continuity Plan to be completed. June 2009	
14	The implications of data on the laptop being unencrypted should be assessed and appropriate arrangements should be made to ensure that personal or sensitive data is not compromised.	EDT Manager/ICT Strategy Officers	Assessments completed and laptops secured	April 2009

REPORT TO: Healthy Halton PPB

DATE: 15th September 2009

REPORTING OFFICER: Chief Executive

SUBJECT: Performance Management Reports for 2009/10

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To consider and raise any questions or points of clarification in respect of the 1st quarter performance management reports on progress against service plan objectives and performance targets, performance trends/comparisons, factors affecting the services etc. for;

- Adults of Working Age
- Older People's and Independent Living Services
- Health & Partnerships

2.0 RECOMMENDATION: That the Policy & Performance Board;

1) Receive the 1st quarter year-end performance management reports;

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

3) Highlight any areas of interest and/or concern where further information is to be reported at a future meeting of the Policy and Performance Board.

3.0 SUPPORTING INFORMATION

3.1 The departmental service plans provide a clear statement on what the services are planning to achieve and to show how they contribute to the Council's strategic priorities. The service plans are central to the Council's performance management arrangements and the Policy and Performance Board has a key role in monitoring performance and strengthening accountability.

3.2 The quarterly reports are on the Information Bulletin to reduce the amount of paperwork sent out with the agendas and to allow Members access to the reports as soon as they have become available. It also provides Members with an opportunity to give advance notice of any

questions, points or requests for further information that will be raised to ensure the appropriate Officers are available at the PPB meeting.

4.0 POLICY IMPLICATIONS

There are no policy implications associated with this report.

5.0 OTHER IMPLICATIONS

There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

The quarterly performance monitoring reports demonstrate how services are delivering against the objectives set out in the relevant service plan. Although some objectives link specifically to one priority area, the nature of the cross-cutting activities being reported means that to a greater or lesser extent a contribution is made to one or more of the priorities listed below;

6.1 **Children and Young People in Halton**

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

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

6.6 **Corporate Effectiveness and Efficient Service Delivery**

7.0 RISK ANALYSIS

N/A

8.0 EQUALITY AND DIVERSITY ISSUES

N/A

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

Document	Place of Inspection	Contact Officer
N/A		

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Adults of Working Age**

PERIOD: **Quarter 1 to period end 30th June 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Adults of Working Age Department second quarter period up to 30 June 2009 It describes key developments and progress against all objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 5

2.0 KEY DEVELOPMENTS

Mental Health
Employment: a key national priority is to improve the employment prospects for people with severe mental health problems, and this has been identified as one of Halton's LAA targets. A Steering Group has been set up through the Disability Employment Network and progress is reported regularly to this group. A new employment worker has been appointed and is in place, working to adults services overall but with an initial focus on mental health services. In addition, a national mental health charity, Richmond Fellowship, has been commissioned to provide a similar employment service specifically for people with mental health problems, building on a successful scheme already in place in Warrington.

Personalisation: is the focus of the transformation of Adult Social Care. The emphasis is a move from traditional models of care, to care and support that is personalised to the individual. Work has begun to deliver this challenging agenda within mental health services. A Steering Group is to be established, chaired by the Operational Director (AWA), to take this forward locally. In addition, work will need to take place across the whole of the 5Boroughs footprint to ensure that the health services are fully engaged in this process. This will also involve service commissioners.

Mental Health Single Point of Access: this is on schedule for delivery by autumn 2009, with a provider service identified by the PCT. A new social work post has been established for this service and the postholder will be fully involved in the development of this service.

Care Programme Approach: this important policy and procedure, which operates jointly across health and social care services, was issued in a revised form by Central Government in 2008. The lead for revision of the policy locally is with the 5BoroughsPartnership. As yet, the new policy and procedure has not been developed but the Council is working closely with the 5Boroughs to ensure that this is delivered.

Personalisation
The ALD and PSD Team continue to lead and progress the personalisation agenda. The planning live programme has enabled 7 individuals across both services to receive an indicative allocation and support plan. PSD are currently implementing the conversion of current direct payment recipients to an individual budget service.

Healthcare for All
A multi agency steering group has been set up to guide the implementation of all health recommendations and targets aligned with learning disabilities. The group is accountable to the Learning Disability Partnership Board and the Executives of the PCT.

3.0 EMERGING ISSUES

Approved Mental Health Professional (AMHP): following the introduction of the Mental Health Act 2007, AMHPs can now be employed within health services, although fulfilling duties on behalf of the local authority. A Steering Group has been established, involving the 5BoroughsPartnership and the social care leads from each of the 5 constituent Local Authorities, to take this forward.

Valuing People Now
Valuing people Now has set out its three year strategy for people with learning disabilities. Making it happen will require leadership at all levels across all agencies, public and private. Leadership for delivery will come from a national, regional and local level. At a local level the Partnership Boards will oversee and monitor the delivery of Valuing People Now. Each Partnership Board will produce an annual report for their regional board signed off by people with learning disabilities and family carers who are members of the board. In preparation there has been a shadow partnership board established whose membership is solely from people with a learning disability and there is an identified chair who attends who co chairs the partnership board.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**15**		**15**		**0**		**0**

Progress has been made against all milestones

5.0 SERVICE REVIEW

There are no service review issues to report this quarter

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**7**		**2**		**1**		**4**

Only three Key Indicators have met their target in Q1

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**9**		**8**		**1**		**0**

In broad terms the majority of indicators are on target although a significant amount of data is still awaited from partner organisations.
Of those measures that can be reported at Q1 Adults with Mental Health Problems helped to live at home is falling below target.

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4. Please refer to Appendix 4

9.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress Against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4- Financial Statement
Appendix 5- Explanation of traffic light symbols

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
AWA 1	**Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for Adults of Working Age**	Contribute to the safeguarding of vulnerable adults and children in need, by ensuring that staff are familiar with and follow safeguarding processes **Mar 2010.** (AOF6)		Audit on case files for vulnerable adults and children completed across the Directorate , action plan agreed
		Person Centred reviews for adults with PMLD, to be implemented in ALD Care Management and influencing strategic commissioning to enhance service delivery **Mar 2010.** (AOF7)		Person centred reviews have been targeted at young people with person centred plans in transition. There is a five year plan which contains the goals and aspirations from PCP's and PCR's and monitors the outcomes. The ALD team in conjunction with Helen Sanderson Associates are now extending this to all adults with a PMLD and individuals with older carers. There is an aggregation day arranged to examine the outcomes in the Autumn.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Redesign the Supported Housing Network to meet the needs of those with the most complex needs **Mar 2010.** (AOF6 & 7)		With the implementation of 'active support' a system devised by Dr Sandy Toogood a behavioural analyst, the service has improved tenants' lives developing a wider range of activities and an increase in social inclusion. Staff complete weekly records of participation for indoor/outdoor activities and community presence. Each tenant has his or her own activity support plan. Tenants are able to participate with activities in their own home i.e. laundry, preparing meals, weekly tasks etc. We use the person centred approach offering choice and empowering tenants. The interactive training being completed with Esther Gibbons and the staff has given the staff more insight to what the tenants are trying to communicate. When this work is complete, the tenants will have care plan to show how people communicate at the very least their likes and dislikes.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Analyse the impact of Valuing People Now on service delivery to ensure that services met the needs and improve outcomes for people with LD **Mar 2010** (AOF 6 & 7)		Action Plan agreed by Partnership Board to implement Valuing People Now, Shadow Partnership Board in process of being established
		Implement strategy to deliver improved services to younger adults with dementias **Mar 2010** (AOF 6)		An overall dementia strategy is being developed and specific actions are being identified as part of this work.
		Fully implement the Volunteer Strategy to ensure appropriate volunteering opportunities are available **Mar 2010** (AOF6)		Strategy now in process of being agreed
		Review implementation of Mental Health Act 2007 to ensure all policies, procedures and processes are fit for purpose **Oct 2009** (AOF 6)		All services have been invited to comment on the existing policies and procedures and put forward amendments. These comments have been received and policies are to be amended in summer 2009.
		Review key partnership working arrangements and associated structures to ensure that they are fulfilling service delivery requirements **Mar 2010** (AOF 7)		Mental Health Partnership currently being reviewed and changes to be agreed at next Board meeting

