Public Document Pack

Health Policy and Performance Board

Tuesday, 17 June 2014 at 6.30 p.m.
Council Chamber, Runcorn Town Hall

Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	Labour
Councillor Joan Lowe	Labour
Councillor Marjorie Bradshaw	Conservative
Councillor Sandra Baker	Labour
Councillor Mark Dennett	Labour
Councillor John Gerrard	Labour
Councillor Margaret Horabin	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Chris Loftus	Labour
Councillor Pauline Sinnott	Labour
Councillor Pamela Wallace	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, 9 September 2014

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

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

REPORT TO: Health Policy & Performance Board

DATE: 17 June 2014

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.

REPORT TO: Health Policy and Performance Board

DATE: 17 June 2014

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing 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.

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 12 March 2014 at Karalius Suite, Halton Stadium, Widnes

Present: Councillors Polhill (Chairman) Morley, Philbin and Wright and S. Banks, J. Bucknall, M. Cleworth, G. Ferguson, J. Heritage, D. Johnson, D. Lyon, T. McDermott, K. Milsom, T. Knight, E. O'Meara, D. Parr, N. Rowe, C. Samosa, N. Sharpe, M. Shaw, R. Strachan, P. Williams, J. Wilson and S. Yeoman

Apologies for Absence: S. Boycott, G. Hayles, A Marr and A.McIntyre.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB54 MINUTES OF LAST MEETING

The minutes of the meeting held on the 15th January 2014 were taken as read and signed as a correct record.

HWB55 PRESENTATION - HALTON HOUSING TRUST - NOEL SHARPE

The Board received a presentation from Noel Sharpe, on behalf of Halton Housing Trust. Members were advised that the Trust was a non-profit organisation which contained 15,000+ homes and was regulated by the Homes and Communities Agency. The presentation outlined:

- examples of groups who had been supported by the Trust;
- the debt and money advice service available to tenants;
- the Trusts' strong emphasis on recruitment which was highlighted by the 22 apprenticeships created in the last year;
- the challenges faced including welfare reform;
- the 'newshoots' scheme and the development of the lettings property pool plus system;
- back to work initiatives including bursaries for tenants;
- details of the sheltered housing review;

- falls prevention initiatives; and
- the memory and cognition preliminary screening pilot 'Living Well Project';

Arising from the discussion Terry McDermott, representing Cheshire Fire Brigade, highlighted the number of fire safety checks the service carried out in homes in the Borough for those over 65 years of age. It was suggested that the Fire Service could work with Halton Housing Trust staff to provide them with the skills to carry out similar safety checks.

RESOLVED: That the presentation be received.

HWB56 PRESENTATION - LIAISON PSYCHIATRY: PROGRESS SO FAR AND NEXT STEPS IN WARRINGTON & HALTON - JOHN HERITAGE (5BP) / DAVE SWEENEY

The Board received a presentation from John Heritage, on behalf of 5 Boroughs Partnership, which detailed what Liaison Psychiatry is and why it was needed. It was noted that a Liaison Psychiatry service, could by identifying a mental health issue:

- produce significant savings to a hospital;
- reduce pressure on an acute Trust; and
- produce improved clinical outcomes.

Members were advised on what services were currently available to Halton residents at Warrington and Whiston hospitals and the impact at Whiston Hospital of a Liaison Psychiatry service. In addition, Members also noted the progress being made to provide Warrington Hospital with a similar Liaison Psychiatry service as that provided at Whiston which included:

- a task and finish group had been set up;
- clinical pathways were being reviewed and refined; and
- agreement had been reached in principle from Halton and Warrington Clinical Commissioning Groups (CCGs) to move to commission enhanced services at Halton and Warrington Hospitals in 2014/15.

RESOLVED: That the presentation be received.

HWB57 APPROVAL OF THE DRAFT BETTER CARE FUND

Following approval by the Board, the draft Better Care Fund was submitted to the Local Government

Association and NHS England on 14th February 2014.

Members noted that initial feedback had been received from NHS England and the Better Care Fund submission had been updated accordingly. An updated submission had been previously circulated to the Board. It was noted that the final draft Better Care Fund would be submitted to the Local Government Association and NHS England by the 4th April 2014.

RESOLVED: That

(1) the content of the report be noted; and

(2) the final draft Better Care submission (Appendix 1) be approved.

HWB58 NHS HALTON CCG 2 YEAR OPERATIONAL PLAN

The Board considered a copy of the NHS Halton CCG 2 year Operational Plan which was to be reviewed as was required by NHS England. The plan identified in detail the finances and level of savings required over the next two to five years and the actions to be undertaken to provide sustainable quality services to improve the health and wellbeing of the people of Halton. In addition, the plan highlighted priorities within the following areas:-

- System Vision;
- Integration and Innovation;
- Quality Improvement
- Sustainability;
- Improvement Interventions;
- Contracting and Governance Overview;
- Key Values and Principles;
- Operational Plan Outcome Measures and Targets;
- Operational Plan NHS Constitution Measures;
- Operational Plan Activity; and
- Better Care Fund Plan.

RESOLVED: That the NHS Halton Clinical Commissioning Group 2 Year Operational Plan be reviewed.

Operational Director Integrated Care Halton CCG

HWB59 PUBLIC HEALTH ANNUAL REPORT

The Board considered a report of the Director of Public Health, which provided an update on the development of Halton Public Health Annual Report (PHAR). The Annual Report was an important vehicle by which a

Director of Public Health (DPH) could identify key issues, flag problems, report progress and serve their local populations. It would also be a key resource to inform local inter-agency action. Whilst the views and contributions of local partners would be taken into account, the assessment and recommendations made in the report were those held by the DPH and did not necessarily reflect the position of the employing and partner organisations.

It was noted that each year a theme was chosen for the PHAR. Therefore, the report did not encompass every issue of relevance but rather focused on a particular issue or set of linked issues. For the 2013-14 PHAR the topic of reducing alcohol related harm in Halton would be covered. This topic had been chosen as alcohol harm reduction was a key priority within the Health and Wellbeing strategy.

The final draft of the report would be presented to the Board in July. Following any further amendments the final version would be available in hard copy and on line.

RESOLVED: That the Board note the theme and development of the Public Health Annual Report.

HWB60 HALTON HOMELESSNESS STRATEGY 2013 - 2018

The Board considered a report of the Strategic Director, Communities, which presented Halton's Homelessness Strategy 2013-2018. The Board was advised that in accordance with the Homelessness Act 2002 the local authority had conducted a full Strategic Review of Homelessness within the area and formulated a Homelessness Strategy for the next five year period.

The Homelessness Strategy 2013 – 2018 was based upon the findings and recommendations of two other documents, one being a comprehensive review of the current homelessness services which was conducted over a nine month period during 2012-2013. The other being the previous Homelessness Strategy 2009-2013, which involved active engagement with service users, providers and Members. It was reported that the Strategic Review of Homelessness had involved active engagement with service users, service providers, all partner agencies and Elected Members. The draft findings had also been discussed and agreed with all key stakeholders prior to the report being finalised.

The Board noted that Halton was experiencing a gradual increase in homelessness presentations and

statutory homelessness acceptances. The Board also noted that there were a number of client groups that did not meet the statutory homelessness criteria but had a pressing housing need. However, it was reported that concerted efforts were being made by the Housing Solutions Team to assist these client groups, offering temporary accommodation for a limited period and facilitating a more efficient and accessible move on process.

Furthermore, it was reported that the Localism Act 2011 had introduced many changes to homelessness and allocations legislation. In November 2012, the Localism Act 2011 had brought into force provisions that allowed local authorities to end the main housing duty to a homeless applicant by means of a private rented sector offer, i.e. a fixed term assured shorthold tenancy for a minimum of 12 months. The Authority should consider the new allocated powers, which would impact upon future homelessness and service delivery.

In conclusion, it was reported that it had been determined that the Council would be able to reduce the length of stay in households in temporary accommodation and the associated costs. Additionally, it would help the Council to avoid future use of B & B accommodation.

RESOLVED: That the report be noted.

HWB61 URGENT CARE - PROGRESS

The Board considered a report of the Strategic Director, Communities, which provided an update in relation to the current projects/areas of work associated with improvements in Urgent Care. In addition, the report outlined examples of the increased demand on NHS hospital resources in both a national and local context.

In Halton, the Council and NHS Halton Clinical Commissioning Group (HCCG) were continuing to actively work together, in conjunction with partners, on Halton's Urgent Care Working Group (UCWG) (new name for Urgent Care Partnership Board), to lead on the development and management of the Urgent Care system used by the Borough's population.

Members were advised that using data produced by AQuA, comparisons had been undertaken between March and December 2013 to benchmark Halton's current performance and to monitor urgent care systems in Halton against other North West local authorities. The outcome of

the exercise was determined in the report and highlighted areas of excellent performance, areas that were improving but still presented significant challenges, areas that remained as significant challenges and areas that remained static.

In addition, the report also outlined a number of current local developments which were having an impact on the Urgent Care system within Halton which included:

- discussions held at UCWG to identify a list of initiatives for 2013/4 to manage the anticipated increase in activity and support in A&E over the winter period;
- a review of current urgent care facilities across the Borough;
- a review of Halton's Urgent Care Response Plan;
- establishment of a Community Multi-Disciplinary Team;
- progress on a care home project – ongoing since July 2013;
- Emergency Care Intensive Support Team whole system review of urgent care across Halton and Warrington.

RESOLVED: That the report and associated appendices be noted.

HWB62 END TO END ASSESSMENT

The Board considered a report of the Strategic Director, Communities, which provided information on the End to End Assessment that was being taken forward on behalf of NHS Halton, Knowsley, St. Helens and Warrington CCGs and NHS England. An independent provider had been commissioned to provide an assessment that would deliver:

- a high level retrospective review of health care activity, spend and patient flows by commissioner and by location per quarter in the past three years;

- an analysis of current health care activity, spend and patient flows by commissioner and by location; and

- project activity, spend and patient flows by commissioner and by setting for the next 3, 5 and 10 years assuming current costs and payment arrangements.

It was anticipated that the assessment would leave all commissioners with a workable model to support decision making and develop strategic approaches to the challenges for the NHS over the next five years and beyond. The work on the assessment was due to commence on the 24th February 2014 and would last for 7 weeks. It was overseen by a Steering Group from constituent CCGs and NHS England. The Project Sponsors were Simon Banks, Chief Officer, NHS Halton CCG and Stephen Sutcliffe, Chief Finance Officer, NHS Warrington CCG.

It was noted that the cost of the End to End Assessment was £94,824, split equally across the five organisations that were part of the work stream.

RESOLVED: That the work in progress be noted.

HWB63 WELLBEING AREA AWARDS AND GRANTS

The Board considered a report of the Director of Public Health, which outlined the development of Health and Wellbeing awards and grants for the local community. It was proposed that the Board endorse the development of the following:-

- a range of Wellbeing Awards in recognition of outstanding work to improve health; and

- a small grant of up to £500 for up to 10 local community projects that supported the Health and Wellbeing Boards' priorities of improving mental health, reducing falls in older people, reducing harmful drinking, improving child development, preventing cancer and early detection of the signs and symptoms.

It was suggested that three nominations be agreed from the Health and Wellbeing Board so that the mechanism for judging the applications could be put in place as soon as possible. Suggested categories for award nominations were as follows:-

- Individual Recognition Award;
- Community Group Award;
- Healthy Workplace Award; and
- Healthy School Award.

A budget of £7,000 had been identified to fund the awards and grants and cover publicity and other materials. Support for the administration of the awards would be

provided by the Community Development and Public Health Teams within the Local Authority. It was anticipated that the scheme would be formally launched at the Health and Wellbeing Community Feedback Event in the Spring.

RESOLVED: That

(1) the report be noted;

(2) the proposal of Wellbeing Awards and grants be endorsed; and

(3) the following three Members of the Board be nominated to become Members of the judging panel: Councillor Wright, Jim Wilson and Sally Yeoman.

Director of Public Health

HWB64 DENTAL HEALTH IN HALTON

The Board considered a report of the Director of Public Health, which set out:-

- the Dental Health of the child population over a 6 year period from 2006 – 2012 and set out the impact that local dental preventative measures had had on the dental health of the child population; and

- the current position with regard to NHS dental access both for regular and irregular attending patients in Halton.

It was noted in 2006, child dental health in Halton was poor. In England at that time 38% of children aged 5 years had experienced tooth decay, the figure in Halton was 51%, with each Halton 5 year old having, on average, 2.01 decayed, missing or filled teeth. Consequently in 2008, Halton and St. Helens PCT introduced a Dental Commissioning Strategy that aimed to reduce childhood population prevalence of dental disease and reduce inequalities in dental caries prevalence. A key element of the Dental Strategy was a programme that distributed fluoride toothpaste and a tooth brush, twice yearly to every child aged 3 – 11 years living within the PCT boundary.

Members were advised that using dental epidemiological data in the period 2006 and 2012 there had been substantial improvements and by 2012, decay levels had fallen by 46% to 1.09, with 33.6% of children affected.

With regard to access to dental care, changes to the

primary dental contract in 2006 put pressure on the NHS Primary Dental Care Service, with many of those wishing to secure an NHS dentist being unable to do so. Central Government recognised the problem and provided additional funding for PCTs to expand their dental services. Halton and St. Helens PCT, as part of its Dental Commissioning Strategy, expanded the number of NHS dentists working locally by an equivalent of 11 whole time equivalents between 2006 and 2012. At the same time the PCT expanded its access to routine dental care, it also redesigned the provision of the emergency "in hours" dental service which further improved dental access.

