Public Document Pack

Health Policy and Performance Board

Tuesday, 4 June 2013 at 6.30 p.m.
Council Chamber, Runcorn Town Hall

Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	Labour
Councillor Joan Lowe (Vice-Chairman)	Labour
Councillor Sandra Baker	Labour
Councillor Mark Dennett	Labour
Councillor Valerie Hill	Labour
Councillor Miriam Hodge	Liberal Democrat
Councillor Margaret Horabin	Labour
Councillor Chris Loftus	Labour
Councillor Pauline Sinnott	Labour
Councillor Pamela Wallace	Labour
Councillor Geoff Zygadllo	Labour

Please contact Lynn Derbyshire on 0151 511 7975 or e-mail lynn.derbyshire@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 10 September 2013

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

Part I

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1. MINUTES	
2. DECLARATIONS OF INTERESTS (INCLUDING PARTY WHIP DECLARATIONS)	
Members are reminded of their responsibility to declare any Disclosable Pecuniary Interest or Other Disclosable Interest which they have in any item of business on the agenda, no later than when that item is reached or as soon as the interest becomes apparent and, with Disclosable Pecuniary interests, to leave the meeting during any discussion or voting on the item.	
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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: Health Policy & Performance Board

DATE: 4 June 2013

REPORTING OFFICER: Strategic Director, Policy & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

Agenda Item 4

REPORT TO: Health Policy and Performance Board

DATE: 4 June 2013

REPORTING OFFICER: Chief Executive

SUBJECT: Shadow Health & Wellbeing 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 Health & Wellbeing Shadow Board Minutes 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.

SHADOW HEALTH AND WELLBEING BOARD

At a meeting of the Shadow Health and Wellbeing Board on Wednesday, 12 December 2012 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Polhill (Chairman), Wright, E. Alcock, S. Banks, P. Cooke, Dr M. Forrest, D. Johnson, D. Keats, D. Lyon, A. McIntyre, E. O'Meara, D. Parr, C Richard, D. Seddon, S. Semoff, N. Sharpe, D. Sweeney, J. Stephens and S Yeoman.

Apologies for Absence: Councillors Gerrard, Philbin and A. Williamson, S. Boycott, I. Stewardson and N.Rowe.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB43 MINUTES OF LAST MEETING

The Minutes of the meeting held on 14th November 2012 were taken as read and signed as a correct record.

HWB44 PRESENTATION - PREVENTION AND EARLY DETECTION OF CANCER - DR D SEDDON

The Board received a presentation from Dr D Seddon, Public Health Consultant, regarding activities currently taking place in Halton for the early detection and prevention of cancers. The presentation included an outline of cancer mortality and incidence data for Halton. Members were advised that at present mortality rates were falling even where incidence rates were rising. However, despite these improvements, cancer accounted for the single biggest cause of death in the borough and was higher than it should be.

The presentation proposed the following essential high level activities for the Health and Wellbeing Board:

- create and sponsor a Cancer Action Team; and
- each organisation that was part of the HWBB to choose one corporate action to improve cancer

awareness, early detection and prevention. For example, corporate communications teams could run three cancer specific awareness campaigns for staff and customers during 2013/14.

RESOLVED: That the presentation be noted.

HWB45 PRESENTATION - WELFARE REFORM- SHELAH SEMOFF

The Board was advised that a copy of the presentation on Welfare Reform would be circulated to members. In addition a You Tube video produced by Halton Housing Trust about the changes could be accessed through the link below:

http://www.youtube.com/watch?v=nsSgiggqDtY

RESOLVED: Noted.

HWB46 HALTON SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2011/12

The Board considered a report of the Chair of Halton Safeguarding Children Board and the Strategic Director, Children and Enterprise, on the Halton Safeguarding Children Board (HSCB) Annual Report 2011/12.

The Board was advised on how organisations and individuals across all sectors were working together to safeguard children and young people. In addition the report highlighted the work undertaken by HSCB over the past twelve months, with an explanation of the national context within which the Board was currently operating and the following priorities for the coming year:

- the effectiveness of Early Help;
- the impact of domestic abuse on children and young people;
- child sexual exploitation;
- NHS Reforms;
- effective and efficient board; and
- funding.

With regard to future funding, from 2013 the Clinical Commissioning Groups take over from the Primary Care Trusts and Halton's Clinical Commissioning would be expected to make a financial contribution to replace that currently proved by NHS Merseyside. Also the financial contribution provided by schools from the Dedicated Schools

Grant had been reducing as more schools take on Academy status. The Board would need to consider approaching Academies and Free Schools to seek a financial contribution.

Arising from the discussion it was agreed that further information would be provided to Councillor Wright on the support services in place for young people in domestic violence situations. — A. McIntyre

RESOLVED: That

1. the contents of the report and the associated Annual Report be noted; and

2. the Board recognise and acknowledge the Early Help contribution to safeguarding children and young people.

HWB47 CCG AUTHORISATION PROCESS - UPDATE - SIMON BANKS

The Board received an update report from Simon Banks, Chief Officer (Designate) on the progress of the Halton Clinical Commissioning Group (CCG) towards authorisation as a statutory organisation as established by the Health and Social Care Act 2012. The report highlighted the following:

- NHS Halton CCG had submitted authorised evidence, cross referenced against 119 Key Lines of Enquiry (KLOE), to the NHS CB by the deadline 1st October 2012;
- the evidence was assessed and evaluated to produce a Desktop Review Report for the CCG which was issued on 8th November 2012;
- the Desktop Review Report had highlighted 62 red KLOE for which the CCG had to provided further evidence of compliance;
- the NHS CB site visit took place on 20th November;
- during the site visit the number of KLOE had reduced from 62 to 8;
- the site visit report was received on 27th November 2012.

It was reported that overall the NHS CB panel felt that Halton CCG was making progress in its transition towards becoming a statutory organisation and it had the potential to succeed. In addition, it was noted that the CCG had developed an action plan to address the 8 outstanding

KLOE which were highlighted in the Desktop Review Report.

RESOLVED: That the progress being made towards authorisation by Halton CCG be noted.

HWB48 COMMISSIONING SUB GROUP

The Board received an update report on progress within the Commissioning Sub Group which was a sub group of the Health and Wellbeing Board. Due to the nature of the group's work and its membership it was suggested that the title of the group be changed to Health and Wellbeing Commissioning Board. A copy of the terms of reference and the aims and structure of the group had been previously circulated to the Board.

In addition it was noted that Commissioning Groups for each of the Health and Wellbeing Board priorities had also been established. These groups were currently developing action plans which would form the basis of their commissioning plans. These commissioning plans would link the CCG and the Health and Wellbeing priorities together and would be fed into the Health and Wellbeing Commissioning Group to produce a cohesive and integrated Health and Wellbeing Commissioning Plan by March 2013.

Members were also advised that the Commissioning Sub Group were currently exploring new models for commissioning teams. Oxford Brookes University had been employed to run 2 workshops in the new year to explore possible models that would deliver improved working, better outcomes and value for money.

RESOLVED: That

1. the progress on the development of commissioning plans for health and wellbeing priorities and dates for completion of an integrated Health and Wellbeing Commissioning Plan be noted; and

2. the Board note that new models for commissioning teams are being explored.

HWB49 NATIONAL COMMISSIONING BOARD - PUBLIC HEALTH FUNCTIONS

The Board received a report of the Director of Public Health which advised that the NHS Commissioning Board (NHS CB) and the Department of Health had published their detailed agreement showing which public health services it

would commission. The agreement set out the outcomes to be achieved in exercising these public health functions and provided ring fenced funding for the NHS CB to commission public health services. The following services were included:

- National immunisation programmes;
- National routine screening programmes (non cancer);
- National routine cancer screening programmes;
- Children's public health services from pregnancy to age 5;
- Child health information systems;
- Public health services for people in prison and other places of detention; and
- Sexual assault referral centres.

It was noted that the agreement:

- provided the NHS CB with £1.8bn from the public health budget for these programmes, in addition to other funding provided for public health in primary care;
- set out how the NHS CB was accountable for the successful delivery of these programmes and arrangements for expert support from Public Health England; and
- provided service specifications which included the public health evidence and advice needed to support effective commissioning.

RESOLVED: That

1. the Board note the report and appendix; and

2. on behalf of the Board, David Parr write to Clare Duggan to invite the NCB to appoint a representative to the Shadow Health and Wellbeing Board. — D. Parr

Meeting ended at 2.50 p.m.

SHADOW HEALTH AND WELLBEING BOARD

At a meeting of the Shadow Health and Wellbeing Board on Wednesday, 16 January 2013 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Polhill (Chairman), Philbin, Wright, S. Banks, S. Boycott, P. Cooke, Dr M. Forrest, G. Hales, D. Johnson, D. Lyon, A. McIntyre, E. O'Meara, D. Parr, C. Richards, N. Rowe, N. Sharpe, D. Sweeney, G. Timson, A. Williamson and J. Wilson

Apologies for Absence: K. Fallon, M. Pickup, I. Stewardson, J. Stephens and S. Yeoman.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB50 MINUTES OF LAST MEETING

The Minutes of the meeting held on 12th December 2012 were taken as read and signed as a correct record. Arising from the minutes the Board was advised that Peter McCann was the Council's contact for enquiries regarding the proposed Government Benefit Reforms.

HWB51 PRESENTATION BY BRIDGEWATER ON THEIR STRATEGIC PLAN

The Board received a presentation from Linda Agnew on behalf of Bridgewater Health Trust which provided a summary of their Integrated Business Plan and highlighted:

- the background to Bridgewater, who they were and what services they provided;
- its mission, which included improving local health and wellbeing in the communities in which they served;
- proposals to develop local services whilst being responsive to the views and needs of the local community;
- challenges faced by the service in Halton;
- how the organisation worked in partnerships with other agencies such as GP's, LinKs, local authorities

and Health and Wellbeing Board's etc;
- the benefits of dealing with a person throughout their lifecycle; and
- how the service would be planning for the future and its financial pressures.

The Board discussed the role of the service when dealing with dementia and were advised that all those service users over the age of 75 were screened. The Service was also involved in on-going discussions with the 5 Boroughs who led on the dementia strategy.

RESOLVED: That the presentation be received.

HWB52 LAUNCH OF HEALTH AND WELLBEING STRATEGY AND DEVELOPMENT OF ACTION PLANS

The Board received a presentation from the Director of Public Health, Eileen O'Meara, to formally launch the Joint Health and Wellbeing strategy. Members were also provided with a progress report on the development of action plans to support the strategy.

RESOLVED: That

1. the presentation be noted;

2. a glossary of acronyms be included in the index;

Director of Public Health

3. a link to the strategy document be placed on the front page of all Member organisation websites; and

4. regular monitoring reports be brought back to the Board.

HWB53 CONSULTATION ON THE NATIONAL ALCOHOL STRATEGY

The Board was advised that the Government had sought views on a number of measures set out in their Alcohol Strategy which was published on the 23rd March 2012. The consultation would run for 10 weeks from the 28th November 2012 until 6th February 2013.

In this consultation views would be sought on five key areas:-

- minimum unit pricing;
- a ban on multi–buy promotions in shops and off-licences;

- a review of the mandatory licensing conditions;
- health as a new alcohol licensing objective for cumulative impacts; and
- cutting red tape for responsible businesses.

Members were advised that as part of the public alcohol strategy consultation, regional road shows would be held and smaller technical groups would meet to discuss a number of the policy areas. It was noted that the Cheshire and Merseyside Directors of Public Health welcomed the Government's consultation on the National Alcohol Strategy and would be responding collectively. Their response would include a call for a minimum unit price set at 50p. A minimum unit price of 50p was well supported by public sector partners across Cheshire and Merseyside.

RESOLVED: That the report be noted and the consultation response by the Cheshire and Merseyside Directors of Public Health be endorsed.

HWB54 CHALLENGE ON DEMENTIA

The Board considered a report of the Strategic Director, Communities which advised that the Prime Minister had launched a Challenge on Dementia in March 2012 to deliver major improvements in dementia care and research by 2015. Subsequently, three sub-groups had been formed to lead on dementia-friendly communities, better research and driving improvements in health and care.

The Co-Chairs of the Health and Care Sub-Group had written to all Chairs of Health and Wellbeing Boards asking for their commitment to the Dementia Challenge and their assistance in taking it forward. In addition, Members were advised that a number of key commitments were made by the Prime Minister as part of the March 2012 launch. Health and Wellbeing Boards were being asked to consider the following in relation to these commitments:-

- reviewing local Dementia Strategy with particular emphasis on enablement and intermediate care access for people with dementia, accommodation solutions, end of life support and health and social care workforce development;

- ensuring the needs of people with dementia and their carers were part of the Joint Strategic Needs Assessment process;

- whether the Health and Wellbeing Board should

make dementia a priority in the Joint Health and Wellbeing Strategy; and

- signing up to the National Dementia Declaration and joining your Local Dementia Action Alliance to work with local partners to drive forward improvements for people with dementia in your area.

In respect of the key commitments outlined above, the local position for Halton within each was outlined in the report. In addition to the commitments set out above the Board were also being requested to sign up to the Dementia Care and Support Compact and to publicise this report on local websites stating how the Board intended to fulfil this commitment and to ask local Health Trusts to do the same. The Board were also being asked to encourage Acute Hospital Trusts to sign up to the call to action – the Right Care: creating dementia friendly hospitals.

It was noted that the Prime Minister had asked the National Dementia Strategy Board to provide a formal update on progress by March 2013. Boards were being encouraged to share progress through the Dementia Challenge "Get Involved" website. It was also noted that dementia was a significant challenge in Halton especially given the increasing population of older people. This challenge had direct implications for all Health and Wellbeing Board partners and would continue to do so in the future. In order to support this increase in prevalence and diagnosis a range of services were currently in place that offered support from early diagnosis right through to end of life care.

RESOLVED: That

1. the contents of the report including local progress to date on the key commitments outlined be noted; and
2. the Board support the local position as outlined in the report;
3. the scope of the strategy be broadened to include other agencies such as Police and Voluntary Sector; and
4. a further report be brought back to the next meeting.

Strategic Director Communities

HWB55 HCA/DOH CARE AND SUPPORT SPECIALIST HOUSING FUND

The Board was advised that the Department of Health

had recently announced a £160m fund to support the development of specialist supported housing for older people and those with disabilities. The fund was to be administered by the Homes and Communities Agency (HCA) which had issued a bidding prospectus. The bid deadline was 18th January 2013 for the first phase of funding which was focussed on new rented provision with a later second phase to focus on open market provision.

It was noted that three schemes were proposed for submission, led by Halton Housing Trust (HHT). The first two were extra care housing schemes for older people on the sites of the former Pingot Day Care Centre off Dundalk Road, Widnes and Seddon's site in Halton Brook in Runcorn. The third was a development of around 10 bungalows designed to accommodate those with physical and/or learning disabilities.

Members were advised that the Council had commissioned Tribal Consulting in 2008 to forecast the demand for extra care housing the resulting strategy identified a current shortfall of 137 units, with a further 59 units needed by 2017, (196 in total).

Since that time HHT had opened a 47 unit scheme in Ditton, however a planned 90 unit development at West Bank and 10 purpose built bungalows for clients with physical and/or learning disabilities had been cancelled due to the financial difficulties of Cosmopolitan Housing Association. Since £400,000 funding was already included in the Council's capital programme to support the development of the 10 purpose-built bungalows, following discussion with HHT, they had agreed to take over the proposed development and a range of site options were currently being evaluated.

As the original scheme was to be developed on sites owned by Cosmopolitan it was likely that the cost of acquiring new sites would now have to be factored in to the financial viability assessment. It was therefore proposed that a bid be made for Department of Health Funding to avoid having to charge excessive rents or reduce the quality of the accommodation.

RESOLVED: That the Board supports the proposed bid submission set out in the report, and that this be conveyed to the Homes and Communities Agency.

Strategic Director Communities

HWB56 THE MANDATE AND EVERYONE COUNTS: PLANNING FOR PATIENTS 2013/14

The Board was advised that the first Mandate between the Government and NHS Commissioning Board, setting out the ambitions for the Health Service for the next two years, was published on the 13th November 2012. The Mandate reaffirms the Government's commitment to an NHS that remained comprehensive and universal – available to all, based on clinical need and not ability to pay – and that was able to meet patients' needs now and in the future. The NHS Mandate was structured around five key areas where the Government expected the NHS Commissioning Board (NHS CB) to make improvements:-

- preventing people from dying prematurely;
- enhancing quality of life for people with long-term conditions;
- helping people to recover from episodes of ill-health or following injury;
- ensuring that people have a positive experience of care; and
- treating and caring for people in safe environment and protecting them from avoidable harm.

In addition the Government had also published Everyone Counts: Planning for Patients 2013/14 which set out how the NHS Commissioning Board intended to ensure that it, and the Clinical Commissioning Groups (CCGs), delivered the requirements of the Mandate and the NHS Constitution. It was reported that the headline measures in the documents were:

- Listening to patients;
- Focusing on Outcomes;
- Rewarding Excellence; and
- Improving Knowledge and Data.

It was also noted that Halton CCG would:

- have to track progress in improving healthcare for their population;

- have to identify an additional three local priorities against which it would make progress during the year, these would be taken into account when determining if the CCG should be rewarded through the Quality Premium;

- be expected to deliver and uphold the rights and pledges from the NHS Constitution and the thresholds set by the NHS CB. and produce a plan to

demonstrate delivery in these areas; and

- maintain the engagement of local people in the development of the Integrated Commissioning Strategy 2013-15 and Integrated Delivery Plan 2013-14.

RESOLVED: That

1. the publication of The Mandate and Everyone Counts: Planning for Patients 2013/14 and the concomitant requirements for the CCG, particularly in regard to the production of clear and credible commissioning plans be noted; and — Simon Banks

2. a draft copy of the CCGs Integrated Commissioning Strategy 2013-15 and an Integrated Delivery Plan for 2013/14 be submitted to the next meeting on 13th March 2013.

HWB57 DEPLOYMENT OF AUTOMATED EXTERNAL DEFIBRILLATORS (AEDS) IN PUBLIC PLACES

The Board considered a report of the Director of Public Health and Strategic Director, Communities, which sought views and advice from Members regarding the deployment of automated external defibrillators in public places. The report had been prepared in response to high profile incidents where defibrillators were not available to save a person's life including Oliver King, a 12 year old who suffered a cardiac arrest at King David High School in Liverpool last year. In addition, a letter had been sent by Halton MP Derek Twigg to the Council requesting the present and future position with regard to the provision of defibrillators at Council Buildings and Schools. It was also reported that Cheshire East had recently trained 300 members of staff and provided defibrillators at all Leisure Centres and other public buildings and places where there was high foot fall. Whilst at Liverpool all primary schools were to have defibrillators.

With regard to the current position within Halton:

- Leisure Centres and pools did not have the equipment;
- Stobart Stadium only had the equipment on site on match days; and
- No schools had the equipment.

The report provided current evidence from the Oliver

King Foundation, Department of Health, British Heart Foundation and The Resuscitation Council (UK) and FIFA. In addition, Members were advised of the potential issues which included costs, training, accessibility, routine upkeep and inspections, use of defibrillators and legal implications.

It was noted that a report by the Directors of Public Health stated as hospital admissions showed over 50s were most at risk, particularly men, it recommended that defibrillators were best used in a highly targeted way in areas where there was a high risk of cardiac arrest i.e.:

- workplaces that employ people over 50 years; and
- leisure, community or sports centres where they accept people for weight management, cardiac rehabilitation or GP exercise on referral.

In addition it was also reported that the following financial implications applied to the provision of defibrillators:-

- a new defibrillator would cost approximately £900 with an additional training cost of £22 per person;
- modern defibrillators usually last 5 years and had a residual value when they came to the end of their life;
- they calibrate and, provided they were manually tested every week, they required little or no maintenance;
- the two main parts that sometimes needed replacing were pads at £23 each and batteries at £190 per machine. Other parts needed to be replaced when used at negligible cost; and
- based on the requirement to provide one defibrillator and train 3 First Aiders at each corporate building an initial outlay for the Authority would be £11,592.

Members discussed possible locations for defibrillators in Halton including schools, supermarkets and Council owned public buildings, the opportunity to invite the North West Ambulance Service to demonstrate defibrillators, training of users, the responsibility for those to manually test the defibrillator each week and signposting at public locations highlighting where the defibrillator was available and who was trained to use it.

RESOLVED: That

1. a report be brought back to the next meeting outlining possible locations for defibrillators and an example of signs which could be used for signposting

Director of Public Health/Strategic Director

defibrillators; and 2. an invitation be sent to the North West Ambulance Service to attend the next meeting to demonstrate the use of defibrillators.	Communities

Meeting ended at 4.25 p.m.

REPORT TO:	Health Policy and Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Public Health Annual Report 2012
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health Policy and Performance Board with an overview and presentation of the Halton and St Helens Public Health Annual Report 2012.

RECOMMENDATION: That the Board note the contents of the report and presentation.

3.0 SUPPORTING INFORMATION

3.1 Since 2000 Directors of Public Health (DPH) in PCTs are tasked with preparing annual reports - an independent assessment of the health of local populations. The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence and interpreted objectively. The development of this report has included consultation with Halton and St Helens PCT, Halton Shadow Health and Wellbeing Board, Halton Clinical Commissioning Group and other stakeholders and partners.

3.2 The annual report is an important vehicle by which a DPH can identify key issues, flag problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action. The annual report remains a key means by which the DPH is accountable to the population they serve.

3.3 The Public Health Annual Report (PHAR) is the Director of Public Health's independent, expert assessment of the health of the local population, based on evidence. Whilst the views and contributions of local partners have been taken into account, the assessment and recommendations made in the report are those held by the DPH and do not necessarily reflect the position of the employing and partner organisations.

3.4 Each year, typically, a theme is chosen for the PHAR. Therefore it does not encompass every issue of relevance but rather focuses on a particular issue or set of linked issues. These may cover one of the three work streams of

public health practice - health improvement, health protection or healthcare public health – supported by public health intelligence, an over-arching theme, such as health inequalities, or a particular topic such as mental wellbeing, cancers, older people etc. As standard, each year the previous reports' recommendations are followed up and a compendium of key statistics included.

3.5 All of these issues have been covered in some form since 2006, the first report covering the Halton & St Helens PCT footprint. The 2012 report will be the final report covering this footprint as the PCT will cease to exist from 31st March 2013, with new NHS and public health commissioning arrangements being fully established on a borough level for both areas from 1st April 2013.

3.6 **Report working title: "A Reflection on Health and Wellbeing in Halton and St Helens."**

3.7 The dissolution of the PCT gives an opportunity to reflect on what has been achieved over the last few years, where improved health outcomes have been seen as well as looking forward, recognising some of the main health challenges that still face the boroughs.

3.8 The report identifies the improvements, challenges and new structures to address the challenges. It also highlights the improvements in health, including:

- Cardio-vascular Disease and recommendations on future action
- Tobacco Control and recommendations on future action
- Dental Health and recommendations on future action

Key challenges include:

- Cancers and recommendations on future action
- Early Years development and recommendations on future action
- Alcohol and recommendations on future action

Finally, it provides an update on last year's recommendations and includes a compendium of data.

4.0 POLICY IMPLICATIONS

4.1 The Public Health Annual Report should be used to inform commissioning plans and collaborative action for the NHS, Social Care, Public Health and other services as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will continue to be addressed in public health annual reports, recognising progress within existing strategies and action plans together with recommendations for further action to improve health outcomes.

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

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to address health inequalities

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime has an impact on health outcomes particularly on mental health. There are also close links between partnerships on areas such as alcohol and domestic violence

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and will therefore need to be addressed in public health annual reports.

7.0 RISK ANALYSIS

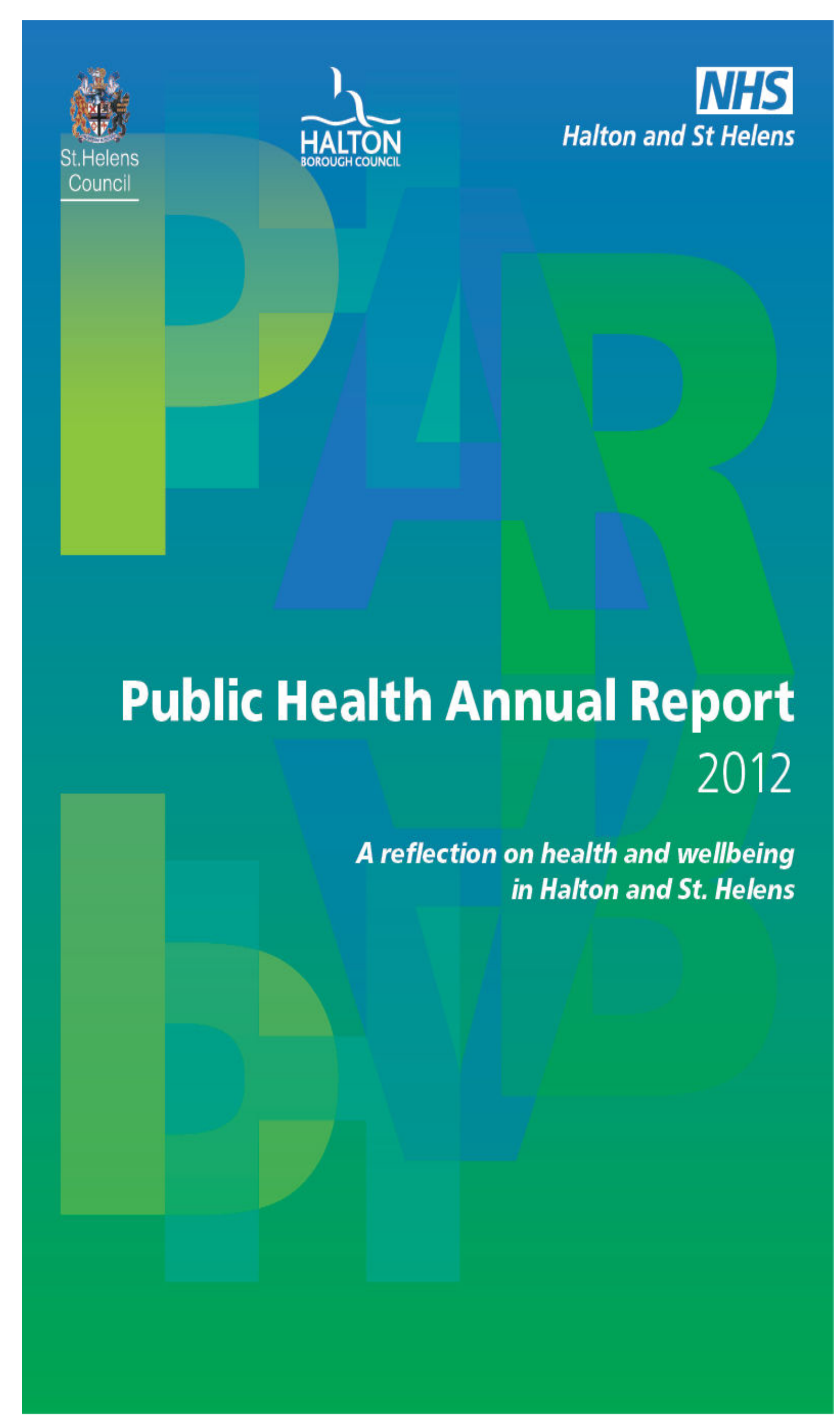
Halton Borough Council may be at risk of not meeting national targets if recommendations outlined in the report are not met. There are no financial risks. The recommendations are not so significant they require a full risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

This is in line with all equality and diversity issues in Halton.

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

Document	Place of Inspection	Contact Officer
Public Health Annual Report	Council Website	Sharon McAteer



Key Messages and Recommendations

Eileen O'Meara
Director of Public Health

Halton Borough Council Health PPB

June 2013

Report Outline

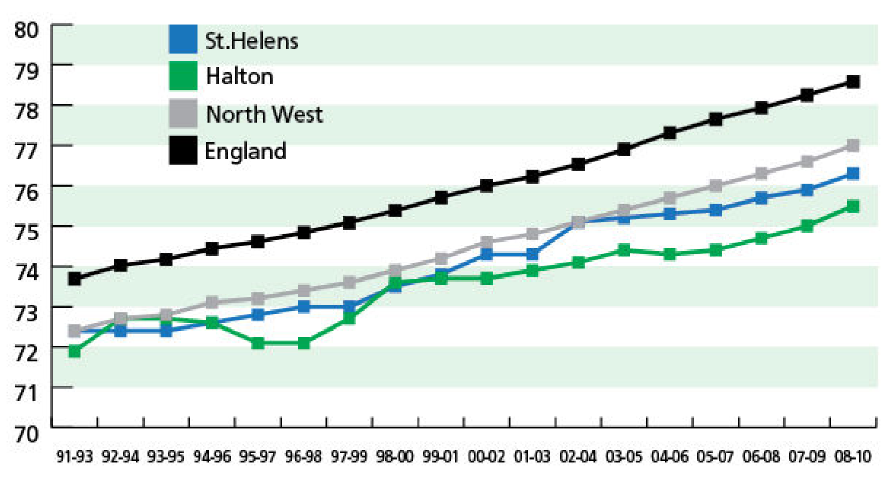
- **Health in Halton and St. Helens**
- **Key Improvements:**
  - Cardiovascular disease
  - Tobacco control
  - Child dental health
- **Challenges:**
  - Early years
  - Alcohol
  - Cancer
- **Progress on recommendations from 2010/11 report**
- **Compendium of statistics**

Health in Halton & St. Helens

- Life expectancy for men and women has improved
- Inequalities in life expectancy remain -11 years within Halton.
- Early deaths from cardiovascular disease and cancers have fallen
- Smoking rates have fallen
- Teenage pregnancy rates have improved
- Improvements in treatment for cancers and management of long-term conditions
- Dementia predicted to rise
- High levels of falls in older people

A picture of health

Figure 1: life expectancy at birth (years), 1991–1993 to 2008–2010 for men (top) and women (bottom)



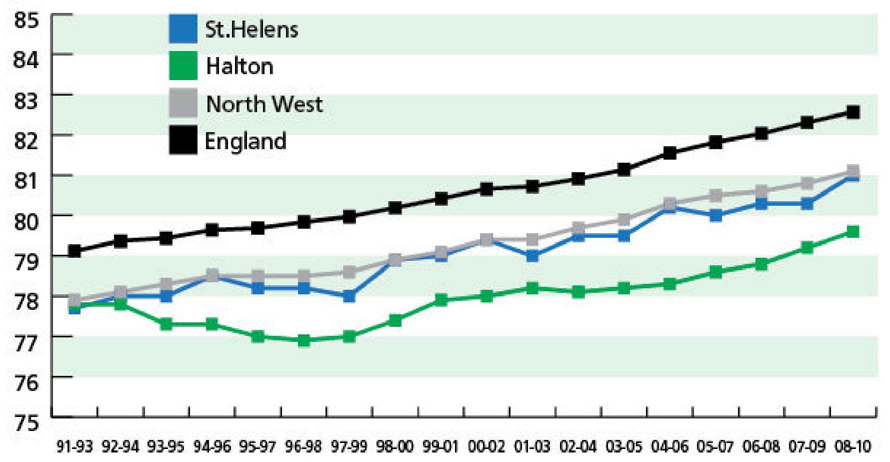
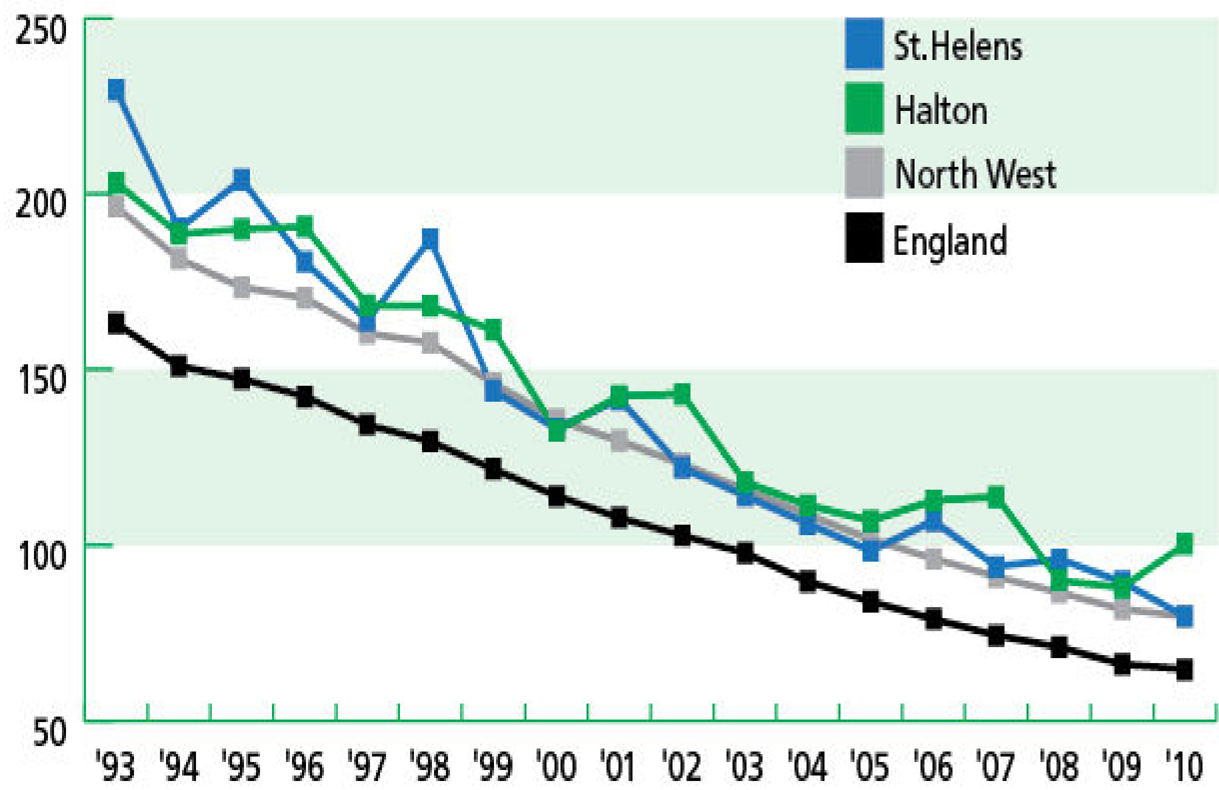


Figure 2: Major cause of death in the under-75s in 1995 and 2010, Halton and St.Helens

	1995		2010	
	No.	%	No.	%
Halton				
Cancer	214	36%	197	41%
CVD	231	39%	133	28%
Total deaths	589		481	
St.Helens				
Cancer	299	31%	245	38%
CVD	405	43%	175	27%
Total deaths	952		645	

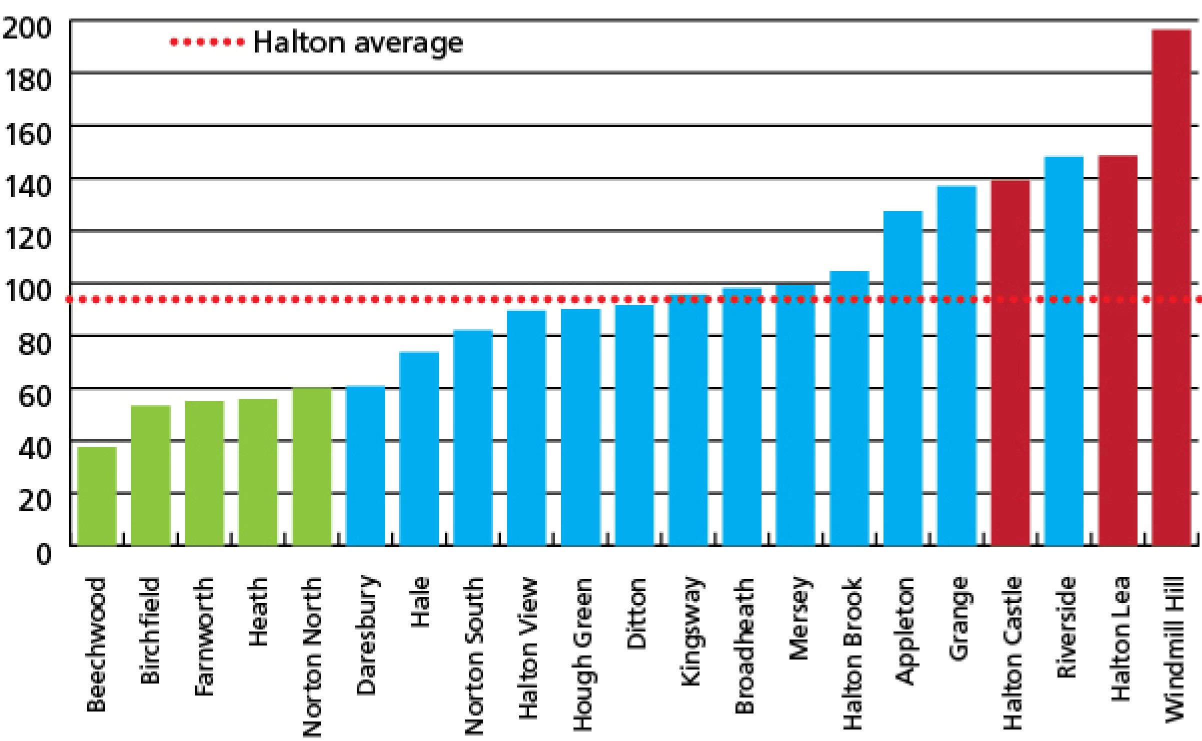
Source: NHS Information Centre Indicator Portal, 2012

Improvement: cardiovascular disease



Annual Report of the Directors of Public Health 2012

Improvement: cardiovascular disease



Annual Report of the Directors of Public Health 2012

Improvement: cardiovascular disease

Local programmes

- Weight management
- Smoking cessation
- Alcohol
- Health checks plus
- QOF

Improvement: cardiovascular disease

Recommendations:

- Local Authority should review health checks plus programme. Make sure people with LD have access
- Continue investment in services to help people manage and/or reduce identified risks
- Healthy Weight Group should ensure implementation and performance management of Healthy Weight Strategy
- Providers should ensure lifestyle services target those most in need to address inequalities

Improvement: Tobacco control

Tobacco Control Strategy: 5 priority areas

- Increasing the number of people stopping smoking
- Prevention of young people starting smoking
- Tackling illegal and underage availability
- Smoke-free lifestyles
- Social marketing

Improvement: Tobacco control

Recommendations:

- Commissioners and providers should review evidence-based interventions that will help to reduce the percentage of young people, especially women, starting to smoke
- Providers should review data collection of pregnancy women smoking at time of delivery and ensure robust processes are in place
- Commissioners, providers and the Health and Wellbeing Board should work nationally, regionally and locally to support advocacy for plain packaging

Improvement: Child dental health

- Child dental health in Halton and St. Helens is worse than the national average.
- Half of all children have had tooth decay by the time they are 5 years old.
- A population based programme developed and run locally has resulted in a 22.4% fall in the level of dental decay. The programme has been running for just 4 years.
- Annual surveys of 5 year olds showed there was a 6% increase in those free from decay. The impact will have occurred in other age groups as well.
- The programme offered all children attending a dentist fluoride varnish 3 times a year. Data shows 70% see their dentist on a regular basis.
- All children aged 3-11years were sent a toothbrush and tube of fluoride toothpaste

Improvement: Child dental health

Recommendations

- Local Authority commissioners should work in partnership with the National Commissioning Board to monitor performance and ensure good access to dental services.
- National Commissioning Board should encourage the application of fluoride varnish by the dental team in their practices in line with *Delivering Better Oral Health - an evidence-based toolkit for prevention (2nd Edition)*.
- Local Authority commissioners should review the work of the Oral Health Promotion team.

Challenges: Early years

- Levels of child poverty are generally worse than the England average
- There have been improvements in infant and child mortality, with rates now similar to England
- There have been increases in uptake of child immunisations, smoke-free homes, and campaigns to reduce the risk of sudden infant death
- Breastfeeding initiation and the percentage of women smoking at time of delivery have improved but remain worse than the England average.
- Hospital admissions due to injury, alcohol and substance misuse are all major sources of concern.
- Halton had the lowest percentage of children achieving a good level of development at age 5 in England. The St. Helens rate was higher than the England average.

Challenges: Early years

Recommendations

- Data quality of local data collection via the Child Health Surveillance System should be reviewed by both commissioner and provider.
- Develop the Health Visitor service, (in line with the Health Visitor implementation plan, 'A Call For Action'21) to ensure that all children have access to the core healthy child programme.
- Midwifery, Health Improvement Team and GPs should monitor the effectiveness of health programmes for pregnant women including early booking, targeted smoking cessation campaigns, access to appropriate weight loss services and encourage a high uptake of seasonal influenza and whooping cough immunisations.

Challenges: Alcohol

- Levels of alcohol related admissions and alcohol specific admissions for those under age 18 are higher than the national average.
- Ward level analysis shows a correlation with deprivation.
- Yet, social marketing research indicates that many men (admission rates are higher for men than women) do not think they are drinking above recommended levels and have little interest in changing their behaviours.
- The healthcare and social costs due to alcohol related harm are higher than the national average. In 2010/11 estimated St. Helens £519 per head of population, Halton £450 per head of population

Challenges: Alcohol

Recommendations

- Ensure that people have accurate, relevant information to enable them to make healthy, safe, informed choices and that messages are promoted in the right settings.
- GPs should promote brief interventions and screening within primary care.
- Commissioners, providers and the Health and Wellbeing Board should work nationally, regionally and locally to support minimum pricing per unit of alcohol.
- All front line staff working with children and young people should receive training to enable them to identify those with drug and alcohol problems, or who show signs of experiencing parental alcohol misuse. This should include providing appropriate support and onward refer as necessary.

Challenges: Cancer

- Deaths from cancers have been falling but remain above the national average.
- Lung cancer has been falling in men, matching the fall in the number smoking. However, it has not fallen in women. This is the legacy of the increase in smoking amongst women 20-30 years ago.
- Treatments have improved leading to increasing survival rates amongst those that do develop the disease.
- Screening uptake rates are good compared to our Merseyside neighbours with cervical screening uptake across the Halton & St Helens being better than its neighbours
- Skin cancer has risen across Halton & St Helens from 22 cases in 1993 to 64 cases in 2009.

Challenges: Cancer

Recommendations

- NHS Commissioning Board should provide regular updates to Health and Wellbeing Boards on improvement in screening and uptake rates and ensure cancer and non-cancer screening programmes are accessible to people with learning or other disabilities.
- Local Hospital Trusts should commit to achieving agreed staging reporting for at least 70% of all cancers, collating, analysing and reporting this staging data after a minimum time delay.
- Commissioners should continue to invest in public awareness of cancer signs and symptoms.

Agenda Item 5b

REPORT TO: Health Policy & Performance Board

DATE: 4 June 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Adults; Children, Young People and Families

SUBJECT: Smokefree Playgrounds

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide a short summary of the above initiative that will be presented to Members of the Board during the meeting.

2.0 RECOMMENDATION: That:

i) The report and presentation of the film be noted; and

ii) Provide feedback to the Director of Public Health.

3.0 SUPPORTING INFORMATION

3.1 The film to be presented at the meeting covers the initiative Play Smokefree, a voluntary scheme which keeps children's play areas in Cheshire and Merseyside smoke free. Halton Borough Council was the first to implement this successful scheme in Cheshire and Merseyside, and through the film, those involved tell the story of how they did it.

4.0 POLICY IMPLICATIONS

4.1 There are no direct policy implications as a result of this report however, the Play Smokefree initiative should have positive implications for local children and their families which are in line with Council and Partnership policies.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

This initiative will contribute towards improving the health and wellbeing of children, young people and their families.

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

None identified.

6.3 **A Healthy Halton**

This initiative directly contributes to improving health in Halton by reducing the incidence of smoking and passive smoking and promoting healthy lifestyles.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

The implementation of this initiative should improve the environment by reducing the amount of waste caused by the inappropriate disposal of cigarette butts within play areas.

7.0 **RISK ANALYSIS**

7.1 None associated with this initiative

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None

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

9.1 None under the meaning of the Act.

Agenda Item 6a

REPORT TO:	Health Policy and Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Vascular Services across Cheshire and Merseyside
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To receive an update, from Alison Tonge, Director of Commissioning - Cheshire, Warrington & Wirral Area Team, NHS England, on the development of Vascular Services across Cheshire and Merseyside following the National Clinical Advisory Team's (NCAT's) further review conducted in February 2013.

2.0 **RECOMMENDATION: That the Board: Note the contents of the report.**

3.0 **SUPPORTING INFORMATION**

3.1 On the recommendation of the Secretary of State for Health, NCAT were invited to re-examine whether the current proposals for Vascular Services across Cheshire and Merseyside would meet the requirements for a modern vascular network in South Merseyside, particularly in light of the concerns raised from surgeons at Arrowe Park Hospital and the updated guidance from the Vascular Society of Great Britain and Ireland.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications as a direct result of this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified at this stage.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

There are no specific implications as a direct result of this report, however the health needs of children and young people are an

integral part of the Health priority.

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

None identified.

6.3 **A Healthy Halton**

The remit of the Health Policy and Performance Board is directly linked to this priority.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 Appropriate consideration will need to be given to associated risks identified as part of the on-going development of Vascular Services in Cheshire and Merseyside.

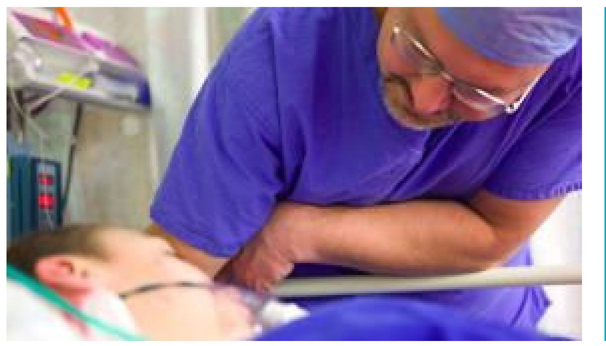
8.0 **EQUALITY AND DIVERSITY ISSUES**

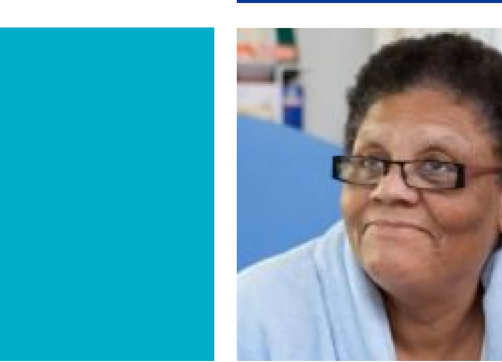
8.1 Any service which seeks to address the health needs of Halton needs to be fully accessible.

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

9.1 None under the meaning of the Act.

Reviewing Vascular Services





Tuesday 4th June 2013

Why review the service?

- Research shows hospitals treating large number of cases produce better outcomes (fewer deaths and complications)

- In 2009, European study showed UK had highest death rates for one type of major vascular surgery (Abdominal Aortic Aneurysm)

- Screening programme for detecting AAA states that all screen detected aneurysms must be treated in high volume centre

- Advent of new technology with lower death rates requires surgeons to develop new skills

Where are we up to?

- Reviews underway across England
- Many completed
- Locally, progress is good:
    - Arterial centre identified
    - Agreements between local hospitals and the arterial centre on what will continue to be done locally and what parts of care will be in centre
    - Arrangements in place for all surgeons to work in both local hospitals and operate in the centre
    - Aim for October implementation.

What will the new system look like?

Before:

- All consultations and treatments take place in local hospitals
- Some complex cases referred on
- Vascular surgeons present most days and on call
- Rehab in local hospital

After the review:

- Majority of appointments with consultant at local hospital
- Tests and investigations at local hospital
- Treatments given in local hospital
- Arterial surgery in new centre
- Vascular surgeons on call in arterial centre (as in neurosurgery, cardiac surgery)
- Vascular surgeons present in local hospitals most days in OPD.

Treatment of leg ulcers

Before

Local Hospital	• Appointment with consultant • Scan of blood flow in legs
Local Hospital	• Trial of medication • Ulcer dressing and specialist bandaging clinics • Reassess healing, if poor consider surgery
Local Hospital	• Pre -op tests • Operation • Discharged home or to rehab
Local Hospital	• Six week follow up appointment • On going clinic visits

After re-organisation

Local Hospital	•Appointment with consultant •Scan of blood flow in legs
Local Hospital	•Trial of medication •Ulcer dressing and specialist bandaging clinics •Reassess healing, if poor consider surgery
Arterial centre	•Pre op test results sent from local hospital •Operation •Discharged home or back to local hospital for rehab
Local Hospital	•Six week follow up appointment •On going clinic visits

Halton residents

Access - balance

- Outpatients , day cases, locally based- majority of care locally.
- You would expect to travel for a specialist service offering high quality
- Ambulance blue light- direct to centre
- Train (looks like direct connection 3 stops to hospital)
- Principles – keeping services local where possible and safe

Quality – for patients

- Strong network of care between three providers
- Clinical teams working together looking at delivering better than what went before
- Dedicated wards, theatres, and out of hours, more expertise available, clinical review
- Latest technology

Warrington Hospital

- Future **role of district general hospital** is to work within networks for specialised care
- And how **work together** and collaborate and share our workforce
- And to work with primary care in health and social care teams supporting localities
- To become **hubs for integration**
- **Learning** from vascular and now created foundations for this wider integration
- Working together on other service quality improvements

Agenda Item 6b

REPORT TO: Health Policy and Performance Board

DATE: 4 June 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: NHS Halton Clinical Commissioning Group (Halton CCG) Integrated Commissioning Strategy 2013-15 and Operational Delivery Plan 2013-14

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 As part of its authorisation requirements, NHS Halton CCG is required to produce an integrated commissioning strategy for 2013-15 and an operational delivery plan for 2013-14.

2.0 RECOMMENDATION:

That the Health Policy and Performance Board:

1) **Note the contents of the report and appended Strategy and Delivery Plan, which include the commissioning intentions for the coming year; and**

2) **Note the next steps outlined in paragraph 3.4 of the report.**

3.0 SUPPORTING INFORMATION

3.1 The NHS Commissioning Board (now known as NHS England) requires all CCGs to produce clear and credible commissioning plans. These must take into account the planning guidance published by NHS England in *Everyone Counts: Planning for Patients 2013/14* (December 2012), the *NHS Outcomes Framework* and the *Mandate* as well as the CCG's local priorities.

