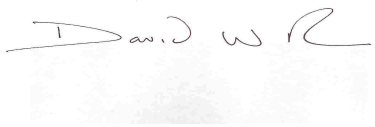
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 10 November 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**
Mr Paul Cooke	**LINk Co-optee**

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, 12 January 2010

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

Part I

(C) PREPARATION FOR SERVICE PLANS 2010 | **228 - 229**

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: 10 November 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: 10 November 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 4 JUNE 2009

EXB8 REDESIGN OF DAY SERVICES FOR PEOPLE WITH PHYSICAL AND SENSORY DISABILITIES AND OLDER PEOPLE WITH ADDITIONAL NEEDS

The Board received a report from the Strategic Director, Health and Community which outlined the key issues and development plan for the modernisation and redesign of Day Services for adults and seeks approval to begin formal consultation with stakeholders.

The Executive Board had recognised, back in July 2004, the need to re-design Day Services in response to the Government's Agenda, '*Valuing People, A New Strategy for Learning Disability for the 21st Century'.*

At that time it was agreed that there was a need for accelerated movement away from traditional building based services and to provide increased opportunities for people with learning disabilities, promoting social inclusion and independence. The example of the closure of Astmoor as a base for Day Services for adults with learning disabilities had clearly demonstrated the value of community based day services as a more effective and preferable model of service delivery. Since that date there had been some significant progress. Astmoor Day Centre was successfully closed as a Day Centre in 2007. The vast majority of people receiving Day Services with learning disabilities are now happily receiving the service from the community. New services had been developed and existing community based services strengthened.

The report continued to characterise the current services provided by the staff based in Bridgewater, namely; Bridgewater Centre, PSD Outreach Team, Community Day Services and Adult Placement Service.

The Strategic Director, Health & Community described the Hub and Spoke model in further detail and explained how people would be consulted on the proposals.

REASON(S) FOR DECISION

To increase opportunities for people with physical and sensory disabilities to access mainstream services, promoting social inclusion and independence.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

The only other option is to maintain this service as it is currently delivered.

IMPLEMENTATION DATE

March 2010.

RESOLVED: That

1) Approval is given to the following as a basis for consultation with service users, families, carers and staff of Bridgewater commencing in July 2009, on the following proposals:

   i) To de-commission Bridgewater as a base for the delivery of Day Services for Adults with Physical and Sensory Disability.

   ii) To continue the development of a "hub and spoke" model of dedicated local resources.

2) The Strategic Director for Health and Community, in consultation with the portfolio holder for Health and Community, be authorised to consider feedback in response to the consultation, to consider this with other information and return to the Board with recommendations.

EXECUTIVE BOARD MEETING HELD ON 16 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.

EXECUTIVE BOARD MEETING HELD ON 24 SEPTEMBER 2009

EXB39 HEALTH & COMMUNITY CAPITAL PROGRAMME 2008-09 AND CAPITAL PROGRAMME 2009-10

The Board received a report of the Strategic Director, Health and Community which informed the Board of the 2008/9 capital programme outturn and the 2009/10 capital programme.

A report was presented to the Board on 2nd April 2009 setting out the forecast outturn for the Health and Community capital programme for 2008/9 and the reasons for monies being carried forward to 2009/10, together with a proposed programme of schemes for 2009/10. Due to the

delay in announcing the housing grant allocations from the Government Office, the report highlighted that assumptions had been made about the level of resources likely to be available in 2009/10.

The Board was advised that the allocation for the housing programme had been announced as £2.911m, an increase of £2.289m over the 2008/9 allocation. After several years of declining grant in Halton, this level of funding considerably exceeded what was expected and was due to the introduction of a revised funding distribution formula which more closely reflected the priorities in the recently revised Regional Housing Strategy.

Given that the housing programme had been supported by corporate capital growth in recent years when the housing grant was reducing, and the current pressures on the Council in terms of capital, it was proposed that the approved carry forward of £0.736m be vired to support the corporate capital programme.

It was noted that there would be a requirement for some resources to be set aside to fund Halton's share of ICT and Software costs for the development and introduction of a sub-regional Choice Based Lettings Scheme, but the amount involved would not be clear until much later in the financial year. A provisional sum of £50,000 had therefore been included in the programme.

This still left £1.329m of the new housing allocation unallocated. There were a number of potential calls on this fund, but the main priority was in the Housing and Supporting People Strategies was to secure the development of additional extra care housing schemes for the growing population of older people in the Borough.

The Board was advised that a further priority was the Registered Social Landlord (RSL) Partnership Agreement. This partnership between HBC and the RSLs began in July 2008. In 2008/9 the Council identified £467k to be used to fund, on a 50:50 basis, home adaptations within RSL properties.

In 2009/10 the Council had allocated £450k to the Partnership Agreement. To date £410k had been paid, committed to schemes agreed and it was anticipated that the RSLs could carry out further adaptations to a value £400k requiring additional partnership funding of £200k, from the Council, to be match funded by £200k from the RSL.

The report set out the actual funding available for the Health and Community capital programme for 2009/10 after the adjustment detailed within the report.

RESOLVED: That

(1) the recommendation in 3.3 of the report be approved; and

(2) the Board recommend the Council to approve the capital programme for 1009/10, as set out in Appendix 1.

EXECUTIVE SUB-BOARD COMMITTEE MEETING HELD ON 24 SEPTEMBER 2009

ES24 NORTON PRIORY BUSINESS CASE

The Sub-Committee received a report of the Strategic Director, Health and Community which informed Members on the progress of the Catering Contract at Norton Priory which had been provided by Adults with learning Disabilities Day Services since 25th October 2008 and which sought approval for the Business Plan.

The Council, like many other Councils across the UK had found it difficult to meet the Care Quality Commission's objectives of finding people known to Social Care, particularly those with Learning Difficulties, suitable employment opportunities.

In July 2008 negotiations with Norton Priory led to the offer from Norton Priory to Adults with Learning Disability Day Services of a contract (SLA) to provide all the catering at Norton Priory. This included special, local and corporate events as well as the café.

Members were advised that Day Services had existing experience at providing community based catering projects at Murdishaw Café and Country Garden Buffet and had included the Norton Priory contract into its current operations without any increase to the establishment. The report set out the businesses run by Adults with Learning Disability Day Services.

The catalyst that enabled these services to become more recognisable as businesses was the award of the contract to provide the catering at Norton Priory, which began officially on 5th December 2008. This had been a genuinely commercial opportunity. The refectory at the museum was staffed Monday to Sunday with at least one member of staff and between 2 and 6 service users per day. Between the Norton Priory site, Murdishaw Café and Vine Street there were currently five service users receiving permitted earnings.

The feedback at Norton Priory continued to be positive and warm with customers commencing favourably on the quality, cost, variety and the friendliness of the service. The standards were closely monitored and the repeat customer base was steadily increasing.

It was noted that monthly meetings were being held with Norton Priory Trust's management team. The relationship remained strong and mutually beneficial. The success of the service and the healthy relationship had provided further opportunities to cater for fetes and large corporate events.

It was noted that since December 08 CGS's takings from Norton Priory, the buffets and the two days per week at Murdishaw Café amounted to £29,500. Two thirds of this was made up from the trade at Norton Priory.

Based on this trading history, the figures demonstrated that it was a profitable business. Margins were around 33% although this must be emphasised that the real costs of labour i.e. the costs associated with the staff who supported the service users to provide the services, were already paid for and effectively subsidised the business. This was not to say that in future the projects could not be outsourced or act as stand-alone enterprises. It was noted that with this had come opportunities to diversify into other areas. The report set out a number of projects and businesses that Day Services and colleagues from the Children and Young People Directorate had worked on in the belief that they are both achievable and sustainable.

RESOLVED: That

(1) the Strategic Director, Health and Community, in consultation with the Portfolio Holder, Health and Social Care be authorised to continue and, where appropriate, extend the contractual arrangements with Norton Priory Trust to provide catering and related services at Norton Priory;

(2) a further financial report be submitted to the Sub-Committee in 12 months time; and

(3) further update reports be submitted to the relevant Policy and Performance Board.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 10 November 2008

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

APPENDIX 1

HALTON HEALTH PARTNERSHIP BOARD

MINUTES OF THE MEETING held on

16 July 2009

Present : Fiona Johnstone (Chair)
Stuart Baxter
Glenda Cave
Dwayne Johnson
Eugene Lavan
Dave Sweeney
Jane Trevor
Karen Tonge

By invitation: David Hall

In Support: Elaine Skelland

		ACTION
1.	**Apologies** Cllr Ellen Cargill, Melissa Critchley, John Kelly, Diane Lloyd, Eileen O'Meara, Jim Wilson	
2.	**Minutes of the previous meeting** These were agreed as a correct record with the following amendments: Eugene Lavan was present at the meeting on 21 May. Page 2 - The work that Laura Neilson is undertaking is in its infancy.	
3.	**Matters Arising:** 7. Evidence is being reviewed against CAA key findings. Dwayne Johnson reported that a timetable had been produced to identify concerns - teenage pregnancy, health inequalities.	
4.	**Community Feedback:** Karen Tonge reported upon the following: ▪ LINKs Annual Report required to include the set up and work on health and community care forum. ▪ HVA - Seminar to be held on flu pandemics. A contingency plan has been developed which has raised some concerns in reporting sickness of volunteers and those taking antivirals. Fiona Johnstone reported that this links with voluntary services through the local authority and she agreed to contact Jan Archer to try to discover from where the recommendations had arisen. ▪ Petitions regarding saving the NHS had been displayed in the market and Grangeway Post office. As no one in the group was aware of any such petitions, Stuart Baxter agreed to follow this up.	**FJ** **SB**

Halton Strategic PARTNERSHIP

	Fiona Johnstone thanked Karen Tonge for her report.	
5,	**Transport Study Results/Feedback** Fiona Johnstone welcomed David Hall to the meeting. David Hall reported that funding had been allocated to carry out the accessible transport study. He confirmed that this was still in the consultation phase and that an action plan had been prepared. The study had looked into gaps in the supplies of accessible transport together with demand change. Studies were made of the current supply and the demographics. The key findings showed a growth in demand by 2011 and that half the borough is using the services. The action plan produced highlights the need for better coordination and more investment and a proposal for joint commissioning of transport services with a closer link to the PCT. Glenda Cave advised the group that Cllr Cargill had asked that the following comments be noted. She felt that the initiative would benefit carers, the elderly and disabled but should also help the environment as those who use cars and taxis could travel on the bus. Dwayne Johnson raised the issue of qualitative access and asked if any comments had been made. He acknowledged that older people were critical of the dial a ride service. It was also felt that the personal agenda of 30% of people going through social services should be factored into the report. David Hall reported that there was an awareness of capacity issues with Halton Community Transport and the door to door service but that it was intended to migrate the picking up procedure to a contact centre. Eugene Lavan advised the group of the short term improvement partnerships being developed, one of which is focussing upon screening and early detection of major diseases in conjunction with Halton Hospital. He felt that there was some assurance that people will attend their appoints with access to accessible transport. Fiona Johnstone raised the issue within the policy findings that half of the eligible residents are using the transport but that no information had been received to outline why other residents are not using these services. She felt this question should be asked, investigations made and these included in the report. She further added that, should these services be jointly commissioned, the flexible use of community transport is critical. Karen Tonge felt that community groups should be informed of the age eligibility and that this could be done via the HVA newsletter. Fiona Johnstone thanked David Hall for the report.	
7.	**Commissioning Group Feedback**: Dave Sweeney reported upon the meetings held by the group and that discussions had been held on how to utilise the under-spend. He reported that both SLAs were ready to be signed off and implemented for teenage pregnancy and dementia. He highlighted that the TOR had been developed to form a dynamic commissioning group. A review had been undertaken of the WNF projects which could be moved on and capital freed. The criteria used	

	was for those groups which had been funded for five years or more. Areas identified were as follows: ▪ Dietetic and exercise intervention programme - this to be fitted into the obesity provision within the CSP. Eileen O'Meara is checking on this. ▪ Reach for the Stars Complimentary Therapies - this to be aligned with depression. Lynn Marsden to undertake this project. ▪ Information out reach service - Mark Holt is reviewing this area for possible psychological interventions and inclusion into the depression project. Dwayne Johnson asked if the hard to reach members of the community were being targeted. Dave Sweeney advised the group that smaller community groups could be offered extra support following the release of the above projects. The Halton Health Partnership Group agreed to move forward with these proposals. A request was made to include bullet points of the outcomes in the next report.	
6.	**Performance Monitoring:** Fiona Johnstone advised the group that some consideration needs to be given to the timing of these meetings so that they are aligned with performance information being available. Glenda Cave advised the group that she had hoped to bring Quarter 1 return to the meeting but that this information had not been available in time. She agreed to circulate this information before the next meeting. Finance Project Update: Glenda Cave advised the group that monitoring is continuing and that claims will be submitted for teenage pregnancy and dementia in Quarter 1. She further reported that not a great deal of expenditure had been noted in the Quarter 1 return as this information is only due today or tomorrow therefore there are no claims against the activities. More information will be available for the next meeting. A summary of activities had been provided. She reported that she had been advised by Lynn Williams that the coordinator of the voluntary sector counselling support project is employed for 28 hours per week and not 18 as stated in the report. Performance Sub Group 8 July: Glenda Cave reported that a review had been undertaken of the indicators detailed on the summary sheet, looking at actual numbers behind the percentage figures to make this more meaningful. Further liaison to be held with Diane Lloyd and Jim Wilson. No issues or concerns had been raised.	
8.	**Health Inequalities Presentation** Jane Trevor introduced Jan Holding to the group and advised that she felt the presentation appropriate to highlight why the conference had been arranged, the benefits and outcomes. Jan Holding circulated copies of the presentation to the group and highlighted: ▪ That a large public debate had been held. People invited from across the communities affected by health inequalities and local speakers also invited.	

Halton Strategic PARTNERSHIP

	▪ Warrington PCT is a spearhead PCT ▪ Women's health worse than men's health within the town. ▪ Warrington in the top 20% of most affluent and top 10% of most deprived. ▪ Conclusion reached that there is a need to raise aspirations and a meeting held after the event for lead facilitators and commissioners who have agreed to work to cultivate aspirations. ▪ It is hoped to have a similar event next year to see if any movement has been achieved. Fiona Johnstone commented upon the similarities in what is happening in Warrington to those occurring in Halton and St Helens and referred to the strong commissioning links around Warrington Hospital. In response to a query raised by Fiona Johnstone, Jan Holding advised the group that, in order to try to achieve the targets, strong neighbourhood work is being undertaken together with community engagement and using those people who are skilled in talking to communities. She also advised that the health improvement team work closely with community engagement officers. Fiona Johnstone proposed a review of the activities undertaken during the past year, Ambition for Health, Health Summit, engagement around CSP and felt that it would be timely to have a follow up summit to highlight the work undertaken and the achievements made. Dwayne Johnson proposed a link with Nick Mannion as the neighbourhood lead. Fiona Johnstone proposed that a list of the work undertaken be produced for the next meeting so that the group can define what format the events should take. Stuart Baxter reported upon an away day he had attended on maximising people in the community. Fiona Johnstone felt that a community health gain schedule is required and Dwayne Johnson agreed to undertake this.	**DJ**
9.	**AOB** Diane Lloyd and Glenda Cave to try to ensure that next year's meeting are aligned to when information is available.	**GC/DL**
10.	**Date and time of next meeting: 10 am 17 September Conference Room 2 Municipal Building**	

Action Summary – previous meetings

Reference	On Whom	Action	Status / Update

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10th November 2009

REPORTING OFFICER: Strategic Director
Health & Community

SUBJECT: Transforming Community Services Programme Update

1.0 PURPOSE OF REPORT

1.1 To inform Healthy Halton Policy & Performance Board of progress in the PCT's Transforming Community Services programme

1.2 To present the Community Services Commissioning Strategy

2.0 RECOMMENDATION

1) **Note the content of the report**
2) **Receive the Community Services Commissioning Strategy (to be tabled)**

3.0 SUPPORTING INFORMATION

3.1 Recent communications from the Department of Health and NHS North West have acknowledged that in the current political and economic climate we need to concentrate our efforts on securing effective and efficient delivery of community services rather than on establishing new organisations. This is reflected in the approach we are taking in our local TCS Programme and particularly in developing our Community Services Commissioning Strategy (CSCS).

The SHA have recently issued further guidance on their expectations from PCTs in respect of the TCS Programme. This proposed that the only 'return' that PCTs were now required to make to the SHA was the 'Separation Self-certificate'. This was duly submitted in October. However there is still a timetable of suggested milestones to deliver the different facets of the programme over the rest of this calendar year. The PCT's TCS Programme Board have agreed that we would continue to work towards these milestones to maintain the momentum of the programme.

Halton Borough Council has senior representation on the TCS Programme Board, and has also contributed to the various workshops held over the last six months in the development of the CSCS. Many of the developments in the strategy are also informed by existing partnership arrangements e.g. Children's Trust, LITs etc.

3.2 The Draft Community Services Commissioning Strategy was submitted to the SHA on 3rd July in accordance with requirements. We received very positive feedback on the Draft Strategy early in September. This has helped to shape the development of the final version of the strategy which is now due to go to the PCT Board on 17th November.

3.3 The CSCS contains a number of important pointers to the future commissioning intentions of the PCT:

- A focus on delivering outcomes rather than organisational form.
- A focus on Patient Pathways rather than services or organisations.
- A subsequent desire to see greater integration (either functional or organisational) along those pathways.
- The development of local clinical networks to support the development and delivery of best practice.
- A greater focus on partnerships in commissioning and service delivery.

These themes have been developed further in the individual sections for each of the 7 Core Service Groups, which also contain the high level, outcome based specifications and some detailed commissioning intentions for existing schemes.

Earlier in the TCS Programme we identified the following 3 areas as being of significant importance:

- End of Life Care
- Services for Children and Families
- Stroke and LTNC

However, as part of the TCS programme we have worked closely with clinicians and social care professionals through existing groups relating to each of the 7 TCS areas to identify a prioritisation matrix that will inform the ultimate delivery of this strategy in terms of outcomes timescales and processes. These priorities are reflected in the plans contained in the strategy. This will be complemented by a rigorous value for money assessment, incorporating Health Needs Analysis and Health Impact Assessments, drawing upon evidence currently held in the PCT, and partner and stakeholder organisations.

We are convinced that this process, driven by front line professionals, is appropriate to ensure we deliver the optimum transformational change, achieving the greatest benefits to the health and wellbeing of the populations we serve.

3.4 The CSCS is, by definition, a strategic document, that requires further detail to fully describe the implementation of the plans for the 7 Core Service Groups. It will therefore be augmented by a TCS Operational Plan, which is currently being developed by the commissioning leads for the 7 areas.

4.0 POLICY IMPLICATIONS

4.1 One of the central themes of the CSCS is that of integration. Research has shown that services integrated along a pathway:

- Are easiest for people to navigate
- Have maximum scope for efficiencies
- Are likely to be more effective
- Are more likely to be personalised care
- Have the least likelihood of handoffs

4.2 The intention of the PCT is therefore to commission more community based services that integrate health and social care, along with complementary services from third sector organisations.

This presents further opportunities to extend and strengthen the partnership commissioning arrangements between the PCT and Halton Borough Council.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 The overall NHS market will be experiencing a toughening financial environment in the next few years and specific areas of the NHS service will be expected to deliver pre-set efficiency savings

In April 2009, the Treasury asked the Department of Health to contribute £2.3bn to the Treasury's £5bn of public spending cuts in 2010-11; further cuts will be expected from 2012. The Budget 2009 explicitly states that efficiency savings will be expected through the world class commissioning programme and through tariff pricing.

5.2 Despite toughening commissioning decisions and the introduction of tariff pricing, the community services market could be expected to contract less than other service areas, or not at all, if it can absorb some of the demand for acute services

Efficiency targets for better utilisation of hospital space could lead to some shift of demand towards outpatient and community-based provision

As a result, the community services market has the potential to expand into a larger share of the overall commissioning spend. Whether this would represent growth in real terms from the present

state, will depend on a variety of additional factors.

Community services currently account for approximately 15% of this commissioning resource and whilst this percentage is expected to increase over time as new schemes are commissioned it is also acknowledged that the current community service delivery model is based on a historical functional model, the adoption of the "TCS programme" will allow for revised pathways of care to be commissioned utilising the proposed new currency and pricing framework which will then need to realise the financial efficiencies as the contractual framework moves from a traditional block to an activity based cost and volume similar to the models in the secondary care sector.

6.0 OTHER IMPLICATIONS

6.1 N/A

7.0 RISK ANALYSIS

7.1 The CSCS includes a risk register containing details of the key risks to implementation and mitigation plans.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 A full Equality Impact Assessment will be completed for the CSCS

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10th November 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Halton Health Campus

1.0 PURPOSE OF REPORT

1.1 To inform Healthy Halton Policy & Performance Board of progress on the Halton Health Campus.

2.0 RECOMMENDATION: That

1) Members receive the Halton Health Campus update.

3.0 SUPPORTING INFORMATION

3.1 The development of progress on the Health Campus has been the subject of regular reports to Healthy Halton Policy and Performance Board. Attached is a report, which provides an update on progress and a member of the PCT will be in attendance to explore the issues in the report further.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The development of a range of services which promote good health will contribute to the health of children and young people, the model should particularly impact on tackling childhood obesity.

6.2 Employment, Learning & Skills in Halton

There may be new opportunities for local residents to access employment opportunities as new services develop.

6.3 A Healthy Halton

Through the concept of a Health Improving Hospital the campus will be able to play a full role in improving the health of Halton residents.

Access to sports and leisure facilities, health promotion services and early diagnostics will all contribute to tackling poor health and health inequalities.

6.4 **A Safer Halton**

The Halton Campus model is designed to promote community cohesion through the provision of a range of services, which will attract local residents while moving away from traditional hospital usage.

6.5 **Halton's Urban Renewal**

Halton and St Helens Primary Care Trust is working closely with the council and has highlighted the importance of the physical environment in the development of the model. This is referred to in the presentation.

7.0 RISK ANALYSIS

7.1 None identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The plans aim to improve the health of all Halton residents, promote social inclusion and contribute to decreasing health inequalities.

HALTON HEALTHCARE CAMPUS PROJECT

1. Summary Position - Stage 4

(a) the Halton Health Campus project was set up in January 2008 following concerns from local stakeholders about the future of the hospital. The PCT gave specific commitments as follows:

- To lead a project: the "strategic vision and mission project" that would define the future vision for the Halton hospital site
- To ensure that local people were engaged and contributed to the project.
- To establish appropriate project management arrangements - A project delivery group and steering group to be established to take the project forward.
- The project was set up in 5 phases:

Phase 1: Project Mobilisation	Complete
Phase 2: The current site utilisation	Complete
Phase 3: Strategic Principles for Change	Complete
Phase 4: The Case for Change	Complete
Phase 5: Outline Business Cases	TBC

(b) Since the project was set up, two key changes have taken place, namely that it was clear that the hospital is full and secondly that there has been a major economic down turn which causes the NHS to review major commitments.

(c) It was agreed during the project group that its focus should be more on improving the health of Halton people and what services they need rather than on buildings and services which have to be on the hospital site.

(d) The key themes of the case for change are as follows

- The hospital should actively promote the health of the population - the concept of the health improving hospital
- The hospital site should develop itself as an early detection and screening centre potentially with on-site leisure and lifestyle services
- The hospital site should further develop its position as a centre of excellence in planned care
- The hospital site should expand its role to promote rehabilitation and re-ablement into the community

(f) All developments are consistent with the PCT's Commissioning Strategic Plan

2. Progress Update

The project delivery group has prioritised the first two recommendations from Phase 4:

- The hospital should actively promote the health of the population - the concept of the health improving hospital
- The hospital site should develop itself as an early detection and screening centre potentially with on-site leisure and lifestyle services

It is envisaged that developments on the Halton hospital site will form part of our overall approach to lifestyle management and the early detection of major illness. The development of the "Health Improving Hospital" will therefore constitute an important part of the PCTs Initiative in the early detection of major illness.

2.1 Halton and St Helens PCT Clinical Pathway Proposals – Health Checks +

A Five Tier System will be developed in conjunction with all stakeholders to facilitate a rapid patient journey.

This process will be preceded by a Social Marketing exercise targeting the adult population to engage in the NHS "Health Checks Plus" Scheme

- Health Checks Plus (HC+) will cover the NHS Health Checks Scheme (mandatory from 2011) and address the Health Inequalities agenda and the objectives of the Commissioning Strategic Plan.
- NHS Health Checks Plus will use various venues including GPs, **Health Improving Hospitals**, Pharmacies and Specialist Outreach Teams to Assess the Health and Life style of 20% of the population each year
- The most vulnerable will be targeted first to prevent the Health inequalities gap widening.
- Information Technology supported by data sharing agreements will facilitate the HC+ information being transferred to the GP clinical systems.

A HC+ Administration Team will also receive information to assist in the management of hard to reach members of the population. This team will co-ordinate outreach teams and analyse the data to re-inform the process on a regular basis and support targeted marketing and interventions.

Tier I

- A full Assessment including Early detection of Vascular disease, CKD, Diabetes, Depression, Cancer and cancer screening also measurement of Height Weight BMI, Blood Pressure and Pulse; if indicated, Additionally lifestyle assessment of Smoking, Alcohol consumption, Exercise and Sedentary behaviour are recorded.
- Tailored Information is to be delivered during the assessment as "red flag" answers are received.

Tier II

- Further diagnostic tests are carried out at this stage as indicated by the HC+ Assessment. In a significant development on a hospital site such as Halton this may include access to Pathology, Radiology and Physiological measurements and Cardio Pulmonary Assessments.

Tier III

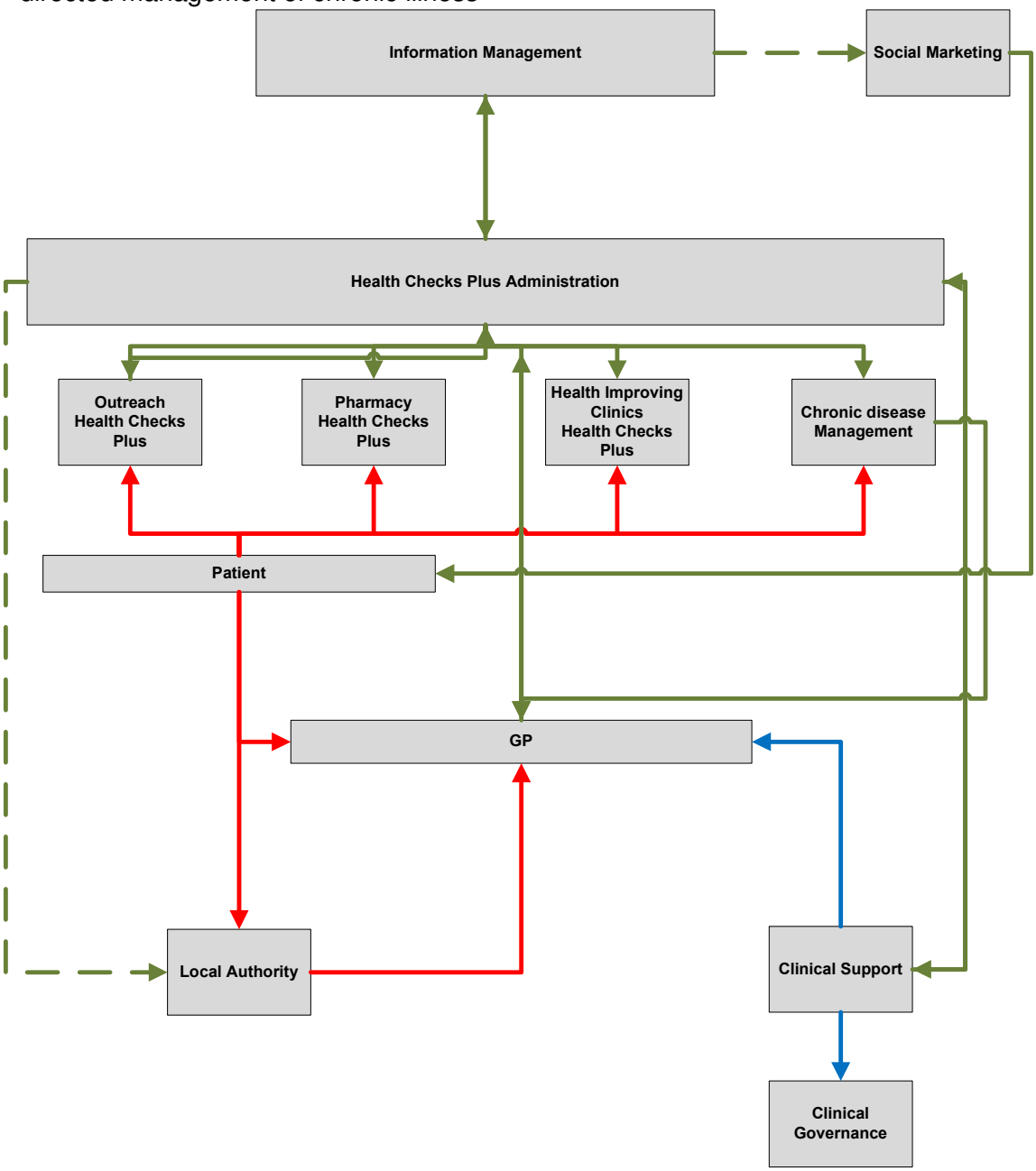
- Staffed by Advanced Practitioner or Specialist Nurse this Tier where appropriate would give a provisional diagnosis and advice. If required the patient would be referred to a Tier IV pathway for Support or Treatment

Tier IV

- Within Tier IV Health Services would be commissioned to provide immediate support. These services are yet to be specified but could include Smoking Cessation, Weight Management, Physiotherapy etc

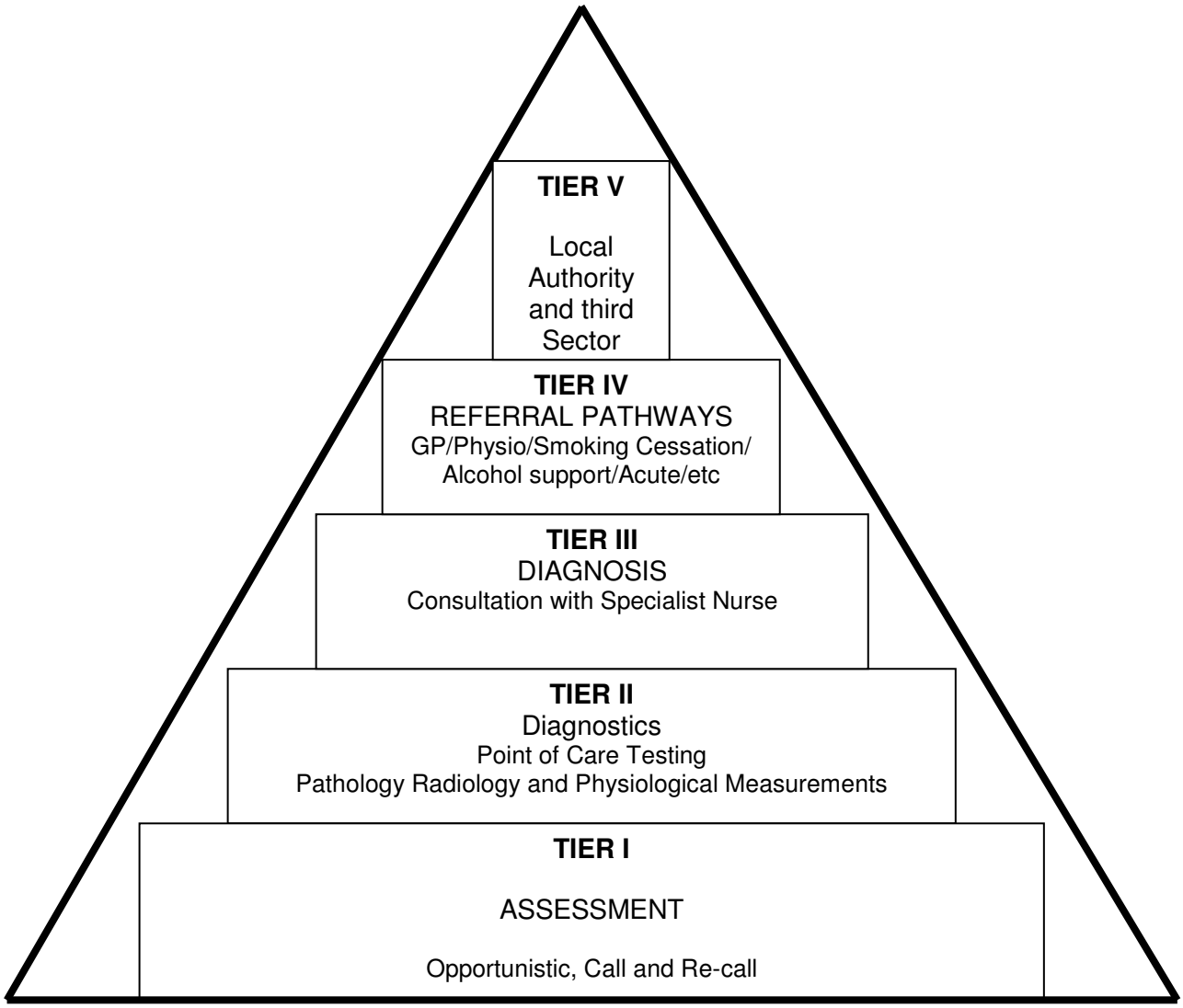
Tier V

- A Tier V referral would complete the patient journey and Local Authority and third sector initiatives for the long term support and management of lifestyle and self directed management of chronic illness



5 TIER SYSTEM

The modular nature of this system would allow it to be partially implemented and then developed over time into a system which provides a single point of access to commonly required services. This will enable the patient to move through the 5 tiers in a single visit.



2.2 Developing Health and Well-Being Services

To support the above, consideration has been given to the provision of services that include the promotion of healthy lifestyles, and leisure and sports facilities. The target audience is:

- Current users of Halton hospital.
- Referrals from health care practitioners (in its widest sense).
- Those directed following early intervention screening activities.
- Those with general lifestyle issues (e.g. obesity).
- Groups targeted by PCT or other social practitioners.
- Those who would subscribe to structured general fitness programmes.

The intention is not to provide a 'pay as you play' facility for casual users. There has to be a reason for being there, although some outdoor facilities offer the potential for casual use.

The proposal is informed by:

- Public engagement activity that has been undertaken as part of the case for change.
- An understanding of the current distribution of facilities. There is no point in replicating services already available either in the public or private sector.
- Nationally accepted standards prescribed by Sport England on that availability, generally based on a 15 minute walk time.
- Good practice elsewhere.

PROPOSED FACILITIES

The following are very broad proposals, details are not provided as general consensus need to be agreed in the first instance. Proposed Facilities to be included in scheme.

Diagnostics Clinic

A range of diagnostics could be undertaken from low level e.g. blood pressure, cholesterol checks, blood/urine sampling, to more sophisticated health checks, for example, ear or eye testing.

Consulting Facilities

This would include a physio facility, a sports injury clinic and a number of consultation rooms. To be determined would be the element of diagnostic facilities associated with this scheme. These could be included elsewhere on the campus.

Gym/Fitness Room

On a relatively small scale (there is a private sector facility across the road). The suggestion would be 30 c/v stations, which would focus on cardio-rehab, but would have a general fitness/obesity application. Included in this would be a weights room, again for rehabilitation purposes.

A Flexible Activity Space

To accommodate 60 people, but capable of partitioning for meetings or smaller activities. Equipped with sprung floor for dance, aerobics, spinning etc. Facility for bocca, table tennis, bowls etc. Would require built in storage for equipment.

Library/Information suite

A relatively small provision that would offer advice and guidance on fitness/medical issues. IT facilities would be included on an individual basis, but also for group training sessions.

Social Break-out area

The opportunity for people to relax, access vending facilities, socialise. Could include 'Wii' facilities or other opportunities to still participate in an informal setting.

Central Reception Area.

Customers need to be welcomed, valued and guided. This would be the front desk of the well-being centre.

Outdoor opportunities

On-site there are possibilities of establishing a green gym/fitness trail that could be accessed by anybody. Similarly a perimeter cycle path. These are low cost activities that require minimal maintenance.

2.2.1 Design Principles

To be successful, most of the above facilities need to be suited together. Users need to feel they are entering a dedicated space, where everything is there. Shared areas such as the changing facilities, reception, social area, library, consultation rooms will enhance this feel.

The facility has to have the ambience of a Leisure Club, not a hospital. There would be a need for soft furnishings, music, a/v in gym etc.

The facility should ideally be situated close to the main entrance, and not 'tucked away'. For a lot of users it will be a big step to use the facilities. Every possible barrier needs to be removed.

The facilities don't just need to be fully DDA compliant, they need to conform to best practice for disability sport. There are a number of good examples nationally.

2.2.2 Issues

Access to the site is crucial. Close-by residential areas are limited, and the site is bounded by major roads. Parking, safer walk-ways, cycle-ways and accessible transport from parts of the borough is essential.

Views on charging need to be considered. Free usage increases footfall, particularly for the 'hard to reach' groups. Cost can be a major barrier to undertaking regular structured exercise.

There are significant costs associated with the proposal. The capital scheme would be estimated at £4million. There would be revenue consequences; facilities require qualified lifeguard and fitness instructors etc, a swimming pool has a high utility and maintenance cost.

As noted above, progress on implementing Tiers 1 to 4 of the patient pathway is not contingent upon having Tier 5 in place. Indeed, the development of Tier 5 services can be made once Tier 1-4 is live and we have a more detailed understanding of the level of need and demand generated.

The scheme could develop further, for example cooking facilities for healthy eating classes, sensory gardens, music relaxation rooms.

2.2.3 Outcomes

The main outcomes would be:

- Low-level interventions that prevent future costly clinical alternatives.
- Increased participation in sport and physical activity to reduce disease, disability, and increase quality of life, self-esteem and self-efficacy.
- Increase the knowledge of the public re: the benefits and opportunities for sport and physical activity.
- Breakdown barriers towards participation in sport and physical activity and achieve sustained participation.
- Rehabilitation programmes.
- Community cohesion.
- A statement that, in its widest sense, that Health is Halton's most important priority.

2.3 Project Management Arrangements

The PDG agreed to establish a multi-agency project group to take forward the "Health Improving Hospital Project". This will incorporate recommendations 1 and 2 of the phase 4 report. A progress report will be submitted to the next Steering group to include outline project plan, key milestones and outline costs.

REPORT TO:	**Healthy Halton Policy and Performance Board**
DATE:	**10 November, 2009**
REPORTING OFFICER:	**Strategic Director, Health & Community**
SUBJECT:	**Stroke Services**
WARDS:	**All**

1.0 PURPOSE OF THE REPORT

1.1 To brief members on the current status of services for people who are at risk of suffering a stroke and for those who have suffered a stroke

2.0 RECOMMENDATION: That

(1) Members note information contained.
(2) Members comment on the joint commissioning intentions contained in the attached document (still in draft form) ***Halton and St Helens A New Ambition for Stroke Services***.

3.0 SUPPORTING INFORMATION

Services for people who have had a stroke are a high priority for Halton and St Helens NHS. As a result, this draft Stroke Commissioning Plan **(Appendix 1)** has been developed but further consultation is required.

4.0 POLICY IMPLICATIONS

None

5.0 FINANCIAL IMPLICATIONS

5.1 There are no financial implications for the Council as in relation to the attached document these services are provided by NHS Halton & St. Helens.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 A Healthy Halton

Implementation of the National Stroke Strategy locally will:

- Help to reduce the burden of ill-health through targeted stroke prevention measures.

- Improve the efficiency of local heath and social care services through the introduction of a community stroke pathway
- Reduce mortality from stroke
- Increase the number of people able to manage own condition (LAA target N124)
- Improve the quality of life for individuals who have suffered a stroke and for their carers by providing better and more timely information, rehabilitation, care and support

7.0 RISK ANALYSIS

The following **risks** potentially arise from the publication of commissioning intentions for improvements in stroke care locally:-

False expectations are raised for the patients and the public. The risk is minimised through continual engagement with service user and carer representatives. The Stroke Partnership Group has representation from Halton OPEN, The Halton Lets Go Stroke Club and The Stroke Association.

The required investment is not secured to realise the improvements contained within the plan. A business case for investment (based on an 'invest to save' approach) will be presented to the PCT management executive in October. The business case will only attract new and additional funding to pump prime priority investments if the cost effectiveness and efficiencies over a fixed period can be demonstrated. In addition to this, Stroke care is one of a number of priority areas contained in the PCTs Commissioning Strategic Plan.