RESOLVED: That

(1) the oral health improvements since 2006 be noted; and — Director of Public Health

(2) the Board agree that the dental prevention programme continues.

HWB65 QUALITY PREMIUM

The Board considered a report of the Operational Director, Integrated Commissioning Halton CCG, which provided a copy of a report on medication error reporting. As part of the 2014/15 planning round, the CCG had 6 Quality Premium measures, one of these was the improved reporting of medication related safety incidents. This had been chosen by NHS England as contributing to the NHS outcomes framework 5 "treating and caring for people in a safe environment and protecting them from avoidable harm" and had been selected as a quality premium measure. This measure would account for 15% of the quality premium (approximately £95,250) and would be awarded if:-

- a specified increased level of reporting of medication errors was seen between Q4 2013/14 and Q4 2014/15;
- the increase must be agreed with a local provider, the Health and Wellbeing Board and the NHS England Area Team;
- the increase could be agreed with more than one CCG with the same provider, but the provider must account for 10% of the CCG's activity;
- primary care could be included as a provider in this measure; and
- reporting was via the national Reporting and Learning System.

The four largest providers of CCG activity had been investigated to determine where potential improvement could be found, the four providers were:-

- Bridgewater Community NHS Trust;
- 5 Borough's Partnership Mental Health Trust;
- Warrington and Halton NHS Foundation Trust; and
- St. Helens and Knowsley NHS Trust.

The report highlighted the percentage of incidents reported that were recorded as "Medication" alongside cluster averages and the rates of recording of all incidents.

It was proposed that Bridgewater Community NHS Trust be chosen as the Quality Premium target provider and for the target to increase its rate of medication error reporting over the year 2014/15.

RESOLVED: That both the provider and the specified increase on the level of medication error reporting be approved.

Meeting ended at 4.00 p.m.

REPORT TO:	Health Policy and Performance Board
DATE:	17 June 2014
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Urgent Care – Progress, including Urgent Care Centre Development (Presentation)
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 Present Members of the Board with an update report in relation to the current projects/areas of work associated with improvements in Urgent Care, including a presentation from Simon Wright, Chief Operating Officer/Deputy Chief Executive of Warrington and Halton Hospitals NHS Foundation Trust in respect of the progress towards the development of Urgent Care Centres in Runcorn and Widnes.

2.0 RECOMMENDATION: That the Board: Note the contents of the report, associated appendices and presentation.

3.0 SUPPORTING INFORMATION

National Context

3.1 Demand on NHS hospital resources has increased dramatically over the past 10 years, with a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75 years.

- Last year, there were over 21 million visits to A&E or nearly 60,000 attendances every day
- The trend of increasing A&E attendances slowed in 2013/14 to 0.6%
- There were 6.8 million attendances at walk in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since these data were first recorded a decade ago
- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008
- Last year, there were 51.4 million GP appointments, one in five due to minor ailments such as coughs, colds and hair lice
- Attendances at hospital A&E departments have increased by more than two million over the last decade
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million

- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13

3.2 A combination of factors, such as an ageing population, out-dated management of long-term conditions, and poorly joined-up care between adult social care, community services and hospitals are seen to account for this increase in demand over time.

3.3 Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6 per cent per year.

3.4 Following the publication of the key findings and recommendations of the second Francis Inquiry which outlines the story of the appalling suffering of many patients at the Mid Staffordshire Hospital, we have recently seen a radical change in how the Care Quality Commission inspects acute hospitals, which includes the introduction of hospital inspection teams.

3.5 Sir Bruce Keogh, the National Medical Director of NHS England, has also recently proposed a fundamental shift in the provision of urgent care, with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment.

3.6 These and other national developments are all having an impact on the whole of the urgent care system, both nationally and locally.

Local Context

3.7 Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (HCCG) are continuing to actively work together in conjunction with our partners on Halton's Urgent Care Working Group (UCWG) (new name for Urgent Care Partnership Board) to lead on the development and management of the Urgent Care system used by the Borough's population. Attached at ***Appendix 1*** is the governance structure associated with the Urgent Care system in Halton.

3.8 The Urgent Care agenda is a complex and challenging one; we need to ensure that there is a system wide approach to Urgent Care which requires high quality and accessible primary, community and social care services to be in place to provide alternatives to A&E attendance and admittance to hospital for the local population.

3.9 Locally we have seen :-

- A 3.4% increase in A&E attendances for the Halton population across the 2 local acute trusts between 2010/11 and 2012/13 with a further 3% increase in 2013/14. A reduction in the number of attendances at Warrington Hospital was offset by an increase at Whiston

- 33% of Halton people admitted to an acute hospital stay less than 24 hours indicating that people required some investigations than would take longer than 4 hours

- An average of 4,000 monthly attendances since April this year at the Widnes Walk in Centre.

- On average there have been approximately 1,500 calls per month to the Out of

Hours GP Service.

- The number of Category A calls received by the Ambulance Service resulting in an emergency response arriving at the scene of an accident is averaging approximately 600 per month.

Current Performance

3.10 There are a range of performance and benchmarking measures that help us to monitor the urgent care system both on a daily basis and over time to establish trends. This range of data includes the NHS and Local Government Quality and Efficiency Scorecards which are produced by the Advancing Quality Alliance (AQuA)

3.11 Comparisons have been undertaken between the dated AQuA produced in December 2013 and that produced in March 2014; these comparisons are attached at ***Appendix 2.*** Appendix 2 actually outlines related performance information over the last 12 months. It should be noted that the September 2013 and December 2013 information did not include Cumbria and as such should be taken into account when considering Halton's position against other NW areas during this time.

3.12 The latest data provided by AQuA does demonstrate excellent performance in the following areas:

- permanent admissions to residential/nursing care – Although it should be noted that there has been an increase in permanent admissions to long term care since September 2013; and

- proportion of Local Authority Adult Social Care spend on residential/nursing care - It should be noted that Halton has previously been ranked the best in the NW in relation to this area, however according to March 2014 information, Halton has now been ranked 2nd and are being out-performed by Bolton – this links to the increase in permanent admissions outlined above.

Due to the increase in these areas over the past few months, work is currently taking place to investigate as to the reasons why. For example Halton's Urgent Care Working Group (UCWG) has established a short term task and finish group to review and develop further the frailty pathways out of acute care. Management Team should note that admissions to long term care from Whiston hospital are higher than those from Warrington hospital. The task and finish group will consist of appropriate representation from across the Urgent care system to explore where improvements can be made and will make necessary recommendations to the UCWG for consideration.

3.13 Areas that are improving but still present significant challenges include:

- non elective admissions and non-elective bed days – Even though Halton still remain on red in these two areas the direction of travel is positive; the figures reported in March 2014 are lower than those reported 12 months ago. These improvements are attributable to a number of initiatives/activities, including the work of the Integrated Discharge Team at Warrington and work with the Team at Whiston which has enabled the development of a more proactive approach to managing length of stay and therefore on associated bed days, whilst initiatives such as the GP acute visiting scheme and Community Multi-Disciplinary teams are having a positive impact on non-elective admissions.

3.14 Areas that remain as significant challenges include:-

- non-elective re-admission rates within 30 **and** 90 days – It should be noted however that performance in terms of 90 day readmission rates has improved over the last 12 months; and
- delayed transfers of Care (bed days) – This is an area which had been improving but performance has dipped during January 2014. Delayed transfers of care can be either attributable to the NHS, Social Care or both and are a difficult area to manage effectively. If we consider the bed days lost in January 2014, the breakdown is as follows:-

    - NHS = 264 days
    - Social Care = 0 days
    - Both = 16 days
    - TOTAL = 287 days

  Delayed transfers of care continue to be one of the persistent contributing factors impacting upon hospital patient flow and ultimately the A&E 4hour target. There can be numerous reasons for delays to occur, for example patient choice; sometimes there can be long and protracted negotiations between acute trusts and patients prior to discharge. Delays can also occur when complex assessments of patients are required, for example when waiting for a best interest or psychiatric assessment.

  Lack of capacity within Intermediate Care (IC) Services can also be a factor; however in Halton we always actively ensure that there is appropriate capacity within the system to help alleviate any issues for the acute trusts. For example, in January 2014 we opened up an additional 6 IC beds over the winter period to ensure that the supply and demand for beds could be appropriately managed.

  It should be noted that it is very rare for any delays in Halton to be attributable to Social Care due to the proactive nature of the work that we undertake with our local trusts to ensure that patient flow is managed as effectively as possible.

3.15 Areas that remain static include:

- proportion of people discharged direct to residential care; and
- proportion of deaths which occur at home – It is hoped that the recent review of the end of life pathways and services that has been undertaken will have a positive impact on performance in this area; the figures reported in this area are only done so every 12 months.

3.16 Work has also been undertaken on the development of an Urgent Care Performance Dashboard, which includes a range of high level indicators such as the numbers of A&E attenders and ambulance turnaround times, which the UCWG use to assess performance within Halton from a 'whole system' perspective. Attached at ***Appendix 3*** is a copy of the Performance Dashboard outlining performance as at February 2014.

<u>Current Local Developments</u>

The following paragraphs outline a number of current local developments currently having an impact on the urgent care system within Halton:-

3.17 **Winter 2013/14**
The delivery of the A&E standard (95% of people seen, treated and discharged within 4

hours) across England throughout winter remained a key priority for NHS England and partners. Since the A&E Improvement Plan was introduced by NHS England in May 2013, UCWGs have been working locally to support the delivery of the 4 hour standard.

Heading into Winter 2013/14, discussions took place at the UCWG to identify a list of schemes/initiatives which had the potential to manage the anticipated increase in activity and support A&E over the winter period. See ***Appendix 4*** for details of these initiatives.

The schemes identified :-

- Support the flow within A&E within Whiston and Warrington Hospitals;
- Support the flow through acute bed base; and
- Deflect admissions from A&E.

These schemes coupled with close operational management of services and work with all providers were designed to managing changes in demand whilst maintaining the high performance and quality of care achieved through the rest of the year.

Both Warrington and Whiston hospitals met the 4 hour target for the year 2013/14

3.18 **Urgent Care Centres (inc. Clinical Assessment Unit)**

Part of NHS HCCG's commissioning intentions 2013/14 included a review of the current urgent care facilities across the borough, development of a preferred model of care and completion of a formal three month public consultation. The developing model of care is being designed to enhance the range of health and support services available within the borough whilst reducing pressures on A&E departments and the acute bed base.

Further detail in terms of current progress towards the Centres development is contained within the presentation associated with this report.

3.19 **Urgent Care Response Plan**

Halton's Urgent Care Response Plan, first produced in November 2012, has recently been reviewed and updated as many of the work programmes and associated projects that were identified in the first response plan have now been completed/achieved.

In addition to a number of on-going projects, the UCWG, via the development of Halton's Accident and Emergency Recovery and Improvement Plan - May 2013, has identified a number of new projects which will further improve the Urgent and Emergency Care system within Halton. Regular monitoring of the progress of these work programmes is taking place via the UCWG.

3.20 **Community Multi-Disciplinary Team (MDT)**

One of the overall aims of the development of a Community MDT approach to the management of people with Complex Needs is ensure the development of individualised programmes of care and support, thus reducing the need for A&E attendance and admission.

Each MDT comprises of a core group of staff including a GP, Senior District Nurse, Community Matron, Social Care Practitioner, Medicines Management, Practice Manager, and Community Wellbeing Officer. The core group may call on members of an 'extended team' and these members would be identified during the initial identification process or subsequent multi-professional meetings. Members of the extended team may include a Social Worker, Mental Health Practitioner or Specialist Nurse etc.

The MDT meet on a monthly basis to begin with. They combine information from practitioner caseloads, practice nominations and a developing set of data within the portal system to identify a group of patients where cross professional discussion will support a coordinated approach to complex case management.

All 17 GP practices within Halton have been involved in this project and further work is ongoing to revise the process in light of the changes to the GP contract.

3.21 **Care Homes Project**

The care home project in Halton is a 12 month project which was established in July 2013.

The team has one very complex, multifaceted objective which is to investigate unmet need in Halton's care homes from the perspective of health and social services. Although this appears to be quite a tough remit, it was felt that the problems needed to be understood before any attempts were made to remedy them.

The care home project has so far reviewed the residents in 4 care homes; Beechcroft, Widnes Hall, St Patrick and St Lukes and are becoming involved in another 3 homes; Croftwood, Halton View and Ferndale Mews.

On-going work has identified 6 key issues, these include:-

- Communication;
- End of life Care;
- Physical Care;
- Pharmacy;
- Equipment; and
- Primary care utilisation.

A number of recommendations have been made to make improvements in these areas and these are in the process of being implemented.

3.22 **Emergency Care Intensive Support Team (ECIST) Whole System Review (Warrington & Halton)**

ECIST have recently undertaken a whole system review of urgent care across Halton and Warrington.

ECIST focus on improving performance, quality assurance and programme enhancement. Assignments for ECIST typically include working with local health communities jointly to diagnose areas for performance improvement; supporting implementation planning and delivery; and transferring knowledge to produce sustainable and resilient solutions.

As part of the review, ECIST had the opportunity to meet with a number of colleagues from across the health and social care economy within Warrington and Halton who all either directly support the UC system or manage areas of work which impact indirectly within this area.

The whole system review report has been presented to the UCWG.

A number of themes emerged from the review, including :-

- Communication and Language – has improved but could improve further;

- Escalation – does the current escalation policy work?;
- Differences between the UCWGs within Warrington and Halton – possible duplication?
- Need for objective measures; and
- Good integration within Halton – the view being supported by partners such as NWAS and WHHFT.