3.2 The commissioning strategy and operational delivery plan are required as part of the CCG's authorisation processes. They have been produced with support from NHS England's Merseyside team. Earlier drafts have been circulated to the CCG's Governing Body, the Health and Wellbeing Board and the Senior Management Team for comments.

3.3 The CCG has developed its commissioning plans via engagement with local people and member practices.

3.4 The strategy describes how the plans were developed and details the resources available to enable their delivery. It includes information about the financial planning to support the commissioning intentions and Halton CCG's commitments to the

transformational change and financial savings programme for Quality, Innovation, Productivity and Prevention (QIPP).

NHS England is currently analysing all CCGs plans. NHS Halton CCG expects to hear confirmation that the plans are accepted, or details of any changes required, between 22 April and 10 May.

Following the feedback from NHS England, the CCG will be required to publish a public prospectus. As yet NHS England has issued no guidance on this but it is anticipated that the prospectus can be produced from the strategy.

4.0 **POLICY IMPLICATIONS**

4.1 NHS England will require the CCG to ensure that all aspects of the *Mandate* and *Everyone Counts* are addressed in the strategy and delivery plan. The CCG will also need to measure progress in each of the five key areas where the Government expects improvements to be made, using the *NHS Outcomes Framework.*

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The CCG's budget is detailed on page 48 of the strategy and the QIPP financial plan is shown on page 51
.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

NHS Halton CCG will work closely with the Children's Trust to commission services for children and young people and to meet statutory responsibilities in regard to safeguarding.

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

None as a result of this report.

6.3 **A Healthy Halton**

Halton CCG is a key partner in this agenda.

6.4 **A Safer Halton**

None as a result of this report.

6.5 **Halton's Urban Renewal**

None as a result of this report.

7.0 **RISK ANALYSIS**

7.1 The CCG has strong governance arrangements in place that will enable the risks associated with the delivery of the *Mandate* and *Everyone Counts* to be transparently managed and mitigated. These arrangements are detailed within the strategy. The

risks and mitigating actions for each workstream are shown in the delivery plan.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no equality and diversity issues as a result of this report. Halton CCG, as a statutory organisation, will comply with the requirements of the Equality Act 2010.

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

Department of Health, *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015,* Department of Health, 13 November 2012, http://mandate.dh.gov.uk/

NHS Commissioning Board, *Everyone Counts: Planning for Patients 2013/14,* NHS Commissioning Board, 17 December 2012, http://www.commissioningboard.nhs.uk/everyonecounts/

Halton Clinical Commissioning Group

Integrated Commissioning Strategy 2013-15

March 2013

Halton Clinical Commissioning Group

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Halton Clinical Commissioning Group

Foreword

On 1st April 2013, under the NHS reforms set out in the Health and Social Care Act 2012, the responsibility for the commissioning of health care services for the people of Halton will be legally passed to three organisations. These organisations are the NHS Commissioning Board (NHS CB), Halton Borough Council and NHS Halton Clinical Commissioning Group (CCG).

This *Integrated Commissioning Strategy* sets out how NHS Halton CCG will deliver the commissioning responsibilities we have been given following the NHS reforms. It is integrated as it sets outs how we will deliver these responsibilities with local people, our member general practices, providers of NHS services and, of course, the NHS CB and Halton Borough Council.

The *Integrated Commissioning Strategy* is the product of over twelve months of engagement with people who live and work in the borough. This engagement has shaped our vision, purpose, values and strategic objectives as a CCG. The *Strategy* therefore demonstrates how, through engagement, our CCG and our member practices are becoming integrated with the local population.

The *Strategy* brings together the 'must dos' for the NHS that are set out in the NHS Constitution, the NHS Mandate and *Everyone Counts: Planning for Patients 2013/14.* The document also sets out the local priorities for Halton that have come from the Joint Strategic Needs Assessment and Health and Well Being Strategy and how the CCG will contribute to delivering these. The *Strategy* therefore integrates national and local priorities in one place and provides clarity as to the outcomes that are to be achieved.

We believe that this *Integrated Commissioning Strategy* paints a rich picture of Halton, of the needs of our population, the challenges we face and what we are going to do to improve access, quality and the experience of the people who use those services. We hope that the *Strategy* becomes a road map for us to deliver our vision of involving everybody in improving the health and well-being of the people of Halton.

Dr Cliff Richards
Chair

Simon Banks
Chief Officer

Executive Summary

- The *Integrated Commissioning Strategy* for 2013-15 describes how NHS Halton CCG developed its plans for conducting business during its first two years as a statutory organisation. It should be read in conjunction with the *Operational Delivery Plan and Commissioning Intentions 2013-14*, which provides more detail about the projects which will underpin organisational development and the commissioning of services in the first year.

- NHS Halton CCG received authorisation from the NHS Commissioning Board (NHS CB) in February 2013 in the third wave of such authorisations, following a rigorous assessment process. This included a review of the CCG's policies, a site visit, assessments of clinical and managerial leadership and work with stakeholders and patients. The *Strategy* forms part of the authorisation process. Its implementation and the delivery of the commissioning intentions will be monitored by the NHS CB.

- This document provides background information about the local area, health priorities, the development of the coming year's commissioning intentions and the achievements of 2012/13. It also details the resources available to the CCG to enable the delivery of its responsibilities, including its budget.

- Early versions of the document have been shared with local authority colleagues by discussion at meetings of the Governing Body (17th January, 21st February, 21st March, 18th April 2013) and the Halton Shadow Health and Wellbeing Board (13th March 2013).

- In accordance with the Constitution of the CCG, the commissioning intentions were approved by the membership (8th February 2013).

- The *Operational Delivery Plan and Commissioning Intentions* sets out our projects in five work programmes.

  - The **corporate development** workstream describes the projects to support the development of the fledgling organisation. These are enabling initiatives which will underpin the delivery of the commissioned services.

  - The engagement process with the general public demonstrated the importance of the **mental health and unplanned care** workstream to our local population. Projects in these areas range from increasing access to psychological therapies to the introduction of rapid assessments for mental health conditions for people presenting at A&E departments.

  - A number of initiatives in **primary, community and integrated care services** provide opportunities for the further development of partnership working with the local authority, such as the redesign of working teams to give a higher quality of support to people discharged from hospital with several different needs. The programme also includes the ongoing development of the 'community wellbeing practices' model, a flagship project for the CCG, which aims to increase the resilience of local communities by harnessing local assets to support wellbeing.

  - The **planned care** work programme contains several initiatives to support people with long-term conditions such as diabetes and respiratory disorders. A number of projects aim to improve the experience of care for people at the end of life.

  - **Women, children and families services** offer a further opportunity to enhance partnership working with the local authority. Plans include a redesign of the care pathway for children experiencing mental health and emotional wellbeing issues and a full review of the community midwifery services.

1. VISION

Our **vision** is to involve everybody in improving the health and wellbeing of the people of Halton.

Our **purposes** are:

- To improve the health and wellbeing of the population of Halton, empowering and supporting local people from the start to the end of their lives by

  - preventing ill-health
  - promoting self-care and independence
  - arranging local, community-based support whenever possible and
  - ensuring high-quality hospital services for those who need them.

- To support people to stay well in their homes, in particular to avoid crises of care that can result in hospital admission. General practices will support and empower individuals and communities by promoting prevention, self-care, independence and resilience.

- To work with local people and with partner organisations including Halton Borough Council, healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

a) Values

The key values and behaviours at the heart of our work are:

Partnership We will work collaboratively with our practices, local people, communities and with other organisations with whom we share a common purpose.

Openness	We will undertake to deliver all business within the public domain unless there is a legitimate reason for us not to do so.
Caring	We will place local people, patients, carers and their families at the heart of everything we do.
Honesty	We will be clear in what we are able to do and what we are not able to do as a commissioning organisation.
Leadership	We will be role models and champions for health in the local community.
Quality	We will commission the services we ourselves would want to access.
Transformation	We will work to deliver improvement and real change in care.

2. CONTEXT

a) Who we are

NHS Halton Clinical Commissioning Group (CCG) is responsible for commissioning health services for its 125,700 residents and others who need emergency care whilst in the area.[1]

Halton has two main towns, Runcorn and Widnes, as well as a number of parishes and villages. The geographical area covered by the CCG is coterminous with the local authority boundary of Halton Borough Council.

The CCG is clinically-led by GPs and other healthcare professionals. We are formed and built on a membership model, drawn from the 17 general practices located within Halton, with the aim of ensuring high quality, cost-effective services within a sustainable system.

Each practice has nominated a GP as its lead for liaison with the CCG and this group meets regularly. Additionally, each clinical workstream has a nominated GP lead. There are also regular meetings of practice managers and we are in the process of developing a nurses' forum.

The CCG has existed in shadow form since November 2011, and was established as a sub-committee of the Board of NHS Merseyside in January 2012. It was formed from practices previously governed by NHS Halton and St Helens Primary Care Trust.

Dr Cliff Richards, a local GP, is the Chair of the CCG. Senior officers are Simon Banks, Chief Officer; Jan Snoddon, Chief Nurse; and Paul Brickwood, Chief Finance Officer.[2] Dave Sweeney, Operational Director – Integrated Commissioning, is a joint appointment with the CCG and Halton Borough Council.

[1] This figure is from the 2011 Census
[2] Paul Brickwood is also Chief Finance Officer of NHS Knowsley CCG and NHS St Helens CCG

Fig. 1: Member practices of Halton CCG

Appleton Village
Beaconsfield
Upton Rocks
LUNTS HEATH
Peelhouse
Hough Green
Newtown
Beeches
DITTON
WIDNES
Oaks Place
Castlefields
West Bank
MANOR PARK
Windmill Hill
RUNCORN
DARESBURY
HALE
HALTON
Murdishaw
PRESTON BROOK
GP Practice
Hospital
Halton Local Authority boundary
Grove House
Weaver Vale
Halton MIU
Tower House
Heath Road
Brookvale

Halton Clinical Commissioning Group

Member practices

Practice name	Address
Appleton Village Surgery	2-6 Appleton Village, Widnes WA8 6DZ
Beaconsfield Surgery	Bevan Way, Widnes WA8 6TR
Beeches Medical Centre	20 Ditchfield Road, Widnes WA8 8QS
Brookvale Practice	Hallwood Health Centre, Hospital Way, Runcorn WA7 2UT
Castlefields Health Centre	Village Square, Castlefields, Runcorn WA7 2HY
Grove House Practice	St Paul's Health Centre, High Street, Runcorn WA7 1AB
Heath Road	Heath Road, Runcorn WA7 5TJ
Murdishaw Health Centre	Gorsewood Road, Murdishaw, Runcorn WA7 6ES
Newtown Health Care Centre	Widnes Health Care Resource Centre, Oaks Place, Caldwell Rd, Widnes WA8 7GD
Oaks Place Surgery	Widnes Health Care Resource Centre, Oaks Place, Caldwell Rd, Widnes WA8 7GD
Peelhouse Medical Plaza	Peelhouse Lane, Widnes WA8 6TN
Tower House Practice	St Paul's Health Centre, High Street, Runcorn WA7 1AB
Hough Green Health Park	Hough Green Road, Widnes WA8 4NJ
Upton Rocks Primary Care	Widnes Rugby Union Football Club Car Park, Heath Road, Widnes WA8 7NU
Weavervale Practice	Hallwood Health Centre, Hospital Way, Runcorn, WA7 2UT
West Bank Medical Centre	2 Lower Church Street, West Bank, Widnes WA8 ONG
Windmill Hill Medical Centre	Norton Hill, Windmill Hill

b) How we are governed

Our governance structure, developed in consultation with member practices, is designed to deliver

- clinical engagement,
- clinical governance, and
- clinically-led commissioning.

It provides a supporting structure which promotes strong governance, proper stewardship of public resources and high quality services.

Our comprehensive Constitution sets out our responsibilities and the procedures by which we operate. These are designed to ensure decisions are taken in an open and transparent manner, so that the interests of patients and the public remain central to our goals.

All the members of every general practice are invited to attend the quarterly meetings of the **Members' Forum**. This group makes the final decision on commissioning intentions, the financial plan and the annual report. Decision-making on other matters is delegated to the **Governing Body**, which is charged with the effective, efficient and economical delivery of the CCG's functions in accordance with the principles of good governance.

Dr Cliff Richards chairs the CCG and the monthly meetings of the Governing Body, the membership of which consists of the CCG's Chief Officer, Chief Finance Officer and Chief Nurse; four GPs/other health care professionals; a secondary care doctor; a registered nurse; a practice manager; and four lay members.

The Governing Body is supported by a number of sub-committees and other groups set up to provide assurances and appropriate member practice engagement.

The **Audit Committee** meets quarterly and its function is to provide an independent and objective view of risk management, governance and internal control systems. To enable this, no CCG staff sit on the committee and representatives from Mersey Internal Audit Agency and the external auditors are in attendance.

The **Quality and Integrated Governance Committee** is responsible for the development, implementation and monitoring of patient safety; patient experience; risk management; information governance; complaints; claims; serious incidents; and statutory responsibilities. This committee is supported by a **Service Improvement Group**, which develops, monitors and reviews a service improvement plan. Additional support comes from the **Practice Leads Group,** which enables the ongoing involvement of member practices in setting the commissioning agenda and the development of plans to make our intentions operational.

Discharge of statutory functions in line with the Standing Financial Instructions is the responsibility of the **Finance and Performance Committee**. This committee also monitors the performance of commissioned services.

The **Human Resources, Remuneration and Organisational Development Committee** has delegated responsibility for all matters relating to staffing, salaries and organisational development of the CCG.

The **Urgent Issues Committee** meets as required to enable speedy decision-making or management of specific issues outside the formal committee structure. These could include risks to service provision and financial, reputation or performance risks.

Fig. 2 on p.10 illustrates this structure.

Conflicts of interest

The CCG has a policy, approved by the Governing Body, for Standards of Business Conduct. This outlines the responsibility of all members of the Governing Body and all employees to adhere to the standards, which include the declaration of conflicts of interest. This policy also applies to GPs and practice staff and there is an implementation plan to ensure its delivery. The Register of Interests and delivery of the implementation plan are monitored by the Audit Committee and MIAA will audit compliance with the policy.

Fig 2: Governance structure

MEMBERSHIP FORUM
Function: All members of every practice are invited to attend this forum. It makes the final decision on the commissioning intentions; financial plan and annual report.
Frequency: Quarterly

PRACTICE LEADS GROUP
Function: Ensure engagement with member practices enabling involvement in setting the commissioning agenda
Frequency: Monthly

GOVERNING BODY
Function: Effective, efficient and economic delivery of the CCG's functions in accordance with the principles of good governance.
Frequency: Monthly

AUDIT COMMITTEE
Function: Independent and objective view of risk management, governance and internal control systems. No CCG staff sit on this committee.
Frequency: Quarterly

QUALITY AND INTEGRATED GOVERNANCE COMMITTEE
Function: Development, implementation and monitoring of all areas of quality and integrated governance – patient safety; patient experience; risk management; information governance; complaints, claims, serious incidents; statutory responsibilities.
Frequency: Monthly

FINANCE AND PERFORMANCE COMMITTEE
Function: Discharge of statutory functions in line with the Standing Financial Instructions; monitors performance of commissioned services.
Frequency: Bi-monthly

SERVICE IMPROVEMENT GROUP
Function: To develop and monitor/review a service improvement plan.
Frequency: Monthly

HUMAN RESOURCES, REMUNERATION AND ORGANISATIONAL DEVELOPMENT COMMITTEE
Function: All HR, remuneration and organisational development matters.
Frequency: Monthly

URGENT ISSUES COMMITTEE
Function: Enables decision-making or management of specific key issues outside the formal committee structure. Could include risks to service provision, financial, reputation or performance risks.
Frequency: Ad hoc as required

KEY:
Green boxes – committees of the Governing Body
Blue box – working group
Lilac box – other

Safeguarding

It is a requirement of all CCG staff that they undertake training in mandatory and statutory areas. These include safeguarding of both adults and children and an introduction to information governance.
All NHS service providers are required to show evidence of their compliance with the safeguarding arrangements against related Care Quality Commission standards. This evidence must be demonstrated as part of the annual regulatory framework.

The Quality and Integrated Governance Committee is responsible for oversight of the effectiveness of safeguarding arrangements.

The Merseyside CCGs have agreed a structure for safeguarding services for both children and adults which is designed to increase resilience across the area. It will improve capability, capacity and quality of service; and ensure statutory duties are fulfilled. From April 2013, Halton CCG will host both the Adult Safeguarding Service and the Children's Safeguarding Service on behalf of the Merseyside CCGs.

Local arrangements for safeguarding are managed by a fully integrated local authority/NHS team.

Complaints and Serious Untoward Incidents

The Quality and Integrated Governance Committee is responsible for ensuring that complaints and serious incidents have been investigated and responded to appropriately. There is ongoing work to raise awareness of identification of serious incidents and to develop a culture of systematic recognition and reporting of complaints and serious incidents. Although it is always regrettable when people are not satisfied with our services, we are working to develop systems which allow us to integrate the learning from such experiences into service improvement and development. We are working within our local health economy to further develop an existing system for the hospitals to raise any concerns they may have about any of our member practices; and for GPs to raise their concerns about any problems they or their patients are experiencing with hospital services.

We are striving for a 'no blame' culture where the investigation of concerns is seen as an opportunity for service development.

Complaints are managed by the Cheshire and Merseyside Commissioning Support Unit (CMCSU). The customer service team operationally manages any complaints received, ensuring investigation and production of a response for the complainant, which is first approved by the chief officer or chief nurse. Most complaints received by the unit relate to primary care but NHS Halton CCG generally has a low number. The team produces monthly reports for the CCG, outlining new complaints; those which are closed; their progress through the system to ensure they are dealt with in the appropriate time frame; and short overviews of the complaint and response. These are reported via the Quality and Integrated Governance Committee.

Responsibility for managing serious incidents will transfer to the CCG, supported by the CMCSU, in April 2013. The process requires reporting of an incident within 48 hours of declaration, via the strategic executive information software system (STEIS). Reports are produced for the CCG on incidents reported by providers. The CMCSU will manage the reporting and performance against timelines and the CCG will form a small internal group to review reports relating to its patients.

c) Our strategic objectives

Our strategic objectives are:

1. Continuous improvement of the health and wellbeing of the people of Halton.
2. Meaningful engagement with local people and communities.
3. Clear and credible plans which continue to deliver improvements in local health services and the **Quality, Innovation, Productivity and Prevention** (**QIPP)** challenge within financial resources, in line with national outcome standards and the local **Joint Health and Wellbeing Strategy (JHWS).**
4. Ensure robust constitutional and governance arrangements, with the capacity and capability to deliver all our duties and responsibilities, including financial control, as well as effectively commissioning all the services for which we are responsible.
5. Establish and sustain collaborative arrangements for commissioning with **other CCGs, Halton Borough Council** and the **NHS Commissioning Board (NHS CB).**
6. Appropriate, affordable and effective external commissioning support.
7. Achieve and maintain authorisation without conditions from the NHS CB.

Achievement of these strategic objectives will be measured via the five domains of the *NHS Outcomes Framework (NHS OF),* which are:

1. Preventing people from dying prematurely.
2. Enhancing quality of life for people with long-term conditions.
3. Helping people to recover from episodes of ill health or following injury.
4. Ensuring people have a positive experience of care.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

d) Our locality

Halton's population, at around 125,700, has increased by approx. 6% in the decade to 2011. The most significant increases were in the 0-4; 45-64 and 75+ age groups. The 5-14 age group has declined.

Ten things you need to know about Halton …

1. **The older people age group (65+) is projected to grow from 18,600 in 2011 to 24,700 in 2021.**
2. **Halton's population is largely white (97.5%).**
3. **Unemployment and worklessness are key challenges in Halton, with variation between wards. Around one-third of adults in Windmill Hill claim an out-of-work benefit.**
4. **The average household income in Halton is £33,800.**
5. **GCSE attainment in Halton is in line with the national average. The range is 30% (Windmill Hill) to 90% (Hale).**
6. **House prices in Halton are low. This means that Halton is a relatively affordable place to live, with house prices around four times average earnings.**
7. **Around a quarter of Halton's population rent homes from registered providers. This is around twice as much as regional and national figures.**
8. **Deprivation is a major issue in Halton. Of the 70 'super output areas', 21 fall in the 10% most deprived areas in England. Over a quarter of children – 6,950 – live in poverty.**
9. **Life expectancy in Halton is low. Female life expectancy is the fourth lowest in the country.**
10. **Halton has been identified as the eighth worst local authority area in England for alcohol-related harm and the 50th worst area for binge drinking.**

Health has improved over the last decade. People in Halton are living an average of two years longer than they were a decade ago. However, they still do not live as long as the national average.

Factors contributing to the overall improvements in health include:

Reductions in:

- Deaths from heart disease and cancers.
- The number of adults who smoke.
- The number of adults and children killed and seriously injured in road traffic accidents.

Improvements in:

- Diagnosis and management of common health conditions such as heart disease and diabetes.
- Detection and treatment of cancers .
- The percentage of children participating in at least three hours of sport/ physical activity. This is above the national average.

Increases in:

- The percentage of children and older people having their vaccinations and immunisations.

The table below shows a baseline view of the population dynamics, assuming recent demographic trends continue.

HALTON'S BASELINE POPULATION DYNAMICS		
Short term 2011-14	**Medium term 2011-17**	**Long term 2011-21**
+ 1%	+ 2%	+ 3%*
Long term (2011-21) projections		
	Younger people (0-15 year olds)	+ 10%
	Working age (16-64 year olds)	- 5%
	Older people (65+)	+ 33%

**This is lower than both North West regional and the national anticipated population growth, projected at 4% and 9% respectively.*

It is evident that prevention and early intervention strategies will be necessary for health and social care services to cope with the expected increased demand from this changing population.

The provider landscape

Healthcare services are commissioned from a wide range of providers. In the Halton area there are

17 general practices
12 dentistry practices
11 optometry practices
31 community pharmacies

contracted to provide NHS services. From 1st April 2013 these contracts will be held by the NHS CB.

In Merseyside, the CCGs have agreed that one CCG will act as co-ordinating commissioner for each of the NHS provider trusts; this is normally the CCG which accounts for the largest proportion of commissioned activity from that trust. The main NHS provider trusts offering services to Halton residents are listed below, with the co-ordinating commissioner shown in brackets.

Community services
Bridgewater Community Healthcare NHS Trust *(NHS Halton CCG)*

Hospital services
Warrington and Halton Hospitals NHS Foundation Trust *(NHS Warrington CCG)*
St Helens and Knowsley Teaching Hospitals NHS Trust *(NHS St Helens CCG)*, also known locally as Whiston hospital and St Helens hospital.

Mental health services
5 Boroughs Partnership NHS Foundation Trust *(NHS Knowsley CCG)*
Child and Adolescent Mental Health Service (CAMHS) for children and young people up to age 18

Ambulance services
The North West Ambulance Service (NWAS) provides emergency services *(NHS Blackpool CCG)*

Specialised services

Specialised services are commissioned nationally by the NHS CB. Generally speaking, these are services or procedures which affect fewer than 500 people across England in any year. The Merseyside area has four specialist hospitals (including one children's specialist hospital).

Third sector and commercial providers

Some services are provided by third sector and commercial providers. A diverse and competitive supplier base will give patients more choice. The network of CCGs on Merseyside has this year undertaken 'Any Qualified Provider' (AQP) procurements of musculoskeletal (neck and back pain) services; hearing aids for adults; and core podiatry.

Halton General Hospital, part of Warrington and Halton Hospitals NHS Foundation Trust

NHS Halton CCG's position on the indicators in the NHS Outcomes Framework

The chart below shows the distribution of CCGs on each indicator. NHS Halton CCG is shown as a red diamond. The yellow box shows the interquartile range and median of CCGs in the same cluster (as defined by the Office for National Statistics) as this CCG. The dotted blue line is the England median. Better outcomes are towards the right of thepage (lighter blue). This illustrates the disease areas where health inequality is greatest.

This CCG is in the Mining & Manufacturing cluster

Outcome Indicator	CCG and cluster distribution
1a Potential years of life lost (PYLL) from causes considered amenable to healthcare	
1.1 Under 75 mortality rate from cardiovascular disease	
1.2 Under 75 mortality rate from respiratory disease	
1.3 (proxy indicator) Emergency admissions for alcohol related liver disease	
1.4 Under 75 mortality rate from cancer	
2 Health related quality of life for people with long term conditions	
2.1 Proportion of people feeling supported to manage their condition	
2.3i Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)	
2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	
3a Emergency admissions for acute conditions that should not usually require hospital admission	
3b Emergency readmissions within 30 days of discharge from hospital	
3.1i Patient reported outcome measures for elective procedures – hip replacement	
3.1ii Patient reported outcome measures for elective procedures – knee replacement	
3.1iii Patient reported outcome measures for elective procedures – groin hernia	
3.2 Emergency admissions for children with lower respiratory tract infections	
4ai Patient experience of GP services	
4aii Patient experience of GP out of hours services	
4aiii Patient experience of NHS dental services	
5.2i Incidence of Healthcare associated infection (HCAI): MRSA	
5.2ii Incidence of Healthcare associated infection (HCAI): C Difficile	

Worse   Better

e) Working Collaboratively With Our Partners

The Halton area has a longstanding practice of close partnership working between public sector colleagues. We will continue to strengthen the existing working partnerships to maximise benefits for our local population.

This could include collaborative working with the council, schools, colleges, job centres, housing associations, the police and criminal justice agencies. It will also involve working with **other CCGs, health care providers,** the **NHS CB**, the **Department of Health** and **Public Health England**, **Healthwatch, patients** and the **public.**

Section 25 of the NHS Act enables local authorities and CCGs to pool resources in order to work together. We have worked with **Halton Borough Council** to produce a *Framework for Integrated Commissioning in Halton.* This explores national good practice, with an action plan aimed at improving the flexibility of both organisations in the use of resources, responsiveness and innovation. In support of the principles outlined within the framework we are developing a partnership agreement with the council to enable maximum levels of integration in the commissioning of health and social care services. This agreement includes urgent care; long-term conditions and complex care. One piece of work already undertaken is *Halton's Urgent Care Partnership's Response Plan*, which was approved by the CCG's Governing Body in September 2012. This sets out a 'whole system' vision for urgent care services in Halton, for which there is an increasing demand; and a strategy for achieving that vision.

At local level, the Health and Social Care Bill 2012 transfers primary responsibility for **public health** from the NHS to the local authority. There is a formal agreement (memo of understanding) between the authority and the CCG about how the public health department and the CCG will work together. Public health will provide specialist advice to the CCG, including the development of a defined specification for comprehensive public health support. Additionally, for agreed topics, public health will assess the health needs of the local population and how they can best be met using evidence-based interventions. The CCG will ensure it incorporates

specialist public health advice into its decision-making processes, in order that this expertise can inform key commissioning decisions. It will also utilise specialist public health skills to target services at the greatest population need and towards a reduction of health inequalities; and contribute intelligence and capacity to the production of the JNSA.

The **network of Merseyside CCGs** has agreed a high-level strategy until 2014-15, taking into account the need to focus on quality, reform and maximised use of resources. A number of pieces of work are undertaken across the whole network area. These include the ongoing QIPP projects, which are co-ordinated and monitored from a central programme office. In addition to the pan-Merseyside schemes, there are other projects undertaken with one or several local partners. For example, we are currently working with **NHS Warrington CCG, NHS St Helens CCG** and **Bridgewater Community Healthcare NHS Trust** to review intravenous therapies.

f) Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS)

We and our local authority colleagues are jointly responsible for assessing and prioritising key health and wellbeing needs. The JSNA provided evidence of local need. In conjunction with the outcomes frameworks for public health, the NHS, adult social care and children and families, it was used to inform an extensive consultation with local people (including children and young people).

The Halton Shadow Health and Wellbeing Board collated and analysed the information from all of those sources, using a prioritisation method which enabled the scoring of the emerging results. This meant that the decisions about the priorities focused on in the JHWS were made from a strong evidence-base.

The five priority areas identified in the JHWS, and the organisation with the lead commissioning responsibility for that priority, are:

- Prevention and early detection of **cancer** – Local Authority (Public Health)
- Improved **child development** – Local Authority and NCB
- Reduction in the number of **falls** in adults – Local Authority (Public Health)
- Reduction in the harm from **alcohol** – Local Authority (Public Health)
- Prevention and early detection of **mental health** conditions – Local Authority (Public Health)

In order to address these priorities, a series of co-ordinated interventions are needed and these are outlined in a multi-agency implementation plan. This commissioning strategy forms part of that plan.

Challenges

Significant progress has been made in increasing life expectancy and reducing health inequalities. However, there remains a range of challenges.

Cancer

- The proportion of women who die from cancer is higher in Halton than anywhere else in the country. Much of this is due to lung cancer caused by smoking.

Child development

- A range of child health indicators remain poor. Child obesity levels at both reception and year 5 remain above the national average. A greater percentage of women continue to smoke during pregnancy and fewer women start breast feeding compared with national rates.

Falls

- The rates of hospital admissions due to falls are higher in Halton than for England and the north west. Rates are especially high in the over 65 age group. Falls in Halton's population in this age group which resulted in a recorded injury were the highest in England in 2010-11.

Alcohol

- Alcohol and substance misuse continue to create challenges for the health service and wider society, in particular crime and community safety. Admissions to hospital due to alcohol-related conditions continue to rise each year.
- Hospital admissions due to alcohol for those under the age of 18 are amongst the highest in the country (2007-2010 figures). Admissions due to substance misuse (age 15-24 years) were the highest in England (2008-11 figures).

Mental health

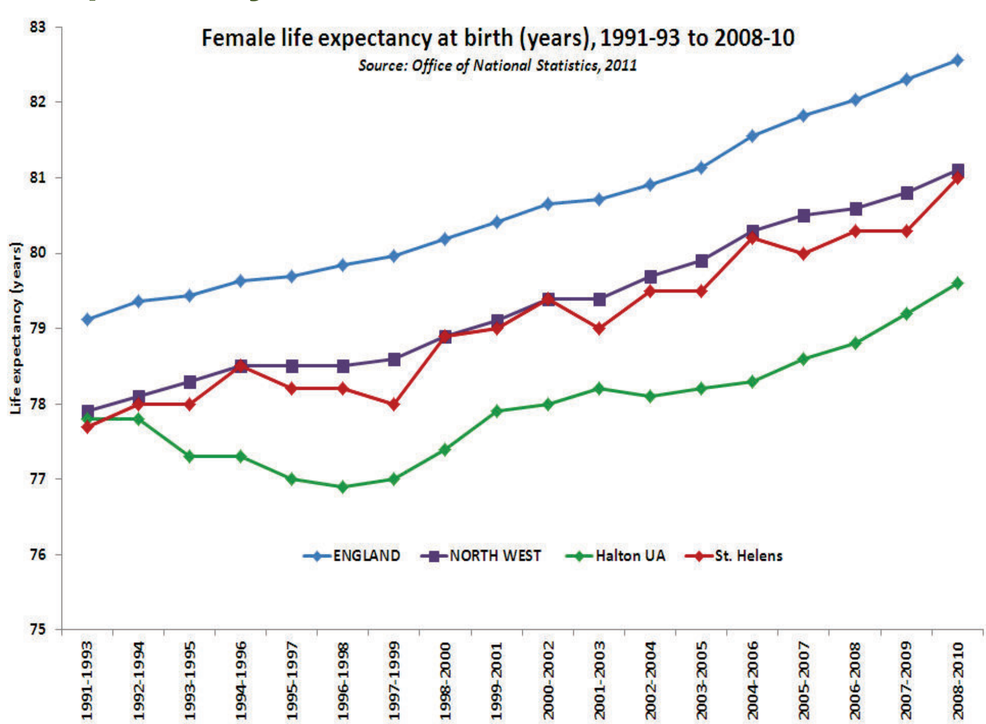
- The ageing population means more people will be living with dementia.

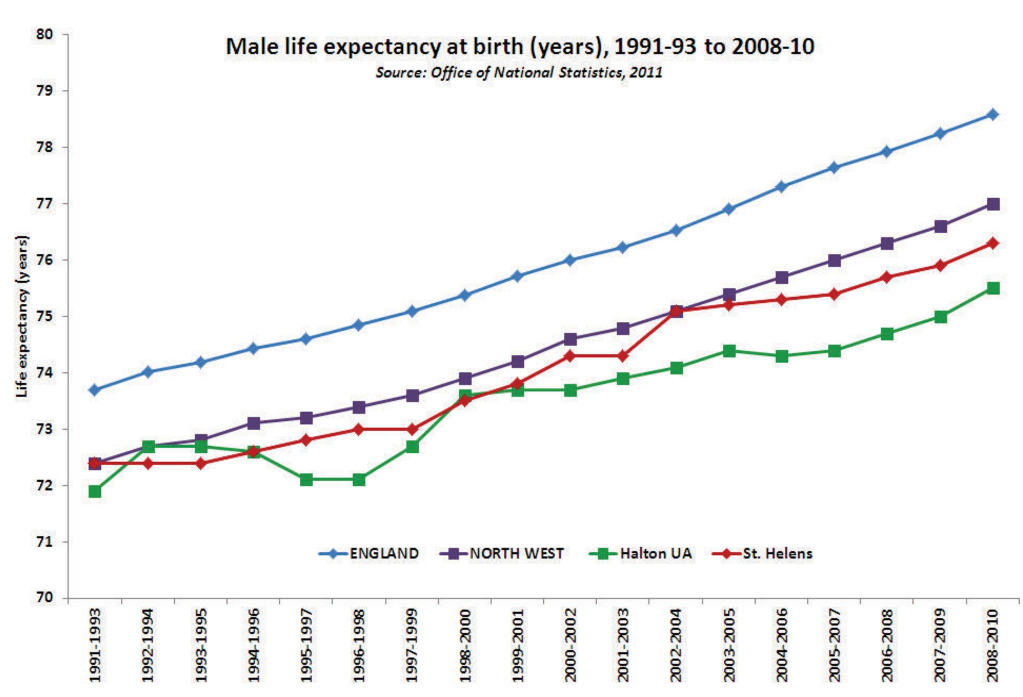
- Significant numbers of people suffer mental health problems, such as depression. One in every four people will develop depression during their life. Mental health problems account for the single largest cause of ill health and disability in the borough.

General

- There are significant inequalities in how long people live across the borough.
- People in Halton live a greater proportion of their lives with an illness or health problem that limits their daily activity than in the country as a whole.
- As Halton's population ages, it is predicted there will be more people with diabetes; this is linked to obesity.
- It is predicted that more people will develop bronchitis and emphysema because of previously high levels of smoking.
- Halton has high levels of people admitted to hospital as emergency cases compared with the country as a whole and many other boroughs. The less wealthy parts of the borough have higher emergency admission rates than those area which are wealthier.
- Teenage pregnancy rates remain high. Having a child before the age of 18 can negatively affect the life chances and health of both the parent and the child.

Life expectancy




Male life expectancy at birth (years), 1991-93 to 2008-10
Source: Office of National Statistics, 2011
Life expectancy (years)
80
79
78
77
76
75
74
73
72
71
70
ENGLAND
NORTH WEST
Halton UA
St. Helens
1991-1993
1992-1994
1993-1995
1994-1996
1995-1997
1996-1998
1997-1999
1998-2000
1999-2001
2000-2002
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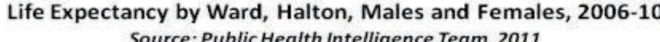
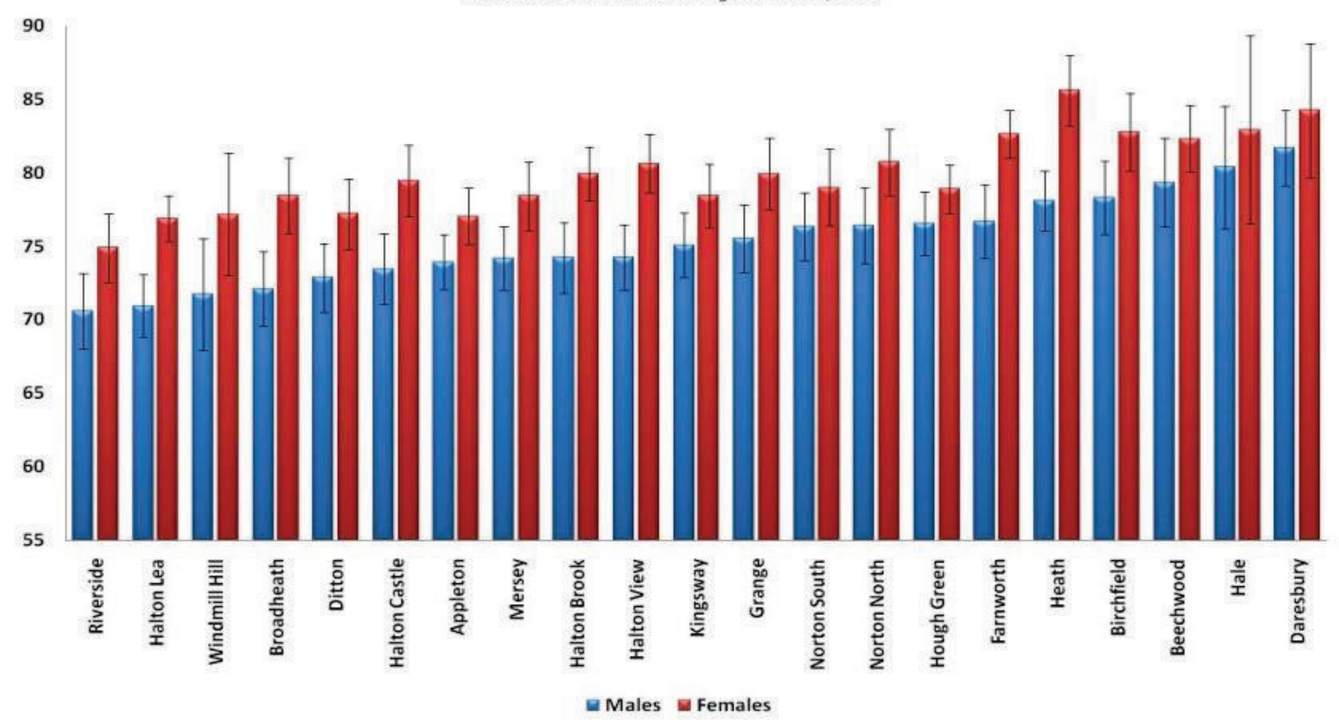
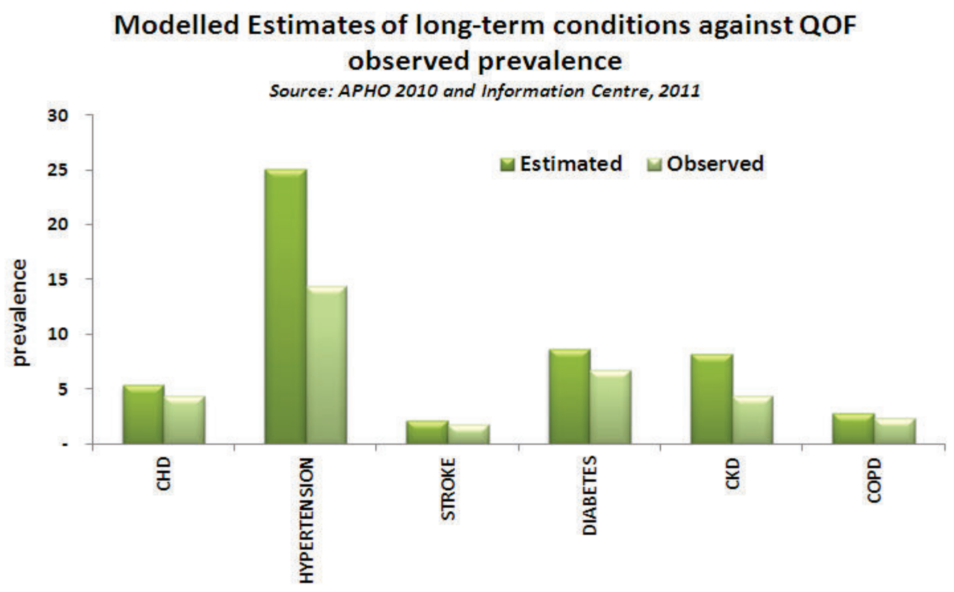

Life Expectancy by Ward, Halton, Males and Females, 2006-10
Source: Public Health Intelligence Team, 2011


90
85
80
75
70
65
60
55
Riverside
Halton Lea
Windmill Hill
Broadheath
Ditton
Halton Castle
Appleton
Mersey
Halton Brook
Halton View
Kingsway
Grange
Norton South
Norton North
Hough Green
Farnworth
Heath
Birchfield
Beechwood
Hale
Daresbury
Males
Females

Disease prevalence: expected against observed rates



LONG TERM CONDITION	MODELLED		OBSERVED	
	Number	Prevalence	Number	Prevalence
CHD	6928	5.40	5,665	4.4
HYPERTENSION	32141	25.10	18,411	14.4
STROKE	2866	2.20	2,362	1.8
DIABETES	8321	8.70	6,901	6.8
CKD	7,474	8.2	4,421	4.4
COPD	3633	2.80	3,048	2.4

g) How our performance will be measured and other key influences

The NHS is going through a time of unprecedented transformational change. The economic situation means that resources are likely to be limited for some time. This, along with an ageing population and increasing demand on services, means that we must find better ways of delivering services.

The **Health and Social Care Act 2012** is the largest piece of health legislation since the creation of the NHS. It legislates for the reform of the NHS first set out in the White Paper *Equity and Excellence: Liberating the NHS.'* The Act legislates for the key principles of:

- Placing patients at the centre of the NHS.
- Changing the emphasis of measurement to clinical outcomes.
- Empowerment of health professionals, in particular GPs.

The **NHS Commissioning Board** is responsible for directly commissioning some health services at a national level. These services are:

- Primary medical, pharmacy, optical and all dental services.
- Specialised services.
- Some specific public health screening and immunisation services.
- Services for members of the armed forces.
- Services for offenders in institutional settings.

The NHS CB is also responsible for the authorisation of CCGs and for carrying out annual assessments of CCGs. The criteria for assessment will be published by March 2013 and will be based on the domains used for authorisation:

- Improving the quality of services.
- Reducing inequalities.
- Obtaining appropriate professional advice.
- Public involvement.
- Meeting financial duties .
- Taking account of the local Joint Health and Wellbeing Strategy.

The Department of Health's (DH) Mandate to the NHS CB sets out the strategic direction for the NHS and objectives that the Board is legally obliged to pursue to March 2015. The Mandate has five improvement areas which correspond to the five domains with the *NHS Outcomes Framework* and indicators from the framework will be used to measure progress.

In December 2012 the NHS CB published *Everyone Counts: Planning for Patients 2013/14.* This document describes which areas CCGs must focus on in 2013/14 and the outcomes which will be used to track progress.

Four measures have been selected as national priorities and the NHS CB will monitor the CCG's progress against them. These are:

1. Potential years of life lost (PYLL) from causes considered amenable to healthcare.
2. Emergency readmissions within 30 days of discharge.
3. Friends and family test.
4. Incidence of healthcare associated infections (HCAI) – (i) MRSA and (ii) *C. difficile*

Additionally, the CCG will agree with the NHS CB three local measures, which take account of the priorities in the Health and Wellbeing Strategy, against which performance will be measured. These are:

- Increased number of physical health checks for people with learning disabilities
- Increased diagnosis/treatment of atrial fibrillation in people over 65
- Increased diagnosis/treatment of impaired glucose response

At the time of writing these priorities are subject to confirmation by the NHS Commissioning Board.

The CCG will also be monitored by the NHS CB on:

- Estimated diagnosis rates for people with dementia.
- Completion of the full roll-out of the access to psychological therapies (IAPT) programme by 2014/15 and recovery rate to reach 50%.

h) Our achievements 2012-13

Commissioning is divided into four workstreams, under the leadership of the Operational Director – Integrated Commissioning. The workplan for the year 2012-13, when the CCG was in shadow form, included ongoing projects from the former NHS Halton and St Helens PCT; the priorities set out by NHS Merseyside and the setting up of the shadow CCG.

Urgent and Unplanned Care

Urgent Care Review

This piece of work is undertaken in partnership with Halton Borough Council. A range of factors are causing an increase in the demand for urgent care services. These include a complex range of access points into the health system, which are not understood by the public, often leading to default to accident and emergency (A&E) departments. There is an increase in the number of A&E attendances which is in part due to people attending with minor ailments. An audit of A&E attendances has been undertaken. This was a two-week, 24/7 'snapshot' of all attendances and the results have been assimilated and analysed. A full options appraisal will follow.

Paramedic Pathfinders

Work has been undertaken with the North West Ambulance Service NHS Trust to agree care pathways for patients who are terminally ill and at the end of life who may suffer a fall. When called to such patients, the paramedics will follow that individual's care plan, only taking them to a hospital if it is necessary. This scheme is being piloted and if successful will be introduced in other care pathways.

Reablement and Rehabilitation Team

This multi-disciplinary team, which includes social workers and therapists, has been formed jointly with Bridgewater Community Healthcare NHS Trust, Warrington and Halton Hospitals NHS Foundation Trust and the local authority. GPs can refer patients for assessment, including blood and other tests, and the most appropriate care will be arranged, avoiding hospital admission unless this is necessary.

Improving Access to Psychological Therapies (IAPT)

The service has been reviewed and redesigned. The service specification was approved by the Governing Body in December and the service will be procured in the current financial year. Benefits of the redesigned service include improved access; reduced waiting times; skills development of existing staff; and financial savings.

Primary, Community and Integrated Care

Tailored care/multi-disciplinary teamworking

This project redesigned integrated discharge teams as part of a bigger piece of work around the ongoing development of community nursing, in partnership with the local authority and a number of nursing homes. There are two general practices piloting the model of multi-disciplinary neighbourhood district nursing teams, which aim to ensure that care is delivered in the most appropriate place at the appropriate time for the individual patient.

Wellbeing practices

Funding was secured to pay for community development workers to engage with practices to develop a Wellbeing Practice scheme. Practices were invited to express interest in participation in the development of a growth model of increasing wellbeing by harnessing community resources. There was much enthusiasm, with eight practices showing keen interest. The aim of this is to develop community resilience, ultimately improving health. The development workers are helping practices to deliver action plans for a diverse range of activities where the practice acts as a hub to signpost people to other services – for example, fruit on prescription scheme; allotment scheme; exercise/parks/waterways; dementia. The learning from this project will be shared both locally and nationally.

Medicines management

As part of the Merseyside-wide QIPP plan, £2m savings were identified from Halton.

Carers

In conjunction with Halton Borough Council, funding for carers' breaks was mapped. Work was undertaken to use additional funding to enhance support for carers in joint CCG/local authority priority areas including hospital liaison, autism and mental health.

GP Portal

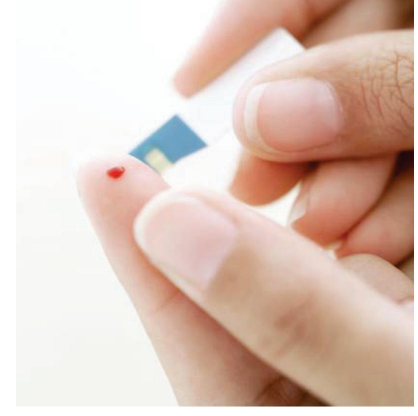
A health intelligence tool was implemented in each practice which gave access to that practice's activity. This can be tracked to individual patient level and allows practices to identify areas for development and improvement.

Planned Care

Diabetes

Several projects have been co-ordinated across the NHS Merseyside geographical area and are now complete. These include:

Insulin passports. Patients who take insulin to control their diabetes have been issued with 'insulin passports' in accordance with National Patient Safety Agency guidance. These documents are kept by the patient and record their current insulin products.



Insulin pumps. A specification for the consistent authorisation of these in accordance with patient need has been agreed and is in the process of being incorporated into provider contracts.

Impaired glucose reaction (IGR). A standard pathway was agreed across Merseyside, which has informed the development of NICE guidance. This will be introduced in primary care. For the Halton area, the capacity of the lifestyle service is to be verified.

24/7 Telephone Advice Service, Specialist Palliative Care. This service previously operated in standard business hours only. It was first extended to standard hours, all week availability and then further extended so that it is now available 24 hours, every day. Benefits include increased access to specialist palliative care advice and support for patients, families and professionals; ensuring the patient's preferred place of care is identified and their choice supported; delivery of NICE Improving Outcomes Guidance; and a reduction in unnecessary hospital admissions.

Any Qualified Provider (AQP) procurements. This work was co-ordinated by the Commissioning Support Unit and specifications were drawn up on a Merseyside-wide basis. There was a national requirement for all CCGs to participate in three AQP procurements, with the aim of extending patient choice. The areas chosen in Merseyside were musculoskeletal services; podiatry and adult hearing aid provision.

Women, Children and Families

Children's trusts were set up as local partnerships which brought together all the organisations responsible for children's services, led by local authority directors and lead members of children's services. Each partner organisation retained its individual responsibilities but worked with other organisations to ensure services worked together. Children's trusts are no longer a legal requirement; however, Halton has chosen to retain this model as it has worked well in the local area. A key priority for Halton Children's Trust is the commitment by all partners to improved outcomes for children and young people through the delivery of integrated early help and support. Recent examples of the success of this approach include an 18% fall in the rate of teenage pregnancy.

The CCG's women, children and families commissioning staff were appointed in January 2013 and work closely with the local authority team. Early pieces of work include:

- The development of a service specification for the coordination of diagnostic panels for autism spectrum disorder; the aim of this is to reduce waiting times for diagnosis.
- Health assessments for looked-after children. Halton has more children in care from other parts of the country than from the borough. This puts pressure on local services.
- Collaboration with primary care to develop scheme for reduction of hospital admissions for asthma.

3. COMMISSIONING INTENTIONS 2013-15

We have actively sought to ensure robust clinical and public engagement in the development of our commissioning plans for 2013-15. Stakeholder events were arranged for member practices and also for patients, community groups, partner organisations and the general public. This approach demonstrates our commitment to the need to reduce inequalities in line with local requirements and to give mental health the same priority as physical health, which are important aspects of the NHS CB's mandate.