The **opportunities** associated with the implementation of the local stroke commissioning plan include:-

Saving lives
Integrated care pathway for Stroke – maximising opportunities for **personalised care** through the support of a multidisciplinary community stroke services that provides flexible life long support.

Greater choice for individuals through extending peer support and enhanced training for generic health, social care and third sector agency staff.

8.0 EQUALITY AND DIVERSITY ISSUES

Access to services for people who have developed disabilities as a consequence of stroke will be improved.

A Stroke Care Pathway for Halton and St Helens

A new ambition for local stroke services.

A Draft Strategic Pathway for Engagement

Strategy Version 1: October 2009

Further information about this document:

Document name	**A Stroke Care Pathway for Halton and St Helens**
Author(s) Contact(s) for further information about this document	**Janet Dunn** **Head of Partnership Commissioning** **Telephone: 01928 593676** **Email: janet.dunn@hsthpct.nhs.uk**
This document should be read in conjunction with	**National Stroke Strategy (December 2007)** **NICE clinical guideline 68 - Stroke: diagnosis and initial management of acute stroke and transient ischaemic attack (TIA) (July 2008)**
Published by	**Halton and St Helens Primary Care Trust** **Victoria House** **Holloway** **Runcorn** **Cheshire WA7 4TH** **Main Telephone Number:(Freephone)** **Main Email Address:**
Copies of this document are available from	

Version Control:

Version History:		
Version Number		**Date**
Draft Stroke Pathway for Halton and St Helens **Draft Version 2**	Circulated to clinical staff and managers in Halton and St Helens (Commissioners and Providers), Local Authority partners, NHS Knowsley and NHS Warrington and Cheshire & Merseyside Stroke Network	**October 2009**

Index

Notes

Throughout this Strategy dates marked with ***** are indicative and approximate only and will be dependent upon the clinical requirements of individuals

Foreword

This report sets out the model of Stroke Services that NHS Halton and St Helens proposes to commission for the people of Halton and St Helens from 2009-2014 with the ambition to ensure the development and provision of world class Stroke services.

The key, evidence based, platforms from which the proposals have been developed are the "National Stroke Strategy", published in December 2007 and "Stroke: national clinical guideline for diagnosis and initial management of acute stroke and transient ischaemic attack (TIA)" published by the National Institute for Health and Clinical Excellence in July 2008.

The proposals support the emerging key priorities for NHS Halton and St Helens in 2009-2010;

Staying healthy for longer and early detection of major illness -

- ✓ reducing the number of TIA patients who go on to have a Stroke
- ✓ promoting healthy lifestyle choices for those identified as being at greatest risk of stroke
- ✓ enhancing long term support to those who have had a stroke

Improving access to psychological therapies -

- ✓ ensuring rapid and sustained access to appropriately trained staff to support patients and carers

Access to health checks -

- ✓ offering support to those identified as at risk through the vascular screening programme for adults aged 25+

Care without Walls -

- ✓ developing a Multidisciplinary Stroke Rehabilitation Service (MSRS) to provide support and active interventions to patients in all settings, including hospital
- ✓ operating a range of options for treatment location according to clinical need and patient choice

Managing variation -

- ✓ supporting improvements and consistency in the diagnosis and timely referral of TIA and Stroke patients
- ✓ providing enhanced and standardised long term support for Stroke and TIA patients in all GP practices

Comments are invited on the proposed model of Stroke Services as described in this report, to be received by **30th September 2009.** Comments should be sent to Janet Dunn, Head of Partnership Commissioning, NHS Halton and St Helens, Victoria House, Holloway, Runcorn WA7 4TH or by email to janet.dunn@hsthpct.nhs.uk If you would like to discuss the report or to arrange for someone to meet with an organised group please call 01928 593676.

Definitions

A&E	Accident & Emergency Department or Accident & Emergency Service
Acute Stroke Unit (ASU)	An acute stroke unit is a discrete area in the hospital that is staffed by a specialist stroke multidisciplinary team. It has access to equipment for monitoring and rehabilitating patients. Regular multidisciplinary team meetings occur for goal setting. (NICE, July 2008)
Carotid Endarterectomy	Two carotid arteries provide the main blood supply to the brain. These arteries are particularly prone to developing narrowing and blood clots can form in the narrowed areas. If the blood clot breaks off it goes into the blood stream and may then block an artery in the brain causing a stroke or a TIA. Carotid endarterectomy is an operation designed to remove the narrowing in the carotid artery before it can cause a stroke.
Community Stroke Rehabilitation Unit (CSRU)	An in-patient Unit or Hospital Ward with dedicated therapy facilities, within which patients receive an active programme of rehabilitation or reablement in order to maximise their personal potential and quality of life.
CT	Computerised Tomography (CT), sometimes also called a CAT scan, takes pictures of the body and uses a computer to put them together. A CT scanner uses X-rays and is a painless procedure. A series of X-rays are taken of the body at slightly different angles, to produce very detailed pictures of the inside of the body. (NHS Choices)
CTA	A Computed Tomography Angiography (CTA) scan gives a view of specific blood vessels (arteries and veins). CTA is often included in a CT exam.

Map of Medicine	A web-based visual representation of evidence-based patient care journeys covering 28 medical specialties and 390 pathways providing an online clinical knowledge resource to help healthcare professionals plan the best possible treatment programmes for patients.
MRA	A Magnetic Resonance Angiogram (MRA) scan is carried out exactly the same as an MRI scan apart from the use of dye which is administered through a needle in the back of a hand. This scan gives a clear picture which may show parts of the brain or other arteries that haven't shown up well on other tests. The dye used in this test has no side effects.
MRI	Magnetic resonance imaging (MRI) uses a strong magnetic field and radio waves to produce detailed pictures of the inside of the body. MRI scans can show muscles, joints, bone marrow, blood vessels, nerves and other structures within the body. The images the scans produce are usually two-dimensional but, in some cases, several different scans can be taken to build up a three-dimensional image that can be displayed on a computer screen. (NHS Choices)
Multidisciplinary Stroke Rehabilitation Service (MSRS)	A multidisciplinary team of Specialist Stroke trained professionals providing support and rehabilitation to Stroke and TIA patients throughout the Service Pathway, including in-reach intervention from the beginning of treatment, supported and early supported discharge and continuing rehabilitation within a wide range of community settings. The MSRS comprises a core team and an extended team to provide the widest and appropriately focussed care. (NHS Western Cheshire)
NHS Improvement	NHS Improvement is a newly formed (April 2008) national improvement programme working with clinical networks and NHS organisations to transform, deliver and sustain improvements across the entire pathway of care in cancer, cardiac, diagnostics and stroke services.
NSF for Older People	National Service Framework for Older People published May 2001 by the Department of Health

PbR	Payment by Results (PbR) aims to provide a transparent, rules-based system for paying trusts. It is intended to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment is linked to activity and adjusted for casemix. The system aims to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers. (Department of Health)
QOF	The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.
SAP	The single assessment process (SAP) was introduced in the National Service Framework for Older People. The purpose of SAP is to ensure that people receive appropriate, effective and timely responses to their health and social care needs and that professional resources are used effectively. In pursuit of these aims, SAP should ensure that the scale and depth of assessment is kept in proportion to people's needs; agencies do not duplicate each other's assessments; and professionals contribute to assessments in the most effective way. The system under which SAP is operated in Halton and St Helens is also known as 'Easy Care'.
Stroke	A 'brain attack' caused by a disturbance to the blood supply to the brain. There are two main types of stroke: • Ischaemic: the most common form of stroke, caused by a clot narrowing or blocking blood vessels so that blood cannot reach the brain, which leads to the death of brain cells due to lack of oxygen. • Haemorrhagic: caused by a bursting of blood vessels producing bleeding into the brain, which causes damage. (National Stroke Strategy, December 2007) --- A clinical syndrome consisting of 'rapidly developing clinical signs of focal (at times global) disturbance of cerebral function, lasting more than 24 h or leading to death with no apparent cause other than that of vascular origin'. (World Health Organization, 2004)

Transient Ischaemic Attack (TIA)	Transient ischaemic attack (TIA), also known as minor stroke, occurs when stroke symptoms resolve themselves within 24 hours. (National Stroke Strategy, December 2007) --- A transient ischaemic attack (TIA) is defined as stroke symptoms and signs that resolve within 24 hours. (World Health Organization, 2004)
Thrombolysis	The use of drugs to break up a blood clot, where this can be safely used for suitable patients. It has to be given within 3 hours of the onset of stroke symptoms
Ultrasound	Carotid Ultrasound is a test that shows the carotid arteries (vessels in the neck that provide blood flow to the brain), as well as how much blood flows and how fast it travels through them. Ultrasound waves are used to make an image of the arteries. This image can be used to find out if there is an abnormality or blockage of the carotid arteries that could lead to stroke.
Vital Signs	Measures of progress against the national priorities for the NHS.

Introduction

The Stroke Care Pathway for Halton and St Helens is designed to ensure that services within Halton and St Helens are responsive to local needs and provide for the best patient outcomes in terms of prevention, treatment and long term care. This involves the identification and implementation of the ideal Stroke care pathway, including services for the prevention of Stroke, those at risk of Stroke, for patients who have had a Stroke and those recovering from Stroke.

NHS Halton and St Helens published its 5 year 'Ambition for Health' Strategy in March 2009. This is an extract from the introduction of the plan.

Our mission:

We believe our contribution to the well being of the people we serve in Halton & St Helens is to enable them to have the best possible health and health care. To achieve this, we have set ourselves three ambitions:

- To improve and tackle inequalities in health.
- To deliver effective and efficient health and related services.
- To be the Best in Class.

Why change:

In comparison to the rest of England, in Halton & St Helens, our local population has high levels of:

- Economic deprivation (within the worst 10%).
- Worklessness (21% with 11% receiving incapacity benefits).
- Smoking, obesity and alcohol & 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 & 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. This health inequality is unacceptable and must be tackled by significantly changing how we go about improving the health of our local population.

Our vision:

To improve the health of our local population…
We will focus on helping people to stay healthy. We will engage and enable people to take greater responsibility and control of their own health and care.
Whilst this is simple to say, we recognise that this is a huge change in emphasis from 'treating sick people' to 'helping people to prevent ill health'. This challenge will only be met by working in partnership with other local agencies. Also, it requires us to enable our staff to form different personalised relationships with patients. In particular it will require targeted, innovative actions to engage 'hard to reach' groups.
Alongside the focus on staying healthy, we will continue to increase the range & scale of our programmes to **detect illnesses earlier**.

Finally, we will also **improve the quality and safety of our health care services**. Poor quality care (which is ineffective and costly) must be addressed both to improve health outcomes and patient experience and to make saving to enable us to afford to increase our investment in ill health prevention and early detection.
Based on this vision, we have identified six ambitions (or goals):

- 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.

This commissioning strategy '***Ambition for Health***' describes, for each of the goals, what we will deliver by 2013. It identifies major priorities that we will tackle through focused initiatives. It describes how we will ensure that we are delivering the initiatives and other 'business as usual projects' and that overall, we are achieving the improvements in health outcomes

Goal 12: By 2013 people with risk factors for heart disease and stroke will be identified and treated to reduce their risk of either event. For people with coronary heart disease or stroke we will have excellent long-term care in place to support them.

Quote from NHS Halton and St Helens Commissioning Strategic Plan.

The current situation / historical context

The National Audit Office report "Reducing Brain Damage: Faster access to better stroke care", published in 2005, outlines the national picture. Key points made by the report are;

- 11% of the deaths in England and Wales each year are due to Stroke (the third largest cause of death);
- awareness of stroke and how to recognise symptoms is low;
- between 20% and 30% of people who have a Stroke die within a month;
- every five minutes someone in England will have a stroke;
- around one in four people can expect to have a stroke if they live to 85;
- over 900,000 people who have had a stroke living in England, about half of whom are left dependent on others for everyday activities
- Stroke affects all age groups, with a quarter of Strokes occurring in people aged under 65;
- people of African or Caribbean ethnicity are at higher risk of Stroke, especially of having Strokes while young;
- Stroke mortality rates have remained constant, at approximately 24%, between 1992 and 2002, while for heart attack patients the chance of dying from their heart attack declined by about 1.5% each year.

There is high variability in the average lengths of stay across acute hospitals. On average one fifth of acute hospital beds, and a quarter of long term beds, are

occupied by stroke patients. Stroke patients occupy one of the largest numbers of acute hospital bed days of any patient group – over 2.6 million per year.

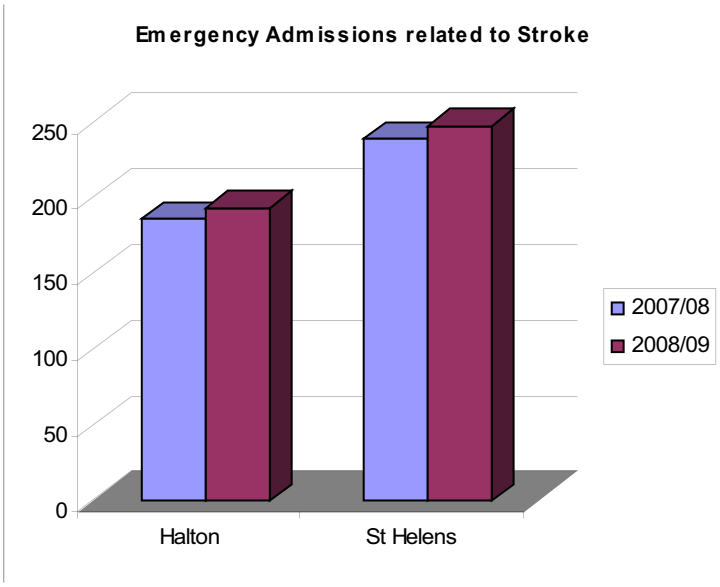
Stroke will become increasingly expensive as the number of people living with stroke increases. People aged 65 years and over increased by nearly four million between 1952 and 2002 and the percentage of older people in England is projected to rise from 16% in 2003 to 23% in 2031. It is predicted that the total costs of stroke care will have risen in real terms by 30% between 1991 and 2010.

Patients cared for in a defined stroke unit with organised stroke services are more likely to survive, have fewer complications, return home and regain independence than patients that stay on a general medical ward.

The Halton and St Helens Perspective

The prevalence of Stroke and TIA as reported through the Quality Outcome Framework (QOF) in 2008/2009 was 5900. The incidence of Stroke in Halton and St Helens is 1.6%; this is 0.2% higher than the current rate for England as a whole. It is predicted that across Halton & St Helens 1152 patients over the age of 65 years have a longstanding health condition caused by a stroke.

In 2008/2009 the number of Stroke emergency admissions was 440, accounting for 7138 bed days. This was a 0.2% increase from 2007/08 figures. A borough split is shown below.



The number of deaths due to Stroke in 2007/08 was 232.

<u>Health Inequalities and Stroke.</u>

- The incidence of stroke in Halton and St Helens is predicted to rise at a greater rate than the rise in heart attack incidence and to rise above that of the national rate. In addition the incidence of stroke predicted to be greater in Halton compared to St Helens (see Table 1 below). Stroke patients have commented that cardiac care has been given greater attention over the past 10 years compared with stroke care.

Table 1: Predicted increase in the incidence of Stroke compared to Heart Attacks in the population aged 65+ between 2008 and 2025

Location	Stroke	Heart Attack
England	**49.4%**	**41.5%**
Halton	**60.1%**	**52.1%**
St Helens	**47.9%**	**36.6%**
Halton and St Helens combined	**52.3%**	**42.3%**

Data source: PCT Public Health and POPPI

The Department of Health National Support Team (NST) for Health Inequalities visited Halton and St Helens in February 2009 and provided the PCT and Council partners with a set of priority actions to help reduce mortality from Cardio Vascular Diseases.
This plan incorporates those key priority areas and it is important to note that the NST also recognised areas of good practice picked up during it's their visit and these were:-

1. Local Acute Providers have demonstrated improvements in Stroke care as evidenced in the 2008 National Sentinel Stroke audit results compared to the results from the same audit conducted in 2006.
2. The PCT has designated Stroke as a commissioning priority
3. A thriving local stroke club in Halton

Drivers for Change

The publication of the National Stroke Strategy by the Department of Health in December 2007 has provided a focus for reviewing the provision of Stroke Care services within Halton and St Helens with local health, social care and third sector partners.

The newly formed "NHS Improvement", established April 2008, includes Stroke as one of the five clinical areas for its 2008/2009 priorities. It has been established to support Stroke Networks and the implementation of the National Stroke Strategy.

Further advice to support the Pathway's development has been made available through the publication of National Institute for Clinical Excellence guidelines, in July 2008. This has supported the framework for a review of the Stroke pathway.

The development of the Pathway also provides the opportunity to review the status of local services in relation to Standard 5 – Stroke within the National Service Framework (NSF) for Older People.

Objectives

The proposed Pathway outlines an ambitious programme of challenges to providers of services for the restructuring and enhancing of Stroke services for the population of Halton and St Helens. It seeks to transform the approach taken to the treatment of Stroke and TIA in order to deliver significant improvements in the outcomes of treatment and the long term support and quality of life which Stroke patients and their carers should expect from World Class healthcare provision.

The overall long term objectives will be the reduction of incidence in Stroke/TIA within the population, improvements in access to timely acute/specialist interventions and appropriate access to rehabilitation and long term support to raise the quality of life outcomes for those with Stroke.

It is NHS Halton and St Helens intention that the proposed pathway will deliver World Class Stroke services to meet the aspirations of the *National Stroke Strategy* (December 2007), the standards of the NICE Guidelines *Stroke: Diagnosis and Management of Acute Stroke and Transient Ischaemic Attack (TIA)* (July 2008) and the accreditation of Acute Stroke services to meet the standards of a Level 3 Stroke Centre, as defined by the British Association of Stroke Physicians (BASP).

Progress towards a World Class Stroke Service will be measured against national indicators (Vital Signs Stroke Indicators) and local outcome targets based on the framework of twenty Quality Markers (QMs) identified in the National Stroke Strategy.

There is also the intent to recognise the stroke pathway as one of a number of key areas of service transformation within the local 'Transforming Community Services' along side the need for the stroke pathway to help deliver the policy changes and service improvements associated with 'Putting People First' and the Transformation of Adult Social Care and The National Carers Strategy (2008).

Transforming Community Services and Putting People First and Outcome Based Accountability (OBA) what does this mean for individuals? The following is a list of expected outcomes for people who have suffered a stroke and their carers:-

- Timeliness (rapid access)
- Optimum recovery support
- Flexible service delivery
- Personalised care
- Open ended / lifelong support
- Support to manage the condition

The Model of Services for Halton and St Helens

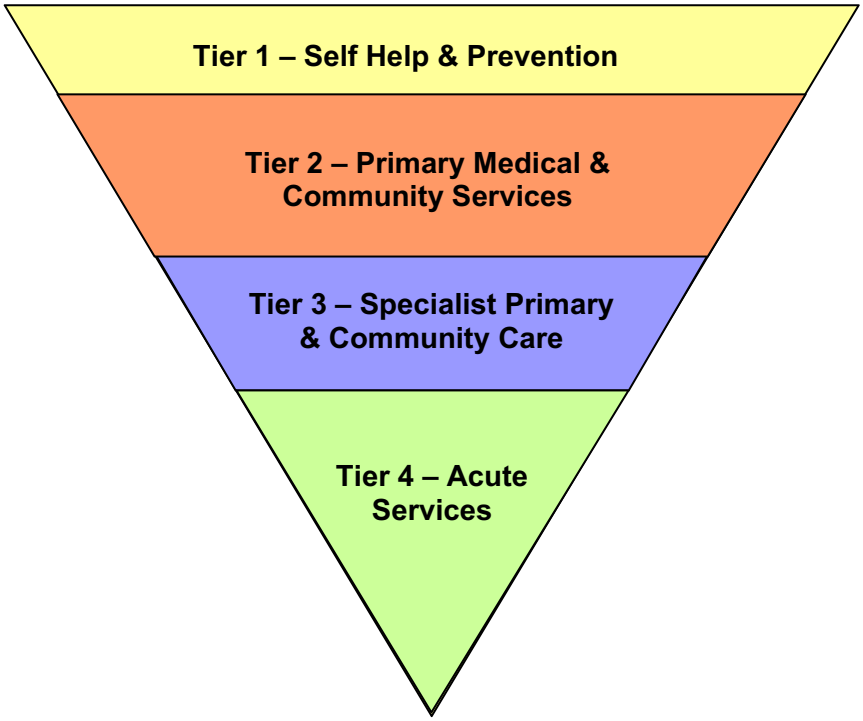
In order to deliver its objectives NHS Halton and St Helens proposes to commission the following Service Model Pathway commencing from April 2010, with a target of full implementation by April 2014.

Wherever possible and appropriate, NHS Halton and St Helens will jointly commission stroke services with partner organisations to support the best possible range of services for stroke patients and their carers and relatives. This will be achieved by working with Halton and St Helens Councils, through a Joint Strategic Needs Assessment supporting the development of NHS Halton and St Helen's Strategic Commissioning Plan and Halton and St Helens Community Services Commissioning Strategy.

The model of care is predicated on a tiered approach. This is in line with 'Our Health, Our Care, Our Say' (DH 2006) which recommends a greater use of self care, telemedicine and telecare and the provision of care either at home or closer to home to promote independence and good health. There are also requirements for improvements in quality, safety, productivity and efficiency. **Patient care will however be of consistent quality and evidence based, as determined by the clinical pathway**

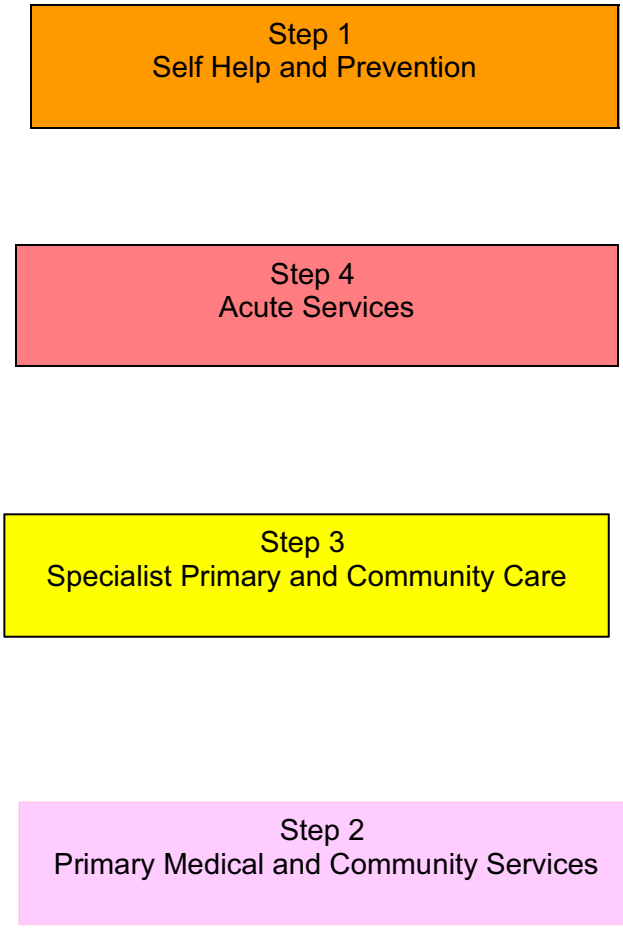
This changes the locations for care, providing more services in community settings closer to where people live and creating a greater concentration of specialist care on the acute hospital site.
The model will enable people with who have had a TIA or stroke to receive more of their care in their local communities and their homes. It will change the way in which care and support is delivered to make best use of the opportunities of technology, improving methods of access for patients and increase efficiency. This may range from telephone consultations to use of decision-support systems and point-of-care testing. It will therefore result in changes in the nature and location of activity.
This tiered approach is entirely consistent with the local health economy's model of care and is demonstrated in the diagram below:

Tiered approach diagram

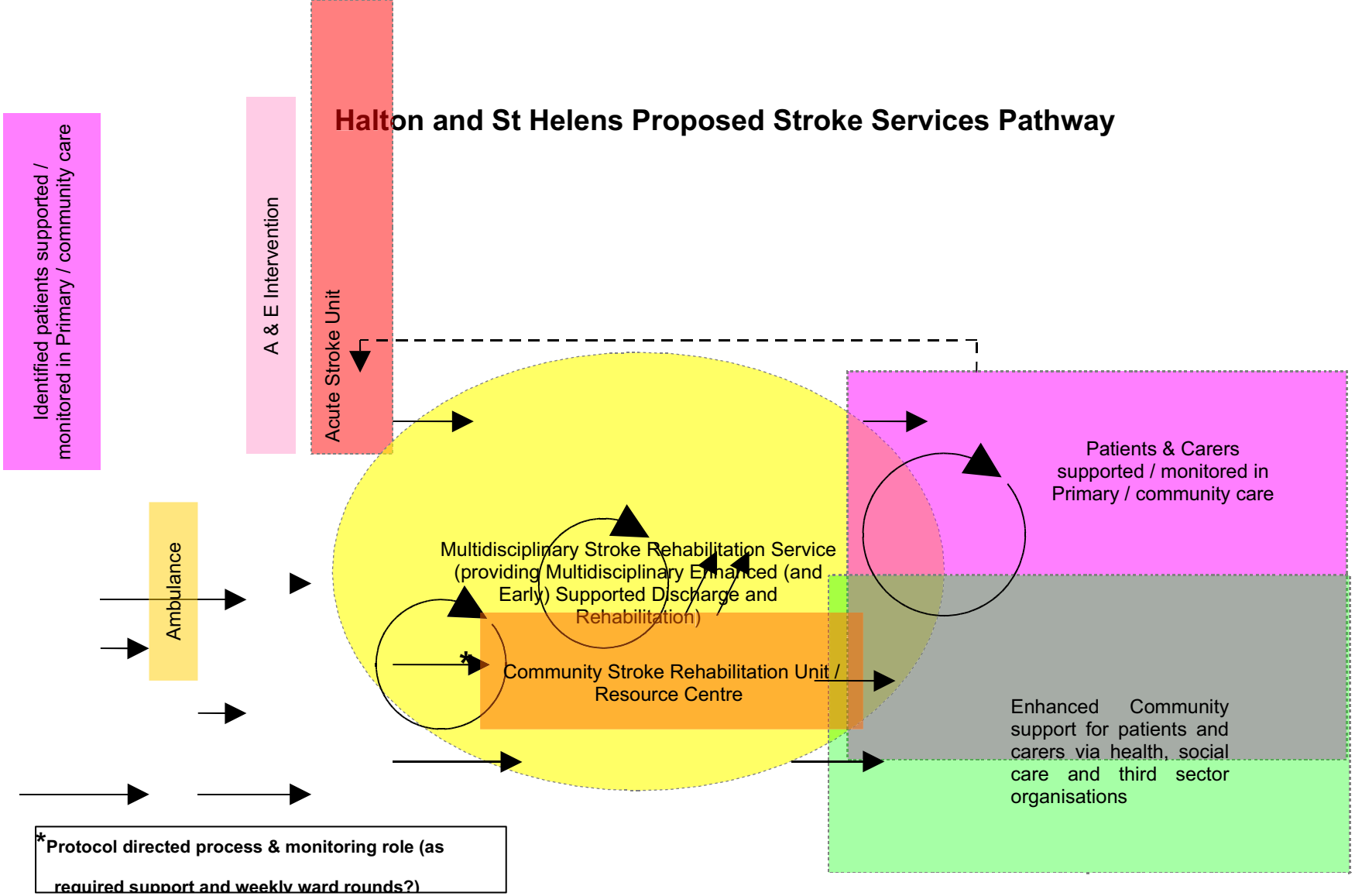


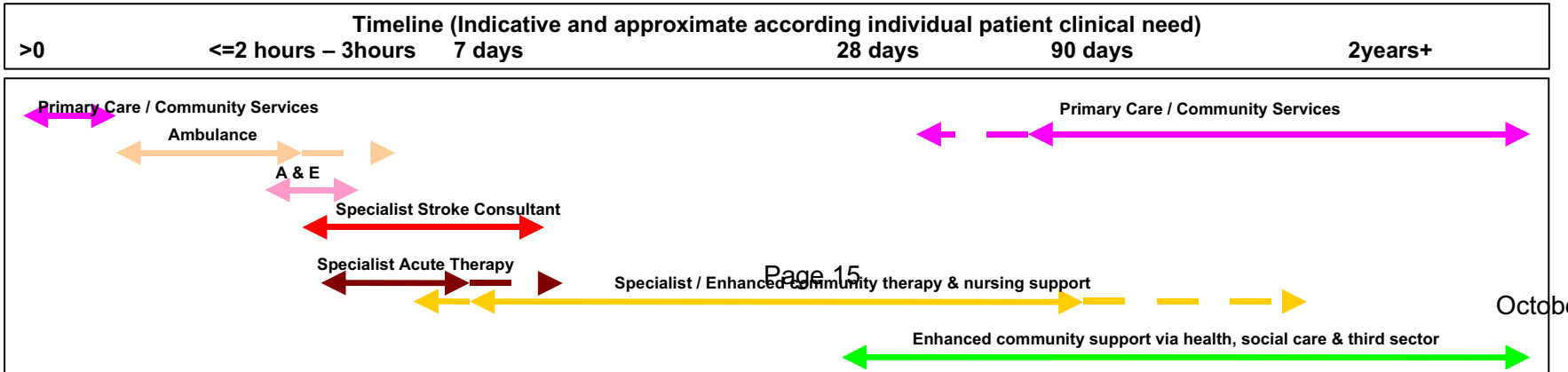
Stroke Care Route Diagram

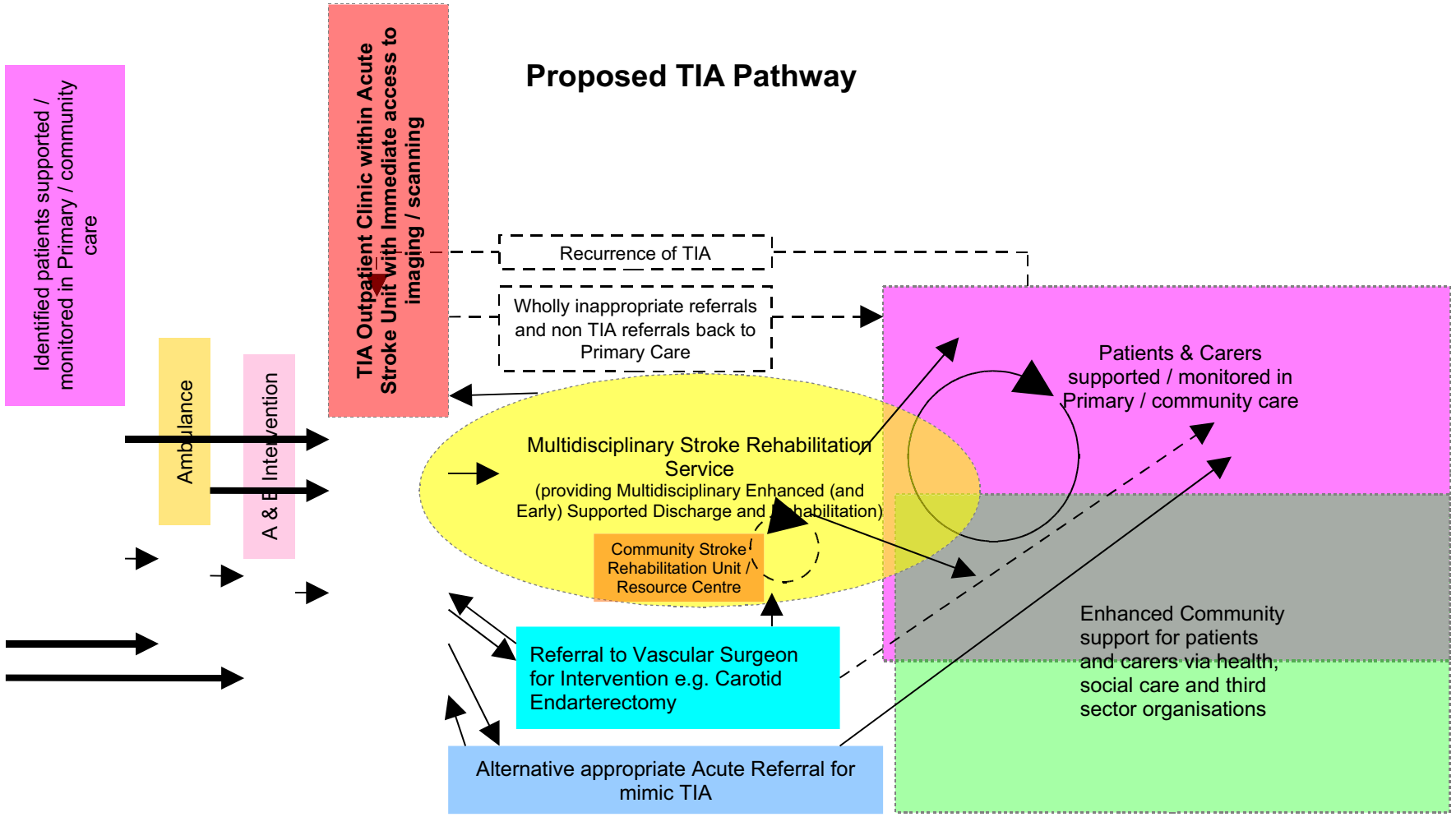
In order to place Stroke within the Tier of Care model, we have broken this down to reflect the proposed Stroke Care Route in line with the new Pathway, as such;

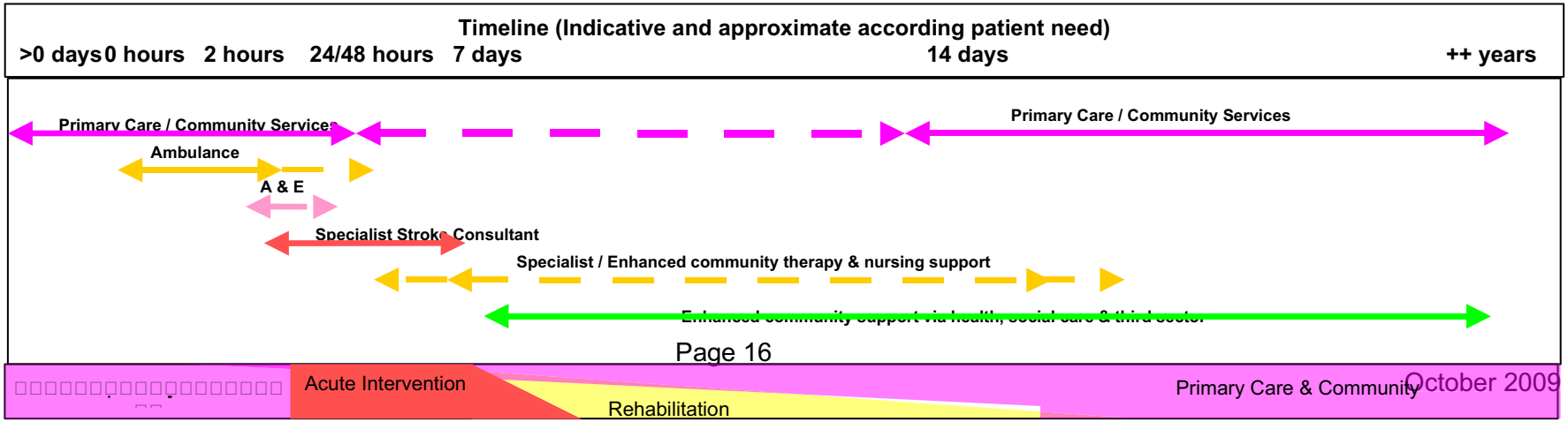

Step 1
Self Help and Prevention
Step 4
Acute Services
Step 3
Specialist Primary and Community Care
Step 2
Primary Medical and Community Services

Halton and St Helens Proposed Stroke Services Pathway






Proposed TIA Pathway
Identified patients supported / monitored in Primary / community care
Ambulance
A & E Intervention
TIA Outpatient Clinic within Acute Stroke Unit with Immediate access to imaging / scanning
Recurrence of TIA
Wholly inappropriate referrals and non TIA referrals back to Primary Care
Multidisciplinary Stroke Rehabilitation Service
(providing Multidisciplinary Enhanced (and Early) Supported Discharge and Rehabilitation)
Community Stroke Rehabilitation Unit / Resource Centre
Patients & Carers supported / monitored in Primary / community care
Enhanced Community support for patients and carers via health, social care and third sector organisations
Referral to Vascular Surgeon for Intervention e.g. Carotid Endarterectomy
Alternative appropriate Acute Referral for mimic TIA


Timeline (Indicative and approximate according patient need)
>0 days
0 hours
2 hours
24/48 hours
7 days
14 days
++ years
Primary Care / Community Services
Ambulance
A & E
Specialist Stroke Consultant
Specialist / Enhanced community therapy & nursing support
Primary Care / Community Services
Acute Intervention
Rehabilitation
Primary Care & Community

Pathway Overview

Pre-Stroke/TIA care and prevention

Working with General Practitioners, the Practice Based Commissioning Consortia, Halton Council and St Helens Council and other partners, NHS Halton and St Helens will seek to improve recognition, understanding and preventative treatment of Stroke within the local population .

Through other work being undertaken by the PCT to meet its Corporate Objectives, including specific related work streams, the ambition is to reduce the incidence of Stroke and TIA through improved general health for the local population;

NHS Halton and St Helens will commission;

- Shared information arrangements throughout the patient pathway using the Single Assessment Process (SAP) as the model to ensure that consistent and informed patient focussed quality care can be delivered by both health and social care providers.
- Stroke services based on detailed patient / clinical pathways developed using *"Map of Medicine"* as the standard pathway structure.

Acute Care/Immediate Care (or Short Term) Rehabilitation

Ambulance Services – The PCT will work with North West Ambulance Service NHS Trust to ensure that protocols are in place to meet the standards outlined in the National Stroke Strategy.

NHS Halton and St Helens will commission the following;

- Accident & Emergency Services – services to provide 24 hour a day support to urgent response protocols and for Specialist Stroke Consultant/s and Stroke Specialist Nurses to be available at all times to ensure immediate direct access to a local Acute Stroke Unit.
- Acute Stroke Unit – a Dedicated Acute Stroke Unit staffed with specialist Stroke trained staff for direct admission from Ambulance and A&E, with adequate capacity for all Stroke patients – and desirably, patients admitted with TIA as a main condition - to be managed within the Unit throughout their stay.
- Specialist Stroke Consultant/s – services for the required minimum number of Consultants trained to the required standard in Stroke care based within SHKHT and WHHFT respectively (to meet BASP standards) . This will ensure the availability of staff with the skills and capacity to provide 24 hour Acute Stroke Consultant cover for Emergency Stroke admissions, working in partnership with A&E to deliver Thrombolysis to an increasing number of

patients and provide access to TIA clinics within 24/48 hours for high risk patients.

- Specialist Acute Stroke Care trained Nursing Staff – services for all stroke patients to be supported by specialist Stroke trained nursing staff with a high level of skills to care for patients in the Acute Stroke Unit and the capacity to train other clinical staff within the Acute Hospital setting.
- Imaging – services for the provision of immediate access to MRI/CT/Ultrasound for all Stroke patients admitted to the Accident & Emergency department and Acute Stroke Unit and urgent access for suspected TIA patients (to meet the standards in "*Implementing the National Stroke Strategy – an imaging guide***"** (Department of Health, June 2008).
- Dedicated Stroke Therapists – a specialist multi-disciplinary team of therapists forming a Multidisciplinary Stroke Rehabilitation Service (providing Multidisciplinary Enhanced (and Early) Supported Discharge and Rehabilitation throughout the pathway both in the hospital and community) to be responsible for the care of stroke patients from admission to the Acute Stroke Unit and throughout the pathway.
- availability of immediate & direct access to the above services for 24 hours a day, 7 days a week (in partnership with other hospitals as appropriate, based on the principle of "service to patient not patient to service" to reduce/minimise patient travel, time and stress).
- A 7 day a week service for key therapies to assess and commence treatment as soon as patient is stable and no more than 24 hours after admission.
- Services to include arrangements for patient & carer involvement in Care Planning from Day One of admission to the Acute Stroke Unit.
- Services for Social Care and Stroke Association Family & Carer Support Service engagement at the earliest possible stage following admission to the Acute Stroke Unit. (This will be dependent upon individual patient need).
- Flexible access to a Specialist Stroke Consultant led TIA Clinic – TIA services to give access for suspected TIA patient's access to be seen by an Acute Stroke Consultant within 24/48 hours, or 7 days, according to urgency.