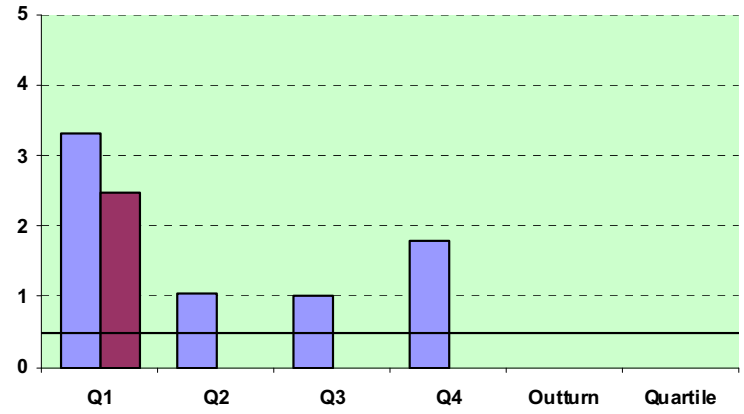
Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Implement agreed recommendations of review of services and supports to children and adults with Autistic Spectrum Disorder **Mar 2010** (AOF 6)		Strategic Group and Stakeholder Group established
		Continue to implement a behaviour solutions approach to develop quality services for adults with challenging behaviour - Models of good practice to be developed **Mar 2010.** (AOF7)		H A proposal has been agreed and a project manager appointed to develop a business case to secure three year funding for a specialist challenging behaviour support service. The proposed service will be available to support mainstream services in working with people with learning disability and/or autism whose behaviour is a significant challenge for services.
AWA 2	**Effectively consult and engage with Adults of Working Age to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required**	Review key partnership working arrangements and associated structures to ensure that they are fulfilling service delivery requirements **Mar 2010** (AOF 7)		Review in progress fro Emergency Duty Team
		Review implementation of Mental Health Act 2007 to ensure all policies, procedures and processes are fit for purpose **Oct 2009** (AOF 6)		See above.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Implement agreed recommendations of review of services and supports to children and adults with Autistic Spectrum Disorder **Mar 2010** (AOF 6)		See above, good progress is being made
		Continue to implement a behaviour solutions approach to develop quality services for adults with challenging behaviour - Models of good practice to be developed **Mar 2010.** (AOF7)		A proposal has been agreed and a project manager appointed to develop a business case to secure three year funding for a specialist challenging behaviour support service. The proposed service will be available to support mainstream services in working with people with learning disability and/or autism whose behaviour is a significant challenge for services.
AWA 3	**Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs**	Review key partnership working arrangements and associated structures to ensure that they are fulfilling service delivery requirements and are being managed in a cost effective way **Mar 2010.**		See above, good progress being made

AWA LI4

Percentage of adults assessed in year where ethnicity is not stated

Lower figures represent better performance



Key

2008/9
2009/10
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

Trend	
	Red
No data for same Qtr last year	Unlikely to hit target for the year

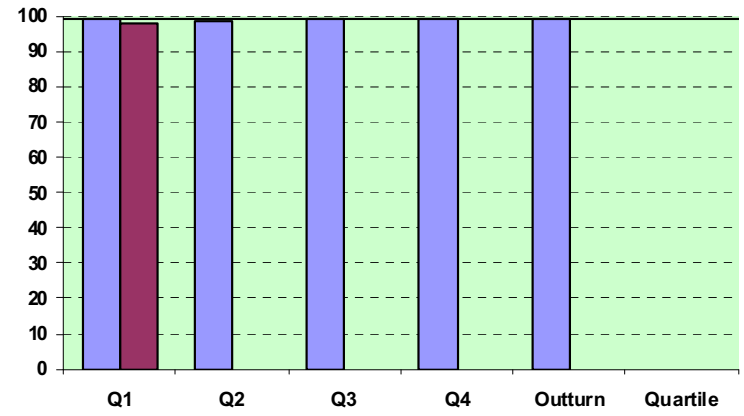
Commentary

The number of clients assessed where ethnicity is not stated relates to 9 clients. This performance is worse than target and is higher than that reported in 2008/09.

AWA LI8

Percentage of people receiving a statement of their needs and how they will be met.

Higher figures represent better performance



Key

2008/9
2009/10
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

Trend	
	Red
No data for same Qtr last year	Unlikely to hit target for the year

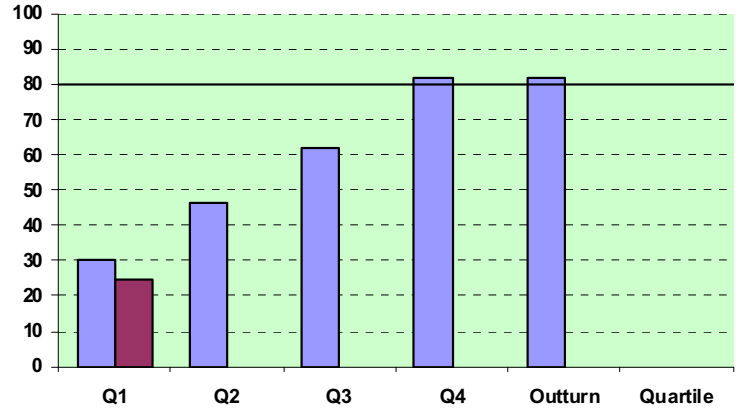
Commentary

Performance for Q1 is falling below target. At current levels the target is not likely to be met, although it is noted that performance is only 1% lower than target. Oerformance has been highlighted with Adult Social Care teams in order that they improve their performance. Exception reporting is also in place to identify anomolies.

AWA LI9

Clients receiving a review as a % of adult clients receiv)ng a service (cost effectiveness PSA Target)

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

Should hit target for the year

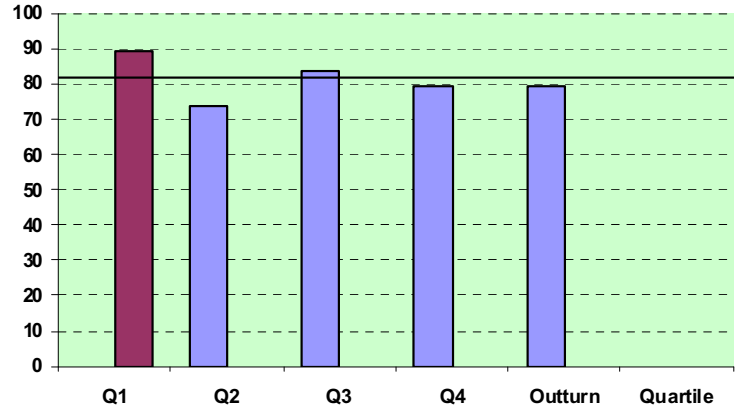
Commentary

Q1 figure is higher than expected in relation to cumulative performance and is expected to exceed target.

AWA NI 132

Timeliness of social care assessment DH DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

Should hit target for the year

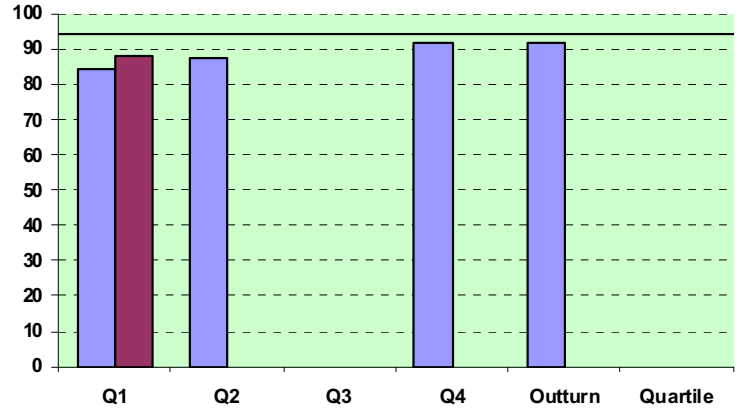
Commentary

Q1 figure is higher than expected in correlation to increased performance for the HHIILS team. Performance is expected to exceed target.

AWA NI 133

Timeliness of social care packages DH DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

	Red
No data for same Qtr last year	Unlikely to hit target for the year

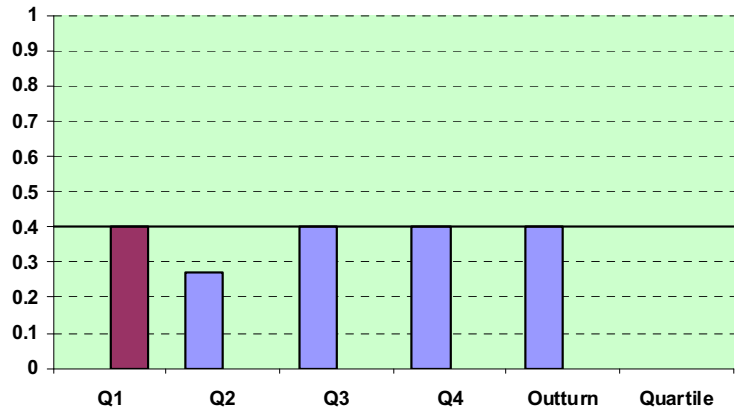
Commentary

Q1 figure is falling below target and is unlikely to be met at current levels. Action is being able to raise awareness and discuss actions to improve performance for this indicator.