The five areas identified in the **JHWS – cancer, child development, falls, alcohol, mental health** – were used as topic areas for discussion. Each of these areas is compatible with at least one of the five domains in the *NHS Outcomes Framework.*

Attendees were invited to put forward their ideas for improvements in these areas. The resulting feedback was used to formulate a long list of potential topics for commissioning. These were added to outstanding projects from the previous year's commissioning intentions and the details fed into an IT system. The link to this system was then sent to every GP practice, enabling the practice team to allocate voting points to each initiative based on set criteria. Votes were analysed to produce a ranking order for the initiatives.

This process has enabled strong clinical engagement in the development of the commissioning intentions. It has also identified the areas of most concern to the public. These were mental health services, alcohol misuse and access to services at evenings and weekends. There is ongoing work on all these issues, including work led by the public health and local authority teams, which complements the projects led by the CCG.

The Halton commissioning plan has been developed to include the consideration of QIPP impact across all schemes. A companion document, *Operational Delivery Plan and Commissioning Intentions 2013-14* provides descriptions of each of the projects. It also details the plans for ongoing corporate development. The CCG's membership approved the commissioning intentions at its meeting on 8th February 2013.

Fig. 3 Flowchart illustrating the formation of the commissioning intentions.

Joint Strategic Needs Assessment – evidence used to inform …

→ Joint Health and Wellbeing Strategy. Chosen priority areas used as focus of debate and to produce initiatives at …

→ … meetings for all practice members and the public.

→ From the discussions, a long list of local initiatives was produced and …

→ … added to national priorities and ongoing projects ….

→ Details of all schemes circulated to member practices

→ Practices prioritised initiatives

→ Feedback on priorities given to member practices and the public; clinical champions identified for each initiative

→ Initiatives developed in operational workplan

Managing performance against our commissioning and financial plans

During 2012/13 NHS Merseyside developed an early warning dashboard (EWD) for each NHS Trust provider, similar to the approach adopted by the NHS CB on a national basis.

The EWD gives an at-a-glance view of performance of that provider against 48 indicators, which include infection control, quality risk profiles and safety measures. The indicators currently in the dashboard are those agreed nationally and locally as effective early markers of possible provider problems or service failure and more can be added when appropriate.

Regular review of the dashboard, which will take into account any additional local knowledge around particular issues, will allow effective and timely responses to manage situations as they arise.

The CMCSU will update the dashboard weekly and send to the Chief Nurse for review. Any concerns will be discussed by the senior management team and, when appropriate, escalated to the Governing Body. This process was agreed by the Quality and Integrated Governance Committee in February 2013, which also agreed to review the dashboard at its monthly meetings.

Internal performance management

We are working with the CMCSU and performance management teams in other CCGs to further develop the business intelligence portal. The aim is to enable us effectively to monitor performance against the requirements set out in *Everyone Counts*, some key information for use in general practices and other issues of importance locally.

Additionally, and in response to feedback received during the CCG's authorisation process, we are developing a programme management office. This function will monitor progress of projects in the commissioning workplan and, when appropriate, escalate issues for the attention of the senior management team; it will also be responsible for delivery of the corporate workstream detailed within the workplan for 2013/14.

Key milestones for each project are set out in the workplan. The early stages of development in each piece of work will include the identification of key performance indicators. We are working with colleagues in the CMCSU to identify a web-based project management system which will enable performance monitoring against plans.

Commissioning intentions

WORKSTREAM: Mental health and unplanned care

COMMISSIONING INTENTION	DESIRED OUTCOMES
MHUC1. Update oservice specifications.	Ensure current service is reflected; support performance monitoring.
MHUC2. Dementia screening in care homes.	Early identification and treatment aided by use of technology.
MHUC3. Redesign of A&E liaison psychiatry service.	Reduced waiting times; improved patient experience and support for families and carers.
MHUC4. Implement procurement of increased access to psychological therapies (IAPT).	Improved access; reduced waiting times; financial savings.
MHUC5. Urgent care redesign.	Reduce A&E attendance and readmissions.
MHUC6. Roll out of NHS 111/Directory of services .	Smooth transition between existing and new services.
MHUC7. Alzheimer's Admiral nurses.	Improved experience of care and quality of life for people with dementia, their families and carers.
MHUC8. Wellbeing care pathway redesign to ensure all patients on the seriously mentally ill register have access to yearly physical health checks.	Improve physical health care for people with severe mental illness..
MHUC9. Implement action plan for learning disabilities services.	Improved care for people with learning disabilities.
MHUC10. DVT pathway – community-based anti-coagulation clinic.	Improved access.

WORKSTREAM: Primary, community and integrated care

COMMISSIONING INTENTION	DESIRED OUTCOMES
PCI 1. Update service specifications.	Ensure current service is reflected; support performance monitoring.
PCI 2. Complex care – pooling of resources and alignment of systems.	Improve patient experience; improve discharge pathways; increase positive outcomes; reduce inappropriate hospital admissions
PCI 3. Mobilisation of new out of hours contract.	Smooth transition between existing and new services.
PCI 4. Redesign of integrated discharge teams.	Reduction in unplanned admissions; improvement management of healthcare-acquired infections.
PCI 5. Develop wellbeing practice model and extend to all practices.	Reductions in inappropriate referrals; integration of community and third sector provision with general practice; increase social cohesion; enhance wellbeing and community resilience.
PCI 6. Modernise six clinical pathways	Avoid inappropriate referrals, emergency attendances and admissions. Increased practice engagement in commissioning cycle.
PCI 7. Electrocardiogram in primary care	Reduce avoidable hospital referrals and admissions; reduce waiting times; improve patient experience.
PCI 8. Atrial fibrillation – routine screening for people aged over 65	Reduce variation in identification rates and significantly increase diagnoses; reduce incidence of stroke and its human, social and financial costs.

WORKSTREAM: Planned care

COMMISSIONING INTENTION	DESIRED OUTCOMES
PC 1. Update service specifications.	Ensure current service is reflected; support performance monitoring.
PC 2. End of life service improvement programme. a) Breathlessness; psychological support. b) QOF end of life (nursing homes) c) Med in Sheds d) Implement electornic palliative care co-ordination e) Local implementation of 'do not attempt cardiopulmonary resuscitation	Improved quality of care at end of life and increased support for patients; reduced inappropriate admissions.
PC 3. Gold standard framework for proactive palliative care	Improved consistency and reliability of care at end of life.
PC 4. Hypoglycaemic pathway.	Introduction of care pathway for people with diabetes who have a hypoglycaemic episode requiring hospital attention.
PC 5. Nebuliser modernisation.	Ensure ongoing provision of service.
PC 6. Procurement of ENT community assessment and treatment services.	Reduced follow-up appointments and reduced number of appointments cancelled by patients. Financial savings.
PC 7. Ophthalmic primary eye care assessment and referral.	Early access to specialist assessment, diagnosis and treatment.
PC 8. Musculoskeletal service.	Ensure ongoing provision of service.
PC 9. Diabetes patient education.	Secure provision of service at end of current contract.
PC 10. Review pathology provision.	Ensure provision of appropriate service.
PC 11. Multi-faceted respiratory education service.	Education programme for healthcare professionals to cover management of asthma; COPD; spirometry performance and interpretation; self-management plans; end of life care; oxygen management and pulmonary rehabilitation.

PC 12. Dedicated respiratory review service for Halton community.	Provision of fast-track consultant-led respiratory service to diagnose, review and optimise patient treatment.
PC 13. Direct access to gastrointestinal diagnostic services.	Reduction in inappropriate outpatient appointments.
PC 14. Modernise spirometry service.	Ensure correct diagnosis of COPD; and appropriate medicines management.
PC 15. Community dermatology service.	Improved patient experience; care closer to home; speedier treatment; improved value for money; reduced referrals to secondary care.
PC 16. Community gynaecology service.	Improved patient experience; care closer to home; speedier treatment; improved value for money; reduced referrals to secondary care.
PC 17. Seven-day TIA service	Reduce delays in diagnosis and risk of re-occurrence of TIA and occurrence of stroke; increase percentage of appropriate patients receiving thrombolysis which improves clinical outcomes.
PC 18. Termination of pregnancy service (TOPS)	Ensure provision of high-quality, cost-effective service.
PC 19. Impaired glucose tolerance pathway.	Increase ability for self-care; reduce risks of complications arising from development of the illness.

WORKSTREAM: Women, children and families

COMMISSIONING INTENTION	DESIRED OUTCOMES
WCF 1. Update service specifications.	Ensure current service is reflected; support performance monitoring.
WCF 2. Maternity services review.	Integrated high-quality community service which is financially viable and meets NICE guidance.
WCF 3. Orthoptic provision in special schools.	Provide service (no current provision); supports implementation of 'Healthy Child' policy.
WCF 4. Redesign of children's mental health and emotional wellbeing services.	Holistic approach to care for under 18s experiencing emotional/mental health issues.
WCF 5. Nasal pharyngeal services for children with complex needs.	Improved quality of service and reduced costs. Delivery of sustainable model for the future.
WCF 6. Update assisted conception/sub-fertility guidance.	Guidance to take account of revised NICE reocmmendations.

4. RESOURCES

a) People

We aspire to be a high-performance commissioning organisation. This means we need to develop leaders of change throughout the organisation in order to deliver our commissioning plans, incorporating quality, innovation, productivity and prevention. We are committed to ensuring that our approach to leadership development involves all within the organisation. We have adopted the NHS Change Model as our methodology and will endeavour to train all staff in the application of the model. This model was developed by the Department of Health and the NHS Institute for Innovation and Improvement. The aim is to create an environment and culture in which everyone can contribute.

Leadership and Organisational Development

A baseline self-assessment was undertaken, using the Diagnostic Tool for Emerging Clinical Commissioning Groups. The tool was established to allow CCGs to assess themselves against the clinical commissioning domains, reflecting upon the values, culture, behaviour and wider organisational health. This work involved members of the shadow board, management team, partners and other stakeholders. From it we identified five organisational development priorities, established a baseline position, identified agreed development needs and timescales for delivery; and produced an action plan to ensure delivery of those priorities.

The action plan is being implemented and is currently on schedule; it is attached as Appendix C.

The priorities and key development areas we have identified are:

i) **Values and behaviours** – These are built into staff induction and personal development review (PDR) processes.

ii) **Developing leadership capacity and capability** – All staff will have an annual PDR. A strategy to support continuous improvement will be developed at both practice and borough level. Training for all clinical and managerial leaders in the NHS Change Model will be provided by the CMCSU. The NHS Leadership Academy Governing Body Framework, AQuA Board to Board and CCG programmes will also be used.

iii) **Developing the workforce** – The composition of the workforce in the CCG is very different from that in the predecessor primary care trust. There is a mixture of directly employed staff, contracted commissioning support staff, Governing Body members and clinicians and practice staff from member practices who will contribute to our development. References to 'our workforce' embrace all of these people as we recognise the importance of the contribution they will make. Engaging the people who work for us in our vision and purpose will make it more likely that they will maintain performance through change and challenge. They are also more likely to contribute to innovation, business improvement and provide higher rates of discretionary effort. An analysis of skills, knowledge and expertise has been undertaken. A learning and development plan will be outlined including formal training, core skills, e-learning, team development sessions and the NHS Change Model. We will ensure our workforce is compliant with the mandatory and statutory skills required of NHS staff. This will be achieved through a core skills programme encompassing nine programmes of learning essential for all staff, including fire safety; manual handling; safeguarding of adults; safeguarding of children; equality and diversity; and an introduction to information governance.

iv) **Engagement and involvement** – The Communications and Engagement Strategy will be regularly reviewed to ensure effective internal communications. Empirical evidence demonstrates the importance of a culture of engagement and involvement in the development of new organisations. There will be a focus on the continued development of effective relationships with the local authority, councillors, and key committees (Social Care, Health and Wellbeing Board); Members of Parliament, providers, patients and the general public.

Those in leadership roles have a specific requirement in their job descriptions to undertake communications with internal and external stakeholders to ensure that true and meaningful engagement takes place. We will work to ensure that member practice development in clinical commissioning is inextricably linked

with our vision and values. Commissioning will become an integral part of practice education and will be multi-professional in its approach.

We will use the Members' Forum to provide protected learning opportunities in regard to clinical commissioning for clinical and non-clinical staff working in member practices. Each practice has a clinical lead for commissioning; this role is the key link between the CCG and the member practices with the lead expected to participate in bi-monthly CCG 'whole team' meetings. This will ensure practices are kept up to date with progress in the CCG. We will also use our website as an essential communications tool with internal and external audiences.

'Liberating the NHS' detailed at the very heart of the strategy the importance of public involvement. Our local strategy reflects this. We intend to work collaboratively with provider organisations and put in place systems to capture patient experience data, analyse this information and use it to inform the commissioning decisions of the CCG.

The established *'Talk To Us´* patient experience programme gives people an opportunity to provide feedback through a variety of channels.

We intend to work towards the development of patient participation groups in each of the 17 practices. It is our intention to form a reference group which will include representation from those groups, along with Halton LINk (local involvement network) and subsequently Healthwatch. There are established links with the voluntary and charitable sectors, local faith groups and other community forums. We will continue to work with these groups to develop an ongoing dialogue.

v) **Governing Body development** – Our Governing Body is acutely aware of its collective leadership responsibilities in shaping a new organisation to serve the people of Halton. It is cognisant of the growing evidence of the causal link between board level effectiveness and organisational performance in the NHS. An implementation plan has been developed to enable us to create a

high-performing Governing Body, providing strong leadership, ensuring all statutory functions are met, including information governance and equality and diversity leadership requirements. Tools from the AQuA Board to Board Programme and NHS Leadership Academy, observations/feedback based on high-performing board indicators and 360° feedback with stakeholders, partners and patients will be used.

b) Supporting Services

Our core team of staff is supported by services provided on a contractual arrangement from the CMCSU. The agreement provides us with resources for core corporate and business functions – strategic and business planning; HR and organisational development; contracting and procurement; and communications. We share a financial team with NHS Knowsley and St Helens CCGs. These arrangements allow us to function efficiently with a small team of core staff, drawing on additional support when necessary to meet business needs.

c) Financial Plan

The first budget plan for the CCG is intended to strike the balance between meeting the financial requirements set by the NHS CB and ensuring funds are available to deliver the commissioning intentions within its commissioning/QIPP plans for 2013/14. It is the foundation on which to build sustainable services for the benefit of people in the borough.

The budget plan takes into account the financial duties on CCGs and the financial planning assumptions provided by the NHS CB in *Everyone Counts* (December 2012). It was approved by the Governing Body on 21 March 2013.

In line with NHS CB guidance published in *Everyone Counts* (December 2012) the following financial planning assumptions are made.

- Income is allocated separately for programme and administrative costs. Administrative costs should not be overspent; but underspends on administrative costs can be spent on programme costs.

- A cumulative surplus at the end of 2013/14 of at least 1% of revenue is planned for, including any historic surplus not drawn down. This will be carried forward into 2014/15.

- In 2012/13, 2% of non-recurrent funding is ring-fenced. Expenditure cannot be made against all or part of these funds without approval from the NHS CB. Additionally, a minimum 0.5 contingency of revenue is ring-fenced to mitigate risk within the local health economy.

- An underlying growth in demand based on demographic and other changes is assumed.

- Running cost allowances for CCGs are £25 per head of population.

- The national provider efficiency requirement for 2013/14 tariff setting is 4%.

- Local authorities will assume responsibility for the management and administration of the funding for reablement provision.

NHS Halton CCG			
Summary of Allocations & Expenditure	**2013-14 Budgets**		
	Recurring £000	**Non-Recurring £000**	**Total £000**
Allocations			
Base Allocation	172,686	-	172,686
Growth	3,972		3,972
Other Anticipated Allocations	370	- 114	256
Total Programme Resources Available	177,028	- 114	176,914
Programme Expenditure			
Acute Services	83,992	2,152	86,144
Mental Health Services	13,505	325	13,830
Community Health Services	22,065	456	22,521
Continuing Care Services (Childrens)	15,383	-	15,383
Primary Care Services	23,963	-	23,963
Other Programme Services	747	-	747
Other Corporate Costs (Non-Running Costs)	811	-	811
Operating Plan Requirements & Reserves	7,429	4,336	11,765
Total Application of Funds-(Programme)	167,895	7,269	175,164
Planned In-year Surplus/(Deficit)	9,133	- 7,383	1,750
Planned Surplus/(Deficit) %	5.2%	6476.3%	1.0%
Running Costs Budget	3100	361	3100

Risk assessment and mitigation

In setting the budget the potential risk that the CCG will be unable to achieve the financial requirements and duties set by the NHS CB was considered. The main reasons this might occur include:

Activity growth for services subject to cost and volume payment systems e.g. payment by results (PbR) and continuing health care (CHC).
The specialised commissioning allocation reduction is not cost neutral as anticipated.
The delay or failure of QIPP schemes to deliver the planned savings.
The impact of unexpected cost pressures being inherited from PCTs.
Further unexpected cost pressures or allocation reductions.

Controls to mitigate against these risks fall into three categories:

Financial systems – Sound financial systems and procedures, including a robust ledger and budgetary control system. The CCG is on track with its project to set

up and use the Integrated Single Financial Environment (ISFE) general ledger provided by NHS Shared Business Services – a joint venture between the DH and Steria plc. Expertise in forecasting and budget-setting are key skills which the CCG has acquired through its shared finance team arrangements.

Internal Governance – These arrangements are intended to ensure that decisions are properly considered and approved and that lal members of the CCG can be assured and that risks are being properly managed. Elements of this include the Audit Committee, Finance and Performance Committee and meetings of the Governing Body and Membership. Other key elements relate to the internal and external auditors of the CCG who will test the robustness of the CCGs internal controls and systems.

Relationships and risk sharing – Examples of this include the risk share 'insurance pool' for high-cost patients who require care in independent private mental health hospitals, shared with neighbouring CCGs within the Mersey CCG network. This arrangement seeks to reduce the risk of a disproportionate number of such cases falling on a single CCG in any one financial year through random chance. A similar arrangement is the creation of a pooled budget between the CCG and Halton Borough Council for adult continuing health and social care cases. Each party agrees to share risk of costs jointly.

Should the CCG still be faced with significant financial pressures despite the controls outlined above then options to deliver short-term financial balance would be considered.

d) QIPP

Quality, Innovation, Productivity and Prevention (QIPP) is a large-scale transformational programme led by the Department of Health and with which NHS Halton CCG has been actively engaged to date. It encourages the exploration of alternative ways of providing services to achieve improved services and greater choice for patients, alongside better value for public money than can be gained from transactional savings.

The planning for QIPP for 2013/14 and beyond is governed by the Merseyside CCG Network at its monthly meetings and led by the CMCSU. The aim of the work is full integration of the principles of quality, innovation, productivity and prevention into the main commissioning agenda, so that those principles are at the heart of all commissioning.

In 2010/11 and 2011/12, the Merseyside health economy delivered QIPP efficiency savings of c. £260m and is expected to have delivered the c. £100m target for 2012/13. Work is currently underway to develop new governance arrangements, which will focus development, performance management, monitoring and delivery of QIPP at CCG level.

The table overleaf shows a headline summary of how the Halton financial QIPP challenge will be delivered within the plan. The sub-heading 'Inherited Transformation Schemes' refers to the following three schemes.

Psychological therapy for military veterans – The NHS Outcomes Framework 2012-13 placed a duty on the NHS to improve psychological support for military veterans. All CCGs in the North West are making a financial contribution to this service. NHS Halton CCG's share is £20,000.

Rehabilitation service – A 'hub and spoke' model has been developed, with The Walton Centre NHS Foundation Trust as the hub and two spokes, at St Helens Hospital (15 beds) and Broadgreen Hospital (10 beds). The CCG has identified £551,000 to support this expansion of services.

Trauma ambulances – In response to national policy, trauma centres have been developed. There is evidence to show that such centres improve outcomes for patients. The Merseyside centre is located on the main site of Aintree University Hospitals NHS Foundation Trust in Fazakerley, with support from The Walton Centre NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust main site in central Liverpool. Serious trauma cases will bypass local A&E departments and go directly to a trauma centre. This will mean longer ambulance journeys for some critically-ill patients and Halton CCG is contributing £47,000 as its share of additional funding for ambulance services.

Halton Clinical Commissioning Group

COMMISSIONING INTENTIONS (QIPP) PLANS

CCG Service Transformational Schemes – project description & no.		2013-14 RECURRENT		2013-14 NON-RECCURENT		2013-14 TOTAL QIPP	
		Gross Saving £000	Investment £000	Gross saving £000	Investment £000	Gross saving £000	Investment £000
COPD pathway redesign	PC 11,12,14	-123				-123	0
Diabetic hypo pathway	PC 4	-21				-21	0
Community MDT Redesign ('Tailored care')	PCI 4	-312	300			-312	300
Wellbeing practices initiative	PCI 5		337			0	337
Out of hours tender saving	PCI 3	-9				-9	
Primary care quality access innovation fund • ECG in primary care • Atrial Fibrillation • Anti-coag clinics • End of Life Gold Standard Framework	PCI 7 PCI 8 MHUC 10 PC 3	-7	200		450	-7	650
Local hospice development	PC 2, PC 3		50			0	50
Orthoptic assessment special schools	WCF 3		70			0	70
Nasal pharyngeal services	WCF 5		20			0	20
MH access to psychological therapy impact	MHUC 4	-37				-37	0
LD Positive Behaviour support	MHUC 4		48				48
Rapid assessment dementia	MHUC 4		381				381
Dementia services	MHUC 2, 7		200				200
Inherited Transformational Schemes							
Psychological therapy for military veterans			20			0	20
Rehab service Walton hub and spoke			551			0	551
Trauma centre- ambulance increase			47			0	47
Prescribing Savings							
2012-13 FYE savings		-3,682				-3682	0
2013-14 4% efficiency target		-899				-889	0
Other Efficiency Savings							
Efficiency based on PbR tariffs		-3,768				-3,768	0
Other NHS providers tariff efficiency		-1,247				-1,247	0
Other non-NHS providers deflation		-507				-507	0
Other commissioner CIPs – PbR challenge re physiology counting		-422				-422	0
TOTALS		-11,034	2,224	0	450	-11,034	2,674

Halton Clinical Commissioning Group

List of Appendices

List of Governing Body membership

Halton Shadow Health and Wellbeing Board terms of reference

NHS Halton CCG Organisational Development Action Plan

NHS Halton CCG Operational Delivery Plan and Commissioning Intentions

Glossary of terms

AQP	Any Qualified Provider – A way of procuring services which increases choice about who can offer NHS services
AQuA	Advancing Quality Alliance. A healthcare improvement body.
CAMS	Child and Adolescent Mental Health Service – for children and young people up to age 18
CCG	Clinical Commissioning Group
CHD	Coronary heart disease
CKD	Chronic kidney disease
CMCSU	Cheshire and Merseyside Commissioning Support Unit. This unit provides support in business intelligence; procurement; and business support services (e.g. communications, organisational development etc). CCGs can purchase the elements of support they require to supplement their core staff.
COPD	Chronic obstructive pulmonary disease
Commissioning	The planning and purchasing of services
CQUIN	Commissioning for Quality and Innovation. A payment framework which allows commissioners to link a proportion of a provider's payment to the achievement of local quality improvements
GP	Medical doctor who is a general practitioner
Local health economy	In this document this phrase is used to describe all the organisations which work together to deliver health services to the local population – the NHS CB; the CCG; hospitals; general practices; community service providers
NHS CB (also known as NHS England)	NHS Commissioning Board. A special health authority responsible for the direct commissioning of specialised services; primary care services; offender health care; some services for members of the armed forces; some public health screening and immunisation services. The NHS CB is also responsible for leading the delivery of improvements against the NHS Outcomes Framework and ensuring patient safety; authorising CCGs and carrying out annual assessments of CCGs. From April 2013, the NHS CB will be known as NHS England
NICE	National Institute for Health and Clinical Evidence. This organisation is responsible for setting standards for quality in healthcare and produces guidance on medicines, treatments and procedures.

PFI	Private finance initiative. A way of creating public-private partnerships by funding public infrastructure projects with private funding.
RTT	Referral to treatment
Statutory organisation	A statutory organisation (also known as a statutory body) is one that is required to exist by law. In addition to CCGs, examples include the police service and local councils.
STEIS	Strategic executive information system. Software system used within the NHS for collecting and reporting management information on secondary care access, adverse incidents and delayed discharges.

References

Constitution, NHS Halton CCG

The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 – March 2015; Department of Health, Nov 2012

Organisational Development Strategy and Action Plan 2012-2015, NHS Halton CCG

NHS Outcomes Framework 2013-14; Department of Health, November 2012

Health and Social Care Act 2012

Halton Health and Wellbeing Strategy 2012-2015

Halton Joint Strategic Needs Assessment

Framework for Integrated Commissioning in Halton

White Paper: *Equity and Excellence: Liberating the NHS*

Everyone Counts: Planning for Patients 2013/14, NHS Commissioning Board, December 2012

Halton Clinical Commissioning Group

OPERATIONAL DELIVERY PLAN AND COMMISSIONING INTENTIONS 2013-14

This document accompanies NHS Halton Clinical Commissioning Group's Integrated Commissioning Strategy 2013-15

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April 2013

KEY TO ABBREVIATIONS

Clinical Commissioning Group Strategic Priorities
1 – Continuous improvement of the health and wellbeing of the people of Halton.
2 – Meaningful engagement with local people and communities.
3 – Clear and credible plans which continue to deliver improvements in local health services and the Quality, Innovation, Productivity and Prevention challenge within financial resources, in line with national outcome standards and the local Joint Health and Wellbeing Strategy.
4 – Ensure robust constitutional and governance arrangements with the capacity and capability to deliver all duties and responsibilities, including financial control, as well as effectively commissioning all the services for which we are responsible.
5 – Establish and sustain collaborative arrangements for commissioning with other CCGs, Halton Borough Council and the NHS Commissioning Board.
6 – Appropriate, affordable and effective external commissioning support
7 – Maintain authorisation from the NHS CB

Other
TBC – to be confirmed
NHS CB – NHS Commissioning Board, known as NHS England
CCG – Clinical Commissioning Group
CMCSU – Cheshire and Merseyside Commissioning Support Unit

Joint Health and Wellbeing Strategy Priorities
1 – Prevention and early detection of cancer.
2 – Improved child development.
3 – Reduction in the number of falls in adults.
4 – Reduction in the harm from alcohol.
5 – Prevention and early detection of mental health conditions.

NHS Outcomes Framework Domains
D1 – Preventing people from dying prematurely.
D2 – Enhancing quality of life for people with long-term conditions.
D3 – Helping people to recover from episodes of ill health or following injury.
D4 – Ensuring people have a positive experience of care.
D5 – Treating and caring for people in a safe environment and protecting them from avoidable harm.

Quality, Innovation, Prevention, Productivity
Q – Quality
I – Innovation
Pro – Productivity
Pre – Prevention

Introduction

This document describes how NHS Halton Clinical Commissioning Group (CCG) plans to deliver its commissioning intentions during its first year as a statutory organisation. It should be read alongside the Integrated Commissioning Strategy 2013-15.

Internal performance management

We are working with the Cheshire and Merseyside Commissioning Support Unit (CMCSU) and performance management teams in neighbouring CCGs to further develop the existing business intelligence portal. The aim of this is to enable effective monitoring of our local performance against the requirements set out in *Everyone Counts: Planning for Patients 2013/14,* published by the NHS Commissioning Board in December 2012; and to provide key information for use in general practices.

Additionally, and in response to feedback received during the CCG's authorisation process, we are developing a programme management office. We are currently recruiting a programme manager to support this function. The postholder will monitor progress of all projects in the commissioning workplan and, when appropriate, escalate issues for the attention of the senior management team; additionally the postholder will be responsible for delivery of the corporate development workstream detailed within this workplan.

Key milestones for each project are set out in this workplan. The early stages of development in each piece of work will include the development of a project initiation document and identification of key performance indicators. We are working with colleagues in the CSU to identify a web-based project management system which will facilitate performance monitoring against plans.

Managing performance against our commissioning and financial plans

During 2012/13 NHS Merseyside developed an early warning dashboard (EWD) for each NHS Trust provider, similar to the approach adopted by the NHS Commissioning Board on a national basis. The EWD gives an at-a-glance view of performance of each provider against 48 indicators, which include infection control, quality risk profiles and safety measures. The indicators currently in the dashboard are those agreed nationally and locally as effective early markers of possible provider provider problems or service failure and more can be added as and when appropriate.

Regular review of the dashboard, which will take into account any additional local knowledge around particular issues, will allow effective and timely responses to manage situations as they arise.

CMCSU will update the dashboard weekly and send it to the Chief Nurse for review. Concerns will be discussed by the senior management team and, when appropriate, escalated to the Governing Body. This process was agreed by the Quality and Integrated Governance Committee in February 2013, which also agreed to review the dashboard at its monthly meetings.

Risk assessment and mitigation

The Governing Body has considered the potential risk that the CCG may be unable to deliver the duties and/or financial requirements set by NHS England. The main reasons this might occur include:

- Unanticipated activity growth.
- Activity growth for services subject to cost and volume payment systems, e.g. payment by results (PbR) and continuing health care (CHC).
- The specialised commissioning allocation reduction is not cost neutral as anticipated.
- The delay or failure of QIPP schemes to deliver planned savings.
- The impact of unexpected cost pressures being inherited from PCTs.
- Further unexpected cost pressures or allocation reductions.
- Capacity and capability within provider organisations including the CSU.

Controls to mitigate against these risks fall into three categories.

Financial systems – Sound financial systems and procedures, including a robust ledger and budgetary control system. The CCG is on track with its project to setup and use the Integrated Single Financial Environment (ISFE) general ledger provided by NHS Shared Business Services – a joint venture between the DH and Steria plc. Expertise in forecasting and budget-setting are key skills which the CCG has acquired through its shared finance team arrangements.

Internal governance – These arrangements are intended to ensure that decisions are properly considered and approved and that all members of the CCG can be assured that risks are being properly managed. These include the performance management arrangements described on page 2. Other elements are the Audit Committee, Finance and Performance Committee and meetings of the Governing Body and membership; internal and external auditors will test the robustness of the CCG's internal controls and systems.

Relationships and risk sharing – Examples of this include the risk share 'insurance pool' for high-cost patients who require care in independent private mental health hospitals, shared with neighbouring CCGs within the Mersey CCG network. This arrangement seeks to reduce the risk of a disproportionate number of such cases falling on a single CCG in any one financial year through random chance. A similar arrangement is the creation of a pooled budget between the CCG and Halton Borough Council for adult continuing health and social care cases. Each party agrees to share risk of costs jointly.

Should the CCG still be faced with significant financial pressures despite the controls outlined above then options to deliver short-term financial balance would be considered.

PROGRAMME: CORPORATE DEVELOPMENT

SENIOR MANAGEMENT LEAD: Jan Snoddon
PROGRAMME MANAGER: Programme Manager, Governance and Authorisation (recruitment planned for April 2013)

WHY IS CHANGE NEEDED?
The CCG is a new organisation with ongoing development needs. The authorisation process highlighted a need for a programme management office. Performance must be closely monitored to that risks can be identified at an early stage and mitigating actions taken.

AIM
To ensure that effective functions are in place to support maintenance of authorisation and enable delivery of the commissioning agenda.

OBJECTIVES

- Set up programme management office
- Develop systematic performance and information monitoring and management
- Support corporate governance and maintenance of authorisation

TRANSFORMATIONAL CHANGE AND IMPROVEMENT INITIATIVES
Implement leadership and organisational development plans, refreshing to take account of changing needs
Development and implementation of web-based project and performance management tools
Support quality and safety initiatives

KEY RELATIONSHIPS FOR DELIVERY
Halton CCG senior management and commissioning teams
CMCSU
NHS England – Merseyside team
Neighbouring CCGs

RISKS	MITIGATING ACTIONS
Potential delays to start of programme dependent on length of time taken between appointment and start date of programme manager	Temporary staffing in place
Potential delay to IT system development would make performance monitoring more labour-intensive, reducing capacity for other work	Development of close working relationships with CMCSU and neighbouring CCGs

PROJECT: Leadership development No: CD 1			PROJECT LEAD: Programme manager (vacant)				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	4, 7	Implement outstanding actions from current project plan. Refresh plan to take account of changing needs.	Development of leadership capacity throughout the organisation to sustain and improve performance	To take up post Q1. Milestones to be identified in Q1.			
JHWB							
NHS OF							
QIPP	All						

PROJECT: Organisational development No: CD 2			PROJECT LEAD: Programme manager (vacant)				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	4, 7	Refresh organisational development plan to take account of changing needs. Implement actions. To include accountability for mandatory training – ensure all staff undertake all appropriate mandatory training (including safeguarding and information governance) and this is evidenced and refreshed at appropriate intervals.	Increase organisational capacity and capability to deliver continuous services improvement.	To take up post Q1. Milestones to be identified in Q1.			
JHWB							
NHS OF							
QIPP	All						

PROJECT: Programme management office No: CD 3			PROJECT LEAD: Programme manager (vacant)				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	4, 7	Set up programme management office. In collaboration with commissioning colleagues and incorporating the use of agreed project methodologies, define standardised documentation to be used across all workstreams. Define monitoring arrangements and escalation procedures.	Systematic monitoring and appropriate escalation of issues, supporting continuous service improvement	To take up post Q1. Milestones to be identified in Q1.			
JHWB							
NHS OF							
QIPP	All						

PROJECT: Corporate governance **No:** CD 4			**PROJECT LEAD:** Programme manager (vacant)				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	4, 7	Develop and implement processes to support delivery of statutory requirements and governance functions. This includes: • Quarterly and annual assessment by the National Commissioning Board; • Production of the CCG's annual report; • Development of implementation plan to roll out and monitor the Standards of Business Conduct, including register of conflicts of interest, to GPs and practice staff; • Development of plan and support for inclusive process of selection of commissioning.	Deliver assurance to Governing Body. Ensure authorisation is achieved and maintained.	Appointment to role, develop workplan	To identify in Q1	To identify in Q1	Start www woo annual report
JHWB							
NHS OF							
QIPP	All						

PROJECT: Performance and information management **No:** CD 5			**PROJECT LEAD**: Programme Manager (vacant)				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	4, 7	Develop and implement systems to enable performance management, including appropriate data gathering and synthesis of information from healthcare and other sources. To include: Monitoring of performance of commissioning programmes	Inform strategic development. Enable performance monitoring and management against national and local targets.	To take up post Q1. Milestones to be identified in Q1.			
JHWB							
NHS OF							
QIPP	All						

PROJECT: Communications and engagement No: CD 6			PROJECT LEAD: Programme Manager (vacant); Des Chow				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	2, 4, 7	Refresh the communications and engagement strategy to reflect the developing needs of the organisation. Develop implementation plan for delivery of the strategy.	Increased engagement with staff from member practices. Appropriate and meaningful stakeholder engagement.	To take up post Q1. Milestones to be identified in Q1.			
JHWB							
NHS OF							
QIPP	All						

PROJECT: Contract management No: CD 7			PROJECT LEAD: Simon Banks; Programme Manager (vacant)				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	2, 4, 6, 7	Monitoring and management of performance of CSU and IT contracts. Work closely with local CCGs to identify KPIs to enable effective monitoring of CCG business priorities and primary care issues.	Ensure value for money and appropriate support for CCG delivery plan.	To take up post Q1. Milestones to be identified in Q1.			
JHWB							
NHS OF							
QIPP	All						

PROJECT: Quality and Safety No: CD 8			PROJECT LEAD: Programme manager (vacant)				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	4, 7	Support the quality committee in developing its workplan. Manage delivery of the workplan. Liaise appropriately with NHS CB and Quality Surveillance Group.	Assurance for Governing Body on clinical effectiveness, safety and patient experience.	To take up post Q1. Milestones to be identified in Q1.			
JHWB							
NHS OF							
QIPP	All						

PROGRAMME: MENTAL HEALTH AND UNPLANNED CARE

SENIOR MANAGEMENT LEAD: Dave Sweeney
CLINICAL LEADS: Dr Anne Burke, Dr Neil Martin
PROGRAMME MANAGER: Jennifer Owen

WHY IS CHANGE NEEDED?

- High incidence of mental illness.
- Mental health issues have a high priority with our local population.
- High usage of A&E
- Opportunity to improve outcomes and service models

AIM

- To ensure effective services at all stages of the pathways
- To reduce unnecessary A&E attendance

OBJECTIVES

- Deliver integrated services for proactive management of mild to moderate mental illness
- To ensure the availability of and timely access to high quality urgent care services

TRANSFORMATIONAL CHANGE AND IMPROVEMENT INITIATIVES

- Introduce routine screening for dementia in care homes as part of integrated care model
- Redesign of A&E liaison psychiatry service across mid-Mersey area
- Reprocurement of psychological therapies service to give all general practices access to primary care mental health care workers and clinics
- Introduction of Alzheimer's Admiral nurses
- Implementation of Winterbourne Review
- Roll out of 111/Directory of services
- Urgent care service redesign
- Community DVT service

KEY RELATIONSHIPS FOR DELIVERY

Halton Borough Council
St Helens and Knowsley Hospitals NHS Trust
Warrington and Halton Hospitals NHS Foundation Trust
Five Boroughs Partnerships
Bridgewater NHS Community Trust
Neighbouring CCGs
CMCSU

RISKS	MITIGATING ACTIONS
Impact of economic situation, local authority and benefits cuts on mental health	Development of Wellbeing Practice model to boost community resilience
Capacity and capability of providers to engage in service redesign	Proactive clinical and managerial leadership

PROJECT: Update all service specifications **No:** MHUC 1 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Jennifer Owen **CLINICAL LEAD:** Dr Anne Burke				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3, 4	Review of six current service specifications (provider: 5 Boroughs Partnership). Define outcome-driven core key performance indicators.	Ensure current service is reflected. Support performance monitoring.	Review 2 specificati	Review 2 specificati	Review 2 specificati	
JHWB	All						
NHS OF	All						
QIPP	All						

PROJECT: Dementia screening in care homes **No:** MHUC 2 **Financial impact:** Investment £200,000 (with project MHUC 7)			**PROJECT LEAD:** Mark Holt (Halton Borough Council) **CLINICAL LEAD:** Dr Anne Burke	
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES** **Q1 Q2 Q3 Q4**
CCG	1, 3	Introduce routine screening in care homes. This is part of a programme of work in care homes, with an integrated health service/local authority team, aimed at reducing hospital admissions and length of stay.	Early identification and treatment aided by use of technology	Project initiation document, including key milestones, to be developed in Q1.
JHWB	5			
NHS OF	D2			
QIPP	Q, I			

PROJECT: A&E liaison **No:** MHUC 3 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Jennifer Owen **CLINICAL LEAD:** Dr Neil Martin				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	3	Redesign of current A&E liaison psychiatry service across mid-Mersey area. This provides rapid assessment of mental health conditions for people presenting at A&E departments with mental health symptoms; or those presenting with physical symptoms if there mental health symptoms indicate they would benefit from an assessment. The model used is the Rapid Assessment Interface and Discharge (RAID) model, which offers comprehensive mental health support within the hospital, promoting quicker discharge and fewer readmissions.	Reducing waiting times Increased quality of patient experience Reduction in bed days Improved support for families and carers	Develop outcomes	Develop specification	Business case inc quality impact assessment	Contract negotiations
JHWB	5						
NHS OF	D2, 3						
QIPP	Q, Pro						

PROJECT: Increased access to psychological therapies (IAPT) – implementation of procurement **No:** MHUC 4 **Financial impact:** Investment of £392,000			**PROJECT LEAD:** Jennifer Owen **CLINICAL LEAD:** Dr Anne Burke				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	3	Reprocure in line with timetable approved by Governing Body in December. To include decommissioning of the Open Mind service; funding re-invested into one community psychological therapies service to give adequate increased access based on prevalence data. All patients will receive a comprehensive personalised care plan. All general practices will have access to primary care mental health care workers and clinics.	Improved access; reduced waiting times; developing skills of existing staff; financial savings; reduction in prescribing of SSRIs for mild depression.	Business case	Develop service specification	PQQ	Service transition
JHWB	5						
NHS OF	D2, 3						
QIPP	Q, Pro						

PROJECT: Urgent care redesign
No: MHUC 5 **Financial impact:** Cost neutral in year
PROJECT LEAD: Jennifer Owen
CLINICAL LEAD: Dr Neil Martin

STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES Q1	Q2	Q3	Q4
CCG	3	Review data to identify key care pathways pathways. Options appraisal including the exploration of development of an urgent care centre on Halton Hospital site.	Reduce A&E attendance and readmissions	Public consultation	Sign off business case	Contract negotiation or begin procurement	Development of project initiation document
JHWB							
NHS OF	D4						
QIPP	I, Pro						

PROJECT: Roll-out of NHS 111/Directory of Services
No: MHUC 6 **Financial impact:** Cost neutral in year
PROJECT LEAD: Jennifer Owen
CLINICAL LEAD: TBC

STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES Q1 – Q3	Q3
CCG	1, 3	These services are being procured across Merseyside with effect from January 2013.	Smooth transition between existing and new services.	Develop governance arrangements; marketing; managing transition from NHS Direct.	Fully operational
JHWB					
NHS OF	D3, 4				
QIPP	Q				

PROJECT: Alzheimer's Admiral nurses
No: MHUC 7 **Financial impact: :** Investment £200,000 (with project MHUC 2)
PROJECT LEAD: Mark Holt (Halton Borough Council)

STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES Q1	Q2	Q3	Q4
CCG	1, 3	Admiral Nurses are mental health nurses specialising in dementia. They work with people with dementia, their families and carers, in community and other settings. Working collaboratively with other professionals they seek to improve the quality of life for people with dementia and their carers, using a range of interventions that help people live positively with the condition.	Improved experience of care and quality of life for people with dementia, their families and carers.	Scope current provision	Options Appraisal ; develop business plan or serviewce redesign		Procurement or contract change
JHWB	5						
NHS OF	D2, 4						
QIPP	Q, Pre, Pro						

PROJECT: Wellbeing care pathway No: MHUC 8	Financial impact: Cost neutral in year	PROJECT LEAD: Jennifer Owen CLINICAL LEAD: Dr Anne Burke				
STRATEGIC OBJECTIVES	**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
			Q1	**Q2**	**Q3**	**Q4**
CCG 1, 3 **JHWB** 5 **NHS OF** D2, Pre **QIPP** Q	To ensure all patients on the serious mentally ill register in primary care have access to yearly physical health checks. Redesign current pathway with two providers (Bridgewater and 5 Borough Partnership) to deliver more coherent integrated response.	Improve physical health care for people with severe mental illness.	Redesign pathway	Implement pathway July	Monitor	

PROJECT: Learning disabilities No: MHUC 9	Financial impact: Cost neutral in year	PROJECT LEAD: Jennifer Owen CLINICAL LEAD: Dr Anne Burke				
STRATEGIC OBJECTIVES	**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
			Q1	**Q2**	**Q3**	**Q4**
CCG 1, 3 **JHWB** 5 **NHS OF** D2 **QIPP** Q	Implementation of self-assessment action plan from 2012/13. Completion of self-assessment framework for 2013/14. Develop response to Winterbourne recommendations.	Improved care for people with learning disabilities.	Data analysis and implmentation of 2012/13 plan		Develop 2013/14 plan	

PROJECT: DVT Pathway No: MHUC 10	Financial impact: Investment (part of £193,000)	PROJECT LEAD: Jennifer Owen CLINICAL LEAD: Dr Neil Martin				
STRATEGIC OBJECTIVES	**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
			Q1	**Q2**	**Q3**	**Q4**
CCG 1, 3 **JHWB** **NHS OF** D3, 4 **QIPP** Q, Pro	Access to community-based anti-coagulation clinic	Improved access for patients.				

PROGRAMME: PRIMARY, COMMUNITY AND INTEGRATED CARE

SENIOR MANAGEMENT LEAD: Dave Sweeney
CLINICAL LEADS: Dr Cliff Richards, Dr David Lyon, Dr Mick O'Connor
PROGRAMME MANAGER: Jo O'Brien

WHY IS CHANGE NEEDED?

- Opportunity to improve outcomes and experience of care for people with complex needs
- Opportunity to develop innovative services in general practice

AIM

- To ensure effective integration between primary care, hospital and social services
- To increase community resilience
- To reduce unnecessary hospital referrals

OBJECTIVES

- Deliver integrated services for proactive case management of people with complex care needs
- Increase access to community-based services

TRANSFORMATIONAL CHANGE AND IMPROVEMENT INITIATIVES

- Wellbeing Practice model – extend to all practices
- Implement new out of hours service
- Redesign of integrated discharge teams
- ECGs in primary care/routine screening for atrial fibrillation for over 65s

KEY RELATIONSHIPS FOR DELIVERY

General practices
Halton Borough Council
St Helens and Knowsley Hospitals NHS Trust
Warrington and Halton Hospitals NHS Foundation Trust
Bridgewater NHS Community Trust
Neighbouring CCGs; CMCSU

RISKS	MITIGATING ACTIONS
Impact of economic situation, local authority and benefits cuts on physical health	Development of Wellbeing Practice model to boost community resilience
Capacity and capability of providers to engage in service redesign	Proactive clinical and managerial leadership
Capacity in primary care	Funding available for locums when practice staff released for CCG activities

PROJECT: Update all service specifications – Bridgewater contract **No:** PCI 1 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Jan Snoddon, Jo O'Brien **CLINICAL LEAD**: Dr David Lyon				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3, 4	Rollling programme of review of all current service specifications (64) to consider 10 per year. Define outcome-driven core key performance indicators. Working in collaboration with St Helens CCG and Bridgewater.	Ensure current service is reflected. Support performance monitoring.	Define services	Develop dashboard		Review
JHWB							
NHS OF	All						
QIPP	All						

PROJECT: Complex care **No:** PCI 2 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Dave Sweeney				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3, 5	Pool social and healthcare resources and align systems to create more effective pathways and outcomes.	Improve patient experience; improve discharge pathways; increase positive outcomes. Reduce inappropriate hospital admissions. Improve value for money.	Implement pooled arrangements, including authorisation panels	Review contracts and commissioning arrangements	Review pathways and align processes	Evaluate outcomes for first 12 months
JHWB							
NHS OF	D2, 4,5						
QIPP	Q, Pro						

PROJECT: Out of Hours **No:** PCI 3 **Financial impact:** Saving of £9,000			**PROJECT LEAD:** Jo O'Brien **CLINICAL LEAD**: Dr Neil Martin				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Develop implementation plan. Mobilise new contract with effect from 21 March 2013 (live date 1 October).	Smooth transition between existing and new services.	Develop plan	Monitor rollout	Go live	Monitoring
JHWB							
NHS OF	D3, 4						
QIPP	Q						

PROJECT: Redesign of integrated discharge teams **No:** PCI 4 **Financial impact:** Saving of £12,000			**PROJECT LEAD:** Damien Nolan (Halton Borough Council)/Jo O'Brien **CLINICAL LEAD**: Dr David Lyon		
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**	
				Q1	**Q2-Q4**
CCG	1, 3	All general practices will have access to dedicated multi-disciplinary teams. This project forms part of the NHS Merseyside Tailored Care QIPP programme. Patients will be identified and an integrated package of care planned for them, with the general practice at the hub. A project plan has been developed to roll out this piece of work in three waves.	Reduction in, unplanned admissions. Improved management of healthcare acquired infections.	Recruit practices and project manager	Roll out one wave in each quarter
JHWB					
NHS OF	D3, 4				
QIPP	Q, Pro				

PROJECT: Wellbeing practices **No:** PCI 5 **Financial impact:** Investment £337,000			**PROJECT LEAD:** Jo O'Brien **CLINICAL LEAD:** Dr Cliff Richards				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 2, 3	Eight local practices are participating in this programme to develop a wellbeing model of support which enhances community resilience. The model uses community resources to drive up wellbeing and prevent ill-health. One community development worker has been appointed to work between two practices with different schemes running from each practice; the schemes range from community allotments to projects supporting people with dementia. They strengthen a practice's capacity to support vulternable, at-risk groups and people with mild-moderate depression and anxiety.	Reductions inappropriate referrals for diagnostic tests and specialist appointments. Integration of community and third sector provision with general practice. Increase social cohesion and enhance wellbeing and community resilience.	Develop and monitor	Extend to all practices		
JHWB	5						
NHS OF	D2, 3, 4						
QIPP	Q, I, P						

PROJECT: QOF – modernise six clinical pathways **No:** PCI 6 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Jo O'Brien **CLINICAL LEAD:** Lead for Quality (vacant)				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Standardisation of pathways. **Dependent on which pathways are chosen*	Avoid inappropriate outpatient referrals, emergency admissions and attendance. Increased practice engagement in commissioning cycle.	*	*	*	*
JHWB	*						
NHS OF	D3, 4						
QIPP	Q, Pro						

PROJECT: Electrocardiogram in primary care* **No:** PCI 7 **Financial impact:** Investment (part of £193,000)				**PROJECT LEAD:** Jo O'Brien **CLINICAL LEAD:** TBC			
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3-4**	
CCG	1,3	Provision of immediate cardiologist interpretation of ECGs. Increase accuracy of diagnosis of atrial fibrillation. Explore use of telemedicine to deliver 24/48 hour ambulatory blood pressure monitoring and 24/48 hour ECG monitoring. **There are interdependencies between this project and the atrial fibrillation LES (see below)*	Reduce avoidable hospital admissions. Reduce referrals to hospital for ECG diagnostics. Reduce waiting times. Improve discharge pathways and increase positive outcomes. Improve patient experience.	Gather evidence, costs, estimate impact on acute trusts	Develop project plan	Implement project plan	
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pre, Pro						

PROJECT: Atrial fibrillation LES* **No:** PCI 8 **Financial impact:** Investment (part of £193,00)				**PROJECT LEAD:** Jo O'Brien **CLINICAL LEAD:** TBC			
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3- 4**	
CCG	1, 3	Routine screening for AF in everyone over 65. LES for practices plus shared resource to cover care homes. **There are interdependencies between this project and the electrocardiogram in primary care project (see above)*	Reduced variation in identification rates for AF. Significantly increase detection rates. Reduce incidence of stroke. Optimise management and outcomes for people with AF. Support achievement of quality markers in the National Stroke Strategy. Reduce the human, social and financial cost of stroke.	Data collection and information gathering, inc QOF guidance	Develop LES and roll out	Monitor	
JHWB							
NHS OF	D1,2,3,4						
QIPP	Q, Pre, Pro						

PROGRAMME: PLANNED CARE

SENIOR MANAGEMENT LEAD: Dave Sweeney
CLINICAL LEADS: Dr Damien McDermott, Dr Mel Forrest, Dr Hong Tseung, Dr Chris Woodford, Dr Mick O'Connor, Dr Fenella Cottier
PROGRAMME MANAGER: Lyndsey Abercromby

WHY IS CHANGE NEEDED?