Stroke Rehabilitation Service

NHS Halton and St Helens will commission the following;

- A Multidisciplinary Stroke Rehabilitation Service (providing Multidisciplinary Enhanced (and Early) Supported Discharge and Rehabilitation throughout the pathway both in the hospital and community) to ensure patients can be safely discharged from the Acute Stroke Unit/Inpatient Rehab Unit to an appropriate setting, with full support to ensure continuity of care and continued treatment. (The Service Team will include; Lead Nurse, Medical, Nursing, Occupational Therapy, Physiotherapy, Speech & Language Therapy, Psychology, Dietetics, Podiatry, Continence, Tissue Viability, Social Care, Health Support workers)
- Community Stroke Rehabilitation Unit – the provision of a community Stroke Rehabilitation Unit as part of the Multidisciplinary Stroke Rehabilitation

Service. The Unit will be staffed by specialist stroke rehabilitation trained nursing and therapy staff. The Multidisciplinary Stroke Rehabilitation Service Team will plan and manage admissions to the Unit, care throughout patients' stay and following discharge. *(this might be part of an existing Intermediate Care Unit)*

- Support from Specialist Stroke Consultants/or specialist stroke nurse – protocols for Specialist Acute Stroke Consultants to participate in patient management in support of the Multidisciplinary Stroke Rehabilitation Service, including the Community Stroke Rehabilitation Unit (CSRU), with arrangements, for example, for weekly ward round.
- These services to be organised on a 7 day a week basis to provide availability of immediate & direct access to the Multidisciplinary Stroke Rehabilitation Service and CSRU.
- Stroke Association Family & Carer Support Service engagement from Day One involvement by the Multidisciplinary Stroke Rehabilitation Service.
- The Stroke Association's Communication Service engagement in discharge planning (as soon as need is identified by the Multidisciplinary Stroke Rehabilitation Service) and from discharge.
- Primary Care/Community Stroke nurse in discharge planning and responsibility for ensuring continuity of patient care and carer support from the point of discharge from the Acute Stroke Unit.
- Patient & carer involvement in Care Planning and discharge planning throughout the involvement of the Multidisciplinary Stroke Rehabilitation Service.

Long Term Patient and Carer Support Services

NHS Halton and St Helens will commission the following;

- Primary Care / Community Matrons – long term support to be delivered by Primary Care services and caseload management by Community Matrons to stroke patients and their carers.
- Access to the Multidisciplinary Stroke Rehabilitation Service – services to ensure that patients and carers following discharge from active treatment by the Multidisciplinary Stroke Rehabilitation Service can directly or via Primary Care (dependent upon patient/carer choice) access the service for advice, support, review and re-admission to the Multidisciplinary Stroke Rehabilitation Service Team's caseload (including access to the Community Stroke Rehabilitation Unit), as appropriate.
- Access to these services 7 days a week.
- Annual reviews (as minimum), enhancing where appropriate, contracts with the Stroke Association Family & Carer Service and Communication Service and any other future third sector providers.
- Resources for long term Patient & Carer support group / activities (e.g. funding for accommodation, refreshments, transport and capacity for facilitation, where

necessary, via PCT, Social Care and Stroke Association staff) working in partnership with Social Care and the Stroke Association.

Acute Care and Immediate Care (or Short Term) Rehabilitation

NHS Halton and St Helens will commission Acute Stroke Services as follows;

- an Acute Stroke Unit with
  - ✓ hyper-acute capabilities, as a discrete (separate) Unit or Ward
  - ✓ capacity that is adequate to enable stroke / TIA patients to be accommodated from admission to discharge
  - ✓ located with easy access from A&E and, where appropriate, for admissions direct from Ambulance
  - ✓ All Stroke and TIA patients to be admitted under the Acute Stroke Consultant/s. Patients should be admitted directly to the Acute Stroke Unit or, if via A&E, transferred directly to the Acute Stroke Unit as soon as possible.
  - ✓ Hyper-acute facilities in order for hyper-acute treatment during the first 24 hours to be available within the Acute Stroke Unit, where appropriate supported by A&E.
  - ✓ staffing by a dedicated team of nursing staff, trained in the acute management of stroke and as a minimum meet Quality Markers 18 and 19 from the National Stroke Strategy (Leadership and Skills and workforce review and development)
- immediate access to MRI/CT/Ultrasound for all Stroke patients admitted to Acute Stroke Unit, essential during the first 24 hours to meet the standards in *"Implementing the National Stroke Strategy – an imaging guide"* (DoH, June 2008)
- Patients already admitted and identified with Stroke or TIA as the primary diagnosis to be transferred to the ASU immediately and to the Acute Stroke Consultant/s.
- Rehabilitation provided by the Multidisciplinary Stroke Rehabilitation Service on an in-reach basis to operate as a seamless continuation following completion of acute stroke and rehabilitation care.
- a core Acute Stroke Team comprising Acute Stroke Consultant/s, Stroke nurse specialists, and Multidisciplinary Stroke Rehabilitation Service staff as a core, with immediate access to others, including, Orthotists, Prosthetists, Orthoptists, for advice, support, care planning, working together to deliver World Class Acute Stroke services.
- 7 day availability of key therapies, from the Multidisciplinary Stroke Rehabilitation Service, to assess and commence treatment as soon as patient is stable and no more than 24 hours after admission to the Acute Stroke Unit.
- Patient & carer involvement in Care Planning from the earliest possible stage after admission to the Acute Stroke Unit, this might be on day of admission or later, depending on the medical stability of the patient

- Social Care and Stroke Association Family & Carer Support Service engagement from earliest possible stage after admission to the Acute Stroke Unit.
- thrombolysis protocols (based on NICE guideline TA122, June 2007, *Alteplase for the treatment of acute ischaemic stroke*) to be agreed with Ambulance, A&E & Imaging to ensure that urgent response to Emergency admission enables patients to maximise the opportunity to consider the option of thrombolysis.
- protocols to be agreed for the planning of care and discharge from the Acute Stroke Unit in conjunction with the Multidisciplinary Stroke Rehabilitation Service, including the continuity of care, prior to discharge with the patient and carer present to ensure confidence in care arrangements. The protocols must include provision for the whole pathway support of patients by the Multidisciplinary Stroke Rehabilitation Service and to manage demand for Acute Stroke Unit beds to enable Emergency Stroke Patients to be admitted directly to the Acute Stroke Unit. Where, in exceptional circumstances, any patients, pending discharge, are temporarily displaced from the Acute Stroke Unit (which should occur only during periods of high demand for Stroke services) protocols to provide for them to be supported by the Multidisciplinary Stroke Rehabilitation Service until discharged home or to another facility under the support of the Service.
- Consultant to Consultant Transfer protocols to be in place for patients identified as having a primary diagnosis of Stroke or TIA to be transferred within 24 hours to the Acute stroke Unit and to be clinically managed by an Acute Stroke Consultant.

Stroke Rehabilitation Services

NHS Halton and St Helens and Halton and St Helens Councils will jointly commission Stroke Rehabilitation Services as follows;

- a Multidisciplinary Stroke Rehabilitation Service with core 'Team' services consisting of specialist Stroke trained staff and as a minimum comprising Occupational Therapists, Physiotherapists, Speech & Language Therapists, Psychologists, Social Services staff, Nurses and Health Support workers .
- additional community support arrangements for the Multidisciplinary Stroke Rehabilitation Service core 'Team' to be supported by direct access to others including Dietetics, Podiatry, Continence, Tissue Viability, Prosthetists, Orthotists, Orthoptists, all with specialist Stroke training and skills.
- A Community Stroke Rehabilitation Unit (CSRU) as part of the Multidisciplinary Stroke Rehabilitation Service
  - ✓ Staffed by specialist stroke rehabilitation trained nursing staff.
  - ✓ the Multidisciplinary Stroke Rehabilitation Service to plan and manage a caseload of individuals, by developing and maintaining close links with the in-patient stroke team throughout stay and following discharge
  - ✓ therapy to be delivered by Multidisciplinary Stroke Rehabilitation Service
  - ✓ Protocols to be in place to provide for patient transfer from Acute / Immediate Care Rehabilitation, admission and readmission from normal place of residence based on a pre planned programme of rehabilitation and re-enablement which can only be delivered more effectively than at the patient's normal place of residence.
- Protocols for Specialist Stroke Consultants/stroke nurse specialist to participate in patient management in support of the Multidisciplinary Stroke Rehabilitation Service, including the Community Stroke Rehabilitation Unit (CSRU), with arrangements, for example, for weekly ward round.
- 7 day a week availability of immediate direct access to Multidisciplinary Stroke Rehabilitation Service, Community Stroke Rehabilitation Unit and Specialist Acute Stroke Consultant/s. This will include ensuring that there is adequate capacity to ensure patients can be assessed, transferred between the tiers of stroke services and receive active support and rehabilitation irrespective of the day they enter, or require review within, the service.
- Stroke Association Family & Carer Support Service engagement at earliest possible stage after admission under the Multidisciplinary Stroke Rehabilitation Service.
- Stroke Association Communication Service engagement in discharge planning and from discharge with early involvement identified within the care planning process.
- Primary Care / Community Matron engagement in discharge planning and in supporting patients and carers following discharge from the Acute Stroke Unit.

- Patient & Carer involvement in Care Planning and discharge plan throughout the involvement of the Multidisciplinary Stroke Rehabilitation Service.
- the Multidisciplinary Stroke Rehabilitation Service to have capacity and protocols in place to support patients to meet individually assessed needs in a wide variety of locations including the patients usual place of residence – e.g. home or care home, non acute unit locations within Whiston and Warrington and Halton Hospitals and local community hospitals e.g. Newton Community Hospital and Halton Intermediate Care Unit
- Resources to support temporary admission of patients for respite care to be included in a Multidisciplinary Stroke Rehabilitation Service Resource and Delivery Plan, which must be developed jointly with partner organisations (e.g. Social Care). The delivery plan will facilitate arrangements in appropriate community based environments and be linked to continued support from the Multidisciplinary Stroke Rehabilitation Service during the episode of respite care. Admission to the Community Rehabilitation Unit will not be used for carer respite.

Long Term Patient and Carer Support Services

NHS Halton and St Helens and its council partners will commission Life Long Patient and Carer Support services as follows;

- The development of a wider range and capacity for life long support to patients and carers.
- continuing regular monitoring of recovering stroke patients and their carers carried out as a regular process within primary care as part of the GP Quality and Outcomes Framework, this might include intervention by other community nurses such as Community Matrons, to ensure that progress with recovery or stabilisation is maintained and that the required support is identified to prevent, wherever possible, crises and breakdown of care.
- life long access to the Multidisciplinary Stroke Rehabilitation Service (core and extended) in order to ensure the monitoring role in Primary Care can effectively be delivered through protocols for direct re-referral to the Multidisciplinary Stroke Rehabilitation Service for advice, support, review, re-admission to the Service or Community Stroke Rehabilitation Unit, as appropriate.
- 7 day a week access to Primary Care, Community Matrons and the Multidisciplinary Stroke Rehabilitation Service.
- Contracts with local voluntary and community and faith sector organisations e.g. the Stroke Association Family & Carer Service to be adequate to provide long term and peer support in order to supplement or provide an informal alternative to the Multidisciplinary Stroke Rehabilitation Service.
- the contract with the Stroke Association Communication Service to be adequate to enable this to be provided in different formats according to patient need, e.g. group or individual, and to support a transition plan for patients moving from this service onto a long term peer support arrangements.
- partnership arrangements to be established and resourced for long term Patient & Carer support group / activities, including identifying and managing funding for accommodation, refreshments, transport and capacity for facilitation, where necessary, via NHS Halton and St Helens, Social Care and Stroke Association and Carers' Association staff to enable appropriate peer support groups for patients and carers.

End of Life Care

A significant theme of the development of the Stroke Care Pathway and the service developments which are proposed to support its implementation are focussed on the prevention of stroke, effective treatment to minimise the impact of Stroke when it happens and the provision of long term support to maximise the quality of life for those recovering from Stroke and their carers, leading to a reduction in deaths from Stroke. In some circumstances the need for end of life care to be provided may be appropriate in circumstances where active rehabilitation would not be appropriate.

NHS Halton and St Helens will commission end of life care as follows;

- Provision of services in line with best practice guidance outlined in the National Stroke Strategy.
- contracts with providers to meet the standards of quality requirement 9 of the "*National Service Framework for Long Term Conditions: 'Palliative Care'* "
- The development of a separate review of services based on the "*End of Life Care Strategy: Promoting high quality care for all adults at the end of life"* published by the Department of Health in July 2008.

TIA Specific Services

NHS Halton and St Helens will commission specific services for TIA patients, as follows (in addition to those commissioned within the general stroke pathway);

- flexible access to a daily Stroke Consultant led TIA Clinic – services to be in place to give access for suspected TIA patients to be seen by an Acute Stroke Consultant within 24/48 hours or 7 days, according to urgency, of referral from General Practitioner, Primary Care, Out of Hours service, A&E, (based on the NICE guidelines definition of high and low risk).
- Standardised and consistently applied protocols used by GPs in primary care to ensure that all patients presenting with TIA symptoms are referred within the appropriate timescale to the TIA clinics, this includes the harder to reach patients such as those who live in care homes, are housebound.
- access to imaging to meet the current NICE clinical guideline 68,*"Stroke: diagnosis and initial management of acute stroke and transient ischaemic attack"*, together with advice provided in *"Implementing the National Stroke Strategy – an imaging guide"* (Department of Health, June 2008), for both interventions and timescales
  - ✓ carotid imaging (Doppler Ultrasound, magnetic resonance angiogram (MRA) or a computed tomography angiogram (CTA) to be, preferably, carried out in all eligible TIA or minor Stroke patients (approximately 80% of patients) during the Consultant TIA Clinic attendance or no more than 24 hours after attending the Clinic.
  - ✓ MRI, including diffusion-weighted imaging (DWI), gradient echo imaging (GRE) and magnetic resonance angiogram (MRA), as appropriate, to be performed on all patients seen at a Consultant TIA Clinic, where there is uncertainty about diagnosis, vascular territory or underlying cause.
  - ✓ Echocardiography and electrocardiogram (ECG) to be performed within 24 hours (if deemed necessary) or within 48 hours of initial assessment by the Acute Stroke consultant, for those patients with a clinical need.
  - ✓ Protocols for patients with suspected non-disabling stroke or TIA who, after assessment by the Acute Stroke Consultant/s, are considered as appropriate candidates for carotid endarterectomy to be referred directly, within 7 days of the onset of symptoms, for assessment by a Vascular Surgeon and undergo surgery within 14 days of the initial onset of symptoms.
- All patients with residual symptoms after TIA or minor stroke to be referred from the Acute Stroke Consultant TIA clinic to the Multidisciplinary Stroke Rehabilitation Service and Stroke Association Family & Carer service, as part of a planned support and stroke prevention programme.
- the Multidisciplinary Stroke Rehabilitation Service to ensure that a follow up review of all TIA or minor stroke patients has taken place one month after the onset of symptoms. This follow up will be carried out by the Acute Stroke Consultant or Stroke Nurse Specialist, Primary Care/Community Matron or the

Multidisciplinary Stroke Rehabilitation Service itself and that any identified follow up action will be completed.

Financial Implications

The commissioners will work with the provider organisations through which it will commission the delivery of services in this Strategy to ensure that;

- effective use is being made of existing resources for Stroke and TIA services
- additional resources required to deliver the Strategy are identified and agreed (e.g. through Payment by Results tariff setting for Acute Services), together with a timetable for implementation
- Performance will be measured through the Quality and Outcomes Framework for Stroke currently being developed by the Halton and St Helens Core Stroke Strategy Implementation Group.

How Progress will be Measured

The Stroke Strategy Group will monitor performance and service quality through a range of measures based on National Indicators (mandatory) and local Indicators (derived from the Quality Markers of the National Stroke Strategy.

In order to support the Stroke Pathway the following should provide a basis for measuring success / outcomes of the Pathway

Vital Signs Monitoring (National) - Mandatory

Patients who spend at least 90% of their time on a stroke unit (VSA14_02).

	2008/2009	2009/2010	2010/2011
National Target	**65%**	**70%**	**80%**
Local NHS Halton and St Helens Target	**65%**	**70%**	**80%**
Actual Performance WHHFT	**56%**		--
Actual Performance SHKHT	**48%**	**At Q2 77%**	--

Higher risk TIA patients who are scanned and treated within 24 hours (VSA14_06).

	2008/2009 Full year final	2009/2010	2010/2011
National Target	**25%**	**45%**	**60%**
Local NHS Halton and St Helens Target	n/a	tba	tba
Actual Performance) WHHFT *	**Data not available**	--	--
Actual Performance) SHKHT	**Data not available**	--	--

***** *Baseline data for WHHFT in 2007/08 was 19% of the high risk TIA patients (Halton and St Helens) were scanned within 24 hours.*

Data on the number of TIA referrals who were deemed to be in the 'high risk' category suggests that overall there were approximately **130 patients** across Halton and St Helens who required rapid access to specialist assessment during 2008/09.However care needs to be taken when estimating the potential caseload

as we need to understand how effective the identification and referral processes are within primary care.

Local targets will also need to be set if the ambition is to exceed the National minimum.

Vital signs recording which contributes to the above reporting:

- No. of people who spend at least 90% of their time on a stroke unit (VSA14_02)
- No. of people who have had a stroke who were admitted to hospital (VSA14_01)
- No of people who have a TIA who are scanned and treated within 24 hours (VSA14_05)
- No. of people who have a TIA who are at high risk (VSA14_04)

Local Performance Measures, based on the National Stroke Strategy

In order to measure progress, performance and success with this Strategy locally determined measures based on the Quality Markers within the National Stroke Strategy will be incorporated within the Quality schedules of the contracting process with service providers.

An appropriate set of local performance measures will be developed, agreed, prioritised and monitored based on the following (the anticipated source of the data is noted in brackets ( ) after the measure);

- Proportion of individuals who seek medical attention within two hours of stroke symptom onset (Primary Care, A&E/ASU)
- Proportion of individuals with suspected acute stroke seen within three hours (A&E, ASU)
- Proportion of people who have had a TIA (or minor stroke) who have received specialist assessment and brain scan within 24 hours (ABCD2 score $\geq$4 or with non-cardioembolic carotid-territory minor stroke) and 48 hours (carotid intervention, echocardiography and 24 hour ECG, where clinically indicated) or 7 days (lower risk) (A&E, ASU)
- Proportion of TIA referrals for 'Carotid imaging' (Doppler Ultrasound, MRA or CTA) scanned within 24 hours of clinical assessment (A&E, ASU)
- Proportion of patients having major stroke prior to investigation (Primary Care, A&E,ASU)
- Proportion of TIA patients started on aspirin (or approved alternative) immediately after clinical assessment (Primary Care, A&E, ASU)
- Proportion of people with TIA identified following 'Carotid imaging' (within 24 to 48 hrs)who receive appropriate Carotid intervention (e.g. Carotid Endarterectomy) within (14 days) (A&E, ASU, Surgery)
- Proportion of Stroke patients scanned within 1 hour of arrival (A&E, ASU)

- Proportion of Stroke patients screened for swallow disorders, by an appropriately trained healthcare professional, within 24 hours of admission (A&E, ASU)
- Proportion of Stroke Patients admitted to ASU on day of admission (ASU)
- Proportion of patients eligible receiving thrombolysis (A&E, ASU) – *national aspirational figures suggest between 4 – 10%*
- Percentage of TIA patients receiving assessment, advice and support in the Acute Clinic. Those with residual symptoms being referred to the Multi-disciplinary Stroke Rehab Service. (MSRS)
- Number and proportion of Stroke patients being supported by the Multidisciplinary Stroke Rehabilitation Service in their usual place of residence from discharge from the Acute Stroke Unit (MSRS)
- Proportion of stroke patients whose assessed needs are being met from joint health & social care arrangements. (MSRS)
- Proportion of patients living independently in their usual place of residence 6 months and 12 months following discharge from the MSRS (with or without intervention from the MSRS during the intervening period) (MSRS, Primary Care)
- Proportion of TIA and stroke patients re-admitted to acute care (Acute Stroke Unit, Primary Care)
- Proportion of patients who die as a result of stroke (A&E, ASU, MSRS, Primary Care) – *national target reduction by 40%*
- Performance reports from third sector organisations (e.g. Stroke Association)
- Number of patients and carers accessing health and social care funded long term peer group activities (MSRS, Primary Care, Social Care, Third Sector)
- Number of stroke patients reporting positive readjustment to their lives following psychological support/counselling. Outcome measures might include early detection and prevention of depression
- Number or proportion of Stroke patients who (*are supported to*) return to work or other opportunities, e.g. volunteering.
- Number of stroke patients receiving regular follow up reviews at 6 weeks, 6 months and 12 months in Primary Care.

Implementation

This plan has been developed by the Halton and St Helens Stroke Strategy Implementation Group and the group comprises a wide stakeholder membership.

The group has identified a number of priorities for early implementation of the local stroke plan and these are as follows:

Priority Development	Key drivers/outcomes	Delivery leads
Extend Thrombolysis for Stroke	Saving lives; improved outcomes for individuals; reduce health inequalities	The Stroke Strategy Group Acute Hospital Trusts
Reduce the incidence of Stroke through prevention and targeted and early intervention and Social Marketing/Public Awareness raising	National Health Checks Programme; Healthy Lifestyle Choices; Tackling Smoking and Obesity; Primary Care Stroke and Heart Disease management ; Self Management of Cardio vascular disease; reduce health inequalities.	GP practices and Primary Health care teams. All stroke specialist teams PCT CSP programmes for Early Detection; Tackling Smoking and Obesity Department of Health media campaigns Local information and awareness raising events
Extend access for patients experiencing symptoms of TIA/Stroke to high quality rapid access assessment and treatment services	Improving access for patients; reduce incidence of stroke and repeat strokes; reduce the overall burden of ill-health and disability; improve quality of life	The Stroke Strategy Group CSP Early Detection programme GPs and Acute Stroke Teams
The development of community stroke rehabilitation to include early supported discharge; communication support and psychological support	Flexible and personalised care for individuals and carers; Care closer to home; Transforming Community Services programme.	The Stroke Strategy Group Community health and social care teams through joint commissioning PCT CSP Early detection of Depression programme
Develop and improve peer support for individuals recovering and resuming their lives after stroke.	Flexible and personalised care for individuals and carers; Care closer to home; Transforming Community Services programme	The Stroke Strategy Group Local Councils Community health and social care teams through joint commissioning

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10th November 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Intermediate Care Services in Halton

1.0 PURPOSE OF REPORT

1.1 To inform Healthy Halton Policy & Performance Board of the current service provision, review and improvements in Halton Intermediate care services.

2.0 RECOMMENDATION

1) That Members receive the presentation on Intermediate Care Services and comment on the presentation.

3.0 SUPPORTING INFORMATION

3.1 Intermediate care services have played a significant part in achieving improvements in overall outcomes for people in Halton over the past 5 years. This has been reflected in a steady reduction in emergency admissions and acute hospital bed utilisation, the reduction being greater in the over 65 population. The number of people living in care homes has more than halved. Over the same period of time the number of people over 65 supported at home has tripled. This approach has also reduced the size of on-going care packages so that people are able to live more independently with lower levels of support.

3.2 The review of intermediate care in 2008, focused on the development of a gold standard and performance management framework against which current services could be assessed and future services commissioned. The review programme involved a range of stakeholders, including public, patient, clinician and practitioners.

3.3 The attached presentation aims to inform the Healthy Halton Policy & Performance Board of the review process and outcomes achieved.

3.4 An information pack will be tabled at the Healthy Halton Policy & Performance Board

.

4.0 POLICY IMPLICATIONS

4.1 Health and social care policy is focused on the delivery of health and social care services away from acute hospital and long term care provision to community based services.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 None

6.0 OTHER IMPLICATIONS

6.1 None

7.0 RISK ANALYSIS

7.1 None.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10th November, 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Social Care In Practice Service

1.0 PURPOSE OF REPORT

1.1 To inform Healthy Halton Policy & Performance Board on the progress and developments made in the Social Care In Practice (SCIP) pilot.

2.0 RECOMMENDATION: That

(1) Healthy Halton Policy & Performance Board Members note and comment on the report.

3.0 Introduction

3.1 The Social Care in Practice (SCIP) service was commissioned by Runcorn PBC Consortium to establish formal links between primary care and social services, so that people with long-term conditions and decreased functional ability can access social care assessments and have a personalised care plan devised to support them within their own home / community wherever possible. It was also envisaged that earlier interventions and signposting to other services and agencies would support primary care patients more effectively and reduce the need for more intensive health interventions.

3.2 It was also anticipated that this proposal would not only facilitate enhanced quality of life for those older people with access to social care in general practice, but would also increase understanding within health and social care of each other's culture, services, access and priorities, including safeguarding issues **(Appendix 1).**

3.3 Evidence from similar models identified a decrease in hospital admissions and lengths of stay for this patients group, resulting in significant savings that could be reinvested to fund practice based social care posts and additional related services.

3.4 The project has a base in 4 health centres enabling 7 separate surgeries to access the SCIP workers. The project consists of 2.5 (WTE) community care workers, a 0.5 (WTE) worker from Sure Start to Later Life, a Practice Manager and admin support. Due to the consortium recognising the value of the service the pilot has now been extended until February 2011. The Practice Manager post, which was funded to develop the service, was initially funded by the Directorate; however, this too is now being fully funded by the Consortium.

3.5 Provision of space for the social care staff within each health centre is different. The social care staff can be located in a room with community matrons; this appears to work well as can be evidenced with the number of referrals received from the two surgeries where this occurs. The other two health centres provide a room for the worker. All workers liaise well with district nurses and continue to work to raise their profile within the health centres.

3.6 The dedicated SCIP CCW's attend their respective Primary Health Care Team (PHCT) meetings, and access clinical systems to enable holistic assessments to be undertaken. They also work closely with the PHCT to provide social care information to enable older patients to fully benefit from the integrated health and social care approach. The SCIP Practice Manager regularly attends practice meetings to continue to raise the project's profile further, to address any issues whilst the service is developing and to support the social care staff.

3.7 Distribution of social care sessions within each practice are based on the proportion of 65+ patients as % of overall practice population, prevalence of LTC's and by considering admissions and readmissions for this age group by practice. By targeting the social care resource in this way it is considered we can have a greater impact on this patient group in each practice, reducing admissions where possible, but also enhancing the PHCT's understanding of available social care support, improving patient and professional pathways to access social care and wider community based solutions, thus improving the quality of life for this vulnerable patient group.

4.0 Evaluation

4.1 When the pilot service was established a number of areas for evaluation were agreed. The majority of these were quantitative, with some qualitative evaluation from case studies. At the recent Steering Group it was agreed that there must be a move towards a more qualitative approach, and a questionnaire is being developed to support this in conjunction with Sandra Harris.

4.2 Evaluation to date:

4.2.1 Number of referrals between July and September 2009:
Source of referrals:

PRACTICE	REFERRALS TO SCIP	SOCIAL CARE ASSESSMENTS	SS2LL REFERRALS
Tower House	37	8	0
Grove House	15	1	0
Murdishaw	7	2	0
Castlefields	38	15	0
Brookvale	17	3	3
Weavervale	7	4	0
Heath Road	0	0	0
Total	**120**	**33**	**3**

These figures show a small decrease on the previous quarter. This is in part due to the holiday season and the effect of swine flu, which drastically reduced the number of people attending the surgeries. The figures show that the largest proportion of referrals did not necessarily lead to a full social care assessment, as many are managed through signposting etc. Recording now identifies all the other outcomes from referral, eg signposting, referral to other services/agencies etc. as well as working towards a more qualitative evaluation.

4.2.2 The consultant who is employed by the PBC consortium identified that it had been too difficult to capture the actual savings that SCIP had made for the Runcorn Consortium, and indicated that the qualitative evaluation tool being jointly developed will be welcomed by the GP surgeries. However, he reports that feedback from the Runcorn Consortium from the GP's perspective is very positive and they are delighted with the outcomes they have seen so far.

5.0 Next Steps

5.1 The PBC consultant has been identified by the PBC to support the further development of the project. David Bowie (Acting Practice Manager SCIP) to be part of the PBC work stream.

5.2 Qualitative data collection/collation is to be developed to evidence the outcomes of the project for the target group.

5.3 Further work is required to proactively identify people who are at risk of hospital admission.

5.4 A new referral form has been developed to provide easier access to service. It will also further identify the long-term conditions of people being referred and evidence that people with complex conditions are being targeted. It has not been taken up by all the surgeries but workers are still able to capture the information that we are requesting from the surgeries.

5.5 To further develop the evaluation framework to provide sufficient information to support decision making on the sustainability of this service.

6.0 **FINANCIAL/RESOURCE IMPLICATIONS**

6.1 The project is now funded until February 2011.

6.2 David Bowie is now acting Practice Manager. PBC are now funding this post.

6.3 The Directorate is currently funding an agency worker to backfill the acting Practice Manager post, this SW post will now be advertised on a temporary basis until February 2011 as the agency costs are significant.

Appendix 1

Anticipated Outcomes

Outcome	**Progress to date**
Provides more rapid, efficient and holistic assessment and care plan coordination and promotes multi-disciplinary working practices	Social care workers are co-located in practices, forming new multi-disciplinary community teams. Referrals to social care are taken in person, cutting out the 'red tape'. Joint home visits and assessments are being undertaken. SAP folders are being issued jointly. Care plan coordination is more holistic.
Ensures older people are better supported and maintained in the community by utilisation of a single point of contact within GP practices for health and social care, with continuity of care and consistency of linked social care staff.	Social care workers are based in each practice and have become the single point of contact for PCHT staff. Primary named workers have been allocated to each practice. All practices are aware of who to contact if the worker is not available.
Increases understanding of each other's contributions and potential inputs between health & social services, including eligibility under FACS and Continuing Care.	Through co-location and joint working social care and PHCT staff are developing a deeper understanding of each other's contributions. Workers are engaging each other in discussions about their own systems and processes.
Enables PHCT members to access to appropriate social care advice, assessment and resources for any identified patient in need of social care input. Enables Social care staff to access medical knowledge And support.	Joint home visits and assessments are taking place. Patient discussions are had regularly and information and advice shared. Resources are being accessed (e.g. packages of care, Intermediate Care). Patients are being signposted to community-based resources.
Improves understanding for clinicians of vulnerable adult abuse, and ease of access to advice and safeguarding processes where abuse is suspected.	Social care workers are providing information to clinicians about safeguarding processes. Social care workers are building up PCHT staffs' understanding of vulnerable adult abuse through case discussion.

Promotes timely multi-disciplinary interventions to prevent, where possible, hospital admission or avoidable admission to long-term care, reduces length of stay in acute care and enhances the ability of OP to live independently for longer within the community.	Referrals to social care are taken in person, cutting out the 'red tape'. There has been some difficulty obtaining data relating to number of admissions to hospital, length of stay from PCT informatics team.
Increases opportunities for older people to be referred or signposted to services or activities that are proven to increase health and wellbeing, facilitate independent living and improve quality of life.	Older People are being referred to and signposted to services. Sure Start to Later Life information officers are holding information clinics at all practices, taking patient self-referrals and referral from professionals. Increase in number of referrals to Sure start from Runcorn Practices
Social care staff to have access to complex information to support people in their own homes	Social care staff all have access to the surgeries computer systems. Feedback is that this has been very valuable and has speeded up times that staff can respond to situations.

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10th November 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Dual Diagnosis Strategy

1.0 PURPOSE OF REPORT

1.1 To inform the Board of the development of a Joint Dual Diagnosis Commissioning Strategy 2009 - 2012 for Halton and St Helens - see appendix 1.

2.0 RECOMMENDATION

i) The Policy and Performance Board to note and comment on the draft Joint Dual Diagnosis Commissioning Strategy.

3.0 SUPPORTING INFORMATION

3.1 The strategy documents the current services already in place for people with both substance misuse and mental health problems, with a view to identifying and analysing the gaps in services and any blockages to delivering a more integrated care pathway.

3.2 Early in 2009, Mental Health Strategies conducted a number of consultation meetings with all stakeholders in both mental health and substance misuse services. They also arranged a number of one to one interviews to gain views on current services and to discuss how services could be improved.

3.3 In response to the analysis and consultation, the Dual Diagnosis Commissioning Strategy states the commissioning intentions over the next 3 years in improving services for people with a dual diagnosis of substance misuse and mental health problems. It identifies the actions and resources required to improve services, in line with Dual Diagnosis Good Practice Guide (Department of Health, 2002).

3.4 The strategy recommends more integrated working between substance misuse and mental health services, with earlier identification and treatment of dual diagnosis problems in primary care and an increase in skills and knowledge in both mental health and substance misuse staff, to enable them to provide care to people with dual diagnosis problems.

3.5 The model of services ensures that whichever service an individual

is referred to for help, whether in substance misuse or mental health, they will experience the same care pathway. This is designed to improve the care experience for people with Dual Diagnosis and reduce waiting times between services.

4.0 POLICY IMPLICATIONS

4.1 The Commissioning strategy implements the recommendations from The Mental Health Policy Implementation Guidance: Dual Diagnosis Good Practice Guide.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 Resource implications are identified within the strategy. Much of the cost will be in terms of organisational and individual time.

5.2 Some funding has been allocated from NHS Halton and St Helens adult mental health budget to support workforce planning and development

6.0 OTHER IMPLICATIONS

6.1 The development of a multi-agency group to agree joint commissioning decisions between substance misuse, alcohol and mental health commissioners is a recommendation in the strategy and will, therefore, require commitment from NHS and Local Authority Commissioning staff to work in partnership.

7.0 IMPLICATIONS FOR THE COUNCIL PRIORITIES

7.1 Children & Young People in Halton

None identified

7.2 Employment, Learning & Skills in Halton

None identified

7.3 A Healthy Halton

Earlier detection and treatment of both substance misuse and mental health problems, plus improvements in providing more integrated services, will ensure that people with dual diagnosis receive the right level of care, delivered by the most appropriate services to enable them to recover.

7.4 A Safer Halton

None identified

7.5 **Halton's Urban Renewal**

None identified

8.0 RISK ANALYSIS

8.1 Not implementing the actions documented in the Dual Diagnosis Commissioning Strategy is likely to lead to significantly poorer outcomes for people with mental health and substance misuse issues.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 None

Mental Health STRATEGIES

St.Helens Council

HALTON BOROUGH COUNCIL

NHS Halton and St Helens

Halton and St Helen's PCT

Joint Dual Diagnosis Commissioning Strategy 2009 - 2012

1st September 2009
MHS1165

CONTENTS

EXECUTIVE SUMMARY

Introduction

This document constitutes the Dual Diagnosis Commissioning Strategy for Halton and St. Helens Primary Care Trust.

The Strategy sets out the commissioning intentions of Halton & St. Helens Primary Care Trust in partnership with strategic partners and stakeholders over the next three years

It is based on both the requirements of national policy, and a clear understanding of what local people want from services.

Strategy objectives

Halton and St Helens Mental Health Commissioners wish to develop and deliver a dual diagnosis strategy for mental health and substance misuse (drug and alcohol), specific to the needs of the people of Halton and St Helens.

Scope

This document takes account of the above, but focuses upon the needs of those individuals who have a substance misuse problem (including alcohol) ***and*** an identified mental health need. 'Substances' in this context include illicit drugs of all classifications, prescribed medication, and legal substances including alcohol.

The strategy covers the whole adult age range of people Halton and St Helens and all tiers of support (i.e., public health, primary care, social care, secondary care and tertiary care). It is concerned with prevention, awareness, early intervention, treatment, after care and recovery.

Method

This strategy has been developed using the following activities:

Questionnaires: Service-mapping questionnaires circulated to local service providers. These were reviewed to identify services and interventions available matched against 'Tiers of Service' as identified by NTA.

Focus groups: three focus groups were organised an attended by primary, secondary, and 3rd Sector staff fror health, social care and criminal justice agencies. A separat commissioning focus group was well attended. Themes fror these group discussions are detailed later in this report

Interviews: a number of one-to-one interviews have been completed as well as small group interviews and site visits to services. The emerging themes are detailed later in this report.

Desk-based analysis*:* A national demographics and prevalence analysis has been undertaken.

Best Practice review: A best practice review has been completed.

Service user engagement: Two separate engagement meetings were held with services users with a dual diagnosis, one organised by CIC and the other by Arch. In both meetings

approximately fifteen people attended and gave consistent feedback.

Definition

The Dual Diagnosis Strategy Development steering group agreed the following definition for the project.

> ***Dual Diagnosis is the 'The co-existence of mental health and substance misuse problems'.*** *(Dual diagnosis: Mental health and substance misuse*. Rethink and Turning Point, 2004)

It is the view of the Dual Diagnosis Strategy Development Steering Group that this definition covered the widest number of people with dual diagnosis issues.

This definition is in line with the 'Changing Habits' report and the 'Commissioning Behaviour Change (Kicking Bad Habits)' report[1]

Principles and Values of Commissioning

This section examines the influencing policy and guidance on commissioning. It has established that the 'Fitness for Purpose' processes will be adopted. That, World Class Commissioning competencies, will be utilised. It identifies the principle commissioning priorities and high level outcomes it wishes to achieve. These, together with the 'future focus of commissioning and service development' set the strategic direction of travel for the next three years.

Best Practice Review

In this section, tables are presented demonstrating the best practice issues or interventions for alcohol and substance misuse.

The table covers the Tiers of intervention, typical service user, point of access, interventions, who delivers the intervention, the outcome for the service user and finally the effectiveness of the intervention.

A diagram demonstrating a good practice pathway for dual diagnosis is presented. This diagram supplements the 'model of care' and 'care pathway' as described in the relevant sections of this strategy.

A key message throughout the review is that 'communit based support and recovery' is the expectation and tho residential and inpatient care is for those people where th severity and risks posed require a period of continuous 24hour care.

DRIVERS FOR CHANGE

National Context

In this section a review of key policy has aimed to give an overview of the national perspective and highlight the key drivers for change. Particular note should be taken of the

[1] Boyce T. et al. (2008) *Commissioning and Behaviour Change: Kicking Bad Habits Final Report*. King's Fund

Models of Care, Substance Misuse and Alcohol and the NTA's review of treatment effectiveness [2](2002).

Local Commissioning Context

The commissioning context is complex. There is one Primary care Trust, two Local Authorities, two DAAT's and two LITs

There is value in developing a joint commissioning board to commission services for those with both mental health and substance misuse issues.

Provision of Services

A range of agencies currently provides, dual diagnosis services, across the two localities. Service provision would appear to be inequitable across the two localities with different service availability, range, and choice.

Population / Deprivation

In this strategic document, the main issues of population and deprivation will be highlighted. A more detailed account of Halton and St. Helens demographics may be found in the respective Joint Strategic Needs Assessments, or local authority data.

[2] *Models of Care for the Treatment of Drug Misusers. National Treatment Agency for Substance Misuse*. National Treatment Agency for Substance Misuse. 2002
Models of Care for Treatment of Adult Drug Misusers: Update 2006. National Treatment Agency for Substance Misuse. July 2006
D. Raistrick et al. *Review of the Effectiveness of Treatment for Alcohol Problems*. National Treatment Agency for Substance Misuse. November 2006

The total population is 297k composed of 119.5k in Halton[3] and 177.5k in St Helens.

The population of Halton is projected to increase by 6% to 126,500 by 2021. An increase of 43% of the 65 plus age group is estimated to grow from 16,400 in 2006 to 23,500 in 2021.

The Population of St Helens is currently 177,600[4] and is projected to increase by 1% up to 2015. St Helens mirrors the national trend. Like Halton will see an increase in the 65 plus population. By 2015 1:5 people will be over 65 years old.

Deprivation

Twenty three percent of the Lower Super Output Areas (LSOA in St. Helens are in the top 10% most deprived areas in Englan and 27% for Halton. However, some areas are ranked as muc less deprived. For both Halton and St. Helens 8% of their LSOA are in the top 25% least deprived areas.

Prevalence

Based on our analysis within Halton and St Helens Primary Care Trust footprint there is projected to be, be 36,900 cases of neurotic disorder (one individual may have more than one type of neurotic disorder). Of this identified population, 590 cases are likely to be moderate to severe alcohol dependence.

[3] http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

[4] http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

The analysis further identifies a projected 3096 cases of neurotic disorder and some form of drug dependence.