AWA LI10

Admissions of Supported Residents aged 18-64 into residential/nursing care

Lower figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

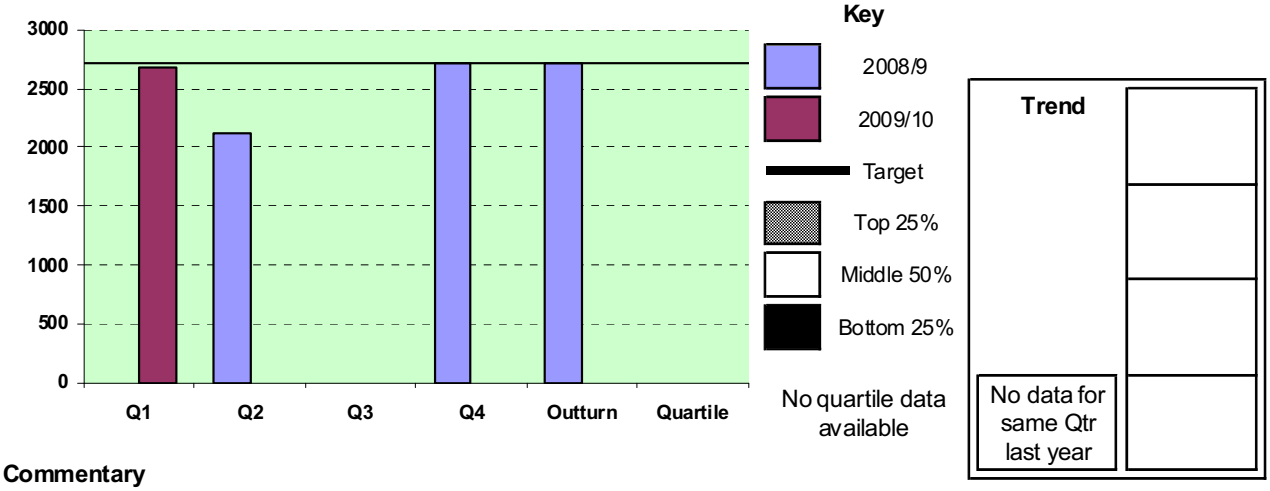
	Red
No data for same Qtr last year	Unlikely to hit target for the year

Commentary

This figure relates to 3 clients aged 18 - 64

AWA NI 136

People supported to live independently through social services (all ages) PSA 18

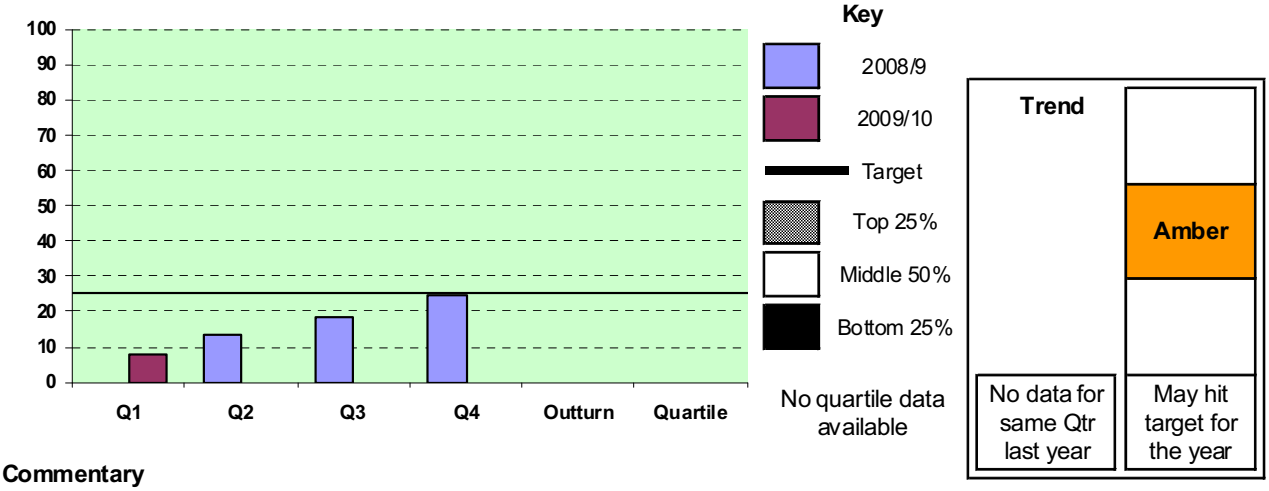


Commentary

Q1 performance has reduced from 2008/09 performance as a result of Changes in population statistics. Helped to live at home continues to be good. No target has been set for 2009/10, therefore a traffic light indicator cannot be allocated.

AWA NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO



Commentary

Q1 figure demonstrates performance above target for the first quarter. Based on current performance the target is expected to be met. However, changes in the definition of Professional Support may reduce the number of clients supported with a service, thus impacting adversely against this indicator. Based on this factor, a cautious amber judgement has been identified.

The following Key Performance Indicators cannot be reported graphically: -
NI 131; Delayed transfers of care – PCT are unable to report any data on this figure

NI 145; Data is not available for this indicator in Q1. Steps are being taken for accommodation status to be reported in Carefirst so that performance can be reported automatically.

Ref.	Description	Actual 2008/09	Target 20091/0	Quarter 1	Progress	Commentary
AWA LI 13	Adults with mental health problems helped to live at home	3.5	3.75	3.5		Q1 figure is falling short of target. The indicator relates to 265 clients.

HEALTH & COMMUNITY – ADULTS OF WORKING AGE (ALD, MH, PSD)

Revenue Budget as at 30th June 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Staffing	3,390	751	731	20	761
Premises	205	19	17	2	17
Other Premises	66	22	20	2	20
Joint Equipment Service	231	95	93	2	93
Supplies & Services	235	25	30	(5)	30
Food Provisions	9	2	1	1	1
Aid & Adaptations	113	28	31	(3)	38
Transport of Clients	633	57	52	5	95
Departmental Support Services	1,089	0	0	0	0
Central Support Services	363	8	8	0	8
Contract & SLAs	864	110	114	(4)	142
Emergency Duty Team	95	24	25	(1)	25
Community Care:					
Residential Care	886	145	125	20	125
Home Care	701	130	127	3	127
Direct Payments	659	206	204	2	204
Supported Living	60	5	4	1	4
Day Care	26	6	2	4	1
Unallocated Grants	346	0	0	0	0
Asset Charges	203	0	0	0	0
Contribution to ALD Budget	6,932	1,488	1,432	56	1,485
Total Expenditure	**17,106**	**3,121**	**3,016**	**105**	**3,176**
Income					
Residential Fees	-136	-31	-8	(23)	-8
Fees & Charges	-151	-35	-38	3	-38
Preserved Rights Grant	-81	-20	-20	0	-20
Supporting People Grant	-371	-20	-14	(6)	-14
Mental Health Grant	-500	-125	-125	0	-125
Carer Grant	-518	-129	-129	0	-129
Mental Capacity IMCA Grant	-85	-21	-21	0	-21
Aids Support Grant	-5	0	0	0	0
Local Involvement Network Grant	-110	-27	-28	1	-28
Community Roll Out Funding	-150	-100	-100	0	-100
Tobacco Control Grant	-100	-100	-100	0	-100
PCT Reimbursement	-450	-120	-121	1	-121
Other Income	-6	-2	-10	8	-10
Total Income	**-2,663**	**-730**	**-714**	**(16)**	**-714**
Net Expenditure	**14,443**	**2,391**	**2,302**	**89**	**2,462**

Comments on the above figures:

APPENDIX FOUR– FINANCIAL STATEMENT
Adults of Working Age

In overall terms revenue spending at the end of quarter 1 is under budget profile by £33k excluding the ALD pool budget. This is due to expenditure on staffing budgets and also on community care services being less than anticipated at this stage of the year.

Staffing related expenditure is less than expected due to the number of front line vacancies within the department particularly in PSD services. Many of these vacancies will be appointed to during the second quarter of the year therefore this budget is not expected to under spend significantly at yearend.

The community care budget has been realigned across the Directorate this financial year to reflect, more accurately, expenditure incurred on services provided. Budgets for homecare and direct payments have been increased whilst the residential care budget has been reduced reflecting the move away from residential placements to care provided within the home environment, enabling more flexibility and choice in service provided. Residential fees & charges targets have also been reviewed in light of this shift.

The community care budget as a whole, including associated income, is currently £10k below budget profile. The implementation of personalised budgets for all client groups later in the year will necessitate close monitoring of the community care budget across the directorate.

A summary of the H.B.C. Contribution to ALD Pooled Budget can be found on the following page:

HEALTH & COMMUNITY – ADULTS WITH LEARNING DISABILITIES

Contribution to ALD Pooled Budget

Revenue Budget as at 30th June 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Residential Care	1,366	237	192	45	192
Supported Living	2,111	500	487	13	501
Home Care	1,353	247	204	43	204
Direct Payments	555	192	209	(17)	209
Day Services	1,868	418	416	2	434
Specialist LD Team	557	139	151	(12)	161
Management Costs	1,142	100	97	3	97
Respite	363	79	73	6	84
Other Expenditure	149	37	33	4	33
Total Expenditure	**9,464**	**1,949**	**1,862**	**87**	**1,915**
Income					
Rents & Service Charges	-28	0	0	0	0
Community Care Fees	-72	-17	-16	(1)	-16
Residential Fees	-125	-29	-23	(6)	-23
Direct Payments	-35	-11	-11	0	-11
Supporting People Grant	-1,075	-225	-201	(24)	-201
Preserved Rights Grant	-331	-83	-83	0	-83
Campus Closure Grant	-57	-57	-57	0	-57
LDDF	-149	-38	-37	(1)	-37
CITC – Astmoor	-53	0	0	0	0
CITC – Special Needs	-6	0	0	0	0
PCT Income	-79	0	0	0	0
CHC – PCT Reimbursement	-363	0	-1	1	-1
Other Fees & Charges	-159	-1	-1	0	-1
Total Income	**-2,532**	**-461**	**-430**	**(31)**	**-430**
Net Expenditure	**6,932**	**1,488**	**1,432**	**56**	**1,485**

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Older People's Services**

PERIOD: **Quarter 1 to period end 30th June 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Older People's Services Department first quarter period up to 30 June 2009 It describes key developments and progress against all objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 5

2.0 KEY DEVELOPMENTS

An Early Intervention and prevention strategy is being developed; which includes intergenerational and health promotion.