- Opportunity to provide more care in community settings
- Opportunity to improve care at end of life
- High burden of chronic illness, including diabetes and respiratory conditions

AIM

- To improve the experience of care for people with long-term conditions
- To increase access to services in the community

OBJECTIVES

- Improve self-management of chronic conditions
- Improve access community services for management of chronic conditions
- Reduction in unnecessary outpatient appointments

TRANSFORMATIONAL CHANGE AND IMPROVEMENT INITIATIVES

- End of life service improvement programme
- Introduction of hypoglycaemic pathway and impaired glucose tolerance pathway
- Review provision of community-based services for ophthalmology, dermatology and gynaecology
- Respiratory education services for healthcare professionals
- Access to TIA services 7 days a week

KEY RELATIONSHIPS FOR DELIVERY

St Helens and Knowsley Hospitals NHS Trust
Warrington and Halton Hospitals NHS Foundation Trust
Willowbrook Hospice
Bridgewater NHS Community Trust
Neighbouring CCGs
CMCSU

RISKS	MITIGATING ACTIONS
Capacity and capability of providers to engage in service redesign	Proactive clinical and managerial leadership
Capacity to deliver services in the community	Development of education programmes; proactive clinical leadership
Willingness of patients to engage in management of their own conditions	Patient education programmes

PROJECT: Update all service specifications No: PC 1 Financial impact: Cost neutral in year			PROJECT LEAD: Lyndsey Abercromby CLINICAL LEAD: Dr Damien McDermott				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	1, 3, 4	Review of all current service specifications. Undertake scoping exercise, then prioritise based on known issues. **There are interdependencies between this project and the atrial fibrillation LES (see below)*	Ensure current service is reflected. Support performance monitoring.	Scope. Review 25%			
JHWB							
NHS OF	All						
QIPP	All						

PROJECT: End of life service improvement programme No: PC 2 Financial impact: Investment of £50,000 (with project PC 3)			PROJECT LEAD: Lyndsey Abercromby CLINICAL LEAD: Dr Mel Forrest				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	1, 3	Project 1: Breathlessness service; psychological support at end of life. Project 2: QOF End of Life (nursing homes) Project 3: Men in Sheds Project 4: Implement electronic palliative care co-ordination (EPaCCs) Project 5: 'Do not attempt cardiopulmonary resuscitation' – local implementation of regional policy	Improved quality of care at end of life and increased support for patients; reduced inappropriate re-admissions	1 & 2 – Q1 project plan to determine milestones. 3 – Q1 notification of result of bid; Q2 development of project plan. 4 – Dependent on national timescales to be notified. 5 – Dependent on regional timescales to be notified			
JHWB							
NHS OF	D2, 4						
QIPP	Q, Pro						

PROJECT: Gold Standard Framework LES for primary care No: PC 3 Financial impact: Investment of £50,000 (with project PC 2)			PROJECT LEAD: Lyndsey Abercromby CLINICAL LEAD: Dr Hong Tseung				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1,3	The GSF is a model of proactive palliative care in a primary care setting. The LES supports the notion that people should have the opportunity to die in a place of their choosing, and unnecessary hospitalisation of the dying should be avoided. The LES aims to elevate GP Practices to a high common standard of Palliative Care for their patients. One factor that could make a significant difference is the extent to which GPs are actively identifying people approaching end of life and putting plans in place to support them as their condition deteriorates.	Improved consistency and reliability of care at end of life. Increased numbers of people dying at their usual place of residence. Reduced inappropriate admissions to hospital	Review existing service	Business case	Develop project plan	Implementation
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro						

PROJECT: Hypoglycaemic pathway No: PC 4 Financial impact: Saving of £21,000			PROJECT LEAD: Lyndsey Abercromby CLINICAL LEAD: Dr Damien McDermott				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	3	Introduction of care pathway for people with diabetes who have had a hypoglycaemic episode requiring hospital attention.	Increased opportunities for self-management of condition; reduced A&E attendances and hospital admissions.	Pilot starts	Monitor	Review	Implement and mobilise
JHWB							
NHS OF	D2, 3						
QIPP	Q, Pro						

PROJECT: Nebuliser modernisation **No:** PC 5		**Financial impact:** Cost neutral in year	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Chris Woodford				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	3	Current contract extended to end March 2014. Review complete end March 2013; likely outcome will be procurement.	Ensure ongoing provision of service.	Business case	Develop service	PQQ	Service transition
JHWB							
NHS OF	D2						
QIPP	Q, Pro						

PROJECT: ENT **No:** PC 6		**Financial impact:** Savings (to be quanitified)	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** TBC				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	3	Procurement of ENT community assessment and treatment services (CATS). Roll out benefits of Widnes pilot across footprint for April 14 start.	Reduced follow-up appointments and reduced number of appointments cancelled by patients. PBR savings.	Project plan	Roll out and monitor		
JHWB							
NHS OF	D3, 4						
QIPP	Q, Pro						

PROJECT: Ophthalmic Primary Eye Care Assessment and Referral **No:** PC 7		**Financial impact:** Cost neutral in year	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Bob Wilkes				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Review community ophthalmology provision. Secure provision of community ophthalmic service as alternative to secondary care.	Early access to specialist assessment, diagnosis and treatment; integrated model of care; community-based service.	Develop project plan and identify milestones		Deliver service	
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro						

PROJECT: Musculotskeletal **No:** PC 8		**Financial impact:** Cost neutral in year	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Cliff Richards				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Secure provision of service at end of current contract (March 2014)	Ensure provision of service.	Business case	Develop service	PQQ	Service transition
JHWB							
NHS OF	D2,3,4						
QIPP	Q,Pro						

PROJECT: Diabetes Patient Education **No:** PC 9		**Financial impact:** Cost neutral in year	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Damien McDermott				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Secure provision of service at end of current contract (March 2014). Option to extend existing contract or re-procure.	Increase ability for self-care; reduce risks of complications arising from development of the illness	Make decision	Dependent on decision.		
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pre						

PROJECT: Pathology provision **No:** PC 10		**Financial impact:** Cost neutral in year	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Cliff Richards/Dr Mick O'Connor				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Review.	Ensure provision of appropriate service.	Scope existing provision and establish whether there is a case for change			
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro						

PROJECT: Multi-faceted respiratory education service **No:** PC 11 **Financial impact:** Savings of £123,000 (with projects PC 12 and PC 14)			**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Chris Woodford				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Education programme for healthcare professionals to cover management of asthma; COPD; AECOPD; inhaler technique; spirometry performance and interpretation; self-management plans; end of life care; oxygen management and pulmonary rehabilitation.	Improved quality of care and quality of life; reduction in unnecessary respiratory admissions; improved medicines management.	Define and plan	Delivery of programme		
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro						

PROJECT: Dedicated respiratory review service for Halton community **No:** PC 12 **Financial impact:** Savings of £123,000 (with projects PC 11 and PC 14)			**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Chris Woodford				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1,3	Provision of a fast-track consultant-led respiratory service to diagnose, review and optimise patient treatment, to complement and maximise benefit from existing community services for people with respiratory conditions.	Care delivered close to the patient. Reduced unnecessary admissions. Optimised care				
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro						

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PROJECT: Direct access to gastrointestinal diagnostic services **No:** PC 13 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** To be advised				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1,3	To ensure that direct access gastroscopy and flexible sigmoidoscopy are available at our local trusts without prior out-patient appointment. Evidence from the QOF QP referral audits, along with observed experience in primary care, suggests that despite written referral for a specified test only, patients are often seen first as an out-patient appointment.	Reduction in unnecessary outpatient appointments and duplication of test Reduced costs.	Plan	SIG to discuss		Implement
JHWB	1						
NHS OF	D1, 4						
QIPP	Q, Pro						

PROJECT: Modernise spirometry service No: PC 14 Financial impact: Savings of £123,000 (with projects PC 11 and PC 12)			PROJECT LEAD: Lyndsey Abercromby CLINICAL LEAD: Dr Chris Woodford				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	1,3	Review current performance including education provision. Early indications demonstrate low accuracy in delivery of service.	Enable CCG to address any quality or educational needs. Ensuring correct diagnosis of COPD. Ensure appropriate medicines management.	Dependent on outcome of review			
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro						

PROJECT: Community dermatology service No: PC 15 Financial impact: Cost neutral in year			PROJECT LEAD: Lyndsey Abercromby CLINICAL LEAD: Dr Damien McDermott				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	1,3	Explore potential service models as alternatives to secondary care dermatology services. These include telemedicine; community service; GP with Special Interest; secondary care clinics in Widnes. Procurement is likely outcome.	Care closer to home; improved patient experience; speedier treatment; improved value for money; improved access; reduced referrals to secondary care.	Business case	Develop service specification	PQQ	Service transition
JHWB							
NHS OF	D2, 4						
QIPP	Q, Pro						

PROJECT: Community gynaecology service **No:** PC 16 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD**: Dr Fenella Cottier				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Explore potential service models as alternatives to secondary care gynaecology services. This may include increasing the range of services available in GP practices and/or a community gynaecology service.	Care closer to home; improved patient experience; faster treatment; improved value for money; reduced referrals to secondary care.	Business case/SIG	Dependent on option selected		
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro						

PROJECT: Seven-day TIA service **No:** PC 17 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** TBC				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	!, 3	Redesign service at Warrington & Halton Hospitals to deliver a 7-day service within current resources. Consider feasibility of redesign of the service at St Helens & Knowsley Hospitals is currently commissioned as a 5-day service.	Reducing delays in diagnosis reduces risk of re-occurrence of TIA and of occurrence of stroke. Increase percentage of appropriate patients receiving thrombolysis which improves clinical outcomes.	Explore issues, define 'must do' and optimal provision	Dependent on outcome of Q1 review		
JHWB							
NHS OF							
QIPP							

PROJECT: Termination of pregnancy service (TOPS) **No:** PC 18	**Financial impact:** Cost neutral in year	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Fenella Cottier				
STRATEGIC OBJECTIVES				**MILESTONES**		
	DESCRIPTION	**BENEFITS**	**Q1**	**Q2**	**Q3**	**Q4**
CCG	1, 3	Establish need to undertake AQP procurement.	Ensure provision of high quality, cost-effective service.				
JHWB							
NHS OF	D4						
QIPP	Q, Pro						

PROJECT: Impaired glucose tolerance pathway **No:** PC 19	**Financial impact:** Cost neutral in year	**PROJECT LEAD:** Lyndsey Abercromby **CLINICAL LEAD:** Dr Damien McDermott				
STRATEGIC OBJECTIVES				**MILESTONES**		
	DESCRIPTION	**BENEFITS**	**Q1**	**Q2**	**Q3**	**Q4**
CCG	1, 3	Implementing pathway in primary care.	Increase ability for self-care; reduce risks of complications arising from development of the illness	Devise project plan	Roll out service		Monitor
JHWB							
NHS OF	D2,3,4						
QIPP	Q, Pro, Pre						

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PROGRAMME: WOMEN, CHILDREN AND FAMILIES

SENIOR MANAGEMENT LEAD: Dave Sweeney
CLINICAL LEAD: Dr David Lyon
PROGRAMME MANAGER: Sheila McHale

WHY IS CHANGE NEEDED?

- A range of child health indicators are poor.
- Children's Trusts are no longer a legal requirement, but Halton has chosen to retain the model as it has worked well locally. This model is led by the Local Authority.

AIM

- To work closely with Local Authority to develop services for women, children and families which address local health inequalities

OBJECTIVES

- Provide integrated, high quality, financially viable community midwifery service
- Ensure services meet NICE guidance

TRANSFORMATIONAL CHANGE AND IMPROVEMENT INITIATIVES

- Full review of stand-alone community midwifery service, including breastfeeding.
- Redesign children's mental health and emotional wellbeing pathway
- Provide orthoptics services for children at high risk of visual problems due to complex health needs
- Increase capacity for delivery of nasal pharyngeal suction for children with complex health needs

KEY RELATIONSHIPS FOR DELIVERY

Halton Borough Council and Children's Trust partners
St Helens and Knowsley Hospitals NHS Trust
Warrington and Halton Hospitals NHS Foundation Trust
Five Boroughs Partnership
Bridgewater Community Healthcare Trust

RISKS	MITIGATING ACTIONS
Some behaviours have proved resistant to change – eg low breastfeeding rates, smoking in pregnancy	Close partnership working with all relevant agencies; improve access to services
Capacity and capability of providers to engage in service redesign	Proactive clinical and managerial leadership

PROJECT: Modernise service specifications **No:** WCF 1 **Financial impact:** Cost neutral in year				**PROJECT LEAD:** Sheila McHale **CLINICAL LEAD**: Dr David Lyon			
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Review six current pathways to agree outcome-focused KPIs.	Ensure current service is reflected. Support performance monitoring.		Identify pathways	3 reviews	3 reviews
JHWB	2						
NHS OF	D4,5						
QIPP	Q, Pro						

PROJECT: Maternity services review **No:** WCF 2 **Financial impact:** Cost neutral in year				**PROJECT LEAD:** Sheila McHale **CLINICAL LEAD**: Dr David Lyon			
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Full service review of stand-alone community midwifery service, including breastfeeding, taking into account new PBR tariff. To be effective from April 2014.	Integrated high-quality community service which is financially viable and meets NICE guidance.	Full review inc options appraisal and business case		Begin procurement OR service redesign with current provider	
JHWB	2						
NHS OF	D4,5						
QIPP	Q, Pro						

PROJECT: Orthoptic provision in special schools **No:** WCF 3 **Financial impact:** Investment of £70,000			**PROJECT LEAD:** Sheila McHale **CLINICAL LEAD:** Dr David Lyon				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Identified gap in service provision. Orthoptic screening and community-based follow-up for children in special schools as a result of complex helath problems, which makes them more at risk of visual problems including loss of sight.	Care closer to home. Supports implementation of 'Healthy Child' policy.	Service proposal	Operationalise	Monitor KPIs	
JHWB	2						
NHS OF	D2,4,5						
QIPP	Q, Pre						

PROJECT: Children's mental health services **No:** WCF 4 **Financial impact:** Cost neutral in year			**PROJECT LEAD:** Sheila McHale **CLINICAL LEAD:** Dr David Lyon				
STRATEGIC OBJECTIVES		**DESCRIPTION**	**BENEFITS**	**MILESTONES**			
				Q1	**Q2**	**Q3**	**Q4**
CCG	1, 3	Children's mental health and emotional well being pathway redesign Consider options for redesign of elements of the pathway for a more joined-up approach for young people experiencing mental health/wellbeing problems.	Holistic approach to the care provided for under 18s experiencing emotional/mental health issues.	Identify issues	Review and options appraisal	Begin redesign or procurement	
JHWB	2						
NHS OF	D2,5,4						
QIPP	Q, Pro, Pre						

PROJECT: Nasal pharyngeal services for children with complex needs No: WCF 5 Financial impact: Investment of £20,00			PROJECT LEAD: Sheila McHale CLINICAL LEAD: Dr David Lyon				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	1, 3	Provision of clinical capability to deliver nasal pharyngeal suction for children with complex needs.	Improved quality of service and reduced costs. Delivery of sustainable model for the future.	Evaluate pilot	Options appraisal	model	Roll out selected
JHWB	2						
NHS OF	D2,4						
QIPP	Q, Pro						

PROJECT: Update assisted conception/sub-fertility guidance No: WCF 6 Financial impact:			PROJECT LEAD: Sheila McHale CLINICAL LEAD: Dr David Lyon				
STRATEGIC OBJECTIVES		DESCRIPTION	BENEFITS	MILESTONES			
				Q1	Q2	Q3	Q4
CCG	1, 3	Update guidance on assisted conception/sub-fertility service to take account of revised NICE recommendations.	Ensure service is delivered in line with NICE guidance.	Update guidance	Implement	Monitor	Monitor
JHWB	2						
NHS OF	D2,5,4						
QIPP	Q, Pro, Pre						

Agenda Item 6c

REPORT TO: Health Policy & Performance Board

DATE: 4 June 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Provider Quality Accounts update

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Health Policy and Performance Board with an update regarding the provider Quality Accounts 2012/13 that have been received and commented on.

2.0 RECOMMENDATION: That: The Board note the report and appended briefing note.

3.0 SUPPORTING INFORMATION

3.1 Organisations providing healthcare arranged and funded by the NHS produce an annual Quality Account.

3.2 Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the Overview and Scrutiny Committee (OSC) in the Local Authority area, inviting comments on the report prior to publication.

3.3 The OSC then have the opportunity to read over the Quality Accounts, review the information that is included and produce a statement covering their view of the content of the document.

3.4 Healthcare providers are legally obliged to publish the statement from the OSC as part of their Quality Account.

3.5 Healthcare providers have a similar duty with their local Clinical Commissioning Groups and as such, both organisations agreed to host a Joint Quality Accounts event for the first time whereby Healthcare providers are invited to present a summary of their Quality Accounts. A briefing note about the event is appended to this report.

3.6 The event is scheduled to take place on Tuesday 30th April and providers that are attending are:

- Bridgewater Community Healthcare NHS Trust

- Warrington and Halton Hospitals NHS Foundation Trust
- Halton Haven Hospice
- 5 Boroughs Partnership NHS Foundation Trust

Quality Accounts have also been received from Clatterbridge Cancer Centre NHS Foundation Trust, although they are not attending the event.

3.7 In respect of the OSC, comments and views on the Quality Accounts will be in the form of a written letter to each provider following the event. Halton Clinical Commissioning Group will send separate comments.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
N/A

6.2 **Employment, Learning & Skills in Halton**
N/A

6.3 **A Healthy Halton**
The Quality Accounts demonstrate performance in healthcare with providers that provide services to the residents of Halton to enable improvement in these areas to be measured, therefore improving outcomes for people using the services.

6.4 **A Safer Halton**
N/A

6.5 **Halton's Urban Renewal**
N/A

7.0 **RISK ANALYSIS**

7.1 Annual monitoring of the Quality Accounts ensures that priority areas for improvement are closely observed. Measures are then put in place to improve standards where necessary.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

None under the Meaning of the Act.

Joint Quality Accounts Event

Briefing Note

The Health Policy and Performance Board (HPPB) and Halton Clinical Commissioning Group (CCG) arranged a Joint Quality Accounts event on Tuesday 30th April 2013.

The aim of the session was to invite local healthcare providers along to the event to present a summary of their draft Quality Accounts. This would enable both HPPB and the CCG to formulate comments on the Quality Accounts, and also for the healthcare providers to demonstrate they have consulted with the relevant organisations.

Presentations were received as follows:

Bridgewater Community Healthcare NHS Trust – Dorian Williams, Director of Nursing, Dot Keates, Deputy Director of Nursing and Quality, Linda Spooner, Head of Clinical and Professional Leadership and Dr Stephen Ward gave their presentation. This included:

- The services they provide
- Transforming health and social care provision
- An affordable solution for local health economies
- Independent Quality and Governance Assessments
- The clinical networks
- Cost Improvement Plans
- Monitor guidance for Quality Impact Assessments
- Priorities for Quality Improvement 2012/13
- Integrated Clinical and Quality Strategy Goals
- Areas of good practice

Bridgewater also produced some extra papers with specific information relating to Halton including:

- Dementia Care
- QUIPP
- Falls
- Patient Involvement in Care Planning

Warrington and Halton Hospitals NHS Foundation Trust – Hannah Grey, Corporate Nursing Programmes Manager and Millie Bradshaw, Associate Director of Governance gave their presentation. This included:

- A description of the services they provide
- Cheshire and Merseyside Treatment Centre
- Facts and figures
- Regulation versus value-based approach
- Clinical governance and quality
- Clinical Research and Development

- Information Governance
- 2012/13 improvement priorities
- Commissioning for Quality and Innovation
- 62 day cancer access target
- Patient Safety
- Clinical Effectiveness
- Patient experience
- Governor Ward Inspections 2012/13

Halton Haven Hospice – Linda Smout, Director of Clinical Services, Shaun Pollard, Director of Corporate Services, Vivienne Gorman, Head of Clinical Services and Graham Ellams, Quality Assurance Officer gave their presentation. This included:

- The services that they provide
- Hospice vision
- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Feedback from patients and relatives
- Clinical governance
- Audits
- Community engagement
- Priorities for improvement 2013/14
- Innovative ideas – Men's Shed

5Boroughs Partnership NHS Foundation Trust – Gail Briers, Director of Nursing and Governance and Louise Cheung, Assistant Director of Integrated Governance gave their presentation. This included:

- Trust background
- Stakeholder consultation
- Quality priorities for 2012/13
- Quality priorities for 2013/14

Following each presentation there were questions and discussions. The presentations along with the questions and discussions will be used to provide formal written responses to each healthcare provider on their Quality Account.

Agenda Item 6d

REPORT TO:	Health Policy & Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Health Policy and Performance Board Annual Report 2012/13
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Annual Report for the Health Policy and Performance Board for April 2012 - March 2013.

2.0 **RECOMMENDATION: That: The Board notes the contents of the report and associated Annual Report (Appendix 1).**

3.0 **SUPPORTING INFORMATION**

3.1 During 2012/13, the Health Policy and Performance Board has looked in detail at many of Halton's Health and Social Care priorities. Details of the work undertaken by the Board are outlined in the appended Annual Report.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications arising directly from the Annual Report. Any policy implications arising from issues included within the Annual Report will have been identified and addressed throughout the year via the relevant reporting process.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 As with the policy implications, there are no other implications arising directly from the report. Any finance implications arising from issues included within it would have been identified and addressed throughout the year via the relevant reporting process.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

There are no specific implications as a direct result of this report however the health needs of children and young people are an

integral part of the Health priority.

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

None identified.

6.3 **A Healthy Halton**

The remit of the Health Policy and Performance Board is directly linked to this priority.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment is not required for this report.

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

9.1 None under the meaning of the Act.

Health Policy and Performance Board

Annual Report

April 2012 - March 2013

As Chair of the Health Policy and Performance Board I would like to thank all Members of the Board for their valued contribution to the Board's work over the last 12 months. I would particularly like to thank Cllr Joan Lowe as Vice Chair of the Board and Cllr Sandra Baker for their massive contribution, help and support whilst undertaking one of the most challenging scrutiny topics we have ever done in terms of the Vascular Services review.

I would also like to extend my thanks to Officers and Partners for their time and contributions to the scrutiny topics and for providing performance and update reports.

As usual, 2012/13 proved to be a very busy year taking on scrutiny of our own social care and health services plus Homelessness and Women's Aid accommodation along with NHS plans to move Vascular Surgery away from our immediate area.

During the course of the year the Board have been actively involved and consulted on a range of issues from policy developments and scrutiny reviews to being kept informed and offering views on the many changes taking place locally as a result of national changes.

The Board have had the opportunity to comment on a number of proposals and developments including the establishment of a Health and Wellbeing Service, the re-configuration of Care Management Services and the establishment of an Integrated Adults Safeguarding Unit.

Cllr Ellen Cargill, Chair

Health Policy and Performance Board Membership and Responsibility

The Board:

Councillor Ellen Cargill (Chairman)

Councillor Joan Lowe (Vice-Chairman)
Councillor Sandra Baker
Councillor Mark Dennett
Councillor Margaret Horabin
Councillor Chris Loftus
Councillor Geoff Zygadllo
Councillor Valerie Hill
Councillor Miriam Hodge
Councillor Pauline Sinnott
Councillor Pamela Wallace
Local Involvement Network (LINk) representation is through co-optee John Chiocchi

The primary responsibility of the Board is to focus on the work of the Council and its Partners, in seeking to improve health in the Borough. This is achieved by scrutinising progress against the aims and objectives outlined in the Council's Corporate Plan in relation to the Health priority.

The Board have met five times in 2012/13. Minutes of the meetings can be found on the Halton Borough Council website

This report summarises some of the key pieces of work the Board have been involved in during 2012/13.

GOVERNMENT POLICY- NHS AND SOCIAL CARE REFORM

NHS Halton Clinical Commissioning Group (HCCG) - Progress on Authorisation

During the year, Simon Banks, Chief Officer of HCCG, became a regular attendee at the Board, keeping Members informed of progress with CCG Authorisation as well as information about recruitment to the Executive Team and Lay Member appointments.

Close to Home – An inquiry into Human Rights in Home Care

In May, the Board considered a report which gave a summary of the findings and recommendations from the Equality and Human Rights Commission Inquiry into Older People and Human Rights in Home Care. Halton Borough Council contributed to the Inquiry and were highlighted a couple of times within the report by the Commission as having best practice within this area e.g. via use of the "Dignity Challenge" approach.

There were a total of 25 recommendations within the report. As a result, it was decided that an in-house self-assessment exercise should be conducted. The results of the self-assessment were presented to the Safeguarding Adults Board where it was acknowledged that many of the recommendations were already in place in Halton. However further developments were progressed to further strengthen Halton's approach to dignity and human rights.

Shadow Health and Wellbeing Board

During the course of 2012/13 the Health PPB received regular updates on developments from the Shadow Health and Wellbeing Board including the minutes of Board meetings. Over the last twelve months the Shadow Board, which will become statutory as from 1st April 2013, has dealt with a wide range of topics including; the development of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy, Children and Young People's Plan Review, Welfare Reform, HCCG Authorisation and the development of local Wellbeing Areas.

Caring for our Future: Reforming Care and Support

In September, the Board considered a report which gave a summary of the White Paper "Caring for our Future: Reforming Care and Support" which sets out the vision for a reformed care and support system, by:

- focusing on people's wellbeing and support them to stay independent for as long as possible;
- introducing greater national consistency in access to care and support;
- providing better information to help people make choices about their care;
- giving people more control over their care;
- improving support for carers;
- improving the quality of care and support; and
- improving integration of different services.

Following this report to the Board it was decided that a Self-Assessment should be conducted against the recommendations outlined in the White Paper. It was reported that the Self-Assessment showed that Halton was in a strong position to respond to these recommendations and a number of actions were identified to strengthen Halton's position.

Public Health Update

As from April 2013, Public Health will transfer from the NHS into Local Authorities. During the year a lot of work has taken place to ensure a smooth transition. In March the Board received a report from the Director of Public Health on the latest

developments including the transfer of staff, contracts and budgets as well as looking at some of the projects that the Public Health team have been working on during the transition year.

SERVICES

Community Wellbeing Model in General Practice

The Board received a report regarding the Community Wellbeing Model in General Practice (CWP). Members were advised that a CWP model looks beyond traditional disease models in health care in order to include the factors that have been shown to generate health and wellbeing in individuals and communities. The CWP model has been underpinned by the ongoing research in the areas of salutogenesis, health assets, resilience and capability all of which focus on creating positive adaptation, protective factors and assets that moderate risk factors and promote wellbeing in individuals and communities.

Integrated Adults Safeguarding Unit

In May a report was provided to the Board relating to the establishment of a 12 month pilot for an Integrated Adults Safeguarding Unit. It was reported that the Unit would be developed using a hub and spoke model. It would be multi-agency, efficient, flexible and responsive to the needs of the local population. The Unit would lead on adults safeguarding and dignity work across the health and social care economy.

Re-configuration of Care Management Services

Members of the Board were informed of changes to the delivery of Adult Social Care in Halton by the reconfiguration of assessment and care management services.

The reconfiguration involved the restructure of the current care management teams to create a dedicated multi-disciplinary duty function team. An Initial Assessment Team (IAT) is now responsible for all referrals, screening, signposting and initial assessments. There are two Operational teams dealing with complex work, (one in Widnes and one in Runcorn) which are locality based care management teams with workers aligned to GP practices. The new model was launched in June 2012.

Health and Wellbeing Service

In January 2013, the Board considered a report which gave details of the work being undertaken to establish a Health and Wellbeing Service via partnership working

arrangements between the Local Authority, HCCG and Bridgewater Community NHS Trust. The new system would embody localism, with new responsibilities and resources for the Borough Council to improve the health and wellbeing of our population, within a broad policy framework set by the Government.

The Partnership Agreement set out a two phased approach to implementation as set out below:

Phase 1 of implementation focused on three areas, as follows:-

- the development of older peoples' services and pathways;
- a review of falls prevention services and associated pathways; and
- the development of the Community Wellbeing Practice model.

Phase 2 of implementation involved examining the wider determinants of public health and influences on health inequalities. This development took a 'Life Course' approach and work took place across adult social care, health, children and young people's services to develop a new Health and Wellbeing Service model. This new model is due for implementation from April 2013.

Reconfiguration of Domestic Abuse Accommodation Services

In November, Members were given an update on the progress of the Homelessness Scrutiny Topic Group and the recommendations for the reconfiguration of Domestic Abuse accommodation services. Following discussion, it was resolved that a further report be submitted to the Executive Board recommending the development and implementation of the preferred Hub and Spoke service delivery option, providing accommodation within a 24 hour hostel and additional move-on accommodation with floating support.

POLICY

Intimate Relationships and Sexual Health Needs Policy, Procedure and Practice

The Board considered a report which detailed the revised Intimate Relationships and Sexual Health Policy, Procedure and Practice. The original policy "Sexual Health Policy, Strategy and Guidelines" was developed in 2003, with subsequent reviews undertaken in 2009 and 2010.

The policy review was undertaken to ensure that all managers, staff and volunteers within the Communities Directorate had current and concise procedures, for

addressing a range of sexual health issues that staff members may encounter with service users.

Positive Behaviour Support Service Policy, Procedure and Practice

At its May meeting, Members received a report which gave details of the Positive Behaviour Support Service Policy Procedure and Practice document. This had been developed in order to provide information and guidance to stakeholders on how to access the service, eligibility and how referrals and assessments would be dealt with by the team.

Gypsy and Traveller sites - Pitch Allocations Policy, Procedure and Practice

The Board received a report setting out the revised policy, procedure and practice for the allocation of pitches on the Council's Gypsy and Traveller sites, which included the permanent site, known as Riverview, located in Widnes and the transit site located in Astmoor, Runcorn.

Adult Social Care User Survey 11/12

In September the results of the Adult Social Care User Survey were presented to the Board. This was the second year that the statutory survey had been undertaken. Some of the highlights included:

- Overall satisfaction levels (Q1) for respondents extremely satisfied or very satisfied (67.7%) with the care and support they receive has increased in comparison to 2010/11 (61.7%).
- Quality of life also demonstrates a positive movement with more individuals reporting a better quality of life in general, compared to 2010/11.

Intergenerational Strategy

The Board considered a draft copy of the Halton Intergenerational Strategy and Action Plan. The Board was advised that the framework aimed to begin the process of developing and implementing a co-ordinated approach towards intergenerational activity in the Borough. It was reported that there were already a range of examples of intergenerational work in Halton within the framework; however, this had often been carried out in isolation and not as an overall strategic approach.

Revised Subject Access requests Policy, Procedure and Practice

In September, the Board received a report detailing the revised subject access requests Policy, Procedure and Practice. The Data Protection Act gives individuals rights to have access to their own personal information. Individuals can send a subject access request (SAR) which requires the authority to tell them about the personal information we hold about them, and to provide them with a copy of that information. In most cases, you must respond to a valid subject access request within 40 calendar days of receiving it. Following a detailed review there is now one streamlined policy and procedure instead of two separate policies for Children and Enterprise and the Communities Directorates. The policy and procedure document has been written to reflect the revised process.

It was reported that by having a more streamlined process in place, responses to SARs would be dealt with more efficiently, and therefore give an improved service to both children and adults who were requesting information.

Health and Wellbeing Strategy

In November 2012, the Board received a report on the emerging Health and Wellbeing Strategy. The Strategy, which is based on robust evidence and the views of local residents and service users, identifies five priorities for action. These are:

- Prevention and early detection of cancer;
- Improved child development;
- Reduction in the number of falls from adults;
- Reduction in the harm from alcohol; and
- Prevention and early detection of mental health conditions.

SCRUTINY REVIEWS

Homelessness Service

During 2011/12 a scrutiny review of homelessness services had taken place.

Following the review, the Working Group made a number of recommendations which were presented to the PPB in September 2012. These are outlined below:

- Deliver on the actions arising from the visits to temporary accommodation schemes;
- Secure efficiency savings through new contracts with Halton YMCA for the YMCA hostel and Nightstop and de-commissioning of Y's Up advice and guidance;

- Secure efficiency savings through a new contract with Plus Dane for floating support services;
- Achieve efficiencies through the reconfiguration of remaining hostel provision for single people in order to improve the distribution of services across the Borough, prioritise access to services for individuals to whom the Council has a statutory duty, increase focus on homelessness prevention to assist individuals to resolve housing issues;
- Consider moving to a crisis intervention model for young homeless people in order to maximise the potential for young people to return home to their family; and
- Consider benefits of alternative models of provision for those escaping domestic violence.

Falls Prevention

During 2011/12 a scrutiny review of falls prevention also took place. The review was a successful and a worthwhile exercise in terms of covering all the outputs and outcomes from the initial topic brief and gaining a thorough knowledge of Falls Prevention in Halton.

It was recognised that although the scrutiny review of Falls Prevention was very positive, improvements could be made in certain areas. Therefore, as a result of the review, an action plan consisting of 19 recommendations have been developed and these will be presented to Board in June 2013.

Vascular Services

A response was received from the Secretary of State (SoS) for Health following a formal referral made to him in October 2012 regarding the proposals for the future development of vascular services across Cheshire and Merseyside not being in the interests of the health service in the area.

The SoS had asked the Independent Reconfiguration Panel (IRP) to undertake an initial review of the referral made and on the advice of the IRP decided not to agree a full review.

The implication of this decision is that the proposal for an arterial centre based at the Countess of Chester will now proceed. However there is some acknowledgement that there will be some considerable challenges to be met prior to implementation and it has been acknowledged that the Board should be fully involved and informed of developments throughout the design phase.

The Board will certainly keep a close eye on developments moving forward.

PERFORMANCE

During the course of the year the Board received information on quarterly monitoring reports and were provided with information on progress in achieving targets contained within the Sustainable Community Strategy for Halton. Other examples of Performance related information reported to the Board included:

- Quality Accounts;
- Performance Monitoring for the Learning Disability Partnership Board; and
- Environmental Health Annual Report.

WORK TOPICS FOR 2013/14:

Mental Health

Significant numbers of people suffer mental health problems such as depression.

Mental Health problems account for the single largest cause of ill health and disability in the Borough and can have a significant impact on a person's ability to lead a full and rewarding life.

The current economic climate and welfare reforms are likely to increase the levels of people suffering from mental distress. However, through a range of evidence based interventions to promote mental and emotional wellbeing this is amenable to change.

Therefore a scrutiny review of Mental Health provision in terms of prevention and promotion will be undertaken during 2013/14. It will examine interventions and materials that are already in place to address this key area and will look at their effectiveness in meeting the needs of the local population.

Report prepared by Diane.Lloyd, Principal Policy Officer (Health), People and Communities Team
Email Diane.Lloyd@halton.gov.uk

Agenda Item 6e

REPORT TO:	Health Policy and Performance Board
DATE:	4th June 2013
REPORTING OFFICER:	Strategic Director Resources
PORTFOLIO:	Resources
SUBJECT:	Performance Management Reports for Quarter 4 year-end of 2012/13
WARDS:	Boroughwide

1.0 PURPOSE OF REPORT

1.1 To consider and raise any questions or points of clarification in respect of performance management of the Prevention and Assessment and Commissioning & Complex Care Departments for the 4th quarter period to 31st March 2013. The report details progress against service objectives/ milestones and performance targets, and describes factors affecting the service.

2.0 RECOMMENDED: That the Policy and Performance Board

1) Receive the fourth quarter performance management report;

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

3) Highlight any areas of interest and/or concern where further information is to be reported at a future meeting of the Policy and Performance Board.

3.0 SUPPORTING INFORMATION

3.1 The departmental objectives provide a clear statement on what the services are planning to achieve and to show how they contribute to the Council's strategic priorities. Such information is central to the Council's performance management arrangements and the Policy and Performance Board has a key role in monitoring performance and strengthening accountability.

3.2 In line with the revised Council's Performance Framework for 2012/13 (approved by Executive Board in 2012/13), the Policy and Performance Board has been provided with an overview report for the Health Priority which identifies the key issues arising from the performance in Quarter 4.

3.3 The full Departmental quarterly reports are available on the Members' Information Bulletin to allow Members access to the reports as soon as

they have become available within six weeks of the quarter end. This also provides Members with an opportunity to give advance notice of any questions, points or requests for further information that will be raised to ensure the appropriate Officers are available at the PPB meeting. The Departmental quarterly monitoring reports are also available via the following link
http://hbc/teams/PERFIMP/Com%20Quarterly%20Monitoring%20Reports/Forms/AllItems.aspx

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications associated with this report.

5.0 OTHER IMPLICATIONS

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Departmental service objectives and performance measures, both local and national are linked to the delivery of the Council's priorities. The introduction of a Priority Based Report and the identification of business critical objectives/ milestones and performance indicators will further support organisational improvement.

6.2 Although some objectives link specifically to one priority area, the nature of the cross - cutting activities being reported, means that to a greater or lesser extent a contribution is made to one or more of the Council priorities.

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Not applicable.

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

9.1 None under the meaning of the Act.

Health PPB Thematic Performance Overview Report

Directorate: Communities Directorate

Reporting Period: Quarter 4 – Period 1st January 2013 to 31st March 2013

1.0 Introduction

This report provides an overview of issues and progress for the Health PPB that have occurred during the fourth quarter 2012/13. It describes key developments and progress against key objectives and performance indicators for the service.

Given that there are a considerable number of year-end transactions still to take place, and in order to avoid providing information that would be subject to further change and amendment, it has not been possible to include Financial Summaries within this report.

The final 2012 / 13 Departmental Financial Statements will be prepared once the Council's year-end accounts have been finalised and made available via the Council's Intranet. A notice will also be provided within the Members' Weekly Bulletin as soon as they are available.

2.0 Key Developments

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

I PREVENTION AND ASSESSMENT SERVICES

Care Management and Assessment Services

The care management and assessment service was reconfigured to create a dedicated multi-disciplinary duty function team, now the 'Initial Assessment Team' (IAT), responsible for all new referrals, screening, signposting and initial assessments. There are two Operational teams dealing with complex work, (one in Widnes and one in Runcorn). The Social Care in Practice Team (SCIP) has been funded by the Clinical Commissioning Group (CCG) for a further year. This will ensure the teams are support to develop to become locality based care management teams, aligned to GP practices across Widnes and Runcorn

The "care and support for you" portal.

There is on-going development of an online, "Care and Support for You" portal. This is a website where you can easily find lots of information about Adult Social Care Support and Services to help you get on with your life and keep your independence. 'Care and Support for You' delivers information and advice, signposting citizens to the relevant information, and towards enabling self-assessment and self-directed support. The portal has now gone LIVE with over 3,000 organisations now available in the public domain. 'Care and Support for You' is also being used by our care management teams to signpost citizens to the relevant information required. System Administration access has been given to a number of providers for them to amend and change information on their own service page; this enables the information on the website to up to date. A marketing plan is being finalised. Once this has been done we can then deliver workshops to the public, clients

and external organisations to promote the website. 'Care and Support for You'. The portal was also advertised in the Easter edition of ' Inside Halton'

Integrated Care Homes Support Team
Within Halton, plans are in place to develop a multi-disciplinary 'Care Home Support Team' to provide additional support to residential and nursing homes, initially as a 12 month pilot project. The team will act as a bridge to support care homes to access existing health services, such as G.P's Community nurses, Geriatricians etc. It will work closely with the local authority Quality Assurance and Contract monitoring Services and the newly developed Safeguarding Unit. The service will have an educational role and provide enhanced support/training to care homes to improve overall standards of care and competencies within the care home sector. Staff are now recruited and the team is being established.

Learning Disability Partnership Board Annual Self-Assessment
The 2012/13 assessment of Halton's progress in implementing the Government "Valuing People Now" strategy submitted in September 2012 and validated in November 2012 by the strategic health authority.

Results for 2011 and 2012

	2011 Halton and St Helens (PCT)	2012 Halton
Green	2	13
Amber	12	13
Red	6	1

Green indicates aspects of service provision that exceeded the standard, amber indicates the standard was met and red indicates there was insufficient evidence to show the standard was met. The 1 red area for 2012 was in relation to comprehensive health checks.

The SHA panel highlighted the following as areas good work had been undertake:
- Response to Winterbourne View.
- Transformation of services.
- Quality assurance and contract monitoring.
- Equalities; pilot site for Hate Crime.
- Robust governance.
- Positive Behaviour Support Service
- Impressed by the level of evidence we were able to submit.

An Action Plan co-owned by the Council and CCG will be developed to continue to with the improvements achieved in 2013. Halton will monitor progress against the action plan via the LD Quality and Performance Board reporting to the LD Partnership Board, which is Chaired by Councillor Marie Wright and CCG Quality and Integrated Governance Committee.

Winterbourne View Review Concordat: Programme of Action was published by the Department of Health in December 2013. Halton CCG and Council are in the process of developing a localised action plan – this will be monitored through the LD quality and

performance then reported to the LD Partnership Board and CCG Quality and Integrated Governance Committee.

- By April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice as a consequence; there will be a dramatic reduction in hospital placements for this group of people.
- The Council has continued to work with health colleagues to review all out of area placements regardless of funding arrangements.

- Halton have a strategic task group set up to ensure those placed out of area are managed and monitored appropriately with professionals tasked with reassessing those individuals to enable them return to Halton. This work has been on-going with successful placements now achieved locally with the co work of the care management teams, health colleagues and the PBSS team.

Learning Disability Nursing Team
The Learning Disability Nursing Team have successfully registered with CQC for the treatment of disease, disorder and injury. Lisa Birtles-Smith is the registered manager. The team continue to work proactively with individuals, their family, carers and professionals such as GPs, allied Health professionals etc.
Progress:

- The men's group is currently taking place with a good number of attendees
- The Friendships and Relationships training via the Learning Disability Training Alliance has taken place, including 3 self-advocates co-facilitating the sessions. The feedback has been excellent and further sessions are planned for the forthcoming year. A number of care managers have attended, who have not previously worked with people with a Learning Disability.
- The walks in the park are continuing with 4 people in attendance regularly. This is being advertised following the success of the trial.
- The first session for SPARC on their 'true grit' project was delivered and a second one planned. This group of young people are some who may not require paid services but need to manage their own health. A second session is planned for the end of April.
- The Big Health Day was attended and presented at by team members. Self-advocates in Halton knew what the team were able to offer and many had positive things to say about the support they had received.
- The team have supported people to remain at home rather than be admitted to inpatients services
- Those individuals who have been admitted to inpatient services, have been monitored throughout their stay via face to face contact with the nursing team, and supported to be discharged with positive prevention plans to reduce the risk of further admissions.
- There have been over 342 referrals to the team from 28th May 2012 to date.
- The team have carried out specialists assessments and interventions, primarily in behaviour, epilepsy and dementia
- The team are working within the pro-active draft dementia pathway for people with Downs Syndrome.

Health Improvement Team
Work has progressed over the last twelve months in response to the government's vision for the need to develop a new, integrated and professional public health system. As such HBC, HCCG and Bridgewater Community NHS Trust have been reviewing the current approach to the delivery of Health Improvement Services delivered by both health and local authority providers. One of the areas specifically addressed has been to align the services provided by the Health Improvement Team (Older People) based at Bridgewater Community NHS Trust to those provided by HBC's Sure Start to Later Life. Building on this and other developments such as the work taking place on Falls Prevention and the Community Wellbeing Practice initiative, further work has taken place on the development of an overall model for the delivery of Health Improvement Services across Halton in the future. It is anticipated that the Service (being implemented from April 2013) will play a significant role in addressing the five priorities contained in Halton's Health and Wellbeing Strategy. The new Service will bring significant benefits through increasing efficiency, improving the patient experience, introducing a consistent approach and changing the culture to one of joint ownership and strong partnership working.

Public Health
Preparation for the transfer of Public Health has been on-going since March 2012. This has included a review across NHS Merseyside which is made up of the 4 Primary Care Trusts of Halton & St Helens, Knowsley, Liverpool and Sefton of all Public Health functions and services.

Halton Borough Council has developed and led a Transition Group chaired by the Director of Public Health which has overseen the safe transfer of all necessary functions including staff transfer and measures letter, public health reports, information governance, emergency resilience, contracts, data connections, risk register, budget transfer and final Public Health Annual Report.

Halton Community Alarm Service
Halton Community Alarm Service was inspected by the Telecare Services Association and has, for the third year on the run, achieved platinum accreditation. This will help to assure service-users, their families and carers that they are in receipt of a quality service they can rely on.

Personalisation
Halton joined the Putting People First Consortium, In Control, and Lancaster University to undertake a local survey on personalisation. The responses have helped to find out how personal budgets and direct payments are working within Halton and what further improvements need to be made. It is anticipated that this survey will be undertaken next year in order to assess progress.

Falls
A joint review between Halton CCG and Halton Borough Council of the falls pathway and associated services in the borough commenced in 2012. Involving key stakeholders, the review is looking at national guidance and demand and capacity to ensure all the elements that support falls prevention are in place. This work has been complemented by the Health Policy and Performance Board Scrutiny review of falls services within the borough

Complex Care Joint Working Agreement

Halton Borough Council and Halton CCG have agreed to a Pooled Budget covering services commissioned for adults with complex needs. The purpose of the pool is to support a joined up approach to delivering effective, high quality, safe and efficient services. During 2013/14 the two organisations will continue to develop the assessment and commissioning elements of the pool.

Adult Safeguarding
In 2012 an Integrated Safeguarding Unit was developed using temporary funding. The work of the unit has been evaluated and demonstrates that this approach has improved the timeliness and quality of the investigation and management of critical safeguarding issues with a focus on multi-agency working. The unit has also supported Halton's Adult Safeguarding Board and key stakeholders in improving the outcomes for people who use services and their families and carers. Halton CCG and Halton Borough Council have agreed ongoing funding for the unit.

II COMMISSIONING AND COMPLEX CARE SERVICES

Domestic Abuse
Executive Board have agreed the priority is to improve the existing refuge provision and consider options for remodelling. Meetings have been held with Riverside/ECHG and draft plans for remodelling the building have been produced. We are currently waiting for Riverside/ECHG Board to approve the capital funding required for the service improvements.

Commissioners and the Domestic Violence Co-ordinator have been working with colleagues in Halton CCG to develop a Perpetrator Scheme to address abusive behaviour and to prevent incidence of repeat abuse. It is proposed that the scheme will be provided through Self-Help, a third sector Provider contracted by Halton CCG to deliver the Improved Access to Psychological Therapies Service (IAPT). Four members of staff will be trained under the respect programme to provide High Intensity Therapy. The service will have capacity to deliver a 26 week programme to eight Perpetrators. Subject to completion of the necessary training it is proposed that the service will be piloted in July 2013.

Homelessness
The remodelling of Orchard House into an integrated Crisis Intervention Service with YMCA Nightstop service is on hold pending confirmation from the Homes and Communities Agency (HCA) that funding has been awarded to build a new homeless hostel in Widnes.

Mental Health Services
Over the past Quarter, the service reconfiguration within the 5Boroughs has begun to settle in. All staff are now in their new teams and work is starting within the Recovery service to ensure that cases are transferred to the appropriate care co-ordinator, according to whether they have a primary health or social care need. Early indications from the redesign are that more people are being supported in the community than before and that there is less of a demand on inpatient services. This will be the subject of continuing evaluation.

Section 136 Mental Health Act 1983: these are powers which allow the police to detain in a place of safety someone found in a public place who appears to have a mental health problem which would place themselves or other people at risk. Work continues with the

police to develop a policy and procedure for these police powers which can operate across the Cheshire footprint. A county-wide group, chaired by an Assistant Chief Constable, meets regularly to deliver this. Additional work is going on within this group to look at the outcomes of referrals by the police of members of the public about whom they have general concerns as to their welfare.

Emergency Duty Team (EDT): the scoping work to consider the appropriateness of another Local Authority joining the EDT Partnership has continued, and a formal request has now been made by that Authority to take this work forward. This will be considered by the Directorate and the EDT Partnership Board, to identify further steps to take.

Interface with children's services: the Directorate continues to engage with the various developmental and practical agendas within children's services, including full involvement in the safeguarding children process, the development of the Inspiring Families programme, the continuing development of the wider team around the Family approach, and the preparation for any forthcoming inspection.

Social Work Reform Board: work has been continuing within the Directorate to deliver the recommendations of the social work reform board, in conjunction with children's services. Four newly-qualified social workers from within the Directorate are now undertaking the first Assessed and Supported Year in Employment (ASYE), which is a rigorous process designed to ensure that professional training and education continues beyond the immediate qualification period, and that staff are fully equipped for their work. A review of the council's position against the national standards for employers of social workers has now been undertaken and work on this will be taken forward in the next Quarter within both Directorates.

Supported Housing Project
In preparation for the tender of Supported Living Services for People with Learning Disabilities and Mental Health Issues, a multi-disciplinary task and finish group has been established. The core function of the group will be to carry out reviews of people in receipt of a service and to quality assure the current providers. This information will be used to evaluate how assessed needs are currently being met and whether this represents value for money, whilst ensuring quality and safety of provision is of a high standard and values are maintained. Learning will then inform the development of the new service specification.

II

3.0 Emerging Issues

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

I COMMISSIONING AND COMPLEX CARE SERVICES

Mental Health Services
Work is continuing to implement a pilot programme for the Mental Health Outreach Team within Primary Care, to support people with lower level needs, intervening at an earlier stage to prevent a harmful deterioration in their condition. The project has been approved in principle by the Clinical Commissioning Group; some additional development work needs to take place but it is anticipated that the project will start within the next Quarter.