The review also commented on :-

- Single Point of Access – needs further review;
- Urgent Care Centre development – deemed to be positive by all;
- Care Homes – Further work required;
- Improved dialogue between primary and secondary care clinicians required; and
- Sub-Acute Unit (Ward B1) – well run.

Overall recommendations included the suggestion to run a 'Perfect Week' at Warrington and Halton Hospitals NHS Foundation Trusts in order to 'recalibrate' the system. This was accepted by the Trust and at the time of writing this report plans are being developed to run the week w/c 13th May; support from partners will be required.

Additional recommendations included the need to standardised inpatient practice – 'SAFER' flow bundle; again accepted by the Trust, rolling ward rounds, introduction of Internal Professional Standards etc.

Further details can be found in the review report attached.

From ECIST's perspective Halton are 'heading in the right' direction, but we cannot be complacent. We need to be ambitious and brave with our plans and the 'Perfect Week' may be an opportunity to trail new developments.

3.23 It is anticipated that these current local developments will have a positive impact on the urgent care system as a whole in Halton. It is anticipated that we will be able to:-

- Match resources better to expected flow;
- Manage patient's experience, safety and outcomes better;
- Measuring quality, outcomes and performance;
- Work with delivery partners to maintain an integrated 24/7 system;
- Identify and develop alternative patient pathways to A&E; and
- Re-direct resources to enable investment in prevention and early intervention services, including public health improvement/promotion, preventing the exacerbation of Long Term Conditions and thus avoiding unnecessary hospital admissions.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 In this current economic climate, where both Local Authority and Health Services available resources are contracting, in line with the national agenda, the flow of resources supporting the urgent care system needs to change to ensure that there is a greater focus on highly responsive, effective and personalised services outside of hospital i.e. within primary,

community/voluntary and social care services. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. Secondly we need to ensure a greater focus on early intervention and prevention work to ensure that people remain healthy for longer, thus reducing the impact on the acute sector and other health and social care services.

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.

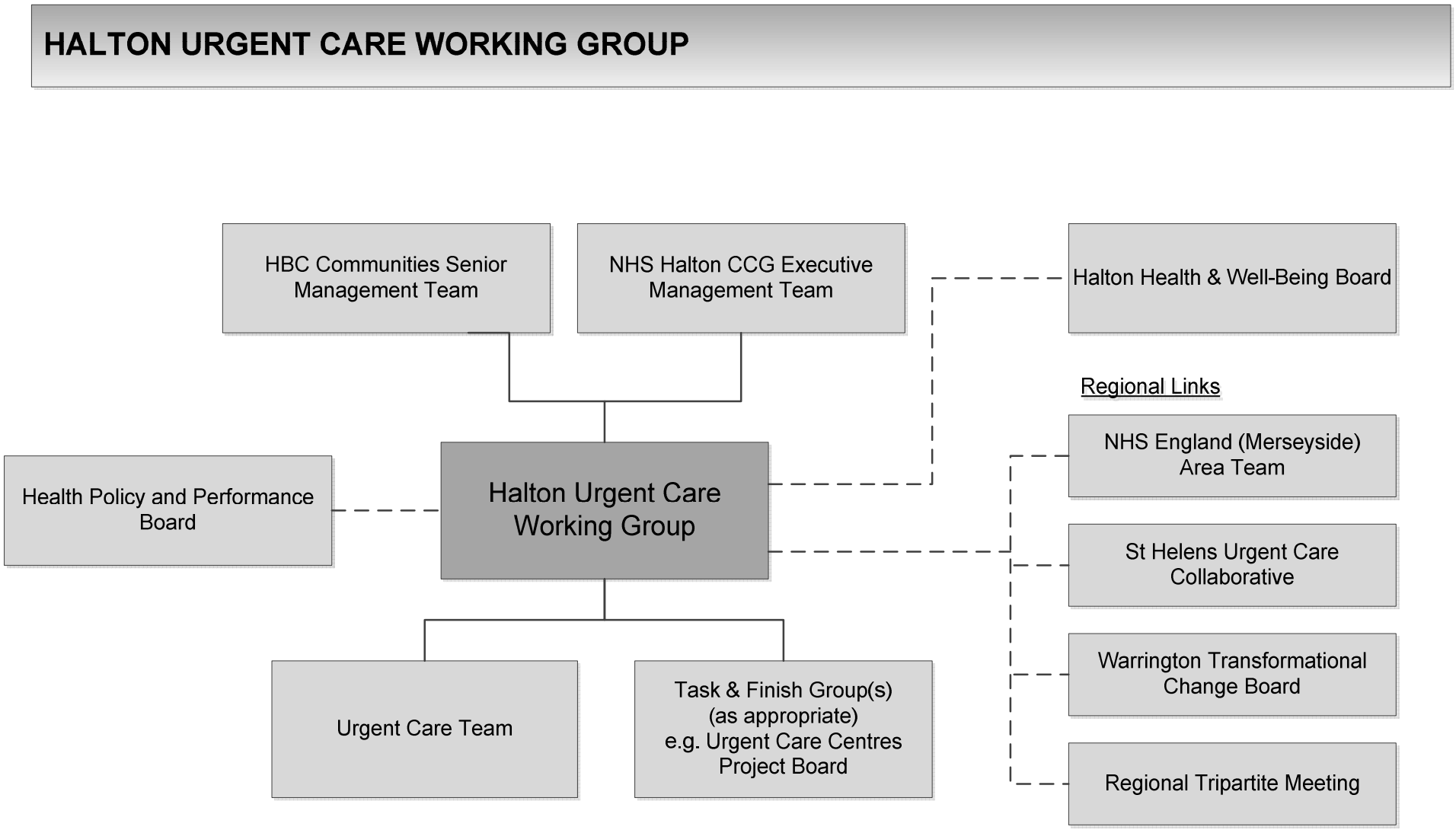
8.0 EQUALITY AND DIVERSITY ISSUES

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.

Halton Urgent Care Governance Structure



AQuA Locality Benchmarking

Indicator	Reporting Date					Direction of Travel (Between Dec 2013 – March 2014)
	March 2013	June 2013	*September 2013	*December 2013	March 2014	
Non elective admissions (65+) - Less is Better	341 (23/23)	322 (21/23)	327 (20/22)	330 (20/22)	316 (20/23)	There has been an improvement between December 2013 and March 2014; figures currently reported are the lowest reported during the last 12 months.
Non elective bed days (65+) – Less is Better	3119 (21/23)	2972 (20/23)	2750 (17/22)	2802 (18/22)	2765 (19/23)	There has been an improvement in non-elective bed days between December 2013 and March 2014; even though Halton remain as red, direction of travel has been assessed as improving as the figure for bed days reported in March 2014 is significantly better than that reported in March 2013.
Non-elective re-admission rates within 30 days (65+) – Less is Better	18% (18/23)	18% (17/23)	18.3% (20/22)	18.5% (18/22)	18.7% (18/23)	Although there has been a slight drop in terms of overall performance, Halton's overall NW position remains static.
Non-elective re-admission rates within 90 days (65+) – Less is Better	29.6% (17/23)	29.6 % (18/23)	27.9% (19/22)	27.0% (17/22)	27.6% (18/23)	Although there has been a slight drop in terms of overall performance between December 2013 and March 2014, Halton's overall NW position remains static. However direction of travel has been assessed as improving as the figure for non-elective readmissions within 90 days reported in March 2014 has improved than that reported in March 2013.

Delayed transfers of care (18+) – Less is Better	329 (21/23) – Jan'13 Bed Days	172 (13/23) – April'13 Bed Days	144 (5/22) – July '13 Bed Days	229 (17/22) – Oct'13 Bed Days	287 (20/23) – Jan'14 Bed Days	There has been a drop in the number of bed days associated with delayed transfers of care.
Proportion of people 65+ discharged direct to residential care – Less is Better	2.4% (14/23)	2.5% (13/23)	2.5% (12/22)	2.6% (14/22)	2.7% (14/23)	Figures have remained fairly static; direction of travel has been assessed as static.
Permanent admissions to res/nursing care (65+) – Less is Better	582 (1/23)	440 (1/23)	515 (1/22)	633 (4/22)	684 (4/23)	There has been an increase in the permanent admissions to res/nursing care, although Halton's performance remains high compared with other NW areas.
Proportion of LA ASC spend on res/nursing care (65+) – Less is Better	44.7%	44.7%	46.9%	49.5%	49.5% (2/23)	Linked to an increase in admissions, the proportion of LA ASC spend has also increased; we are still 2nd in the NW only being outperformed by Bolton
Proportion of deaths with occur at home/care homes (65+) – More is Better	40.6% (17/23)	40.6% (17/23)	40.6% (16/22)	40.6% (16/22)	40.6% (17/23)	NB. Figures only reported Jan- Dec 2012

*September & December 2013 figures did not include Cumbria; the March 2014 figures do now include information from Cumbria.

NB. Figures in () indicate Halton's position against other NW Local Authority areas.

Benchmarking Key

Best 1st – 6th	
7th – 12th	
13th – 18th	
19th – 23rd	

Urgent Care Performance Dashboard - February 2014

	Performance Indicators	Operational Standard/Plan	Lower Threshold	Baseline	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Direction of Travel
Accident & Emergency																
	(1) A&E Attendances - Type 1				2628	2749	2699	2775	2647	2634	2541	2505	2474	2617	2394	↓
Narrative	The number of Type A A&E Attendances in February is in line with February 2013 , The number of admissions following A&E atetndance was also similary in February 2013 and February 2014															
	(4) Percentage of patients who spent 4 hours or less in A&E Whiston	>=95%	>=94%		94.9%	97.8%	98.1%	97.4%	97.9%	97.4%	97.0%	95.8%	94.2%	92.5%	94.0%	↑
	(4) Percentage of patients who spent 4 hours or less in A&E Warrington	>=95%	>=94%		93.6%	96.7%	97.6%	95.1%	96.2%	95.0%	94.9%	95.5%	95.4%	94.3%	94.9%	↑
Narrative	Warrington A&E performance in February was marked by the first week with less than 91% seen within 4 hours, however by the end of February a significant improvement had been recorded and between 98% and 99% of people were being seen by the end of the month. At Whiston the 95% target was not met in any week in February, however an improvement has been seen in March with performance recorded at over 96%															
	(6) % of Type 1 A&E attendances where referral source is GP				3.81%	3.02%	3.15%	3.68%	3.25%	4.37%	3.94%	3.91%	4.57%	5.58%	4.59%	↓
Narrative	In February, there were 110 Type 1 A&E attendances where the referral source was recorded as GP, This is in line with recent figures.															
	(9) (%) Conversion rate - A&E type 1 attendances admitted to hospital	28%			38.05%	35.43%	35.31%	33.66%	35.81%	34.47%	36.25%	37.13%	36.66%	37.68%	36.97%	↓
Narrative	The conversion rate for Halton residents is higher than than the conversion rates at the individual trusts as a whole. For Whiston the conversion rate for the Trust is approximately 35% at Warrington the conversion rate for the Trust is approximately 27% For Halton residents the conversion rate at both sites is broadly similar at 37%.															
Non-Elective Emergency admissions - (based on Admission method 21 - 'Accident and emergency or dental casualty department of the Health care Provider)																
	(19) No. of patients discharged following admission via A&E				1001	969	963	951	943	897	896	958	907	958	871	↓
Narrative																
	(23) % of patients discharged following admission from A&E with zero length of stay				32.77%	37.46%	34.06%	29.76%	34.15%	32.33%	32.92%	31.63%	31.97%	32.46%	30.08%	↓
Narrative	There were 262 patients discharged with a zero length of stay in February. The average length of stay is 5 days.															
	(31) Emergency Re-admissions 30 days				225	268	253	258	247	233	223	226	235	230	194	↓
Narrative	February's figure is likely to be an under-reporting of the true picture as re-admissions are only coded on discharge of the readmission. Putting Februarys figure to one side, there has been no significant movement in emergency readmission figures since April 2013															

	Performance Indicators	Operational Standard/Plan	Lower Threshold	Baseline	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Direction of Travel
Walk in Centre - Provider code RY2 - 'Bridgewater Community Healthcare NHS Trust'																
(34)	All Attendances - Halton walk in centre				3793	4076	3835	4368	4059	3994	2755*	2647*	2780*	2827*	2734*	
Narrative	(Note - * Bridgewater advised that following transfer to a new system in October 2013 they have identified some clinic based actiivty i.e. (Ad-Hoc Bloods) were being entered into the old system in error. Therefore Apr - Sep data is higher. This should be rectified from the 1st April and the old figures with the ad-hoc blood figures removed will be available															
Out of Hours																
(52)	Total number of Halton calls completed on Adastra				1696	1707	1415	1301	1489	1343	1313	1481	1894	1635	1559	↓
Narrative	The proportion of calls with a definiative clinical assessment within 20 mins was 15%, this is the lowest proportion this year. In December and January the proportion was over 20% and the average to January was 19%															
Ambulance - NWAS																
(78&81)	The number of category A (red 1& 2) calls resulting in an emergency response arriving at the scene of the incident				610	565	559	577	772	601	582	639	621	606	565	↓
Narrative	The high figure of 772 in August is due to the additional activity created by Creamfields event. In February there was 25 Category A (Red 1) calls, of these only 16 arrived within 8 minutes (64%) against a target of 75%.															
	Turnaround times (Average) (mins) Whiston	<15	<30		-	-	-	-		28.3	27.2	26.7	27.8	29.6	27.29	↓
	Turnaround times (Average) (mins) Warrington	<15	<30		-	-	-	-		25.7	25.2	23.4	23.1	23.6	22.99	↓
Narrative	Performance in February was much better in February than in January for Whiston. The number of days in the month wher the average turnaround time exceeded 30 minutes reduced from 10 to 4. In Warrington there were no days in either Janaury or February where the average turnaround time exceeded 30 minutes.															
Delayed Discharge Transfers - Halton GP registed patients - Snapshot taken last Thursday of the Month																
(149 & 150)	Number of delayed discharge transfers				8	6	2	5	6	12	5	7	6	12	6	↓
Narrative	This is the total number of delayed discharges regardless of accountability. There were 6 delayed discharges as measured on the last Thursday in January 4 of which were NHS Accountability. 1 delay was due to completion of assessment, 1 was waiting for a residential home placement, 2 wating for a care package in their own home and 2 were patient choice.															
Intermediate Care Services - Halton Borough Council																
	Numbers referred to Intermediate care				157	158	112	148	125	125	138	118	107	149		↓
Narrative	January's figure is an estimate, we are still awaiting confirmation of the figures from 1 team															