Implementation of the dignity agenda is progressing with the new appointment of a dignity coordinator.

A Joint Dementia strategy is on target to be completed by July 2009, this will result in some further work required around implementation.

The Community Extra Care Service evaluation is near completion, which will result in further service development.

Virtual Ward model agreed in partnership with PCT, to be in place by January 2010

SCIP partnership with the Runcorn PBC extended until February 2011, further work underway to evaluate effectiveness of the service against agreed targets

3.0 EMERGING ISSUES

Work is progressing with the PCT to address health inequalities across Halton, which may have an impact on workload.

Review of Palliative Care and End Of Life services within the PCT.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**15**		**13**		**2**		**0**

Most milestones are on target. Continuing development involving identifying needs of older people has meant that the first quarter is as yet not meeting target. Also further development work and review on early intervention is being undertaken before completion of an engagement strategy with service users. Additional details are provided within Appendix 1

5.0 SERVICE REVIEW

Environmental improvement work in Oak meadow is ongoing over the next 6 months. This includes an overall review of infection control policies and procedures.

Review of new Reablement service will be completed this year.

Review of restaurant provision at Dorset Gardens.

Review of the OPCMT will be completed this year.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**7**		**3**		**1**		**3**

Some data still awaited from Health at the time of publication of this report and additional commentary for those measures that can be reported is included within Appendix 2.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**5**		**2**		**1**		**1**

Some data still awaited from Health at the time of publication of this report. For those measures that are being reported by exception additional details are provided within Appendix 3.

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4. Please refer to Appendix 4.

9.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4- Financial Statement
Appendix 5 - Explanation of traffic light symbols

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
OPS 1	**Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for Older People**	Commission specialist housing provision for older people with higher levels of need **Mar 2010.** (AOF6 & 7).		Two residential homes changed registration to support older people with dementia. Continued development of extra care housing programme, identifying needs of older people.
		Implement of the Gold Standard and Performance Management Framework for Intermediate Care **Apr 2009** (AOF 6 &7)		Completed on target.
		Increase the numbers of carers provided with assessment leading to the provision of services, to ensure Carers needs are met **Mar 2010.** (AOF7)		Target exceeded last year. Work ongoing to continue to increase the numbers of carers whose needs are met.
		Maintain the number of carers receiving a carers break, to ensure Carers needs are met **Mar 2010.** (AOF7)		Carers sub group established to ensure we are providing breaks, which meet the needs of carers.
		Comprehensive pathways for using transitional care within Halton are in place **Mar 2010** (AOF 6 &7)		Pathways and service provision in relation to transitional care are being developed and on target for completion March 2010.

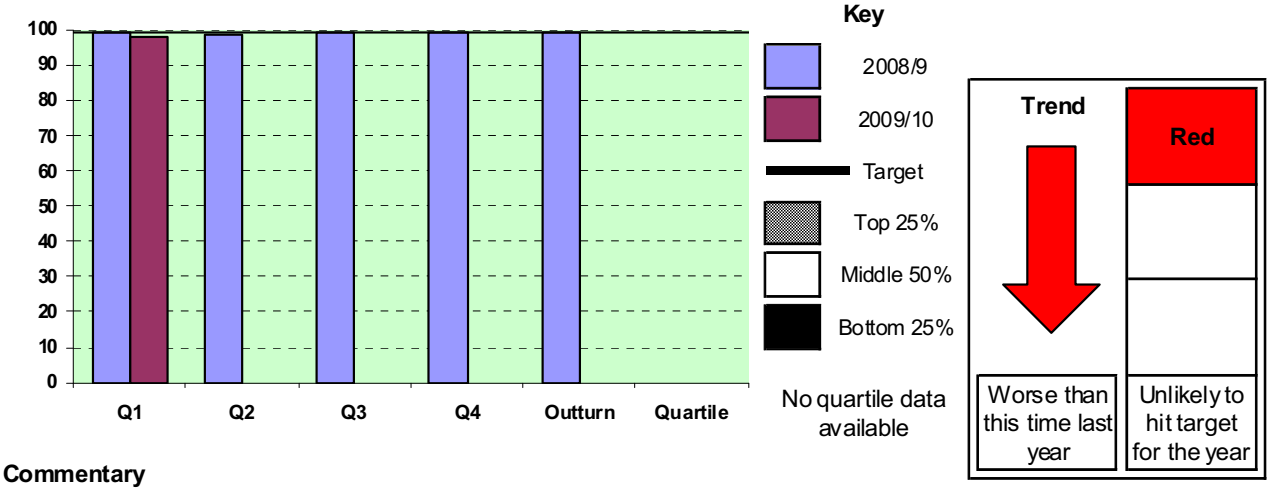
Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Intergenerational activities project established as part of the review on early intervention and prevention aimed at improving outcomes for Older People **June 2009** (AOF 6 &7)		Service Level Agreement for intergenerational work due for completion by early July. This includes specific outcome based targets that will be reviewed through the Older People's Local Implementation Team. First intergenerational conference took place in April with almost 200 older and younger people attending.
		Review of Long Term Conditions and Therapy services commissioned jointly with NHS Halton and St Helens **Apr 2009** (AOF 6 &7) NB. Deadline dependent on contribution from the Primary Care Trust		Ruth McDonough please complete
		Agreement with the PCT on the responsibility for Medication Prompts in place **Sept 2009** (AOF 7)		Work ongoing and on target for completion by September 2009.
OPS 2	Effectively consult and engage with Older People to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-	Review local arrangements for continuing health care by following National Review **Apr 2009** (AOF 2&7) NB. Dependent on National Review being completed to timescale of Jan 2009.		Completed within timescales.
		Implement revised Joint Commissioning Strategy for Older People **March 2010** (AOF 2 & 7)		First draft of the strategy due for completion in July, implementation plan will form part of the overall strategy.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
	design of services where required	Evaluate joint service developed with Runcorn PBC **Mar 2010** (AOF2 & 4)		Ongoing evaluation of the service will ensure completion within timescales.
		As part of the review on early intervention and prevention aimed at improving outcomes for Older People, develop a meaningful engagement strategy with Service Users **June 2009** (AOF 7)		Review on early intervention and prevention in the process of being completed, SMT report on progress due for submission in July. Engagement strategy will be developed by Halton OPEN (Older People's Empowerment Network) as part of their continuing development and will be presented to the Older People's Local Implementation Team in early 2010.
		Establish Social Care element of the 'Virtual Ward' established with Widnes PBC **March 2010** (AOF 2)		Completed and on target for service implementation October 2009.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
OPS 3	**Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs**	Analyse need and submit bids to DoH, Housing Corporation or other pots for at least one extra care development to provide additional extra care tenancies in Halton **Mar 2010.** (AOF6 & 7)		The approach taken has been to: 1. Seek to identify HBC owned sites 2. Contact RSLs about possible re-modelling of existing sheltered schemes, or identify land they own 3. Look for other sites in private ownership The Council has worked with different partners to identify 11 potential development opportunities to meet the identified need. It has been given the highest priority within the Council and support from the relevant Boards (7 sites have been prioritised by the Asset Management Group based on deliverability). We anticipate RSL submissions being made to the HCA by March 2010 for approximately 90 units and are dependent on these being successful in order to meet the identified need in our strategy.
		Implement new residential and domiciliary care contracts for older peoples services **Sept 2009** (AOF6 & 7)		Contracts for Domiciliary care awarded within timeframe, within budget and with minimal disruption to SUs. Terms of new residential contract agreed with residential providers within agreed timeframe and within budget.

OP LI7

Percentage of people receiving a statement of their needs and how they will be met.

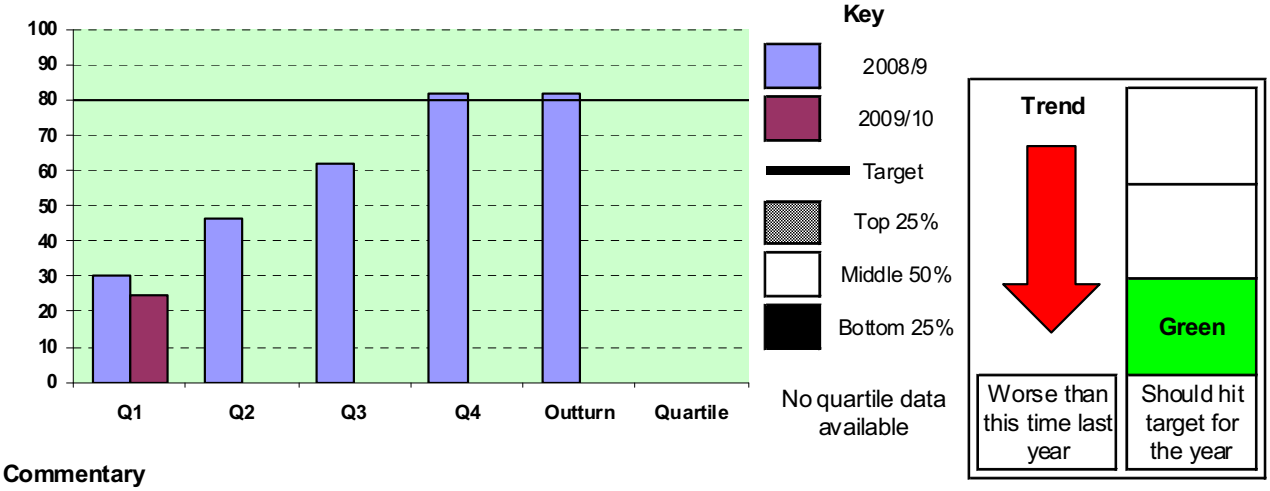


Commentary

Performance for Q1 is falling below target. At current levels, the target figure is unlikely to be met.