II PREVENTION AND ASSESSMENT SERVICES

Deprivation of Liberty Safeguards
From 1st April 2013 Local authorities will become the Supervisory Body for the Deprivation of Liberty Safeguards in hospitals - a role currently undertaken by Primary Care Trusts. Hospitals will apply to local authority Supervisory Bodies where they think they may need to deprive a patient of their liberty to treat them.
The Independent Living Fund (ILF) has published details of its transfer review programme, which it has designed in partnership with stakeholders to deliver an effective transfer of support for ILF users. This follows the Government announcement to close the ILF on 31 March 2015 and transfer responsibility for supporting ILF users to local authorities in England. Work is being undertaken locally to support this transfer programme.

Vision Services
In order to check progress in delivering the UK Vision strategy, SMT are supporting a Joint Review of Halton Low Vision Services. A report went to the Clinical Commissioning Group requesting their support for the review to be included in the 2013/14 work programme. And this has been agreed.

Learning Disability Nurses
The Nursing team have identified via the Friendships and Relationships training they have recently delivered, that Learning Disability awareness training would be beneficial across the council and other providers. A course is being developed and will be delivered within the next 3 months.

Urgent Care
The development of a joint Urgent Care Strategy between Halton Borough Council and Halton CCG has supported a number of work areas that will improve people's use of urgent care services. During 2013 wider consultation will be undertaken to support the development of services within the borough to provide suitable alternatives for people who currently to attend and are admitted to acute hospitals.

Community Multi-disciplinary Teams
During 2013/14 work will commence to develop community based Multi-disciplinary Teams focused around GP practices and neighbourhoods. Bringing together staff from different professional groups and organisations in the borough to jointly assess and plan treatment, care and support for people with long term conditions and frailty this development will support Halton CCG and Halton Borough Council to commission services that deliver care closer to people's homes.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. During the development of the 2012/13 Business Plan , the service was required to undertake a risk assessment of all key service objectives with high risks included in the Directorate Risk Register.

As a result, monitoring of all relevant 'high' risks has been undertaken during Quarter 4. Progress against the application of the risk treatment measures is reported at the end of the report.

5.0 Progress against high priority equality actions

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

6.0 Performance Overview

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

I ***Commissioning and Complex Care Services***

Key Objectives / milestones

Ref	Milestones	Q4 Progress
CCC1	Conduct a review of Homelessness Services to ensure services continue to meet the needs of Halton residents **Mar 2013** (AOF4)	✓
CCC1	Monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2013.** (AOF 4)	✓
CCC1	Implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2013**. (AOF 4)	✓
CCC1	Implement 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2013** (AOF 4)	✓
CCC1	Work with Halton Carers Centre to ensure that Carers needs within Halton continue to be met. **Mar 2013** (AOF 4)	✓
CCC2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2013** (AOF 21)	✓
CCC2	Continue to negotiate with housing providers and partners in relation to the provision of further extra care housing tenancies, to ensure	✓

Ref	Milestones	Q4 Progress
	requirements are met (including the submission of appropriate funding bids). **Mar 2013** (AOF18 & 21)	
CCC2	Update the JSNA summary of findings, following community consultation, to ensure it continues to effectively highlight the health and wellbeing needs of people of Halton. **Mar 2013** (AOF 21 & AOF 22)	✓
CCC3	Consider with our PCT partners the recommendations and implications of the review of Halton's section 75 agreement in light of the publication of the Government White Paper 'Equity and Excellence: Liberating the NHS'. **Mar 2013.** (AOF21, AOF 24 & AOF 25)	✓

SUPPORTING COMMENTARY

Review of Homelessness Services
A draft review of homelessness services was completed February 2013 and a consultation event was held on 27th March 2013. The event allowed the authority to consult with all stakeholders which was considered a successful day and all the consultation details will be included in the final review document. It is anticipated that the Strategy review and Action Plan will be completed and circulated by August 2013 and the relevant Homeless Forum Sub Groups and Strategic Commissioning Group will form part of the development and implementation of the strategic review process.

Autistic Spectrum Disorder
Review recently updated and is on target.

Local Dementia Strategy
There are a small number of actions from the original dementia strategy that have not been implemented, however, the strategy and all actions have been reviewed and the strategy is being refreshed. This refresh will include a number of new actions mainly relating to the effective use of the dementia pathway as well as the commissioning of the new Later Life and Memory Service planned for June 2013.

5Boroughs NHS Foundation Trust Mental Health redesign proposals
The 5 Boroughs Partnership has successfully completed its first full quarter of service since the redesign of the Acute Care Pathway. Initial findings have been extremely positive in both the quality and the timeliness of delivery of care. Progress will continue to be monitored.
The redesign of the Later Life and Memory Service for older people is currently being undertaken. Findings from an agreed pilot in Wigan have been analysed and implementation plans for Halton have been developed. The redesign will be in place by April 2013.

Carers Centre
The Directorate continues to work closely with the Carers Centre to ensure that the highest quality support is delivered to local carers. A review of the way that assessments of carers needs take place across a range of agencies has been agreed, as has a review of the performance requirements for reporting activity on carers breaks, and these reviews will start in the next Quarter.

Establishment of Local Healthwatch
Healthwatch Halton went live on April 1st. The organisation has been set up as a community interest company and two non-paid Directors have been recruited. The contract and service specification has been completed and a separate tender exercise to commission the

Independent Complaints Advocacy Service took place with Liverpool City Council as the lead commissioner. A six month action plan is being developed to ensure statutory workload is managed and completed.

Development of Extra Care Housing Provision
Bids have been submitted to the Homes and Communities Agency for two extra care schemes, each of 50 units, on land at Halton Brook and Pingot. The outcome of the bids is expected in May 2013.

Joint Strategic Needs Assessment
Completion of the summary JSNA 2012 has been delayed due to delays in publication of nationally verified data.
Data has been updated e.g. hospital admissions and GP QOF data. This is available on the public health page of the HBC intranet (public health evidence & intelligence/JSNA).
An in depth needs assessment of children & adults with autism and learning disabilities is in development, due for completion July 2013.
A completion date for the summary has not yet been agreed but is likely to be May 2013.

Section 75 Agreements
Aligning Public Health, the Clinical Commissioning Group and Directorate priorities is underway. The Executive Board has approved a proposal to establish a pooled budget across Health and Social Care. Work is also underway of reviewing commissioning priorities across Health and Social Care.
As an example the new integrated strategy for Mental Health is being developed.

Key Performance Indicators

Ref	Measure	11/12 Actual	12/13 Target	Q4	Current Progress	Direction of travel
CCC 6	Adults with mental health problems helped to live at home per 1,000 population (Previously AWA LI13/CCS 8)	3.97	3.97	3.23		
CCC 7	Total number of clients with dementia receiving services during the year provided or commissioned by the Council as a percentage of the total number of clients receiving services during the year, by age group. (Previously CCC 8)	3.4%	5%	4.0%		
CCC 8	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 9).	0	1.2	0		
CCC 9	Number of households living	6	12			

	in Temporary Accommodation (Previously NI 156, CCC 10).			6		
CCC 10	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough) (Previously CCC 11).	4.71	4.4	5.42		
CCC 11	Carers receiving Needs Assessment or Review and a specific Carer's Service, or advice and information (Previously NI 135, CCC 14).	21.64%	25%	18.87 %		

Supporting Commentary

CCC 6
Although this indicator has reduced, the actual numbers of people concerned are small. There are two main reasons for this – the overall adult population figures for Halton have increased as a result of the latest census (which reduces the overall proportion of people who are receiving a service), and redesign of the service provided by the 5Boroughs means that a number of people have been discharged back into primary care services. This means that the service is now targeted more effectively on those people who most need care and support from social workers.

CCC 7
Target not met, however performance for Q4 is better than performance reported in Q4 in the previous year (3.4%).
It is clear that there are issues on how dementia is recorded within Carefirst. This is particularly challenging as people diagnosed with dementia may well have dual diagnosis and this would be how they are categorised on Carefirst.
In addition, there has been a significant increase in the number of people supported by both 5 Boroughs Partnership and the Alzheimer's Society, but neither cohort is currently recorded on Carefirst. A solution to this is being sought.

CCC 8
The Authority signed up to the Merseyside Sub Regional, No Second Night Out scheme in 2012. The service provides an outreach service for rough sleepers and has a close working partnership with Halton to identify and assist this vulnerable client group.. The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district.

CCC 9
Established prevention measures are in place and the Housing Solutions team will continue to promote the services and options available to clients.
There has also been a change in the TA process and accommodation provider

contracts. The emphasis is now focused on independence, which has developed stronger partnership working and contributed towards an effective move on process for clients. The Authority will strive to sustain the reduced TA provision.

CCC 10
The Housing Solutions Team promotes a community focused service. During the last 2 years there has been an increase in prevention activity, as officers now have a range of resources and options to offer clients threatened with homelessness. Due to the proactive approach, the officers have continued to successfully reduce homelessness within the district.

CCC 11
Performance in this area has dipped this year. This is mainly due to major reorganisation in the way social work services have been set up, which has meant that some performance delivery has reduced. A project is currently being established to look at how carers assessments can be delivered more efficiently in 2013-14, and how this links in a more structured way to services delivered by the Carers Centre, and this is expected to lead to an improvement in performance.

II *Prevention and Assessment Services*

Key Objectives / milestones

Ref	Milestones	Q 4 Progress
PA1	Support the transition of responsibility for Public Health and Improvement from NHS Halton & St Helens to Halton Borough Council. **Mar 2013**. (AOF 2 & 21)	✓
PA1	Implementation of the Early Intervention/Prevention strategy with a key focus on integration and health and wellbeing. **Mar 2013.** (AOF 3 & 21)	✓
PA1	Review current Care Management systems with a focus on integration with Health (AOF 2, AOF 4 & AOF 21) **Aug 2012**	✓
PA1	Continue to establish effective arrangements across the whole of Adult Social Care to deliver Self-directed support and Personal Budgets. **Mar 2013** (AOF 2, AOF 3 & AOF 4)	✓
PA1	Continue to implement the Local Affordable Warmth Strategy, in order to reduce fuel poverty and health inequalities. **Mar 2013** (AOF 2)	✓

SUPPORTING COMMENTARY

Transfer of Public Health to Halton Borough Council
The Public Health team has now successfully transferred to Halton Borough Council. Preparation for the transfer has been on-going since March 2012. This has included a review across NHS Merseyside which is made up of the 4 Primary Care Trusts of Halton & St Helens, Knowsley, Liverpool and Sefton of all Public Health functions and services.
Halton Borough Council has developed and led a Transition Group which has overseen the safe transfer of all necessary functions including staff transfer and

measures letter, public health reports, information governance, emergency resilience, contracts, data connections, risk register, budget transfer and final Public Health Annual Report.

Implementation of the Early Intervention/Prevention strategy
HBC, HCCG and Bridgewater Community NHS Trust have been reviewing the current approach to the delivery of Health Improvement Services delivered by both health and local authority providers. One of the areas specifically addressed has been to align the services provided by the Health Improvement Team (Older People) based at Bridgewater Community NHS Trust to those provided by HBC's Sure Start to Later Life. Building on this and other developments such as the work taking place on Falls Prevention and the Community Wellbeing Practice initiative, further work has taken place on the development of an overall model for the delivery of Health Improvement Services across Halton in the future. It is anticipated that the Service (being implemented from April 2013) will play a significant role in addressing the five priorities contained in Halton's Health and Wellbeing Strategy. The new Service will bring significant benefits through increasing efficiency, improving the patient experience, introducing a consistent approach and changing the culture to one of joint ownership and strong partnership working.

Review of current Care Management Configuration
A new model for adult services has been launched at the beginning of June 2012. An Initial Assessment Team (IAT) is now responsible for all new referrals, screening, signposting and initial assessments. There are two Operational teams dealing with complex work, (one in Widnes and one in Runcorn) that are to become locality based care management teams with workers aligned to GP practices. This will be supported by Social Care in Practice (SCIP) in the coming year.

Self-directed support and Personal Budgets
Self-directed support is offered across the whole of Adult Social Care and with personal budgets to all Service Users. Systems are continually monitored and reviewed for improvement. There is a working group reviewing the direct payments and self-directed support policy and guidance.

Affordable Warmth Strategy
Implementation of the strategy continuing and a review will be due in Quarter 1, 2013- 2014

Key Performance Indicators

Ref	Measure	11/12 Actual	12/13 Target	Q4	Current Progress	Direction of travel
PA 1	Numbers of people receiving Intermediate Care per 1,000 population (65+) (Previously EN 1)	91.67	99	84.35	✗	↓
PA 4	Number of people receiving Telecare Levels 2 and 3 (Previously PA 6)	240	259	262	✓	↑

PA 5	Percentage of Vulnerable Adult Abuse (VAA) Assessments completed within 28 days (Previously PA 8)	90.80%	82%	86.73%		
PA 11	% of items of equipment, and adaptations delivered within 7 working days (Previously CCS 5, PA 14)	97.04%	97%	94%	N/A	N/A
PA 12	Clients receiving a review as a percentage of adult clients receiving a service (Previously PCS 6 PA16)	80.77	80	82.87		
PA 14	Proportion of People using Social Care who receive self-directed support and those receiving Direct Payments (ASCOF 1C) (Previously NI 130, PA 29)	48.31%	55%	75%		
PA 15	Permanent Admissions to residential and nursing care homes per 1,000 population (ASCOF 2A) (Previously PA 31)	147.89	130	86.12		
PA 16	Delayed transfers of care from hospital, and those which are attributable to adult social care (ASCOF 2C) (Previously NI 131, PA 33)	1.86 (as at end March 2012)	3.0 (PCT Target)	2.05 (Q3 data)	Refer to comment	Refer to comment
PA 17 (SCS HH 10)	Proportion of Older People Supported to live at Home through provision of a social care package as a % of Older People population for Halton	15.7%	14.8%	14.2%		
PA 18	Repeat incidents of domestic violence (Previously NI 32, PA 28)	27.6%	27%	36%		
PA 19	Number of people fully independent on discharge from intermediate care/reablement services (Previously PA 5)	58%	42%	57%		

SUPPORTING COMMENTARY

PA 1
This is a cumulative figure of 1573 and equates to 409 people in receipt of Intermediate Care this quarter in the 65+ age bracket. This indicator is subject to increases in the estimated population of older people in Halton.

PA 4
This target has been exceeded.

PA 5
We have exceeded this target. The discrepancy from last year's figure is due to changes to the Safeguarding threshold.

PA 11
Unable to access full March 2013 data from Helena Partnerships website. Therefore 94% is data as at 08/04/2013.

PA 12
We have exceeded this target and the performance from the previous year. Better performance is likely to be as a result of Carefirst 6 now practitioners are loading their own assessments.

PA 14
We have exceeded this target. This is due to every new service user is going through a self-directed support process and existing clients who are reviewed.

PA 15
This is the position at February 2013 and it looks like the target will be achieved. Performance has improved considerably in comparison to last year.

PA 16
Q4 data is not available therefore Q3 data has been used as a guide. Currently we are bench marking performance against baseline year 2010-11. Delays in transfer's delays have increased in Q3 due to winter/systems pressures across Trusts.

PA 17
We have fallen just short of our set target. A population increase of approximately 7% as evidenced by the last Census has impacted on this target.

PA 18
(27%) is a local historical target and we should be looking to move away from it 2013-14; CAADA (Coordinated Action Against Domestic Abuse) is the National lead for all things MARAC, I have included their guidance in the update, CAADA suggest that for a mature MARAC such as Halton's the range should be between 28% 40% so in that sense we are in fact on target and I would suggest that in the future we should be looking to their National expertise rather than local historical targets. *Research has shown that it takes the average victim of domestic abuse more than 35 incidents of domestic abuse incidents against them before they call the Police – consequently and particularly if a victim chooses to stay in the relationship and the case has appeared at MARAC once and not again, it is very likely domestic abuse is continuing in the household but they are choosing not to seek support, a worse scenario especially if there are children or vulnerable adults in the household. There is an argument to suggest that repeat cases at MARAC could be indicative that victims have a growing confidence in local statutory agencies and*

their ability to assist not only them but their children.

PA 19
Intermediate Care services have continued to work together and with community, primary and acute care sectors to support more people to live independently in their own homes and arranging long term services as required.

Adult Social Care Outcomes Framework Indicators (2011/12)

Finalised statutory return information is available in Q1 2012/13 for the previous financial year's performance, as shown in the Table below.

Ref	Measure	10/11 Actual	11/12 Actual	12/13 Target	Direction of travel
CCC 18	Social Care-related Quality of life (ASCOF 1A) (Previously CCC 38)	18.9	19.7	19	⇧
CCC 19	The proportion of people who use services who have control over their daily life (ASCOF 1B) (Previously CCC 39)	79.2%	80.6%	80%	⇧
CCC 23	Overall satisfaction of people who use services with their care and support (ASCOF 3A)	61.7%	69.2%	65%	⇧
PA 20	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (ASCOF 2B) (Previously NI 125, PA 32)	68.83%	74.07%	70%	⇧
PA 21	The Proportion of people who use services and carers who find it easy to find information about support – Adult Social Care Survey (ASCOF 3D) (Previously PA 34)	65.4%	65.5%	65%	⇧
PA 22	The Proportion of People who use services who feel safe – Adult Social Care Survey (ASCOF 4A) (Previously PA 35)	51.3%	66.2%	54%	⇧
PA 23	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B Previously PA 36)	N/A New Indicator for 11/12	79.1%	79.1%	N/A

SUPPORTING COMMENTARY

CCC 18 – This is a composite measure which brings together the outcomes from a number of questions asked as part of the Adult Social Care Survey. The set of eight questions are aggregated to provide an overall indication of quality of life. Out of a possible total score of 24, those included in the 2011/12 survey resulted in a score of 19.7. This score indicates a strong score for quality of life.

CCC 19 – Performance increased from 2010/11 to 2011/12, 80.6% of those who responded to the Adult Social Care survey in 2011/12 reported that positively that they have control over their daily life. To contribute to this score, respondents answered either; 'I have as much control over my daily life as I want' or "I have adequate control over my daily life".

CCC 23 – Performance increased from 2010/11 to 2011/12, 69.2% of those who responded to the Adult Social Care survey in 2011/12 reported that they were either 'extremely' or 'very' satisfied with the care and support services they receive from Halton Borough Council.

PA 20 - Performance increased from 2010/11 to 2011/12, from 68.83% to 74.07%. This measures the benefit to individuals from re-ablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. A higher figure is better.

PA 21 – Performance remained constant from 2010/11 to 2011/12, 65.5% of those who responded to the Adult Social Care survey in 2011/12 reported that they found information about support was either, 'Very easy to find' or 'fairly easy to find'.

PA 22 - Performance increased from 2010/11 to 2011/12, 66.2% of those who responded to the Adult Social Care survey in 2011/12 reported 'I feel as safe as I want'.

PA 23 - 79.1% of those who responded to the Adult Social Care survey for the first time in 2011/12 reported that support services helped them to feel safe. This indicator reflects directly whether the support services that Halton Borough Council provides has an impact on an individual's safety. This is in comparison to PA21 which is a general measure of whether an individual feels safe – which could be as a result of a multitude of factors. A higher figure is better.

Ref	Risk Identified	Treatment Measure	Progress	Supporting Commentary

Commissioning & Complex Care

Ref	Description
CCC1	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care Needs.

1	Not implementing the Local whole system Dementia Strategy.	Review existing action plans to ensure consistency.	✓	The local Dementia strategy has been reviewed and refreshed, although there are a small number of actions that have not been completed the strategy and action plan have been refreshed to clearly react to the new commissioning requirements of the Clinical Commissioning group.
2	Failure to implement 5 Boroughs NHS Foundation Trust proposals to redesign pathways for people with acute Mental Health problems and services for Older People with Mental Health problems.	Monitor the usage of inpatient beds at 5boroughs and resulting pressures on the associated systems.	✓	The planned rollout has taken place from January 2013. All of the processes are in place and the new pathway and associated referral processes will go live in June 2013. Although this is later than originally planned, it has been important to ensure that the rollout is ready and not rushed.

Ref	Risk Identified	Treatment Measure	Progress	Supporting Commentary

Prevention & Assessment

Ref	Description
PA 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people.

Ref	Risk Identified	Treatment Measure	Progress	Supporting Commentary
1	Transition of responsibility for Public Health and Health Improvement to HBC not fully embedded and appropriately embedded.	Ensure sufficient transfer of finance associated with Public Health to ensure effective delivery of statutory responsibilities.	✓	The announcement of the ring fenced public health grant allocations on 10th January was favourably received with national figures of £2.5billion for 2013/14 and £2.8billion for 2014/15 representing real term growth. The allocation for Halton is £8,510 million for 2013/14 and £8,749 million for 2014/15 which is an increase from the anticipated initial allocation of 2.8% each year.
2	Uncertainties in relation to the future direction the Department of Health will take in terms of the impact the wider health changes will have.	Work with Mersey region transition group to ensure effective and appropriate responses to changes can be made.	✓	Halton's Transition Group has effectively worked with the Merseyside Transition Group to ensure all key milestones have been met for a smooth transfer. A paper has been signed off by Halton's Executive Board to this effect. Halton's Public Health Team are working with PHE, the NHS Commissioning Board and Merseyside Commissioning Support Unit to ensure services commissioned and delivered by parties other than the LA are in place.

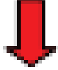
APPENDIX

Symbols are used in the following manner:

Progress		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red	![red]	Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*

Agenda Item 7a

REPORT TO: Health Policy and Performance Board

DATE: 4 June 2013

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health and Adults

SUBJECT: Urgent Care – Options Appraisal

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 As part of the consultation process, present Members of the Board with details of the options being considered to develop a local response to Urgent Care.

2.0 RECOMMENDATION: That the Board Note the contents of the report.

3.0 SUPPORTING INFORMATION

Background

3.1 A Business Case was prepared for the development of an Urgent Care Centre on the Halton Hospital site, and was submitted to the Clinical Commissioning Committee in September 2010.

It was anticipated that the development of an Urgent Care Centre at Halton would provide the following benefits:

- Equity of access across Runcorn and Widnes;
- More clinically appropriate services available within the community; and
- Reduce the overall admission rates through the development of alternative local provision.

3.2 The original business case proposed a new centre, operating between 8am and 10pm, 365 days per year. The service would work in partnership between Halton Clinical Commissioning Group, Halton Health, Warrington and Halton Hospital Foundation Trust, North West Ambulance Service (NWAS), Halton Borough Council (HBC) and community providers to provide a seamless urgent care experience for the local population.

3.3 As part of NHS Halton Clinical Commissioning Group's (HCCG) commissioning intentions for 2012/13, a review of the original business case along with a current winter pressures Accident and Emergency Department (AED) audit was completed to inform an options appraisal and to reflect the health care system changes within urgent care that have taken place during the last 2 years, which includes increased demand/pressures on capacity and innovation within partner organisations such as NWAS-community plans, kite marks for Urgent Care Centre's/Walk in Centre's and Paramedic pathfinders.

3.4 There is a raft of national evidence that exists in terms of how to reduce admissions and re-

admissions. In addition to this, details are also available of the urgent care services currently available to the residents of Halton along with information about how they are currently used. All this information, along with the outcome of the AED audit (headline messages outlined below) were considered as part of the work to develop options for the delivery of an urgent care model at a local level :-

- Total number of questionnaires completed: 212 (96%), with 9 (4%) being partially completed
- 52% were self-referral
- 20% of patients felt their condition could have been managed elsewhere
- 29% of patients attempted to go elsewhere (GP/WIC etc.)
- 29% attended AED following advice from a healthcare professional
- 25% of patients felt AED was most appropriate for their condition
- 15% felt it was the only option available
- 19% of patients had attended other services within a 7 day period
- 19% of patients needed an X ray
- 8% of patients had a soft tissue injury
- 26% of patients were admitted with 66% of patients being discharged
- Excluding those admitted, 56% of patients could have been managed elsewhere within current service provision
- 41 patients received X rays - of which 76% (31) could have been managed elsewhere
- With a change in local facilities, 15% could have been managed within the community

<u>Identified care pathways to support a local model of care</u>

3.5 In "Delivering Care Closer to Home" it is acknowledged that "Acute services will still be an absolutely vital part of the pathway, but it will be possible, and for many people preferable, for an increasingly large proportion of the care pathway to be situated outside of an Acute hospital setting, making greater use of community urgent care services and of ambulance services, whose potential as a hub and a connector has not yet been fully realised. The potential for new technology, with its mobility, flexibility and rapid transfer of information to support far greater levels of service in home and community settings is real and immense, as we are already starting to see in telecare services, and in the transfer of diagnostic services into the community" (Department of Health, 2008).

3.5.1 Taking this and other considerations into account, pathways that could be developed locally include:-

- X ray facility
- Ultra sound/Doppler scan provision
- Bloods/redressings/sutures
- Paediatric specialist nursing provision- including cold room
- Deep Venous Thrombosis pathway
- Direct referral in outpatient facilities i.e. ophthalmology
- Direct referral into mental health AED liaison
- Acute warfarin initiation
- ECG
- Atrial Fibrillation clinic

3.5.2 The key benefits of service redesign include the :-

- Provision of a service that meets with patient needs, either through immediate treatment or by arranging future appointments with the appropriate service;
- Provision of an urgent care service that is accessible for the local population;
- Provision of a service that caters for both minor injury and illness;
- Improvement of performance by streaming patients into the appropriate service (e.g. reduction in A&E attendances);
- Ensuring that where people require urgent care this is received in an effective and timely manner;
- Provision of a service that is safe and of high quality; and
- Provision of access to harder to reach groups of people (e.g.: working men aged 18 -49, teenagers requiring sexual health advice)

Proposed Options for Reconfiguration

3.6 Three options have been considered for the delivery of an urgent care model within Halton, these are summarised below, with details in terms of each option's associated pathways being outlined in **Appendix 1** :-

- ***Option 1***- Creation of an additional Walk in Centre plus a Clinical Decision Unit at Halton Hospital Site; Maintain Walk in Centre at Widnes
- ***Option 2*** - Creation of an additional Walk in Centre at Halton Hospital Site
- ***Option 3*** - Development of a Clinical Decision Unit at Halton Hospital Site – plus extended primary care hours to provide Walk in provision within primary care localities

3.7 These options have been presented to both Halton's Urgent Care Partnership Board and HCCG's Governing Body and the preferred option supported by both Groups for further consideration was ***Option 1***.

It is therefore proposed that business cases are developed for Option 1 to ensure its financial viability. These business cases along with the results of public consultation will be presented to the following forums for further consideration :-

- Urgent Care Partnership Board
- HCCG Senior Management Team (SMT)
- HCCG Governing Body
- HBC's Executive Board
- Relevant Trust Executive Directors: Bridgewater, St Helens & Knowsley Teaching Hospital and Warrington Halton Hospital Foundation Trust.

Current Activities

3.8 A number of activities are planned over the next few months to support developments, these include :-

- Business cases to be developed for Option 1 prior to public consultation;
- Development of St Helens & Knowsley, Warrington Halton Hospital Foundation Trust and Bridgewater NHS Community Trust implementation plans directed at Option 1, including procurement timetable if appropriate and interim arrangements for

implementation of a Clinical Decisions Unit within Halton Hospital Site; and
- Development of a Service Specification and Mobilisation Plan for Option 1.

3.9 In addition to the activities outlined above, extensive work is taking place on the development of processes to support the formal consultation process which needs to take place.

It is anticipated that formal consultation will commence from 1st June 2013 and run until 31st August 2013. (The presentation of the options to the Health Policy and Performance Board form part of this consultation process).

The activities being undertaken include the development of a Communications and Engagement Strategy with a supporting Action Plan, which will address issues such as how to identify those that are 'hard to reach' or 'less likely to engage' and outline the tools and methodologies which will be used to target these individuals.

Other activities include the development/adoption of a range of tools and methodologies to support the patient and public engagement process e.g. use of an electronic, web based consultation tool.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The current minor injuries unit and Widnes Walk-in Centre cost approximately £2.2m.

5.2 It should be noted that 'back room' costs are not included in this report, but will significantly increase the overall cost of the programme these include, XRays/ Doppler/ Ultrasound, including agreed pathways that may be redirected into the Clinical Decisions Unit, all of which will be developed and included in the business case that is being developed for Option 1.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified.

6.2 **Employment, Learning & Skills in Halton**
None identified.

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
None identified.

6.5 **Halton's Urban Renewal**
None identified.

7.0 RISK ANALYSIS

7.1 None identified at this stage.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

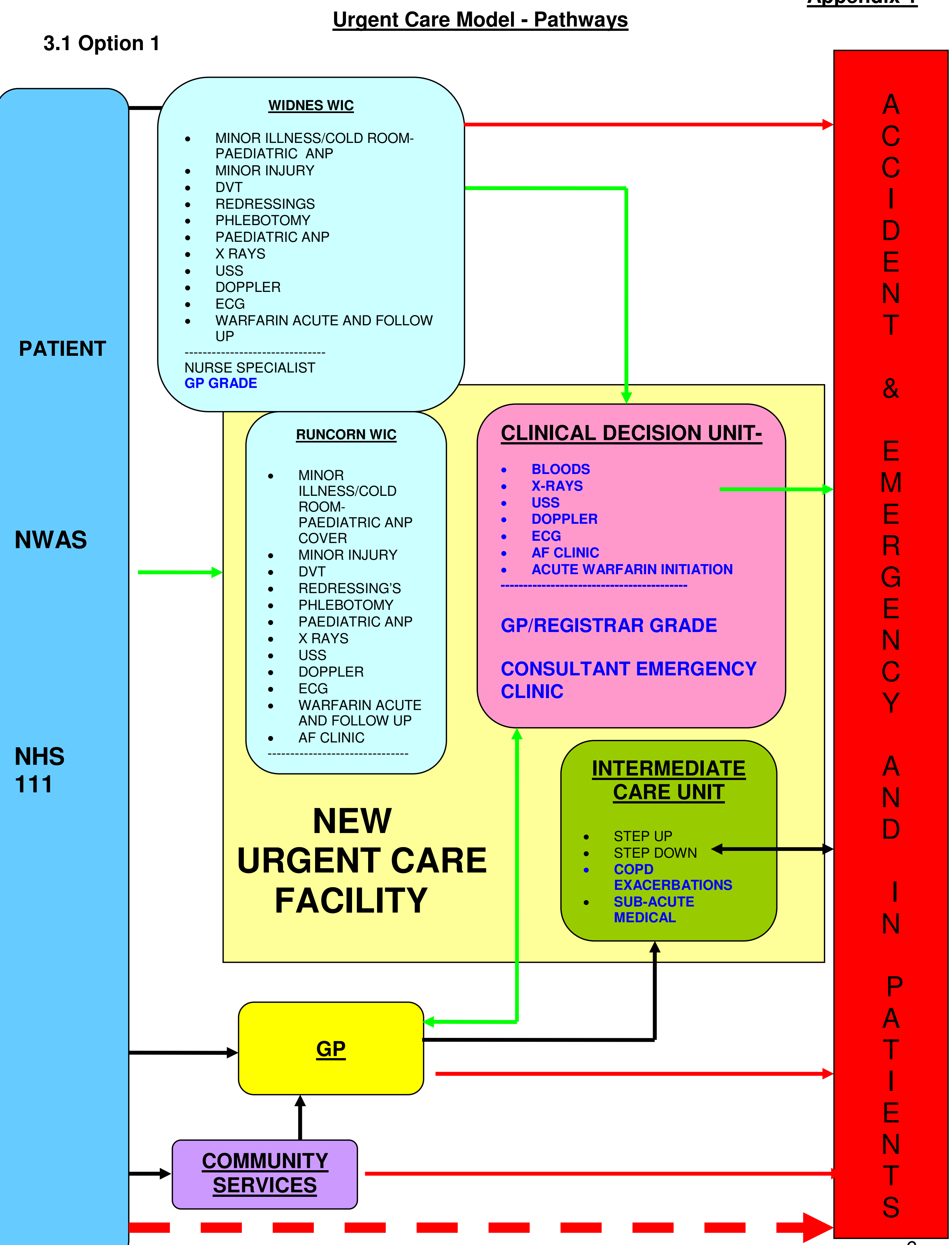
9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act.

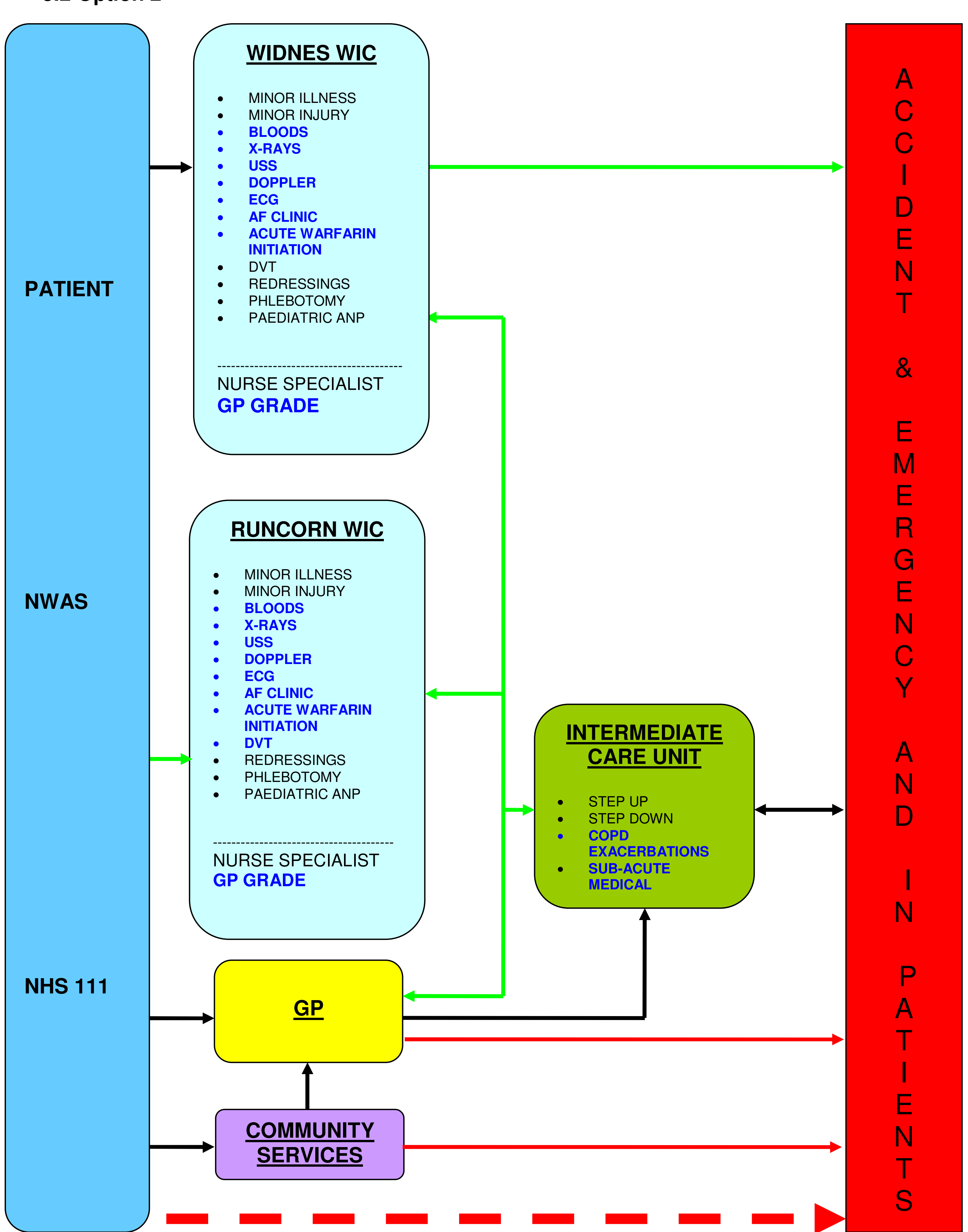
Appendix 1

Urgent Care Model - Pathways

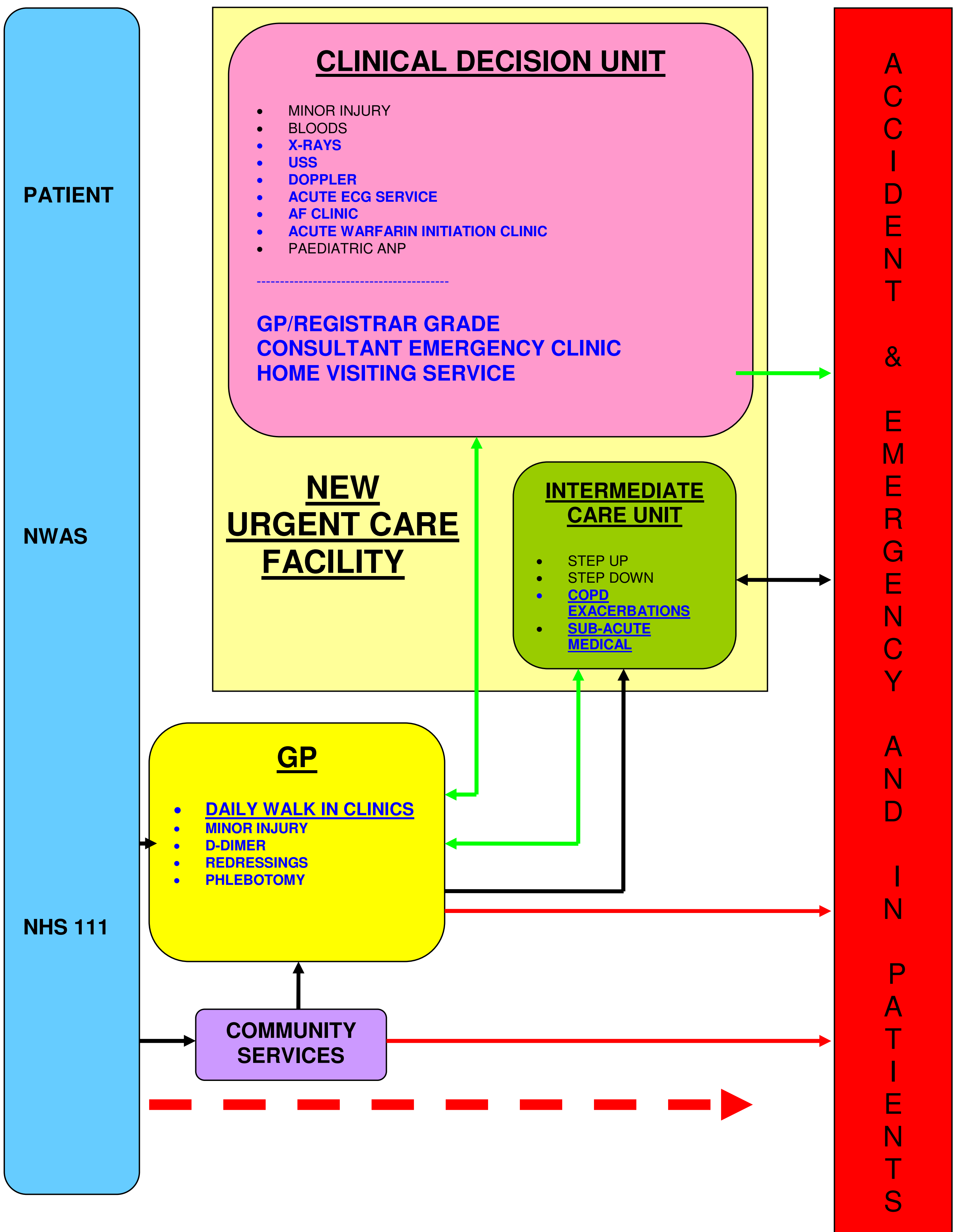
3.1 Option 1



3.2 Option 2



3.3 Option 3



Agenda Item 7b

REPORT TO:	Health Policy & Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Draft Falls Prevention Scrutiny Review Report
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the draft Scrutiny Review of Falls Prevention report for approval to go forward to Executive Board.

2.0 RECOMMENDATION: That:

i) **The Board comment on the findings of the Scrutiny Review; and**

ii) **The Board endorse the Scrutiny Review and its recommendations to go forward to the Executive Board.**

3.0 SUPPORTING INFORMATION

3.1 This report (attached as Appendix 1) was commissioned by the Health Policy and Performance Board. A scrutiny review working group was established with seven Members from the Board, a Principal Policy Officer from the policy team and the Divisional Manager Intermediate Care.

The report was commissioned because falls are a leading cause of mortality due to injury amongst older people aged 65 and over. They also contribute to the life expectancy gap between Halton and England. People who have been admitted to hospital following a fall are at increased risk of falling again in the next 12 months, experiencing loss of confidence and fear of falling, and of losing their independence through entering a residential care home.

The scrutiny review was conducted through a number of means between April 2012 and January 2013, as follows:

- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff from the Council and Health (detail of the presentations can be found in *Annex 2*);

- Provision of information;
- Service-user consultation;
- Field visit to a Falls Prevention exercise class

4.0 **POLICY IMPLICATIONS**

4.1 Existing policies are endorsed by the report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The recommendations highlighted within the Action Plan will be undertaken within existing resources with some redesign.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
N/A

6.2 **Employment, Learning & Skills in Halton**
N/A

6.3 **A Healthy Halton**
The scrutiny review report and recommendations support the Council's strategic priority of Improving Health. Taking on board the recommendations from the report will be positive steps to improving all aspects of Falls Prevention for the residents of Halton.

6.4 **A Safer Halton**
N/A

6.5 **Halton's Urban Renewal**
N/A

7.0 **RISK ANALYSIS**

7.1 The report and recommendations support the Council's strategic priority of Improving Health. Taking on board the recommendations from the report will be positive steps to improving Falls Prevention services for people in Halton.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The implementation of the recommendations will help to improve services in Halton for people who want to access the Falls Prevention Service.

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

None under the meaning of the Act.

Draft Scrutiny Review of Falls Prevention

Report

March 2013

CONTENTS

Contents	Page	Paragraph
Purpose of the report	3	1.0
Structure of the report	3	2.0
Introduction	3	3.0
Methodology	4	4.0
Evidence and Analysis with findings/conclusions and recommendations	5 - 11	5.0 – 5.9
Overall Conclusion	11	6.0

Annexes	Number
Topic brief	1
Methodology	2
Statistical information from the Clinical Commissioning Group	3
Documents Considered including National Best Practice within the review	4
Action Plan	5

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1.0 PURPOSE OF THE REPORT

The purpose of the report, as outlined in the initial topic brief (at *Annex 1*) is to:

- Examine the effectiveness of the current pathways for assessments and appropriate interventions for those at risk of falls in Halton
- An understanding of the work undertaken by the Falls Prevention Service and the benefits their interventions can bring to those at risk.
- An understanding of the role that partner agencies including the fire services and the third sector have in helping prevent falls.
- Consider national best and evidenced based practice in relation to pathways for assessment and appropriate interventions for those at risk of falls.
- Consider ways to continue to make improvements to services, thus enabling Halton to reduce admission rates to Hospital as a result of a fall.
- Examine the quality of care someone receives if they do have a fall.

2.0 STRUCTURE OF THE REPORT

This report is structured with an introduction, a brief summary of the methodology followed by evidence, analysis with findings/conclusions and recommendations. The annexes include the topic brief, methodology detail and an action plan to capture the recommendations from the scrutiny review.

3.0 INTRODUCTION

3.1 Reason the scrutiny review was commissioned

Falls are a leading cause of mortality due to injury amongst older people aged 65 and over. They also contribute to the life expectancy gap between Halton and England. People who have been admitted to hospital following a fall are at increased risk of falling again in the next 12 months, experiencing loss of confidence and fear of falling, and of losing their independence through entering a residential care home.

The risk of falling increases with age, particularly in those 65 and over. 35% of over 65s are at risk of falling each year, rising to 45% of people aged 80 and over. Between 10- 25% of those people who fall will sustain a serious injury. Between 22% and 60% of older people suffer injuries from falls, 10-15% suffer serious injuries from falls, 2-6% suffer fractures and 0.2 – 1.5% suffer hip fractures.

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Regardless of the outcome, falls are associated with a loss of confidence, and a subsequent restriction in physical activity which leads to a further loss of capability and bone density. This increases the risk of another fall and also the likelihood of entering residential care.

Nationally the number of people aged over 65 is due to rise by a third by 2025, which is associated with increased incidence of falls of 2% per year. In Halton the number of people aged 85 plus is projected to increase, and this is the most vulnerable group.
(Source : Halton Joint Strategic Needs Assessment)

3.2 Policy and Performance Boards

This report was commissioned as a scrutiny working group for the Health Policy and Performance Board.

3.3 Membership of the Scrutiny Working Group

Membership of the Scrutiny Working Group included:

Members	Officers
Cllr Ellen Cargill (Chair) Cllr Joan Lowe Cllr Margaret Horabin Cllr Geoff Zygadllo Cllr Pamela Wallace Cllr Sandra Baker Cllr Pauline Sinnott	Damian Nolan – Divisional Manager for Intermediate Care Emma Sutton-Thompson – Principal Policy Officer

4.0 Methodology Summary

This scrutiny review was conducted through a number of means:

- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff (detail of the presentations can be found in *Annex 2*);
- Provision of information; and
- Service-user consultation.

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5.0 Evidence (summary of evidence gathered) and Analysis with findings/conclusions

5.1 Falls Prevention Awareness

The first meeting of the Falls Prevention Scrutiny Review Topic Group took place on 20th June 2012. Rosina Price, Nurse Specialist from the Falls Prevention team attended and gave a presentation about Falls Prevention Awareness. The presentation covered: local and national statistics, reasons why people fall, the prevention of falls, Accident Prevention Exercise (APEX), other related services, falls pathway in Halton, referral criteria and assessments. Rosina mentioned that the team follow the National Institute for Health and Clinical Excellence (NICE) guidelines.

Conclusion

The presentation was very detailed and comprehensive and gave the topic group a good understanding of the topic and areas to look into further.

Recommendations:

(i) Bone density/diet hand-outs to be made available/distributed as widely as possible.

(ii) Leaflets or small examples of housing equipment that is available to be located at doctor's surgeries so that people know what they can expect.

(iii) Use of the TV facilities at doctor's surgeries for use with publicity regarding Falls Prevention.

(iv) Promote the fact that people can self-refer to the Rapid Access and Rehabilitation Service (RARS) team.

5.2 Data and Monitoring of Falls

Throughout the review, data and the monitoring of falls arose. The topic group wanted to find out how falls are monitored across the various agencies.

During the August meeting of the topic group, Rosina Price, Nurse Specialist from the Falls Prevention team explained that Bridgewater were implementing an updated IT system for monitoring activity called PARIS in January 2013. Potentially, this system could be used internally to record more information for falls monitoring.

The topic group also looked at information from the Joint Strategic Needs Assessment (JSNA). The JSNA is a means by which Primary Care Trusts and Local Authorities describe the future of health and wellbeing needs of local populations and the strategic direction of

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service delivery to meet these needs. Information from the JSNA regarding falls in the borough was used initially to identify the need for this scrutiny review, as described in 3.1.

Following the topic group meeting in October, a request was submitted to the Halton Clinical Commissioning Group for data regarding falls related to A&E attendances and Emergency Admissions in the over 65s to local hospitals, broken down into quarterly information so that seasonal variations could be noted (Annex 3).

Within the A&E dataset provided by the Trusts falls are not readily identified as a reason for attendance, instead it is mainly recorded as diagnosis such as 'head injury' or 'sprain' instead. This makes it very difficult to identify falls. The inpatient information includes a diagnosis specifically related to falls and is shown within the spreadsheet.

Conclusion

It is clear from the evidence gathered that due to the way that statistical information is recorded, information regarding hospital admissions due to falls is difficult to quantify.

Recommendation:

(i) Regular statistical reports from the CCG regarding falls related to A&E attendances and Emergency Admissions to be presented at the Health PPB under Quarterly Monitoring.

5.3 Funding and Pooled Budgets

During the topic group meeting in August, Chris Durr, Assistant Warden Manager and Kerry Smith, Warden from Halton's Warden Service attended the meeting and gave a presentation regarding the Warden Service in Halton. Chris explained that the service currently has 1993 people on the community alarm system and of these, 263 people have additional chair and bed sensors. The presentation included a demonstration of the cushion that is used by the Wardens when assisting people to get up from a fall.

Conclusion

The topic group were very impressed with the Warden Service that is available in Halton.

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Recommendation:

(i) Look into a wider pooled budget as the Warden Service contributes to a reduction in hospital admissions.

5.4 Quality Assurance

During the September topic group meeting, Benitta Kay, Contracts Officer from the Quality Assurance Team (QAT) attended. Benitta distributed a question and answer sheet detailing contract management of falls in care homes and talked through each section. Podiatry arose during this session and Benitta mentioned that the majority of people in their contracted providers pay up to £17 per session for podiatry instead of using the NHS, due to either long waiting times on the NHS, or the person preferring to use the podiatrist they previously used when they lived at home.

It was noted that some care homes might do less activity with people because of the risk of falls and Dr Lyon stated that by doing exercise the residents would actually reduce the risk of falling. Benitta confirmed that the Quality Assurance Team needs to work positively with providers to encourage the use of exercise.

Benitta discussed a new contract and specification for residential/nursing homes that is currently being developed to be implemented in April 2013.

Conclusion

With there being a new contract and specification being developed for implementation in April 2013, this could be a good opportunity to improve falls monitoring and include something specific about falls into the contract.

Recommendations:

(i) Suggest that the QAT team add an item onto their monitoring checklist for residential and nursing homes regarding the use of exercise;

(ii) Add access to telecare and a falls risk assessment element to the new contract for residential/nursing homes;

(iii) Add a question to the questionnaire to homes regarding the Age UK DVD about accessing podiatrist services; and

(iv) Put together a list of podiatrists in the Halton area and distribute to homes to increase their choice.

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5.5 Service User Consultation

As part of the scrutiny review the topic group consulted with service users who had experience of Halton's Falls Prevention Service. On 26th November, three service users and their carers attended the topic group meeting to talk about their experiences.

Mr B and Mrs H both wanted to praise the work of the Falls Prevention team as they had received very positive experiences that had improved their mobility and confidence. Mr B had been into hospital for a planned admission and on discharge had been given good information. Following this, Mr B's doctor then signposted him to the Falls Prevention team.

Mr O had fallen at home and not received a great service throughout the stages of his care. On discharge from hospital Mr O was not given a package of care or signposted to other services. A relative had given Mr O the number for Halton's Rapid Access and Rehabilitation Service who then arranged a short-term package of care.