Winter Plan 2013/14 : Winter Schemes to Manage Increased Activity and Support A&E Target

Schemes to support flow within A&E (6 month only)

Scheme	Costs (£000's)	Activity	Expected impact and data source	Lead Officer
Funds to Warrington CCG to support winter pressures planning at Warrington & Halton Hospitals NHS Foundation Trust	230	Numerous winter initiatives have been agreed with Warrington CCG and funds will be transferred to Warrington CCG from Halton CCG to support Halton patient pathways.	Business case and data source to be developed across WCCG and WHHFT **Data source**: • Urgent Care Dash Board • Escalation recovery plans	Linda Bennett
Funds to St Helens CCG to support winter pressures planning at St Helens & Knowsley Teaching Hospitals NHS Trust	300	St Helens CCG have worked with providers to develop plans, specifically to support A&E by developing front end primary care provision. Funds will be transferred to St Helens from Halton CCG to support Halton patient pathways.	Business case and data source to be developed across St Helens CCG and STH&K **Data source**: • Urgent Care Dash Board • Escalation recovery plans	Lisa Kieran
Provision of community matrons within A&E departments	41	Deploy community matrons into AED to support patient flows within the department **Timescales:** To commence Monday 16th December 2013 and will run until the end of March 2014.	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence;	Ged Timson

		The matron/nurse will work alongside the existing matron in A&E in diverting patients who do not require emergency admission to community services where possible and appropriate thus avoiding unnecessary admission and pressures on the acute service.	• Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting • This will increase the flow out of A&E back into community services. **Data source**: • Urgent care Dash Board • Bridgewater Quality performance indicators	
Admission and Alternative Contact Service for Community Services	12	This will support a reduction in GP/RARS admissions by providing a liaison service between community and acute provision for all secondary care providers. The expectation is that patients will be deflected to community provision before being admitted to acute provision. **Timescales :** In place	**Expected impact:** • Reduce hospital admissions; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Urgent Care Dash Board • Bridgewater Quality performance indicators • SPA performance dataset to	Steve Holbrook

			be agreed and added to Urgent Care Dashboard	
Development of Merseyside escalation and diversion policy. This Cheshire and Merseyside initiative is being developed across commissioning and provider agencies. Part of the initiative is to review the CMS IT system and its usage and potential impact.	zero	The development of two task and finish groups: CMS group- review CMS system and makes recommendations regarding potential usage in the future and its development (future procurement of the CMS system will also need to be considered within the recommendations). Policy- group lead by Liverpool CCG urgent care lead to review and merge North west escalation policy and NWAS diversion policy with consideration given to command and control arrangements **Timescales :** Policy due to be ratified 19.11.13	**Expected impact:** • This will support the flow through of A&E departments across the health economy • Increase communication across Provider Trusts including community provision • Enable flow to be dealt with, in response to current demand without maintaining delays in the system • Reduce escalation up to command and control **Data Source**: • RUCAT • Provider/Commissioner-system feedback	Leigh Thompson-Greatrex
TOTAL	**583**			

Schemes to support flow through acute bed base (4 months only)

Scheme	Costs (£000's)	Activity	Expected impact and data source	Lead Officer
Increase Intermediate Care bed capacity x 6 beds (Nursing)	63.5	Commission 6 beds from independent sector **Timescales :** To commence Monday 16th December 2013 – to run for 21 weeks	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Urgent care Dash Board • SPA performance dataset to be agreed and added to Urgent Care Dashboard	Damian Nolan
Increase capacity in hospital discharge		Review of Integrated discharge	**Expected impact:**	Damian Nolan

teams	45.5	hospitals teams, including the taskforce which will:- • review any duplication across the teams; • support ward staff to identify discharges earlier; • ensure speedy discharge through a single assessment process; and • employment of additional social work capacity. **Timescales :** To commence Monday 16th December 2013 – to run for 21 weeks	• Release acute beds at Warrington and Whiston Hospitals; • Reduces the number of 'non-acute' patients occupying beds; and • Strengthen the ability of Warrington and Whiston Hospitals to continue to meet the 18 week target for Halton patients **Data source**: • Urgent Care Dash Board • SPA performance dataset to be agreed and added to Urgent Care Dashboard • RUCAT	
Increase capacity in MDT Intermediate Care support (community and beds) 1 X OT, 1 x PT, 1 x SW	78	Increased complexity and demand requires additional skilled assessment and intervention work to maintain safe and efficient care. These staff will support additional bed capacity, maintain through put in existing bed bases and support community services	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home	Damian Nolan

		Timescales : To commence Monday 16th December 2013 – to run for 21 weeks	for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Urgent Care Dash Board • Bridgewater Quality performance indicators • SPA performance dataset to be agreed and added to Urgent Care Dashboard	
Increase equipment and extend delivery hours	80	Changes in demand during the winter period mean that the type of equipment needed changes with more bed related. Extending delivery hours will support hospital discharges ICES will extend delivery times (16 week period) to 7pm Mon-Friday to support urgent hospital discharges. It will also extend its out of hours support beyond these times for complex equipment i.e. hospital beds, mattresses, hoists. The weekend service will operate	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Bridgewater Quality	**Ged Timson**

		from 9-12 noon for all equipment and outside of these hours for complex equipment. **Timescales :** In place	performance indicators	
TOTAL	**267**			

Schemes to deflect admissions from A&E (6 month only)

Scheme	**Costs (£000's)**	**Activity**	**Expected impact and data source**	**Lead Officer**
Development of a MDT within Primary Care	zero	Development of Multi-disciplinary Team approach in Primary Care to the management of high intensity users of health and social care utilising risk stratification. Through the development of a locally enhanced service. The LES will be designed to: • Undertake risk profiling and stratification of registered patients on a monthly basis (LES) following an holistic approach to embracing physical and mental health problems	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting	Damian Nolan

		• Work within a local multidisciplinary approach to identifying those who are seriously ill or at risk of emergency hospital admission • Co-ordinate with other professionals the care management of those patients who would benefit from more active case management **Timescales :** In place	**National Guidance:** • National Service Specification • NHS England 2013/14 DES **Data source**: • LES/DES activity template	
Acute Visiting Scheme (inc.deflection)	195	To develop a Pathfinder Tool which will enable NWAS to work with other services to provide alternatives to hospital transfer. The use of the Pathfinder Tool identifies which patients are safe to be left at home subject to their being another service available to continue appropriate assessment and care of patients in a timely manner, which would include an Acute Visiting Scheme. A dedicated Urgent Care 24 GP would enable NWAS to avoid	**Expected impact:** • Reductions in emergency ambulance activity • Reductions in A&E attendances • Reductions in hospital admissions • Improved ambulance incident times • Improved response to RED ambulance patients *Based on pilot outcomes NWAS gave a deflection rate of 89% of patients seen.*	Jenny Owen

		hospital transfers to A&E, this would include a 2 hour response time. **Timescales:** Scheme to start Monday 2nd December 2013 and run for 5 months.	This scheme will aim to demonstrate QIPP by: • Increasing treatment at home by deploying clinicians to the patient and through access to alternative community services • Reduce unnecessary conveyance by Patient Emergency Services (PES) clinicians/vehicles • Reduce non-elective admissions by helping to avoid unnecessary Emergency Department attendance and subsequent attendance to admission conversion rates • Provide a robust approach to managing clinical risk underpinned by a strategic alliance clinical governance framework • Develop the urgent care workforce knowledge, skills and competencies across the strategic alliance • Maintain public confidence as traditional modes of	

			ambulance response are superseded by more flexible and responsive services tailored to the needs of the patient • Enable further research into clinical decision making tools that facilitate safe closer to home using appropriate providers within an appropriate time scale **National and local Guidance/Evidence:** • Urgent Care options appraisal 2013 • NWAS and UC 24 Acute Visiting Scheme • AED Audit 2013 **Data source**: • Urgent Care Dash Board • Out of Hours Quality performance indicators	
Patient Education - Publicity Campaigns 'Examine your options' an initiative across Merseyside CCGs including Halton and Warrington.	32	Development of campaign across Merseyside to support wider strategic responsibilities around business continuity and	**Expected impact:** • Reduce attendance into AED through the education	Louise Wilson

		emergency preparedness, alongside the requirement to inform and engage communities around the appropriate use of urgent care services. Costs are Halton's contribution to Merseyside scheme. **Timescales :** Campaign commenced 4th November 2013 and will run until w/c 28th April 2014	of the local population • Deliver accurate, timely and consistent advice to the public and health professionals, key stakeholders and the local media • Support improved understanding and navigation of the NHS system to effectively support demand management • Support seasonal flu preparedness and prevention, including staff and public vaccination programmes **National and local Guidance/Evidence:** • Urgent Care options appraisal 2013 • AED Audit 2013 • Urgent Care Public consultation	
1st Stage of implementation of Urgent Care Centre	160	The provision of extended X-ray facilities and extra medical cover	**Expected impact:**	Jenny Owen

		at the Minor Injuries Unit would support the diversion of diagnostic in hours and out of hours linked to Primary Care, Out Hours GP cover - UC 24 etc. **Timescales :** To be in place from Monday 2nd December 2013	• Develop the urgent care workforce knowledge, skills and competencies • Reduce flow into AED in hour and out of hours divert 17% out of A&E departments based on AED Audit **National and local Guidance/Evidence:** • Urgent Care options appraisal 2013 • NWAS and UC 24 Acute Visiting Scheme • AED Audit 2013 **Data source**: • Urgent Care Dash Board • Bridgewater quality and performance dashboard	
TOTAL	**387**			

GRAND TOTAL	**1,237**			

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Development of Urgent Care in Halton

Simon Wright
Chief Operating Officer/Deputy Chief Executive
Warrington and Halton Hospitals NHS Foundation Trust

HALTON BOROUGH COUNCIL
Halton NHS Clinical Commissioning Group
5 Boroughs Partnership NHS Foundation Trust
NHS Cheshire and Merseyside Commissioning Support Unit
NHS Urgent Care 24
St Helens and Knowsley Teaching Hospitals NHS Trust
Bridgewater Community Healthcare NHS Trust

Urgent Care Review (2012/13) carried out by Halton Urgent Care Board

- Review planned as part of NHS Halton CCG's commissioning intentions for 2012/13

- Underpinned by:
  - Review of a previous business case for an Urgent Care Centre
  - Review of information on use of Urgent Care services by Halton people
  - Review of national and local priorities and intentions
  - A+E questionnaire
  - Widnes Walk In Centre audit
  - Runcorn Minor Injuries Unit audit

Urgent Care Review

A&E Questionnaire (2012)

- Only 25% felt A+E was the most appropriate place for their condition

- 19% needed an x-ray

Urgent Care Review

Key Urgent Care Utilisation Statistics

- Attendance at A&E by the Halton population has increased by 3% in the last year – national rise is circa 0.6% this has plateaued having seen 10 years of increases

- The conversion rate for A&E attendance by a Halton resident to an admission is circa 35% (24% for Warrington)

Overview of Preferred Model

- Urgent Care Centre development within the existing Widnes Walk in Centre (WIC) and Runcorn Minor Injuries Unit (MIU) sites – self presentation
- Both centres 'kite-marked' by NWAS so provide alternative destination to A&E for paramedic crew utilising 'pathfinder protocol'
- Develop model for higher level diagnostic and medical consultation across 7 day period – Halton Hospital site
- Ensure continuity of care through electronic solutions and pathway development
- Appropriate links through to Community Health Services and Social Care (inc. Mental Health) Services

Specifics of Model

Urgent Care Centre Runcorn

MINOR ILLNESS
MINOR INJURY
AMBULATORY CARE PATHWAYS
X-RAY
USS
DVT
DOPPLER
DIAGNOSTIC BLOODS

MEDICAL STAFF

Urgent Care Centre Widnes

MINOR ILLNESS
MINOR INJURY
AMBULATORY CARE PATHWAYS
X-RAY
USS
DVT
DOPPLER
DIAGNOSTIC BLOODS

MEDICAL STAFF

Specifics of Model

CLINICAL ASSESSMENT UNIT

BLOODS
X-RAYS
USS
DOPPLER
ECG
AF CLINIC
ACUTE WARFARIN INITIATION

GP/REGISTRAR GRADE

CONSULTANT EMERGENCY CLINICS

USE BED CAPACITY AT HALTON FOR THOSE REQUIRING SHORT STAY

Progress to Date

Key developments include:-

•Partnership approach (via the Urgent Care Centre Development Project Board)