OP LI8

Clients receiving a review as a %age of adult clients receiving a service



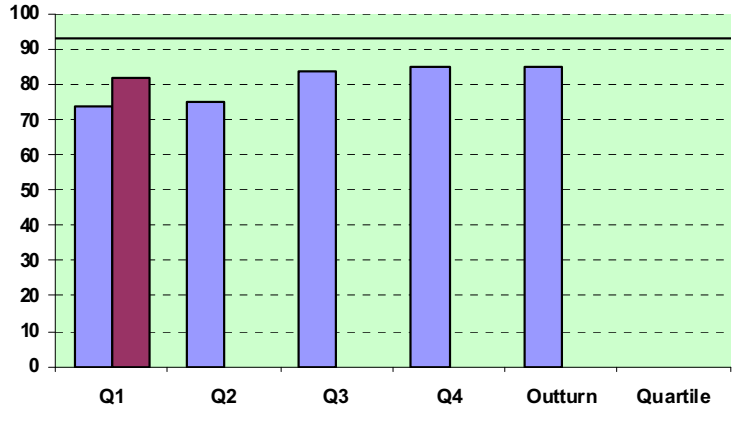
Commentary

Q1 figure is higher than expected in relation to cumulative performance and is expected to exceed target.

OP LI9

Percentage of items of equipment delivered within 7 working days

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Red

Better than this time last year

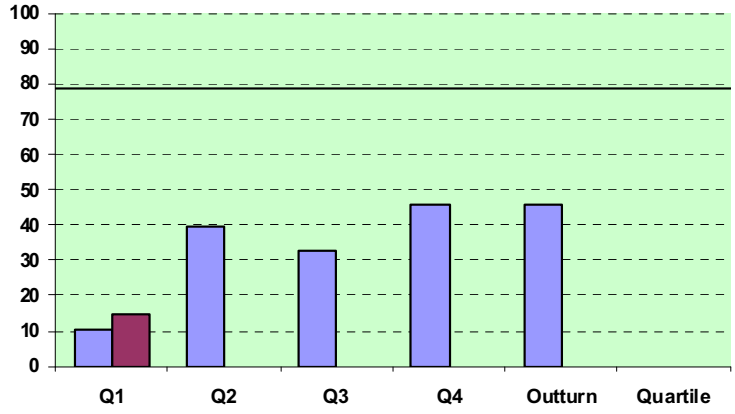
Unlikely to hit target for the year

Commentary

Q1 performance month by months is variable. Combined Q1 performance is falling short of target and is significantly lower than target.

OP LI10

Admissions of supported residents aged 65+ to permanent residential/nursing care (per 10,000 population)



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

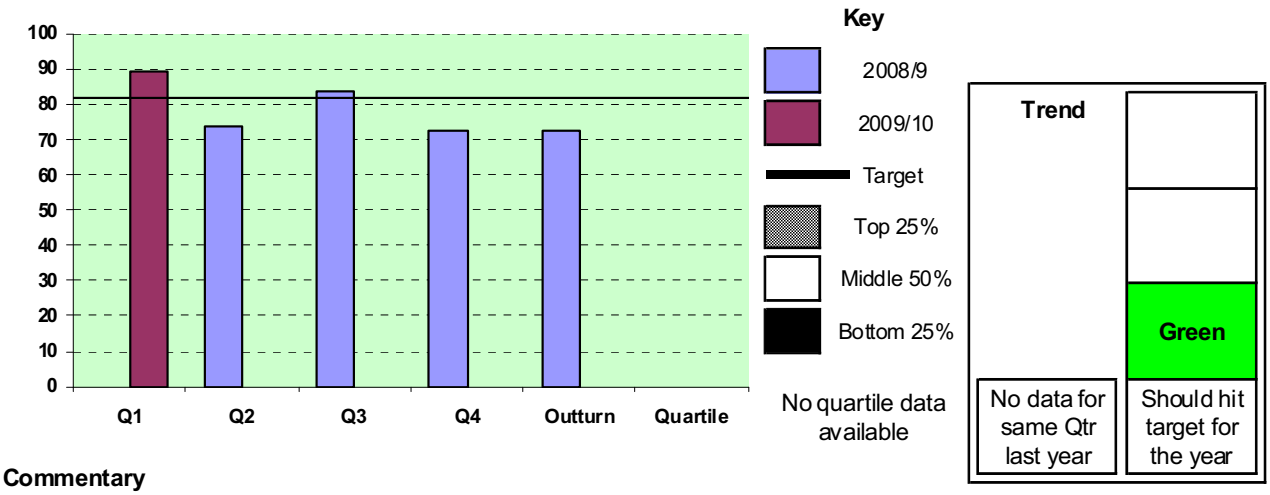
Better than this time last year

Should hit target for the year

Commentary

25 older people have been admitted to permanent residential and nursing care in Q1. At current levels, performance is expected to be lower than target at year end. Lower admissions to residential and nursing care equates to good performance.

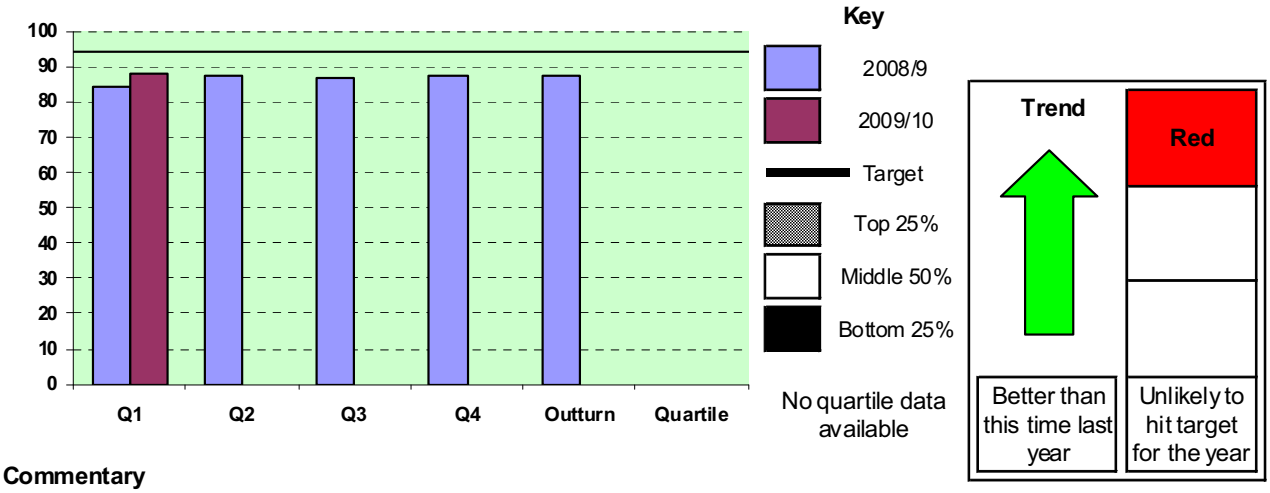
OP NI 132 **Timeliness of social care assessment DH DSO**



Commentary

Q1 figure is higher than expected in correlation to increased performance for the HHIILS team. Performance is expected to exceed target.

OP NI 133 **Timeliness of social care packages DH DSO**

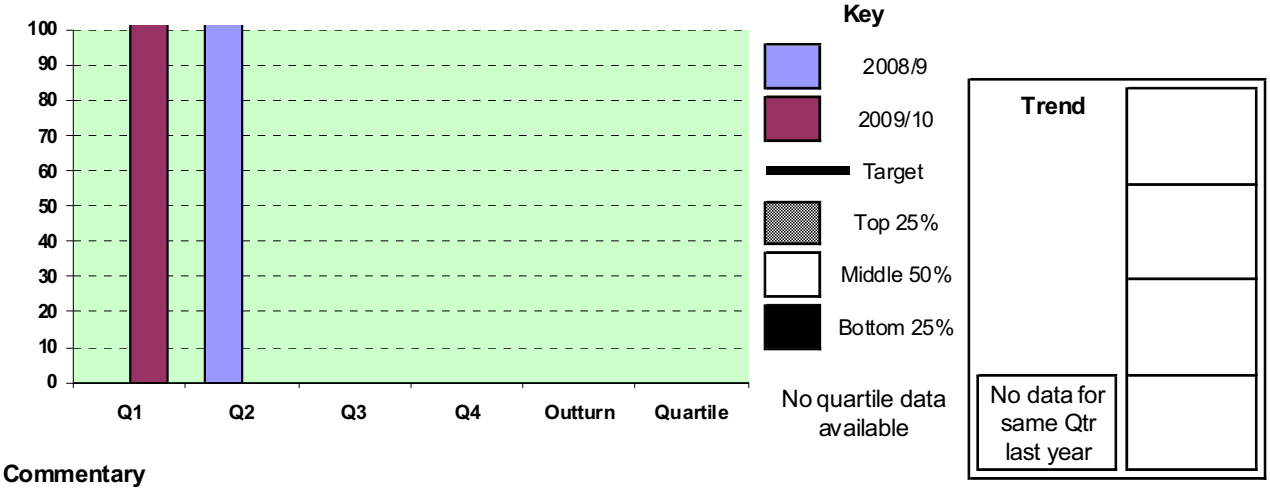


Commentary

Q1 figure is falling below target and is unlikely to be met at current levels. Action is being able to raise awareness and discuss actions to improve performance for this indicator.