All three service-users now attend an APEX exercise class once a week through the Falls Prevention Service that they thoroughly enjoy and benefit from. Mr B invited the Topic Group members to visit one of the APEX exercise classes so they could see it for themselves.

Conclusion

Experiences were mixed regarding wider health care and other agencies, but very positive regarding Halton's Falls Prevention Service.

Recommendation:

(i) Topic Group members to attend/observe an APEX exercise class.

5.6 Communication

Communication is a subject that appeared throughout the scrutiny review, both positively and negatively. The service-users that were consulted with were all very positive about communication once they had been put into contact with the Falls Prevention team, although experiences varied in establishing that link in the first place. Communication needs to be strengthened with signposting at the discharge from hospital point, as well as from GPs.

During the September Topic Group meeting, Dr Lyon, Clinical Lead from the Clinical Commissioning Group attended. A discussion regarding the communication links between GPs and the Falls Prevention team took place and it was agreed that communication in this area could be improved.

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The topic group also had a discussion about sharing information and the difficulties that present around sharing information across agencies in terms of confidentiality and Caldicott.

Documentation regarding the Discharge Policy and Policy for the Reduction and Management of Patient Falls was received from St Helens and Knowsley Teaching Hospitals NHS Trust. During the Topic Group meeting of 20th February 2013, the group looked through the documents and commented on how thorough and comprehensive they were. At the same meeting, Alison Lynch, Associate Director of Nursing Corporate Nursing for Warrington and Halton hospitals attended. Alison talked through the systems and processes that they have in place regarding Falls Prevention and the Discharge and Transfer Policy which is currently under review.

Conclusion

The service user consultation highlighted that hospital discharge arrangements can play a pivotal part in falls prevention. Having a positive discharge from hospital with the right package of care and signposting to other services can help contribute to a speedy recovery to full health, whereas, receiving a negative discharge from hospital can potentially prolong the recovery time. This discussion raised the question does there need to be a future scrutiny review topic focussed purely on Hospital Discharges.

Receiving the documentation regarding the Discharge Policy and Policy for the Reduction and Management of Patient Falls from St Helens and Knowsley Teaching Hospitals NHS Trust showed the topic group that policies and procedures are in place. It was useful for the topic group to meet with Alison Lynch, Associate Director of Nursing Corporate Nursing for Warrington and Halton hospitals and hear first-hand how they are implementing initiatives to reduce the number of falls in hospitals.

Recommendations:

(i) Communication between the Falls Prevention team and GPs are strengthened;

(ii) Write out to hospitals to ask what their hospital discharge policy is and how they monitor it; and

(iii) Consider a future scrutiny review topic to be Hospital Discharges.

5.7 Health and Wellbeing

During the October Topic Group meeting an Age UK DVD entitled “Be Strong, Be Steady” was discussed. The DVD contains a programme of chair-based and standing exercises devised specially for older people. If done regularly, the exercises will strengthen muscles, increase

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flexibility and improve balance, all of which can reduce the risk of a fall. The programme is introduced by people who describe the important role exercise plays in their lives and how enjoyable it can be.

The group discussed previous health and wellbeing events that had taken place in the borough and agreed that these were valuable.

Conclusion
The group watched some of the DVD and thought it would be useful to ask a sample of homes/schemes for their feedback regarding the use of the DVD. The group also concluded that it would be useful to consider re-establishing an annual health and wellbeing event that would benefit people in the borough.

Recommendations:

(i) ***The CCG and Halton Borough Council to consider organising an annual health and wellbeing event at the stadium;***

(ii) ***Evaluation of Age UK exercise DVD "Be Strong, Be Steady" by staff and service users at Dorset Gardens, Oakmeadow, Victoria Court and Beechcroft; and***

(iii) ***If (ii) is positive, create a Halton version of an exercise DVD involving Halton residents to be widely distributed to community group/residential/nursing homes.***

5.8 Joint Review of the Falls Prevention Team and National Guidance

The main national guidance documentation for Falls Prevention is the NICE guidance "Falls: the assessment and prevention of falls in older people". The guidance contains key priorities for implementation and research recommendations. This was circulated to the topic group at the beginning of the scrutiny review and discussed throughout.

During the last meeting of the scrutiny review topic group Damian Nolan updated the topic group on the joint review of the Falls Prevention Service that is being carried out by HBC and the Clinical Commissioning Group. They are using the national guidance to review against and identify any gaps in provision. As part of this work, a revised Falls Strategy will be developed, including an implementation plan containing the recommendations.

Lisa Taylor, Health Improvement Manager, attended the Health Policy and Performance Board in January 2013 and gave a presentation about the joint review of the Falls Prevention Service.

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Conclusion
Working towards the national guidance and identifying any gaps in service in comparison to the national guidance is a positive way forward in improving the falls prevention service.

Recommendation:
(i) Keep abreast of the recommendations from the joint review of the Falls Prevention Service with a bi-annual progress report to the Health PPB.

5.9 Winter Pressures
The topic group discussed the increase in falls over the winter months and actions that could alleviate this. Gritting and the availability of grit in grit bins came up as a big issue for the borough.

Conclusion
The topic group concluded that due to the positive effect of gritting in terms of falls prevention, consideration should be given to a pooled budget with the CCG for the purchase of grit over the winter months.

Recommendation:
(i) Consideration be given to the use of a pooled budget with the CCG for the purchase of grit over the winter months.

6.0 Overall Conclusion

This scrutiny review has been both a successful and a worthwhile exercise in terms of covering all the outputs and outcomes from the initial topic brief and gaining a thorough knowledge of Falls Prevention in Halton.

It is clear from the scrutiny review that the work of the Warden Service is contributing to a reduction in admission rates to hospital as a result of a fall.

The scrutiny review identified that the quality of care someone receives if they do have a fall in Halton is very good. Service users that were consulted as part of the scrutiny review were keen to praise the work of the Falls Prevention Service and, in particular, how much the APEX exercise classes have improved their confidence and quality of life in general.

It is recognised that although the scrutiny review of Falls Prevention has been very positive, improvements could be made in certain areas. Recommendations for further improvement that have been identified from this scrutiny review have been arranged into an Action Plan at Annex 5 for ease of reference and monitoring.

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Annex 1

TOPIC BRIEF

Topic Title: Falls Prevention

Officer Lead: Damian Nolan – Divisional Manager, Intermediate Care

Planned start date: June 2012

Target PPB Meeting: March 2013

Topic Description and scope:
A review of the Falls Prevention Service to ensure that there is an effective multi agency approach to addressing the causes of falling and that the treatment and rehabilitation service in place is effective, thus ensuring that those who have fallen can continue to live healthy, safe lives with increased independence.

Why this topic was chosen:
Falls are a leading cause of mortality due to injury amongst older people aged 65 and over. They also contribute to the life expectancy gap between Halton and England. People who have been admitted to hospital following a fall are at increased risk of falling again in the next 12 months, experiencing loss of confidence and fear of falling, and of losing their independence through entering a residential care home.

The risk of falling increases with age, particularly in those 65 and over, as shown the table below.

Age Group	Risk of Falling each year
Over 65s	35%
Over 80s	45%

Between 10- 25% of these people who fall will sustain a serious injury. The table below shows the severity of injury.

Percentage of Older People	Severity of injury
22% - 60%	Suffer an injury
10% – 15%	Suffer a serious injury
2% - 6%	Suffer a fracture
0.2% - 1.5%	Suffer a hip fracture

Regardless of the outcome, falls are associated with a loss of confidence, and a subsequent restriction in physical activity which leads to a further loss of capacity and bone density. This increases the risk of another fall and also the likelihood of entering residential care

Nationally the number of people aged over 65 is due to rise by a third by 2025, which

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is associated with increased incidence of falls of 2% per year. In Halton the number of people aged 85 plus is projected to increase, and this is the most vulnerable group. *(Source : Halton Joint Strategic Needs Assessment*)

Key outputs and outcomes sought:

- Examine the effectiveness of the current pathways for assessments and appropriate interventions for those at risk of falls in Halton
- An understanding of the work undertaken by the Falls Prevention Service and the benefits their interventions can bring to those at risk.
- An understanding of the role that partner agencies have in helping prevent falls.
- Consider national best and evidenced based practice in relation to pathways for assessment and appropriate interventions for those at risk of falls.
- Consider ways to continue to make improvements to services, thus enabling Halton to reduce admission rates to Hospital as a result of a fall.
- Examine the quality of care someone receives if they do have a fall.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

A Healthy Halton

- Healthy and Active Lifestyles - Improve the future health prospects of Halton residents, particularly children, through encouraging and providing opportunities to lead healthier and physically active lifestyles.

- Good Public Health - Providing services and facilities to maintain and promote good public health and well-being.

- Intervention and Prevention - Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions.

- Maintaining Individual Independence - Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Nature of expected/desired PPB input:
Member led scrutiny review of Falls Prevention.

Preferred mode of operation:

- Review of the NICE (National Institute for Health and Clinical Excellence) guidance related to Falls Prevention and how this is applied within Halton.
- Meetings with/presentations from relevant officers within the Council/Health Services and partner agencies (including the work of the High Impact Falls Working Group) to examine current practices regarding falls prevention.
- Presentation from the Falls Prevention Service regarding the aims of their

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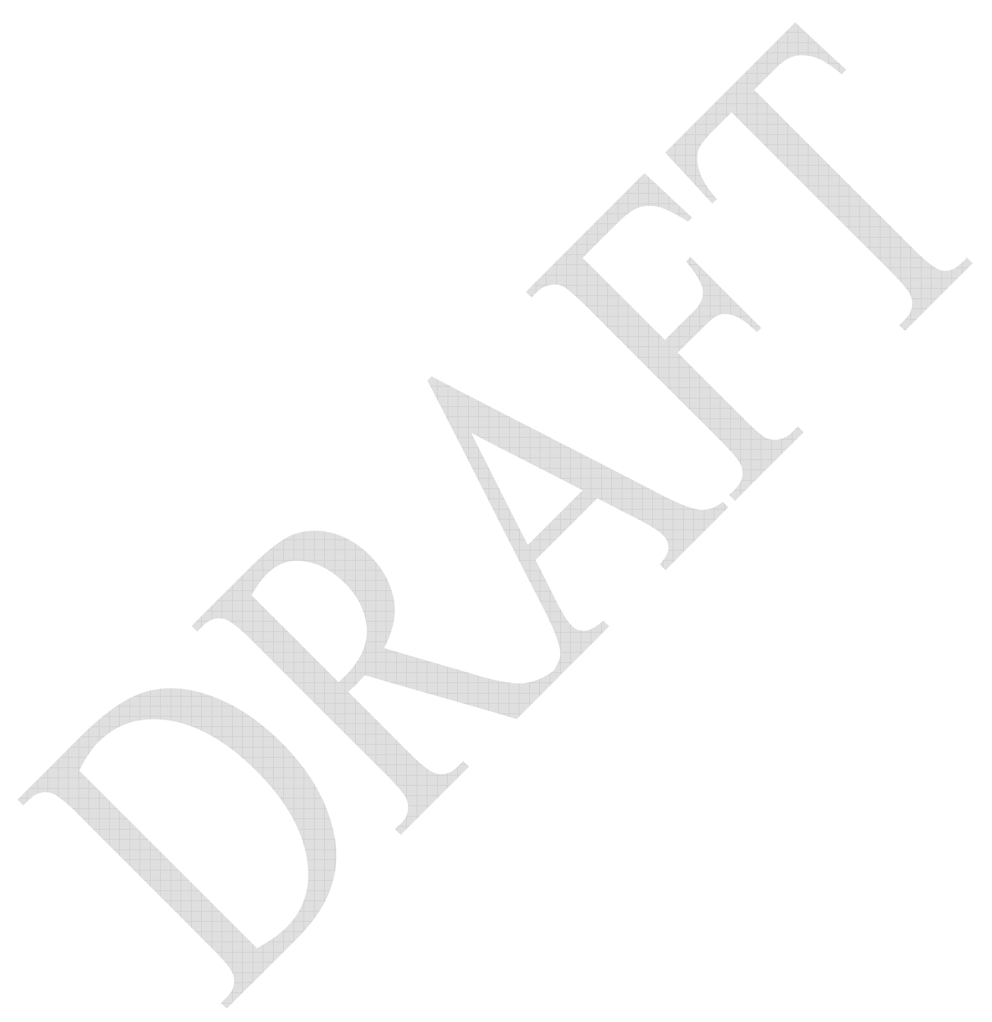
service, support/interventions they offer to those at risk.

Agreed and signed by:

PPB chair ……………………… **Officer ……………………………**

Date …………………………….. **Date ……………………………….**



Annex 2

METHODOLOGY DETAIL

a) Presentations

The following officers gave presentations as part of this scrutiny review:

Name of officer	**Title of Presentation**
Rosina Price, Nurse Specialist, Falls Prevention Team and Damian Nolan, Divisional Manager Intermediate Care	Introduction to Falls Prevention
John Coburn, Physiotherapist and Julie Reilly Physiotherapist	Physiotherapist input into the Falls Prevention Team
Chris Durr, Assistant Warden Manager and Kerry Smith, Warden	The Warden Service
Dr David Lyon, Clinical Lead, Halton Clinical Commissioning Group	
Benitta Kay, Contracts Officer, Quality Assurance Team	Contract Management of falls in care homes

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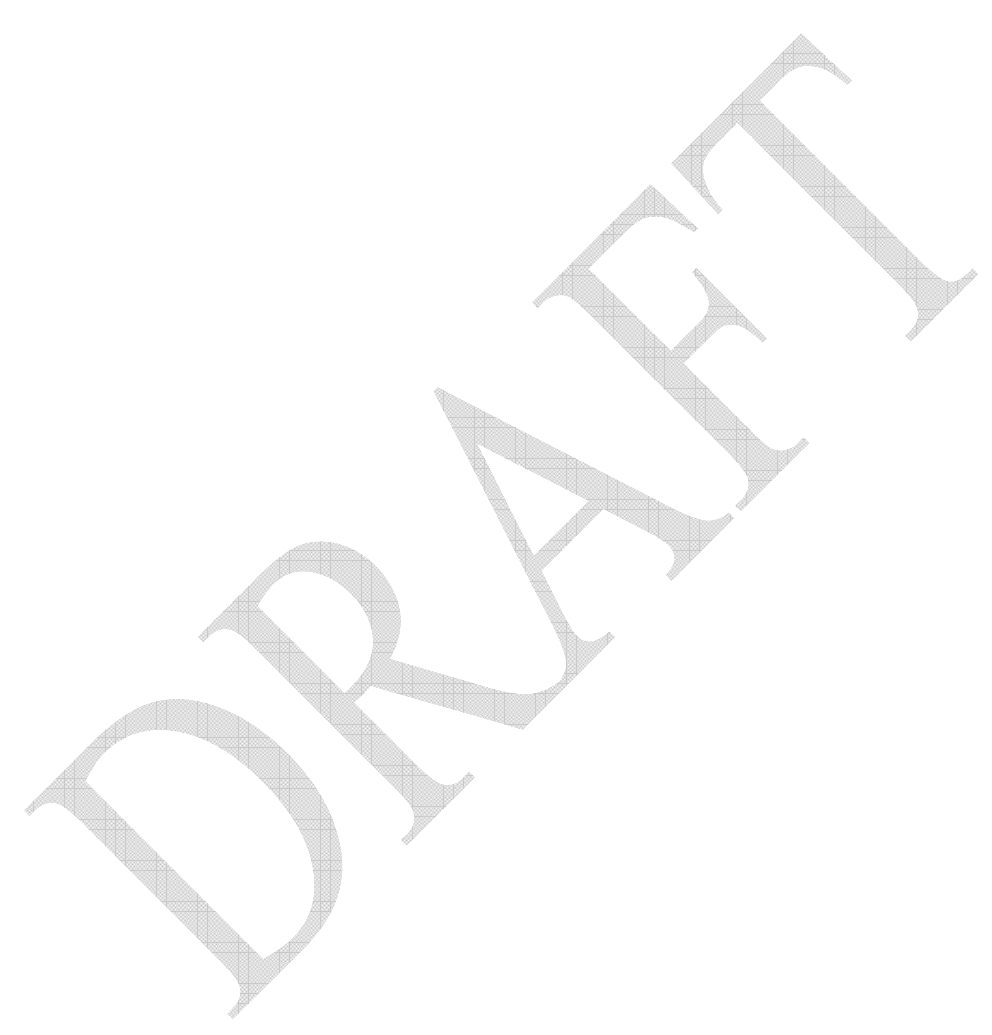
ANNEX 3

Statistics from the CCG re: admissions to hospital due to a fall

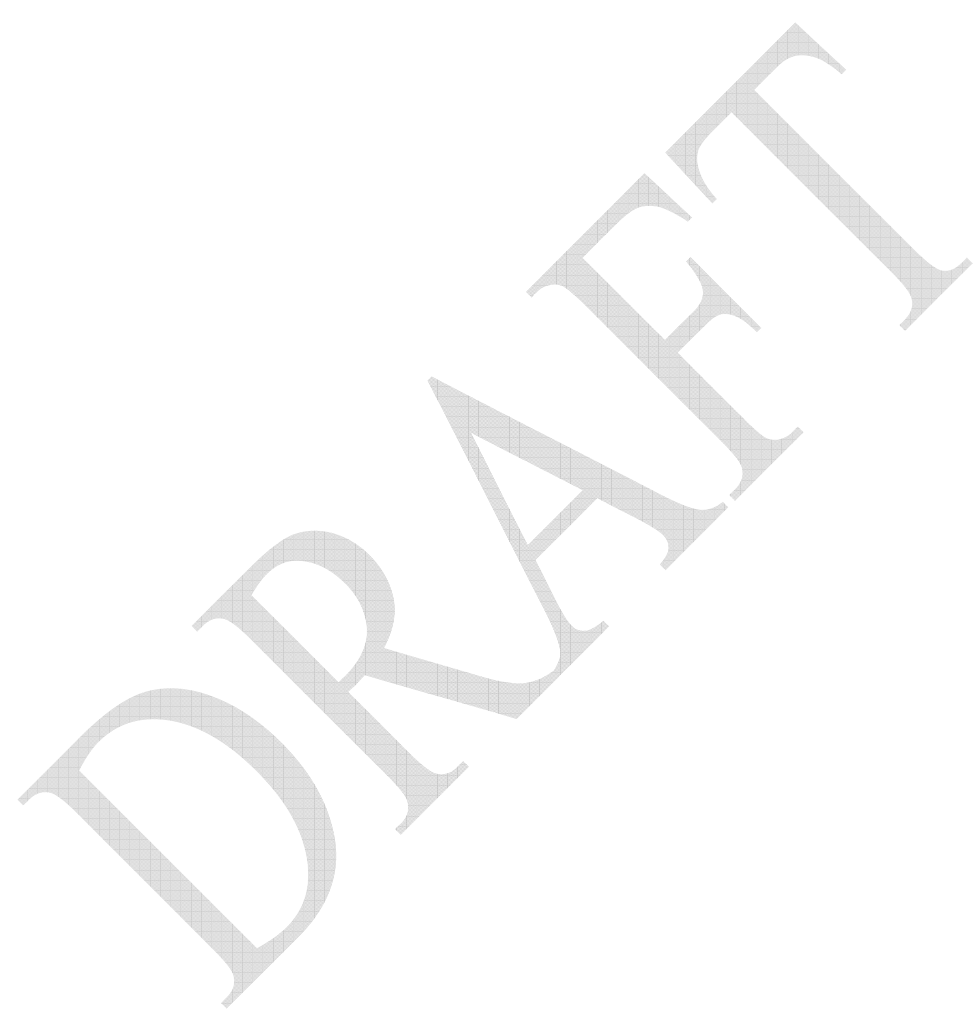
Attached as a separate Excel document



Annex 4

Documents Considered including National Best Practice

National Institute for Health and Clinical Excellence (NICE) “Falls: the assessment and prevention of falls in older people”.



FALLS PREVENTION SCRUTINY REVIEW
ACTION PLAN **ANNEX 5**

Action No.	Action	Responsible person	Timescale	Progress
1	Bone density/diet hand-outs to be made available/distributed as widely as possible.	Rosina Price, Falls Prevention Team	June 2013	
2	Leaflets or small examples of housing equipment that is available for purchase to be located at doctor's surgeries so that people know what they can expect.	Rosina Price, Falls Prevention Team	June 2013	
3	Use of the TV facilities at doctor's surgeries for use with publicity regarding Falls Prevention.	Jo O'Brien, Senior Commissioning Manager, CCG	September 2013	
4	Promote the fact that people can self-refer to the RARS team for physiotherapy.	Jackie Johnson, Principal Manager, RARS	June 2013	
5	Regular statistical reports from the CCG regarding falls related to A&E admissions and Emergency Admissions to be presented at the Health PPB under Quarterly Monitoring.	Simon Banks, CCG	Quarterly	
6	Look into a wider pooled budget as the community Warden Service contributes to a reduction in hospital admissions.	Sue Wallace-Bonner, Operational Director	September 2013	
7	Suggest that the Quality Assurance Team add an item onto their monitoring checklist for residential and nursing homes regarding the use of exercise.	Benitta Kay, Quality Assurance Team	June 2013	
8	Add access to telecare and a falls risk	Benitta Kay, Quality	June 2013	

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	assessment element to the new contract for residential/nursing homes.	Assurance Team		
9	Add a question to the questionnaire to homes regarding the Age UK exercise DVD about accessing podiatrist services.	Emma Sutton-Thompson	February 2013	Completed
10	Put together a list of podiatrists in the Halton area and distribute to homes to increase their choice.	Julie Griffiths, Service Manager, Podiatry	September 2013	
11	Topic group members to attend/observe an APEX exercise class.	Topic group members	February 2013	Representatives from the Topic Group attended the Castlefields APEX exercise class on 19th February 2013.
12	Links between the Falls Prevention team and GPs to be strengthened.	Rosina Price, Falls Prevention Team	September 2013	
13	Write out to hospitals to ask what their hospital discharge policy is and how they monitor it.	Emma Sutton-Thompson	January 2013	Received documents from St Helens and Knowsley Teaching Hospitals NHS Trust. Had discussions with Associate Director of Nursing Corporate Nursing for Warrington and Halton hospitals.
14	Consider a future scrutiny review topic to be Hospital Discharges.	Health PPB		
15	CCG and HBC to consider organising an annual health and wellbeing event at the stadium.	CCG and HBC	September 2013	
16	Evaluation of Age UK exercise DVD "Be Strong, Be Steady" by staff and service users	Damian Nolan/Emma	April/May 2013	

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	at Dorset Gardens, Oakmeadow, Victoria Court and Beechcroft.	Sutton-Thompson		
17	If Action 16 is positive, create a Halton version of an exercise DVD involving Halton residents to be widely distributed to community groups/residential/nursing homes.	Damian Nolan/Emma Sutton-Thompson	December 2013	
18	Keep abreast of the recommendations from the joint review of the Falls Prevention Service with bi-annual progress reports to the Health PPB.	Damian Nolan, Divisional Manager	Bi-annual	
19	Consideration be given to a pooled budget with the CCG for the purchase of grit over the winter months.	Sue Wallace-Bonner, Operational Director	September 2013	

A&E Attendances quarterly between 2009/10 to Q2 2012/13. Data taken from SUS A&E. Main Providers of St Helens & Knowsley and Warrington.

Criteria - Patients above the age of 65years who have had an A&E Attendance which is not a reuslt of any of the following; Road Traffic Accident, Assualt, Deliberate Self-harm, Sports Injury, Firework Injury and brough in Dead.

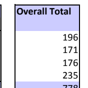
The A&E SUS data extract does not highlight patients who have specifically attended due to falls, I have highlighted below a number of diagnoses which could have resulted from a fall.

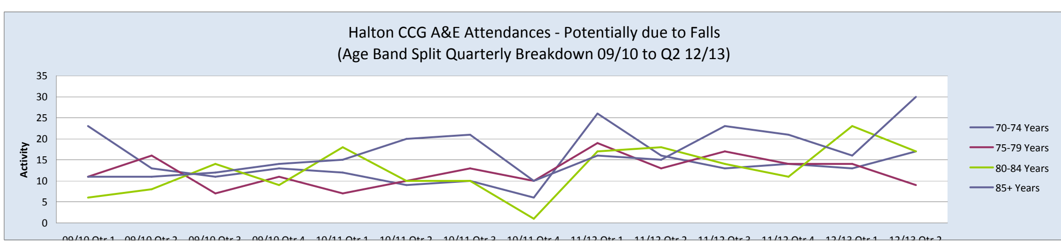
	2009/2010					2010/2011					2011/2012					2012/2013		
Diagnosis Names	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**09/10 Total**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**10/11 Total**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**11/12 Total**	**Qtr 1**	**Qtr 2**	**12/13 Sub Total**
Allergy (including anaphylaxis)	2		3	1	6	1	2			3		1	2		3	3	4	7
Bites/stings			1	1	2								2	2	4	3	2	5
Cardiac conditions			1		1	1				1								
Central Nervous System conditions (excluding strokes)				1	1													
Cerebro-vascular conditions	28	12	5	17	62	6	11	7	1	25	20	29	36	37	122	36	32	68
Contusion/abrasion											1			3	4	1		1
Dermatological conditions	3	1	3	1	8	2	2	1	2	7	1	1	2	2	6	2		2
Diabetes and other endocrinological conditions	1				1													
Diagnosis not classifiable	29	12	6	15	62	14	76	154	97	341	70	26	49	76	221	70	91	161
Dislocation/fracture/joint injury/amputation				1	1	2	2		2	6		2	5	1	8	1	1	2
ENT conditions	15	6	6	10	37	13	7	11	8	39	11	8	15	17	51	10	6	16
Facio-maxillary conditions	2	3	2	5	12	4	1			5		1		2	3	3	1	4
Foreign body	1		1		2		1			1	2		1	1	4		1	1
Gastrointestinal conditions	1	3	2	2	8		1	1	1	3			2		2			
Gynaecological conditions	2	1	1	4	8		1		1	2		1	3		4	5	1	6
Haematological conditions	8	4	10	5	27	5	3	2	1	11	5	7	4	5	21	6	2	8
Head injury													1		1	1		1
Infectious disease						1				1								
Laceration	5	5	12	9	31	10	9	12	10	41	17	16	14	11	58	11	19	30
Local infection	14	7	9	6	36	1	7	5	6	19	8	5	10	9	32	10	6	16
Muscle/tendon injury	25	24	26	23	98	33	13	17	3	66	27	14	13	18	72	19	14	33
Nerve injury				2	2		3			3	1	1		1	3	1		1
Nothing abnormal detected	6	1	4	2	13	2	6	5	7	20	6	14	7	7	34	10	14	24
Obstetric conditions												1			1	1		1
Ophthalmological conditions	1	1	5	3	10	2	1	1		4	2	2	3	1	8	5	4	9
Other vascular conditions	4	7	5	5	21	3	2	1	7	13	4	3	1	1	9	1	5	6
Psychiatric conditions		1	1	2	4	1	1	1	3	6		2	2	4	8	4	3	7
Respiratory conditions	1	1	3	2	7	2	2	1	2	7	1				1	2	1	3
Septicaemia	3		2		5	1	3	4		8	1	2	1	6	10	3	2	5
Social problem (includes chronic alcoholism and homelessness)	1				1		8	2	1	11	6	2	4	3	15	4	6	10
Soft tissue inflammation	16	17	5	10	48	4	18	15	9	46	21	20	18	15	74	18	24	42
Sprain/ligament injury	5	2	1	2	10	3	4	10	3	20	11	9	16	11	47	14	15	29
Unknown	834	943	975	965	3717	897	840	841	910	3488	950	972	965	924	3811	969	911	1880
Urological conditions (including cystitis)	24	32	24	26	106	27	31	23	15	96	31	25	26	26	108	38	22	60
Vascular injury	2				2	1	1	4		6	2		2	2	6	2	1	3
Visceral injury														1	1			
Grand Total	**1033**	**1083**	**1113**	**1120**	**4349**	**1036**	**1056**	**1118**	**1089**	**4299**	**1198**	**1164**	**1204**	**1186**	**4752**	**1253**	**1188**	**2441**

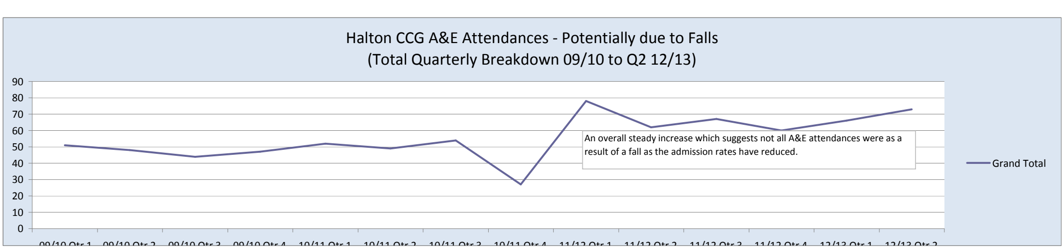
The figures below relate specifically to patients who have attended and had a diagnosis of one of the above highlighted in yellow

	2009/2010					2010/2011					2011/2012					2012/2013		
Provider	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**09/10 Total**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**10/11 Total**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**11/12 Total**	**Qtr 1**	**Qtr 2**	**12/13 Sub Total**
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	50	48	44	44	186	49	47	50	25	171	76	61	66	58	261	63	70	133
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	1			3	4	3	2	4	2	11	2	1	1	2	6	3	3	6
Grand Total	**51**	**48**	**44**	**47**	**190**	**52**	**49**	**54**	**27**	**182**	**78**	**62**	**67**	**60**	**267**	**66**	**73**	**139**

	2009/2010					2010/2011					2011/2012					2012/2013			
Age Band	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**09/10 Total**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**10/11 Total**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**11/12 Total**	**Qtr 1**	**Qtr 2**	**12/13 Sub Total**	**Overall Total**
70-74 Years	23	13	11	13	60	12	9	10	6	37	26	16	13	14	69	13	17	30	196
75-79 Years	11	16	7	11	45	7	10	13	10	40	19	13	17	14	63	14	9	23	171
80-84 Years	6	8	14	9	37	18	10	10	1	39	17	18	14	11	60	23	17	40	176
85+ Years	11	11	12	14	48	15	20	21	10	66	16	15	23	21	75	16	30	46	235
Grand Total	**51**	**48**	**44**	**47**	**190**	**52**	**49**	**54**	**27**	**182**	**78**	**62**	**67**	**60**	**267**	**66**	**73**	**139**	778





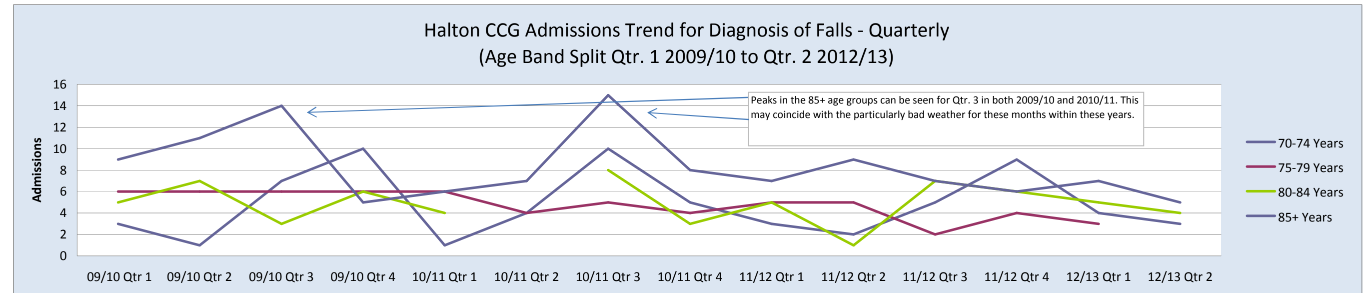


Data taken from SUS for Halton CCGs Main Providers - St Helens & Knowsley Hospital and Warrington Hospital

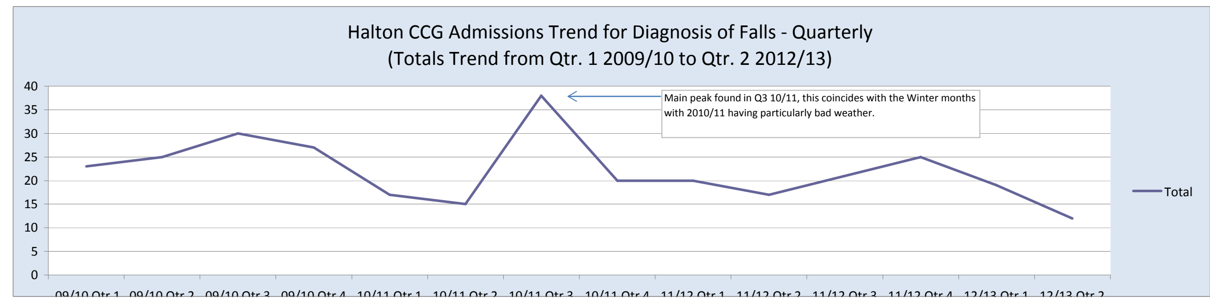
Criteria - Patients above the age of 65years who have had a Primary or Secondary Diagnosis code of Falls under the ICD-10 codes of *W00 - Falls on same Level involving Ice & Snow* and *W01 - Fall on same level from slipping, tripping and stumbling* .

	2009/2010					2010/2011					2011/2012					2012/2013		
Providers	Qtr 1	Qtr 2	Qtr 3	Qtr 4	09/10 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	10/11 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	11/12 Total	Qtr 1	Qtr 2	12/13 Sub Total
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	16	17	24	12	69	9	7	22	13	51	15	6	13	12	46	14	10	24
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	7	8	6	15	36	8	8	16	7	39	5	11	8	13	37	5	2	7
Grand Total	23	25	30	27	105	17	15	38	20	90	20	17	21	25	83	19	12	31

	2009/2010					2010/2011					2011/2012					2012/2013			Overall Total	
Age Bands	Qtr 1	Qtr 2	Qtr 3	Qtr 4	09/10 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	10/11 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	11/12 Total	Qtr 1	Qtr 2	12/13 Sub-Total		
70-74 Years	3	1	7	10	21	1	4	10	5	20	3	2	5	9	19	4	3	7	67	
75-79 Years	6	6	6	6	24	6	4	5	4	19	5	5	2	4	16	3		3	62	
80-84 Years	5	7	3	6	21	4		8	3	15	5	1	7	6	19	5	4	9	64	
85+ Years	9	11	14	5	39	6	7	15	8	36	7	9	7	6	29	7	5	12	116	*85yrs+ Group stands out as the highest admission rate for Falls.
Grand Total	23	25	30	27	105	17	15	38	20	90	20	17	21	25	83	19	12	31	309	



	2009/2010					2010/2011					2011/2012					2012/2013		
Diagnosis of Fall	Qtr 1	Qtr 2	Qtr 3	Qtr 4	09/10 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	10/11 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	11/12 Total	Qtr 1	Qtr 2	12/13 Sub-Total
Fall on same level from slipping, tripping and stumbling	23	24	26	20	93	17	15	30	19	81	20	17	19	23	79	18	12	30
Fall on same level involving ice and snow		1	4	7	12			8	1	9			2	2	4	1		1
Grand Total	23	25	30	27	105	17	15	38	20	90	20	17	21	25	83	19	12	31



	2009/2010					2010/2011					2011/2012					2012/2013			
Admission Method	Qtr 1	Qtr 2	Qtr 3	Qtr 4	09/10 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	10/11 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	11/12 Total	Qtr 1	Qtr 2	12/13 Sub-Total	
Emerg Oth		1			1	1		1	1	3									
Emerg-A/E	23	24	30	26	103	16	15	35	19	85	19	16	20	24	79	18	11	29	*Admissions via A&E are the most common and follow the overall downward trend of Admissions for falls.
Emerg-Clin								2		2						1		1	
Emerg-GP				1	1						1	1	1		3		1	1	
Other Prov														1	1				
Grand Total	23	25	30	27	105	17	15	38	20	90	20	17	21	25	83	19	12	31	

Agenda Item 7c

REPORT TO: Health Policy and Performance Board

DATE: 4 June 2013

REPORTING OFFICER: Strategic Director – Communities

PORTFOLIO: Health; Children, Young People and Families

SUBJECT: Scrutiny Topic 2013/14 : Mental Health

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with an update on the mental health scrutiny topic following the report presented to the Board on 5th March 2013.

2.0 **RECOMMENDATION: That:**

i) The focus of the mental health scrutiny review be the joint mapping of mental health prevention services across Children and Adult services; and

ii) The development of an intergenerational anti stigma campaign.

3.0 **SUPPORTING INFORMATION**

3.1 In March 2013 the Board approved the topic brief to review mental health prevention and promotion provision in Halton. Nominated members of the topic group are:

Cllr Ellen Cargill
Cllr Joan Lowe
Cllr Sandra Baker
Cllr Mark Dennett
Cllr Geoff Zygadllo
Cllr Miriam Hodge
Cllr Margaret Horabin
Cllr Pam Wallace
Cllr Geoff Logan
Cllr Kath Loftus

3.2 However discussions at that meeting examined the feasibility of establishing a joint Health / Children, Young People and Families topic group to consider mental health provision across Adult and Children's services including the development of an intergenerational campaign to address discrimination and stigma and promote mental health.

3.3 There are already significant pieces of work being undertaken, in relation to mental health, that fall outside of the proposed scope of this scrutiny review topic. These include: a full review of Child and Adolescent Mental Health Services (CAMHS) provision, development of an Acute Care Pathway for adults and development of Later Life and Memory Services (LLAMS) as part of the Dementia Strategy. The Board will be kept up to date on these developments.

3.4 It is therefore proposed that the Health PPB topic group, and representatives from the Children, Young People and Families PPB, focus activity on the mapping of mental health prevention and promotion, in addition to the development of a joint intergenerational prevention and promotion campaign.

4.0 POLICY IMPLICATIONS

4.1 The Children and Young People's Plan prioritises children and young people's emotional health and the Health and Wellbeing Board has prioritised mental health. The Clinical Commissioning Group also supports this priority.

4.2 The recommendations from the resulting scrutiny review may result in a need to review associated policies and procedures.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Emotional and mental health and wellbeing is a critical factor in supporting children and young people's social development, behaviour and resilience, educational attainment and achievement and life chances. This area of work also supports Halton's focus on Early Health and Support and the priorities within Halton's Children and Young People's Plan.

6.2 **Employment, Learning & Skills in Halton**
Good emotional and mental health and wellbeing is a vital factor in children and young peoples and adults accessing learning and future employment opportunities.

6.3 **A Healthy Halton**
Emotional and mental health services impact directly upon the

health and wellbeing of children and young people with an identified need or who are at risk of developing a need. Halton's Health and Wellbeing Board have chosen 'prevention and early detection of mental health conditions' as one of their five priorities for action during 2013-2016.

6.4 **A Safer Halton**
Those who do not experience good emotional and mental health and wellbeing are more likely to be subject to a range of risk factors that can impact negatively on community safety issues.

6.5 **Halton's Urban Renewal**
None Identified

7.0 **RISK ANALYSIS**

7.1 National and local evidence demonstrates that failure to ensure that appropriate services to support emotional and mental health and wellbeing of children and young people is likely to impact negatively on their outcomes and life chances. Failure to provide effective mental health prevention and promotion services across the life course could also result in an increase in the need for specialist services thus leading to potentially increased costs to the Council.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

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

9.1 None identified under the meaning of the Act

“Halton's Like Minds Campaign”

- Halton's own life size art exhibition of 16 stories all through the generations.
- Using local people, local stories.
- The aim: to raise awareness of mental wellbeing and help reduce the stigma surrounding mental health.

Danny from Castlefields

I first starting feeling different when I was about 13, felt sad all the time for no reason. I have good mates who I normally had a laugh with, but for some reason I could not be bothered with them anymore. I started hating school and got into loads of bother. Everything made me angry and I turned it all against my Mum.

It was only when we had a visitor into School who talked about emotions and being mentally well that I realised something was wrong. I plucked up the courage to speak to a teacher I trusted and started to talk through my feelings. She gave me loads of websites and I realised I was not alone and this kind of stuff was very common. All the best Dan!!

Anna 17 from Appleton Village

I was 16 when started to self harm after failing most of my GCSEs, I felt like I was in a bubble and cutting myself made me feel real and the bubble went away. My family didn't understand and shouted a lot, this just made it worse and I started to cut myself more often.

My friends and boyfriend thought I was attention seeking and told me I was stupid, I just could not explain my feeling because people did not understand.

The A&E department must have been sick of seeing me cause I was there all the time.

My Mum helped me into a young persons group, girls and lads all with similar stories to me. I was able to express myself and it helped so so much.

I went back to college now and studying to resit my exams, my message to anyone with a similar story,,, PLEASE TALK TO SOMEONE!

Jess 26 from Cronton

Imagine how I felt when everybody was saying how fantastic it was for me to be pregnant. It is everything I wanted but still something niggled away at me and it did not make sense. I had a lovely health baby girl, my parents and partner were over the moon. My niggle grew, for some reason I could not bond with her, everything felt alien to me. I put this down to a few baby blues, but the feeling grew. I was so guilty I could hardly look at myself in the mirror.

My health visitor innocently asked me how I was at my second visit. I could not hold it back I broke down in tears. The stigma about postnatal depression was my biggest fear, people thinking I was a rubbish Mum.

I went to a local Mum supporting Mums group, it was such a relief to here other Mums in the same situation. I did get help from my GP and I'm much better now. It was a horrible situation and I would urge any woman in the same situation to talk. Believe me you are not on your own.. Jess x

Agenda Item 7d

REPORT TO:	Health Policy and Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Francis Inquiry
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide to the Board an overview of the key findings and recommendations of the second Francis Inquiry and the actions to be delivered locally to ensure the quality and safety of health care provision for the population of Halton.

2.0 RECOMMENDATION: That the Board:

i) Note the contents of this report and the findings of the Inquiry; and

ii) Note the actions planned locally.

3.0 SUPPORTING INFORMATION

3.1 The Francis 2 High Level Enquiry (following on from the first published 2009) tells the story about the appalling suffering of many patients at the Mid Staffordshire Hospital. This was caused by a serious failure on the part of the Provider Trust Board who did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.

3.2 This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking and maintaining foundation trust status to be at the cost of delivering acceptable standards of care. The story continued as the checks and balances which should have prevented serious systemic failure of this sort including agencies, scrutiny groups, commissioners, regulators and professional bodies also failed

3.3 The report is three volumes and runs to just under 2000 pages. The findings of the inquiry when read alongside the findings of Francis One and the stories included within the report as described by the families and friends of patients involved make harrowing reading.

The findings of the inquiry whilst not a surprise as much was known in advance, outlines the following key areas:

- The culture focused on doing the system's business – not that of the patients;

- The institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;

- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;

- Too great a degree of tolerance of poor standards and of risk to patients;

- A failure of communication between the many agencies to share their knowledge of concerns;

- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;

- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;

- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;

- Ensure openness, transparency and candour throughout the system about matters of concern;

- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;

- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;

- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;

- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;

- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

3.4 All NHS Provider Trusts are now required review this High level Enquiry and assess and have an action plan in place for monitoring by the Governance Committee on behalf of the Board of Directors. This is a requirement within the Quality Contract for 13/14 for submission to the Commissioners during early 2013.

3.5 The report outlines nine areas of action for commissioners:

Commissioning Impact

- The report requires that commissioning organisations in healthcare should consider the findings and recommendations and that they should announce the extent to which they accept the recommendations and how they will implement them (reporting on a regular basis). The report suggests that the health select committee should receive regular updates on actions to deliver all recommendations.

Culture

The reports outlines the need to ensure a common culture made real throughout the system – an integrated hierarchy of standards of service

- Fundamental standards of minimum quality and safety- where non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations
- Enhanced quality standards- such standards are higher than fundamental standards. The NHS commissioning board together with CCGS should devise enhanced quality standards designed to drive improvement. Failure to comply should require performance management by commissioners rather than the regulator.
- Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness, these are implemented by commissioners and progressive providers

Responsibility for, and effectiveness of healthcare standards

- A co-ordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in real time

Effective Complaints handling

- Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and the outcomes on as near a real time basis as possible

Commissioning for Standards

- GPs must have continuing partnership with their patients. They have a responsibility to all their patients to keep themselves informed of the standards of service available at various providers in order to make patient choice a reality.
- Consider whether commissioners should be given responsibility for commissioning patient advocates and support services for complaints against providers.
- Commissioners should wherever possible apply a safety and quality standard in respect of each item of service it is commissioning and agree a method of measuring compliance and redress for non-compliance, including powers of intervention where substandard or unsafe service are being provided
- Commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards.
- THE NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure information conveyed is both candid and comprehensive.
- Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist

clinical advice and procurement expertise.
- Commissioners need to have close engagement with patients (via membership forums, patient representatives etc.) to ensure fundamental safety and quality standards are maintained.
- Commissioners- not providers- should decide what they want to be provided, in consultation with clinicians both from potential providers and elsewhere.
- Commissioners wherever possible need to identify and make available alternative sources of provisions.
- Commissioners must have the capacity to monitor performance of every commissioning contract on a continuing basis during the contract
- Commissioners should be entitled to intervene in the management of an individual compliant on behalf of the patient where it appears to them it is not being dealt with satisfactorily.
- NHSCB and local commissioners must ensure proper scrutiny of commissioned provider services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.

Performance management and strategic oversight
- The NHS Commissioning Board (through regional offices) should support the development of metrics on quality and outcomes of care for use by commissioners in managing performance of providers.

Openness, transparency and candour
- There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner. The care quality commission's duties should be supported by monitoring undertaken by local commissioners.

Nursing
- All commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non- executive directors.

Information
- Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations. These accounts should be lodge with and contain observations of commissioners.

3.6 The Government produced its response to Francis Two in March 2013 –Patients First and Foremost, in which it states that the NHS is there to serve patients and must therefore put the needs, the voice and the choice of patients ahead of all other considerations. The response outlines actions in five key areas:

- Preventing problems – consistent culture of compassionate care including Chief Inspector of Hospitals role, transparency and excellence in leadership, consequences for failure and clear accountability. Time to care and safety in the DNA of the NHS delivering the safety review by Professor Don Berwick.
- Detecting problems quickly –data systems, early warnings, outcomes for all services, ratings, expert inspection, duty of candour, ban on clauses to prevent public interest disclosures and a complaints review
- Taking action promptly –fundamental standards, regime for failure (quality as well as

finance)
- Ensuring robust accountability professional regulation, health and safety executive to use sanctions, barring failed managers in the NHS and clear responsibilities for tackling failure
- Ensuring staff are trained and motivated – revalidation for nurses, code of conduct and minimum training for health care assistants barring system for health care assistants, attracting professional and external leaders to senior management roles.

Actions for Commissioners

3.7 To ensure the full implementation of all areas of the inquiry recommendations, NHS Halton Clinical Commissioning Group has/will:

- Included within the contract requirements the submissions of review and action plan for the Francis inquiry report including a commitment to the Duty of Candour.
- Included within the contract quality metric (CQUIN) in relation to time to care, nursing/Care assistant training, clinical leadership and organisational culture.
- Will receive and review outcomes including delivery of actions required of internal reviews and respond appropriately.
- Develop and maintain a process to ensure cost improvement programmes within providers are reviewed and impact assessed for any potential impact on quality and safety.
- Develop and maintain process for GPs and others including members of the public to raise concerns regarding the quality of care and ensure these are investigated and acted upon.
- Develop and maintain a robust early warning system for care quality across all providers and ensure any issues are acted upon effectively.
- Be an active member of the Quality Surveillance Group locally to ensure early warnings of issues in local providers are identified and managed.
- Work with providers in a supportive way to support continuous improvements and developments in quality whilst ensuring any issues are monitored and managed effectively.
- Ensure open, regular and robust reporting of performance of providers locally and ensure local people are engaged in these processes for reporting.

4.0 POLICY IMPLICATIONS

4.1 None identified

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The quality of Health care provision impacts directly on the life expectation and potential for independence of people post periods of ill health. It is important to note that health care is not just delivered in hospitals but is also delivered in people's homes, in care homes, in nursing homes and in community services. All of these services need to be delivered to a high level of quality. It is essential that as we commissioner care in an integrated way we develop further our processes to ensure quality across all care provision and work together to ensure the safe and effective provision of care for all locally.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified

6.2 **Employment, Learning & Skills in Halton**
None identified

6.3 **A Healthy Halton**
Safe and effective health care provision is essential to the on-going delivery of healthy Halton. It is essential that the services commissioned deliver high quality safe and effective care. The people of Halton have many health and other challenges the quality of the health care they receive when they are their most vulnerable must not add to these challenges and therefore it is incumbent on us as commissioners to ensure that all providers are delivering the highest quality of care to the people of Halton.

6.4 **A Safer Halton**
None identified

6.5 **Halton's Urban Renewal**
None identified.

7.0 RISK ANALYSIS

7.1 Health care by its nature is risky, care is provided across a large number of organisations and venues and can provide both complex and difficult to manage. The greatest areas of risk at this time in health care relate to managing the complexity of service provision, including the changing landscape of providers, the complexity of care need and the need to manage the cost of care provision. It is essential therefore that impact assessments in any developmental or cost reduction areas are carried out effectively.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 All service must be delivered in line with the requirements of Equality and Diversity legislation and these requirements are monitoring and measured through the contracting process for all NHS providers

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972
None under the meaning of the Act.

Agenda Item 7e

REPORT TO:	Health Policy & Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Draft Adult Social Care Annual Report 2012/13
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with the Draft Adult Social Care Annual Report 2012/13 for approval.

2.0 **RECOMMENDATION: That: The Board comment on the draft Adult Social Care Annual Report 2012/13 at Appendix 1.**

3.0 **SUPPORTING INFORMATION**

3.1 This is the second Adult Social Care Annual Report that the Directorate has produced since they were introduced in 2011. Although not a mandatory requirement, the Association of Directors of Adult Social Services (ADASS) supports Council's producing annual reports as good practice.

3.2 An initial framework was developed for the content of the Annual Report using the Adult Social Care Outcomes Framework (ASCOF) domains. Managers were asked to provide detail of progress and achievements in these areas during 2012/13, written with the audience being the general public.

3.3 The draft will be shared with Service Users and Carers by Commissioning Managers through community groups such as Halton Speak Out, Halton Disability Partnership, Healthwatch, Halton Open, etc., to enable their views and comments to be considered.