To the informed reader these figures may appear the wrong way around.
For the avoidance of doubt however, 590 cases (an individual may have more than one disorder –see page 30) will experience a moderate to severe **alcohol dependence. Whereas 3096 cases will experience a drug dependence. In this context drug dependence refers to 'any drug' and will include those who are drinking alcohol at harmful / hazardous levels.**

These figures were calculated as follows:
4% of men with any neurotic disorder had moderate/severe alcohol dependence and 0% for women (see http://www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf page 66). Halton and St Helen's male neurotic disorder population is 14,756 and so, 4% of 14756 is **590**.

There is estimated to be 12% of males with any neurotic disorder who have ***any*** drug dependence (inc. cannabis, amphetamines, crack, cocaine, ecstasy, tranquillizers and opiates) and 6% for females (see page 70 of Tobacco report).

Applied to Halton and St Helen's male neurotic population this equals 0.12 x 14,756=**1771** and for female neurotics 0.06*22,097=**1326.** Therefore, the total for males and females equals **3096** as documented.

Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months based on **current eligibility criteria**. Should eligibility change to be more inclusive the expectation would be that this figure would increase. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

It is acknowledged that the numbers of individuals experiencing some form of dual diagnosis is likely to be higher than that identified here. This is likely to be the result of a restrictive definition and / or eligibility criteria. The demand therefore for appropriate services is not captured.

Halton and St. Helens reported 116 appropriate referrals to their Substance Misuse Service team. The figures in the table below are calculated using the 116-referral figure and the prevalence rates from the COSMIC study

Estimated Number of Mental Health Cases in Halton and St. Helen PCT's SMS Service April 08 to October 08 (6 months period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

Performance

Substance Misuse service users retained in treatment

Halton and St. Helens DAAT NTA data suggests that they perform less well than their statistical neighbours (ranked 8 out

of 11) but better than the England average. It also shows us that Halton and St Helens are keeping more drug users in sustained treatment (12 weeks+) than they were the previous year in 2006/7 (but all of the neighbours did better than the previous year except for Ashton PCT.) All of Halton and St Helen's statistical neighbours outperformed their local PCT plan for how many drug misusers they would have in treatment. Halton and St. Helens outperformed less than the comparator average but more than the England average.[5]

The table below show data from '2008/09 quarter 2 adult drug treatment partner information reports' St Helens and Halton 31st October 2008. This table shows the difference in performance between Halton and St Helens.

Data from 2008/09 quarter 2 adult drug treatment partner information reports. Halton & St Helens 31st October 2008

	St Helens	Halton
Adults in effective treatment 1/7/07 to 30/6/08	1025	709
% retained in treatment 12 weeks or more period 1/7/07 to 30/6/08	85%	76%
% not in effective treatment period 1/7/07 to 30/6/08	13%	23%

Stakeholder Feedback

As one would expect from such a wide stakeholder mix there was a wide range of views expressed, yet there were some striking themes that emerged as issues in a consistent manner, these included the following.

- Alcohol rather than substance misuse was the major issue
- The blocks and gaps in service provision were at Tier 2 and the interface with Tier 3.
- People with dual diagnosis are far more prevalent than definitions record. Few people who abuse alcohol or other substances do not have some underlying mental health need. Likewise, very many people with a mental health diagnosis will 'self prescribe' with othe substances – be that alcohol, variations on the medication routine or illicit drugs.
- Many services were difficult to access due to th exclusion (rather than inclusion) criteria of many service This meant there was little ownership: all service recognised the need to help the individual, but felt it was not their responsibility to deal with it.
- Too often, the above situation meant interventions only occurred when a crisis presented itself and the criminal justice system was invoked.
- Staff groups work in a silo culture of mental health, substance misuse or alcohol workers without recognising their skills and the needs of their service users were far more cross cutting than that.

There was also a consensus articulated as to how future services should be developed, as follows.

[5] *Drug Misusers in Treatment: Primary Care Trusts Overview – New National Targets 2007/2008*. Healthcare Commission. Available from http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisusersintreatment.cfm

- Services should work much better together and 'share the care' more often.

- Services need to be more holistic and recognise the wider needs, including;
  - The family context
  - Worklessness and its impact on the individual and their family
  - The underlying causes of offending behaviour
  - Housing issues
  - Domestic Violence
  - Looked After Children
  - Education and social problem solving

- Services should be recovery and outcome focused.

- There is need for services to be consistent across the Halton and St Helen's footprint and therefore they should be commissioned consistently to eliminate service gaps and provide equity.

- There needs to be better performance management systems to ensure services deliver what they are supposed to do.

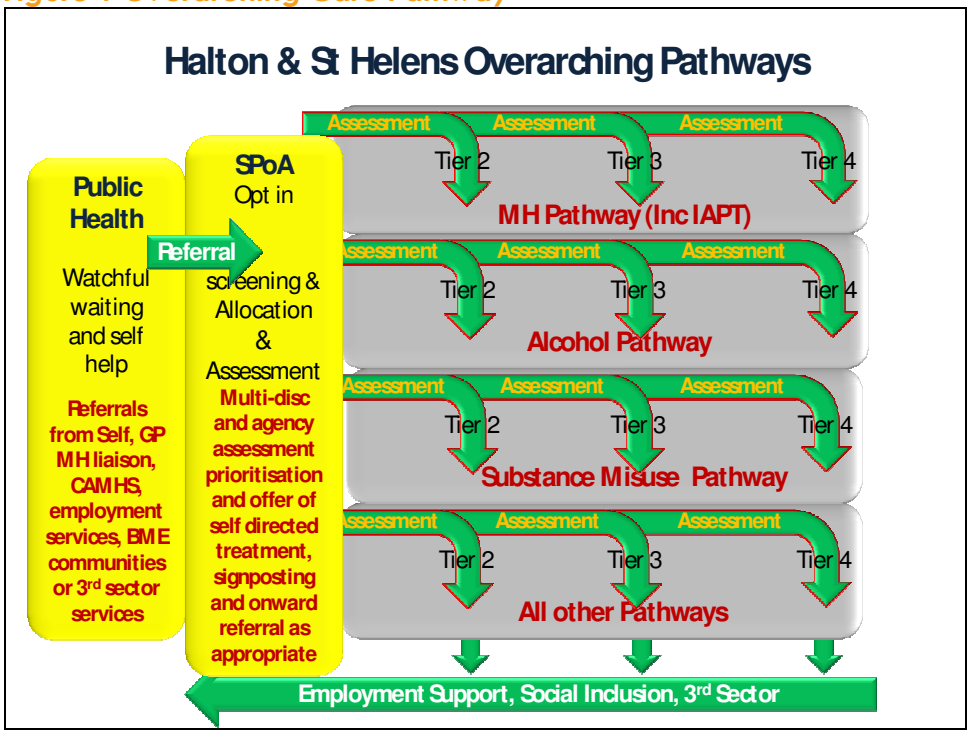
- More resources need to be devoted to primary care with an emphasis on promotion, prevention, and early intervention.

Where we need to get to

Model of Care / Care Pathway

The proposed model of care to be adopted based on a 'shared care – integrated approach' is set out. It has stated the basic principal of Dual Diagnosis Care being led by Mental Health Services whether this is in Primary or Secondary Care. To facilitate this, the role of Advanced Practitioner will be developed and work in conjunction with Dual Diagnosis Workers in Secondary Care. Figure 1 shows a Care Pathway that is aimed at ensuring an equitable and integrated approach is delivered.

Figure 1 Overarching Care Pathway



Conclusion – Commissioning Intentions

This strategy has set out the definition of Dual Diagnosis to be adopted. This definition embraces the principle of inclusion. That is, those who need a service will be offered care and treatment and that eligibility criteria will not stand in the way of accessing care.

The model of care to be adopted is based on best practice and the principle of 'mainstreaming'. This model is based on the practice of 'integrated and shared care.' The care pathway to be adopted seeks to reinforce the practice of integration. Mental Health will take a lead in the coordination of care for those experiencing both a mental health probler and a substance misuse dependency. The report recognise that alcohol, especially at the Tier 2/3 interface presents th greatest pressures for current services. To facilitat improvement in this deficit the role of Advanced Practitioner i Primary care will be developed and a review of the role c. Dual Diagnosis Worker in secondary care will be undertaken.
A range of actions is now necessary to implement this strategy. A more detailed account of these actions can be found within the chapter entitled Conclusion and Commissioning Intentions

Actions

These action include:

- Reconfigure the current commissioning mechanisms.
  Aim. To develop coordinated commissioning and a performance management process equitable across

Halton & St Helens, including all stakeholders delivering care along the pathway.

- Establishing the model of care and single care pathway
  Aim. To establish clarity of entry and exit points within services.

- Implementation of the single point of entry.
  Aim. To ensure service users access the right services at the right time.

- The development of a work force plan.
  Aim. Ensure that all staff at all levels have the appropriate skills and qualification to deliver the care and treatment required.

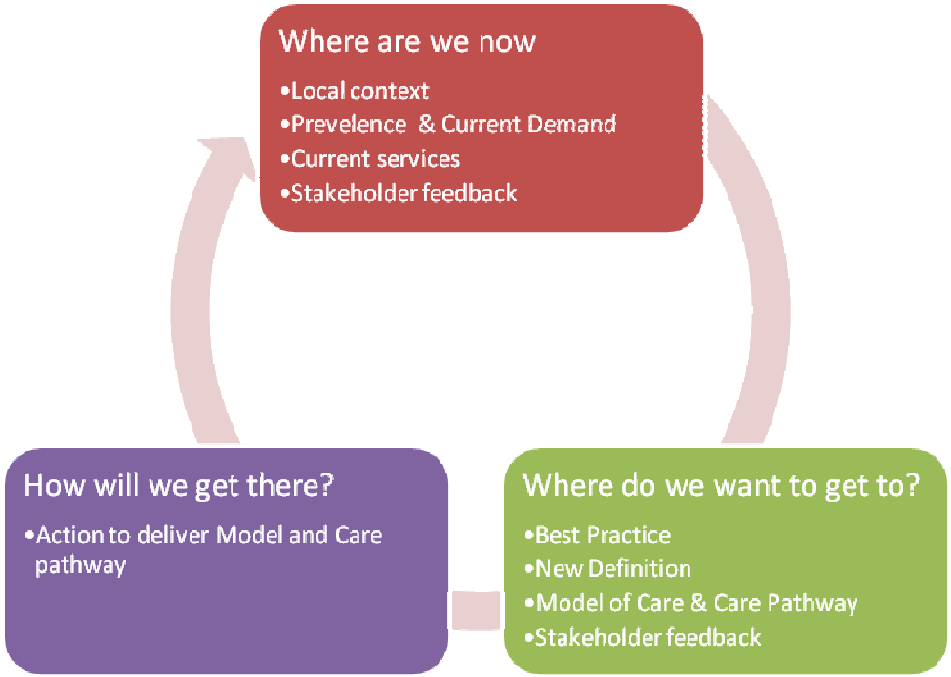
- The development of service specifications in line with the new NHS standard contract
  Aim. To ensure appropriate and inclusive eligibility criteria, and smooth interface between services. That all individuals have access to crisis services when required, irrespective of their dependence on substances.

- The development of a specific Dual Diagnosis service user forum in Halton
  Aim. To facilitate service user engagement and the provision of peer support.

- The development of a Provider Forum.
  Aim. To promote integrated working between providers, to assist identify blockages and barriers to service delivery.

- Commissioning will be based on the priorities identified to meet the identified capacity and capability issues of delivering the future model of care and care pathway.
  Aim: Prioritisation of commissioning. Achieve best value.

- To ensure that this strategy is complemented and a 'strategic fit' it is recommended that the current Mental Health Strategy be reviewed/updated as soon as practicable.



INTRODUCTION

This document constitutes the Dual Diagnosis Commissioning Strategy for Halton and St. Helens Primary Care Trust.

The Strategy sets out the commissioning intentions of Halton & St. Helens Primary Care Trust in partnership with strategic partners and stakeholders over the next three years

It is based on both the requirements of national policy, and a clear understanding of what local people want from services

This dual diagnosis strategy will provide an overall framework for performance and service improvement. The aim is to provide a contextual background, consider organisation' priorities, benefits, risks, and contain action plans to deliver programme of work on dual diagnosis. It will set out a visio and general principles that all the partners can sign up to, an help develop services for service users and carers that w have a positive impact on their health and quality of life.

The report will approach the subject in the following sequential order.

- Identifying the strategies objectives and scope
- Methods
- Review of literature and best practice, including government policy directions
- Review the local context, including what is currently provided and by whom
- Demographics and performance
- Identify themes from stakeholder engagement events
- Describe a new model of care and care pathway

- Provide the framework to list initiatives to achieve the desired outcomes
- Appendices include more detailed supporting evidence.

STRATEGY OBJECTIVES

The purpose of this strategy is to develop a strategic approach to meet the needs of those with a dual diagnosis (drug and alcohol) across the whole of Halton and St Helens locality.

STRATEGIC CONTEXT & SCOPE

Halton, St Helens and the surrounding areas have complex needs. There are pockets of high levels of deprivation, sitting alongside the relative wealth of some commuters, all within well established and relatively newly developed communities.

The recent reconfiguration of PCT boundaries, coupled with increasingly stronger links to the Local Authority and more robust commissioning frameworks (including World Class Commissioning), all provide the opportunity to better co-ordinate services to meet the needs of those individuals with the complex range of needs associated with mental health, substance and alcohol misuse and their related health and social care/welfare domains.

Like most areas, previously each locality and service sector has developed services in relative isolation. However, this new context provides the opportunity to achieve economies of scale and scope, to build upon 'what works', and better integrate successful interventions for individuals along the 'whole dual diagnosis pathway'.

Mainstream mental health services have a responsibility to address the needs of people with a dual diagnosis. Substance misuse services should not be ghetto services. Where they exist, specialist teams of dual diagnosis workers should provide support to mainstream mental health services.

It is therefore essential that local care pathways be fully integrated be they in primary, secondary, mental health or substance misuse in their orientation. Robust care planning procedures at an individual level and clear strategic integration at a corporate level all need to be achieved.

The mechanism to accomplish all of this is robust integrate commissioning at a local level.

By its very nature any dual diagnosis, or co-morbidity, spans more than one domain and excludes others. The current mental health strategy for Halton and St Helens is due for review and work has commenced within the locality negotiating a '**single point of access' (SPoA)** its scope, role and function**. Each DAAT has a Harm Reduction Strategy.** At the time of writing an Alcohol Strategy is also being developed.

This document takes account of the above, but focuses upon the needs of those individuals who have a substance misuse problem (including alcohol) ***and*** an identified mental health need.

Individuals who have a mental health need but who do not have a substance misuse problem are excluded from the strategy. Similarly, those who have a substance misuse problem but do not have identified mental health problem are also excluded.

'Substances' in this context include illicit drugs of all classifications, prescribed medication and legal substances including alcohol.

The strategy covers the whole adult age range of people Halton and St Helens and all tiers of support (i.e., public health, primary care, secondary care and tertiary care). It is concerned with prevention, awareness, treatment, after care and recovery.

The development of a Dual Diagnosis Commissioning Strategy would in the normal course of events 'follow on' from an over arching **Mental Health Strategy.**

At the time of writing the mental health, strategy is due for review. Consequently reference to overall mental health policy and general health and social care policy and guidance needs to be stated. These significantly affect a developing model of care, and integrated working.

METHODS

This section will outline the strategy's process of development and methods used.

Questionnaires: Service-mapping questionnaires were circulated to local service providers. These were reviewed to identify services and interventions available and matched against 'Tiers of Service' as identified by the NTA.

Focus groups: three focus groups were organised and were attended by primary, secondary, and social care staff as well as 3rd Sector staff, from a wide range of health, social care and criminal justice agencies. A separate commissioning focus group was well attended. Themes from these group discussions are detailed later in this report

Interviews: a number of one-to-one interviews have been completed as well as small group interviews and site visits to services. The emerging themes are detailed later in this report.

Desk-based analysis*:* A national demographics an prevalence analysis has been undertaken.

Best Practice review: A best practice review has bee completed.

Service user engagement: Two separate engagement meetings were held with services users with a dual diagnosis, one organised by CIC and the other by Arch. In both meetings approximately fifteen people attended and gave consistent feedback.

DEFINING DUAL DIAGNOSIS

At its most simple, the *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings* (DH 2006 p.1) document, defines it

as ". a diagnosis of mental illness and a diagnosis of substance misuse disorder".

The term "dual diagnosis" poses many problems as it simply refers to the presence of more that one clinical diagnosis. Historically this has referred to those individuals with a severe and enduring mental health problem and a substance misuse problem. This term does not inform commissioners or providers in any detail of the health and social care needs of this group of service users. Dual Diagnosis is a term used to define an increasingly large section of service users that have both a mental health and substance use problem. This term is progressively including people with substance use problems such as alcohol dependence that also have anxiety disorders, and people with schizophrenia who have problems with cannabis use.

The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (2002 p.7) states that the term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex.
Possible mechanisms include:

A primary psychiatric illness precipitating, or leading to, substance misuse.

Substance misuse worsening or altering the course of a psychiatric illness

Intoxication and/or substance dependence leading to psychological symptoms.

Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.

These definitions are secondary care focussed and would limit the range of service users who would be considered under these definitions / description.

The Changing Habits[6] report brings together intelligence from the North West region on the treatment needs and current service provision for service users with a 'dual diagnosis'. The aim of this is to promote the recovery of individuals.

This report illustrates

> 'Dual Diagnosis is a 'whole system' multi-agency issu affecting a broad cross section of adults, with varying levels o severity and impact on the individual, their friends and famil as well as local communities
>
> A population based approach to commissioning and managing integrated Dual Diagnosis service provision, which utilises existing resources to support the maximum number of people across broad spectrum of need within local Dual Diagnosis treatment populations.'[7]

[6] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West
[7] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West

The 'Changing Habits' report suggests a more encompassing and wide ranging description of who may benefit from accessing services.

The needs of children and young people experiencing these difficulties will be different to those experienced by adults and to older adults. There, will also be cultural and ethnic differences within dual diagnosis, as well as gender and sexuality issues.

For the purposes of this report the Dual Diagnosis Strategy Development steering group agreed to adopt the following definition.

> ***Dual Diagnosis is the 'The co-existence of mental health and substance misuse problems'.*** (From *Dual diagnosis: Mental health and substance misuse*. Rethink and Turning Point, 2004)

It is the view of the Dual Diagnosis Strategy Development Steering Group that this definition covered the widest number of people with dual diagnosis issues.

This definition is in line with the 'Changing Habits'[8] report and the 'Commissioning Behaviour Change (Kicking Bad Habits)' report[9]

[8] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report*. CSIP North West
[9] Boyce T. et al. (2008) *Commissioning and Behaviour Change: Kicking Bad Habits Final Report*. King's Fund

PRINCIPLE AND VALUES OF COMMISSIONING

The guiding principles by which the project was conceived, developed and evaluated were cognisant of wider imperatives including the following.

World Class Commissioning[10]: places Primary Care Trusts and their commissioning partners at the forefront of leading the future NHS at a local level. Great emphasis is placed on quality interventions that meet the local demand, provide value for money, and are measured by their outcome rather than mere activity.

The 'Darzi' Review[11]: Lord Darzi's review of the NHS, ***High Quality Care for all***, sets the agenda for future NHS services, ensuring they are fair, effective, personal and safe. It called fo PCTs to commission comprehensive well-being and preventio services, in partnership with local authorities and local partner based on local identification of need. It called for the NHS t focus on six key goals: reducing smoking rates, tackling obesit treating drug addiction, improving sexual health, improvin mental health and reducing alcohol harm.[12]

Putting People First[13] and Transforming Social Care[14]: sets the vision for the radical reform of social care by promoting strong

[10] DH. (2007) *World Class Commissioning: Vision*
[11] Lord Darzi. *High Quality Care for All: NHS Next Stage Review Final Report*. (Cm 7432, 2008)
[12] DH. (2008) *The Operating Framework for 2009/10 for the NHS in England*
[13] DH. (2007) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*
[14] *LAC(DH)(2008)1: Transforming Social Care*

local leadership in the promotion of individualised care build upon the principles laid out in **Our Health Our Care Our Say[15].**

Various mental health strategies[16] [17] highlight the need to develop better treatment responses for dual diagnosis.
Halton and St Helens Primary Care Trust 'Ambition for Health Strategy' sets out the Primary Care Trust outcomes and ambitions. These ambitions have come from understanding of the needs of our local population, and our desire to ensure that we are able to deliver two critical outcomes: These are:

Improving health and tackling inequalities in health
"To work with partners and local people to promote a positive experience of good health and equal opportunities for health, not simply an absence of disease".

Delivering effective and efficient health and related services
"To provide effective and efficient health care services that place the needs of the patient at their core"

Our ambitions are:

- To support a healthy start in life
- To reduce poor health that results from preventable causes
- To ensure that when people do fall ill from some of the major diseases, they get the best care and support
- To provide services which meet the needs of vulnerable people
- To make sure people have excellent access to services and facilities
- To play our part in strengthening disadvantaged communities

Fitness for Purpose

Commissioning a Patient-led NHS saw the reconfiguration of PCTs as the first stage in delivering a robust infrastructure from which to strengthen the commissioning function of PCTs. Stage two focuses on ensuring that PCTs are fit for purpose. This process looks at Strategic Planning, Care Pathway Management, Provider Management and Monitoring an Remediation.

Changing Habits[18]

This report offers a direction of travel to enable local stakeholders to test out how to overcome some key issues:
Ensuring individuals engaged with Community Drug Teams receive access to mental health treatment including psychological therapies, improving joint working and co-ordinating service provision/investment such as Primary Care Mental Health Services and 'shared care' services and promoting treatment choice such as abstinence from cannabis through wider smoking cessation initiatives.

[15] DH. *Our Health, Our Care, Our Say: A New Direction for Community Services.* (Cm 6737, 2006)
[16] DH. (1999) *National Service Framework for Mental Health*
[17] Appleby, L. (2004) *National Services Framework 5 years on*. DH

[18] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West

Kicking Bad Habits:

This report assesses existing and innovative methods the health service can use to persuade people to live more healthy lifestyles, including providing information and personal support and offering financial incentives. This report aims to help those within the NHS
and beyond who are tasked with finding cost-effective solutions to the problems caused by unhealthy lifestyles and behaviour. It examines four bad habits; smoking, alcohol misuse, poor diet and lack of exercise.

New Contract Guidance

Wherever possible a coordinated approach to commissioning is to be adopted. This will assist in best value and a coordinated care pathway approach.
A Stepped Commissioning Framework for Dual Diagnosis[19] will be developed in Halton and St Helens. This will facilitate a 'whole system approach' to the development of services. This commissioning strategy is the first phase of this process.

The priorities of Halton & St. Helens Dual Diagnosis commissioning group include:

- The further development of mechanisms for involving service users and their carers in the commissioning reform of Dual Diagnosis services

- To deliver the complete commissioning cycle in relation to the services covered by this approach

- Undertake commissioning at a number of levels and bring them into a cohesive whole system approach.

- Review commissioning mechanisms and structures to facilitate a coordinated approach and to achieve best value. Developing a governance framework to ensure there is clarity and agreement about where decisions and commitments are made. Working towards a focus on commissioning for the outcomes set out in the national commissioning framework.

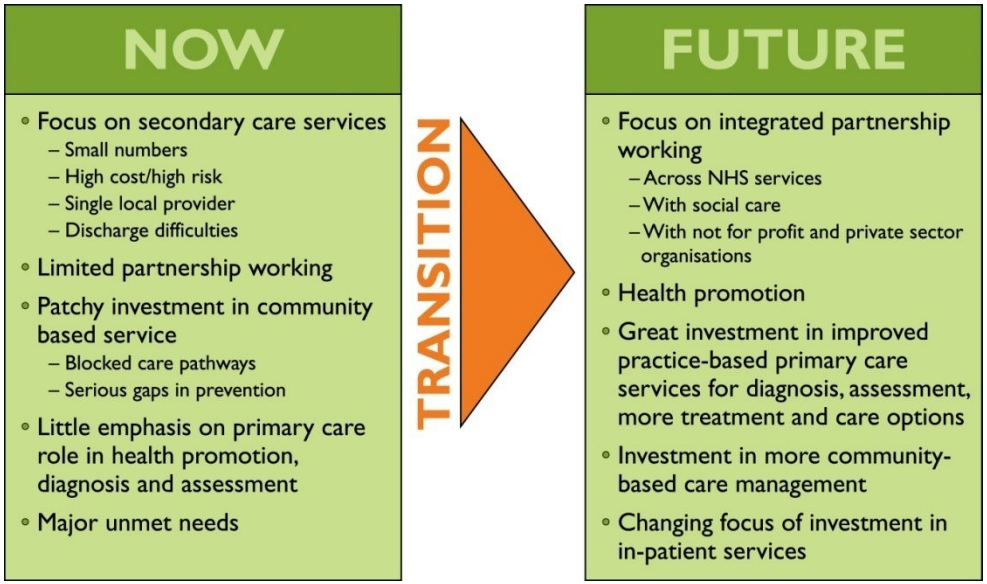
- Ensure that national policy is implemented in a way that takes account of local circumstances and needs.

- The commissioning partners will ensure that there ar improvements in health and well being and reductions i health inequalities and social exclusion. This will includ improved quality, effectiveness, and efficiency c services, together with increased choice and a bette. experience of care. Critical to the improved experience of care is the continued partnership working across health and social care and further developing a shared and integrated model of care.

The following diagram adapted from 'The Commissioning Friend for mental health services' indicates a broad direction of travel for the development and commissioning of future dual diagnosis services.

[19] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report*. CSIP North West

Figure 2 Future focus of commissioning and service development



Outcomes

Halton and St Helens are moving toward a more 'outcome focussed' approach toward commissioning and the table below begins to identify key outcomes that will be measured.

The mechanism for monitoring these outcomes will be subject to a key action plan to implement the strategy. This will entail the setting of these outcomes as core markers within the new contracts and agreeing the core KPI that show progress on these outcomes.

HIGH LEVEL OUTCOME
Improved patient outcomes
Increased independent living
Recovery and socially inclusive focus
Improved vocational and social outcomes
Decreased hospital admissions and readmissions
Increased patient choice
Increased positive risk taking
Local, agreed, targets met
Best value
Training of staff in assessing use of alcohol and drugs and how to handle patients who are drunk or under the influence of drugs

NATIONAL CONTEXT

Accurate diagnosis and selecting the appropriate treatments for dual diagnosis can be difficult as symptoms can overlap. It is therefore essential not to make early assumptions.

Weaver et al (2002): Substance misuse is often not picked up by mental health teams, similarly substance misuse teams often failed to spot mental health problems, thus highlighting a need for more staff training and routine assessment

Prevalence

Rethink's Briefing (2006) highlights the psychiatric problems commonly associated with dual diagnosis as Depressive disorder, Anxiety disorder, other psychiatric disorders such as schizophrenia and personality disorder

Substance misuse among those with mental health problems is common. A study by Weaver et al (2002) reported that 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems. 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels within the past year.

In terms of co-morbidity, alcohol is the most commonly misuse substance. S. Banejee et al. *Co-existing Problems of Ment Disorder and substance Misuse (Dual Diagnosis)* Colleg research Unit, 2002 found that people diagnosed with mental health problem have a significantly greater risk of substance misuse, those with schizophrenia are more likely to misuse alcohol

The Weaver study (2002) came up with the following prevalence estimates

	Prevalence estimates	
	% Drug treatment pop.	% Alcohol treatment pop.
Psychotic disorder	7.9	19.4
Personality disorder	37	53.2
Depression and/or anxiety disorder	67.6	80.6

Severe depression	26.9	46.8
Mild depression	40.3	33.9
Severe anxiety	19	32.3

The *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice* (2002) found prisons have a high prevalence of drug dependency and dual diagnosis.

D'Silva & Ferriter. *Substance use by the mentally disordered committing serious offences –a high-security hospital study*. The Journal of Forensic Psychiatry & Psychology Vol 14 No 1 April 2003 178–193 reports that in high secure hospitals, between 60 and 80% of patients have a history of substance use prior to admission.

Impact on Individuals

Both substance misuse and untreated mental illness are linked to higher levels of suicide. Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide.

National Audit of Violence 2003-2005, Healthcare Commission and Royal College of Psychiatrists, identified alcohol and drug misuse as the main trigger for violence in mental health services

Treatment

Historically substance misuse and mental health problems were dealt with separately, clients with both problems were usually treated by one service provider or the other, meaning that some areas of their problems went undiagnosed or not dealt with effectively. The Weaver study (2002) reported that 38.5% of drug users with psychiatric disorder were not receiving any treatment for their mental health problem.

The *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice* (2002) introduced the 'mainstreaming'. The term was used to recommend that the care co-ordination for people with severe and enduring mental illness and substance misuse should be the responsibility of a mental health team. The idea was that patients should not be moved between different services where there could be a risk of the whole problem not being treated. It recommended more collaboration between mental health teams an substance misuse teams.

Hindrances to overcome

Homelessness is frequently associated with substance misus problems, *Mental Health Policy Implementation Guide: Dua Diagnosis Good Practice, 2002*. Homelessness almost trebles a young person's chance of developing a mental health problem. Assertive outreach to these groups and in-reach to hostels are necessary.

The Weaver study (2002) highlighted the typical characteristics of co-morbid patients and the subsequent impact this has on treatment adherence. The study found that co-morbid patients were perceived as more chaotic and aggressive, making them less compliant with care plans.

The Mental Health Policy Implementation Guidance, Dual Diagnosis Good Practice Guide[20]

This guide summarises current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse. The substances concerned include legal and illegal drugs, alcohol and solvents, but not tobacco. It represents an addition to the Mental Health Policy Implementation Guide which supports implementation of the NSF for Mental Health.

Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems, deserve high quality, patient focused, and integrated care. **This, should be delivered within mental health services.** This policy is referred to as "mainstreaming." Patients, should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services, which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis, are dealt with effectively by mental health and substance misuse services, these services as a whole will fail to work effectively.

Dual diagnosis in mental health inpatient and day hospital settings[21]

This guidance covers the assessment and clinical management of patients with mental illness being cared for in psychiatric inpatient or day care settings who also use or misuse alcohol and/or illicit or other drugs*. It also covers organisational and management issues to help mental health services manage these patients effectively.

The key message is that the assessment and management of drug and alcohol use are core competences required by clinical staff in mental health services.

The guidance aims to:

- encourage integration of drug and alcohol expertise and related training into mental health service provision:
- provide ideas and guidance to front-line staff an manages to help them provide the most effectiv therapeutic environments
- help mental health services plan action on du diagnosis†.

The management of dual diagnosis is a significant concern for both mental health policy and practice.

This was highlighted by the National Director for Mental Health, Professor Louis Appleby, in his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health‡:

[20] DH. (2002)*The Mental Health Policy Implementation Guidance, Dual Diagnosis Good Practice Guide*

[21] DH. (2006) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*

Services for people with 'dual diagnosis' – mental illness and substance misuse –are the most challenging clinical problem that we face.[22]

Closing the Gap (DH, 2006)

Closing the Gap: A Capability Framework for Working Effectively with People with a Combined Mental Health and Substance Use Problems draws on existing national occupational standards in mental health,
substance misuse and other fields to bring together one set of competencies for working with people with a dual diagnosis. There are three levels: core, generalist and specialist.[23]

[22] DH. (2006) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*
[23] Hughes, L. (2006) *Closing the Gap*. DH

BEST PRACTICE REVIEW

Informed by the above research and guidance, this section captures the best practice issues or interventions for mental health, alcohol and substance misuse. The following tables cover the Tiers of intervention, typical service user, point of access, recommended interventions, who delivers the intervention, the outcome for the service user and finally the effectiveness of the intervention.

A diagram demonstrating a good practice pathway for dual diagnosis is also presented. This diagram will supplement the 'model of care' and 'care pathway' as described in the relevant sections of this strategy.

Alcohol

Figure 3 Best Practice Review Alcohol – The Four Tiers of Intervention

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
Tier 1: Alcohol-related information and advice, screening, simple brief interventions and referral	Hazardous, harmful and dependent drinkers	Includes: Primary healthcare services A&E Social services Homelessness services General hospital wards Police settings Prison service	Includes: Alcohol advice and information Targeted screening and assessment for those exceeding government alcohol limits Simple brief interventions for hazardous and harmful drinkers Referral for those requiring specialised alcohol treatment Partnership with specialised alcohol treatment services	A wide range of agencies, the main focus of which is not alcohol treatment. GPs, nurses or trained non-medical practitioners	Reduction of alcohol consumption (abstinence or moderation goal)	Brief interventions ar effective in reducin alcohol consumptic among hazardous an harmful drinkers at lov risk levels Effects of brief interventions last for up to 2 years after intervention and perhaps as long as 4 years There is no evidence that opportunistic brief interventions are effective among people with more severe alcohol problems and

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
		Education services				levels of dependence *Review of the Effectiveness of Treatment for Alcohol Problems* (2006)
Tier 2: Open access, non-care planned, alcohol-specific interventions	Harmful and dependent drinkers	Includes: Specialist alcohol services Primary healthcare services Acute hospitals Psychiatric services Social services Domestic abuse agencies	Includes: Alcohol-specific information, advice and support Extended brief interventions and brief treatment to reduce alcohol –related harm Alcohol-specific assessment and referral of those requiring more structured alcohol treatment Partnership with staff from Tier 3 and 4 provision or	Competent alcohol workers	Improvement in health and reduction of alcohol consumption (abstinence or moderation goal)	There is mixed evidence on whether extended brief interventions in healthcare settings add anything to the effects of simple brief interventions There is some evidence that extended brief intervention is effective among male hazardous or harmful drinkers in the contemplation stage of change *Review of the Effectiveness of*

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
		Homelessness services Probation services Prison services Occupational health services	joint care of individuals attending other services providing Tier 1 interventions Triage assessment			*Treatment for Alcohol Problems* (2006)
Tier 3: Community-based, structured, care-planned alcohol treatment	Dependent drinkers	Includes: Specialist alcohol treatment services (in the community or within a hospital site) Outreach services Primary healthcare services	Includes: Comprehensive substance misuse assessment Care planning and review for all those in structured treatment Community care assessment and case management of alcohol misusers Evidence-based prescribing interventions in the context of a package of care, including community-based medically assisted detoxification Evidence-based psychosocial therapies	Competent drug and alcohol specialist practitioners	Reduction of alcohol dependence Improvement in alcohol related social problems	The community reinforcement approach is an effective treatment modality, particularly relevant to service users with severe alcohol dependence. I is particularly effective with socially unstable and isolated service users with a poor prognosis for traditional forms of treatment Social behaviour and network therapy is an effective treatment for alcohol problems Behavioural self-control training is the most effective treatment available for service users considered

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
			within a care plan to address alcohol misuse and co-existing conditions such as depression where appropriate Structured day programmes and care-planned day care Liaison services with other services			suitable for a moderation goal Coping and skills training is an effective treatment among moderately dependent drinkers *Review of the Effectiveness of Treatment for Alcohol Problems* (2006)
Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation	Severely dependent drinkers	Includes: Specialist statutory, independent or voluntary sector inpatient facilities For medically assisted detoxification Residential rehabilitation units for alcohol misuse	Includes: Comprehensive substance misuse assessment Care planning and review for all inpatients residential structured treatment Evidence-based prescribing interventions in the context of a package of care, including medically assisted detoxification in inpatient or residential care Psychosocial therapies to address alcohol misuse Provision of information,	Alcohol specialist in specialist setting	Reduction of alcohol dependence Improvement in alcohol related health problems	

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
			advice and training to others delivering Tier 1, 2 and 3 services			

Substance Misuse

Figure 4 Best Practice Review Substance Misuse: The Four Tiers of Intervention

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment	Wide range of clients including drug and alcohol misusers	Includes: General healthcare settings Social care Education settings Criminal justice settings Drug treatment is not the main focus for any of the above	Includes: Drug and alcohol screening, assessment and referral mechanisms to drug treatment services from generic, health, social care, housing and criminal justice services Management of drug misusers in generic health, social care and criminal justice settings (e.g. police custody) Health promotion advice and information Hepatitis B vaccination programmes for drug misusers and their families	Wide range of professionals including: Medical services Social workers Teachers Community pharmacists Probation officers Homeless person units All need to be sufficiently trained to deal with drug misusers
Tier 2: Open access drug and alcohol treatment services	Wide range of drug and alcohol misusers referred from a variety of	Includes: Primary care settings Outreach Pharmacy settings	Includes: Drug-related information and advice Triage assessment and referral for structured drug treatment Interventions to reduce harm and risk	Competent drug and alcohol specialist workers

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
	sources including self-referral	Criminal justice settings Tier 2 interventions may be delivered separately from Tier 3 but will often be delivered in the same setting and by the same staff as Tier 3 interventions	due of infections for active drug users eg needle exchanges Brief psychosocial interventions for drug and alcohol misuse Brief interventions for specific target groups including high-risk and other priority groups Drug-related support for clients seeking abstinence Drug-related support for clients who have left care-planned structured treatment Outreach services engaging clients into treatment	
Tier 3: Structured community-based drug treatment services	Drug and alcohol misusers in structured programme of care	Includes: Specialist drug services within their own premises, the community or hospital Outreach Primary care settings Pharmacies Prison settings	Includes: Comprehensive drug misuse assessment Care planning, co-ordination and review for all in structured treatment Community care assessment and case management for drug misusers Harm reduction	Competent drug and alcohol specialist workers

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
			Prescribing interventions Psychosocial interventions Liaison services for acute medical and psychiatric health services and for social care services	
Tier 4: Residential services for drug and alcohol misusers	Drug and alcohol misusers with a high level of presenting need	Includes: Dedicated inpatient or residential substance misuse units or wards Those with co-existing medical needs may be being services in the setting of those medical needs Prison detoxification units	Includes: Inpatient specialist drug and alcohol assessment, stabilisation and detoxification/assisted withdrawal services Inpatient detoxification/assisted withdrawal provision directly attached to residential rehabilitation units	Medical staff with specialised substance misuse competency

Mental Health

The NSF Mental Health 1999 set the scene for major investment in mental health services and there are now many Policy Implementation Guides for mental Health. The 'stepped care model' is referred to in, NICE Guidance on Treatment of Depression and in the Improving Access to Psychological Therapies programme. This stepped care model can be utilised across mental health care systems and provides a cross reference point for alcohol and substance misuse interventions.

Figure 5 Best Practice Review Mental Health: Stepped care model

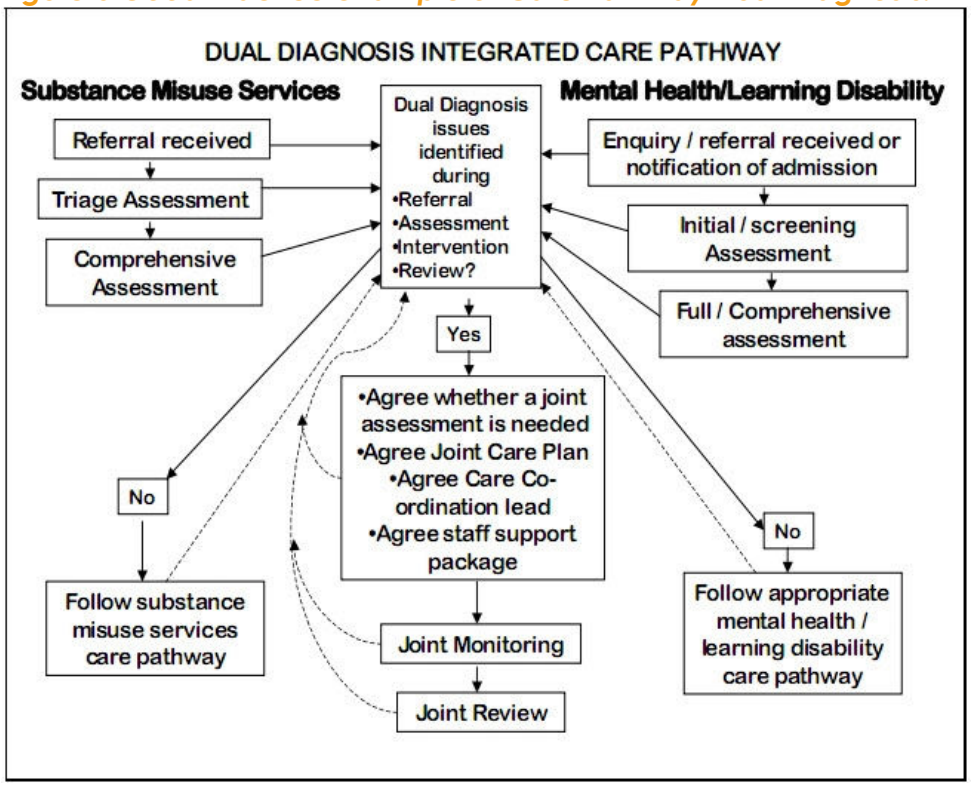
Step	Point of Access	Level of Mental Health Problem	Involves/Intervention	Carried out by
Step 1	Primary care and general hospital setting	Recognition (either the patient refuses treatment or the health professional thinks they will recover without treatment)	Watchful waiting	GP Practice nurse
Step2	Primary care setting	Mild	Guided self-help Computerised CBT Brief psychological interventions	Primary care team Primary care mental healt worker
Step 3	Primary care setting	Moderate to severe	Medication Brief psychological intervention Social support	Primary care team Primary care mental health worker
Step 4	Specialist mental health setting	Treatment-resistant Recurrent Atypical and psychotic depression Those at significant risk	Medication Complex psychological interventions Combined treatments	Mental health specialists including crisis teams

Step 5	Specialist mental health setting	Risk to life Severe self-neglect	Medication Combined treatments ECT	Inpatient care teams Crisis teams

Dual Diagnosis

As the care and treatment of a Dual Diagnosis, or co morbidity of substance misuse (including alcohol) and mental health problems is the combination of best practice from the relevant services the figure 6 below is suggested as a mechanism for ensuring that the 'shared care' 'Integrated approach is achieved. Discussion of this model of care can be found at 'Model of Care' section. Although this diagram references only substance misuse for Halton and St Helens' purposes this should be read to include alcohol too.