OP NI 136

People supported to live independently through social services (all ages) PSA 18

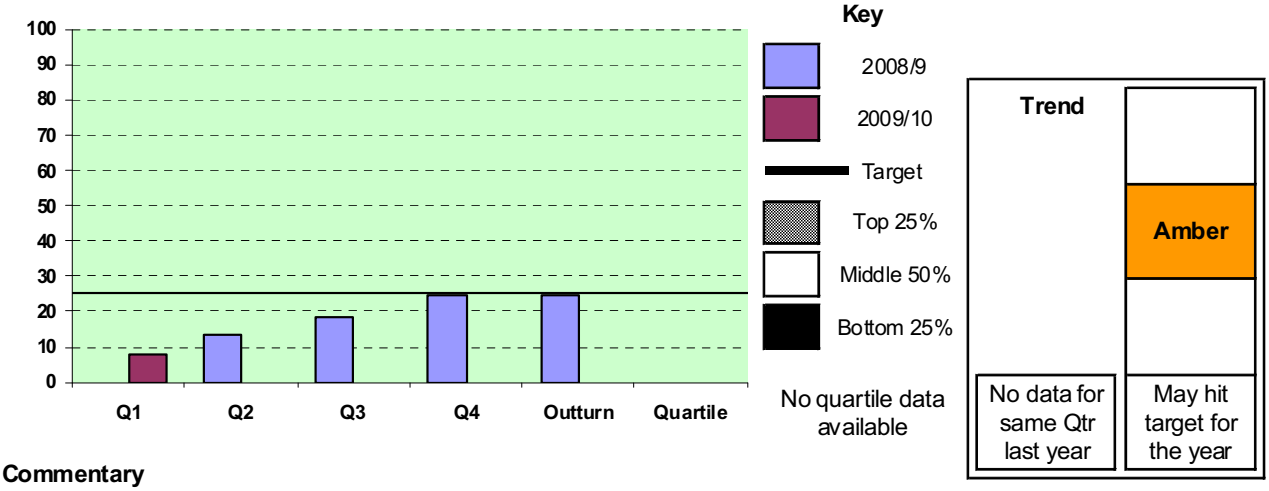


Commentary

Helped to live at home continues to be good. No target has been set for 2009/10, therefore a traffic light indicator cannot be allocated

OP NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO



Commentary

Q1 figure demonstrates performance above target for the first quarter. Based on current performance the target is expected to be met. However, changes in the definition of Professional Support may reduce the number of clients supported with a service, thus impacting adversely against this indicator. Based on this factor, a cautious amber judgement has been identified.

The following KPIS have not been represented graphically: -
NI 125; Achieving independence for older people – relies on survey, no survey taken in Q1
OP LI3; Insufficient data to report on Q1
NI 131; Delayed transfers of care – PCT are unable to report on this indicator

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 1	Progress	Commentary
Fair Access						
OP LPI 4	Ethnicity of older people receiving assessment	1.7	1.5	0		No older people 'other than white' have been assessed in Quarter 1.
Quality						
OP LI 11	Household (all adults) receiving intensive homecare (per 1000 population aged 65 or over) Key Threshold > 8	11.43	13	10.3		Q1 figure is based on HH1 (Home Care) sample week in September 2008. An updated figure is not available. The HH1 is not longer reported as a statutory return. From 09/10 the data is based on planned activity from Carefirst. Gaps in data capture exist in carefirst and action is being taken to ensure data is captured for 09/10.

HEALTH & COMMUNITY – OLDER PEOPLE

Revenue Budget as at 30th June 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Employees	5,750	1,517	1,511	6	1,614
Premises Support	234	58	58	0	58
Other Premises	58	11	7	4	49
Food Provisions	173	43	71	(28)	259
Supplies & Services	311	115	112	3	164
Transport	242	14	11	3	11
Departmental Support Services	1,704	0	0	0	0
Central Support Services	592	148	148	0	148
Community Care:					
Residential Care	6,764	1,149	796	353	796
Home Care	2,360	256	203	53	203
Supported Living	405	87	86	1	86
Day Care	39	8	6	2	6
Direct Payments	352	75	50	25	50
Other Agency	250	13	14	(1)	15
Specific Grants	64	0	0	0	0
Asset Charges	52	0	0	0	0
Total Expenditure	**19,350**	**3,495**	**3,073**	**422**	**3,459**
Income					
Residential Fees	-2,426	-560	-366	(194)	-366
Fees & Charges	-989	-228	-193	(35)	-193

Preserved Rights Grant	-144	-36	-36	0	-36
Supporting People Grant	-857	-150	-141	(9)	-141
PCT Reimbursement	-21	-5	-5	0	-5
Minor Repairs & Adaptations Funding	-50	-50	-50	0	-50
Joint Finance – PCT	-33	-8	-9	1	-9
Adult Stroke Services Grant	-85	-85	-85	0	-85
Reimbursements from PCT	-42	-11	-12	1	-12
Other Income	-174	-174	-213	39	-213
Total Income	**-4,821**	**-1,307**	**-1,110**	**(197)**	**-1,110**
Net Expenditure	**14,529**	**2,188**	**1,963**	**225**	**2,349**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 1 is under budget profile by £225k. This is mainly due to expenditure on community care being lower than anticipated at this stage of the year although this has been offset slightly by a corresponding underachievement of residential fees and associated charges.
Expenditure on food provisions is currently over budget profile due to an increase in the demand for the meals on wheels service as the shift away from residential care to homecare continues. However this in turn has resulted in additional income being earned. This budget will be closely monitored throughout the year and will be realigned accordingly.

The success in gaining continuing health care continues to be realised throughout the first quarter of this financial year which has resulted in expenditure on the community care budget being less than anticipated. However this is still a volatile budget and will be subject to a number of pressures throughout the year and must therefore be continued to be monitored carefully.

Older People

Capital Budget as at 30th June 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Redesign Oakmeadow Phase 2	60	2	2	58
Major Adaptations for Equity release/Loan Schemes	100	34	34	66
ILC market garden canopy	16	0	0	16
Bridgewater	2	0	0	2
Total Spending	**178**	**36**	**36**	**142**

APPENDIX 4 FINANCIAL STATEMENT
Older Peoples Services

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Health & Partnerships**

PERIOD: **Quarter1 to period end 30th June 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Health & Partnerships Department first quarter period up to 30 June 2009 It describes key developments and progress against all objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 6

2.0 KEY DEVELOPMENTS

Housing
On 29th June Government announced an additional £1.5 billion stimulus to boost the housing market. A range of initiatives were announced or expanded, to build more social housing and unblock stalled private sector developments.

The announcement also referred to plans to allow Councils more flexibility in framing their allocations policies to give increased priority to local residents, although no detail has yet emerged on this.

To the extent that these are new initiatives, and the outcomes of the bidding process are not yet known, it is difficult to predict what the local impact will be.

Quality Assurance
Tender for advocacy and service user involvement service completed- contract awarded to SHAP.

Commissioning
Draft dementia strategy complete.

Report taken to PCT MET to offer assurance that the PCT and its local authority partners are responding appropriately to Government policy and strategy as it relates to Adults with a Learning Disability.

Business Support
The Annual Review Meeting with the Care Quality Commission (CQC) to assess the Directorates performance took place on the 15th July 2009 and initial feedback received from CQC was positive.

Carefirst 6 is due to be implemented by the Adults with Learning Disabilities team in September 2009. The system will then be rolled out across all operational teams.

Service Planning & Training
A comprehensive training programme commenced in April 2009 to support the implementation of Self Directed Support and Personal Budgets. The training programme aims to provide managers and staff with the appropriate skills they require in order to implement self-directed support effectively. We have also commissioned training for contracted providers, which will help them make the changes that are required to deliver personalised services and Individualised Service Funds.

3.0 EMERGING ISSUES

Housing
Following the initial consultation exercise by 4NW on Draft RSS Traveller pitch requirements, a revised set of proposals has emerged. Halton's initial target to identify sites to accommodate an additional 60 permanent pitches by 2016 has been reduced to 45. Representations will continue to be made to 4NW to seek a further reduction.