3.4 The final draft will be formatted by Communications and Marketing at the beginning of June, and publication of the Annual Report will be during July.

3.5 Performance information is limited until adult social care annual returns have been completed towards the end of May, so this information will be added at that time.

4.0 **POLICY IMPLICATIONS**

4.1 The Towards Excellence in Adult Social Care (TEASC) national programme board has outlined that one of the key principles of sector-led improvement is "that stronger accountability through increased transparency drives further improvement. One of the key challenges to this is finding meaningful ways of reporting back to citizens and consumers about performance locally".

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The Local Account is to be published as a Web-accessible document on the Halton Borough Council website. Publicity associated with publishing on the web is presented in the Communications Plan in Appendix 2.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
N/A

6.2 **Employment, Learning & Skills in Halton**
N/A

6.3 **A Healthy Halton**

N/A

6.4 **A Safer Halton**
N/A

6.5 **Halton's Urban Renewal**
N/A

7.0 **RISK ANALYSIS**

7.1 Failure to produce a Local Account for Halton may be perceived negatively by ADASS in terms of sharing learning and best practice. However, Councils are no longer mandated by Government and are able to exercise local discretion regarding how and when the Local Account is published.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The Local Account meets Council requirements in association with the local equality and diversity policy.

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

None under the Meaning of the Act.

Halton Borough Council

Adult Social Care Annual Report 2012/13

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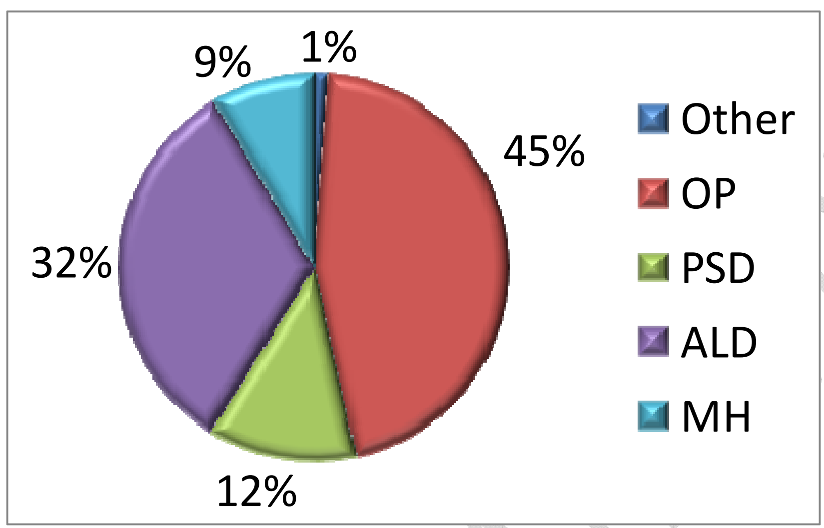
CONSULTATION DRAFT

Foreword

Welcome to the second annual report on Halton's adult social care services. Councils who provide social services must publish an annual "Local Account". Here we let local people know about our services and the progress we have made in delivering quality adult social care and support since the previous report.

In this year the Council budget on adult social care and support is £????. We want to make sure the money helps to improve people's quality of life, provides value for money and that choice and control for local people is at the heart of all we do.

% Split of Net Expenditure per Client Group



CONSULTATION DRAFT

As with all councils, there are many challenges ahead as we focus upon improving quality we also need to be efficient. In recognising this, the council will:

- Make sure people are able to access safe, efficient and good quality care;
- Make services more efficient to minimise the impact of reduced budgets;
- Empower people who use services to become independent and not dependent on care services; and
- Make sure our services are better integrated with health and that we make the right connections with housing, leisure, transport and skills.

Vision

At Halton Borough Council, we have a responsibility to support, care for and protect the most vulnerable people in the community, as well as providing information and support to the residents of Halton. Halton's vision for Adult Social Care is: "To promote effective, affordable, quality services that are accessible, equitable, timely and responsive and to enable individuals and groups in Halton to make informed choices."

Councillor Marie Wright
Health and Adults Portfolio Holder

Introduction

As in previous years there continues to be increasing challenges facing Adult Social Care due to the limited and reducing resources available, at the same time as changes in the makeup of the local community increase the need in certain areas, for example an aging population.

This year, these challenges have been set against a backdrop of some of the most major changes seen in Local Government and NHS organisation for a number of years.

2012/13 saw the implementation of some new major legislation, the Health and Social Care Act, which will see the transfer of Public Health over to the Local Authority with effect from 1st April 2013 and the establishment of Clinical Commissioning Groups (CCG).

Within Halton, the NHS Halton CCG is clinically-led by GPs and other healthcare professionals which has been formed and built on a membership model, drawn from the 17 general practices located within Halton, with the aim of ensuring high quality and cost-effective services.

From April 2013, Local Authorities have a new duty to promote the health of their population, supported by the local Health and Wellbeing Board to ensure a community-wide approach to promoting and protecting the public's health and well-being. Adult Social Care Services are playing an essential role in supporting the Health and Wellbeing Board achieve the five strategies priorities set out in its first Health and Wellbeing Strategy. The priorities being action on cancer, child development, falls, alcohol and mental health.

For example if we look at falls which is the leading cause of mortality due to injury amongst older people over 65 and are a major contributing factor to the life expectancy gap between Halton and the rest of England, Adult Social Care Services are leading on the work taking place to review the Falls Prevention Pathway and develop an associated Falls Strategy to help reduce the number of people in Halton experiencing falls.

In addition to the above organisational changes, the publication of the 'Caring for our Future' White Paper and associated draft Care and Support Bill will see some fundamental changes in how Adult Social Care Services are commissioned and delivered in the future. Residents of Halton can be assured that the Local Authority in partnership with our colleagues in the CCG etc. are in a strong position to effectively respond to these changes.

Undertaking the challenges ahead and the need to continually improve our services requires the continuing dedication and enthusiasm of staff, together with the Council's commitment to recruit, retain and train staff who are able to meet the challenges of the future and much of our work over the next 12 months will focus on responding to these changes.

The Council recognises that the success of its business is based upon the knowledge, expertise and commitment of its workforce and as such have developed a People Plan looking at four main areas: Attract, Develop and Retain Excellent People; Excellence in Leadership and Management Development; being an Excellent employer; and Promoting Organisational Excellence.

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In Adult Social Care Services all professional staff require to be registered with the appropriate body, for example, all social workers are registered with the Health and Care Professions Council. This ensures that they meet certain standards for their training, professional skills and behaviour.

The implementation of the Social Work Reform Board will also raise standards across the social work workforce and put social workers on a more professional footing, in line with other professions, such as teachers.

Unlike the first Adult Social Care report which mainly focused on a description of services delivered and some related performance information, this report provides details of the areas which we have focused our activity on over the last 12 months and gives some real examples of some of the improvements we have made to our services, which have made a real difference to people lives.

We have divided the information in this report into four themes, which will help you see how we are performing.

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Dwayne Johnson

Strategic Director, Communities

Enhancing the Quality of Life for People with Care Needs

Social Workers

We have changed our social work teams to make it easier for people to access services or to be signposted quicker to other services that are more appropriate. This involved creating a team that acts as an Initial Assessment Team (IAT) which is responsible for all referral, screening, signposting and initial assessments. We also have two operational teams dealing with complex work, (one in Widnes and one in Runcorn). The service is also open to those people who self-fund their support.

Once you are in touch with us, Self-Directed Support is a way for people who are eligible for funding from social services to get the support they need, to be part of their community and to stay safe, healthy and independent for longer. Following a social care assessment you will be told how much is available to meet your eligible support needs. You can have a Personal Budget if you have been assessed by a Social Worker as needing support to help you to live independently.

You can tell us in a Support Plan how you wish to spend the money to meet your needs. You can have help to put together your Support Plan if you wish. Once your Support Plan is completed the Social Worker will check that the choices you have made about spending the money will meet your support needs and make sure you will be safe and well. Finally, you spend or ask us, on your behalf, to spend the money in ways that you feel best meets your needs. One of the ways money can be paid to you is via a Direct Payment and the Government are promoting this method. You are in control as long as you spend the money in the ways you have stated in your Support Plan. We'll check with you from time to time to make sure that you are living your life in a way that suits you and is meeting your needs.

3976 people received self-directed support in 2012/13, an increase of approximately 43% on the previous year.

We are also developing an online 'Care and Support for You' portal. This is a website where you can easily find lots of information about Adult Social Care Support and Services to help you get on with your life and keep your independence. 'Care and Support for You' delivers information and advice, signposting you to the relevant information, and towards enabling self-assessment and self-directed support. The portal has now gone LIVE with information about over 3,000 organisations now available in the public domain. 'Care and Support for You' is also being used by our care management teams to signpost citizens to the relevant information required.

The Resource directory of 'Care and Support Services,' encompasses both care and support in a broader sense. It incorporates a person's environment, housing, family, social and educational opportunities as well as their physical and mental health. As such, it is an attempt to put together a resource that will be regularly updated. The aim is to enable people to see for themselves what services are available in Halton for their specific needs and interests. Armed with such information they can contact the appropriate services directly, having first looked at their website or contacted them for further assistance and guidance.

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Blue Badge

The Blue Badge Scheme provides a National Arrangement of parking concessions for some people with disabilities who travel either as drivers or passengers. The Scheme allows badge holders to park close to their destination without charge or time limit in the on-street parking environment, and for up to three hours on yellow lines, unless a loading ban is in place.

As a result of a National Strategy Review the local Blue Badge Policy has been updated. The main changes are outlined below:

- Personal Independence Payments (PIP) will begin to be introduced for people who are aged 16 to 64 from 8 April 2013;
- From October 2013 onwards PIP will begin to replace Disability Living Allowance (DLA) from existing DLA recipients aged between 16 and 64.

This will affect people who are applying for a Blue Badge without further assessment as those individuals who are currently in receipt of DLA Higher Mobility Component have been automatically eligible for a Blue Badge. It has been decided that when DLA is replaced by PIP there should still be a link, that means that those people who score 8 points or more in the 'moving around' activity of PIP will be automatically eligible for a Blue Badge. This means that future eligibility for a Blue Badge will be as similar to the current eligibility criteria for the scheme as possible.

Local GP's no longer undertake the Mobility Assessments for applications needing medical assessments; this is now undertaken by Halton Borough Council's Initial Assessment Team and Complex Care Teams.

Halton Borough Council now levies a charge of £10 per badge application. This increase was has had to be applied in response to the new costs incurred through the new Blue Badge Improvement Scheme.

Homelessness

Halton Borough Council has a statutory duty to ensure that advice and information regarding homelessness is readily available to everyone within the borough. Ideally every person at risk of homelessness will be offered a full interview to help them deal with their situation.

The Council is developing the Homelessness Strategy Review and Action Plan 2013 - 2017, looking at ways to reduce and prevent homelessness and improve service delivery. Consultation with all partner agencies is underway and all views and comments will form part of the agreed final Action Plan.

During the past twelve months a number of changes have been made to the service which resulted in the following improvements for people using the service:

- Timely intervention and assistance with rent and mortgage arrears;
- Timely referral for Debt Management advice;
- Increased Family Mediation;

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- Improved referral routes to Specialist Services, including Substance Misuse and Mental Health;
- Increased housing provision within the Private Rented Sector;
- Increased advice in respect to tenancy rights and responsibilities in both social and private housing sectors; and
- Increased advice in respect to illegal eviction and disrepair issues.

Halton has recently seen a gradual increase in homelessness which is in common with other local authorities within the region. The welfare reform and present economic climate is considered contributable towards the gradual increase in homelessness.

The Mortgage Rescue officer works closely with homeowners and tenants, offering advice and assistance and direct liaison and negotiation with lenders to agree revised repayment agreements and reduced mortgage payments, which enable clients to remain within their homes.

Mortgage Rescue Support (MRS) has proven successful in a number of cases. However, due to the financial economy and the present housing market there continues to be demand from people under threat of repossession. The following table indicates the level of activity and outcomes of the work undertaken by the Housing Solutions Mortgage Rescue Officer:

ACTION	2011 / 2012	2012 / 2013
Advice for homeowners	73	168
Homeless Prevention	56	82
MRS Successful Cases	11	49
MRS Successful Buy Back Option	0	2
Debt Advice referrals (Shelter National Homelessness Advice Service and Citizens Advice Bureau)	43	56

Homelessness Case Study

Client A approached the Council for assistance with their homeless situation. Because of deteriorating health, they were unable to work and could not maintain the payments on their mortgage and secured loan. A referral was made to the Mortgage Debt Advice Service provided by the National Homelessness Advice Service who worked with Client A to ensure they were receiving all of the benefits they were entitled to and to determine the family's affordability of the property.

It was determined that the family could afford the mortgage payments, so an agreement was reached with their lender for them to pay their mortgage, plus a monthly contribution towards the arrears. The lender agreed to postpone all eviction action as long as this arrangement continued.

The family was not financially able to keep paying their secured loan, so it was decided that a full and final offer was to be made to the lender from the Mortgage Repossession Fund. This was accepted and their account was cleared in full. The client and family were able to remain in the property and the mortgage is still continuing successfully to date.

Extra Care Housing

Extra care housing is a type of sheltered housing that can offer care to support independent living whilst providing support and packages of care designed to meet individual needs. It can be ideal for

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people who are less able to manage on their own or people who are still active but want the security of knowing there are people there to help if needed.

Extra care housing offers care and support that is flexible and designed around an individual, it can also adapt with a person so as needs change so does the care and support that is offered. Extra care offers an alternative for those people who feel their existing accommodation is no longer meeting their needs or are feeling lonely or isolated.

The numbers of older people are increasing as a percentage of the local population and the Council has prioritised the development of Extra Care schemes to provide a greater choice of housing for people in their retirement. This has culminated in the opening of a brand new scheme in 2012. Naughton Fields on Liverpool Road, Widnes, opened in November 2012 and has 47 rooms, some available to buy and some for rent. This scheme now complements the existing scheme in Runcorn, Dorset Gardens and offers an exciting housing option for older people in the borough.

Transition

Transition is the process of change from being a young person to being an adult. This is a time of great change and opportunity for all young people, but it can also be a difficult time, particularly for young people who have social and health care needs arising from sensory and physical disabilities, long-term conditions, learning disabilities or mental health problems. Within Halton the process begins when children are 14 years of age and continues beyond the young person's 18th birthday.

The young person and their carer are central to the transition planning and are kept fully informed and involved in the planning process. The transition process aims to build on the strengths of young people as they become adults, promoting self-esteem, self-confidence, independence and choice, through personalisation and support planning. Young people and their families/carers work with services to identify their needs and plan for their future. They are given information about services and the processes involved to ensure that young people and families/carers have realistic expectations of adult services. A multi-agency approach is taken across adult health and social care teams who work closely with colleagues from children's services (Education, Social and Health Care) including the young person and families/carers to ensure a trouble free transition across services.

On the 28th February 2013, Halton Borough Council held a Transition event at the Stobart Stadium with information stalls and guest speakers aimed at providing Young People and their families/carers with relevant information, advice and future planning options.

Day Services and Employment Services

Halton Community Services provides meaningful daytime community opportunities across the borough for adults with disabilities and operates in two areas; Employment and Volunteering and Health and Wellbeing. The aim is to develop ground breaking employment/volunteering initiatives so that people with a disability can learn the ethics of work and gain valuable employment skills in order to compete for jobs with the non-disabled community and to break the cycle of benefit dependency.

Examples of these innovative approaches include Altered Images hairdressing salon based in the High Street in Runcorn. This initiative is the first of its type in the country and has built up a strong customer base who recognise the value of the salon by giving trainee stylists (adults with a learning disability) a community profile.

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Currently there are 168 adults with a learning disability enjoying multiple work experience opportunities in the business area of the service either as trainee stylists, brewers, catering assistants or customer care assistants.

For people with more complex disabilities, the team have developed a small chicken farm, which provides eggs to the service's catering outlets. Some 6 to 8 people with profound and multiple learning disabilities and those on the autistic spectrum whose behaviour challenges, have benefited from being involved in chicken husbandry it has had a positive effect on their wellbeing as they are engaged in meaningful activities linked to the services businesses.

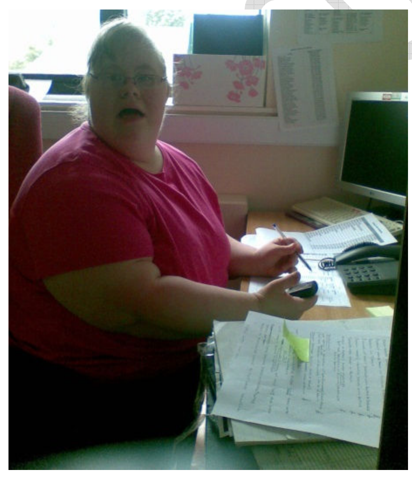
Country Garden Kitchens is supplied with fresh organic fruit and vegetables from the Mylers Meadow Market Garden mini business, which provides ten people with learning disabilities, permitted earnings. Cup Cake Caterers, managed by people with physical disabilities, including those recovering from brain injury and stroke, creates homemade cakes and confections, which are sold at the services catering outlets thus providing another.

Opportunities in Halton Community Services include a catering business, which serves up to 60,000 people annually, three cafes, tea room, ice-cream making parlour, cupcake caterers &market garden, all created and staffed by day care staff and its service users. The diversity of placements is a factor that we feel make our programme special. Our approach to the world of employment has shown that it is possible to start small, choosing businesses appropriate to the local conditions and market. The catering business began as a two day project in which one member of staff took five people with a learning disability and supported them to prepare, cook serve and clean.

85% of adults with a learning disability live in the own home or with family.

Roberta's Story

Hello my name is Roberta and I would like to share with you my Story accessing Halton Community Services.



When I left school I went to Astmoor day centre like most people did in those days nearly all of my activities was centre based, Astmoor closed down in 2006 and we all moved into community venues so we could get more opportunities to be involved in community life.

I liked being in the community venues but I was a bit bored in some places that I went to and would quite often prefer to look through catalogues. I suppose you could say that I was difficult to motivate but then what was on offer at the time was not what I liked to do.

That all changed in 2010 as I got my first work placement one day a week as a clerical assistant based in the office at Bredon, my key tasks are to answer the phone, typing, photo copying, taking the register and passing on information to the duty senior. I have also got my own email address; I can send messages to the staff.

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I work as a team at Bredon with other clerical's who guide me, I like being given responsibilities, makes me feel important plus I was travel trained by the service so that means I make my own way there on public transport, sometimes I pop into the local shop on way there and buy my lunch just like other people do.

Equality and Human Rights Commission - Close to Home: An Inquiry into Older People and Human Rights in Home Care

As a result of wanting to find out whether the human rights of older people wanting or receiving care in their own homes were being fully promoted and protected, the Equality and Human Rights Commission undertook a systematic inquiry into the issue and the results of the inquiry were published in November 2011.

The inquiry concluded that of the 500,000 older people who receive essential care in their own home paid for by their local authority, for far too many, this care, delivered behind closed doors was not supporting the dignity, autonomy and family life which their human rights should guarantee. The inquiry concluded that bare compliance with the Human Rights Act was not enough; public authorities also needed to have 'positive obligations', to promote and protect human rights.

Like many other Local Authorities, Halton Borough Council contributed to the inquiry and were highlighted within the Commission's report as having best practice within the area of promoting and protecting human rights and dignity, for example via use of the 'Dignity Challenge' approach.

However, the Council felt that we could do even more and therefore a number of developments were undertaken which included the:-

- Introduction of the 'Help Us, Help You' approach which helps to make raising concerns or complaints easier;
- Setting up the Integrated Adult Safeguarding Unit; and
- Introduction of a training programme for elected members.

Mental Health

Mental Health has been identified as a key priority for the new Health and Wellbeing Board and a new Public Mental Health Strategy has been developed, with a strong emphasis on prevention and intervention in mental health issues at a much earlier stage in a person's condition, supporting them to regain good mental health as quickly as possible.

A new Mental Health Strategic Commissioning and Partnership Board has been developed with membership from all key partners. The aim of this group is to build on the achievements that came about locally through the delivery of the National Service Framework for Mental Health, and ensure delivery of the new national policy guidance, No Health Without Mental Health.

In Halton, services for people with the most complex mental health needs are provided by the 5Boroughs Partnership NHS Foundation Trust. Social workers are a full part of the services provided from within the 5Boroughs and play a key role in delivering personalised care and support. In the past 12 months, there has been a significant redesign of the way the 5Boroughs provide their services, with a shift in focus to treating more people in the community and a greater emphasis on helping people achieve recovery.

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Reducing the need for Care and Support

Sure Start to Later Life

Sure Start to Later Life began in July 2007 and consists of Information Officers who can help older residents of Halton access the information they need, when they need it and make referrals to other services if need be. The team delivers a personalised individual approach and can carry out assessments in the person's own home or over the phone if they prefer.

We want to help people to achieve their desired goals, whether that be maintaining or regaining independence, improve health and well-being, making new friends and getting out more, learning new skills, remaining in their own home or preventing the feeling of isolation and loneliness.

We have volunteers who support people in their own homes – befriending or helping a person get out and about. There are also volunteer roles to help people access information technology from first steps to IT, introducing people to the Internet or to supporting the person to an IT course.

In the last 12 months, approximately 1296 hours of volunteer support has been provided to those most in need.

The newest part of t***he Sure Start to Later Life Service*** is the Day-Trippers. The aim is to reach people in the community who would not normally have the opportunity to go out on trips or for meals to a place that is accessible and suitable to their needs.

Anyone can join the Day-Trippers and all pay the same fee. Transport is provided by Halton community transport and is door to door. There are now nearly 200 residents of Halton, including carers and family, on the Day-Trippers group, and it continues to grow.

Most recently the group has won the Asda "Chosen by you, given by us" which is part of the Community Life Programme Asda run to support community groups. The group were awarded a £200 grant.

Prevention Agenda – Windmill Hill (Case Study)

As part of Halton Borough Council's drive to increase older people's involvement, a project has been set up with the Windmill Hill Drop In club. This is a group of older people who live on the Windmill Hill estate in Runcorn. The estate is one of the most deprived in Halton.

A one day workshop was facilitated by a council officer and was entitled "What would it take to make Windmill Hill a better place to grow older in?" The group looked at what the current reality about the area was. This included what they were proud of about the area, what their concerns were and what opportunities were open to the estate. The group then presented their "dream" for the area. The afternoon was spent putting together an action plan to try and bring the current reality of the estate nearer to their dream for the area. Officers of the council are currently working with the group to try and complete the actions from the plan. Future projects will be facilitated in all areas of the borough. Some of the comments are below:

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Proud Of	Fears	Hopes	Action
Living in Windmill Hill	Being trapped indoors	A community centre	Explore "Big Lottery" funding
Friendships made	Path surfacing	More transport	Investigate funding for transport
Environment (woods, canal)	Lack of transport for getting out and about	Gritting boxes	Look into Community Car Scheme
Access to local landmarks	Hills – walking up and down in bad weather	Funding to make improvements	Social enterprise ideas/activity
Safe area	Younger and older people being involved	Improved health centre	Check out podiatry service in area

Falls Prevention Team

People who are at risk of falling will often benefit from information, advice and services that improve their general health and well-being including reviewing medication, healthy eating, exercise, getting out and about and looking at their home environment. Halton has an established group of professionals within the falls prevention service. These include nurses, physiotherapists, occupational therapists, podiatrist, health trainers and exercise specialists. Working with other community, health and social care teams the service develops individual plans of support, exercise and treatment to help reduce the risk of falling.

During 2013 Halton Borough Council and NHS Halton Clinical Commissioning Group have been reviewing how we commission and provide services within the Borough, with the aim to further reduce the risk of falls. This work has been undertaken with the Royal Society for the Prevention of Accidents and will support the development of a new falls strategy for the Borough and ensure that existing services continue to improve outcomes for people who are at risk of falling.

Halton Community Alarm Service

The service provides an emergency response system 24/7 365 days of the year. When activated contact is made and if necessary triggers a visit from the Community Wardens.

The service can provide and fit equipment which enables people to summon help, environmental sensors to monitor for fire, flood, fluctuations in temperature and monitoring sensors to pick up falls or failure to go to bed.

Halton Community Alarm Service provides reassurance to family and friends whilst maintaining a person's independence in their own home. Last year the service answered 92,410 calls of which 99.48% of the calls were answered within 60 seconds.

Case Study

Betty is 96 and lives at home in her bungalow. Betty has limited mobility with a slight impairment. Betty suffered a fall and was admitted to hospital and then moved on to a rehabilitation unit. After a period of rehabilitation Betty wanted to go home but her family were concerned for her safety. Betty has already got a community alarm in place but does not always use her pendant when she requires assistance. Betty returned home and additional automated sensors were installed which would activate if Betty did not press her pendant alarm following a fall. Betty did suffer a fall and did not press her alarm. The automated sensors detected the fall and raised a call to the contact centre. Community Wardens were dispatched and Betty was taken to hospital. With the implementation of

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the bed and chair sensors linked to the community alarm system, Betty's family now feel reassured that if another fall occurs, the automated alarms will activate help.

Independent Living

Occupational Therapists are based within Complex Care Management Teams and assess people with more complex needs to establish how their health or disability issues affect their ability to manage everyday tasks. The Occupational Therapists work closely with other services and provide statutory complex assessments for aids and major adaptations. In order to ensure the best outcome for people they also work with other social care and health professionals and refer to various other teams and agencies as appropriate. They prescribe items of equipment to aid daily living and more specialised equipment. They recommend minor adaptations such as grab rails and banister rails, and work with the Home Improvement Service to provide major adaptations such as shower rooms, door widening, ramps and stair lifts.

People are also able to access their own assessment for equipment, for example, raised toilet seats, tap turners using the internet via 'SmartAssist'. This is an online assessment system free to anyone living in Halton.

3740 people Helped to Live at Home.

Intermediate Care

In Halton we are committed to helping people stay living safely and independently in their homes for longer, with a better quality of life. We offer a wide range of Home Care, Intermediate Care and Reablement Services seven days a week that may include support from nurses, care assistants and occupational therapists. Help is also available to people recovering from a hospital stay and needing temporary help to maintain their independence and quality of life at home.

Integrated Hospital Discharge Team

Most people spend a very short period of their lives in hospital; their discharge follows a fairly predictable pattern and they usually return home. However for those people already in the care system, or for those who will need on-going support when they leave hospital, discharge processes should ensure continuity of the right care in the right place. The Warrington and Halton Integrated Discharge (ID) and the Whiston ID teams operate as a single point of referral for all patients within the hospitals, irrespective of which borough they are resident in. The person's discharge is planned irrespective of whether it is a health or social care discharge.

Benefits of this approach to discharge include earlier engagement with patients and families to better manage need and expectations, therefore reducing delays and reduction in admissions to long term care.

Dementia

In Halton services for people with dementia begin at the diagnosis stage with access to Dementia Care Advisors and Dementia Cafés run by The Alzheimer's Society and Age UK offering support and information for both the person diagnosed with dementia and the carer. This support remains in place for as long as it is needed and is designed to help someone through any difficult transitions if they need hospital care or access to other clinical services. Specialist services are delivered through

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the 5 Boroughs Partnership and include memory clinics, specialist assessments access to counselling and any specific clinical services.

Urgent Care

Urgent Care is the range of responses that health and care services provide to people who require - or who perceive the need for - urgent advice, care, treatment or diagnosis. The vision for urgent care services in Halton is 'A streamlined urgent and emergency care system which is simple for patients and professionals to access, which delivers high quality and productive care meeting national best practice standards, and supports patients return to health and independence'.

In November 2012, the Borough Council and NHS Halton Clinical Commissioning Group published its Urgent Care Partnership Response Plan. This Plan outlines a 2 year vision for the delivery of urgent care services in Halton. The plan aims to ensure the successful delivery of clinically led integrated services to deliver improved, higher quality care in terms of safety, patient experience and clinical outcomes.

In addition to the Response Plan, an Urgent Care Strategy was also developed which outlines the strategic direction for the delivery of urgent care in Halton over the next five years. The Strategy and associated Response Plan outline a common approach to the provision of Urgent Care Services and creates a framework within which care providers and commissioners can work to ensure seamless, high quality and appropriate care.

Halton funded a pilot scheme during the winter of 2012/13 at Warrington hospital, through which the hospital attempted to telephone all Halton people discharged from the Trust within 24 hours of them being discharged. The scheme has been invaluable in understanding the quality aspects of discharge arrangements. Halton and Warrington Clinical Commissioning Groups have agreed the extension of this scheme into 2013/14 through the Trust contract.

???% of 65+ people still independent and at home after discharge from hospital.

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Ensuring People have a Positive experience of Care

Feedback from users and their carers

Feedback from our users and their carers is very important to us in all aspects of our work. We have different ways to consult with our users and this includes: surveys such as the Carers survey, Adult Social Care survey and Residents survey and user involvement groups and forums.

Healthwatch

Healthwatch is the new consumer champion for both health and social care. It will exist in two distinct forms – local healthwatch that supports local people in Halton and Healthwatch England that supports at a national level. At a local level healthwatch will be an independent organisation, able to employ its own staff and involve volunteers, so it can becomethe influential and effective voice of the public. The aim of the local healthwatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within Halton.

In addition to this Healthwatch Halton will provide people with information about their choices and what to do when things go wrong. It will also build on the good work that has already been carried out by Local Involvement Networks (LINks) over the past four years. Healthwatch will offer local people a unique opportunity to really make a difference with the services currently provided as well as influencing the services for the future.

Case Study – Consultation

In February 2012 over 100 older people met to discuss local transport provision for older people in the borough. A number of issues were raised and as a result of the event the following actions took place;

- Funding agreed to for Halton Community Transport
- New vehicles purchased to aid vulnerable people in bad weather.
- Newly formed joint Health, Social Care and Transport group working together to solve issues that vulnerable and older people face in the borough.

"Help Us, Help You" enables you to speak to us about any concerns that you have about services provided or arranged by the Council, for you or someone you know. We will help you to get your concerns sorted out as informally or formally as you want, ranging from a 'quiet word' to a formal complaint. 'Help Us Help You' is also about us learning; and finding out what works well is just as important, so please do tell us what works well for you. That way we can help develop services to reflect what people want and need.

For matters concerning Adult Social Care, you can contact the Social Care Customer Care Team direct on: Tel: 01928 704411 Text 07775 765489 e-mail: ssdcomplaints@halton.gov.uk

85 compliments about Adult Social Care were received throughout 2012/13 and

52 complaints about Adult Social Care were received throughout 2012/13.

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Carers

A Carer is someone who spends a significant proportion of their life providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

Caring is increasingly part of all our lives. For many carers, looking after their own health, combining caring with work, or simply having time to take a break and go away for a weekend can be a major challenge. It often means that Carers end up juggling the support they give with their other responsibilities, in a difficult balancing act. People who provide a lot of care tend to have lower incomes, poorer health, and are less likely to be in work than their counterparts.

For Carers in the borough to have the same opportunities as everyone else, the Council, the NHS Halton Clinical Commissioning Group and Halton Carers Centre have pooled their resources to ensure that Carers receive advice and information with which they can make informed choices about the things that effect their caring role, that they have access to emotional support or a break away from caring which helps them to look after their own health, and that they can talk to the people who are providing support services to the person they are caring for so that they both receive the best, possible care.

Today there are over 4,000 people registered as Carers in Halton. The 2011 Census states that there are 15,000 carers in Halton which means there are many "hidden" carers that we don't know about and are not accessing the services that we offer. If you would like advice, help or support with your caring situation, contact Halton Carers Centre on 01928 580 182.

77% of carers who used social services found it easy to find information about those services.

Carers Case Study

Paddy and Maggie are husband and wife and came to Ashley House over twelve months ago. This was to ask for help as they didn't know what to do regarding their son's substance misuse.

Both Maggie and Paddy were emotional and upset when they first came to speak to us at Ashley House. As Maggie says it broke her heart to see her son abuse himself. They were concerned that he was going to die and had serious mental health issues. Every week Paddy and Maggie attended the carers support group. Sharing and taking part in discussions to help support each other.

They both have participated in mental health training and are shortly due to take part in Geese theatre drama workshop. Maggie says that she "always comes away from the group feeling in a better frame of mind, and just wants to get her son back".

Both Paddy and Maggie volunteered to take part in a DVD film promotion about carers of someone else's drug and alcohol addiction for Ashley House. The film promotion shows hope and real life experiences of families trying to deal with life and gaining strength from groups such as the carer's group at Ashley House. This can be seen on the internet on YOUTUBE carers of some-one else's drug and alcohol addiction.

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Paddy and Maggie continue to attend Ashley House and say that they “don’t feel so alone anymore”. They have good and bad days but say that they are managing the situation better than they have done in the past.

Provider Involvement – Domiciliary Care and Residential Care Survey

Halton Borough Council’s Quality Assurance Team (QAT) monitors a range of services across Residential, Domiciliary, Supporting People, Carers and the Voluntary Sector.

During 2012-13 there were 149 monitoring visits, 51 contract performance meetings and a number of consultation visits carried out. In 2013 the QAT are moving towards more unannounced monitoring visits, including evening and weekend visits to reflect on some issues that have been raised during the past year.

In November 2012 to January 2013 the Quality Assurance Team undertook its annual survey to measure the views of the care delivered across Residential and Domiciliary Care. A summary of the findings is as follows:

Residential Care – 249 family members sent back responses to the questionnaire forms.

- 99% said the care staff are polite and respectful to their family member all or most of the time;
- 95% said they were very or fairly satisfied with the care their family member received;
- 91% said their family member is provided with a good variety of food and drink.

Area Highlighted – 76% said their family member is always treated with dignity and respect.

Action taken – Halton Borough Council have raised this at the provider’s forum in March 2013 and individually where people have raised concerns.

Domiciliary Care – 210 people who use domiciliary home care services responded to the questionnaire.

- 99% said the support made them feel safe and secure;
- 99% said they are treated with dignity and respect; and
- 96% said the services enable them to be as independent as possible.

Area highlighted – 75% said the care agency involves them in the discussions with their care.

Action taken – Providers have been asked to provide an Action Plan on how they plan to improve the identified areas.

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Safeguarding Vulnerable People and Protecting them from avoidable harm

Halton's Safeguarding Adults Board

The Safeguarding Adults Board's overarching priority is to safeguard and promote the welfare and dignity of vulnerable adults, both in terms of prevention and as a robust response to concerns. The importance of including dignity emphasises that vulnerable adults' experience should reflect the right to be treated at all times with dignity as well as to be safeguarded.

The Board's four priorities are:-

Priority 1: To promote awareness of abuse and of all individuals' right to be safe and be afforded dignity, particularly amongst people who are 'vulnerable' or at risk and others, including the wider community, staff and volunteers.

Priority 2: To increase the contribution from service users and carers, including individuals who use services and wider communities, by seeking to ensure that their views and experience inform the Board's work and service developments, and by ensuring that individualised services are available in a way that keeps people safe but enables them to make informed decisions about risk.

Priority 3: To ensure there is a strong multi-agency approach to assuring the safety, wellbeing and dignity of vulnerable adults.

Priority 4: To equip employees with the necessary tools to both safeguard vulnerable adults and ensure their dignity is respected.

???% of people who use services who feel safe.

Safeguarding Training
Halton's Safeguarding Adults Board has identified and commissioned a range of Learning and Development to ensure that staff, elected members and volunteers in all agencies, groups and sectors have the appropriate knowledge, skills and attitude to be able to act appropriately regarding safeguarding adults in Halton.

An e-learning package has also been developed that covers the basic awareness elements of safeguarding vulnerable adults and is widely available to providers and partner agencies free of charge. The different types of training reflect the level of responsibility, complexity and specialist knowledge required in relation to safeguarding Adults.

Integrated Adults Safeguarding Unit
Safeguarding is everybody's business, keeping people safe and ensuring that they are treated with dignity and respect continues to be a high priority for the Council and its partners. In recognition of this commitment the Council have set up a joint Integrated Adults Safeguarding Unit with the NHS Halton Clinical Commissioning Group. The unit undertakes the most complex of cases which include multi-agency police investigations and multiple abuse allegations within nursing and residential homes. The establishment of the Unit has strengthened the support provided to Halton's Safeguarding Adult Board, the Local Authority and other agencies operating within Halton.

Case Study
A female who was known to Social Services and had mental health issues, was experiencing harassment from her neighbours. Following the initiation of the Vulnerable Adult Safeguarding investigation, extra support and strategies, (including the use of the Community Support Officer) to

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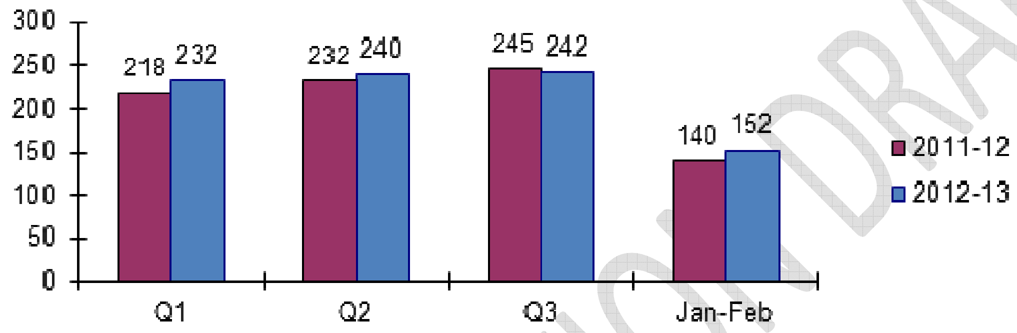
reduce the risks to the female were put in place. Following ongoing review of the situation, involving a range of professionals and partners, the package of support has been adjusted to ensure that it continues to meet the needs of the female and enables her to live safely and independently in the community.

Domestic violence and abuse

Domestic abuse isn't just physical; it can be psychological, sexual, emotional or even financial. Domestic abuse occurs in all groups and sections of society, affecting people across all social, economic and geographic backgrounds regardless of age, income, ethnicity or sexual orientation.
Domestic violence is a serious and high-volume crime. It is a pattern of controlling and abusive behaviour, held together by the threat and use of violence. Domestic abuse is widespread: approximately every minute in England and Wales the Police receive a call for assistance. One in four women has experience domestic abuse and one in six men.

Domestic Abuse Incidents



Halton Domestic Abuse Forum (HDAF) is a multi-agency partnership that focuses on domestic abuse and sexual violence issues within Halton. The purpose of HDAF is to:

- Prevent violence and abusive behaviour within the domestic abuse and sexual violence context;
- Support victims of domestic abuse and sexual violence;
- Reduce incidents of these crimes;
- Improve the understanding and response to domestic abuse and sexual violence;
- Create and implement a strategic response to these issues; and
- Develop and sustain an effective multi-agency response to domestic abuse and sexual violence

There were 70 repeat high risk Domestic Abuse cases reported in Halton in 2011/12. There are a number of domestic abuse support services available in Halton for those who have been affected or experienced domestic abuse in any of its forms.

Dignity in Care

Dignity in care is about creating a care system where there is zero tolerance of abuse and disrespect of people in care – this includes hospitals and care homes where being treated with dignity and respect is not an optional extra, but a basic human right.

Halton Borough Council's Dignity in Care Co-ordinator role is to work with all health and social partners to:

- Influence them to have higher standards of care by driving forward the dignity campaign in Halton;
- Raise awareness and understanding about Dignity in Care; and
- Help challenge beliefs and attitudes that can contribute to lack of dignity for older people.

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Halton's Key Achievements:

- Dignity Charter developed to embed dignity in care – supported by dignity champions in each organisation;
- Awareness sessions provided to improve understanding;
- Dignity training to support the local workforce in understanding the issues related to dignity/respect;
- Dignity in Care Action Plan introduced to promote higher standards of care across all organisations;
- Practitioners Network developed to improve practice/peer support; and
- All council contracts including care services include dignity in care.

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Feedback page

We welcome your comments on the 2012/13 Adult Social Care Annual Report. Please take a few moments to complete this questionnaire to let us know your views and suggestions on the report.

1. How much of the Annual Report did you read? (Please tick all that apply)

☐ I have read all of the Annual Report

☐ I have read the chapters most relevant to me

☐ I have only read the facts and figures

☐ I have only read the case studies

☐ I have skimmed over the Annual Report

☐ I have not read any of the Annual Report

How easy or difficult was the Annual Report to:

	Very Easy	Easy	Neither easy nor Difficult	Difficult	Very Difficult
Read	☐	☐	☐	☐	☐
Understand	☐	☐	☐	☐	☐

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2. **How satisfied or dissatisfied are you that this report provides a meaningful overview of the differences made to people's lives in Halton by Adult Social Care? (*please tick one option*)**

☐ Very satisfied ☐ Fairly satisfied

☐ Neither satisfied nor dissatisfied

☐ Fairly dissatisfied ☐ Very dissatisfied

3. Please use this space if you have any other comments about this Annual Report?

Thank you for giving us your views.

Please return your completed feedback form to:

Communities Policy Team

Halton Borough Council

Runcorn Town Hall

Heath Road

Runcorn

WA7 5TD

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ADULT SOCIAL CARE ANNUAL REPORT 202/13 **APPENDIX 2**
MARKETING & COMMUNICATIONS PLAN

Area of Activity: (press; internal communications; digital; design; print; advertising etc)	**Description of activity**	**Progress**	**Outline of responsibilities**	**Key milestones and deadlines**	**Completed (date)**
Website	Create short url for report		Web Team	July 2013	
PR	Press release to publicise report & promote website address		Press and Public Relations Team	July 2013	
PR	Circulate Press release to all partners, Police, NHS, Housing etc. for inclusion on intranets, newsletters, notice boards etc.		Press and Public Relations Team	July 2013	
Website	Press release news story on Internet homepage		Web Team	July 2013	
Advertising	Display screen advert on Halton Direct Link screens		Press and Public Relations Team	July 2013	
Advertising	Display screen advert on Halton Library screens		Press and Public Relations Team	July 2013	
Internal Communication	Press release news story on Intranet homepage		Internal Communications Team	August 2013	
Internal Communication	Article in Team Brief, Leaders Newsletter, Information Bulletin		Internal Communications Team	August 2013	
Internal Communication	Article in InTouch staff magazine		Internal Communications Team	August 2013	
Advertising	Article and in Inside Halton Magazine		Press and Public Relations Team	September 2013	

Agenda Item 7f

REPORT TO:	Health Policy and Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director Communities
PORTFOLIO:	Communities
SUBJECT:	Sustainable Community Strategy Quarter 4 year-end Progress Report 2012-13
WARDS:	Borough wide

1.0 PURPOSE OF REPORT

1.1 To provide information to the Health Policy & Performance Board on the progress in achieving targets contained within the 2011 – 2016 Sustainable Community Strategy for Halton.

2.0 RECOMMENDED THAT:

I. **The report is noted**

II. **The Board considers whether it requires any further information concerning actions taken to achieve the performance targets contained within Halton's 2011-16 Sustainable Community Strategy (SCS).**

3.0 SUPPORTING INFORMATION

3.1 The Sustainable Community Strategy, a central document for the Council and its partners, provides an evidenced-based framework through which actions and shared performance targets can be developed and communicated.

3.2 The previous Sustainable Community Strategy included targets which were also part of the Local Area Agreement (LAA). In October 2010 the coalition government announced the ending of government performance management of local authorities through LAAs. Nevertheless, the Council and its Partners need to maintain some form of effective performance management framework to:-

- Measure progress towards our own objectives for the improvement of the quality of life in Halton.
- Meet the government's expectation that we will publish performance information.

3.3 Thus, following extensive research and analysis and consultation with all stakeholder groups including Elected Members, partners and the local community and representative groups, a new SCS (2011 – 26) was approved by the Council on 20th April 2011.

3.4 The new Sustainable Community Strategy and its associated "living" 5 year delivery plan (2011-16), identifies five community priorities that will form the basis of collective partnership intervention and action over the coming five years. The strategy is informed by and brings together national and local priorities and is aligned to other local delivery plans such as that of the Halton Children's Trust. By being a "living" document it will provide sufficient flexibility to evolve as continuing changes within the public sector continue to emerge, for example the restructuring of the NHS and Public Health delivery, and the delivery of the 'localism' agenda.

3.5 As such, articulating the partnership's ambition in terms of community outcomes and meaningful measures and targets to set the anticipated rate of change and track performance over time, will further support effective decision making and resource allocation.

3.6 Placeholder measures have also been included where new services are to be developed or new performance information is to be captured, in response to legislative changes; for which baselines for will be established in 2011/12 or 2012/13, against which future services will be monitored.

3.7 Attached as Appendix 1 is a report on progress for the period to year-end 31st March 2013, which includes a summary of all indicators for the Health priority within the SCS.

3.8 An annual 'light touch review' of targets contained within the SCS, has also been conducted to ensure that targets remain realistic over the 5 year plan to 'close the gaps' in performance against regional and statistical neighbours. This review has been conducted with all Lead Officers being requested to review targets for 2013/14, 2014/15 and 2015/16. Targets were thus updated where appropriate in the light of actual/ anticipated performance. All SCS measures are included in the draft medium term Directorate Business Plans 2013-16

3.10 The Health Policy and Performance Board is also asked to consider the inclusion of any additional measures to the above set to "narrow gaps" in performance where appropriate or respond to legislative/ policy changes; thereby ensuring that all measures remain "fit for purpose".

4.0 CONCLUSION

4.1 The Sustainable Community Strategy for Halton, and the performance measures and targets contained within it will remain central to the delivery of community outcomes. It is therefore important that we

monitor progress and that Members are satisfied that adequate plans are in place to ensure that the Council and its partners achieve the improvement targets that have been agreed.

5.0 POLICY IMPLICATIONS

5.1 The Sustainable Community Strategy for Halton is central to our policy framework. It provides the primary vehicle through which the Council and its partners develop and communicate collaborative actions that will positively impact upon the communities of Halton.

6.0 ATTACHED DOCUMENTS

6.1 The publication by Local Authorities of performance information is central to the coalition government's transparency agenda.

7.0 IMPLICATIONS FOR THE COUNCILS' PRIORITIES

7.1 This report provides information in relation to the Council's shared strategic priorities.

8.0 RISK ANALYSIS

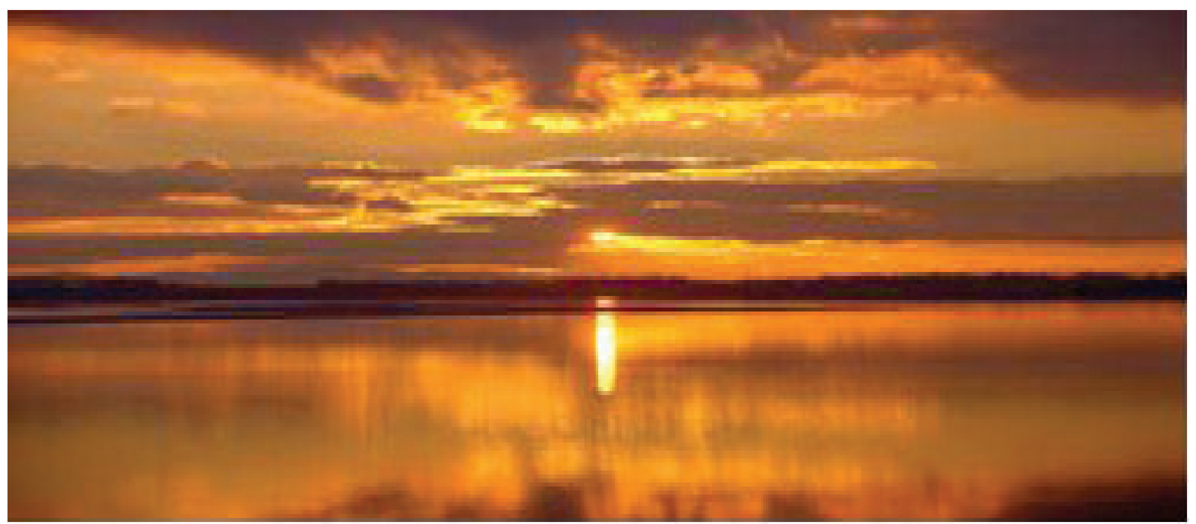
8.1 The key risk is a failure to improve the quality of life for Halton's residents in accordance with the objectives of the Sustainable Community Strategy. This risk can be mitigated through the regular review and reporting of progress and the development of appropriate interventions where under-performance may occur.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 One of the guiding principles of the Sustainable Community Strategy is to reduce inequalities in Halton.

10.0 LIST OF BACKGROUND PAPAERS UNDERSECTION 100D OF THE LOCAL GOVERNEMNT ACT 1972

Document	Sustainable Community Strategy 2011 – 26
Place of Inspection	2nd Floor, Municipal Building, Kingsway, Widnes
Contact Officer	Mike Foy (Performance & Improvement Officer)



The Sustainable Community Strategy for Halton 2011 – 2016

Year-end Progress Report

1st April 2012 – 31st March 2013

Healthy Halton

Document Contact (Halton Borough Council)	Mike Foy Performance &Improvement Officer Municipal Buildings, Kingsway Widnes, Cheshire WA8 7QF mike.foy@@halton.gov.uk

This report provides a summary of progress in relation to the achievement of targets within Halton's Sustainable Community Strategy 2011 – 20116 to year-end 31st March 2013.

The following symbols have been used to illustrate current performance as against the 2012 - 13 targets and as against performance for the same period last year.