•Warrington and Halton Hospitals NHS Foundation Trust taking the lead with support from Halton Urgent Care Team and Clinical Leads

•Project Board includes senior clinicians and managers from CCG, both Acute Trusts, Bridgewater Community Healthcare NHS Trust, 5 Boroughs partnership, NWAS, Urgent Care 24 (GP Out of Hours Provider) and Social Care within Halton Borough Council; Project Board reports to Halton Urgent Care Working Group

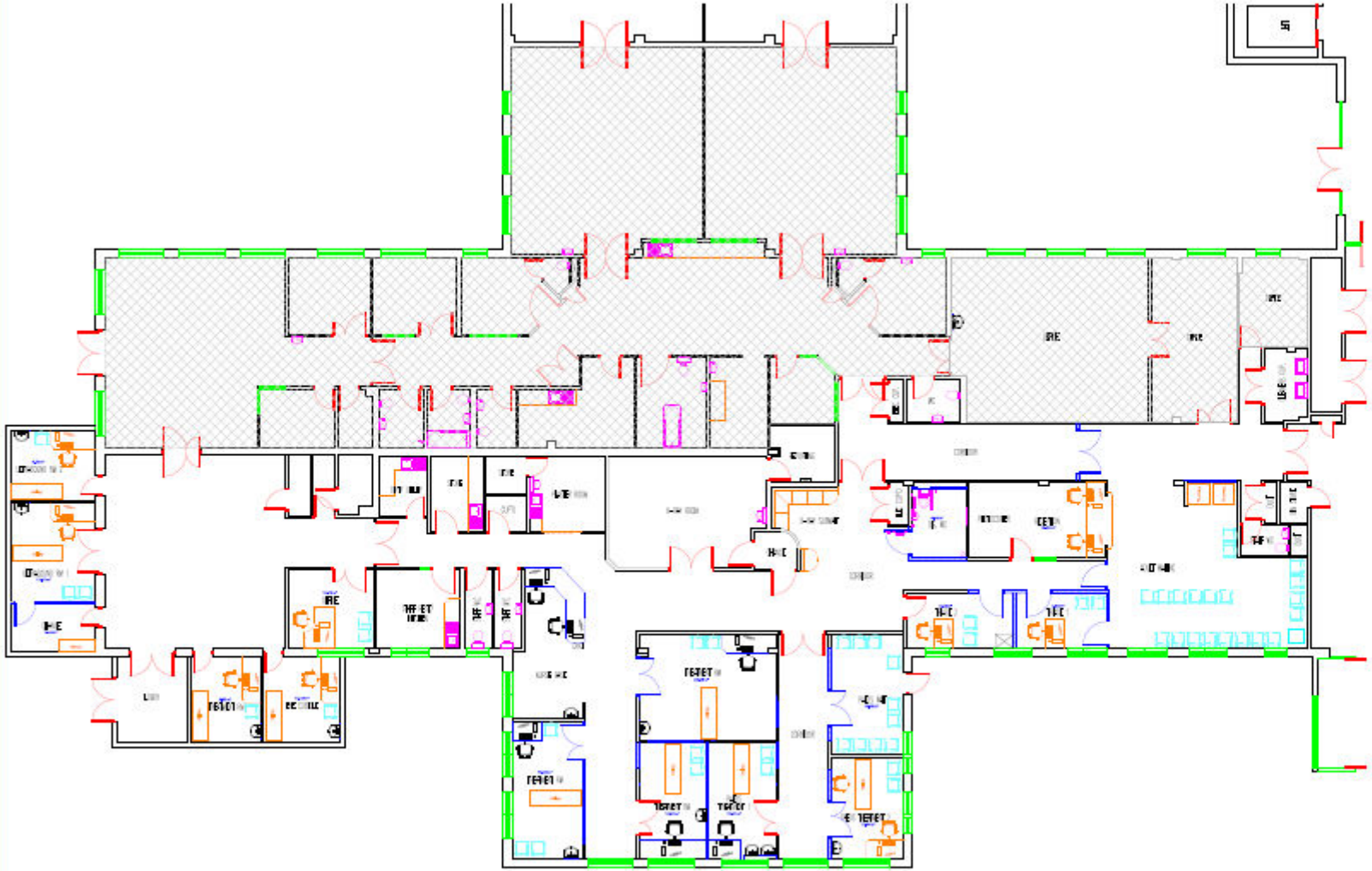
Progress to Date (Cont'd).....

- Sub-groups established to look at:
  - Clinical Pathways & Governance
  - Workforce
  - Infrastructure
  - Finance and Performance
  - Communications & Marketing
- Public consultation events held, in addition to development sessions with Clinical Practitioners
- Clinical Model of Care developed, outlining the additional pathways that the Centres will be able to deal with in addition to minor injuries/illnesses e.g. Diabetic emergencies, AF etc.

Progress to Date (Cont'd).....

- Imaging and pathology pathways agreed between Warrington and Halton Hospitals NHS Trust and St Helens & Knowsley Teaching Hospitals NHS Trust
- Communications and Marketing Plan developed to promote Services available and assist in the changing of people's behaviour in respect of Urgent Care Services
- Workforce analysis and modelling, including medical cover, diagnostics, nursing and administration & clerical
- Plans developed to change the layout of the Widnes and Runcorn Centres to accommodate the necessary clinical space and X-Ray facilities

URGENT CARE CENTRE PROPOSED PLAN



KEY:

New Stud Walls

No Works to this area

Please do not scale from this drawing

Notes:

Rev B - Revised layout to limit works area 25.4.2014

Rev A - First Issue

Warrington and Halton Hospitals NHS

NHS Foundation Trust

Capital & Planning Department
1st Floor Lancashire House
Warrington Hospital
Lovely Lane
Warrington
WA5 1QG
Tel: 01925 662 113

Project Title: PROPOSED UCC

Location: HALTON

Drawing Title: PROPOSED LAYOUT

Drawn By: LDP

Scale: NTS@A1 Date: APR 2014

Drawing Number: H-PN2-LDP-UCC-P-01 Rev: B

jmarchitects

WIDNES URGENT CARE CENTRE

PROPOSED GROUND FLOOR PLAN LOADED

KNOWSLEY PCT

Runcorn NHS Urgent Care Centre

A number of additional developments have happened/ are planned at the Halton Hospital site, as part of the ongoing development of the health campus, which will support/ complement the services to be delivered in respect of Urgent Care, including:-

•Location of a diagnostic centre providing primary care access for all modalities of imaging at Halton in place MR/CT/X-Ray/Ultrasound
•Respiratory specialist nurses supporting the MIU
•AED senior clinician available through the week at MIU
•Anti natal services now on site
•Applying for Joint Advisory Group (JAG) accreditation for endoscopy to provide a local solution for such investigations
•Additional vascular access clinics
•Currently developing a pediatric community nursing model, a foot ulcer service, a Pain Management service and exploring the options for a midwifery led unit, sports injury service.
•TIA Clinics

Widnes NHS Urgent Care Centre

The main focus of the work that has taken place on the Widnes Site is in respect of the estate, to ensure that the facilities are going to be fit for purpose to deliver the clinical model of care required. This has included:-

•Ensuring the building plans include the conversion of the available space at the current Resource Centre as a whole, into clinical space
•Increasing the size of the current WIC footprint to accommodate the necessary facilities to support the Urgent Care Centre development, including X-ray and Ultrasound facilities
•Identification of additional car parking facilities (over the road)
•Vascular Clinics
•ENT Clinics
•Urgent Access Clinics

Education & Wellbeing

- Market Place
- Health Checks
- Education & Awareness
- Choose Well
- Stroke Checks
- Heart Failure

Current Key Issues/Challenges

- Finances to support the developments, particularly in respect of estate redesign
- IT solutions to all different systems
- Timescales
- Integrating the provision

Next Steps

- Phase 1 – Complete in Autumn
- Phase 2 – Clinical Assessment Unit & Step Up Beds (Halton)
- Phase 3 – Rotation of Staff through AED

Questions ?

- Simon Wright
simon.wright@whh.nhs.uk

- Louise Wilson
louise.wilson@halton.gov.uk

REPORT TO:	Health Policy & Performance Board
DATE:	17 June 2014
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Clatterbridge Cancer Centre NHS Foundation Trust
WARD(S):	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with details of the proposals for change and expansion of the Clatterbridge Cancer Centre Services, the rationale for these changes and the implications.

2.0 RECOMMENDATION: That the Board:

i) Note the contents of the report and associated appendices; and

ii) Agree that these proposals constitute a significant variation to services provided to the residents of Halton and as such agree to a joint scrutiny of proposals as outlined in paragraph 3.3 and 3.4.

3.0 SUPPORTING INFORMATION

3.1 The Board have received formal notification from NHS England (NHSE) Cheshire, Warrington and Wirral Area Team Specialised Commissioning, as the accountable commissioners, and Clatterbridge Cancer Centre (CCC) NHS Foundation Trust, as the providers of cancer care for the people in Halton, of the proposed changes to the services provided by CCC. Attached at ***Appendix 1 – 6*** are details of the proposals, background and consultation plan

3.2 NHSE and CCC plan to carry out a formal 12-week public consultation on the proposals during the Summer. They believe that under the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 that the proposed changes may deem to be a substantial development or variation in the provision of cancer care to the people of Halton.

3.3 As such the Board will need to consider the proposals and agree that they do constitute a significant variation to the services provided to the residents of Halton. If this is agreed then the proposals will be subject to joint scrutiny as determined by the protocol for establishment of joint health scrutiny arrangements for Cheshire and Merseyside agreed by full Council in April 2014. Following the agreed protocol, it is likely that the lead Authority will be Liverpool or Wirral.

3.4 NHSE and CCC have requested responses and comments to the proposals by 7 November 2014 and as such a joint meeting would need to be organised as soon as practicably possible and appropriate terms of reference drawn up giving the meeting powers to take appropriate decisions in line with the protocol and regulations.

3.5 NHSE and CCC have written to all local authorities across Cheshire and Merseyside asking them to consider the proposals and confirm whether the proposals are deemed to be a substantial development of variation and that they impact on health services in their area.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

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 policy 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 As part of the joint scrutiny of the proposals, a thorough assessment of the implications on local services will need to be undertaken.

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 under the meaning of the Act.

The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

NHS England

23rd May 2014

Councillor Ellen Cargill
Chair
Health Policy and Performance Board
Halton Borough Council
41 Haywood Crescent
Waters Edge
Runcorn
WA7 6NA

Dear Councillor Cargill

Re: Arrangements for Overview and Scrutiny consultation on proposed changes to provision of services by The Clatterbridge Cancer Centre NHS Foundation Trust

In line with the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations regarding health scrutiny we are writing to inform you that we are planning a formal public consultation on proposed changes to services provided by The Clatterbridge Cancer Centre NHS Foundation Trust and to request consultation with the Health Overview and Scrutiny Committee regarding the planned changes.

Collectively, we believe this may be a substantial variation in the provision of cancer care for people in your area. We plan to carry out a formal 12-week public consultation on the proposals in summer 2014, which as you may recall we highlighted in previous correspondence in late 2013/early 2014. A summary of our pre-consultation is appended to the 2014 Consultation Plan (enclosure 2).

We are seeking your consideration under the revised statutory framework which authorises local authorities to:

- Review and scrutinise any matter relating to the planning, provision and operation of the health service; and,
- Consider consultations by a relevant NHS body or provider of NHS-funded services on any proposal for a substantial development or variation to the health service in the local authority's area.

As accountable commissioners (NHS England Cheshire, Warrington and Wirral Area Team Specialised Commissioning) and the provider (The Clatterbridge Cancer Centre NHS Foundation Trust) of the services affected by these proposals, we are asking each local authority to individually reach a view on whether they are satisfied that this proposal is deemed to be a substantial development or variation and that it impacts on the health services in your area. This proposal affects all local authorities across Cheshire and Merseyside, namely;

- Cheshire East Council
- Cheshire West and Chester Council
- Halton Borough Council
- Knowsley Council
- Liverpool City Council
- St Helen's Metropolitan Borough Council
- Sefton Council
- Warrington Borough Council

- Wirral Borough Council

The Clatterbridge Cancer Centre has sent details of feedback following the pre-consultation phase to each local authority's Health Overview and Scrutiny Committees/Panels and has attended several local authority committees this year to feedback our insight following the pre-consultation period.

NHS England Area Team specialist commissioning and The Clatterbridge Cancer Centre would ask that where more than one local authority agrees this proposal to be a substantial variation, that a joint Overview and Scrutiny Committee is formed for the purpose of considering The Clatterbridge Cancer Centre NHS Foundation Trust proposal for change collectively.

During our feedback to local authorities, we have informed local scrutiny officers of our intentions and we are aware that a protocol for the establishment of a joint Health Scrutiny arrangement for Cheshire and Merseyside areas has been under discussion.

In making this request we would like to confirm the following details to support your decision making process.

- As the accountable commissioner and provider, we would need your response and comments to the proposal by 7 November 2014.

- The Clatterbridge Cancer Centre NHS Foundation Trust intends to make its final decision (subject to NHS England and Monitor approval) whether to implement the proposal by 30 January 2015.

- The Clatterbridge Cancer Centre NHS Foundation Trust will be publishing these dates and all consultation documentation by 1 July 2014.

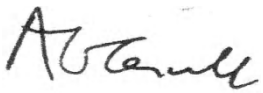
- If these dates alter The Clatterbridge Cancer Centre NHS Foundation Trust will inform the local authorities and update our publication materials accordingly.