Figure 6 Good Practice example of Care Pathway Dual Diagnosis.



(Source Dual Diagnosis A multi – agency strategy for County Durham and Darlington -2005)

This pathway would ensure that any service user who had been referred directly to any service would not 'fall through the net'.

For the avoidance of doubt, the principles of integrated care as drawn in figure 6 can be applied both in primary and secondary care and include alcohol and substances. With the development of the single point of access where, comprehensive multi-disciplinary assessments occur, the expectation would be that the majority of service users requiring a coordinated approach to their care are identifie much earlier in the care system.

Within the Halton and St. Helens Dual Diagnosis Model, ment health services either primary care or secondary care woul take a lead in ensuring that the service user had both the substance and mental health care needs met.

WHERE ARE WE NOW?

LOCAL CONTEXT

This section describes the local commissioning, and provider arrangements
outlines the demographics of the Halton and St Helens footprint.

Overview

At the time of writing this strategy, a number of initiatives were taking place in parallel. Notably the development of a 'single point of access' into mental health services and the development of an Alcohol Strategy. The Mental Health Strategy itself is now due for a review.

Commissioning

Halton and St. Helens Primary Care Trust has recently evolved from the merger of Halton Primary Care Trust and St Helens Primary Care Trust. It currently operates in a complex commissioning context: there are two Local Authorities (Halton Borough Council and St Helens Council), there are two Drug and Alcohol Action Teams (DAAT) and two Local Implementation Teams (LITs mental health). Currently these organisations are responsible for the commissioning of Mental Health, Alcohol, and Substance Misuse Service Services.

Dual Diagnosis provision is a combination of these services led by mental health.

Providers of Service

A range of agencies currently provide dual diagnosis services, across the two localities. Service provision would appear to be variable across the two localities with different service availability, range, and choice.

From the information obtained, from the self -report questionnaires, and subsequent interviews with staff. Greater clarity is required regarding the outcomes services are commissioned to deliver.

A distinction between the tiers of service, service delivery, an outcomes would assist providers and commissioners manag the gaps in service provision.

Insufficient data regarding Halton services required a 'be.. guess' approach to determining the current care pathway.

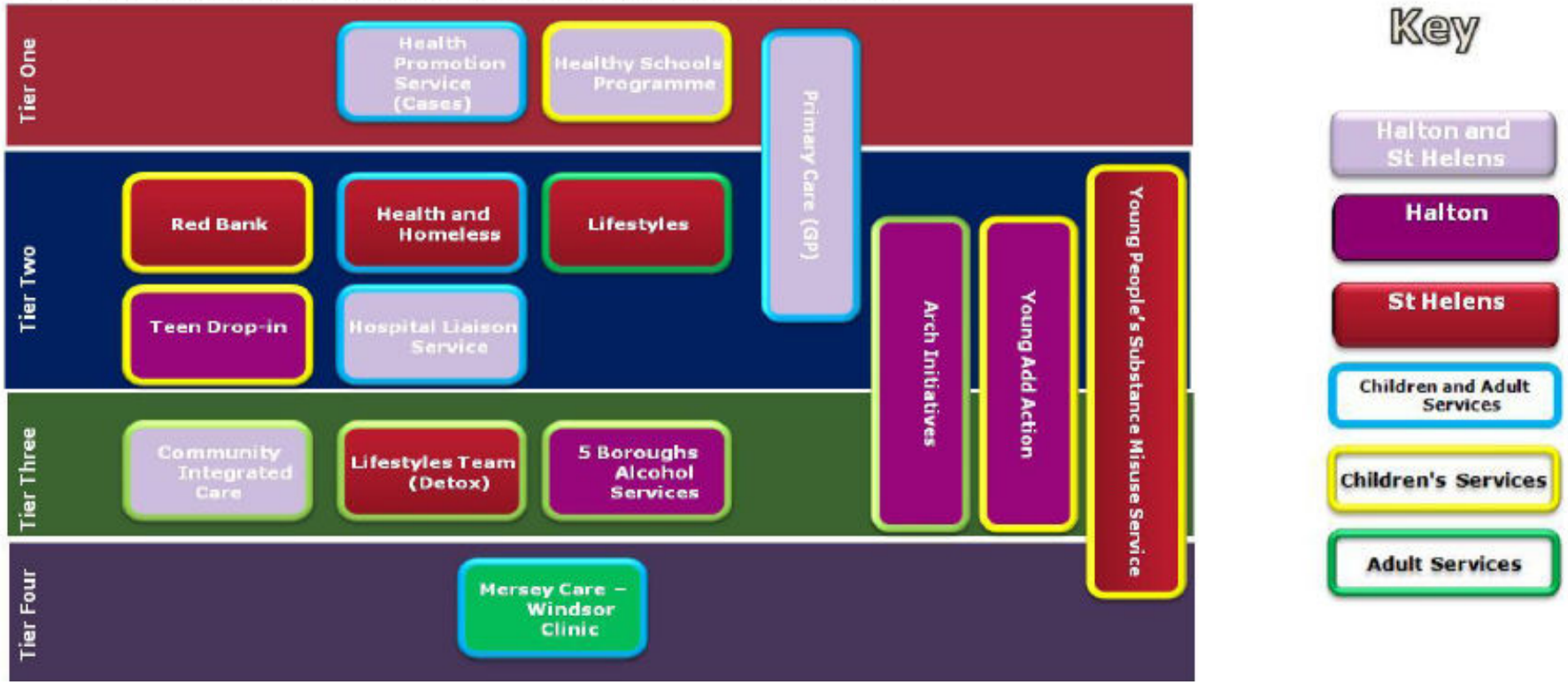
An existing pathway is present in Halton but requires a review in light of this document.

Residential Care recovery is available via the respective Local Authority Community Care Funding Panels.

A more detailed view of alcohol services is provided in the Alcohol Strategy and is reproduced here for convenience.

Figure 7 Alcohol Services by locality

- Tier 1 interventions: Alcohol related information and advice; screening; simple brief interventions (up to 4 interventions) and referral
- Tier 2 interventions: Open access, non care planned alcohol specific interventions and extended brief interventions
- Tier 3 interventions: Community based, structured, care planned alcohol treatment
- Tier 4 interventions: Alcohol specialist in-patient and residential detox



(Source Halton And St. Helens Alcohol Strategy 2008 p17)

The above diagram demonstrates that Halton services include Arch and Young Add Action across Tiers 2 and 3, an Alcohol service provided by the mental health trust for Tier 3 and Teen Drop In providing a Tier 2 service. This compares to St Helens that have a Young Peoples Substance Misuse service provided across Tiers 2, 3 and 4. Lifestyles provide a service to Tiers 2 and 3. Red Bank provide a service to Tier 2. Services shared across Halton and St Helens include; Primary Care, (Tier 1&2. Health Promotion (Tier 1) and Community Integrated Care (Tier 3). This does not indicate the capacity of these services within each of the localities.

DEMOGRAPHICS

In this section brief details of population and deprivation are given. This is followed by an examination of prevalence issues. A more detailed account of Halton and St. Helens demographics may be found in the respective Joint Strategic Needs Assessments.

Population

The total population is 297k composed of 119.5k in Halton and 177.5k in St Helens

The population of Halton is projected to increase by 6% to 126,500 by 2021. An increase of 43% of the 65 plus age group is estimated to grow from 16,400 in 2006 to 23,500 in 2021.

The Population of St Helens is currently 177,500 and is projected to increase by 1% up to 2015. St Helens mirrors the national trend. Like Halton will see an increase in the 65 plus population. By 2015 1:5 people will be over 65 years old.

The ONS mid year estimates for 2007 however, show that there is a significant difference in the 15-64 year populations. St Helens estimated as 116.9k and Halton as 80.2k[24]

Deprivation

Deprivation is linked to an increase in the prevalence of some mental health problems[25] The Index of Multiple Deprivation 2007 (IMD 2007) measures deprivation in small areas (known as super output areas), and consists of seven "domains" relating to income, employment, health and disability, education and training, housing and services, the living environment, and crime.

Twenty three percent of the LSOAs in St. Helens are in the to 10% most deprived areas in England and 27% for Halto However, some areas are ranked as much less deprived. Fo both Halton and St. Helens 8% of their LSOAs are in the top 25 least deprived areas. The respective Joint Strategic Need Assessments and Local Authority data will give information that is more detailed.

Prevalence Estimates

[24] ONS Table 9 Mid-2007 Population Estimates: Quinary age groups and sex for local authorities in the United Kingdom.

[25] Amongst many studies, Meltzer H, Gill B, Pettigrew M and Hinds K (1996) **"The prevalence of psychiatric morbidity among adults living in private households: OPCS surveys of psychiatric morbidity in Great Britain"** Report 1 HMSO London: HMSO

According to the ONS, 1 in 6 of adults experience some sort of neurotic disorder, the most prevalent type being mixed anxiety and depression. This is described as a "catch all" category which includes people with significant neurotic psychopathology who could not be coded into any of the other five neurotic disorders. Estimates of life time prevalence range from 1 in 6 to 1 in 4.

At the time of writing, an audit of primary care services was under way in the locality. This audit is to establish the actual number of people within GP practices who would have a substance or alcohol problem co existing with an emotional or psychological difficulty.

Halton and St. Helens Prevalence Summary

1. **Alcohol dependence + any neurotic disorder in general population**

We predict that there are 590 people with moderate/severe alcohol dependence and one or more neurotic disorders. The neurotic disorders are listed below:

- Mixed anxiety and depressive disorder
- Generalised anxiety disorder
- Depressive episode
- All Phobias
- Obsessive compulsive disorder
- Panic disorder

2. **Any drug dependence + any neurotic disorder in general population**

In total it is estimated that 3096 people in Halton and St. Helens have one or more neurotic disorder/s and any drug dependence.

To arrive at the this figures in 1 and 2 above we used data from the psychiatric morbidity survey, Tobacco, alcohol and drugs use and mental health report (2000) and the ONS population estimates for Halton and St. Helen's.

To the informed reader these figures may appear the wrong way around.
For the avoidance of doubt however, 590 cases (an individual may have more than one disorder –see previous paragraph) will experience a moderate to severe **alcohol dependence. Whereas 3096 cases will experience a drug dependence.** I **this context, drug dependence refers to 'any drug'.**

These figures were calculated as follows:
4% of men with any neurotic disorder had moderate/severe alcohol dependence and 0% for women (see http://www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf page 66). Halton and St Helen's male neurotic disorder population is 14,756. And so 4% of 14756 is **590**.

There is estimated to be 12% of males with any neurotic disorder who have ***any*** drug dependence (inc. cannabis, amphetamines, crack, cocaine, ecstasy, tranquillisers and opiates) and 6% for females (see page 70 of Tobacco report).

Applied to Halton and St Helen's male neurotic population this equals 0.12 x 14,756=**1771** and for female neurotics 0.06*22,097=**1326.** So the total for males and females equals **3096** as documented.

3. Substance misuse + mental health disorder in substance abuse population

The prevalence rates of mental health disorder in drug and alcohol services from the COSMIC study (Weaver et al. 2003) and the number of referrals (116 in 6 months) in Halton and St. Helens were used to estimate the number of co-morbid cases.

Estimated Number of Mental Health Cases in Halton and St. Helens PCT's SMS Service April 08 to October 08 (6 month period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

Note: one person can be present in multiple disorder categories above.

4. Dual diagnosis in Adult CMHT and Inpatient services population

Assuming there is a similar level of referrals over time, the Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

The total number of referrals used to arrive at these figures was sourced from Halton and St. Helen's own activity data. The prevalence rates are taken from DH policy guidance.

Current Demand

The information available to date includes:

The numbers recorded in treatment for St. Helens 01/07/2007 to 30/06/2008 is 1025

The numbers recorded in treatment for Halton 01/07/2007 to 30/06/2008 is 709

Those in Alcohol treatment in Halton and St. Helen at November 2008 are No in treatment – 588
New Presentation – 41
No in Treatment YTD – 989

This equates to 2723 people who are or, have been treated for a substance abuse problem in the last year.

Commissioner feedback included the fact that 96 people were in treatment (Drugs Service) 20 of whom were in contact with mental health service the remaining 76 were considered to have anxiety and depressive problems but 73 were not in contact with any mental health service

Mental Health data informs us that

1. Halton and St Helens GPs have registered 2324 people with a severe and enduring mental health problem (Primary Care Trust Data)

From Tony Ryans & Associates: Case Load Audit of 5 Boroughs Partnership NHS Trust (5BP) report July 2007

2. Halton >65 population 606 people receiving a service from 5BP
3. Halton 16-64 population 1314 people receiving a service from 5BP

Total Halton 1920 people

4. St Helens >65 popn 1422 people receiving a service from 5BP
5. St Helens 16-64 popn people receiving a service from 5BP
6. Total St Helens 3367 people

Open cases to 5BP as at 20/01/09 5BP data
Halton = 4504
St Helens = 4700
Total 9204 people

This data would benefit from further analysis to begin t determine trends and a 'mostly likely' figure of actua incidence of Dual Diagnosis.

There would be some merit in determining prevalence or expected demand range against actual activity. This would highlight the success of the care pathway in identification, assessment, and treatment of those with co morbidity.

Performance

This section will consider the relationship between this strategy and substance misuse targets. The section will compare the performance of Halton and St Helens in relation to 'statistical near neighbours'.

The tables below show the relevant statistical neighbours as per CIPFA Model further information regarding this model can be found at: www.cipfastats.net

Figure 8 Statistical Neighbours of Halton UA

Position	Neighbour Authorities	Statistical Distance	Corresponding PCT
1	Stockton-on-Tees	0.05	North Tees Primary Care Trust
2	Middlesbrough	0.08	Middlesbrough Primary Care Trust
3	Telford & Wrekin	0.08	Telford and Wrekin Primary Care Trust
4	Hartlepool	0.10	Hartlepool Primary Care Trust
5	Darlington	0.11	Darlington Primary Care Trust

Figure 9 Statistical Neighbours of St. Helens LA

Position	Neighbour Authorities	Statistical Distance	Corresponding PCT
1	Rotherham	0.04	Rotherham Primary Care Trust
2	Wakefield	0.06	Wakefield District Primary Care Trust
3	Barnsley	0.07	Barnsley Primary Care Trust
4	Wigan	0.08	Ashton, Leigh and Wigan Primary Care Trust
5	Doncaster	0.09	Doncaster Primary Care Trust

Source: CIPFA Nearest Neighbours Model http://www.cipfastats.net/

The data in the tables below are derived from the HCC annual health check 2007/8. The HCC get the data from the National Treatment Agency.

Figure 10 An assessment of the 12 week retention rate for Financial Year 2007/2008 in comparison with the 12 week retention rate for Financial Year2006/2007

PCT	%
Ashton, Leigh and Wigan Primary Care Trust	92.2
Doncaster Primary Care Trust	101.0
Telford and Wrekin Primary Care Trust	103.8
Halton and St Helens Primary Care Trust	**105.0**
Middlesbrough Primary Care Trust	106.3
Wakefield District Primary Care Trust	107.1
Hartlepool Primary Care Trust	109.3
North Tees Teaching Primary Care Trust	111.0
Rotherham Primary Care Trust	113.9
Barnsley Primary Care Trust	115.9
Darlington Primary Care Trust	119.2
Comparator Average	108.0
England Average	104.4

Source: HCC http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9590

The above table compares the 12 week retention rate of service users in the years 2006 / 07 to 2007 / 08

Measuring the percentage of drug misusers who were retained in treatment for 12 weeks or more, focuses on the effectiveness of the local treatment system in engaging drug users and minimising early drop out.

Evidence suggests that drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more, resulting in reduced drug use, reduced morbidity and mortality associated with misuse, reduced crime and improved health and social functioning. Benefits include substantial

financial savings in both the criminal justice system through reduced offending and in the NHS through reduction in blood-borne diseases amongst drug misusers.[26]

This table tells us that Halton and St. Helens perform less well than their statistical neighbours (ranked 8 out of 11) but better than the England average. It also shows us that Halton and St Helens are keeping more drug users in sustained treatment (12 weeks+) than they were the previous year in 2006/7 (but all of the neighbours did better than the previous year except for Ashton PCT.)

Figure 11 The actual number of drug misusers accessing treatment divided by the planned number of drug misusers accessing treatment

PCT	%
Rotherham Primary Care Trust	107.6
Middlesbrough Primary Care Trust	125.0
Halton and St Helens Primary Care Trust	**131.7**
North Tees Teaching Primary Care Trust	132.4
Ashton, Leigh and Wigan Primary Care Trust	132.4
Wakefield District Primary Care Trust	134.4
Doncaster Primary Care Trust	134.6
Telford and Wrekin Primary Care Trust	141.1
Darlington Primary Care Trust	146.3
Barnsley Primary Care Trust	148.1
Hartlepool Primary Care Trust	165.7
Comparator Average	136.8
England Average	125.8

Source: HCC http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9590

The above table shows that all of Halton and St Helen statistical neighbours outperformed their local PCT plan fo how many drug misusers they would have in treatment. Halto and St . Helens outperformed less than the comparato average but more than the England average.[27]

[26]http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisuserssustainedintreatment.cfm

[27]http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisusersintreatment.cfm

STAKEHOLDER FEEDBACK

In this section stakeholder, views are recorded. Stakeholders in the Dual Diagnosis strategy cover a wide range of organisations and individuals. This includes; alcohol and drug misuse services alongside mental health services. These services are statutory and non – statutory in origin.

The key themes included the following.

Defining Dual Diagnosis: Most people when considering dual diagnosis as a topic immediately refer to the relative low prevalence, high cost, high risk, high complexity, highly dependent poly drug users with psychosis requiring multi-agency interventions. However, almost without exception, most went on to say...

Alcohol is greater concern than substance misuse: In terms of volume and impact upon the whole community alcohol was perceived to be a far greater issue. Alcohol impacted upon all age bands, economic classes, it has significant impact upon the criminal justice, public health and treatment agendas.

Shared Care: there were issues about the roles, responsibilities between statutory and 3rd Sector agencies. Services providers often work in silos: sometimes by choice, on other occasions out of necessity due to exclusion criteria (e.g., some mental health services refusing to work with individuals who were still drinking). All stakeholders acknowledged the need to 'share' the care for individuals both in the formal sense and in a more informal mutually supportive manner. In some areas clear protocol existed with clear structures of accountability in others this was not the case. In all cases appropriately qualified individuals needed to be engaged to ensure appropriate governance

Clarity in Commissioning intentions: the flip side of the shared care approach was the articulation that each service should have a clearly defined role and purpose and that these should be explicitly agreed in advance with commissioners. Currently due to a desire to collaborate (i.e., share the care) some services are providing support that they were never commissioned to do, or conversely they are not providing services due to the explicit documentation in their service level agreements or contracts. In both instances the gap in service provision is masked: where there is a gap in service provision should be provided for by appropriately funded an commissioned services. Commissioners contended in respons that there was not a lack of clarity regarding their intentior and expectations, rather there was on occasions a lack c providers 'hearing' what was being articulated.

Efficient and effective commissioning: in support of the above point stakeholders expressed a view that DAAT commissioning and Mental Health commissioning could be brought together or ***aligned***. This would maximise resources, attain best value, and address eligibility criteria. Performance management could also be unified across the commissioning process with providers being clear what key performance indicators were being measured. (see also alcohol strategy where this is also an issue)

Single point of Access: awareness of the emerging single point of access for mental health services is variable across the localities and consequently different practices of referral and routes into services persist. This results in too great a variation in who gets (or doesn't get) accepted into services, and for a perception that many people remain in the service of first contact regardless of whether that was the most appropriate one.

Crisis Access: A frequent comment from those who work in primary care services was that there is a need for an alcohol and substance misuse crisis service. Too often other agencies criteria for access will not intervene at the point of greatest need, resulting in an escalation of issues and risks.

Pathway gaps: For those who do access services there are not sufficiently robust care pathways for service users to navigate. Service offerings and therefore their outcomes vary significantly between services. The greatest articulated gap appears to be that between primary and secondary care services (between tiers two and three).

Pathway blocks: Even where there are defined pathways to access services there is too often a wait between referral and intervention. This is most notable in brief interventions in primary care that 'open up' deeper issues for individuals but then they have to wait up to 4 months to have their needs addressed in a distressed state. Similarly, there are still reported waiting issues in accessing detoxification and rehabilitation support resulting in a further deterioration in individuals, including on occasions fatalities. Tier 4 services are reported hard to access both in psychiatric and general hospital services.

Variation in provision and providers in each locality: Dual Diagnosis practitioners operate within St Helens CMHTs and recent appointments have been made to Halton CMHTs.. Stakeholders also debated the role and function of this role it was felt that this role should be more of a consultative function and a support to other workers and agencies, rather than 'hold a case load'. This was perceived to be a misuse of their expertise as they would soon become ineffective due to under capacity. In other words they would spend all their time working with single individuals they would not be able to tackle the wider partnership and interface issues needed to deliver seamless care.

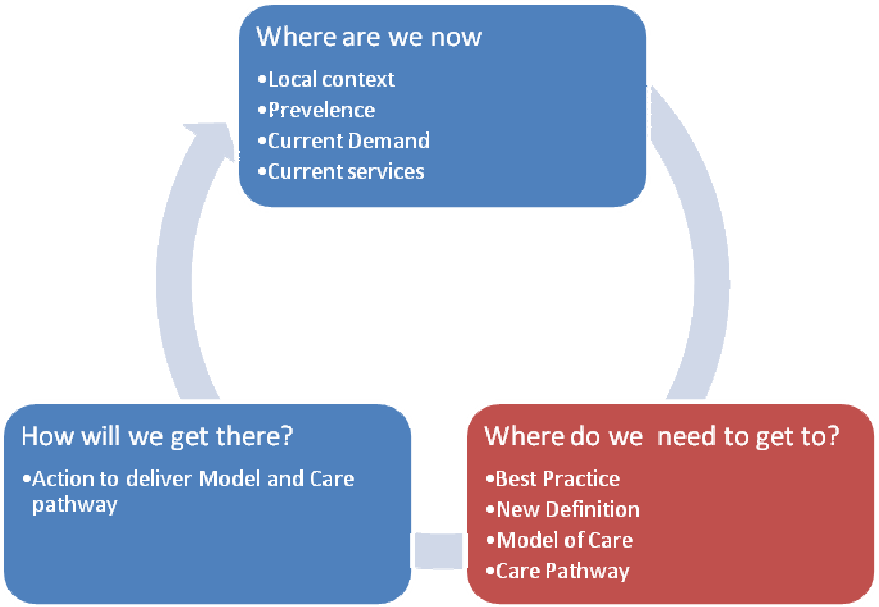
The Arch service operates in Halton and is based at Ashle House. Young Addaction and the 5 Bouroughs Partnershi Alcohol services also operate in Halton. The Lighthouse projec services St Helen's. CIC provide different services to th different localities. There was an articulation that a singl consistent pathway(s) should be developed in both areas even if the agencies that provide it are different.

Specialist verses generic?; Despite specialist dual diagnosis practitioners being funded, there was a strongly held view that give +75% of service users in secondary mental healthcare had some form of alcohol or substance misuse issue, then shouldn't all staff have addiction training as a core skill?

Need for more training: Whether, generic or specialist there was a clearly articulated view that greater addiction training was required for all staff grades tailored to the tier of care in which they operate.

Governance: The complexity of the client group's needs, the range of agencies concerned and the demographic and geographic issues there is a perception of a lack of leadership at a strategic level. The process of developing this strategy has been welcomed but stakeholders have expressed the view that clearer roles and responsibilities need to be established between the DAAT, the LIT, public health and the criminal justice system. More 'joined up' commissioning for all age groups is required and the consensus appears to be for this to be led by the PCT.

WHERE WE NEED TO GET TO!



MODEL OF CARE & CARE PATHWAY

In this section, a model of care is defined. This has been influenced strongly by the views of stakeholders and all the previous sections.

Key Features of Model

As stated above in the Stakeholder feedback emphasis on Integrated and shared care was a key theme

Shared Care

> Shared care is the joint participation of specialists and GPs [and other agencies as appropriate] in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange beyond routine discharge and referral letters. It may involve the day-to-day management by the GP of the patient's medical needs in relation to his or her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the patient's treatment and care. These may include prescribing substitute drugs in appropriate circumstances".[28]

> Medical practitioners should not prescribe in isolation but should seek to liaise with other professionals who will be able to help with factors contributing to an individual's drug misuse. A multidisciplinary approach to treatment is therefore essential."[29]

Integrated Care

Integrated care is an approach that aims to **combine** and **co-ordinate** all the services required to meet the assessed needs of the individual.
It requires:

- treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug and alcohol users;
- the service response to be needs-led and not limited b organisational or administrative practices; and
- collaborative working between agencies and servic providers at each stage in the progress of the individual i treatment, from initial assessment onwards

People who have drug or alcohol misuse problems will, in many cases, have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behaviour and debt. This means that a wide range of interventions and a range of organisations will need to be involved to assist any individual with substance misuse problems.

[28] Dept of Health 1995 and *Drug Misuse and Dependence: Guidelines on Clinical management*. Department of Health 1999)

[29] Drug Misuse and Dependence – Guidelines on Clinical Management 1999

An integrated care approach founded on co-operation and collaboration between all relevant providers will have a number of benefits for individual service users. It should:

- Promote early assessment and intervention: ensuring that services are accessible and appropriate to the service user's needs.
- Remove barriers to progressing towards recovery: supporting the service user to identify and achieve their own goals whilst acknowledging their own beliefs and culture.
- Provide consistent, co-ordinated and comprehensive care: ensuring that all care providers are working towards a shared aim and minimising unnecessary duplication of activity.
- Ensure a comprehensive and timely response: making sure that all the needs of the service user, physical, psychological and social, are considered and addressed appropriately.

The **overarching aim** of integrated care is to support drug or alcohol users to overcome their drug or alcohol problem and their associated health and social difficulties by providing effective, co-ordinated and timely treatment and care.[30]

As this strategy is also about individuals who experience mental health problems as well as drug or alcohol difficulties it is even more important to ensure that a 'shared care' 'integrated approach' is the foundation upon which we develop services and our approach to service delivery.

The main problem is in determining the referral pathway. When the severity of both mental illness and substance misuse is high, then shared care working between mental health and addiction teams might be the best solution. If the substance misuse and mental health issues are of a moderate nature then the agency first attended may be able to deal with both issues. However, the agency would need to be well supported and staff appropriately trained.

Figure 12 Allocation of care by need

[30] (2008) *Integrated Care for Drug or Alcohol Users: Principles and Practice Update* 2008 Available from http://openscotland.gov.uk/Publications

	Low degree of mental illness	High degree of mental illness
Low level of substance use	Mainstream or addiction service Anxiety spectrum disorders Depressive disorders Moderate severity personality disorders	Mainstream service only Korsakoff's psychosis and dementia Severe personality disorder Obsessive-compulsive disorder
High level of substance use	Addiction service only Withdrawal states including delirium Wernicke's encephalopathy Residual psychoses	Mainstream and addiction services Schizophrenia Bipolar affective disorder Post-traumatic stress disorder

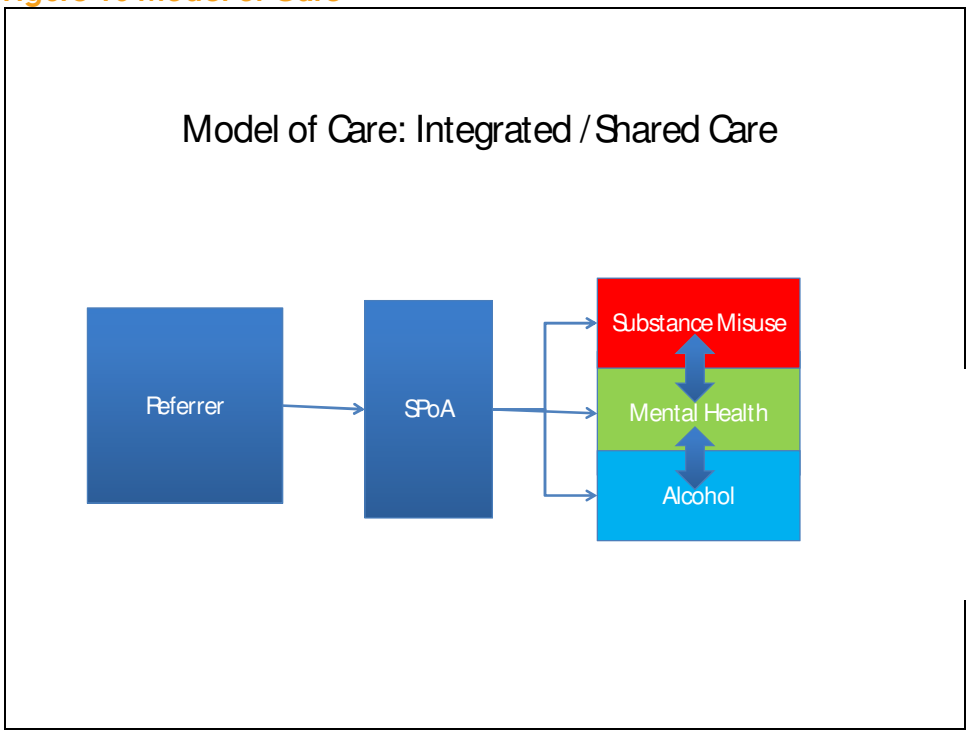
Table 13d: Example of possible allocation of care by diagnostic group

(Adapted from Department of Health (2002))

(source NTA for substance misuse –Review of effectiveness of treatment for alcohol problems Raistrick et al –DH 2006 p158)

The above table depicts a model for allocation of care. People with a low degree of mental illness can be supported by primary care. Whereas a high degree of mental illness must be supported by secondary care services.
This can mean a high number of people with mild /moderate dual diagnosis issue receive their care within primary care services and this is an area that requires further development in order to support primary care practitioners

Figure 13 Model of Care



(adapted from National Treatment Agency for Substance Misuse – Review of the effectiveness of treatment for alcohol problems (DH 2006) Raistrick D et al. Service models p157)

The above figure depicts the proposed model. Here referrers including self- referral are made through a single point of access. At this point a multi-disciplinary assessment is carried out. This will ensure that, the individual is assisted to engage, with all the relevant elements of service. As can be seen in the diagram mental health services overlap with both substance

and alcohol services, so indicating an integrated and shared care approach.

Commissioning integrated care pathways

An integrated care pathway (ICP) describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. A system of care should be dynamic and able to respond to changing individual needs over time. It should also be able to provide access to a range of services and interventions that meet an individual's needs in a comprehensive way. Previous consultation has shown that the majority of respondents found that the ICPs set out in Models of Care 2002 had been useful to them in their work. ICPs should be developed for drug and alcohol misusers for the following reasons:

- Drug and alcohol misusers often have multiple problems that require effective co-ordination of treatment.
- Several specialist and generic service providers may be involved in the care of a drug and alcohol misuser simultaneously or consecutively.
- A drug and alcohol misuser may have continuing and evolving care needs requiring referral to services providing different tiers of intervention over time.
- ICPs ensure consistency and parity of approach nationally (i.e. a drug misuser accessing a particular treatment intervention should receive the same response wherever they access care)
- ICPs ensure that access to care is not based on individual clinical decisions or historical arrangements.

Elements of integrated care pathways

Commissioners should ensure that each drug and alcohol treatment intervention should have an ICP. This should be agreed with and between local providers, and built into service specifications and service level agreements.

Integrated care pathways should contain the following elements:

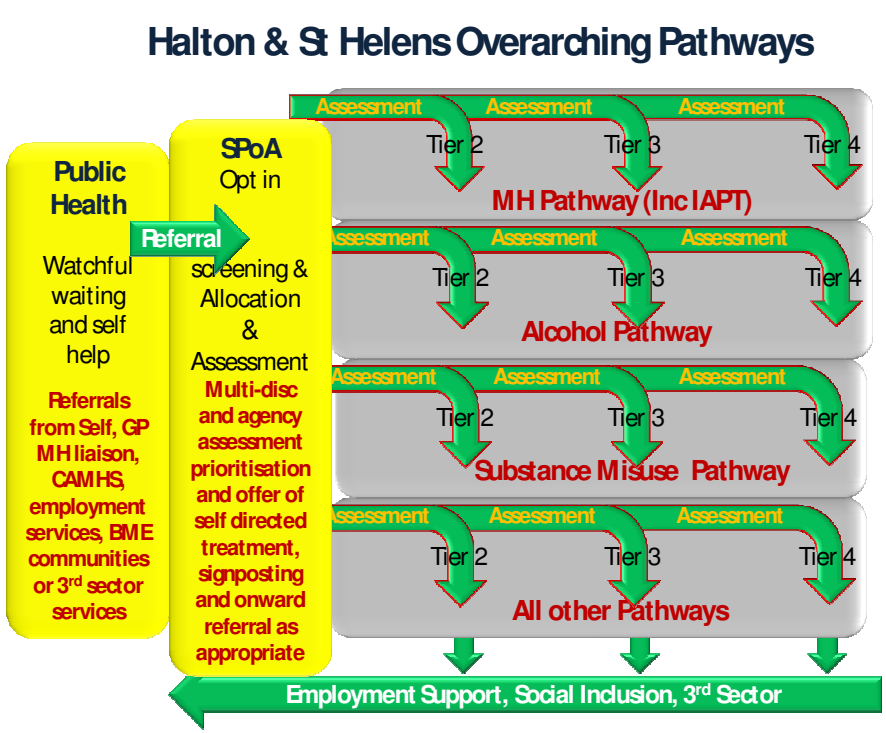
- A definition of the treatment interventions provided
- Aims and objectives of the treatment interventions
- A definition of the client group served
- Eligibility criteria (including priority groups)
- Exclusions criteria or contraindications
- A referral pathway
- Screening and assessment processes
- Development of agreed treatment goals
- A description of the treatment process or phases
- Co-ordination of care
- Departure planning, aftercare and support
- Onward referral pathways
- The range of services with which the interventions interface.[31]

[31] National Treatment Agency for Substance Misuse. (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*

Care Pathway

With the above in mind and taking into account the views of stakeholders, the following is the proposed care pathway

Figure 14 Overarching Care Pathway



The above diagram adds some detail to the 'Model of Care Diagram'. This shows that following a referral and assessment that there are a range of service options in various pathways of care at different levels of need to meet the individuals' needs for care and treatment. The expectation would be that Mental Health Services from either primary care or secondary care services would take a lead depending on the severity of the mental health issue.

NHS Contracting have developed a specific care pathway for alcohol services and this can be found at http://www.pcc.nhs.uk/204.php

The proposed role of Advanced Practitioner in Primary Car would be critical to the success of this model. The Advance Practitioner would carry out a similar role to that of the Du Diagnosis Worker in Secondary Care.

It is envisaged that these roles would provide support and supervision/consultation to staff across both the statutory and non - statutory services. They would take responsibility for ensuring appropriate protocols were in place and that compliance to these was ensured. The remit of the AP would be to ensure that the interface between primary and secondary care was clear and those individuals moving from one area of care to another did so with minimal disruption to their care. A primary role would be co-working with colleagues. It is not envisaged that these role would manage a case - load.

The above diagram now shows the specific care pathway for Dual Diagnosis.

Mental Health Services will lead this and from the Tier 3 point onwards be care coordinated from the secondary care mental health service. Access to Tier 4 services – inpatient detoxification will be via the crisis resolution and home treatment team in accordance with their role and function to ascertain that inpatient care is the only safe option and best meets the individual care needs. It is anticipated that this will be agreed in conjunction with the Dual Diagnosis Worker and Care Coordinator.

Figure 15 Halton and St Helens Dual Diagnosis Care Pathway

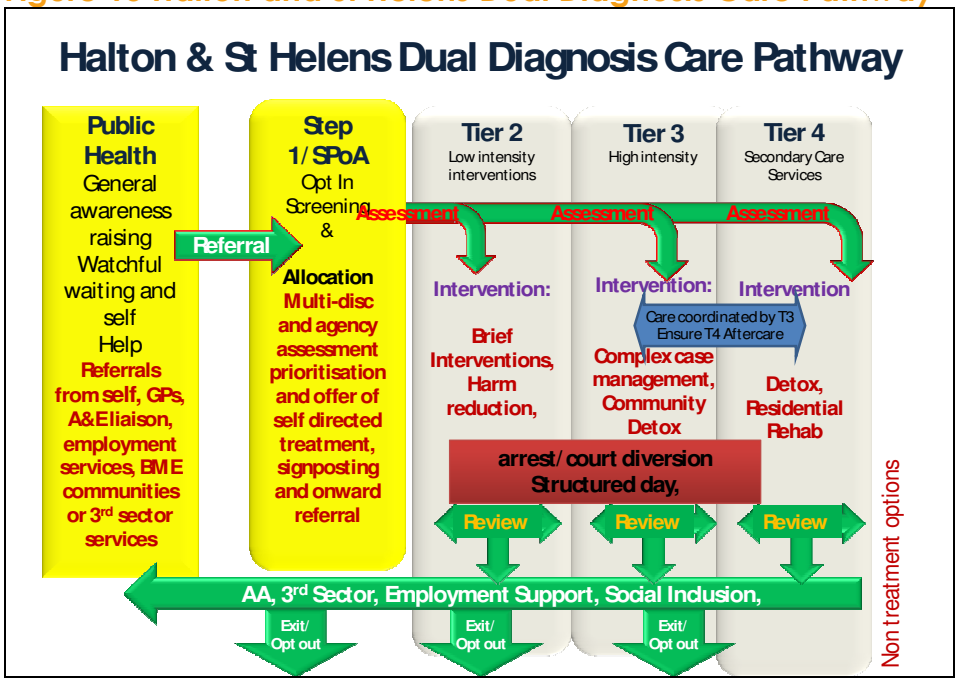


Figure 16 Operational Map – Care Pathway

T1 Primarily Public Health Information self help access to health trainers, lifestyle options
T2 Primary Care inc IAPT services Brief interventions low needs
T2/3 Advanced Practitioner - moderate to severe needs - provides supervision, consultancy, training to Primary care (equivalent to Mod Matron)
T3/ 4 Blue/Red = 5BP these services also include members of Local Authority Social Care Services
Consultant Nurse Practitioner provides link between 5BP and other services
T3 DD Worker
Moderate to severe need plus SMI.
(as Adv Prat but in 2° Care)
All inpatient services via CRHT inc Detox
3rd Sector includes structured day services

The diagram above shows how this model of care might look utilising current services and organisations.

The aim with this model of care and operational map is to highlight the need for one care pathway across the Halton and St Helens footprint. However, there may be different providers of service. The intention is to ensure equitable services across the localities. This may mean extending the remit of some service to include both Halton and St Helens.