Commissioning
Halton in collaboration with the PCT and St Helens MBC is submitting an expression of interest to the NDTi to become a demonstration site around supporting learning disabled people to move out of residential accommodation and achieve housing and support options that promote social inclusion. The target group will be people currently in "specialist" out of area placements. The EOI will also cover the reconfiguration of LD residential services to supported living.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**23**		**20**		**3**		**0**

Most milestones are on target. Where this not the case plans are in place to rectify the situation and additional details are provided within Appendix 1..

5.0 SERVICE REVIEW

There are no service review issues to report this quarter

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**4**		**2**		**0**		**2**

Where KPIs have not reached target commentaries explain that actions are planned or underway to rectify the situation and additional details are provided within Appendix 2

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**9**		**7**		**1**		**1**

Where a target has not been reached, that is in the case of homeless households and the number of directly employed SSD staff that have left policies are being reviewed to rectify the situation. Some PIs are still awaiting data from Health Authorities

7.0 PROGRESS AGAINST LPSA TARGETS

There are no LPSA targets for this service

8.0 RISK CONTROL MEASURES

During the production of the 2009-12 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4. Please refer to Appendix 4

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress Against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4 Financial Statement
Appendix 5- Explanation of traffic light symbols

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
HP 1	**Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for the community of Halton**	Develop commissioning strategy for challenging behaviour/Autism Spectrum Disorder **Mar 2010** (AOF 6 & 30)		Appropriately skilled Project Manager now appointed. There is strong multi agency commitment across the agencies. Refined Business case developed
		Commission combined advice, support and sanctuary service for people experiencing domestic violence **Mar 2010** (AOF 6, 30 and 31))		Service specification agreed - Tender process underway- on target for completion.
		Commission feasibility study for Supporting People 'Gateway' or single point of access service **Mar 2010** (AOF 6, 30 and 31)		Feasibility study complete - recommends phased approach to introduction of gateway service.
		Establish effective arrangements across the whole of adult social care to deliver self directed support and personal budgets **Mar 2010** (AOF6)		Comprehensive training programme underway. Additional staff appointed to team. Good progress being made.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Commission supported living services for Adults with Learning Disabilities and People with Mental Health issues **Mar 2010** (AOF 6, 30 and 31)		**Learning Disability services:** Purchase of property progressing for 2 people whose health needs now require more accessible accommodation. Assessments of 12 people in residential provision underway and advocacy support in place to offer choice for more independent living. Work is progressing with the PCT, St Helens, Warrington and Knowsley to develop options for a comprehensive community based service to more effectively supported people with complex needs enabling further reductions to be made to in-patient capacity and to reduce reliance on out-of-area placements. **Mental Health Services:** Contracts section leading on the review of MH supported living and residential services. Sector reviews planned – some delay to start of project due to a change in the role of the Joint Commissioning Manager for Mental Health.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Redesign the housing solutions service to ensure the continued effective delivery of services **Mar 2010** (AOF 6 & 30)		Work is ongoing to integrate the homeless prevention and homeless assessment teams, and to identify accommodation to relocate the service from Catalyst House.
		Deliver against the government target to reduce by half (by 2010) the use of temporary accommodation to house homeless households **Mar 2010** (AOF 6, 30 and 31)		A range of measures are being developed to ensure achievement of the target, including the re-designation of Grangeway Court as supported housing and negotiations with RSLs to provide a smaller number of units for use as furnished temporary accommodation.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Introduce a Choice Based Lettings scheme to improve choice for those on the Housing Register seeking accommodation **Dec 2010** (AOF11and 30.)		Following Exec Board in principle agreement to participate in the development of a sub regional CBL scheme, work with sub regional partners to draft a common allocations policy has been slow but is now nearing the stage where the policy will be presented to the respective Councils. A preferred ICT supplier has been identified, subject to agreement by the partner Councils, and work is about to start to put some costings to the project. It is anticipated that a report will go to Board in the Autumn seeking endorsement of progress to date, and for Halton's continued involvement in the project.
		Commission floating support services for vulnerable groups **Mar 2011** (AOF 6, 30 and 31)		Work ongoing to review floating support services - tender to be prepared to procure services within 12 months of the commencement of the Gateway service.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Work with the Council's Planning Department to introduce an affordable housing policy within the Local Development Framework **Mar 2011** (AOF 11)		The Local Development Scheme timetable currently envisages an adopted affordable housing SPD by November 2011 but, depending on whether the issue is dealt with under the Core Strategy, a Development Plan Document or a Supplementary Plan Document, it may be possible to accelerate this.
HP2	**Effectively consult and engage with the community of Halton to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required**	Introduce new advocacy and service user involvement service **Mar 2010** (AOF 6 and 30)		A Tender process complete - contract awarded to SHAP. Aim to have service up and running August 2009.
		Update JSNA summary following community consultation **Mar 2010** (AOF 6)		JSNA 2009 refresh process under way, ahead of full JSNA to be completed in line with 2011 key strategic documents. Research & Intelligence Section currently looking at data updates for core and localised datasets.
		Continue to survey and quality test service user and carers experience of services to evaluate service delivery to ensure that they are receiving the appropriate outcomes **Mar 2010** (AOF 32)		Surveys are ongoing however in addition outcome focussed assessment; planning and reviews will enable more accurate recording of outcomes delivered and satisfaction with services to be assessed. Processes will be reviewed as part of the Carefirst 6 project.

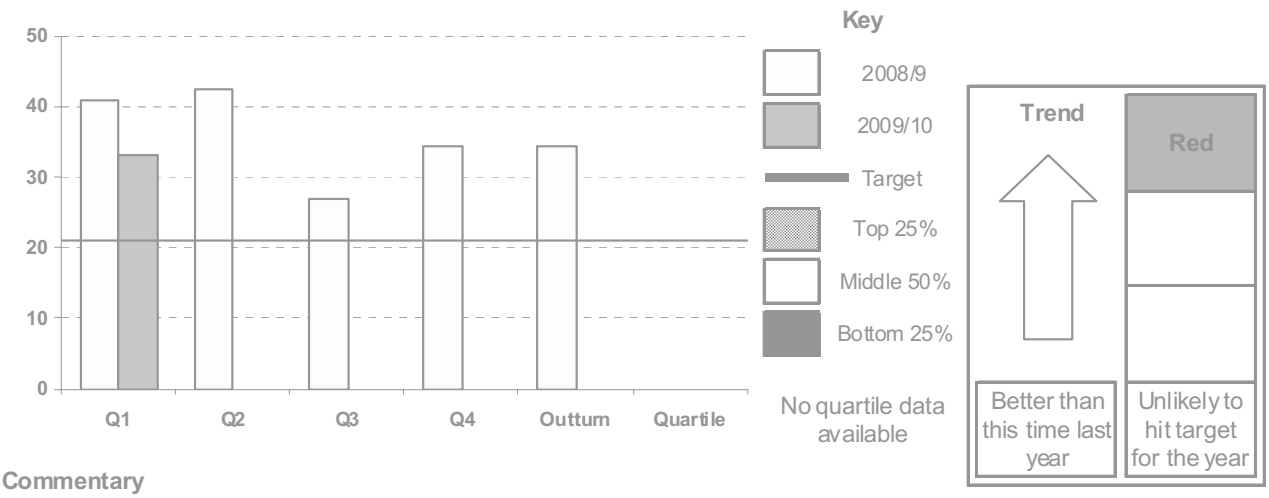
Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
HP3	**Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs**	Agree with our PCT partners the operational framework to deliver Halton's section 75 agreement Mar 2010 (AOF 33,34 and 35)		External Consultants, commissioned by PCT currently producing options to develop operational and commissioning framework.
		Review commissioning framework for Supporting People to ensure links to LSP **Mar 2010** (AOF 33 and 34)		Work ongoing to review performance reporting and commissioning plans in line with government strategy for SP-draft PPB report and commissioning plan produced- to be presented to CB and members by Sept 08.
		Assess, on a quarterly basis, the impact of the Fairer Charging Policy strategy to ensure that the charging policy is fair and operates consistently with the overall social care objectives **Dec 2009** (AOF34)		To ensure service delivery the teams have on the job training and team meetings to access workload issues. Procedure manuals are updated when necessary.
		Following the publication of the new national guidance on complaints, review, develop, agree and implement a joint complaints policy and procedure to ensure a consistent and holistic approach **Nov 09** (AOF 33)		National guidance has not been published yet. It is anticipated this will be published in Nov 09.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Review and revise the performance monitoring framework according to changing service needs to ensure that any changing performance measure requirement are reflected in the framework and the performance monitoring cycle **Sep 2009** (AOF33)		Helen Sanderson Associates will be commissioned to produce an outcomes performance framework for the Directorate that links to the work they are currently doing on the development of person centred process within the Directorate.
		Develop and implement appropriate workforce strategies and plans to ensure that the Directorate has the required staff resources, skills and competencies to deliver effective services **Mar 2010** (AOF 39)		2009/10 Workforce strategy complete and approved at SMT. Work ongoing to develop workforce strategy linked to the personalisation agenda.
		Develop a preliminary RAS model and explore impact on related systems **Apr 2010** (AOF 34)		Regular meetings are ensuring any areas of concern are addressed quickly. This coupled with wide spread training is proving to be successful. The questionnaire is being developed and the RAS development underway.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Review existing Direct Payment arrangements to ensure alignment with the personalisation agenda **May 2010** (AOF 34)		Direct Payment consultation event held on 24/04/09 to inform DP users about Personal Budgets. Building Common Ground consultation event held on 09/06/09 with service users, carers, self-funders to form a Transformation steering group. Consultations will be arranged throughout the year as and when required.
		Review & update, on a quarterly basis, the 3 year financial strategy **Mar 2010** (AOF 34)		Work is scheduled appropriately to meet the Directorate's needs.
		Review and deliver SP/Contracts procurement targets for 2009/10, to enhance service delivery and cost effectiveness **Mar 2010**. (AOF35)		Annual work plan completed and incorporated into divisional workplan. Progress to be reviewed on a quarterly basis at DMT.