NHS England will also be undertaking its own assurance process of the proposals and this process should be completed by the end of June 2014. A copy of the report will be provided in due course.

Further information about the case for change and the service changes proposed in response to this is enclosed, together with our detailed consultation plan. We would of course be happy to provide any further detail or clarification that you would find helpful.

Please do not hesitate to contact us if you would like further information or have any questions.

Yours sincerely,



Alison Tonge
Interim Area Director
Cheshire, Warrington and Wirral
Area Team
NHS England

Andrew Cannell
Chief Executive
The Clatterbridge Cancer Centre
NHS Foundation Trust

Enclosures

1. Case for Change
2. 2014 Consultation Plan

The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

TRANSFORMING CANCER CARE

AN OPPORTUNITY TO SIGNIFICANTLY IMPROVE THE DELIVERY OF CANCER SERVICES ACROSS THE MERSEYSIDE AND CHESHIRE CANCER NETWORK

May 2014

Contents

1. INTRODUCTION

The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) is a highly regarded specialist cancer Trust providing non-surgical treatment for patients suffering from solid tumour cancers within the Merseyside and Cheshire Cancer Network (MCCN).

This document has been produced by CCC, supported by Cheshire, Warrington and Wirral Area Team, its commissioner of services. The document describes the background to the Transforming Cancer Care project, the proposals for change and expansion of the CCC services, and both the clinical rationale for these changes and the benefits which will result from them.

2. THE CATCHMENT POPULATION SERVED BY THE CLATTERBRIDGE CANCER CENTRE

The Trust serves a population of around 2.3 million with the majority of patients drawn from the areas shown in Table 1 below:

Table 1: Population served by CCC shown by Clinical Commissioning Group[1]

Clinical commissioning group	Population	% of total
South Cheshire	175,943	8
Vale Royal	102,144	5
Warrington	202,709	9
West Cheshire	227,382	10
Wirral	319,837	14
Halton	125,722	6
Knowsley	145,903	7
Liverpool	465,656	21
South Sefton	159,764	7
Southport and Formby	114,205	5
St Helen's	175,405	8
Total	**2,214,670**	

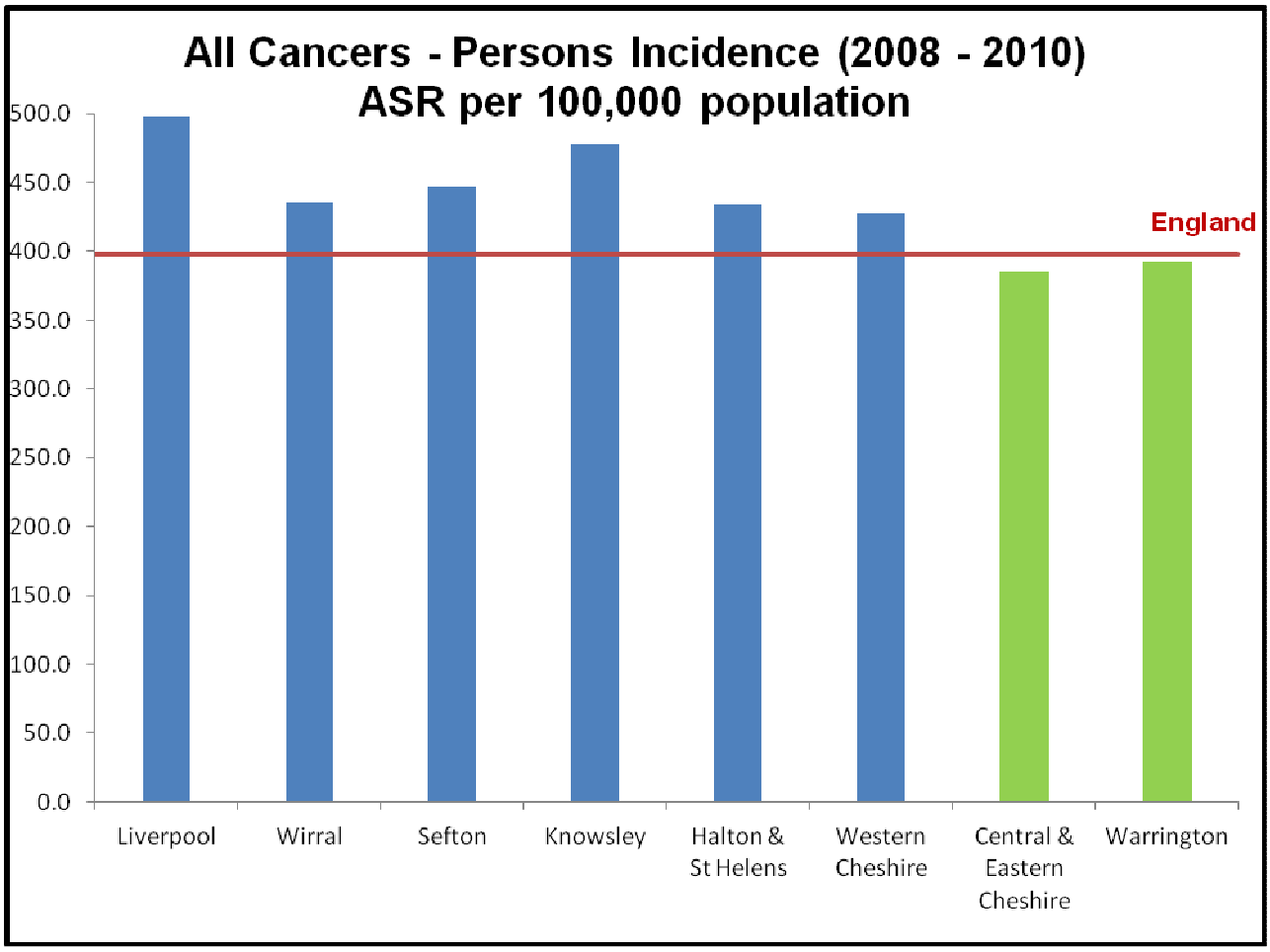
1. ONS - mid 2011 population by CCG - includes people under 16y.

From the above it can be seen that around 67% of the catchment population for the CCC live north of the River Mersey. The current CCC site at Bebington is therefore neither central to its geographical catchment nor close to its centre of population density.

3. CANCER INCIDENCE AND MORTALITY ACROSS THE MERSEYSIDE AND CHESHIRE CANCER NETWORK (MCCN)

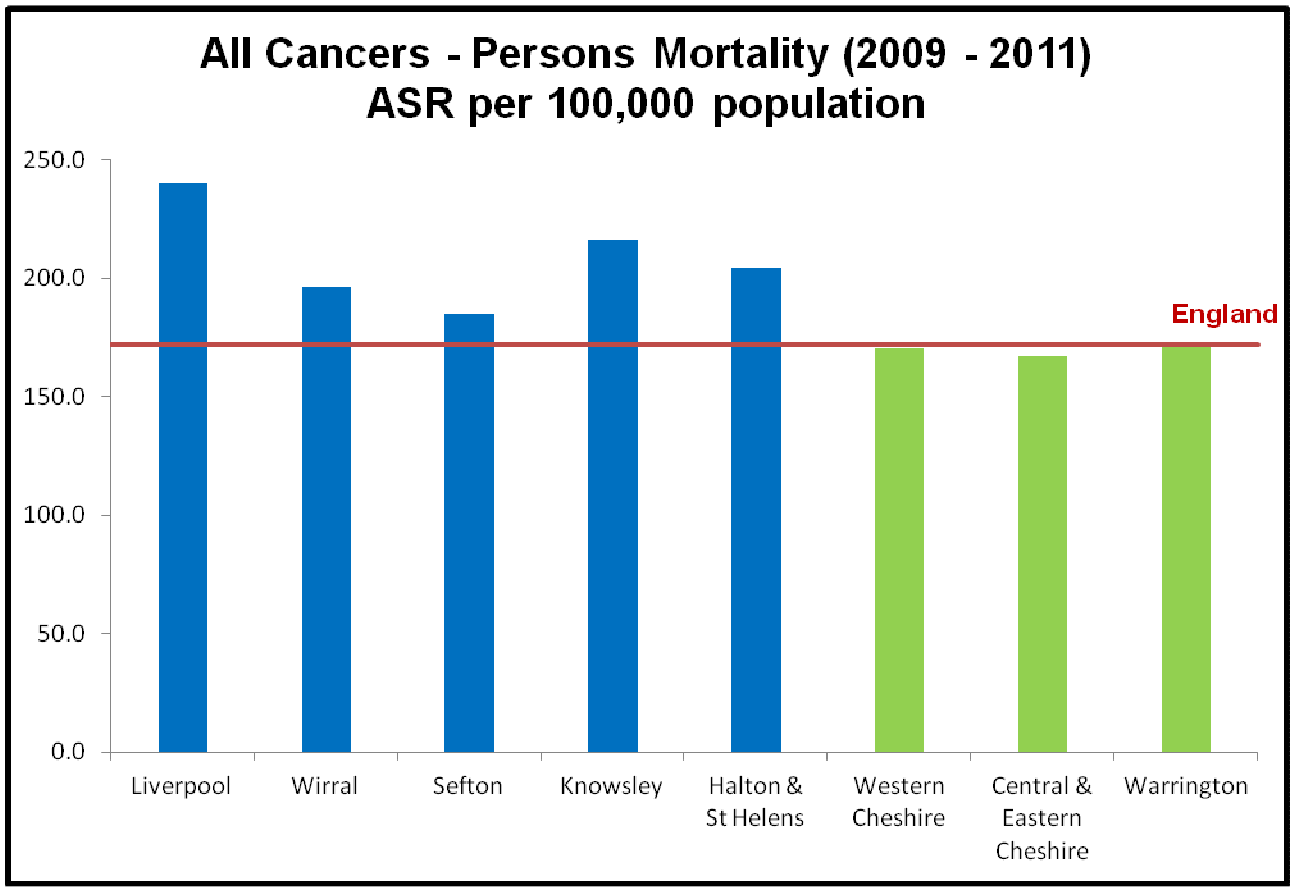
The incidence (new cases) of and mortality (death rates) from cancer represent a major challenge within Merseyside and Cheshire. The incidence and mortality rates for each Primary Care Trust (PCT), the most recent 'units' for which this data is available, are shown in Figure 1 and Figure 2 below in comparison with the rate for England as a whole.

Figure 1: Incidence of all cancers across the MCCN, compared with the average for England.



1. Age standardised ratio

Figure 2: Death rates from all cancers across the MCCN, compared with the average for England.



From the above figures it can be seen that the both the incidence of cancer, and deaths from cancer are higher across almost all areas compared to the England average, with Liverpool and Knowsley particularly badly affected.

Breast, lung, colorectal, prostate and upper gastro-intestinal (GI) cancers account for over 90% of all new cases of cancer and over 75% of cancer deaths, both nationally and across the cluster.

The incidence of breast cancer is generally above the national average across the network, as are deaths due to breast cancer.

The incidence of new cases of lung cancer across the cluster is higher than the national average and almost twice the national rate in Liverpool and Knowsley. Similarly, lung cancer mortality rates across the cluster are higher than the national average and almost twice the national rate in Liverpool and Knowsley.

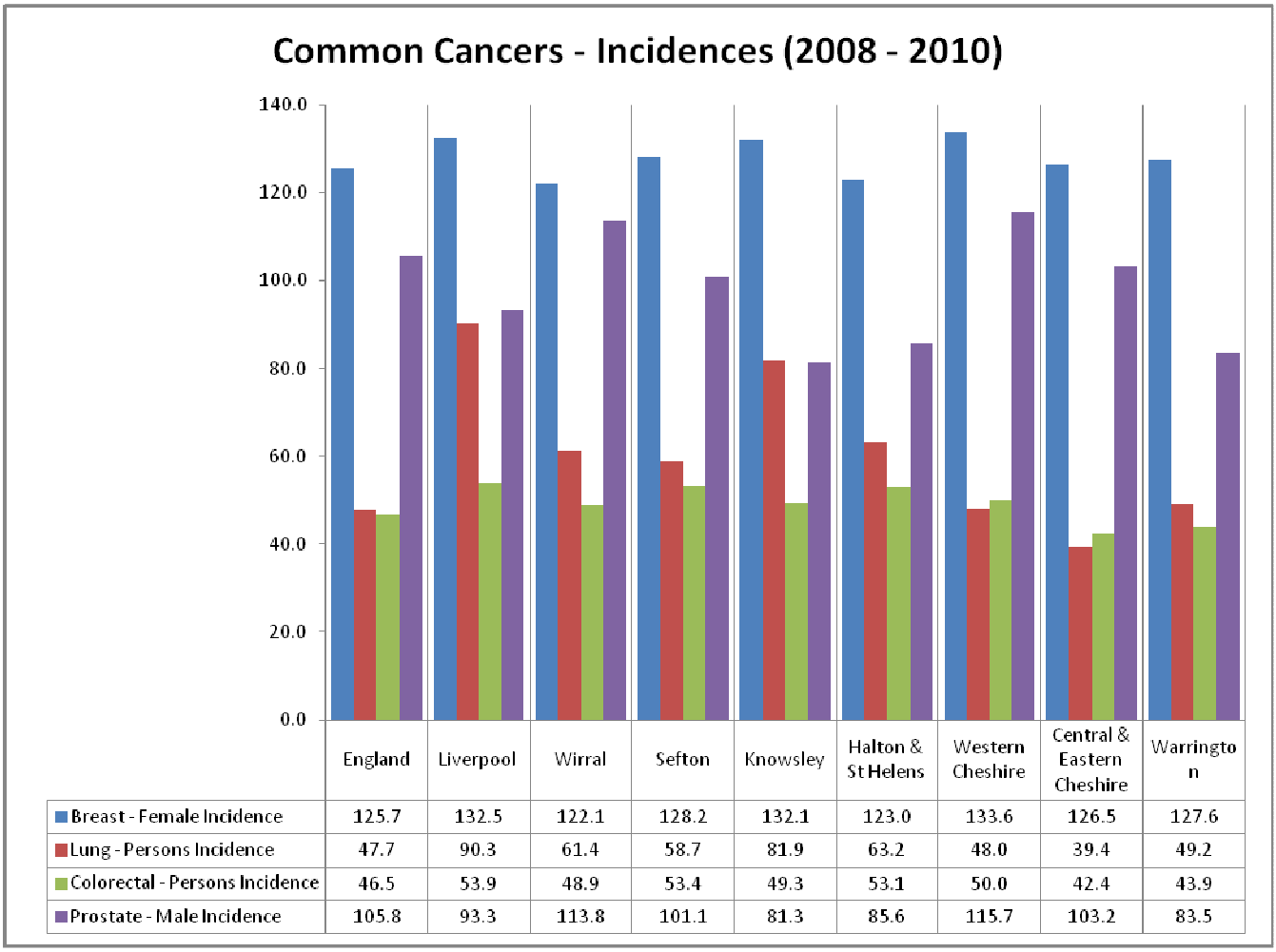
The incidence of new cases of colorectal cancer and colorectal cancer mortality rates are higher across the cluster than the national average.