The following features will underpin commissioning intentions and the further development of a 'whole systems approach' to commissioning dual diagnosis services

- A broad spectrum of provision which is primary and community focused.
- Access locally to a complete range of primary and secondary services
- Improved pathway of care between services irrespective of provider
- Non reliance on inpatient care
- Integrated pathways where these can improve outcomes.
- Jointly commissioned services by Primary Care Trust/Local Authority
- Broad range of providers giving service user choice
- Service Users and Carers pro-actively involved in the commissioning planning delivery and quality control of services.
- A focus on prevention and promotion of health and well being
- Development of a broader range of social prescribing
- Avoidance of large institutional settings
- Services and their delivery will be based on individual assessment of need.
- A needs led service irrespective of age, or disability

In order to implement an equitable service across the locality ensuring that each locality has access to the complete range of primary and secondary services (Tier 1 to 4) a review of contracted services will be necessary. The aim of the review will be to ensure that a 'whole systems approach' is being commissioned that ensures consistency, continuity, and collaboration.

Summary

This section has identified the proposed model of care to b adopted based on a 'shared care – integrated approach' .. has stated the basic principal of Dual Diagnosis Care being led by Mental Health Services whether this is in Primary or Secondary Care. To facilitate this, the role of Advanced Practitioner will be developed and work in conjunction with Dual diagnosis Workers in Secondary Care.

Figure 32/33 shows a Care Pathway that is aimed at ensuring an equitable, and integrated approach is delivered.

This section further identifies a number of features of the model that will underpin commissioning intentions to develop a 'whole systems approach' to 'Dual Diagnosis'

CONCLUSION - COMMISSIONING INTENTIONS

This strategy has set out the definition of Dual Diagnosis to be adopted. This definition embraces the principle of inclusion. That is, those who need a service will be offered care and treatment and that eligibility criteria will not stand in the way of accessing care.

The model of care to be adopted is based on best practice and the principle of 'mainstreaming'. This model is based on the practice of 'integrated and shared care.' The care pathway to be adopted seeks to reinforce the practice of integration. Mental Health will take a lead in the coordination of care for those experiencing both a mental health problem and a substance misuse dependency. To facilitate this role of Advanced Practitioner in Primary care will be developed and a review of the role of Dual Diagnosis Worker in secondary care will be undertaken.

Demand

Based on our analysis within Halton and St Helens Primary Care Trust footprint there is projected to be, be 36,900 cases of neurotic disorder (one individual may have more than one type of neurotic disorder). Of this identified population, 590 cases are likely to be moderate to severe alcohol dependence.

The analysis further identifies a projected 3096 cases of neurotic disorder and some form of drug dependence.

Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

Halton and St. Helens reported 116 appropriate referrals to their SMS teams. The figures in the table below are calculated using the 116 referral figure and the prevalence rates from the COSMIC study (Weaver et al 2002).

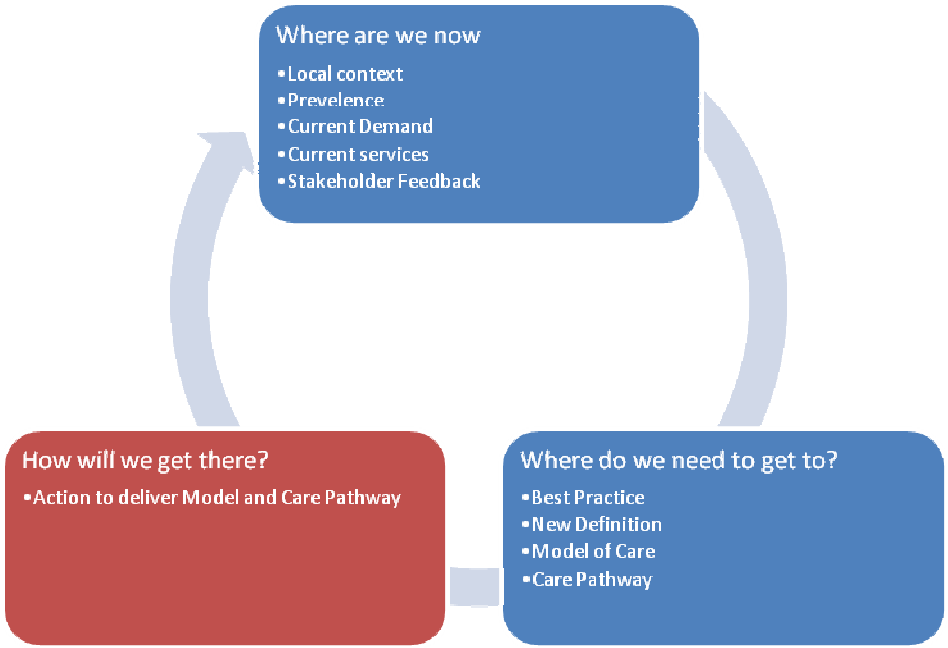
Estimated Number of Mental Health Cases in Halton and St. Helens PCT's SMS Service April 08 to October 08 (6 months period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

In this strategy document, we have used reported data in relation to the demand and estimates have been calculated accordingly. It must be noted however, that stakeholder feedback suggested that the majority people experiencing a mental health problem had an alcohol or drug problem. This may be due to individuals 'self-medicating' and that many people with a drug or alcohol problem also had a mental health issue.

A range of actions is now necessary to implement this strategy. A detailed account of these actions follows.

HOW WE GET THERE



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This section sets out the action now necessary to implement this strategy.

Each of these actions is set out within a template that describes the initiative to deliver the model.

Actions

The first of these actions will be to review the current commissioning mechanisms. Stakeholder feedback supported a move to a more aligned commissioning process. The proposal is to develop a joint commissioning board that will commission services that implement integrated care pathways for people who have both mental health and substance misuse (including alcohol) issues.

This would facilitate a coordinated approach to commissioning with a lead commissioner identified. A 'best value' approach will then be facilitated.

A performance management process equitable across Halton & St Helens with core key performance indicators and outcome measures to be delivered identified for each tier of service and provider.

Establishing the model of care and single care pathway will bring benefits to both service users and providers clearly establishing role and function This would demonstrate clarity of entry and exit points within services.

As part of this care pathway development, the implementation of the single point of entry to services will facilitate good assessment and care / treatment options being identified.

The development of a work force plan is integral to this strategy to ensure that all staff at all levels have the appropriate skills and qualification to deliver the care and treatment required. This work force plan will also include training, advice and support for primary care staff to ensure appropriate governance regarding 'shared care'

This workforce plan will also take account of the need to develop the role of Advanced Practitioner in primary care and the review of the role of Dual Diagnosis worker in secondary care and the role of Support, Time and Recovery (STaR) workers in primary care to develop an individual's capacity for adopting various strategies in relation to 'social problem solving'

The development of service specifications in line with the ne NHS standard contract will be developed as part of th process. Attention will be given to eligibility criteria an interface issues between services, Tiers of service deliver between organisations and between primary and secondai care. The principle adopted will be 'criteria for inclusion'.

Further reflection is required to ensure that all individuals have access to crisis services when required, irrespective of their dependence on substances.

The development of a specific dual diagnosis service user forum in Halton based on the model already in place in St Helens, will be undertaken.

The development of a Provider forum will be established to promote integrated working between providers, to assist identify blockages and barriers to service delivery. It will, also,

provide commissioners with the opportunity to discuss gaps in service and identify ways in which these may be filled.

As the Model of Care is developed and care pathway implemented commissioning will be based on the priorities identified to meet capacity and capability of delivering the model and care pathway.

To ensure that this strategy is complemented and a 'strategic fit' it is recommended that the current Mental Health Strategy be reviewed as soon as practicable.

An implementation plan to deliver this strategy will now be required.

INITIATIVES TO DELIVER THE NEW MODEL #1

Initiative Title **Review current commissioning process and mechanisms with a view to developing a joint commissioning group for mental health, alcohol, and substance misuse services.**
Rationale (including evidence base) Current commissioning is via several commissioning groups and sources of revenue. This leads to duplication and a lack of coordination A Dual Diagnosis commissioning group would facilitate a coordinated approach and achieve 'best value' across primary and secondary care This is in line with new contracting guidance
Current position There are two Local Authorities Two DAATs one Primary Care Trust. Two Local Implementation Teams, One Mental Health Provider Trust and numerous 3rd sector providers. Revenue sources are: Alcohol, Substance Misuse, Mental Health plus education, public health and other social care sources
Commissioner Issues Develop a project group which includes all commissioning partners including PCT, PbCs, Local Authorities Develop a strategic action plan Develop an implementation plan
Provider Issues Providers need to recognise the authority and position of commissioning organisations
Financial impact

The review will necessitate commissioners devoting time to undertake the review.
Cost will be in terms of organisational / individual time.
The review may identify some efficiency savings.

Timescale

Primary Care Trust and Local Authority Commissioners identify Dual Diagnosis Commissioning Group - September 2009
Agree Strategic Plan for change - October 2009
Implementation of Change - March 2010

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reduction in health inequalities
5. Manage knowledge and undertake robust regular needs assessments – develop a full understanding of current and future local health needs
10. Manage the local health system
11. Make sound financial investments to ensure sustainable developments and value for money

Also new contract guidance suggests a coordinated approach to commissioning is the preferred option.

Links to other local strategies and initiatives

Mental Health Strategy
Alcohol Strategy
Substance Misuse
Ambition for Health

Expected Outcomes

Reduction in the possible duplication of services commissioned by current substance misuse and mental health commissioning Boards.
Increased collaborative and integrated working between services.
Early intervention for people with dual diagnosis, especially those currently receiving care in primary care services only.
Clear and easily accessible care pathways.

Agreement on cordinated use of resources
How this will benefit service users and their carers By collaborative coordinated commissioning, more service users will benefit from accessing the appropriate interventions. As services will be better coordinated the 'patient journey' will become clearer and smoother interface between organisations and services will develop. This should result in a better service user experience.

INITIATIVES TO DELIVER THE NEW MODEL #2

Initiative Title **Develop a performance management process which is robust, equitable, and consistent across Halton & St. Helens footprint**
Rationale (including evidence base) The development of core key performance indicators and outcome measures applicable to all providers. This will enable commissioners to actively compare providers and ensure delivery of outcomes commissioned. – This is a value for money issue alongside promoting improvement and innovation.
Current position There would appear to be a lack of coordinated KPI and outcome measures across the locality therefore no base line
Commissioner Issues Development of core KPI and outcome measures applicable to all services This links to the new contract development. This is core data for the contract. The core KPI and Outcome measures will need to be implemented and enacted.
Provider Issues Ability to provide data on request Development of data improvement plan Development of quality improvement plan Development of data sets, performance management as set by commissioners. This is part of the new contract development and key to its success.
Financial impact The development will necessitate commissioners and providers both statutory and non-statutory devoting time to undertake the development work Cost will be in terms of organisational / individual time. Costs in developing framework and agreeing implementation Time of individuals to agree and implement a reporting framework. Cost of any IT solutions to implementing reporting framework

Timescale

Development of project group - September 09
Identify Core KPI and Outcome measure - January 2010
Develop reporting mechanism - February 2010
Go live - April 2010
This links to new contract development

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
6. Prioritise Investment according to local need and service requirement
8. Promote and specify continuous improvement
   Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality outcomes
11. Make sound financial investments

Links to other local strategies and initiatives

This links to the all the Primary Care Trusts key activities – primarily contracting and performance management

Expected Outcomes

Agreed joint key performance indicators and outcomes for dual diagnosis service users, their carers and families.
Integrated performance management of services for people with dual diagnosis
Robust data collection
Improved service user and carer outcomes

How this will benefit service users and their carers

It ensures quality care and outcomes, best value process will enable more service users to benefit from appropriate and timely interventions. It will also hold services to account. One of the measures will be the data received from the Patient Survey so the service user's voice will be clearly captured and reflected in the performance management of services.
The data will enable service users to make informed choices where there are comparable services and interventions suited to their needs

INITIATIVES TO DELIVER THE NEW MODEL #3

Initiative Title **Establish the model of care and care pathway including the single point of access.**
Rationale (including evidence base) This would facilitate better access to services and interventions, avoid duplication. This would give clarity to commissioners, providers and most importantly service users and their carers as to the expected 'patient journey' Each organisation and discipline would understand their role and function and that of others Deliver a better service user experience
Current position There would appear to be an unclear alcohol pathway. There are identified barriers to accessing mental health services There is a lack of capacity and capability at some levels of service
Commissioner Issues Develop a project group Develop project plan Develop an implementation plan
Provider Issues Providers statutory and non statutory will be required to engage with commissioners to ensure best outcomes are delivered to service users. Providers will be required to engage in service redesign and modernisation processes.
Financial impact Commissioners and providers will need to ensure sufficient time and appropriate staff are enabled to undertake this work. Therefore, initial costs will be in terms of organisational and individual time. Implementing the model and care pathway will necessitate a review of commissioned services and reviews of individual contracts. Service redesign and modernisation process are likely to have financial implications It may be that providers are required to extend their current service delivery across both Halton and St Helens.

Further capacity may also be required at tiers 2 and 3
The implementation of the Advanced Practitioner role will incur significant costs. Funding for these roles have been allocated within Mental Health Development Funding

Timescale

Development of Project Group - September 09
Development of Project Plan - December 09
Development of Implementation Plan - February 10
Pilot Model and Care Pathway - April – June 10
Implementation of Model and Care Pathway - September 10

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
7. Stimulate the market
8. Promote Improvement and Innovation
10. Manage the local health system
3. Engage with public and patients

Links to other local strategies and initiatives

This Model of Care will primarily link to the following strategies and services:
Public Health, Alcohol, Mental Health, Substance Misuse

Expected Outcomes

Clear and accessible care pathways that make sense to referrers and service users and carers.
Early interventions in primary care that are coordinated and integrated which will offer help and support at the earliest opportunity to those experiencing both mental health and substance misuse problems.
Agreed protocols between mental health and substance misuse services that eliminate the blockages to people receiving integrated care.
A holistic assessment that focuses on the needs of the individual rather than just the diagnosis and facilitates help for identified health and social care problems.

How this will benefit service users and their carers

The proposed new model of care and care pathway will facilitate easier access and integration of service. This will ensure a better service user experience. Service users in future will experience one comprehensive assessment of their needs. This will facilitate an integrated care package from the start of their treatment. This avoids silo service delivery and will shorten the overall duration of interventions for many people.

INITIATIVES TO DELIVER THE NEW MODEL #4

Initiative Title

Development of Workforce Plan

Rationale (including evidence base)

Explain the need and the objective of change
Ensure a staff compliment that is equipped and supported to deliver high quality care.
Ensure that all staff across both health and social care are equipped to deliver; advice and brief interventions at first point of contact.
Ensure key staff are qualified and meet the minimum standards required to be commissioned to undertake 'shared care' responsibilities.
Ensure sufficient capacity and capability are employed to deliver high quality care
Develop new role of Advanced Practitioner within Primary Care
Develop role of STaR workers in primary care
Review role and function of Dual Diagnosis Workers
Ensure a robust recruitment and retention plan is in place

Current position

Inequalities in service provision exist across the two localities
Capacity gaps exist at Tiers 2 and 3
After care services are required.
Access to Mental Health Services are an area for development particularly in regard to Common Mental Health Problems
Improved access to Crisis Services is required.

Commissioner Issues

Commissioners will need to be assured that appropriate governance, capacity and systems are in place to support

staff
Commissioners will need to be assured that appropriate protocols and interface between providers is robust.
Commissioners will require evidence that where appropriate providers comply to NHSLA standards
Commissioners will require assurance that all staff are appropriately qualified to deliver the care and treatment required.
Commissioners will need to assure themselves that an appropriate whole systems model of care is delivered giving attention to social as well as health issues

Provider Issues

To work with commissioners to facilitate the above
Work force issues are predominantly the ultimate responsibility of the provider of service, therefore a close working relationship with all providers will be necessary to ensure the above assurances to commissioners are achieved
Ensuring staff are aware of other organisations and individuals roles.

Financial impact

The development of the workforce plan will be the single most revenue intensive development
The development of Advanced Practitioner role A4C band 7
Development of Star role in Primary Care A4C band 3
Training of all Primary Care, Social Care, Police, Probation and other front line staff in advice and brief interventions.

Timescale

Development of Project Group - September 10
Development of Project Plan - November 10
Implementation of Plan and recruitment process - January 10
Implementation of training package - January 10
Review of Recruitment and training progress - June 10
The training of staff will be an ongoing

Links to WCC

1. Locally lead the NHS
2. Work with community partners
4. Collaborate with Clinicians
   Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
6. Priorities investment
7. Stimulate the market
   Effectively stimulate the market to meet demand and secure required clinical and health and well being outcomes
8. Promote improvement and innovation
   Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
10. Manage the local health system
11. Make sound financial investments
    Make sound financial investments to ensure sustainable developments and value for money.

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse

Expected Outcomes

Increased communication and shared training between services.
Increased knowledge and skills in primary care to work with people with dual diagnosis problems.
Access to dual diagnosis advice and support for primary care staff
Close Primary / secondary mental health care interface working
A network of practitioners who can successfully work together for the benefit of the service user, their carers / family when required.

How this will benefit service users and their carer

This initiative will enable more frontline staff provide advice and brief interventions so impacting on the demand of related services. Service users will therefore access advice and brief interventions quicker. There will be increased capacity and expertise within the care pathway and so will have a positive impact on waiting times and an improved service user experience.

A 'whole systems' workforce plan will ensure that the right staff in the right numbers are available in the right places to deliver the appropriate interventions. This should result in shorter waiting times, duration of intervention may be less as the principle of early intervention is that if treated early this will prevent the individual's problems becoming longterm.

INITIATIVES TO DELIVER THE NEW MODEL #5

Initiative Title **The development of service specifications in line with the new NHS standard contract will be developed as part of this process attention will be given to eligibility criteria and interface issues between services, Tiers of service delivery, between organisations and between primary and secondary care. The principle adopted will be 'criteria for inclusion'**
Rationale (including evidence base) Explain the need and the objective of change Develop clear KPI and outcome measures for each service Develop clear kpi and outcome measures for each TIER of Service delivery and mechanism for data capture and measurement Ensure all service users have access to a crisis service when they need it Address new contract issues **Links to Initiative 1** **Links to initiative 2**
Current position Primary Care Trust commissioners are preparing new contracts DAAT Commissioners will have a review programme for contracts Local Authority will have a review programme for contract The processes are not coordinated and have different performance management structures.
Commissioner Issues Develop project group Develop project plan Identification of contracts, and service specification to review. Prioritise review process Develop Implementation plan Impact assessment and sustainability of changes to service specifications. **Links to Initiative 1** **Links to initiative 2**

Coordination of contracting and service specification development.

Provider Issues

Engage with commissioners to facilitate best outcomes
Providers will need to undertake impact assessment of changes to service specifications.
Development of data quality improvement plan
Development of quality improvement plan

Financial impact

The review of service specifications may impact upon:
Eligibility criteria; leading to more people accessing services leading to impact on capacity of services.
Ways of working; changes in interface with other organisations, job descriptions, new posts

Timescale

Development of project group - September 09
Development of Project Plan - October 09
Commencement of implementation of Plan - November 09
Review of progress - January 2010
Complete review and all service specifications in place - February 2010
Sign off for new contracts - February 2010

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services t hat optimise health gains and reductions in health inequalities
4. Collaborate with Clinicians
   Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
8. Promote Improvement and Innovation
   Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
10. Manage the local health system
11 Make sound financial investments

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse

Expected Outcomes Clear, specific and robust service specifications for all services working with people with dual diagnosis problems People are not excluded from services, based on particular diagnoses and that care pathways are developed for all those requiring services. Local services are flexible, coordinated and responsive to identified dual diagnosis issues.
How this will benefit service users and their carers This initiative will improve access, improve quality so improving the service user experience. Service specifications will be developed on the principle of 'criteria for inclusion' this will result in more people being able to access services and so reducing barriers to access. This should also have an impact on waiting times and service users remaining in inappropriate services due to inaccessible interventions. This will impact on the service delivery in terms of organisations and services working together more so delivering an integrated service.

INITIATIVES TO DELIVER THE NEW MODEL #6

Initiative Title **The development of a specific Dual Diagnosis service user peer group support forum in Halton.**
Rationale (including evidence base) Meaningful engagement with service users and their carers, Development of mutual support and self help.
Current position Currently no service
Commissioner Issues Facilitate Providers develop forum
Provider Issues Develop service and support
Financial impact Finances will be required to cover cost of venue, refreshments, any literature and publicity materials, time of staff to support the group.
Timescale Identify staff to facilitate set up and initial organisation - October 09 Identification of Venue - November 09 Identification of Service Users and Carers - December 09 Start Group - January 10
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 10. Manage the local health system

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse plus Management of Long Term Condition

Expected Outcomes

An opportunity for peer support groups across both Halton and St Helens.
Increase service user and carer involvement mechanisms across Halton and St Helens.
Increase equity across the PCT footprint

How this will benefit service users and their carers

Facilitate engagement and give a voice and support to service users and their carers. It will assist in the shaping and development of new services.
Service users engaging in this forum will benefit from informal peer support, being able to discuss their difficulties with people who have experienced similar problems in a non-threatening environment.

INITIATIVES TO DELIVER THE NEW MODEL #7

Initiative Title **The development of a Dual Diagnosis Provider forum**
Rationale (including evidence base) To promote integrated working between providers, to assist identify blockages and barriers to service delivery. Provide commissioners with the opportunity to discuss gaps in service and identify ways in which these may be filled
Current position Currently Local Authority manage a broad provider forum not dual diagnosis specific
Commissioner Issues Develop Forum Engage with providers
Provider Issues Engage with the process
Financial impact The financial impact will be on the time of commissioners from Primary Care Trust, Local Authorities, and DAATs to organise and run forum. Some costs may be incurred in providing venue and refreshments
Timescale Identification of lead commissioner - October 09 Identification and invitations to providers - November 09 Identification of agenda and 1st meeting January 10
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 5. Manage knowledge and undertake robust and regular needs assessment that establish a full understanding of current and future health needs and requirements 6. Prioritise investments according to local needs and service requirements

7. Effectively stimulate the market to meet demand and secure required clinical and health and well being outcomes 10. Manage the local health system
Links to other local strategies and initiatives This will primarily link to the following strategies and services: Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse, Management of Long Term Conditions
Expected Outcomes Regular meetings of service providers to discuss any blockages and delays between services and identify which systems are working well. An opportunity for providers to hear the views and experiences of service users. A forum where commissioners can work with providers to continuously improve services across the care pathway
How this will benefit service users and their carers Ensure continuous improvement in service development. Providers should be supported at the forum by elected service user representatives. The provider forum will assist in the smooth working between organisations and services reducing blockages and barriers and identifying problem areas sooner and bringing a collective approach to problem solving and meeting service user needs.

INITIATIVES TO DELIVER THE NEW MODEL #8

Initiative Title **Mental Health Strategy to be reviewed**
Rationale (including evidence base) The aim of this will be to ensure that an up to date Mental Health Strategy is a 'Strategic Fit' with all other related Strategies and plans
Current position Current Mental Health Strategy is now out of date
Commissioner Issues Develop a Project Group Develop Project Plan Develop Implementation Plan
Provider Issues Engage with the process
Financial impact Organisational and individual time will be required to complete the review and update the strategy
Timescale Develop project group - October 09 Develop Project Plan - November 09 Develop Implementation Plan - December 09
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 5. Manage knowledge and undertake robust and regular needs assessment that establish a full understanding of current and future health needs and requirements 6. Priorities investments according to local needs and service requirements

7. Effectively stimulate the market to meet demand and secure required clinical health and well being outcomes 10. Manage the local health system
Links to other local strategies and initiatives This will primarily link to the following strategies and services: Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse, Management of Long Term Conditions
Expected Outcomes Increased understanding of mental health commissioning plans across primary, secondary and tertiary care and the context for delivering services to people with dual diagnosis. Ensuring a closer 'fit' between any mental health commissioning strategy, substance misuse strategy and alcohol strategy for people with dual diagnosis problems
How this will benefit service users and their carers The development of an up to date Mental Health Strategy will facilitate the progress of a 'whole systems approach to commissioning and the provision of services. So leading, to a better service user experience, and patient journey. An up to date Mental Health Strategy will take account of New Ways of working, and recent policy and guidance. This will impact on; how services are managed, and delivered. The outcome of which, will improve access, reduce waiting times and provide a vehicle for partnership working. Service Users and their Carers will be critical informants to the development of the strategy.

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http://www.southeast.csip.org.uk/our-work/mental-health/mental-health-programme/dual-diagnosis/dual-diagnosis-key-resources.html

http://www.londondevelopmentcentre.org/mental-health/dual-diagnosis/dual-diagnosis-news.aspx

http://www.pcc.nhs.uk/204.php

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10th November 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: '*Shaping the Future of Care Together'* Green Paper

WARDS: Borough–wide

1.0 PURPOSE OF THE REPORT

1.1 To present a summary of the Green Paper's key points and potential impact on the Authority and the Authority's response to the consultation questions

2.0 RECOMMENDATION: That the Board: -

(1) Note and comment on the content of the report

3.0 SUPPORTING INFORMATION

3.1 Shaping the Future of Care Together Green Paper's (published on 14th July 2009) main thrust is the building of a National Care Service to provide care and support that is fair, simple and affordable.

3.2 It is acknowledged in the paper that the current system is piecemeal, inconsistent and full of uncertainties. It makes poor use of resources. The 'demographic time bomb' is highlighted in that by 2026, 1.7 million more adults will be in need of care and support. The absence of any reform will result in further rationing of public resources. This is an opportunity to build on Putting People First concordat (Dec 2007).

3.3 The Green Paper lists 6 things that people should be able to expect from a National Care Service:

- The right support to help people stay independent and well for as long as possible and not get worse. Those leaving hospital should have a right to 6 weeks re-enablement.
- Wherever you live in England, the assessments and the funding should be the same.
- All services will work together smoothly and be joined up, particularly when needs are assessed.
- The system will be simplified to enable people to find their way round it.

- Care and support will be based on people's individual circumstances and need.

- Money will be spent wisely and everyone who qualifies will receive some financial support.

3.4 To make this vision a reality it is proposed that there is a need for more joined up services between health, housing and social care and between social care and the disability benefits system, resulting in a wider range of services with better quality and innovation.

3.5 The Green Paper states that there needs to be better use of the public money already in the system, with the bringing together of a number of allowances, (e.g. Attendance Allowance, disability benefits). There also needs to be new money in the system. In addition to being fair, simple and affordable, it needs also to be both universal and personalised

3.6 There are 5 funding options spelled out for the National Care Service:

- **Pay for yourself**. Insurance policies to cover some of these costs, or use income/savings. This is ruled out as is fundamentally unfair because people can not predict what care and support they will need

- **Partnership**. The state would pay a set proportion of costs which the individual would have to make up.

- **Insurance**. This could be private or a state scheme. People could pay by instalments or a lump sum, before or after retirement or the payment could be deferred until after death. It is estimated that about £25000 would be needed. Care would then be free when required.

- **Comprehensive.** Everyone over retirement age would have to pay into a state insurance scheme. Contributions would be varied according to income but care would then be free.

- **Funded from general taxation**. This is ruled out because of the burden it puts on those currently working. *(In all these schemes the costs of food and accommodation would need to be met by the individual).*

3.7 The Government believes that 2, 3 and 4 are worth further consideration but inclines towards the Partnership model. Under Partnership, existing Government funding is allocated more fairly and everyone would get some help with paying for care and support.

3.8 In the new system everyone who needs care and support will get a national assessment, information and advice leading to personalised care and support. These measures will help carers by making the process of getting appropriate care and support easier. By improving

support to people who need care, carers will be supported, particularly people who care for those who would have received no state funding under the current system.

3.9 There is still a debate as to whether the system should be a 'fully national' one or allow for local flexibilities ('part national'). In 'fully national' it may be more difficult for local authorities to tailor the care package and to respond to local circumstances. However a 'fully national' system would be easy for people to understand and plan for and enable people to move around more freely. In 'part national' the local authority would be responsible for deciding how much an individual should receive, giving flexibility. But this would mean that people could still get differing amounts of funding dependant on where they live. Whichever is chosen, local authorities would have, as at present, a key role to play.

3.10 There are 3 consultation questions and the responses will be used to frame the White Paper to be published in 2010. Any changes will be phased in over a period yet to be determined. Consultation runs until the 13th November 2009. The Consultation Questions and Halton Borough Council's response can be found in **Appendix 1.**

4.0 POLICY IMPLICATIONS

4.1 What ever the outcome of the consultation, there will be a significant impact on Local Authorities in the delivery and management of care and support.

4.2 In the new National Care Service, everyone who qualifies for care and support from the state will get some help paying for it. Local Authorities may be responsible for deciding how much an individual should receive for care and support, giving them flexibility to allow for local circumstances, or national government would decide how much funding people get, instead of local authorities.

4.3 Local Authorities will be responsible for ensuring that there is a wide range of services available in their area and encourage the development of new services – this could impact on the commissioning process to identify innovative care.

4.4 The role of the Joint Strategic Needs Assessment (JSNA) will be fundamental in understanding how care and support services will need to adapt to meet future demands.

4.5 Strategies and policies will need to support greater joint working between housing, social care and health and changes in national systems such as the benefits system.

5.0 OTHER IMPLICATIONS

5.1 The cost of implementing the future white paper is not yet known. The issues set out in the Green Paper and the possible responses will need to be consistent with the Government's economic and fiscal strategy, and considered alongside other public spending priorities and their affordability.

5.2 If a national scheme is adopted it is likely that this may result in a reduction of funding for Local Authorities in order to finance the scheme i.e. Less local discretion/flexibility for Local Authorities in the services they deliver.

5.3 Charging for residential care costs are covered under statute by Charging for Residential Accommodation Guide (CRAG). Charging for non-residential can be determined locally. Within the Green Paper it does not reference CRAG or changes to it. The Green Paper states that although the state would contribute towards the cost of care within residential care, there still may be some costs, which the individual may have to pay. In addition, accommodation costs for residential care will have to be covered by the individual if their assets are above the threshold eligible for full state support. In a bid to ensure that nobody is forced to sell their house in order to cover their residential costs during their lifetime, the Green Paper outlines proposals to extend the option of deferred payment schemes (already available to some by their local authority) making it universal and available for all, so individuals can defer payment of care and accommodation costs until after death.

5.4 The Green paper comments that that care costs for women tend to be higher. As actual rates for care services are identical for men and women, this comment must be based on either a) women having a longer lifespan and therefore receiving services for a longer period of time or b) the benefits system paying couples benefits to husbands, therefore leaving wives with very little income of their own and so causing LA's to fund them to a higher degree.

5.5 Since the publication of the Green Paper, and the subsequent Party Conferences, there has been widespread media coverage on this issue. A summary of the main political parties current views on how social care should be funded in the future can be found in **Appendix 2.**

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 The impact on the Local Authority is likely to be significant, but as the funding model (Partnership, Insurance, Comprehensive etc) and whether the implementation will take a National or Part National approach is not yet known, the impact on the Council's Health and Wellbeing priorities will not be clear until the White Paper is published (expected in early 2010).

7.0 RISK ANALYSIS

7.1 A risk assessment will be undertaken when the outcome of the green paper is known

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 A summary of the key messages arising from the likely impact of the reforms being considered with the Green Paper on the different equality strands:

- **Age:** Reform of the system will improve risk management to reduce the likelihood of financial exploitation. The proposed systems would also help reduce the possibility of unmet needs among older people.

- **Gender:** Changes to the funding system would mean that women in particular would benefit as they would be entitled to a degree of state care which, given the fact that 'care costs for women tend to be higher', could help to reduce the cost of care for women, particularly those who currently self-fund their entire care.

- **Disability:** Extension of the personal budget approach would have a positive impact on quality of life outcomes as a result of greater choice and flexibility, particularly for people with mental health problems and other disabilities. A national assessment process would provide greater flexibility, particularly for young disabled people, to move around more freely as the new assessment process will be standardized and portable. In addition, as there would be a minimum threshold for which someone was eligible for state support, this means that people with a certain level of need will receive funding to meet their care costs wherever they live.

- **Sexual orientation:** Personal budgets are seen to have great potential in delivering personalised care that meets the lifestyle and cultural needs of LGBT people. Reform of the assessment process, in particular the way carers are considered within the new system, will need to ensure that the definition of 'carers', which usually defines them as family members, recognises that for LGBT people the term 'family members' is more broad, and that carers are often friends or partners of the individuals in need

- **Faith/belief:** One of the few exceptions found that there were high levels of concern among some religious groups about the idea of releasing equity from homes to pay for care, feeling that it was the right of the individual to leave an inheritance to his or her family members. The preferred funding options provide these groups with greater protection of their inheritance, with the choice to protect more of their inheritance through insurance.

- **Race:** Personal budgets are seen to have great potential in

delivering personalised care that meets the lifestyle needs of BME groups, as it allows them flexibility to acquire the care they need according to cultural requirements. A simpler system may result in more applications from BME groups. However, these groups are often not in touch with the care and support system and greater awareness would need to be created so these groups felt more comfortable to apply.

Appendix 1

Halton Borough Council's response to '*Shaping the Future of Care Together'* Green Paper Consultation September 2009

Consultation Questions – Proposed response from Halton Borough Council Health & Community Directorate

1. **We want to build a National Care Service that is fair, simple and affordable. We think that in this new system there are six things that you should be able to expect:**

   Prevention services
   National assessment
   A joined-up service
   Information and advice
   Personalised care and support
   Fair funding.

   a) Is there anything missing from this approach?

The role of appropriate transport to support services

Financial advice should form a critical part of the 'information and advice' principle to ensure that service users are able to make informed choices

   b) How should this work?

There should be choice and flexibility within the system to enable Local Authorities to make decisions to support the preventative agenda, based on local issues.

Agreed that greater integration with other providers, including Health Services is required to provide a more joined up service, although not clear how this will be achieved given there are differing outcomes and performnace frameworks.

An opportunity to provide feedback on services, and services to commit to be responsive to this feedback needs to be built in.

2. **We think that, in order to make the National Care Service work, we will need services that are joined up, give you choice around what kind of care and support you get, and are high quality.**

   a) Do you agree?

Whilst the logic behind the proposed National Care Service is clear, Local Authorities will need to maintain a level of autonomy and discretion to meet the needs particular to the local area

b) What would this look like in practice?

Requirement for innovation in the provider market place, and within local authority services, to develop a diverse range of services to provide increased choice of what type of care and support is available.

Information and advice, coupled with brokerage will need to be high quality and may impact on the 'traditional' role of the social worker and will have workforce development implications.

c) *What are the barriers to making this happen?*

There is no explanation of what 'care and support' means in practice or how this is different from healthcare

Attendance allowance is an important benefit in relation to independence and prevention, however, the removal will inhibit people's ability to maintain that independence and in fact ensure that they are dependent. The removal of attendance allowance will potentially further increase the gap between the adults who receive DLA and subsequently ILF unless DLA is increased to cover the over 65's. If AA and DLA is subsumed into the care and support pot, how will people who currently receive these benefits but who are not eligible for other forms of financial support get assistance? Given that attendance allowance and disability living allowance the is concern where the preventative agenda will go in the light of the removal of attendance allowance

Other potential barriers include Timing; Information constraints; Funding constraints; Not everyone will be willing to join up; Boundary issues; Differing priorities; impact on workforce skills requirements,

3. The Government is suggesting three ways in which the National Care Service could be funded in the future:

Partnership – People will be supported by the Government for around a quarter to a third of the cost of their care and support, or more if they have a low income.
Insurance – As well as providing a quarter to a third of the cost of people's care and support, the Government would also make it easier for people to take out insurance to cover their remaining costs.
Comprehensive – Everyone gets care free when they need it in return for paying a contribution into a state insurance scheme, if they can afford it, whether or not they need care and support.

a) Which of these options do you prefer, and why?

The Partnership Option is the preferred option, dependent on the framework in which it will be operated. Without the detail of how these options will be financed is it difficult to choose.

b) Should local government say how much money people get depending on the situation in their area, or should national government decide?

There is a balance required between a more equitable approach versus Local Authority discretion. Local Authorities should be able to maintain an element of flexibility and discretion to meet specific local need.

General observations/comments

- Lack of focus on younger disabled adults and working age adults who have complex needs like learning disabilities and how changes will affect them

- Although the government is clear regarding the service's underlying principles it is less clear regarding the financial detail or even to recommend a funding option so how will they choose

- The intended change in attendance allowance will affect the whole of the UK, however, the remit of the green paper will be for England, it is not clear how this will be resolved

- There are issues regarding the variable costs of care in the country and in different parts of the country;

- Questions about peoples ability to purchase insurance;

- Equity regarding ability/willingness to pay for services – how this is decided

- Charging for residential care costs are covered under statute by CRAG. Charging for non-residential can be determined locally. Within the Green Paper it does not reference CRAG or changes to it

Appendix 2

Summary of the main political parties current views on how social care should be funded in the future

Labour

The Shaping the Future of Care Green Paper rules out paying for care entirely from taxation or from individuals' own resources. It sets out three options for the state and individuals to share the costs of care in partnership, with different levels of contribution by individuals.

As the Green paper focuses primarily on older people, further clarity is need about the implications for working age adults with disabilities and about the affordability of a free system for those of working age that doesn't impact on current benefits.

£20,000 that the Department of Health has estimated would be the upper amount everyone over retirement age would need to contribute to a new compulsory social insurance fund, either as lump payments or periodic contributions.

That system would provide all adults with free social care at the point of need, although those who needed a care home would still have to pick up the bill for accommodation costs, typically just over half of the average weekly charge of £500.

Although the £20,000 cost would initially be borne by over-65s, the green paper proposes that this might eventually evolve into a payment people could spread over their working life.

However, at the recent 2009 Labour Party Conference, the Prime Minsiter made a pledge for free personal care in their own homes for people over the age of 65 with critical needs under the Fair Access to Care (FACS) eligbility criteria. This measure was not indetified as an option within the Green Paper. There is litle information available about how this much will cost and how it will be funded, but figures cited within the Demographic Health Network *Health and Social Care Round-up* bullitin (Sept 09) suggest that it will be in the region of £670 million over two years, with £400 million to be found from the Department of Health and the remainder from Local Authroties.

Conservative

Conservatives plan for a social insurance system costing around £8,000 per person that would cover residential care costs for life. The up-front charge to the retired, would go into a pool and pay for those among the cohort – just over a quarter – who would end up needing long-term residential care
The 'Home Protection Scheme' would be voluntary, with the one-off fee paid at 65

Points for consideration

- Residential care is just one form of social care support.
- Older people may prefer to stay in their own homes for as long as possible
- There is a risk that this scheme will create a perverse incentive whereby those with insurance are more likely to go into 'free' residential care rather than stay in their own homes, where they would have to pay for their own care and living costs.
- More detail is required about how this scheme would guard against inflating care home prices, encourage better quality and avoid reinforcing historical over-supply of care homes in some areas.

Liberal Democrats

Proposed introduction of a ‘Care Guarantee’ by spending 2 billion on personal care payments for all elderly people requiring care, based on need and not their ability to pay.

The Liberal Democrat’s approach is based on the partnership model in which the Government would pay for a minimum standard of care for everyone according to need, without regard for their means topped up by private contributions until a maximum benchmark is reached.

There is also a heavy emphasis on both the use of individual budgets to give those needing care more control and on support for unpaid carers.

Source*: Demographic Health Network Health and Social Care Round-up*

Source: *Health & Social Care Journal*

Source: *The King’s Fund*. The King's Fund aims to be a resource to parliamentarians at Westminster and the devolved institutions by providing impartial analysis on health and social care developments

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10th November 2009

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Safeguarding Vulnerable Adults

1.0 **PURPOSE OF REPORT**

1.1 To present the Annual Report of Halton's Safeguarding Adults Board, for the year 2008/09, and to brief the PPB on key issues and progression of the agenda for Safeguarding Vulnerable Adults.

2.0 **RECOMMENDATION:**

i) That the PPB note and comment on the content of the Annual Report of the Safeguarding Adults Board 2008/09 and recent/current key issues.

3.0 **SUPPORTING INFORMATION**

3.1 **Annual Report of the Safeguarding Adults Board (SAB)**

The Annual Report outlines the strategic framework and operation of the multi-agency arrangements for safeguarding adults in Halton who are vulnerable to abuse. The report provides details of work undertaken from April 2008 to March 2009 and summarises priorities and planned activity for the year April 2009 to March 2010.

The report is made available on Halton Borough Council's website and is sent to lead officers and senior managers in partner agencies in all sectors.

3.2 **Up-date**

Since April 2009, key issues to report are:

3.2.1 ***Locally***:

- Safeguarding Adults Board (SAB) and sub-group terms of reference and work plans have been reviewed & updated.
- The operation and chair of the SAB is under review.
- The local authorities of Halton, St Helens & Warrington, together with Halton & St Helens PCT and Warrington PCT have agreed in

principle to work towards a multi-area approach in commissioning substance misuse and alcohol services. The Joint Service is due to commence in April 2010 and will potentially help to prevent abuse of those whose circumstances exacerbate their vulnerability.