	Target is likely to be achieved or exceeded.		Current performance is better than this time last year
	The achievement of the target is uncertain at this stage		Current performance is the same as this time last year
	Target is highly unlikely to be / will not be achieved.		Current performance is worse than this time last year

Healthy Halton

Page	Ref	Descriptor	2012 / 13 Target	Direction of travel
4	HH1*	a) Alcohol related hospital admissions (NI 39) (Rate 100,000 pop.)	✓	↑
		b) Alcohol related hospital admissions – AAF =1 (Rate)	✓	↑
6	HH 2	Prevalence of breastfeeding at 6-8 weeks (NI 53)	N/A	↓
7	HH 3	a) Obesity in Primary school age children in Reception (NI 55)	✓	↑
8		b) Obesity in Primary school age children in Year 6 (NI 56)	✓	↑
9	HH 4	Reduction in under 18 Conception (new local measure definition for NI 112)	✓	↑
11	HH 5	a) All age, all-cause mortality rate per 100,000 Males (NI 120a)	✓	↑
13		b) All age, all-cause mortality rate per 100,000 Females (NI 120b)	✓	↓
14	HH 6	Mortality rate from all circulatory diseases at ages under 75 (NI 121)	✓	↓
16	HH 7	Mortality from all cancers at ages under 75 (NI 122)	✗	↓
18	HH 8	16+ Smoking quit rate per 100,000 (NI 123)	N/A	↓
20	HH 9	Mental Health – Number of people receiving Community Psychological Therapies (IAPT) (New Measure)	✓	N/A
22	HH 10	Proportion of older people supported to live at home through provision of a social care package (NEW 2011):	✗	↓
23	HH 11	a) Increase the % of successful completions (drugs) as a proportion of all in treatment (over 18)	✓	↑
24		b) Increase the % of successful completions (Alcohol) as a proportion of all in treatment (over 18)	New Measure 2012/13	N/A

NB - Measures HHI and HH11 are also reported within the Safer Halton priority area as SH 10 and SH7 respectively.

Healthy Halton

SCS / HH 1[1]	Reduce alcohol related hospital admissions (NI 39) Rate per 100,000 population

	2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
a) Alcohol related hospital admissions AAF > 0 (Previously NI 39)	2837*	3027	1311.4	At Jan 13 2200.0	✓	↑
b) Admissions which are wholly attributable to alcohol AAF = 1 (Rate)	994.5*	1020.7	422.7	At Jan 13 729.1	✓	↑

NI 39: Alcohol related hospital admissions (Rate)

	2008/09	2009/10	2010/11	2011/12

Legend: Halton Target, Halton Actual, All England, North West, St. Helens Actual

Data Commentary:

This indicator measures the cumulative rate of alcohol related hospital admissions per 100,000 population using Hospital Episode Statistics.

The verified LAPE performance data for 2011/12 is now included in the table above. *Please note that the 2011/12 alcohol related admission rate has been recalculated using the mid-2011 Census based population estimates. This means that the 2011/12 actual rate is now lower than previously thought, as the 2011 Census showed the Halton population to be higher than had been previously estimated.

The second measure provides further detail and relates to admissions which are wholly attributable to alcohol in other words AAF=1. *Please note that the 2011/12 rate has been recalculated using the mid-2011 Census based population estimates.

Local Data can be utilised as an interim measure. Q2 is an actual to September 2012 and Q4 is an actual to January 2013, as final 2012/13 data is not yet available.

Performance Commentary:

Comments on alcohol admissions (All fractions):

- At the end of Jan 2013, the Alcohol Attributable Admission rate (2200) was lower than at the same time the previous year(2277), 2011/12
- Also, at the end of Jan 2013, the Wholly Attributable Admission rate (729.1) was lower than at the same time the previous year (832.6), 2011/12

Summary of Key activities taken or planned to improve performance:

1. Strategic

A revised Halton Local Alcohol Strategy is under development following the release of the National Alcohol Strategy in 2012 and further consultation is needed with key stakeholders to agree priority work streams.

[1] SCS / HH1 is also replicated under Safer Halton as SCS / SH10

An Alcohol action plan has been developed to achieve key outcomes in the next 2 years.
Alcohol Harm Reduction has been agreed as a priority by the Halton Health & Wellbeing Board.

2. Contract transition

All contracts which aim to reduce alcohol harm have transferred to Public Health in Halton Borough Council as part of the Public Health Transition from 1st April 2013. All contracts will be reviewed as part of an on-going review process following transition.

3. Alcohol Liaison Nursing Service at Whiston and Warrington Hospitals

The Alcohol Liaison Nursing Service developed at Whiston Hospital during 2012 continues to operate (funded until September 2014).

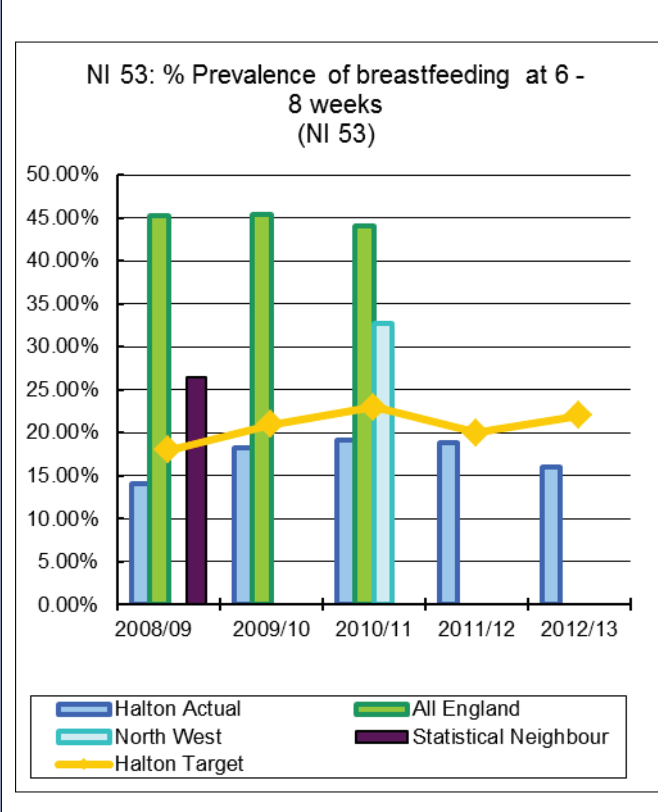
The Alcohol Nursing Service continues to operate at Warrington Hospital and work is underway to ensure that there are streamlined pathways into the Community Treatment Service in Halton (CRI). The cost of the Service is being met by both NHS Warrington and NHS Halton & St Helens.

4. Alcoholic Liver Disease

Work is underway to explore actions which could assist with prevention in relation to alcoholic liver disease.

5. **Robust Health Assessments** are being carried out by the Community Alcohol Provider for Service Users (including Criminal Justice clients) who attend for treatment. This includes identifying dental issues and smoking cessation.

SCS / HH2 % Prevalence of breastfeeding at 6-8 weeks (NI 53)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
18.9%	22%	16%	17.4% (at Dec 12)	N/A	⬇

Data Commentary:

Quarter 3 is the latest available data from Public Health.

Good performance is an 2% increase in prevalence year on year and maintenance of a minimum of 95% coverage.

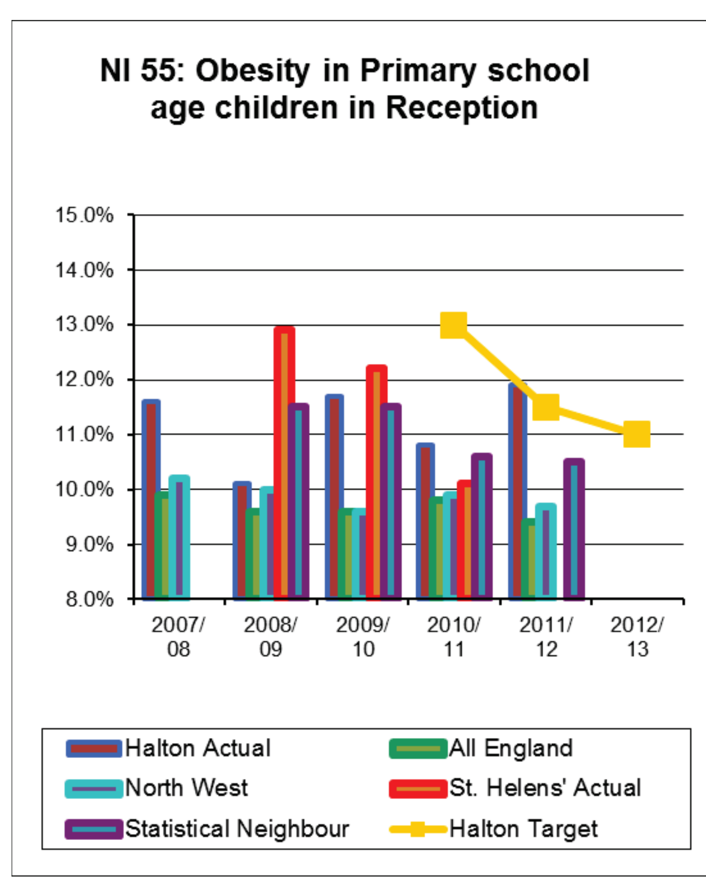
Performance Commentary:

The choice to breastfeed is influenced by local cultural beliefs, and as such change takes time. The results for this quarter are disappointing, while some quarterly variation is to be expected it is not clear why figures have continued to drop. Factors that impact upon breastfeeding rates are multifactorial.
Data coverage continues to exceed the target of 95%.

Summary of Key activities taken or planned to improve performance:

- Breastfeeding workshop for all partners to identify actions to improve rates
- Bridgewater Halton and St Helens division continues to work towards UNICEF Baby Friendly stage 2 and are on target for the November assessment.
- Breastfeeding peer support services are available and work is underway to develop this service further.
- St Helens and Knowsley Hospital trust continue to work towards CQUIN targets to increase breastfeeding initiation and breastfeeding at discharge
- Continue to maintain baby friendly premises
- The Department of Health plan to collect breastfeeding data at additional points in the child’s development. Preparation underway for changes to DH breastfeeding data collection next year.
- From April 2013 the department of health will report breastfeeding data on a local authority footprint.

SCS / HH3a	Obesity in Primary school age children in Reception (NI 55)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Actual	Current Progress	Direction of Travel
11.9% (Sept 2010- Aug 2011)	11%	N/A (annual figure)	9.6% (Sept 2011 – Aug 2012)	✓	⇧

Data Commentary:

The percentage of children in who are obese in reception, as shown by the National Child Measurement Programme (NCMP).

For the purposes of this indicator, children are defined as obese if their body-mass index (BMI) is above the 95th centile of the reference curve for their age and sex according to the UK BMI centile classification (Cole TJ, Freeman JV, Preece MA. Body mass index reference curves for the UK, 1990. 1995; 73: 25–29). A child's height (in metres), weight (in kilograms), date of birth and sex are needed to calculate their BMI.

Performance Commentary:

The 2011/12 official figure shows that the percentage of obese children in Reception has decreased from 2010/11.

Summary of Key activities taken or planned to improve performance:

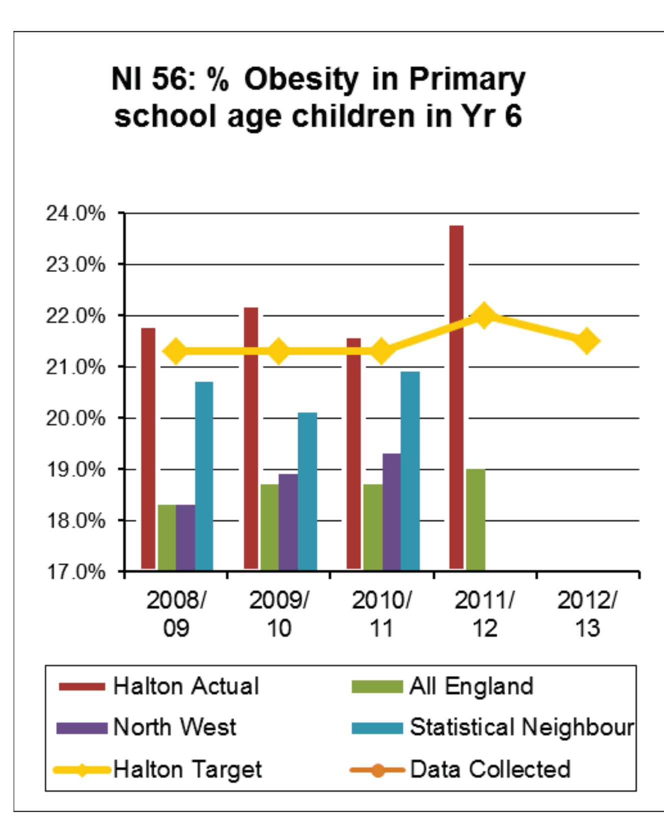
Halton's performance has shown fluctuation with a continued variable trend over the last few years.

In 2011/12 Halton has improved and is now similar to the national and north west average. Halton has shown a reduction in obesity rates against a background of increasing obesity rates for the England and North West averages.

A number of healthy weight programmes are now in place for early years and are having an impact. These include Healthy Early Years Programme (fit for life) for the up to 5's and their families, cookery lessons for parents, active tots groups and education and training for parents and service providers. The development of an infant feeding team and weaning services should have an impact in the future years.

Children's Centres and Early Years Providers continue to work to meet the Healthy Early Years Standards which include food standards and healthy eating. The national programme of increasing numbers of Health Visitors will also work to improve rates in the future.

SCS / HH3b	% Obesity in Primary school age children in Year 6 (NI 56)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Actual	Current Progress	Direction of Travel
23.8% (Sept 2010-August 2011)	21.5%	N/A (annual figure)	19.4% (Sept 2011 – August 2012)	✓	↑

Data Commentary:

The percentage of children in year 6 (aged 11) who are obese, as shown by the National Child Measurement Programme (NCMP).

For the purposes of this indicator, children are defined as obese if their body-mass index (BMI) is above the 95th centile of the reference curve for their age and sex according to the UK BMI centile classification (Cole TJ, Freeman JV, Preece MA. Body mass index reference curves for the UK, 1990. 1995; 73: 25–29). A child's height (in metres), weight (in kilograms), date of birth and sex are needed to calculate their BMI.

Performance Commentary:

The 2011/12 official figure shows that the percentage of obese children in Year 6 has decreased from 2010/11.

Summary of Key activities taken or planned to improve performance:

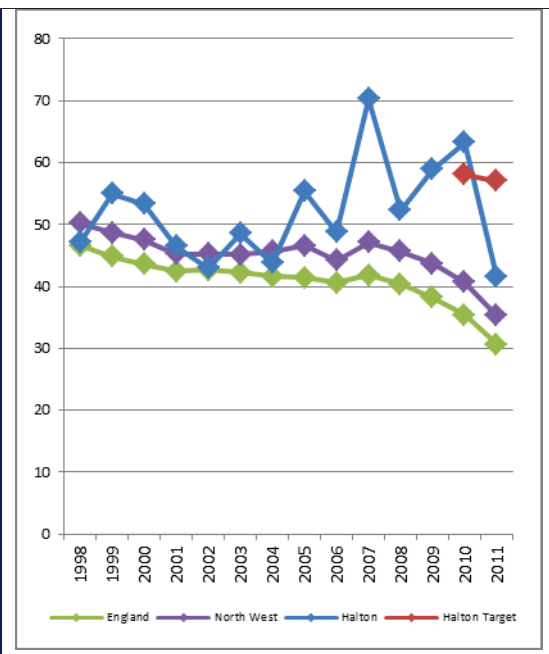
Halton's performance has shown fluctuation with a continued variable trend over the last few years. In 2011/12 Halton has improved and is now similar to the national and north west average. Halton has shown a reduction in obesity rates against a background of increasing obesity rates for the England and North West averages.

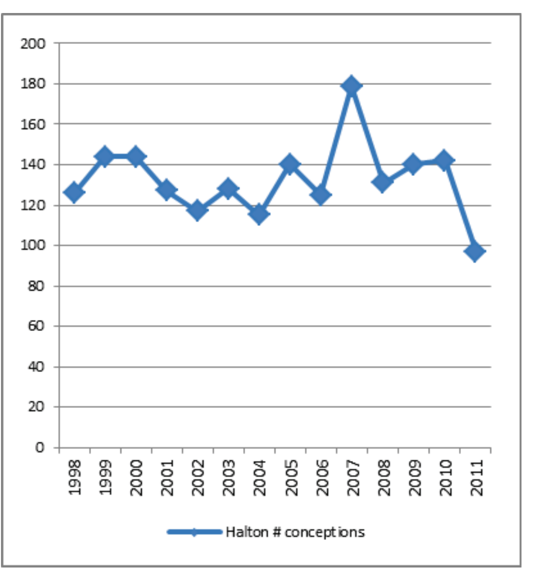
The school Fit4Life Programme which tackles overweight and has had an impact on year 6 obesity rates. The Fit4Life programme targets schools with the highest obesity rates. It offers education for teachers and children and their parents in cooking, healthy eating and the importance of exercise. It runs fun exercise classes for all children in the school. Data from the programme shows a reduction in obesity amongst those schools that participate.

An additional programme is also being delivered called Healthitude which links to Personal Social and Health education curriculum and has healthy eating component to it. This is being offer to all schools. We have maintained the Healthy schools programme which will also work on this agenda.

Healthy Halton

SCS / HH4	Reduction in under 18 Conception (new local measure definition for NI 112)





2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
63.3 (rolling quarterly average) 4.4% increase	56.3 (rolling quarterly average) 3% reduction	51.1 (rolling quarterly average) 7.8% reduction	41.5 (rolling quarterly average) (This represents a reduction of 34.44% on 2010)	✓	↑

Data Commentary:

In February 2013 ONS released data which detailed performance for the whole of 2011.The number of conceptions in 2011 was 97, which is a significant reduction on the number in 2010 (142). Performance represented a reduction of 34.44%.

Performance Commentary:

Halton saw the biggest reduction in the number of conceptions (45) and the rate per 1000 43.44% in the North West and saw the 4th biggest reduction in conceptions nationally.

This represented a 34.44% reduction on the 2010 rate of 63.3 conceptions, per 1000.

Halton total number of conceptions totalled 97 and this is the first time since the beginning of the National Strategy in 1998 conceptions were below 100 in Halton.

Summary of Key activities taken or planned to improve performance:

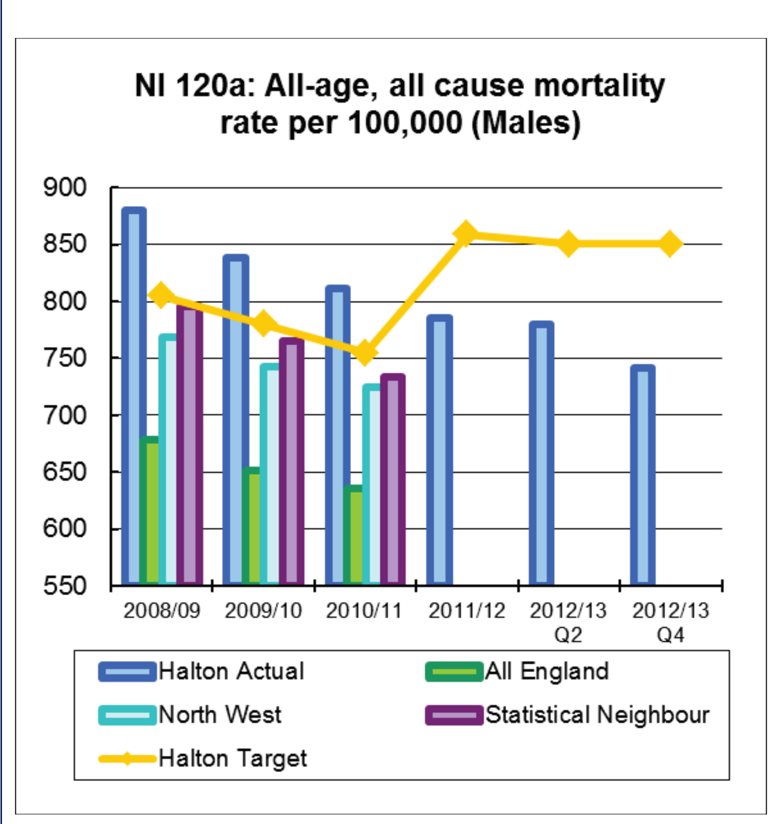
At a time when all areas are required to undertake measures to contribute to a reduction in the national deficit, it is essential that the most cost effective measures currently in place to tackling teenage pregnancy are identified and sustained. To support this, Halton will:

- Continue to work with schools to increase the number offering holistic health services delivered in schools, by youth workers.
- Prioritise initiatives that will have the widest and sustainable impact on reducing conceptions.
- Increase workforce training on Teens and Toddlers and reducing risk taking behaviour
- Through the IYSS further develop universal, targeted and specialist support and advice on positive relationships.

- Increase the number the evidence based DfE funded Teens and Toddlers programmes in identified schools throughout 2012/13.
- Improve access to contraceptive services and provision for young people, including LARCs (Long Acting Reversible Contraception), Ensure robust care pathways are in place for prevention and support in all high schools.
- Continue to support pregnant young women to remain in education, employment and training.
- Identify appropriate courses for young parents with flexible start dates.
- Continue to deliver comprehensive co-ordinated packages of support for teenage parents within specialist and targeted youth provision
- Further increase the numbers of young people signed up to the C-Card condom distribution scheme.

Healthy Halton

SCS HH5a All age, all-cause mortality rate per 100,000 Males (NI 120a)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
785.1 (Dec 2011)	850.2	779.9	741.4 (Dec 2012)	✓	↑

Data Commentary:

The indicator is reported and monitored as two separate mortality rates - one for males and one for females. Each of these rates is a single figure for all causes and all ages combined. Single year rates are used to enable timely reporting. (The associated national target is assessed using 3-year average figures).
Mortality targets are based on calendar year and not financial year.
Data for 2012 is unverified and based on public health mortality files. Final verification of 2011 data has been delayed and will be released June 2013; final verified 2012 data is expected in early 2014.

Performance Commentary:

Provisional data for 2012 (calendar year) shows an improvement in males deaths since 2011 and is also exceeding target. The local data is based on an annual age standardised death rate up until the end of December 2012.

There are two very important caveats that go with this information,

- Firstly Health Service data and much of the Public Health data has a very slow turn around period, much slower than your reporting structures call for. Thus data on mortality, circulatory disease and much of the morbidity data is actually only useful when collated annually as many of the trends are chance or artefactual in nature. It needs to go through an accuracy checking phase before we can confidently ascribe any changes to it.
- Secondly much of the activity linked to performance is likely to have more regular data available but the activity itself is likely to take some time to show any influence, again the reason for this can partly be attributed to my first caveat but other reasons also.

Summary of Key activities taken or planned to improve performance:

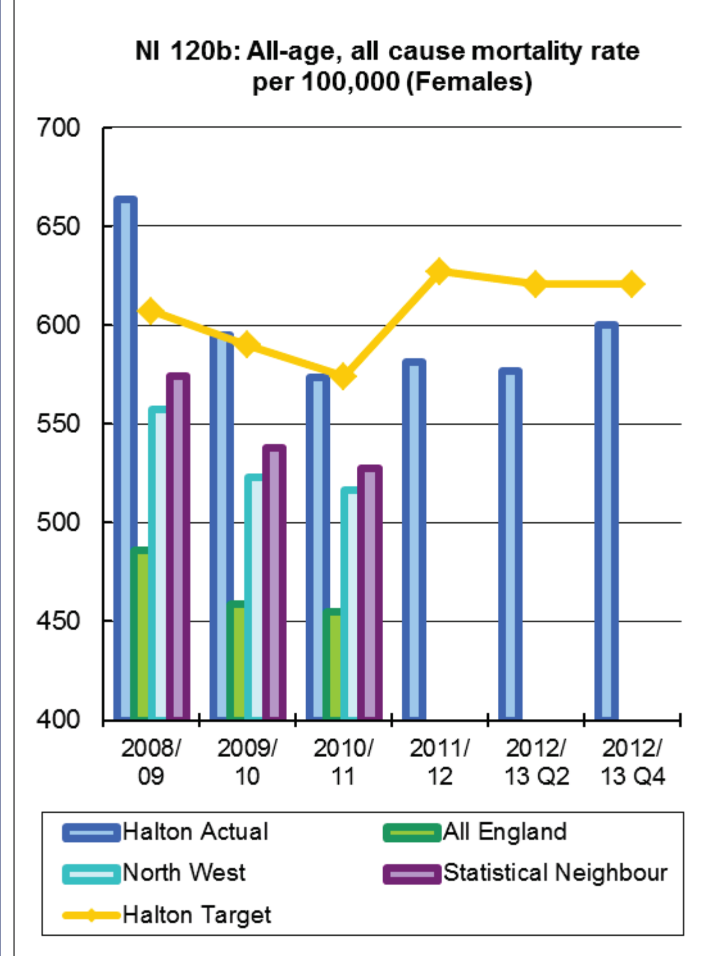
The major causes of death for males are circulatory diseases and cancers. Cancers now kill more people in Halton than circulatory diseases and because of this they have been identified as a Health and Wellbeing Strategy priority area. The activities will be described more fully in the cancer mortality performance section.

Healthy Halton

Lifestyle factors contribute to early deaths from the 2 biggest causes of deaths in Halton and therefore there is a continued focus on Healthy weight and obesity, Tobacco Control and smoking cessation and Alcohol related harm.

Early detection of risk factors and those that can be treated for issues such as high blood pressure, high cholesterol and diabetes are continuing to happen as part of the Health Checks Programme which is now set to include additional checks to identify dementia and use of alcohol.

SCS / HH5b All age, all cause mortality rate per 100,000 Females (NI 120b)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
581.0 (Dec 2011)	620.8	577	599.9 (Dec 2012)	✓	⬇

Data Commentary:

The indicator is reported and monitored as two separate mortality rates - one for males and one for females. Each of these rates is a single figure for all causes and all ages combined. Single year rates are used to enable timely reporting. (The associated national target is assessed using 3-year average figures).
Mortality targets are based on calendar year and not financial year.
Data for 2012 is unverified and based on public health mortality files. Final verification of 2011 data has been delayed and will be released June 2013; final verified 2012 data is expected in early 2014.

Performance Commentary:

Provisional data for 2012 (calendar year) shows female deaths are exceeding target, although the rate is slightly higher than at the same point in 2011. The local data is based on an annual age standardised death rate up until the end of December 2012. The caveats referred to above apply to this information.

Summary of Key activities taken or planned to improve performance:

The two biggest causes of death for females is still circulatory diseases and cancers.

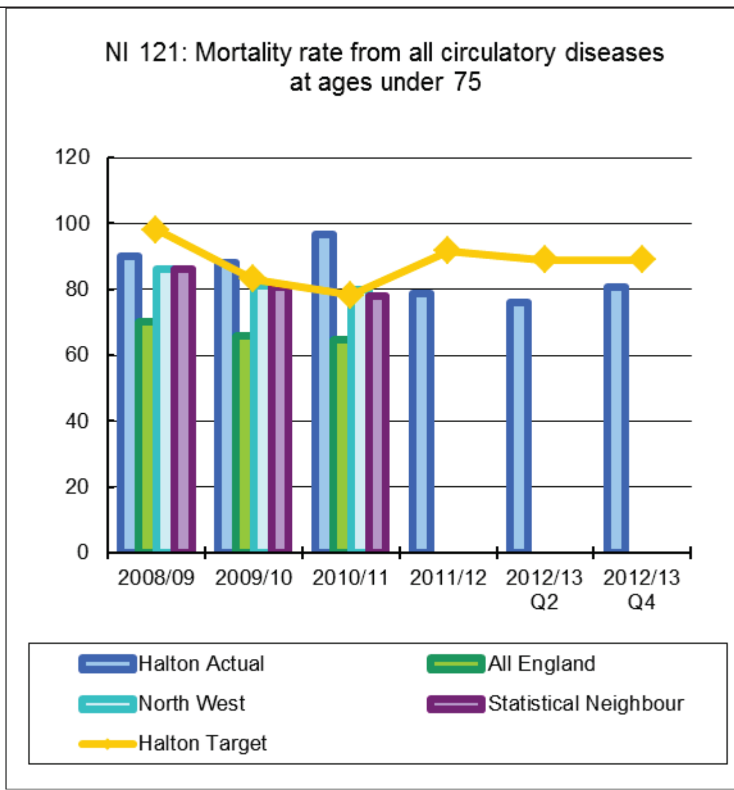
Lifestyle factors contribute to the majority of and in particular to the 2 biggest causes of deaths in Halton and therefore there is a continued focus on:

- Healthy weight and obesity
- Tobacco Control and smoking cessation
- Alcohol related harm

Early detection of risk factors and those that can be treated for issues such as high blood pressure, high cholesterol and diabetes are continuing to happen as part of the Health Checks Plus Programme. The Health checks programme is now a Local Authority responsibility to be led by Public Health. The current service specification and historic performance data is being reviewed to ensure that Halton has the best possible services to deliver on this target.

Healthy Halton

SCS / HH6 Mortality rate from all circulatory diseases at ages under 75 (NI 121)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
78.7 (Dec 2011)	89	76.2	80.6 (Dec 2012)	✓	⬇

Data Commentary:

This is a Department of Health PSA Target. Circulatory disease is one of the main causes of premature death (under 75 years of age) in England, accounting for just over a quarter of all such deaths in this age group. Reducing mortality rates will therefore make a significant contribution to increasing life expectancy.

Mortality targets are based on calendar year and not financial year. Data is unverified and based on public health mortality files. Final verification of 2011 data has been delayed and will be released June 2013; final verified 2012 data is expected in early 2014.

Performance Commentary:

Provisional data for 2012 (calendar year) shows circulatory deaths are exceeding target, although the rate is slightly higher than at the same point in 2011. The local data is based on an annual age standardised death rate up until the end of December 2012.

The reductions in rates means that our current verified rates are now only slightly higher than those of our peer industrial hinterlands based on the 2010 official data. These reductions need to be sustained in order that the difference in death rates for circulatory disease under 75 between England and the Halton are finally reduced. This is an area of success that needs to be acknowledged.

The caveats referred to above apply to this information.

Summary of Key activities taken or planned to improve performance:

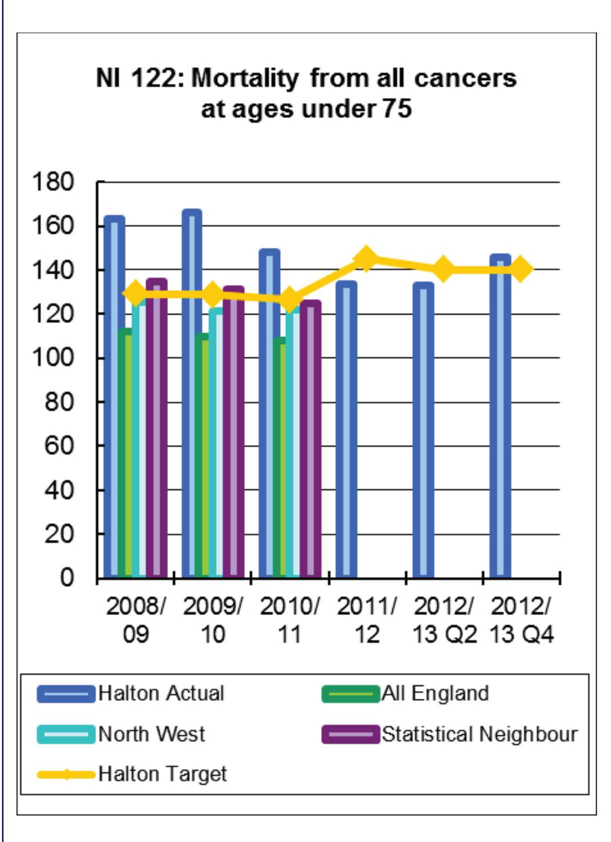
Lifestyle factors contribute to early deaths due to circulatory diseases in Halton and therefore there is a continued focus on:

- Healthy weight and obesity
- Tobacco Control and smoking cessation
- Alcohol related harm

Early detection of risk factors and those that can be treated for issues such as high blood pressure, high cholesterol and diabetes are continuing to happen as part of the Health Checks Programme.

Alcohol and dementia have recently being added to the programme widening the remit but providing greater opportunities to identify and reduce risk in these areas. Health Checks itself is undergoing a whole system review. The Quality Outcomes Framework (QOF) programme managed by primary care that will be the remit of the national commissioning board monitors performance relating to treatment within general practice. The national Cardio vascular disease (CVD) health profiles shows that in this profile practices across Halton and St Helens perform well.

SCS / HH7	Mortality from all cancers at ages under 75 (NI 122)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
133.4 (at Dec 2011)	140	132.9	145.6 (at Dec 2012)		

Data Commentary:

Cancer is one of the main causes of premature death (under 75 years of age) in England, accounting for nearly 4 in 10 of all such deaths in this age group. Reducing mortality rates will therefore make a significant contribution to increasing life expectancy.

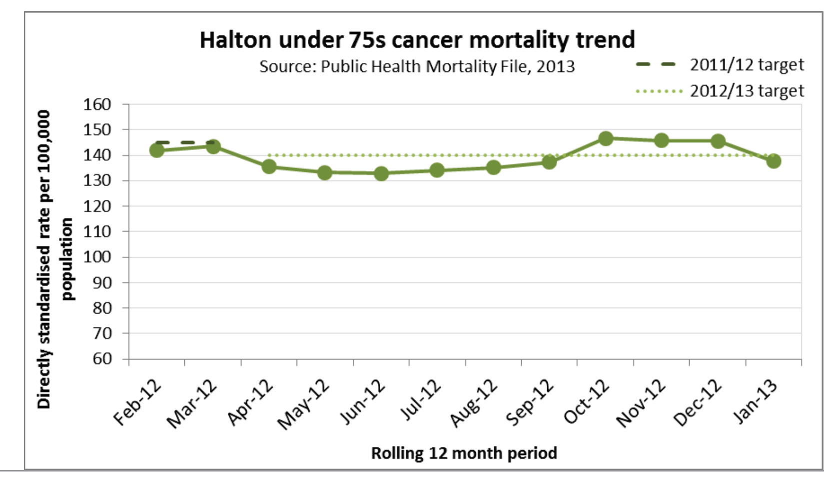
This is a Department of Health PSA Target.

It is important to note that these quarterly data are provisional, unvalidated, mortality rates per 100,000 (based on one year's worth of data). Nationally validated data is available about one year after the end of the respective calendar year. Data for 2011 and 2012 is unverified and based on public health mortality files. Final verification of 2011 data has been delayed and will be released June 2013; final verified 2012 data is expected in early 2014.

Performance Commentary:

Cancer deaths account for almost one in every three deaths in local people under age 75. Cancer mortality rates are falling in Halton, but with large year to year fluctuations.

Latest available confirmed annual figures are for the calendar year 2010. Subsequent quarterly provisional data have shown an overall improvement, although a slight increase was seen during the last few months of 2012, have resulted in a mortality rate above target. The chart below displays this trend in more detail.



Although the targets for cancer under 75s mortality rate of 140 per 100,000 for 2012/13 was not achieved, the target of a decrease of 5 points each year to 125 for 2015/16 remains realistic. Target for 2013/14 is set at a mortality rate of 135 per 100,000.

Summary of Key activities taken or planned to improve performance:

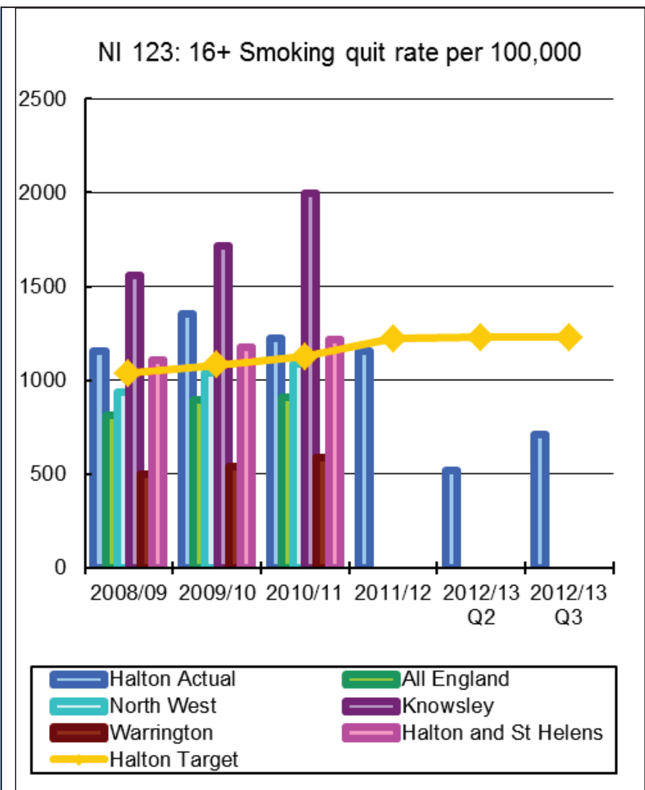
Existing activities are:

- The local "Get Checked" campaign to improve early detection of breast, bowel and lung cancers
- A Cancer Network project to support every general practice team in developing their own cancer action plan
- Specific local efforts to improve uptake in the three cancer screening programmes
- National campaigns to promote early recognition of bowel and lung cancer
- 2 week referral pathways for specialist appointments where cancer is a possibility
- Audits of cancer diagnosis in primary care

The new Halton CCG has selected cancer as a priority area, and have a named commissioning manager as lead for cancer. They are engaged in the design and launch of a local Halton Cancer Action Plan for 2013-14, whilst supporting current initiatives and activities. Funding has been secured for a local MacMillan GP to lead on cancer, but an appointment has not yet been made. The H&WBB has chosen cancer early detection and prevention as a priority and asked for the Halton specific action plan to be developed for 2013-15.

Output measures:
Bowel cancer screening is now offered to a further cohort of people: those between 70 and 74 years. Uptake rose by about 5% following the national bowel cancer campaign.
Breast cancer screening is now offered to some women over 70, and some between 47 and 50 years old. Digitisation of the programme has improved quality. A Quality Assurance visit early in 2012 gave a very positive report, and recommendations for improvement are being actively followed.
Cervical screening: results are now sent to 98% of women within 14 days. Uptake has risen slightly for the first time in several years, halting a slow decline in uptake.

SCS / HH8	16+ Smoking quit rate per 100,000 (NI 123)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
1157.74	1228.5	516.52	710.74 (at Dec 2012) **Q3**	N/A	↓

Data Commentary:

This indicator relates to clients receiving support through the NHS Stop Smoking Services. A client is counted as a self-reported 4-week quitter if they have been assessed 4 weeks after the designated quit date and declares that he/she has not smoked even a single puff on a cigarette in the past two weeks. The indicator is a count of treatment episodes rather than people. So, if an individual undergoes two treatment episodes and has quit at four weeks in both cases, they are counted twice.

The data for Q2 has been refreshed. Data is only available up to Q3; Q4 will be available in June 2013. This is because those setting a quit date during Q4 need to be followed up. Quitting smoking is seasonal with the majority of quitters stopping in January. Therefore, until the full year's data is received, it is not possible to assess performance against target.

Performance Commentary:

Whilst overall smoking rates in Halton have decreased considerable in recent years, tobacco is a major risk factor for cancer and heart disease and a major contributor to the health inequalities gap between Halton and England. Halton now has the 3rd highest quit rate in the North West.

The cumulative rate per 100,000 population up to Q3 equates to 688 quitters.

It should be noted that quit rates are down approximately 10% nationally and around 13% in the North West, much of this **may** be attributable to the increase availability and popularity of the e-cigarette which is not endorsed as a smoking cessation tool.

Healthy Halton

Summary of Key activities taken or planned to improve performance:

Key tobacco control initiatives to run throughout the year are:

- Delivery of smoking prevention programmes for schools and young people
- Training for teachers on illicit tobacco and its dangers.
- Tobacco Control training provided for 60 PSHE primary teachers across Halton & St Helens per annum, including support and evaluation of cascade of training to pupils.
- Social marketing driven, comprehensive, and highly visible coverage of targeted interventions delivered across Halton and St Helens.
- Deliver 12 Brief Intervention training sessions-1each month.
- Implement new intervention to encourage pregnant smokers to stay quit for the term of the pregnancy.
- Raise profile of SUPPORT stop smoking services by targeted brief Intervention training to Halton General and HCRC staff Pre-Op, Cardio respiratory, minor Injury 100% outpatient services in Halton General and 5 Borough Mental Health settings in Halton, trained in referral pathway to stop smoking services.
- Increase the number of Pharmacies offering support to smokers from 15 to 25.
- Increase in cessation data collected from GP practices
- 10% Increase in annual numbers of under 18 attending support to stop smoking
- Increase awareness of the Support service to areas of High deprivation and deliver targeted campaigns to pregnant and manual smokers.
- Incentive scheme developed for pregnant smokers.
  Social marketing programme delivered for pregnant smokers.

SCS / HH9 Mental Health – Number of people receiving Community Psychological Therapies (IAPT) (New Measure)

Increased access to Psychological Therapies (IAPT) implementation is highlighted in the Operating Plan for 2012-13 with a prevalence target population of 45,559 for Halton and St Helens. The current service will be expected to provide provision to 15% (6,840) of that target population of Halton and St Helens. Therefore the expectation in 12/13 is that 4,104 patients will enter into treatment, and at least 60% of the targeted population will enter treatment and of those receiving treatment at least 50% will move to recovery.

Please note that this prevalence is in relation to anxiety and depression only.

2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
New Indicator	4,104	1.6%	4507.51 at 9.86% (9.86% Achieved across Halton and St Helens)	✓	N/A

Data Commentary:

The period the data relates to is 12/13. New regional Increased access to Psychological Therapies (IAPT) access targets will be set in 13/14 in Q4.
Actual verified access targets achieved for 12/13
Q1- 2%
Q2- 1.6%
Q3- 1.4%
Q4- 4.86%

Trajectories agreed and met were 9.85% this differs from prevalence/access targets this is due to the increase in demand in step 3 activity.

Across Halton and St Helens PCT the 15% access was not achieved (see performance commentary below)
5.14% under performance. However 9.2% of the prevalence was being met from Q1-3 with number of referrals.

Performance Commentary:

An IAPT deep dive was completed by the National/Regional IAPT team-for 12/13 the IAPT programme achieved 9.86% access rate. Under performance had been identified and linked to:

- The service specification and contract following a National directive and not reflecting local need- locally Halton has a greater need for high intensity provision at step 3 and this blockage has increased waiting times and reduced the capacity of the high intensity therapists .Step 2 provision is currently commissioned locally to meet the need of the population.

- Cleansed data has been an issue throughout the life of the programme

Summary of Key activities taken or planned to improve performance:

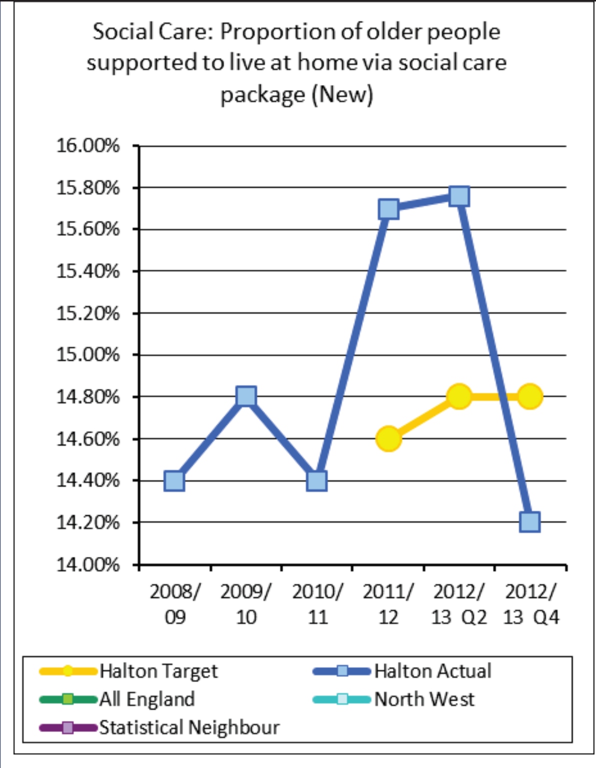
13/14 onwards
Halton Clinical Commissioning Group (CCG) has redefined the IAPT targets locally and the NHS CM Local Area Team has confirmed prevalence data for Halton (16,401) targets for 13/14 (10.5%) and 14/15 (target to

be agreed with Local Area team) the above has been submitted to the NHS CM Local Area Team for approval on 28/3/13. The above target also reflects the lack of cleansed data around this access target.

The service specification and contract will be reviewed to reflect delivery for the 10.5% target in 13/14. Under spend and DOH training provision has ensured that both service providers can recruit to HITs vacant post and increase provision to reflect the population's needs.

Healthy Halton

SCS / HH10	Proportion of older people supported to live at home through provision of a social care package (NEW)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
15.7%	14.8%	15.76%	14.2%		

Data Commentary:

This indicator measures the proportion of older people (65+) who are supported by Adult Social Care Services to live independently in their own home.

The indicator measures The number of people 65+ who are supported with an Adult Social Care Service Package as a percentage of the Older people population for Halton.

Performance Commentary:

We have fallen just short of our set target. A combination of factors has caused this:

- A population increase (of approximately 7%) as evidenced by the last Census
- A slight decrease (about 2%) in the numbers of older people receiving community based services
- The continuing development of services designed to support people at an earlier stage in their condition, which reduces the numbers of people who need support at home.

Summary of Key activities taken or planned to improve performance:

The recommendation is that this target should be retained. The target was achieved in 2011/2012 and indications at quarter 3 of this financial year are that last year's performance will continue at slightly increased level.

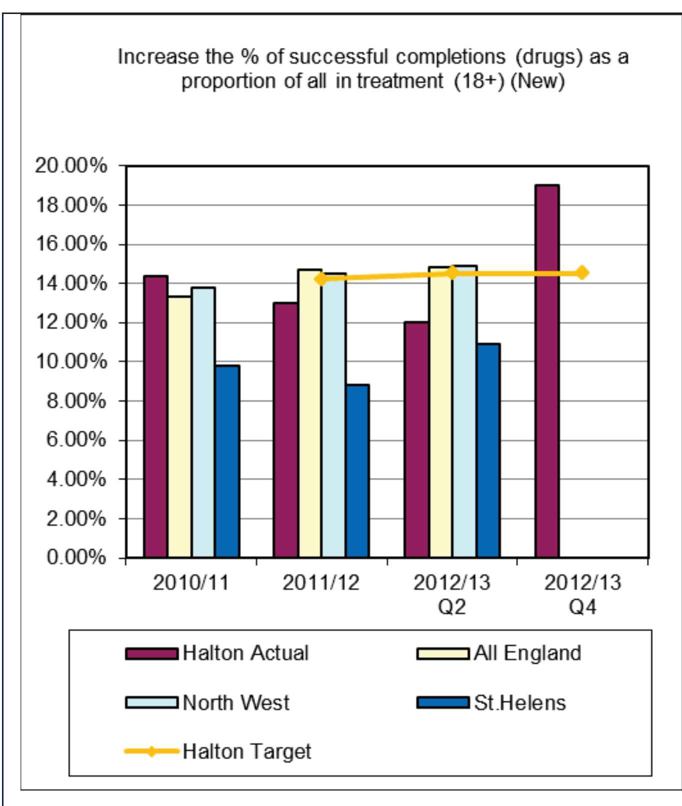
Performance in this area reflects the shift to early intervention and preventative models of care, which prevent hospital admissions/readmissions and admissions to long term care (residential and nursing placements), widespread use of technology to maximise independence and greater emphasis on personalised care.

The social care teams have recently reconfigured and plans are in place to integrate health and social care services within health neighbourhoods improving effectiveness and performance in this area.

Plans for complex care pooled budgets across health and social care will improve outcomes for Halton residents and will enable people to remain at home for longer with appropriate support. (Target date for implementation April 2013)

Healthy Halton

SCS/ HH11a[2]	Increase the % of successful completions (drugs) as a proportion of all in treatment (18+)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
13%	14.5% (Above NW average)	12%	19%	✓	⇧

Data Commentary:

The new substance misuse service, provided by CRI commenced on 1st February.

January 2013 figures for comparison:
NW=15.9%
All England=14.7%
St Helens=15.0%

Performance Commentary:

Latest data is rolling 12 months to January 2013. In spite of the low number of discharges in the last quarter of 2011/12 (handover to new Service Provider), the percentage is on target. The number of successful completions is 120/637 (19%). This compares to January 2012 where the rate was 14%

Summary of Key activities taken or planned to improve performance:

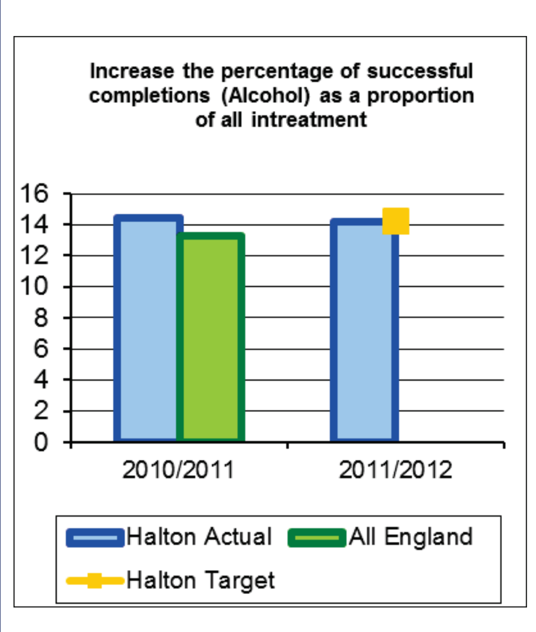
The factors that have contributed to the improving stats are:

- The introduction of the Foundations of Recovery
- The new style strength based assessment and recovery planning process
- Routes out of treatment being as much of a priority as routes in
- The introduction of counsellors
- Visible recovery on site via: peer mentors, recovery champions, recovery events
- Breaking Free online (CBT self-managed modular programme)
- Improved internal communication systems
- Improved case management

[2] SCS / HH 11a is also replicated under Safer Halton as SCS /SH 7a

Healthy Halton

SCS/ HH11[3]b	Increase the % of successful completions (Alcohol) as a proportion of all in treatment (18+)



2011/12 Actual	2012/13 Target	2012/13 Qtr 2	2012/13 Qtr 4	Current Progress	Direction of Travel
New measure	Baseline to be established in 2012/13	Refer to comment	Refer to comment	Placeholder 2012/13	New Measure

Data Commentary:

The aim of this service is to increase the % of successful completions as a proportion of all people in treatment for an alcohol addiction. It is a measure of how successful the Tier 3 Community Service is, in treating alcohol dependency and ensuring that the in-treatment population does not remain static.

Performance Commentary:

This new service will be established in 2012/13. Targets will then be set following the collection of data in year 2012/13 and a baseline established.

Summary of Key activities taken or planned to improve performance:

Data is not yet available in this format, however work is underway to develop data sets in line with local and National Treatment Agency requirements.

[3] SCS / HH 11b is also replicated under Safer Halton as SCS / SH 7b.