The incidence of new cases of prostate cancer across the cluster is lower than the national average except for Wirral and West Cheshire; however deaths as a result of prostate cancer are higher than the national average in a number of areas, particularly Sefton and Wirral.

The incidence of new cases of upper GI cancer across the cluster is higher than the national average. Similarly, upper GI cancer mortality rates across the cluster are higher than the national average.

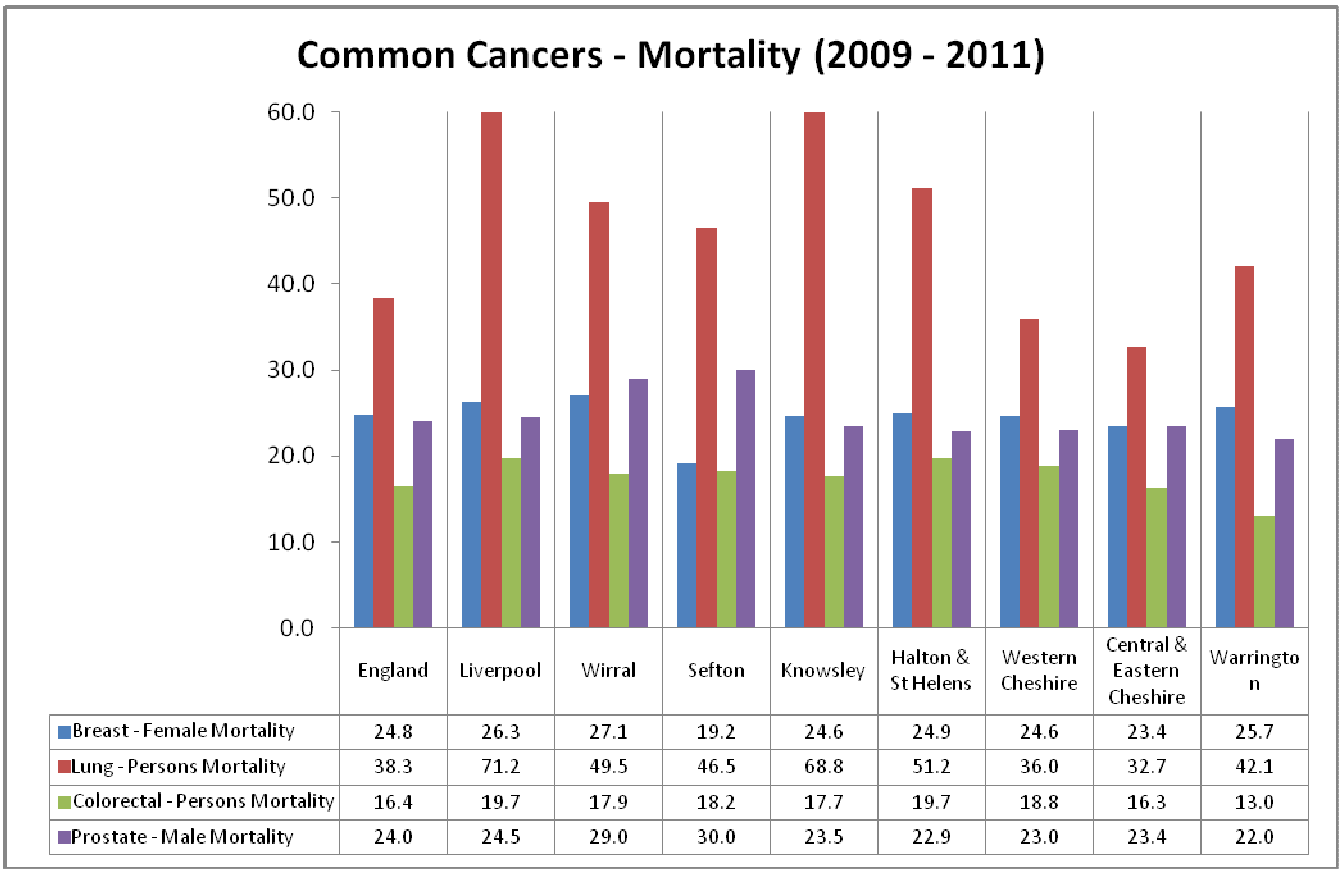
The incidence of, and deaths from the common cancers are shown in Figures 3 and 4 below, in comparison with the England average.

Figure 3: Incidence of the common cancers across the MCCN network, compared with the average for England.



	England	Liverpool	Wirral	Sefton	Knowsley	Halton & St Helens	Western Cheshire	Central & Eastern Cheshire	Warrington
Breast - Female Incidence	125.7	132.5	122.1	128.2	132.1	123.0	133.6	126.5	127.6
Lung - Persons Incidence	47.7	90.3	61.4	58.7	81.9	63.2	48.0	39.4	49.2
Colorectal - Persons Incidence	46.5	53.9	48.9	53.4	49.3	53.1	50.0	42.4	43.9
Prostate - Male Incidence	105.8	93.3	113.8	101.1	81.3	85.6	115.7	103.2	83.5

Figure 4: Death rates from the common cancers across the MCCN, compared with the average for England.



	England	Liverpool	Wirral	Sefton	Knowsley	Halton & St Helens	Western Cheshire	Central & Eastern Cheshire	Warrington
Breast - Female Mortality	24.8	26.3	27.1	19.2	24.6	24.9	24.6	23.4	25.7
Lung - Persons Mortality	38.3	71.2	49.5	46.5	68.8	51.2	36.0	32.7	42.1
Colorectal - Persons Mortality	16.4	19.7	17.9	18.2	17.7	19.7	18.8	16.3	13.0
Prostate - Male Mortality	24.0	24.5	29.0	30.0	23.5	22.9	23.0	23.4	22.0

By comparing the mortality rate for each PCT with the average for England, the number of cancer deaths above the national average can be determined. This is the number of lives that could be saved each year if the mortality rate across the network was the same as the average in England. This equates to 589 deaths each year as shown in Table 2 below.

Table 2: Comparison of excess deaths from cancer across the cancer network.

PCT	Excess deaths per year in comparison with England average*
Liverpool	316
Halton & St Helen's	97
Wirral	77
Knowsley	64
Sefton	35
Warrington	0
West Cheshire	-4
South Cheshire	-8
Total each year	**589**

*** 2008-2010 National Cancer Intelligence Network (NCIN) data**

Cancer is now the biggest single cause of death in Cheshire and Merseyside.

4. CURRENT CONFIGURATION OF CANCER SERVICES PROVIDED BY CCC ACROSS THE MCCN

CCC operates a networked cancer service across the whole of the MCCN. The current configuration of CCC cancer services is shown in Table 3 below.

Table 3: Current geographical distribution of CCC clinical services

Site	Inpatient beds	TYA	Chemo daycase	R'therapy treatment	R'therapy planning	Acute Oncology	Out patients
CCC – Clatterbridge	Y	Y	Y	Y	Y	Y	Y
CCC - Aintree	-	-	-	Y	-	-	Y
Aintree University Hospital	-	-	Y	-		Y	Y
The Walton Centre	-	-	-	-	-	-	Y
Royal Liverpool University Hospital	-	-	Y	-	-	Y	Y
St Helen's & Knowsley Hospitals	-	-	Y	-	-	Y	Y
Warrington & Halton Hospitals	-	-	Y	-	-	Y	Y
Arrowe Park Hospital	-	-	-	-	-	Y	Y
Alder Hey Children's Hospital	-	-	-	-	-	-	Y
Liverpool Women's Hospital	-	-	Y	-	-	-	Y
Liverpool Heart and Chest Hospital	-	-	Y	-	-	-	Y
Southport Hospital	-	-	Y	-	-	Y	Y
Countess of Chester Hospital	-	-	Y	-	-	Y	Y

From the above it can be seen that the CCC's principal site currently is the Cancer Centre located on the Clatterbridge Health Park at Bebington on the Wirral. The only other site currently providing radiotherapy is CCC's satellite unit at Aintree hospital.

CCC also operates an extensive network of chemotherapy clinics and outpatient clinics in partner NHS Trusts across the MCCN, as well as an acute oncology service, supporting partner Trusts in the care of cancer patients who have been admitted to these hospitals.

5. PROPOSALS TO TRANSFORM CANCER SERVICES IN MERSEYSIDE AND CHESHIRE – THE CASE FOR CHANGE

In 2008 the Merseyside and Cheshire Cancer Network (MCCN) commissioned an expert review of the configuration of Cancer Services across the area with the aim of developing recommendations to ensure that services were delivered in the best way to improve outcomes for patients. The resulting report 'The organisation and delivery of non-surgical oncology services in the Merseyside and Cheshire Cancer Network'[1] was presented to the local Cancer Taskforce in October 2008.

The report identified a number of reasons for considering a change in the service model location and delivery of non-surgical oncology in the MCCN area including:

- Encouraging the major expansion of radiotherapy through the development of satellite radiotherapy units closer to the populations served and limiting the size of major centres to a maximum of eight Linear Accelerators.
- The decentralisation of chemotherapy which requires a larger clinical workforce with a greater local presence.
- More flexible service delivery models required which were less dependent on a single centre and more served through networks of care.
- The increasing use of multi-modality treatment regimes suggesting that, in the longer term, isolated oncology centres were no longer appropriate.
- The organisation of hospital services in MCCN meant that integrated cancer care was dependent on oncologists to secure the integrity of patient pathways. It was more difficult to achieve this from a remote centre.
- The needs of the network population were high in terms of cancer care but the results were likely to be inhibited by poor accessibility to oncology services as well as by late presentation. Closer alignment of oncologists to local general hospitals would shift the balance of leadership in cancer care and would support improving the overall organisation and delivery of care.
- Developing cancer research in Liverpool, an essential component of all cancer care and of medical research, was compromised by the absence of academic oncology leadership. The isolation of the current cancer centre and its distance from surgical oncology and Specialist Multi-Disciplinary Teams were factors in the difficulty in addressing this deficiency.

Consequent on these findings, a number of immediate steps were taken which included:

- the enhancement of clinical services at CCC to increase the Trust's ability to care for very acutely ill patients
- the opening of the satellite radiotherapy unit at Aintree
- the establishment of a number of Chairs in a variety of cancer-related fields, in partnership with the University of Liverpool

[1] "The organisation and delivery of non-surgical oncology services in the Merseyside and Cheshire Cancer Network" A feasibility study into the potential relocation of non-surgical oncology services from Clatterbridge to Liverpool (October 2008)
Prof. M R Baker and Mr R C Cannon

- The establishment of an acute oncology service in partner trusts

However more still needs to be changed in order to fully address the points identified by Baker and Cannon and ensure that all local people are able to receive the highest quality care available and to benefit from the best possible clinical outcomes.

First and foremost is the issue of the geographical location of the specialist Cancer Centre on the Clatterbridge hospital site. In their report Baker and Cannon confirmed that:

> *"When it was first established, the Clatterbridge campus provided a wide range of medical and surgical services; this is no longer the case and the oncology facilities are now isolated from modern medical and surgical practice. During this time, the complexity of cancer treatments has increased dramatically, patients are older and sicker and the treatments have more side effects. In most cancer centres, most of the beds are used for patients who are seriously ill because of their underlying cancer or because of the side effects of treatment. The management of these conditions requires ready access to both critical care facilities and the on-site access to the full range of general medical and surgical expertise. This is no longer possible at Clatterbridge."*

Following the acceptance of the recommendation contained within the Baker Cannon report in 2009, the then Merseyside Cluster Board commissioned PricewaterhouseCoopers to undertake a high-level feasibility study on the establishment of a new acute cancer centre in Liverpool. The findings of this study were presented to Merseyside Cluster Board by Liverpool PCT; as a consequence of this approval was given to allocate funding for project costs to deliver a business case for the creation of a new cancer centre in Liverpool, together with a capital allocation towards the cost of its construction. At the same meeting the need was identified for further recurring funding to be set aside to support the project, delivered through annual commissioning arrangements.