- An additional Detective Inspector post has been created in the Northern Public Protection Unit of Cheshire Constabulary, thereby providing a dedicated DI for Halton instead of covering both the Halton & Warrington areas. A dedicated vulnerable adults officer has also been appointed at Detective Constable level.
- The PPU formally responded to recommendations of HBC's 2008 Scrutiny Review of the Safeguarding service.
- A Dignity Coordinator has been appointed. The Coordinator has joined and will regularly report into the SAB, to ensure that the essential links between dignity and the recognition and prevention of abuse are made and sustained. The Coordinator has also joined the NHS Trusts/HBC sub-group.
- A Dignity Champions' Network has been established, with membership including local representatives from the health, voluntary, independent and statutory sectors. The chair of the Network is the Older People's Champion, Doreen Shotton.
- Development of 2-way secure email facility is being progressed, between Halton Borough Council and the Police, for Safeguarding and Multi-agency Risk Assessment Conference (MARAC) correspondence particularly, and if possible between HBC and local NHS Trusts.
- The Local multi-agency Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Standards (DoLS) steering group is reviewing governance arrangements, training arrangements, understanding of the law and policies, procedures & guidance. Guidance on implementing the MCA has been provided for the Police.
- Usage of the Independent Mental Capacity Advocacy (IMCA) service is under review and steps being taken to raise awareness and ensure access.
- Steps have been taken to raise awareness of the Intermediary (vulnerable witness support) service, among Police and HBC officers.
- Warrington & Halton Hospitals NHS Foundation Trust have appointed the Director of Nursing & Governance as Lead Safeguarding Adults manager, who has joined the SAB membership. The Trust also secured funding to invest in a whole time equivalent Safeguarding Adults Matron post.
- NHS Halton & St Helens Primary Care Trust has appointed both a Safeguarding Adults Lead manager, who has joined the SAB, and Safeguarding Adults Coordinator.

Developments are ongoing in both Trusts.

- The links and tensions between Safeguarding and arrangements to extend Self Directed Support are under consideration by both the SAB and HBC, to ensure access to adequate safeguards are available to those who choose to direct their own support arrangements, without eroding their right to self determination and independence.
- The Investigators training course target group has been extended to incorporate (4) NHS Trusts' staff who participate in investigations, and learning outcomes & course content reviewed in consultation with the Trusts.
- A Train the Trainer course has been launched to provide full and comprehensive grounding and ongoing support for people with responsibility to cascade basic awareness training.
- HBC is working towards providing better training attendance analysis.
- The Police (PPU) have committed to providing input on an increased number of Referrers and Investigators courses provided by HBC this year, and the content and format of Referrers and Investigators courses reviewed with regard to Police input.
- The Training & Development sub-group has reviewed voluntary sector training needs.
- A multi-agency Publicity & Community sub-group has been set up and terms of reference and work plan agreed.
- Displays of publicity and information were sited at a number of venues during national Carers' Week and on Disability Awareness Day.
- A publicity material distribution to local recipients has begun.
- Tragedies occurring in other localities have been utilized to benchmark local services and provide opportunities for learning and development. These included the death of Baby Peter in Haringey and a housing situation in Hounslow involving adults with leaning disabilities and their family.
- An external audit of safeguarding within HBC Adults Services has been undertaken, focussing both on Safeguarding Vulnerable Adults and, where there were Child Protection concerns, the interface issues with children's services. All recommendations were progressed through an action plan and will be monitored through the HBC Safeguarding Performance Group. Additionally, a protocol for joint working has been set up in HBC.
- Adult Social Care reviewed their internal arrangements regarding the MARAC and produced a report containing recommendations, which were all progressed, including some about governance of the MARAC and reporting mechanism.
- Contractual agreements and service specifications applied to substance misuse services and advocacy services have recently

been reviewed and now incorporate further standards and measurable indicators relating to specifically to safeguarding vulnerable adults. Service standards include protection from abuse, compliance with legislation, training, staff recruitment and selection, and supervision. Providers are specifically required to ensure that staff trained to recognise safeguarding issues.

Nationally:

3.2.2

- Halton's Safeguarding Adults Board submitted a comprehensive consultation response to the second phase of the review of 'No Secrets' (DH 2000) national guidance on safeguarding adults.
- Halton /Borough Council responded to a consultation on the review of 'Ordinary Residence' guidance, which includes reciprocal arrangements for dealing with safeguarding concerns arising when residents reside outside of their funding authority area.
- The Law Commission plans to review adult social care legislation, including that which applies to safeguarding adults, during 2010.
- HBC has incorporated a national data for safeguarding adults into its client record recording system and is furthering development of an electronic recording system. Partner agencies are taking steps to facilitate their providing internal safeguarding adults data to the SAB.

4.0 POLICY, LEGAL AND FINANCIAL IMPLICATIONS

4.1 There are no legal, policy or resource implications in endorsing the Annual Report or in this report to the PPB.

All agencies supporting the multi-agency arrangements retain their separate statutory responsibilities in respect of safeguarding vulnerable adults and adult protection, whilst Halton Borough Council's Health and Community Directorate has a lead responsibility for coordination of the arrangements.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

None identified.

5.2 Employment, Learning & Skills in Halton

None identified.

5.3 **A Healthy Halton**

The safeguarding of vulnerable adults is fundamental to their health and well-being.

5.4 **A Safer Halton**

The effectiveness of Adult Protection policies; physical, emotional and economic to make Halton a safe place of residence for vulnerable adults.

5.5 **Halton's Urban Renewal**

None identified.

6.0 **RISK ANALYSIS**

6.1 Failure to address a range of safeguarding adult issues could expose individuals to abuse.

6.2 The scrutiny report makes recommendations to mitigate risks for vulnerable adults in Halton.

7.0 **EQUALITY AND DIVERSITY ISSUES**

7.1 It is essential that the Council addresses a range of equality issues, in particular those regarding race, gender, sexuality and disability when considering its safeguarding policies.

2008-09

Annual Report

of
Halton's Multi-Agency

Safeguarding Adults

Board

CONTENTS

1. FOREWORD FROM CHAIR OF THE SAFEGUARDING ADULTS BOARD

As the recently appointed chair of Halton's multi-agency Safeguarding Adults Board, I am pleased to present this Annual Report, which describes how organizations and committed individuals in all sectors are working together to safeguard vulnerable people.

This has been another productive year for Halton and the Safeguarding Adults Board and has also seen a number of important and influential events nationally.

Locally, partner agencies dealt with more than 370 referrals of alleged abuse throughout the year, investigating those concerns, putting safeguarding arrangements in place and supporting people who find themselves in abusive situations.

As well as reporting on its work over the past year, the Board's fifth annual report explains the national context in which we all operate and lists our priorities for the coming year.

I want to assure local people and partner agencies of a continuing commitment to this work, which is essential to the quality of life and experience of people whose circumstances make them vulnerable.

Safeguarding adults is a complex and challenging area of work and I would like to thank all those involved for their vital contribution to the partnership.

Sue Wallace Bonner
Chair of Safeguarding Adults Board
Operational Director (Older Peoples Services) for Halton Borough Council (Health and Community Directorate)

2. NATIONAL CONTEXT

This has been an eventful year, which has seen a number of key drivers and developments in the context of safeguarding adults:

A review of '*No secrets' (DH 2000) was* launched by Phil Hope, Minister for Social Care, in October 2008, and is the most significant opportunity in eight years to address the way that local adult safeguarding activity is supported and directed by national guidance and/or legislation. Phil Hope MP said: "This consultation paper is about learning. It is about how we as a society learn to empower people - both the public and the professionals – to identify risk and manage risk. It is about how we empower people to say no to abusive situations and criminal behaviour. It is about locating safeguarding in the wider agenda of choice and control. It is about recognising safeguarding as everyone's business. It is about identifying the tools we need for better safeguarding." The consultation was aimed at everyone including, for example, questions for social workers, housing officers, police officers, lawyers, members of the public and people who use safeguarding/adult protection services.

The charity, Action on Elder Abuse have undertaken a high profile and concerted campaign for Adult Protection legislation and the Law Commission is reviewing a number of pieces of legislation, which it is anticipated will include safeguarding.

Adult social services continue to prepare for meeting the challenge of developing the *Putting People First* agenda in their service cultures and operational arrangements. A significant aspect of this is addressing the tension between facilitating self-directed support and safeguarding those whose circumstances make them vulnerable.

The Commission for Social Care Inspection (CSCI) carried out a programme of themed inspections of local authority adult social services, each incorporating a significant scrutiny of safeguarding arrangements. Bolton's safeguarding adults service was rated 'excellent' and officers from Halton recently attended an event hosted by Bolton, to see what we can learn from them to benefit the service we provide to people locally.

Reports arising from the inspections can be found on the Care Quality Commission (CQC) website:

http://www.cqc.org.uk/publications.cfm?widCall1=customDocManager.search_do_2&tcl_id=2&top_parent=4938&tax_child=4940&search_string=

The Commission for Social Care Inspection, the Healthcare Commission, and the Mental Health Act Commission ceased to exist

on 31 March 2009, when the Care Quality Commission (CQC) became the independent regulator of health and social care in England from 1 April. The CQC will regulate health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations and will have a remit to protect the rights of people detained under the Mental Health Act.

The CSCI produced the findings of two studies carried out nationally, into the views of people who use safeguarding services and other key people and organisations (which will contribute to the review of 'No Secrets') and a study of the effectiveness of safeguarding services. The reports can be found at the CQC website:

http://www.cqc.org.uk/publications.cfm

Elements of the Safeguarding Vulnerable Groups Act 2006 came into force during the year, when the Independent Safeguarding Authority (ISA) took over decision-making authority from the Protection of Vulnerable Adults (PoVA), Protection of Children Act (PoCA), List 99 and Disqualification Order systems. The ISA scheme has a much wider remit than current provision for vetting and barring staff and volunteers 'employed' to work with vulnerable people, affecting more workers and professions than before. As a result, safeguarding will be improved, with more professions and specific job roles closed to those who are barred under the new lists. The ISA is an independent body with its own remit and barring criteria, which may differ from the current regimes. The scheme goes fully 'live' in October 2009 and will be introduced through a phased approach in order to extend the current 'vetting and barring' and registration arrangements.

The first international Anglican conference, 'Creating a Safer Church', was held in 2008. The conference unanimously agreed and endorsed the advantages of information sharing and networking, and recommended that a report would go to the Anglican Consultative Council seeking support for this.

Despite any statue and regulation, policy and guidance, throughout the year a number of vulnerable adults and children suffered abuse at the hands others and in some cases tragically died.

- In Hounslow, a family were effectively 'imprisoned' in their own home, a flat rented from the local council, where they were repeatedly assaulted and abused by local youths. The parents, each of whom had learning difficulties, had applied to move to alternative accommodation but recommendations for re-housing had not been acted upon by the local authority. The resulting legal judgement clarified the duty of care of councils

- The Healthcare Commission report into the appalling state of affairs at the Mid Staffordshire NHS Foundation Trust stated that there

were deficiencies at "virtually every stage" in the care of people admitted as emergencies.

- The Commission also published a joint report with the Commission for Social Care Inspection (CSCI), and the Mental Health Act Commission (MHAC), reviewing how councils and Primary Care Trusts (PCTs) commission services on behalf of people with a learning disability.

- 'Six lives: the provision of public services to people with learning disabilities' was the Ombudsman's response to the report 'Death by Indifference' which related some significant and distressing failures in service across both health and social care, leading to situations in which people with learning disabilities experienced prolonged suffering and inappropriate care.

- The tragic death of 'Baby Peter' in Haringey led to a review of the way the case was dealt with, the local safeguarding children service and child protection arrangements nationally, which is ongoing.

Whether concerning adults or children, all of these events provide us with opportunities to consider our local safeguarding arrangements, to learn from the events that have led to abuse and how they might inform the way we work together and individually.

3. HALTON SAFEGUARDING ADULTS BOARD VISION

As a Board, our vision for adults who are vulnerable to abuse is encompassed in the following statements:

- ✓ *"A Halton where vulnerable people are safe from abuse/harm; empowered to make their own choices and to choose risks; where the professionals are supported and developed to deliver this."*

- ✓ *"The Safeguarding Adults Board will lead and co-ordinate multi-agency strategy and direction, with energy and commitment, to achieve our shared vision."*

- ✓ *"By working together with top-level commitment from all agencies, the Board will raise awareness and inspire positive changes in people's lives."*

4. KEY DEVELOPMENTS & LOCAL ACTIVITY 2008-09

4.1 WORKING TOGETHER

4.1.1 STRATEGIC FRAMEWORK AND LINKS WITH RELATED SERVICES

At the centre of local developments are:

- The multi-agency strategic decision-making body, the Safeguarding Adults Board (SAB)
- Sub-groups of the SAB
- Links with related services
- Individual partner agency developments

The SAB and sub-group structure and reporting mechanisms, SAB Terms of Reference, membership and list of people SAB minutes are circulated to, appear in Appendices 1 – 4 of this annual report. Sub-groups are multi-agency and their membership, terms of reference and work plans are available, on request, from the Adult Protection Coordinator (Julie.hunt@halton.gov.uk Tel: 01928 704523).

SAB and sub-group members' meeting attendance, contributions and commitment continue to be invaluable. Meetings provide the arena for developing Halton's safeguarding arrangements, and the consultation and decision-making involved in moving forward our challenging agenda to combat abuse. It is important to recognise and acknowledge that this is underpinned by a sound, ongoing commitment to effective inter-agency working and the vital contribution made by organisations and individual staff and volunteers in all sectors.

Achievements this year have included the following:

- Safeguarding Adults Board (SAB) held an **Away [half] Day** in January 2009, where we compiled a SAB response to the consultation on the **review of 'No Secrets'** and reviewed & prioritised the SAB **Work Plan**. The event was well attended by SAB members.

- Continued to contribute to **regional forums** e.g. Adult Protection/Safeguarding Coordinators, review of 'No Secrets', Commission for Social Care Inspection (CSCI) presentation of 'Safeguarding Adults' report

- A North West forum of Safeguarding Adults Coordinators was set up, chaired by Dwayne Johnson, Strategic Director, Halton Borough Council, with the aim of promoting good practice and shared learning.

- SAB members are kept informed of significant **national news and events** regarding safeguarding vulnerable adults and related matters, including those that provide potential for local developments

- Partner agencies encouraged to appoint **Safeguarding Vulnerable Adults leads** and many of those represented on the SAB do so. Protocols support this good practice.

- **Local Protocols** exist between Cheshire Constabulary (Northern Public Protection Unit – in respect of Halton area) and Halton Borough Council (HBC), and between four NHS Trusts and Halton Borough Council, and are regularly reviewed

- A protocol between **children's and adults services** has been implemented and reviewed

- **National protocols** are accessed and disseminated as appropriate

- Regular **management liaison meetings** occur between the NHS Trusts & HBC and the Police & HBC, monitoring the implementation of protocols and addressing other strategic and operational arrangements

- Developed and implemented **Deprivation of Liberty Safeguards (DoLS)** policies and procedures across health and social care services, to ensure that vulnerable people who lack capacity to make decisions about their living circumstances have the opportunity to have their situation reviewed on a regular basis and be managed under the least restrictive regime

- Increased the numbers of people referred to the **Independent Mental Capacity Act (IMCA) service** and taken steps taken to raise awareness

- Adult Protection Coordinator now attends the **Learning Disabilities Partnership Board**, to strengthen arrangements for safeguarding individuals in the local community affected by learning disabilities

- Links with Halton's **Domestic Abuse Forum** continue, to ensure close working partnerships in preventing and dealing with domestic abuse involving vulnerable adults

- Meetings have been held with the aim of improving referral arrangements to **substance misuse and alcohol services**

- A Multi-Agency Risk Assessment Conference (**MARAC**) convenes meets monthly to consider high risk domestic abuse cases

- The **secure email facility** set up for the Police to make referrals to HBC has been monitored

- **Community Safety** Manager and the Adult Protection Coordinator brought a paper to the SAB in September 2008, which looked at strengthening links between the related services

- Steps have been taken to raise awareness & encourage appropriate referrals to the **Intermediary (Witness Support) Service**

- Briefings provided to service **providers who contract with Halton Borough Council** e.g. on vetting and barring arrangements, restrictive physical interventions policy/procedures/guidance and training

4.1.2 INDIVIDUAL AGENCY DEVELOPMENTS and STATEMENTS OF COMMITMENT

Information received about agency commitment and progress in developing their internal safeguarding/adult protection arrangements includes the following:

AGE CONCERN MID-MERSEY

Philip Longworth, Chief Executive, provided the following statement:

Age Concern remains committed to ensuring that safeguards are in place to support vulnerable older people living within Halton. We value being part of the Safeguarding Board and working with other partners to raise awareness within the local community. Within Age Concern we strive to ensure that our staff and volunteers maintain and update their knowledge around this topic in a planned way, and will endeavour to ensure that older people are treated with dignity and respect through the safeguarding processes.

NHS HALTON & ST HELENS PRIMARY CARE TRUST

Helen Smith, Head of Safeguarding, provided the following information:

NHS Halton and St Helens Primary Care Trust provides community services to both adults and children across the boroughs of Halton and St Helens. The PCT also commissions services for its local population.

The PCT is committed to working in partnership with Halton Safeguarding Adults Board to ensure that vulnerable adults are protected from harm and supported in the most appropriate way.

The Community Health Services, the provider arm of the PCT, appointed a Head of Safeguarding Adults in January 2009 and have subsequently developed a Safeguarding Co-ordinator role. These roles will ensure that all safeguarding issues are appropriately and effectively managed.

The Head of Safeguarding is a member of the Safeguarding Adults Board in both Halton and St Helens boroughs.

Community Health Services are putting forward a positive plan to promote the Safeguarding Agenda.

The PCT will ensure that safeguarding issues are highlighted in all contract discussions with providers of healthcare services.

5 BOROUGHS PARTNERSHIP NHS TRUST

Marie Worthington, Lead Nurse Vulnerable Adults and Head of Service (Substance Misuse), provided the following statement:

Enhanced partnership working and the recognition of the need to improve multi agency data collection to provide a trends analysis will enable the data to be utilised as a planning tool in the prevention of abuse of vulnerable adults and perpetrators who may be vulnerable themselves. I hope to have a simple system in place by the end of June 2009, as a starting point.

Hope to have a simple data collection and reporting system in place by the end of June as a starting point.

HALTON BOROUGH COUNCIL

Halton Borough Council's Health and Community Directorate continues to take a **lead role** in developing our local multi-agency arrangements, including service developments, support to the SAB and sub-groups and their work plans, training and publicity.

Self-Directed Support - A Self Directed Support Group has been established with identifiable work streams including finance, self-assessment, personal budgets commissioning, workforce and outcomes. The tension between facilitating self-directed support and safeguarding people whose circumstances can make them vulnerable to abuse will be addressed through this forum.

In both Day Services and Halton Supported Housing Network (HSHN) **services for adults with learning disabilities**, the commitment to safeguarding vulnerable adults is a priority. All staff have been through adult protection training and the service has developed its own internal training which is frequent and regularly updated. The service commissioned a Quick Guide to Policies and Procedures which focused on those policies critical to front line staff - Safeguarding being one of those included. Policies and procedures are part of the fixed agenda for all staff supervision, team meetings and house meetings with tenants. A regular Quality Assurance Group (QAG) facilitated by an independent voluntary organization, Halton Speak Out (HSO) is held 4 times per year based on the Reach* standards. HSO are also involved with service users in Day Services and report back to management with any concerns across a range of issues - Safeguarding included. HSHN was awarded a three star rating by the Commission for Social Care Inspection (CSCI) in February 2009,

reflecting the work done around safeguarding and other service provision.

(*For more information on Reach standards, follow the link below):
http://www.paradigm-uk.org/articles/Reach__Standards_in_Supported_Living/52/43.aspx

ST HELENS & KNOWSLEY TEACHING HOSPITALS NHS TRUST

Tina Cavendish, Safeguarding Adults Lead and Senior Nurse - Clinical/Quality Standards, provided the following information:

St Helens and Knowsley Teaching Hospitals NHS Trust is committed to actively promoting the well being of vulnerable adults and ensure patients in its care are protected from abuse.

We are looking forward to having a safeguarding adult committee that is strongly rooted in the governance agenda. We will ensure the committee is robust in its expectations of high quality safeguarding in the Trust.

Achievements in the past year have included the following:

- An internal review by the Trust safeguarding adult committee has reviewed progress and identified priorities for action
- Trust now has access to Knowsley's E-learning Safeguarding Adult package
- Safeguarding Adult monitoring form updated
- Safeguarding Adult Flow chart updated
- "A duty to Safeguard Adults" poster updated and now include SA advisory team names and contact numbers
- Safeguarding adult group email set up enabling staff to contact advisory team for assistance
- The Trust's Human Resources Department are preparing for implementation of the Safeguarding Vulnerable Groups Act (2006) in October 2009, including delivery of awareness sessions with various groups of people within the Trust, informing them of the changes it will bring about.

WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST

Simon Wright, Director of Operations and recently appointed Executive Safeguarding Adults Lead**,** provided the following information:

Funding has been secured to invest in a whole time equivalent Safeguarding Adults Matron post for the Trust, who will attend relevant sub-groups

The Executive Lead will attend the Safeguarding Adults Board and will ensure that the new post-holder has a good understanding of the various stakeholders so they can play an active role across the Trust in this important area.

The trust provides a multi-agency Vulnerable Adults Committee that oversees safeguarding arrangements.

CHESHIRE CONSTABULARY

Cheshire Police (Northern Public Protection Unit) provided a written response to the findings of **research** undertaken by the University into service users' and carers' experience of vulnerable adults service and attended a conference to present the response.

Halton's **MARAC** (Multi Agency Risk Assessment Conference) process, which is chaired and administered by the Police, is firmly embedded within its domestic abuse strategy. The MARAC is held monthly and contributes towards safeguarding vulnerable adults through a range of multi agency interventions.

4.2 RAISING AWARENESS

4.2.1 TRAINING AND DEVELOPMENT

Our training and development plans aim to provide for a skilled, informed workforce and community that recognises abuse and its signs, is enabled to prevent abuse where possible, knows what to do when abuse happens or concerns arise, and are able to fulfil their responsibilities. Our aims are to ensure that vulnerable people are effectively safeguarded, whilst facilitating independence and ensuring a timely and appropriate response when allegations or concerns are raised.

Achievements this year have included the following:

- Delivered, developed and evaluated a **suite of courses**, which are in-line with National Minimum Standards and Skills for Care Sector Skills Agreement. Courses continued to be provided by Halton Borough Council, in consultation with partner agencies, and included the following:
    - Multi-agency Basic Awareness courses held centrally
    - Onsite Basic Awareness courses held Feb/March 2009 at North Cheshire Hospitals
    - Basic Awareness courses provided Oct 08 & March 09 for Elected Members
    - Multi-agency Referrers courses
    - Investigators training for Council managers and social work practitioners
- Referrers, Chairing Skills & Investigators **courses reviewed**
- **Police** provided **input** on some training courses
- **Train the Trainer course** designed and commissioned for 2009-10, including input from Trainer and Halton Borough Council Training Officer and an information pack and DVD to support delivery
- Developed an **electronic training** package
- Re-tendered a **training provider contract** & agreed content of training and handouts.
- Produced **guidance** on **Refresher/Update training** and disseminated it to partner agencies and service providers
- With Halton Borough Council's Children and Young Persons' Directorate, took action to ensure **better information flow in schools** that take young people aged 18years and over

- Implemented a policy of **charging [for non-notified] non-attendance**, with the aim of improving attendance and better use of training resources

- **Contract** between Halton Borough Council and service providers **reviewed** in terms of training attendance and staff development

- Provided a further briefing on Multi-Agency Public Protection Arrangements (**MAPPA**) to Adult Social Care staff and managers

- Considered adequacy of arrangements for training in respect of generic **Restrictive Physical Interventions** policy

- **Training feedback form** reviewed & revised, whilst recognising that the feedback form is only a first stage in eliciting whether training was useful and affected practice

- Details of training courses and refresher training guidance added to Safeguarding **website**

- Drafted **Terms of Reference & Action Plan** for Training and Development Sub-group

- Sought more secure **representation on the Training and Development Sub-group** from NHS Trusts and representation from the voluntary sector

- Considered ways to **extend distribution of training course adverts** to a wider group of Halton Borough Council staff

- **Extended distribution** of training course adverts, particularly in the third sector – to include, for example, faith groups

- Training **feedback monitored**. The majority was positive, but any that raised concerns was dealt with via an individual action plan and subsequent monitoring

- Addressed issues of concern about a training **venue** used for Referrers courses

- All training **attendance and non-attendance** fully recorded and some targeted analysis

Basic Awareness **training attendance** and overall attendance increased in 2008-09, as follows:

	2007-08 Number attended	2008-09 Number attended	Increase	% Increase
Basic Awareness course attendance	97	480	383	395%
TOTAL training course attendance	305	663	358	117%

4.2.2 PUBLICITY & COMMUNICATION

Getting the message across continues to be one of the most important elements of our safeguarding/adult protection work it can:

- Raise awareness of what constitutes abusive behaviour
- Help people to know what they can do to prevent abuse from happening and what to do if they believe someone is being abused
- Act as a gateway to empowering vulnerable people to keep safe and to seek help when abuse happens
- Support other people, including paid and unpaid carers, in fulfilling their responsibilities.

Achievements this year have included the following:

- Safeguarding Adults Board agreed to set up a **sub-group with a remit for publicity and communication**. Terms of reference and a work plan drafted
- **Staff leaflet** updated
- **Public Information flier** reviewed and updated
- Advertisement placed in **Halton Community Safety / Crime Reduction booklet,** which is delivered to over 42,000 addresses in Halton
- **Information widely distributed** with the revised version of 'Adult Protection in Halton – inter-agency Policy, Procedures and Guidance', to all agencies, organisations and groups that might have contact with vulnerable adults
- Briefing session provided to **Halton Housing Trust**
- Presentation and information stand provided at the **Supporting People Inclusive Forum**
- **Publicised research** undertaken locally by the University of Liverpool and Halton Borough Council's and Cheshire Constabulary's responses to the findings, through:
  - a **conference** to which all participants and other key people were invited
  - a local **press article**
  - publication on **websites** – University of Liverpool, Action on Elder Abuse, Halton Borough Council
  - in **collaboration with the University of Liverpool and Action on Elder Abuse,** provided a **'Knowledge Café'** to which representatives from other localities were invited.

An introduction to the research, summary and full report are available on the University and Council websites:
www.halton.gov.uk/adultprotection

Safeguarding Vulnerable Adults/Adult Protection website

Halton Borough Council's (HBC) Internet and intranet Safeguarding Vulnerable Adults/Adult Protection WebPages have been updated on an ongoing basis. They contain general information and documents, and provide links to related sites such as Domestic Abuse, Safeguarding Children/Child Protection, Consumer Protection and Care Quality Commission (CQC).

(The following links can be used to access the Safeguarding Vulnerable Adults/Adult Protection Webpages):

(a) The **Internet**:

http://www.halton.gov.uk/adultprotection

http://www.halton.gov.uk - access via the A-Z index under 'Adult Protection' or 'Safeguarding Vulnerable Adults'.

(b) **Halton Borough Council's (HBC) intranet** Webpage can be accessed by HBC staff by using the following routes:

Follow the link:

http://intranet/content/directorates/healthandcommunity/adultprotection/?a=5441
Or:
Home page > Health and Community > Safeguarding Vulnerable Adults/Adult Protection link.

Cheshire Police and the four NHS Trusts that interface with Halton have **links to the Halton Borough Council Website/Safeguarding Vulnerable Adults page.**

4.3 INFORMATION AND MONITORING

4.3.1 DATA

Quantitative data does not reveal the human experience of the people to whom it appertains. Reliable data recording, analysis and reporting systems can, however, provide us with a picture of what abuse is being reported, how it is being dealt with and what the outcomes are for people who experience and perpetrate abuse, whether intentional or not. Data and trend analysis can be utilised as a planning tool in the prevention of abuse of vulnerable adults and also perpetrators who may be vulnerable themselves. By informing our developments and practice, provision of reliable and informative data can ultimately assist in improving the individual circumstances of vulnerable people in Halton.

Achievements this year have included the following:

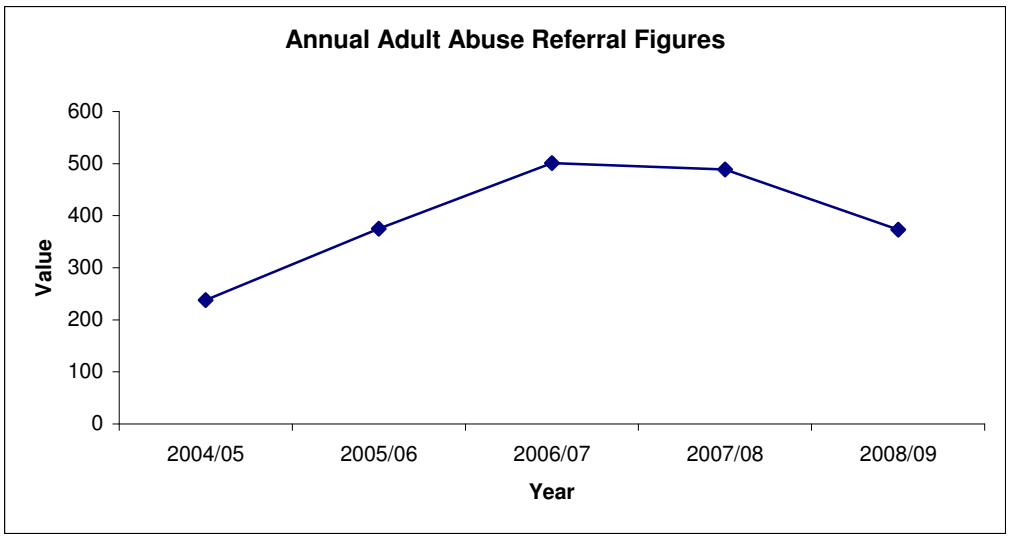
- Enhanced partnership working has led to an acknowledgement of the need to improve multi agency data collection and reporting. NHS Trusts (the 5 Boroughs Partnership, NHS Halton and St Helens [PCT], St Helens & Knowsley Hospitals, and Warrington & Halton Hospitals) and Cheshire Police (Northern Public Protection Unit [PPU]) have committed to providing systems that will report data to a central reporting point and are developing their internal systems accordingly. The Trusts have agreed timescales for progress, and have been informed of the national data set issued by the Information Centre for implementation by local authorities. The Police are aiming to provide data on cases dealt with by officers operating outside of the specialist PPU.
- Halton Borough Council (HBC) has collected data about referrals received during the year and this has informed the graphs and commentary provided below
- Until recently, no nationally recognised or mandatory system or data set existed for the collection of safeguarding adults/adult protection data. This omission was remedied in March 2009, when a data set that had been piloted in 2008 was issued for implementation by local authorities by October 2009. The Council's safeguarding adults/adult protection case recording and data collection form has been developed to incorporate the data set
- In Halton Borough Council, monthly reports of outstanding cases and timescales for conclusion have been refined to define those open for longer than a given timescale. This aims to encourage follow up to ensure timely conclusion and closure of open records on concluded cases

Presentation of Local Data and Commentary

Table 1, below, shows the **total number of referrals in Halton**:

- Rose by a total of 110% over a 3-year period 2004-05 to 2006-07
- Fell by just over 2% in 2007-08
- Fell a by further 24% this year, 2008-09:

Table 1

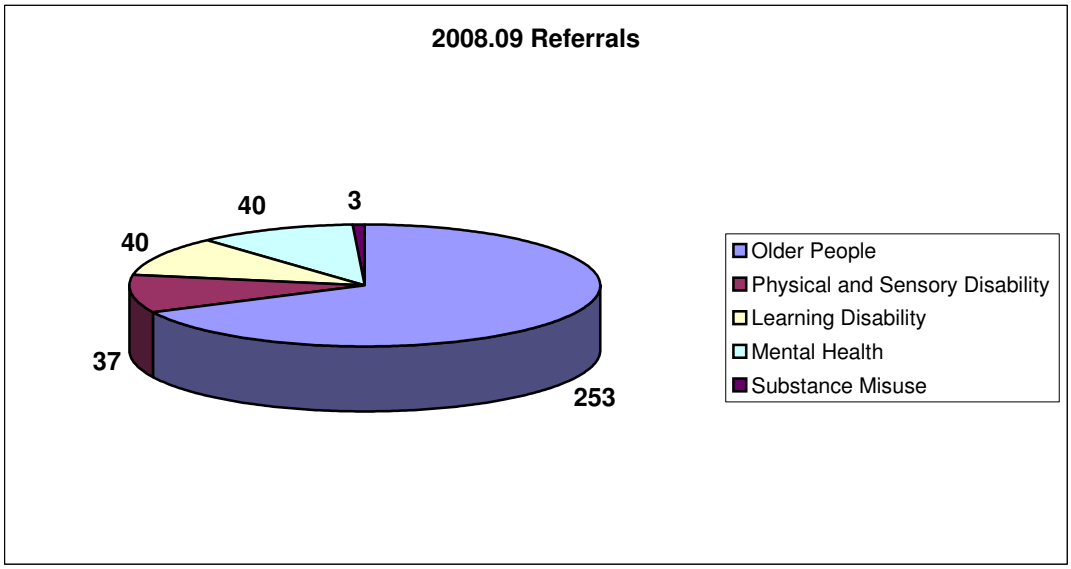


On the face of it, the fluctuation in referral numbers could be seen as a cause for concern. Comparable information from the development of child protection, however, which is several years ahead of the safeguarding adults agenda, shows that high reporting levels do not necessarily mean higher prevalence and is more likely to be a reflection of local action to raise the profile and awareness through, for example, publicity and staff training.

The decrease from 2007-08 to date could be ascribed to work done with the assessment and care management teams, on screening possible safeguarding referrals to better enable managers and staff to distinguish safeguarding allegations from other concerns, providing guidance on options of approach depending on circumstances.

Halton's referral numbers by service user group during 2008-09 show the greatest number of alleged victims to be older people, followed by people with learning disabilities and those with mental health issues, followed by those with physical & sensory disabilities, with a small number of those who misuse substances:

The pattern of relative proportions of Halton's **referrals** by **service user group** sees both slight and significant variations **from 2007-08 to 2008-09:**



	2007-08		2008-09	
	Number of Referrals	**% of Total Referrals**	**Number of Referrals**	**% of Total Referrals**
Older People	262	54%	253	67.75%
Learning Disabilities	142	29%	40	10.75%
Physical/Sensory Disabilities	54	11%	37	10.0%
Mental Health	31	6%	40	10.75%
Substance Misuse	0	0%	3	0.75%
TOTAL	489		373	

Data provided by Halton Police Public Protection Unit (PPU) shows the following **Criminal Justice System involvement by the PPU** during **2007-08 and 2008-09**:

	Referrals (Number not known for 2007-08)		**Police Involvement**		**Police Investigation**		**Crown Prosecution Service (CPS) Advice**		**Alleged Perpetrator Charged**	
	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09
Runcorn	-	33	12	7	21	8	3	1	0	1
Widnes	-	29	6	15	11	4	3	1	1	1
TOTAL	-	62	18	22	32	12	6	2	1	2

(**Police involvement*** means specialist Police Officer has given advice only and not physically left the office).

(**Police Investigation*** means specialist Police Officer attended strategy meetings or case conference or the alleged perpetrator voluntarily attending the Police station for an interview under caution).

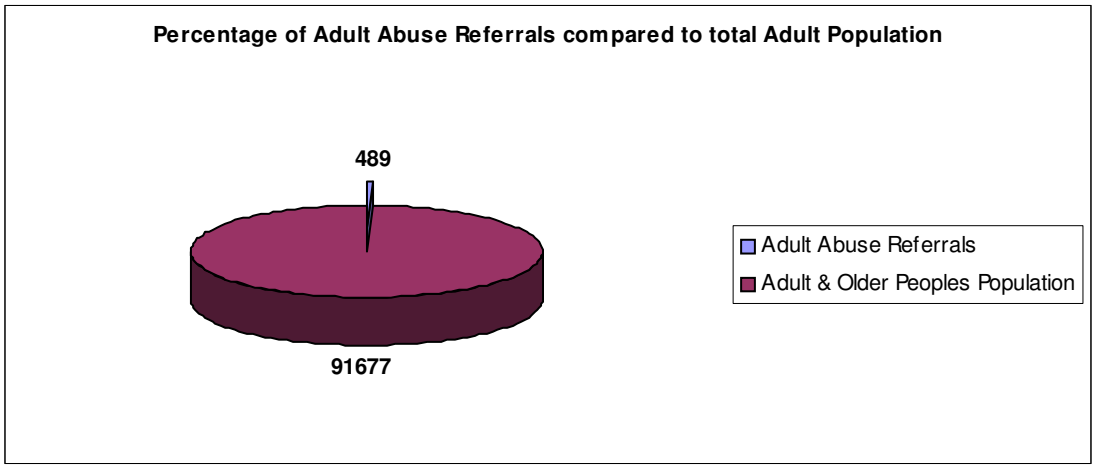
The data provided in the above table **relates only to Public Protection Unit investigations** and does not reflect investigations across other policing departments that will at various times deal with vulnerable adult victims. It should also be seen in the context of the reduction in referrals shown in Table 1, above.

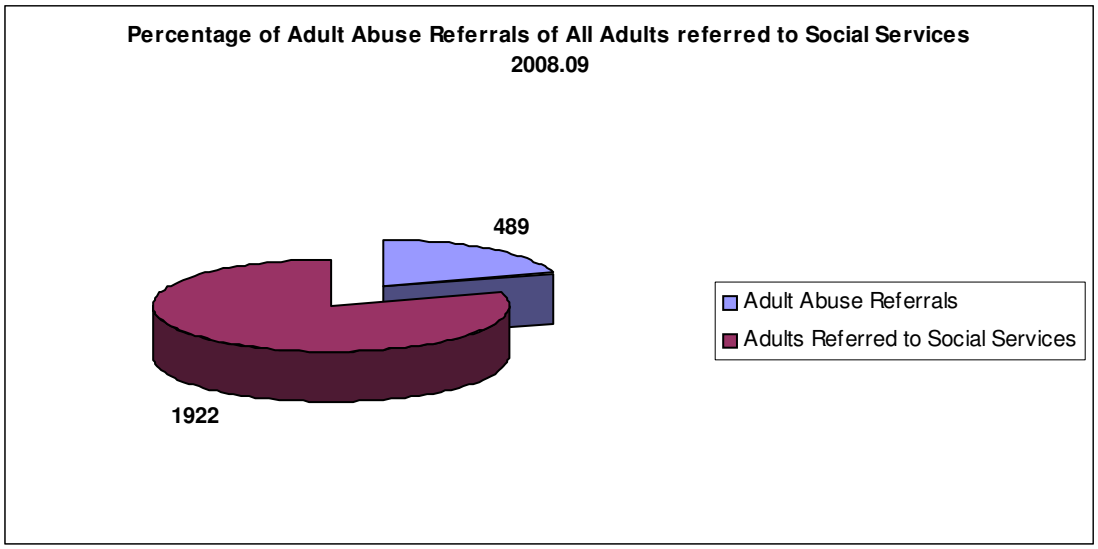
Police colleagues have explained that the above data supplied from their records cannot be guaranteed totally accurate, but if anything is likely to be an under-estimate rather than an over-estimate. More reliable data is anticipated next year.

The method of collection and analysis of data provided by the Police is being reviewed and steps taken, where possible within the constraints of IT systems, to provide a more detailed picture of all Police involvement in cases of alleged vulnerable adult abuse.

The following two charts show the **percentage of alleged adult abuse referrals compared with:**

- **The total adult population in Halton and**
- **The total number of adults referred to Halton Adult Social Services.**


Percentage of Adult Abuse Referrals compared to total Adult Population
489
91677
Adult Abuse Referrals
Adult & Older Peoples Population


Percentage of Adult Abuse Referrals of All Adults referred to Social Services 2008.09
489
1922
Adult Abuse Referrals
Adults Referred to Social Services

4.3.2 SCRUTINY AND QUALITY

The Safeguarding Vulnerable Adults Partnership Board reports into the Safer Halton Partnership (http://www.haltonpartnership.net/site/), where support for safeguarding activities has continued to be demonstrated.