NI 156

Number of households living in Temporary Accommodation



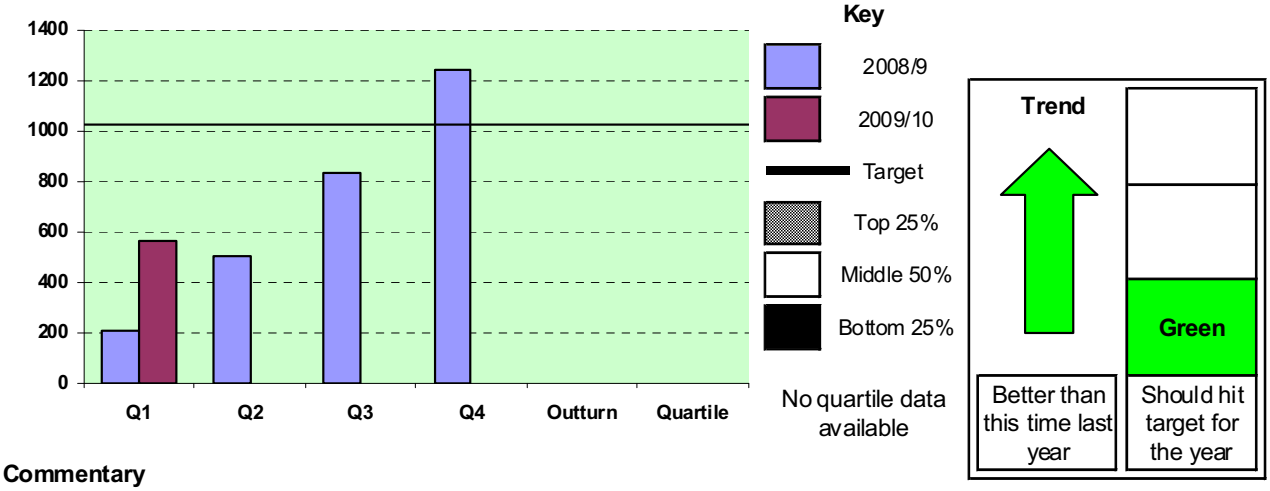
Commentary

This is the number of households that were in temporary accommodation on the 30th June. However work to be undertaken to re-designate Grangeway Court therefore seeing a reduction in figures

NI 130

Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets) DH DSO

Higher figures represent better performance



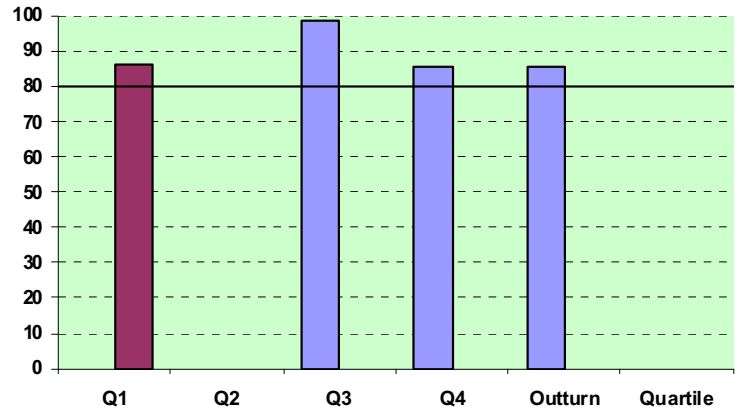
Commentary

This indicator is reported by weighted average and equates to 218 Clients and 132 carers = 350 in total. Targets have been developed on a team by team basis for 09/10. An overall target of 1,024 clients and carers has been set which equates to the weighted average target of x.

HP NI 141

Number of vulnerable people achieving independent living CLG DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

Should hit target for the year

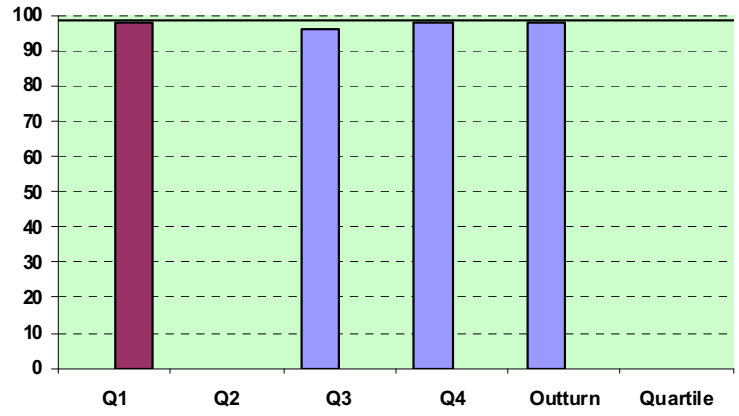
Commentary

Quarter 1 figure has not been completely validated - some information is still outstanding

HP NI 142

Number of vulnerable people who are supported to maintain independent living CLG DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Red

No data for same Qtr last year

Unlikely to hit target for the year

Commentary

One service with an action plan currently in place has shown improved performance and figures for that service are currently at 96.3%

The following KPI has not been reported graphically: -
NI 127; Self reported experience of social care users – this figure is to be reported by the NHS and Social Care Information Centre to councils but is not yet available

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 1	Progress	Commentary
HP LI 5	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough).	5.4	4.0	1		58 cases 58 / 54.392 = 1 Due to the high volume of referrals to the team there has been a backlog of 'inputting' outcomes on the database. Steps have been taken to rectify this, but it means that the number of prevented cases recorded is probably lower than the actual number. Next quarters statistics therefore will be amended to show this.
HP LI 7	Percentage of SSD directly employed staff that left during the year.	7.58	8	8.82%		At quarter 1 the leavers figure is slightly over the target set for this year. The Exit Interview Policy is due for review over the next couple of months and as part of this review the exit interview questionnaire will be revised.

HEALTH & COMMUNITY - HEALTH AND PARTNERSHIP

Revenue Budget as at 30th June 2009

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000	Actual Including Committed Items £'000
Expenditure					
Employees	4,105	1,009	979	30	997
Premises Support	142	18	15	3	15
Other Premises	33	8	10	(2)	44
Supplies & Services	497	219	218	1	292
Training	36	9	7	2	8
Transport	19	5	7	(2)	8
Departmental Support Services	174	0	0	0	0
Central Support Services	733	177	177	0	177
Agency Related	219	19	17	2	31
Supporting People Payments to Providers	7,222	1,661	1,658	3	1,658
Unallocated Grants	240	0	0	0	0
Asset Charges	963	0	0	0	0
Total Expenditure	**14,383**	**3,125**	**3,088**	**37**	**3,230**
Income					
Sales	-13	-3	-3	0	-3
Receivership Income	-69	-17	-20	3	-20
Rents	-92	-102	-105	3	-105
Departmental Support Services Recharges	3,687	0	0	0	0
Supporting People Main Grant	-7,411	-1,882	-1,885	3	-1,885
Social Care Reform Grant	-559	-559	-559	0	-559
Adult Social Care Workforce Grant	-364	-91	-91	0	-91
Supporting People Admin Grant	-112	-28	-28	0	-28
Disabled Facilities Grant	-40	-40	-42	2	-42
Homelessness Grant	-30	-46	-46	0	-46
Other Grants	-88	-88	-88	0	-88
Re-imbursements	-121	-84	-86	2	-86
Other Income	-84	0	0	0	0
Total Income	**-12,670**	**-2,940**	**-2,953**	**13**	**-2,953**
Net Expenditure	**1,713**	**185**	**135**	**50**	**277**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 1 is £50k under budget profile, due in the main to staff related expenditure being less than expected at this stage of the financial year. There is also a slight overachievement of income particularly on rents and receivership income. Employee costs are lower than expected due to the number of vacancies within the department and the secondment of staff to other areas within Health & Community.

Unallocated Grants include the Social Care Reform Grant and the Adult Social Care Workforce Grant. Theses grants will be allocated to specific budgets throughout the year as project plans are developed further.

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Health & Partnership

Capital Budget as at 30th June 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
IT	28	0	0	28
Total Spending	**28**	**0**	**0**	**28**

Housing Strategy & Support Services

Capital Projects as at 30th June 2009

	2009/10 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Private Sector Housing				
Housing Grants/Loans	354	30	13	17
Disabled Facilities Grants	1,301	325	108	217
Home Link	10	0	0	0
Energy Promotion	100	0	0	0
	1,765	**355**	**121**	**234**

APPENDIX FOUR FINANCIAL STATEMENT
Health & Partnerships

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.