The Annual Report of the Safeguarding Adults Board is also presented to and scrutinised by the Safer Halton and Healthy Halton Policy and Performance Boards of Elected Members, and to the Domestic Abuse Forum and Learning Disabilities Partnership Board.

One of the main mechanisms for checking standards of safeguarding/adult protection work in operation is individual agency line management and supervision.

The multi-agency Scrutiny/Quality sub-group also has a remit to consider the quality of the service, make recommendations for improvement and monitor action plans, including those arising from cases that have given rise to concern either locally or in other areas.

Achievements this year have included the following:

- The **University of Liverpool** produced a final report of the findings of 2 years of **independent research** conducted into service users' and carers' experience of the safeguarding service, and Halton Borough Council and Cheshire Police each provided a full response. (The Publicity and Communication section of this annual report explains how the research was publicised.). The findings provided valuable opportunities for us to improve the local service
- Halton's Policy and Performance Boards set up a **Scrutiny Review Topic Group of Elected Members** with a brief to scrutinise the Safeguarding/Adult Protection service. The group reported its findings (which were, on the whole, positive) and recommendations in August 2008. Recommendations have been taken forward through work plans, progress reviewed and two were deferred for further consideration by members
- Supporting framework for the **Scrutiny/Quality sub-group** has been developed and the group started to operate during 2008
- The Scrutiny/Quality sub-group has considered **learning opportunities** arising from cases in other localities:
  - a legal judgement made with regard to a council's duty of care to a family in Hounslow
  - the death of Baby Peter, in Haringey
- Halton Borough Council set up an internal **Safeguarding Performance Group**, with terms of reference and an action plan focussed on improving standards of recording, data collection and

information reporting. This aims to provide a better quality of information to form a basis for the work of the scrutiny group.

- Warrington and Halton Hospitals NHS Trust have a **Safeguarding Vulnerable Adults Committee** that has a remit for dealing with issues of service quality and improving Trust and partnership working
- Halton Borough Council's safeguarding adults/adult protection case recording and data collection form has been developed (in draft) to incorporate **service user or carer comments** on the safeguarding process & any **learning points** and how they have been disseminated
- Devised a **framework for Halton Borough Council Contact Centre Advisors** to use when receiving referrals
- Reviewed the **contract** between Halton Borough Council and service providers and the content of **service specifications for Domiciliary Care & Care Homes** to ensure robust in respect of safeguarding arrangements, including staff recruitment, supervision, training
- Links between Halton Borough Council's **Customer Care** service and Safeguarding Vulnerable Adults service further strengthened.

4.4 POLICIES, PROCEDURES & GUIDANCE

Policies, procedures and guidance provide a sound value base, consistent and considered approach, facilitate compliance with statutory requirements and good practice standards, support line management and supervision and provide a sound operational framework. They aim to contribute to effective service provision to vulnerable people and carers, preventing abuse from occurring and supporting us in dealing with it effectively when it occurs.

Achievements this year have included the following:

- Revised version of '**Adult Protection in Halton – Inter-agency Policy, Procedures and Guidance' distributed**, along with training and publicity details and other information. Distribution extended to include over 100 additional third sector organisations, including faith groups, advocacy services and all voluntary sector organisations known to operate locally
- NHS Trusts and Halton Borough Council are continuing to develop their **internal policies, procedures and practice guidance**
- **Professional Boundaries Handbook** for social care staff in Halton Borough Council completed and shared with partner agencies and contracted providers. Will be provided to all staff through induction and line management.
- **Restrictive Physical Interventions Policy, Procedures and Guidance*** reviewed, and extended to be **generic**. Agreed by the SAB and for implementation in Halton Borough Council and NHS Halton and St Helens (PCT)
- Produced **draft checklist for Halton Borough Council managers** in a supporting role to staff against whom allegations are made. Passed to corporate personnel & trade union to take forward.
- Further development of criteria/guidance for Halton Borough Council managers **screening possible safeguarding referrals**, including case examples and flowcharts, to better enable staff to distinguish safeguarding allegations from other concerns, providing guidance on options of approach depending on circumstances.
- **Case recording and data collection form** further developed to incorporate service quality standards e.g. advocacy, service user/carer comments and learning points.
- The Practitioners Group and the Safeguarding Adults Board are often **consulted** in the development of policies, procedures and guidance that are intended for internal application in Halton Borough Council only. Final **documents are shared** to enable other agencies, including service providers, to adopt or adapt them where applicable.
- All relevant **documents are available on the Internet**, via Halton Borough Council's website at :http://www.halton.gov.uk/adultprotection - also accessible via links from partner agencies websites.

4.5 PREVENTION OF ABUSE

The Safeguarding Adults Board's vision is of a Halton where vulnerable people are safe from abuse/harm, whilst being empowered to make their own choices and to choose risks.

Crucial to working towards achieving this aim are the actions we take to prevent abuse from happening or to prevent it from happening again when it has occurred.

Achievements this year have included the following:

- Implemented measures to **minimise risks posed by people** who have a known history of abuse or who are likely to pose such risk, such as the Multi-Agency Public Protection Arrangements [**MAPPA**], Multi-Agency Risk Assessment Conference [**MARAC**], referral to the Protection of Vulnerable Adults [**PoVA**] Scheme and Independent Safeguarding Authority (**ISA**).

- Effectively **supported people** at home or in other settings, promoting independence and options whilst putting safeguards in place, as part of care and support planning and service provision.

- Offered **Direct Payments recipients** the opportunity to take up Criminal Records Bureau (CRB) checks on people they seek to employ.

- **Appointee and Receivership** arrangements pursued where indicated appropriate.

- Provided **effective support arrangements** to prevent abuse from occurring, especially where there is potential for it to occur as a result of ignorance, poor practice or lack of support for carers.

- Promoted **effective quality assurance mechanisms**, through contractual and monitoring arrangements and the scrutiny and action planning supported by the Scrutiny/Quality sub-group.

- Reviewed and further strengthened **contracts** between Halton Borough Council and service providers, incorporating Safeguarding standards

- **C**ontributed to consultation to inform **commissioning plans**

- Implemented effective **policies, procedures, guidance and other information** that seek to prevent abuse and enable people to act upon concerns and disclosures.

The Inter-agency Policy, Procedures and Guidance, staff leaflet, professional boundaries handbook, and restrictive physical interventions policy and procedures are examples of these.

- Started to plan for provision of a **Handyperson** scheme to enable minor repairs to be carried out by vetted staff.

- Through training and publicity particularly, **raised** the **awareness** of vulnerable people, the public, staff and volunteers, to enable them to recognise what constitutes abuse, how it can be prevented and what are the consequences of abuse, both for the victim or survivor, for the perpetrator and for those who have been culpable in abusive situations.

- Further worked with the Police and other partner agencies and related services, to provide a **conduit for referral by the Police** particularly into, for example, drug and alcohol, bereavement and health services. In some cases this will have helped to ensure that people who become known to the Police and experience a degree of vulnerability, but do not need the adult protection service at that time, have access to other support services that they need and which might prevent their level of vulnerability from increasing.

- Sought to **learn from past events** in both adults' and children's services and to further develop our arrangements for effectively working together.

- Promoted a culture of **'zero tolerance' of abuse**, ensuring that all referrals of alleged or suspected abuse are acted upon effectively and as a priority.

4.6 RESOURCES

Whilst **"No Secrets"** requires statutory agencies to work together in partnership with all agencies in the public, independent and voluntary sectors and with service users and carers, to ensure that local Policies and Procedures are in place to protect vulnerable adults from abuse, no additional funding has been made available from Government to achieve this objective.

Funding the service and costs associated with the Safeguarding Adults Board's activities, during 2008-09, is shown in the table below.

Halton and St Helens NHS Primary Care Trust and North Cheshire Hospitals NHS Trust and 5 Boroughs Partnership NHS Trust contributed to funding the Adult Protection Coordinator post and training and committed the same funding for the years 2007-08 and 2009-10.

The University of Liverpool provided funding towards the cost of a conference held in July 2008.

Agency	Spending 2008-09 £
Warrington & Halton Hospitals NHS Foundation Trust	2,533
NHS Halton & St Helens Primary Care Trust	12,665
University of Liverpool	300
Halton Borough Council	57,789

The above figures do not include investment in leadership and front-line services.

Additionally, Halton Borough Council has invested more in multi-agency training this year, seeing a 56% increase over last year, as follows:

MULTI AGENCY SAFEGUARDING VULNERABLE ADULTS/ADULT PROTECTION EXPENDITURE		
	2007-08 Spend	2008-09 Spend
Basic Awareness	1050.00	4725.00
Referrers	1800.00	1800.00
TOTAL	**£2850.00**	**£6525.00**

5. CONCLUSION - OUTCOMES FOR SERVICE USERS AND CARERS

The Safeguarding Adults Board's overarching vision is of a Halton where vulnerable people are safe from abuse/harm, whilst being empowered to make their own choices and to choose risks.

The following are some of the outcomes we aim to ensure for people who use services and for their carers:

- People are able to live in safe and secure surroundings without fear of harassment, abuse or neglect
- People experience dignity and respect throughout the safeguarding processes
- Vulnerable people can make decisions about their living circumstances, have the opportunity to have their situation reviewed on a regular basis and managed under the least restrictive regime
- People receive a timely and appropriate response when allegations or concerns are raised
- People are able to receive information that they have a right to and, where appropriate, facilitates their taking informed decisions
- Support is provided by a skilled, informed workforce to ensure that people are supported at home or in other settings
- People receive support to manage risk
- People can maintain involvement in local activities, policy development and decision-making

6. PRIORITIES FOR 2009-10

- Continue to provide an effective multi-agency framework for operation, including the Safeguarding Adults Board and sub-groups with membership that reflects the safeguarding 'community'. **Review SAB and sub-group terms of reference, membership, sub-group work plans and reporting arrangements**;
- **Review the structure and capacity to respond**;
- **Implement recommendations arising from the review of 'No Secrets'**
- **Raise the local profile** of safeguarding **and raise awareness** of abuse: how to prevent abuse and what to do if concerned; engage people in securing a safer local environment;
- **Increase local knowledge** of safe working practices and processes through, for example, training and development, practice guidance and access to information;
- Ensure the maintenance of safeguarding as a high priority throughout the delivery of the **personalisation** agenda, whilst ensuring that service users and carers achieve increased choice and control;
- **Appoint a Dignity in Care Co-ordinator** who will ensure quality care and the dignity of service users, reporting to the Safeguarding Adults Board;
- **Appoint a Domestic Abuse Coordinator,** with a responsibility to link with the Safeguarding Adults Board;
- Ensure **clear routes for referral** and to allow concerns to progress to referral;
- Make safeguarding integral to service planning and development, and to operational practice;
- **Strengthen links** between agencies and services related to safeguarding vulnerable adults, starting with agreed shared definitions;
- Develop a **2-way secure email link** between Halton Borough Council and the Police and consider the viability of a similar arrangement with the NHS Trusts;
- Agree a **strategy for assuring quality** and consistency of approach and response across partner agencies and that actions are person centred, friendly towards the people involved, communications clear and understandable, and people involved are able to state their wishes and feelings;
- Further **develop data collection, reporting and analysis** arrangements, to implement national reporting requirements and also better inform quality monitoring and service development. Developments will incorporate implementing the revised (paper based) case recording and data collection form, an electronic recording form, and supporting IT system;
- **Pursue learning opportunities** available, to the benefit of the service to vulnerable people and carers;

- Ensure that evidence of **outcomes** is embedded in **performance management** frameworks so that they are monitored and reviewed appropriately;
- Re-commission **advocacy** services to support vulnerable adults in relation to safeguarding investigations, increasing significantly the profile within the contract, with timely access to advocacy support being a key component;
- Strengthen the focus on **prevention of abuse**, for example ensuring safeguards are built into commissioning and contracting arrangements
- Ensure that **information** is updated;
- Conclude the review of Halton Borough Council Adult Social Care (ASC) **MARAC** arrangements and take forward recommendations about the operation of the multi-agency forum and HBC ASC's internal arrangements.
- Keep the provision of the Independent Mental Capacity Advocate (**IMCA**) service under review to ensure it is available to service users with a right to access

Other actions planned:

Training & Development

- Gain full commitment from **Police to input** on increased number of selected courses
- Provide a comprehensive **Train the Trainer course** with follow up
- Extend the review and **analysis of training attendance** data
- **Increase training attendance** and target action where appropriate
- Review and broaden **training distribution**
- Review **MAPPA and MARAC training** provision
- Consider **voluntary sector training needs**
- Agree **Terms of Reference & Action Plan** for Training and Development Sub-group
- Further develop the **electronic training package**

Publicity & Communication

- Set up a **sub-group** with a remit to devise and implement a publicity and communication **strategy for raising awareness**
- Further develop the Safeguarding Vulnerable Adults/Adult Protection **website and access arrangements**
- Review and update the **accessible guide** and distribute widely
- Provide an **Information Pack** to all Supporting People providers

Scrutiny and Quality

- **Independent researcher**s from the University of Liverpool will conduct further work to monitor the implementation of actions arising from their research findings. Provide local support for this work
- Review the terms of reference and operating framework, and develop a work plan, for the **Scrutiny/Quality sub-group**

- Continue to pursue actions arising from **learning opportunities** that will enable Halton's services to be developed
- Implement revised **case recording and data collection form** in Halton Borough Council, incorporating service quality standards, service user feedback, learning points, national standard data set and learning from external audit carried out in 2009
- Carry out **trends analysis and utilise the findings** in planning developments of the service, to better prevent abuse of vulnerable adults and provide a sound response to concerns

Policies, Procedures & Guidance
All single agency documents devised in Halton Borough Council are made available to partner agencies.

- Devise **Templates** for Meeting Minutes & Report to Safeguarding Meetings
- Review and revise Halton Borough Council's **Sexual Health Policy**, incorporating more on intimate relationships
- **Finalise and 'roll out' generic policy, procedures and guidance on** Restrictive Physical Interventions **to signatory agencies and others**
- Further extend provision of **Professional Boundaries Handbook** to other sections in Halton Borough Council, adapting it to be more readily applicable to other than 'social care' staff and other agencies
- Further support the development of **internal and inter-agency policies, procedures and guidance**, ensuring that the former ties in appropriately with the latter.

Prevention of abuse
Many of the actions and priorities stated above will be preventative in their effects.

- Continue to review what preventative measures are in place, and consider how we support their continuity and further develop safeguarding mechanisms.
- Promote implementation of the vetting and barring arrangements provided by the **Safeguarding Vulnerable Groups Act 2005**

Resources
- Review **funding** arrangements
- An additional **Detective Inspector (DI) post** will be provided in the Northern PPU of Cheshire Police, thereby providing a dedicated DI for the Halton area.
- Warrington And Halton Hospitals NHS Foundation Trust will be providing a **dedicated Executive lead and Safeguarding Coordinator**
- NHC Halton and St Helens Primary Care Trust will appoint a **Safeguarding Adults Coordinator**

7. USEFUL INFORMATION

- **'Adult Protection in Halton – Inter-agency Policy, Procedures and Guidance' Version 6 Revised 2008**
- **Other policies, procedures, protocols, practice guidance, leaflets etc**
  Available on the Halton Borough Council website:
  Internet: www.halton.goc.uk/adultprotection
  Intranet:
  http://intranet/content/directorates/healthandcommunity/adultprotection/?a=5441

- **"No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse"** *Home Office and Department of Health 2000.* Available on the Department of Health website at: www.dh.gov.uk

- **"Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work"** *Association of Directors of Social Services (ADSS) Safeguarding Adults Network 2005* Available on the Association of Directors of Adult Social Services (ADASS) website at: www.adss.org.uk

APPENDIX 1

STRUCTURE AND REPORTING FRAMEWORK

APPENDIX 2

SAFEGUARDING ADULTS BOARD TERMS OF REFERENCE

1. PURPOSE

The purpose of Halton's **Safeguarding Adults Board** (SAB) is to:

1.1 Act as a multi-agency partnership board of lead officers and key representatives, which takes strategic decisions aimed at safeguarding vulnerable adults in Halton.

1.2 Determine and implement policy, co-ordinate activity between agencies, facilitate training and monitor, review and evaluate the adult protection service.

1.3 Promote inter-agency cooperation, to encourage and help develop effective working relationships between different services and agencies, based on mutual understanding and trust.

1.4 Develop and sustain a high level of commitment to the protection of vulnerable adults.

1.5 Ensure the development of services to support people from hard to reach groups
"The terms "vulnerable" and "adult" are as defined in "Adult Protection in Halton – Inter-agency Policy, Procedures & Guidance" available at www.halton.gov.uk/adultprotection.

2. RESPONSIBILITY, ACCOUNTABILITY and REPORTING

2.1 Local agencies should work together within the overall framework of Department of Health guidance on joint working. The lead agency with responsibility for the establishment and effective working of the SAB is Halton Borough Council's Health and Community Directorate.

2.2 All agencies should designate a lead officer and, if necessary, a nominated other representative.

2.3 All main constituent agencies are responsible for contributing fully and effectively to the work of the SAB.

2.4 The SAB reports to the Community Safety Partnership through the Safer Halton Partnership, which is chaired by the Chief Executive of Halton Borough Council and the Superintendent of Halton Police.

2.5 A formal report of the SAB will be compiled annually and presented to the Safer Halton Partnership, and other forums by agreement.

3. FUNCTIONS

The functions of the SAB are to:

3.1 Ensure that there is a level of agreement and understanding across agencies, about operational definitions and thresholds for intervention.

3.2 Develop, monitor, review and evaluate the implementation and effectiveness of Halton's SAB's work plan and sub-groups' work plans for the implementation of strategic decisions and policy.

3.3 Develop and keep under review, local policies, procedures, systems and protocols for inter-agency work to safeguard vulnerable adults.

3.4 Audit and evaluate the implementation and effectiveness of the safeguarding adults service and associated policies, procedures, systems and protocols.

3.5 Promote agreed policies, procedures and protocols to managers, staff, volunteers, service users and the public.

3.6 Arrange for information to be gathered and used in the evaluation of the adult protection service, through performance assessment and monitoring systems and through consultation with stakeholders.

3.7 Develop a training and development strategy, incorporating joint training where appropriate.

3.8 Facilitate training and ensure its delivery and evaluation, to help improve the quality of adult protection and inter-agency working.

3.9 Ensure that service developments take into account the needs of all vulnerable adults, regardless of their age, gender, race, sexuality, disability, religion or belief, who may experience discrimination and disadvantage.

3.10 Ensure that service developments take into account all relevant current legislation, including the Human Rights Act 1998.

3.11 Review national guidance and research information as it is issued, consider the implications and make recommendations for local implementation. Action and monitor such implementation.

3.12 Respond to consultation exercises where appropriate.

3.13 Commission serious case reviews where a vulnerable adult has died or, in certain circumstances, is seriously harmed, and abuse or neglect are confirmed or suspected, acting in accordance with Halton's Serious Case Review Procedure.

3.14 Improve local ways of working in the light of knowledge gained through national and local experience, research, Serious Case Reviews, internal and external inquiries, investigations and case studies. Ensure that practitioners benefit from learning and development attained through the SAB and that lessons learnt are shared, understood and acted upon.

3.15 Link with other agencies, sectors and forums that have a responsibility for protecting those at risk, such as Halton's Safeguarding Children Board, Domestic Abuse Forum and the Safer Halton Partnership, to ensure that both adult and child protection arrangements benefit from the learning, developments and work undertaken by the other, where appropriate.

3.16 Raise awareness within the wider community, of the need to safeguard vulnerable adults, explain how the community can contribute to this process, and facilitate such involvement.

3.17 Support and ensure the implementation of the development of quality standards for vulnerable adults, both locally and nationally.

3.18 Carry out an annual audit of alleged adult abuse and adult protection in Halton, through analysis of data and outcomes; report these and forecast developments, through the Annual Report of the Safeguarding Adults Board.

4. MEETINGS

4.1 The SAB will meet on a quarterly basis, with the schedule of meetings published in advance for a year. Meetings can be called more frequently as circumstances dictate.

4.2 The agenda will be prepared by the Adult Protection Coordinator, in consultation with the Chair of the SAB, and will be issued to all members at least one week before the meeting takes place.

4.3 Meeting agendas will progress the work plan.

4.4 All SAB members will be able to bring appropriate items to the agenda, through the Chairperson or Adult Protection Coordinator. Standing items on the agenda will be by agreement of SAB members.

4.5 The chairperson will arrange for minutes of meetings to be taken and a copy of the minutes sent to each SAB member and other people by agreement, including the Chairs of the Safer Halton Partnership, Practitioners Group and senior managers of public sector partner agencies.

4.6 The accuracy of minutes will be checked at the subsequent meeting.

5. SUB GROUP

5.1 Sub-groups are currently as follows:

- Training and Development
- Publicity and Communication
- Scrutiny and Quality
- Police and Halton Borough Council
- NHS Trusts and Halton Borough Council
- Halton Borough Council Safeguarding Performance Group

5.2 Other sub-groups may be set u for particular purposes on a short term or standing basis, by agreement of the SAB, to:

- Carry out specific tasks;
- Provide specialist advice;
- Represent a defined geographical area within Halton's boundaries.

5.3 All groups working under the auspices of the SAB will be established by the SAB, report to the SAB, and work to agreed terms of reference and work plans or a specific, stated purpose and lines of reporting to the SAB.

6. CHAIRING

6.1 The SAB will be chaired by a senior manager of Halton Borough Council's Health and Community Directorate, as the agency with lead responsibility for coordinating the arrangements for safeguarding vulnerable adults/adult protection in Halton.

7. ATTENDANCE CODE OF CONDUCT

Members of the SAB make the following undertakings:

7.1 To demonstrate a commitment to attend the meetings.

7.2 To submit apologies if they cannot attend.

7.3 To seek to arrange for an agreed representative to attend if the SAB member is unable to do so.

7.4 To send any agenda items to the chairperson at least two weeks before the meeting. Urgent items that arise outside this timescale can be raised through any other business on the agenda or as agreed by SAB members.

7.5 To feed back to their department/organisation/agency/sector and canvas views to bring to meetings where appropriate.

7.6 To act as a conduit between the SAB and the department/organisation/agency/sector they represent or whose views they reflect, to further the adoption of policies, procedures, guidance, protocols and other items endorsed by the SAB.

7.7 To listen to SAB members and other attendees and address comments to all attending.

7.8 Comments made by anyone attending the SAB, that contribute to any form of discrimination in respect of the age, gender, race, sexuality, disability, religion or belief of others, or the bullying or victimisation of others, are not acceptable and will be challenged by the chairperson and other SAB members.

8. MEMBERSHIP

8.1 In order to carry out its responsibilities effectively, the SAB will seek to have members from each of the main agencies in the public, private and voluntary sectors responsible for working together to safeguard vulnerable adults.

8.2 Members' roles and seniority will enable them to contribute to developing and maintaining strong and effective systems, policies, procedures and protocols.

8.3 The SAB will arrange to involve others in its work as needed, where they have a relevant interest.

8.4 Membership is detailed in a separate table that reflects changes and is routinely updated.

9. REFERENCES

No Secrets – Department of Health – 2000
Adult Protection in Halton – Inter-Agency Policy, Procedures and Guidance
Working Together to Safeguard Children – Department of Health, Home Office, DfES 1999

DATE TERMS OF REFERENCE REVIEWED: April 2009

TERMS OF REFERENCE REVIEW DATE: April 2010

APPENDIX 3

SAFEGUARDING ADULTS BOARD MEMBERSHIP AT 31ST MARCH 2009

ORGANISATION / SECTOR		NAME
HBC – Health & Community Directorate	**Chair**	Sue Wallace-Bonner - Operational Director – Older People's Services
HBC – Health & Community Directorate		Audrey Willamson – Operational Director – Adults' Services
Adult Protection Co-ordinator		Julie Hunt - Adult Protection Coordinator
HBC Legal Services		Lesley Baker - Solicitor
HBC Commissioning and Contracting		Angela McNamara – Divisional Manager – Planning & Commissioning
HBC - Self Directed Support		Marie Mahmood – Divisional Manager – Self-Directed Support
HBC - Assessment & Care Management services		Jacqui Maguire Safeguarding Adults Lead – Divisional Manager – Older People's Services
		Helen Moir - Divisional Manager – Adults with Learning Disabilities and Physical & Sensory Disability Services
		Lindsay Smith - Divisional Manager Mental Health Services
NHS Halton & St Helens Primary Care Trust		Helen Smith – Head of Safeguarding
Warrington & Halton Hospitals NHS Foundation Trust		Sian Edwards - Matron
St Helens & Knowsley Teaching Hospitals NHS Trust		Tina Cavendish - Senior Nurse Quality/Clinical Standards & Safeguarding Adults Lead
5 Boroughs Partnership NHS Trust		John Kelly – Director of Adult Services
		Marie Worthington - Head of Service - Substance Misuse & Lead Nurse Vulnerable Adults

ORGANISATION / SECTOR		NAME
Police		Nigel Wenham – Detective Inspector – Northern Public Protection Unit Richard Langford – Detective Sergeant - Constabulary Headquarters
Drug Action Team		Steve Eastwood - Drug Action Team Manager
Domestic Abuse Forum		Awaiting appointment of Domestic Abuse Coordinator
Dignity Campaign		Awaiting appointment of Dignity Coordinator
Education – HBC		Teresa Miskimmon - Inclusive Learning Co-ordinator
Probation Service/MAPPA		Ian Smith – MAPPA Coordinator
Consumer Protection		Dawn Walton
Housing - Residential Social Landlords		Joe Edwards - ASB Floating Support Officer - Plus Dane Housing
		Alison Adzobu – Cannell Court – Housing 21
		Nicola Cagliarini - Supported Housing Team Leader - Liverpool Housing Trust
Halton Voluntary Action		Janet Roberts - Counselling Partnership Coordinator
Age Concern		Philip Longworth - Chief Executive - Age Concern
Carers Group		Diane Smith - Carer
Advocacy services		Mark Weights – Director - SHAP
Independent Sector Provider Services		Andrew Lyons – Manager - Woodcrofts
		Sheila Wood-Townend – Operations Manager - CLS Care Services
		Andrew Bain - General Manager - Carewatch
Halton Borough Council Provider Services		Ruth McDonogh – Divisional Manager
		Stiofan O'Suillibhan – acting Divisional Manager
Health & Social Care Regulator		Ann Gray – Regulation Manager – Care Quality Commission

APPENDIX 4

CIRCULATION LIST FOR MINUTES OF SAFEGUARDING ADULTS BOARD MEETINGS

- Chief Executive, Halton Borough Council (also Co-Chair, Safer Halton Partnership)
- Superintendent of Police (also Co-Chair, Safer Halton Partnership)
- Strategic Director, Health & Community Directorate, Halton Borough Council
- Chief Executive – NHS Halton and St Helens (Primary Care Trust)
- Chief Executive – 5 Boroughs Partnership NHS Trust
- Chief Executive – Warrington & Halton Hospitals NHS Foundation Trust
- Chief Executive – St Helens & Knowsley Hospitals NHS Trust
- Service Planning Manager - Policy & Support, Halton Borough Council
- Divisional Manager - Adult Learning and Skills Development, Halton Borough Council
- Chris Gwenlan – Cheshire Probation Service (Halton)
- Principal Manager - Customer Care & Information, Halton Borough Council
- Strategic Director, Children & Young People's Directorate, Halton Borough Council
- Business Relationship Manager - Commission for Social Care Inspection
- Operational Director – Culture & Leisure, Halton Borough Council
- Operational Director – Health & Partnerships, Halton Borough Council
- Chief Crown Prosecutor – Crown Prosecution Service, Cheshire
- Learning Disabilities Partnership Board

REPORT TO: **Healthy Halton Policy & Performance Board**

DATE: **10 November 2009**

REPORTING OFFICER: **Strategic Director, Health & Community**

SUBJECT: **Customer Care end of year report for Adult Social Care Comments, Compliments and Complaints 1 April 2008 – 31 March 2009**

WARDS: **All**

1.0 PURPOSE OF THE REPORT

1.1 To report and provide an analysis on complaints processed under the statutory Social Services Complaints Procedure for Adults during 2008/09.

2.0 RECOMMENDATION: That

(1) the report be accepted; and
(2) the proposals for the development of the complaints procedures (nationally and locally) be noted.

3.0 SUPPORTING INFORMATION

Context

3.1 The aims of the Social Care complaints regulations are for people to have their complaints resolved swiftly, and wherever possible, by the people who provide the service.

3.2 **A New Complaint Process for 2009/10**
From 1 April 2009 a new Department of Health complaints process was introduced for dealing with complaints within both Health and Social Care services.

3.2.1 More emphasis is placed on getting the response to a complaint right first time by; understanding the complaint, selecting the most appropriate method of investigation and response, setting out a plan of how to respond to the complaint and keeping the complainant informed throughout.

3.3 **Complaint Stages and Timescales for 2008/09**

3.3.1 For the purpose of this report the old 2008/09 complaints process applied. This complaints procedure had a process of up to 3 stages:

3.3.2 Stage 1: Aimed to resolve the problem as quickly as possible (within 10 working days, or 20 if complex) at the point of service delivery.

3.3.3 Stage 2: If people were unhappy with the response at stage 1 they could ask for the complaint to be investigated by someone independent of the service area involved.

3.3.4 Stage 3: If still dissatisfied, people could ask for a Review Board to consider whether the local authority dealt with the complaint adequately.

3.4.0 Complaints Closed

ITEM	2006/07	2007/08	2008/09
No of Stage 1 complaints closed	63	68	55
% of complaints completed at Stage 1 within 20 days *NB: 2008/09 reduction noted and being monitored **	65%	76%	73% *
Complaints proceeding to Stage 2 (Independent Investigation)	2	0	5
Complaints proceeding to Stage 3 (Review Board)	1	1	1
Ombudsman Enquiries	0	0	0

3.4.1 The table above shows the number of complaints received over the last three years. 55 complaints were closed during 2008/09, 13 fewer complaints than last year. This reduction can be attributed to a drop in the number of finance related complaints, from 18 in 2007/08 to 4 in 2008/09.

3.50 Complaints, Comments and compliments – Improving the Process

3.5.1 Analysis of the complaints and comments we receive allows us to reflect on the lessons that can be learned, and we use this learning to inform and develop the services we provide and commission.

3.5.2 Comments, compliments and complaints provide essential information to help shape and develop services, and complement the wide range of consultation exercises that the Directorate undertakes, (including postal and telephone surveys, open forums, consultation days, participation in service developments and representation of users and carers on strategic boards).

3.5.3 During the last year, improvements have been made to the complaints database to help monitor, analyse and report comments, compliments and complaints including:

- Customer Care Training was given to staff to ensure they apply good practice when investigating and responding to complaints.

- The complaints database has been changed to make it easier to perform data analysis.
- Since December 2008, when complaints are closed, complainants are contacted by telephone to complete a short questionnaire to ascertain how satisfied they were with the way their complaint was dealt with. This has resulted in getting more questionnaires completed with 18 questionnaires have been completed.
- New standards and guidance for formal investigations were introduced to ensure good practice is applied to all investigations.

3.60 What have we learned from complaints and changed as a result?

3.61 Whilst complaints have resulted in changes for individuals, collectively we can use this information to help us improve the services we provide or commission. Examples of improvements made as a result of complaints in the last year include:

- Changes to finance forms to help people to understand the charging policies better.

- Changes in various policies and procedures to prompt appropriate action and information sharing with people.

- Changes to the respite voucher scheme to allow greater flexibility of how respite can be taken.

- Prior to a complaint progressing to formal investigation, Divisional managers now provide a short report to Operational Directors outlining the complaint and resolution actions taken to ensure that all appropriate avenues for resolution have been considered.

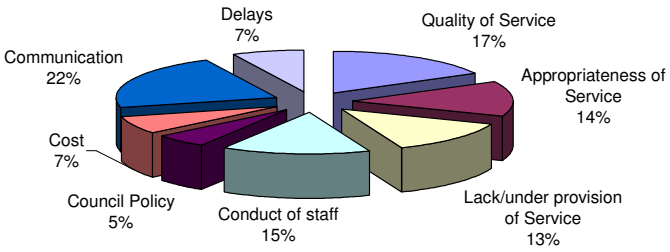
- Operational Teams and Contract Team working in closer liaison to resolve complaints or ongoing concerns with new agency contracts.

- Halton continues to be a part of the Care Services Efficiency Delivery (CSED) pilot to develop a process that provides people with information at the earliest possible point.

3.70 Types of Complaint

3.7.1 The information illustrated in the following graphs continues to be developed to enable us to identify trends and emerging issues. The graph below analyses the types of complaint received for the period 1 April 08 – 31 March 09.

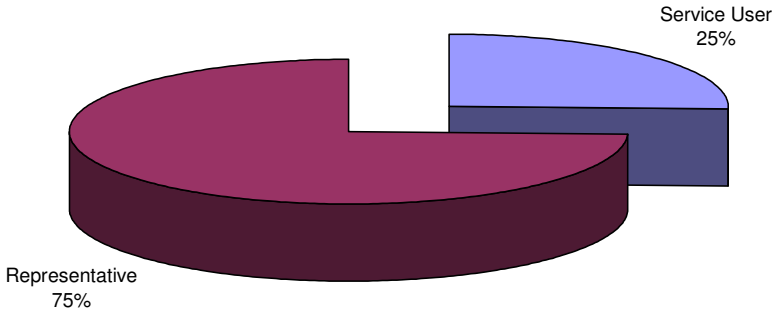
3.7.2



3.7.3 Analysis of complaints received show that in 22% of complaints an element of dissatisfaction could be attributed to a communications issue. A series of Customer Care staff training sessions were held in November 2008 emphasising how better communication can reduce dissatisfaction caused through misunderstanding.

3.80 Category of people making complaints

Person making the complaint 2008/09



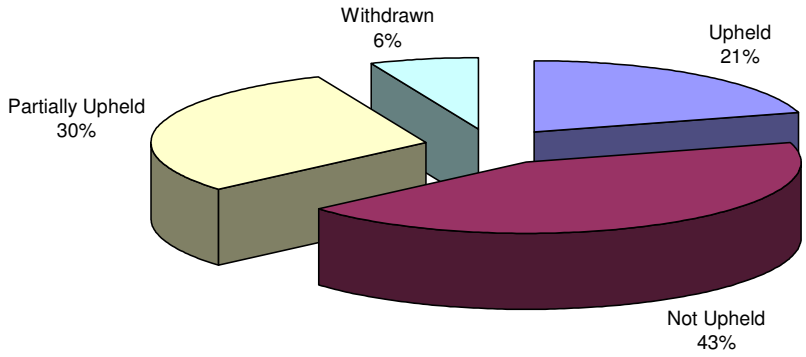
3.8.1 The high proportion of complaints being initiated by a relative or representative can be attributed to the vulnerability of individuals who access adult social care services.

3.90 Outcome of Complaints

3.9.1 The following graph gives an indication of the outcome of the investigation of complaints for the period 1 April 08 – 31 March 09.

3.9.2

Outcome of Complaints 2008/09

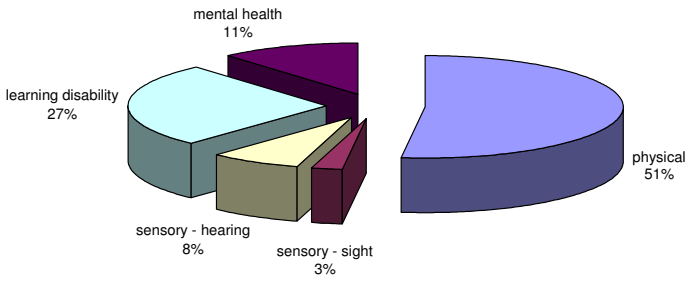


3.10 Monitoring Diversity

3.10.1 The graphs below give an indication of the data that is now being recorded and monitored by disability, age and gender for trend analysis:

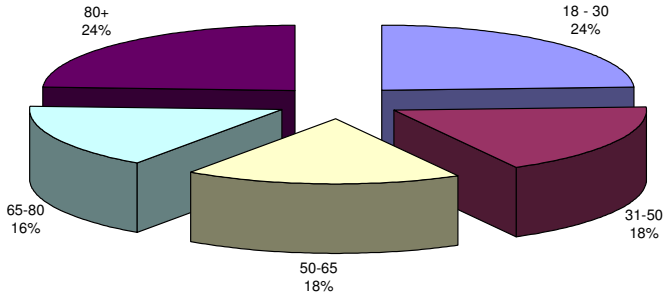
3.10.2

People with Disabilities Accessing the Complaints Process 2008/09

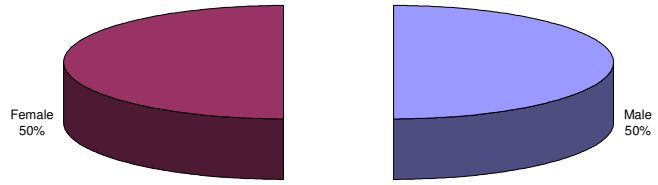


3.10.3

Age profile of complainants 2008/09



Gender of Complainants 2008/09



3.10.4 **Ethnicity**

All complainants were white British**.**

3.11 COMPLIMENTS

A total of **88** compliments were recorded between 1 April 2008 and 31 March 2009 for Health and Community Directorate. It is encouraging to note that the number of compliments received **exceeded** the number of complaints (61).

4.0 POLICY IMPLICATIONS

Complaints, comments and compliments provide essential information and inform the development of Halton Borough Council services and policies.

5.0 OTHER IMPLICATIONS

5.1 Improvement and quality assessment agendas increasingly consider the robustness of Complaints procedures and how they are demonstrably used to inform and drive change.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton** – Adult Social Care has a close relationship with Children and Young Peoples social care services, particularly to support young people during transition from Children and Young Peoples services to Adult Social Services and we will continue to work closely with each other on relevant complaint issues.

6.2 **Employment, Learning and Skills in Halton** – social care aims are often closely associated with these, to improve people's life chances and to be as independent as possible.

6.3 **A Healthy Halton** – another core aim in social care is to prevent or delay reliance on institutional care, enabling people to be as independent as possible.

6.4 **A Safer Halton** – adult social care has a close relationship with protection procedures for the vulnerable adults, the frail etc.

6.5 **Halton's Urban Renewal** – many social care initiatives surround housing issues, enabling people to live as independently as possible in their community.

7.0 RISK ANALYSIS

7.1 A weak complaints process will fail individuals who want to use it and the organisation from learning from complaints.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Ethnicity of complainants is monitored. To date all complainants have been from the group where they described themselves as White British.

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10 November 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Business Planning 2010–13

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To offer a timely opportunity for Members to contribute to the development of Business Plans for the coming financial year.

2.0 IT IS RECOMMENDED THAT:

The Board indicates priority areas for service development or improvement over the next 3 years.

3.0 SUPPORTING INFORMATION

3.1 Each Department has been required to develop a medium-term business plan, in parallel with the budget, that is subject to annual review and refresh. The process of developing service plans for the period 2010-2013 is just beginning. Given the changes to departmental structures that are presently emerging, it is proposed that this year, four Directorate Plans will be produced rather than 19 Departmental Service Plans. This will provide a means of setting objectives for newly configured service departments. At this stage members are invited to identify a small number of areas for development or improvement (possibly 3-5) that they would like to see reflected within those plans. Strategic Directors will then develop draft plans which will be available for consideration by PPBs early in the New Year.

3.2 Service Objectives and Performance Indicators and targets will be developed by each Department and this information will be included within Appendices to the Directorate Plan. Additionally relevant departments will still be required to provide Quarterly Performance Monitoring Reports in their existing format during the coming 2010 – 11 financial year.

3.3 Plans can only be finalised once budget decisions have been confirmed in March.

3.4 To assist Members in their considerations it is proposed that each Operational Director will give the Board a short presentation setting out the key issues and challenges for their current service over the coming 3 years.

4.0 POLICY IMPLICATIONS

4.1 Business Plans form a key part of the Council's policy framework.

5.0 OTHER IMPLICATIONS

5.1 Directorate Plans will identify resource implications.

6.0 IMPLICATIONS FOR THE COUNCILS PRIORITIES

6.1 The business planning process is the means by which we ensure that the six corporate priorities are built into our service plans and priorities, and thence cascaded down into team plans and individual action plans.

7.0 RISK ANALYSIS

7.1 Risk Assessment will continue to form an integral element of Directorate Plan development. This report mitigates the risk of Members not being involved in setting service delivery objectives.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Those high priority actions that result from Impact Review and Assessment will be included within Directorate Plans and will continue to be monitored through Departmental Performance Monitoring Reports.

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

There are no relevant background documents to this report