The Transforming Cancer Care project was therefore established by CCC following this network-wide agreement to implement the recommendations of the Baker Cannon report, the most material of which is the development of a new Cancer Centre in Liverpool adjacent to the redeveloped Royal Liverpool University Hospital.

6. THE CURRENT STRATEGIC ENVIRONMENT

Since the Baker Cannon report was published, the conclusions contained within this have been reinforced by a number of strategic, policy and operational factors. These include:

- An increase in the number of acutely-ill CCC inpatients who have needed to be moved in order to access specialist opinion or facilities not available on the CCC site. These transfers have grown from 53 in 2011 to 67 in 2013 and in the majority of cases patients were receiving radiotherapy or chemotherapy which had to be interrupted because of their transfer. This is clearly not ideal in a modern healthcare system.
- The recognition that organisational isolation is a risk factor in the delivery of sub-optimal care (Prof Sir Bruce Keogh: Review into the quality of care and treatment provided by 14 hospital trusts in England). Although there is ample evidence which demonstrates that the care delivered at CCC is very good, the acknowledgement of this risk factor is consistent with the findings of Baker and Cannon.
- The increasing acknowledgement of the importance of clinical research in the delivery of cancer care. *'Equity and excellence: Liberating the NHS',* produced by the Department of Health, notes that organisations with strong participation in research tend to have better outcomes, and that research-active organisations are therefore able to offer increased patient benefits both through a direct contribution to knowledge and through enhanced organisational performance. The same document noted that "*a thriving life sciences industry is critical to the ability of the NHS to deliver world-class health outcomes. The Department will continue to promote the role of Biomedical Research Centres and Units, Academic Health Science Centres and Collaborations for Leadership in Applied Health Research and Care, to develop research and to unlock synergies between research, education and patient care".*

The investment proposal is supported by the Trust's commissioner of clinical services, Cheshire, Warrington and Wirral Area Team, as well as by the Merseyside Area Team and by local CCGs, who do not directly commission specialist cancer services but nonetheless have a very strong interest in the delivery of high quality cancer care to their respective populations. The project also has the strong support of clinicians within CCC, as well as those with a cancer interest across the MCCN.
The project is consistent with the strategic plans for the delivery of clinical and other services across Merseyside and Cheshire. In particular it supports Liverpool City Council's vision for the future of the city region which sees healthcare and life sciences research as a core component in the ongoing development of the city *(Liverpool City Region's knowledge economy: delivering new opportunities for growth).*

The project also sits alongside Liverpool CCG's Healthy Liverpool Programme which has been set up to help the CCG adapt to face future challenges, such as an ageing population and increase in long-term conditions, while also improving the health of residents. Although the location of some services may change as a result of this

Programme it is clearly understood that the Royal Liverpool University Hospital will remain a hub for delivery of acute services to the population of Liverpool and, as such, will provide the type of services which will complement the cancer services which are planned to be delivered by CCC on the Royal Liverpool campus.

The retention of a full range of cancer outpatient services at the existing Clatterbridge site is also supportive of Wirral Council's vision for retention and potential development of the Health Park at Bebington. As CCC further develops its own strategic plans there will be opportunities to work closely with partners in Wirral to explore ways in which to maximise the role of CCC on this site.

7. OUTCOME OF THE PRE-CONSULTATION ENGAGEMENT WORK UNDERTAKEN OVER THE WINTER OF 2012/13

A wide ranging pre-consultation exercise was held over the winter of 2012/13 to understand the views of the public on the central proposal within the Transforming Cancer Care project – the opening of a new Cancer Centre in Liverpool. This exercise reached over 90,000 people through 114 roadshows and 96 group sessions, and involved 7 District General Hospitals and 12 Primary Care Trusts. Every Healthwatch and a wide range of Cancer Support Groups were also part of this process. 14,500 people visited the roadshows and 4,164 formal written responses were received.

People were asked a Principal Consultation Question (PCQ):

"After finding out about the plans to develop a new Clatterbridge Cancer Centre for Cheshire and Merseyside, which would be based next to the Royal Liverpool University Hospital, do you think this is a good idea?"

Respondents could either answer *yes*, *no* or *not sure*. Respondents were then asked to provide comments about their chosen answer (*"why do you think this?"*).
Overall, the results were as follows:

Yes – **82.63%**
No – **12.70%**
Not sure – **4.66%**

This showed overall strong support for the proposal. However further analysis of the responses by postcode showed significant differences in view, with the greatest number of people answering 'no' or 'not sure' appearing in the CH postcode areas i.e. those areas closest to the existing CCC site. When only answers from the CH areas the results were as follows:

Yes – **40.53%**
No – **49.75%**
Not sure – **9.72%**

When people explained their view by answering the follow-up question 'why do you think this?' there were similar themes regardless of whether they thought the proposal was a good idea. The main areas highlighted are shown below:

- Accessibility
- Cost
- Good current services
- Ill health (and the impact on ability to travel)
- Loss of services (from the current location)
- Travel
- Visits

In a number of these areas some people saw advantages whilst others saw disadvantages in the proposal. For example, those living in the Liverpool area were likely to comment on a beneficial impact for service accessibility whilst those living on the Wirral were likely to cite adverse impact on accessibility.

The information received from the pre-consultation engagement work has already had an impact upon the Transforming Cancer Care project. In particular it has:

- Emphasised strongly the importance placed by patients on access to sufficient, convenient and free car parking when attending for treatment.
- Highlighted the value placed by patients on the existing organisational culture and values of CCC, and identified the need for the Trust to ensure that this organisational culture is extended to the operation of the new Cancer Centre in Liverpool.
- Endorsed the overall direction of travel through the strong support given by the public to the consultation question.

The pubic consultation planned to run over the summer of 2014 will be used to gain more information on these issues identified as significant as a result of the pre-consultation engagement work.

8. THE PROPOSED CHANGES IN CANCER SERVICES AS A CONSEQUENCE OF THE TRANSFORMING CANCER CARE PROJECT

In their work to look at options for the future location of the Cancer Centre to address the issues above, Baker and Cannon looked at a long list of nine options which were assessed against ten criteria. The preferred option identified as a result of this appraisal process was the establishment of a new Cancer Centre adjacent to the Royal Liverpool University Hospital.

This new Cancer Centre would provide all inpatient oncology beds for the Cancer network, together with outpatient oncology services for those patients for whom the Liverpool site is the most accessible. The new Cancer Centre would operate as the hub, supporting a network of cancer services which would include the satellite radiotherapy centre at Aintree, the existing Cancer Centre at Clatterbridge which would continue to deliver outpatient cancer care to its local population on the Wirral and in West Cheshire, and the distributed network of CCC outpatient and chemotherapy clinics operated in partner hospitals throughout the MCCN.

This preferred option was considered and supported by the Cancer Taskforce, which included representatives from the MCCN, Trusts and PCTs across the network.

It is this preferred option which the Transforming Cancer Care project now aims to take forwards.

The consequences of this can be summarised in Table 4 below:

Table 4: Current (C) and proposed (P) geographical distribution of CCC clinical services with changes highlighted+

Site	Inpatient beds	TYA	Chemo daycase	R'therapy treatment	R'therapy planning	Acute Oncology	Out patients
New Cancer Centre – L'pool	–	–	–	–	–	–	–
	P	**P**	**P**	**P**	**P**	**P**	**P**
CCC – Clatterbridge	**C**	**C**	**C**	**C**	**C**	**C**	**C**
	-	**-**	**P**	**P**	**P**	**P**	**P**
CCC - Aintree	**-**	**-**	**-**	**C**	**-**	**-**	**C**
	-	**-**	**-**	**P**	**-**	**-**	**P**
Aintree University Hospital	**-**	**-**	**C**	**-**	**-**	**C**	**C**
	-	**-**	**P**	**-**	**-**	**P**	**P**
The Walton Centre	**-**	**-**	**-**	**-**	**-**	**-**	**C**
	-	**-**	**-**	**-**	**-**	**-**	**P**
Royal Liverpool University Hospital	**-**	**-**	**C**	**-**	**-**	**C**	**C**
	-	**-**	(provided instead in new	**-**	**-**	**P**	(provided instead in new

			CCC on site)				CCC on site)
Arrowe Park Hospital	-	-	-	-	-	C	C
	-	-	-	-	-	P	P
St Helen's & Knowsley Hospitals	-	-	C	-	-	C	C
	-	-	P	-	-	P	P
Warrington & Halton Hospitals	-	-	C	-	-	C	C
	-	-	P	-	-	P	P
Alder Hey Children's Hospital	-	-	-	-	-	-	C
	-	-	-	-	-	-	P
Liverpool Women's Hospital	-	-	C	-	-	-	C
	-	-	P	-	-	-	P
Liverpool Heart and Chest Hospital	-	-	C	-	-	-	C
	-	-	P	-	-	-	P
Southport Hospital	-	-	C	-	-	C	C
	-	-	P	-	-	P	P
Countess of Chester Hospital	-	-	C	-	-	C	C
	-	-	P	-	-	P	P

To summarise the above table, the **key proposed changes** would be:

- The creation of a new Cancer Centre on the Royal Liverpool campus, bringing together inpatient cancer services with critical care, other support facilities and a wide range of medical and surgical experts.
- The relocation of all CCC's cancer inpatient beds from the Wirral to Liverpool.
- The relocation of the Teenage and Young Adult Unit (including their inpatient beds) from the Wirral to Liverpool.
- The establishment of a new radiotherapy service in Liverpool and an overall increase in radiotherapy capacity.
- The relocation of complex outpatient radiotherapy from the Wirral to Liverpool, representing about 6% of treatments given.
- An increase in the capacity of chemotherapy and outpatient services in Liverpool.

The things that would **stay the same** would be:

- The continuation of the existing Cancer Centre on the Wirral as an important site for the delivery of cancer services.
- Retention of an outpatient radiotherapy service on the Wirral for treatment of the common cancers, which comprise around 94% of treatments given.
- Retention of a chemotherapy and outpatient service on the Wirral.
- The services delivered at the Aintree radiotherapy satellite centre.
- The services delivered by CCC in other hospitals across the cancer network.
- The national eye proton therapy service, based at the existing CCC site at Bebington.

9. BENEFITS WHICH WOULD BE DELIVERED BY THE PROPOSED CHANGES

When the establishment of a new Cancer Centre in Liverpool was first proposed in 2008 it was noted that such a centre would enable the benefits described below:

Benefits expected as a result of a new Cancer Centre in Liverpool

- Better co-ordination of pathways of care for cancer patients by bringing together key specialist services on a single health campus which currently hosts the majority of Specialist Cancer Multi-Disciplinary Teams which are central to the delivery of high quality cancer care.

- Improved access for CCC inpatients to specialists from other clinical disciplines and to specialist clinical facilities eg intensive care, which cannot be provided in the existing Cancer Centre.

- Delivery of cancer treatments nearer to home for the majority of patients.

- Location of the Teenage and Young Adult Unit closer to both the Royal Liverpool University Hospital and Alder Hey Children's Hospital and closer to the majority of the population served, improving patient access and choice.

- Closer integration between the NHS and research teams within the University of Liverpool and other key research partners in the public and private sector.

- An increase in patients who benefit because they are able to take part in clinical trials.

- Location of specialist services in a place more easily accessible to the majority of patients so that more patients can benefit from improved access, particularly those who need repeated and regular radiotherapy for certain types of cancer and for palliation.

- Best use of NHS resources by enabling clinical teams to work more effectively and efficiently together.

- Establishment of a focus for innovation and knowledge, complementing and amplifying the efforts of all partners including local employers and councils to promote the region as a premier choice for investment.

- Maintenance of those NHS services which are best delivered in more local settings, including district general hospitals and the community.

The development of the new Cancer Centre in Liverpool would bring the inpatient facilities for radiotherapy and chemotherapy onto a single large acute teaching hospital campus adjacent to both university and private sector research partners.

This would give the people of Merseyside and Cheshire, an area with some of the very poorest cancer outcomes in the country, access to the same sort of comprehensive cancer facilities as are already available in other major cities across the UK such as London, Manchester and Birmingham.

The above reasons together form the clinical benefits arising from the changes proposed by the Transforming Cancer Care project.

The National Clinical Advisory Team, who until April 2014 were responsible for reviewing the clinical justification for any proposed service change, assessed the Strategic Outline Case which had been prepared by the CCC as a first step in implementing the recommendations of the Baker Cannon review. **This report unequivocally supports the establishment of a new Cancer Centre in Liverpool in order to deliver the benefits described.**

10. IMPACT ON PATIENTS AS A CONSEQUENCE OF THEIR PLACE OF TREATMENT

General accessibility

The existing Cancer Centre at Bebington is not well served by public transport – the new Cancer Centre in Liverpool would be much more accessible by both bus and train because of its City Centre location. From an analysis of travel times it can be shown that when using public transport, a number of areas which are geographically closer to the Bebington site are closer from a time and convenience perspective to the proposed site in Liverpool.

An Equality Impact Assessment of the proposed changes which was undertaken by Liverpool John Moores University in March 2013 drew the following conclusions:

- There are a number of areas geographically close to the Bebington site where travel time by public transport is over an hour.
- The rail network that links the Wirral and Liverpool works in the favour of those Wirral residents travelling to the Royal Liverpool over those Liverpool-side residents travelling to Bebington.
- Patients from Sefton, Western Cheshire, Knowsley, St Helen's and Halton can expect in most cases to travel for more than an hour to reach either site, although a good proportion of these patients might be able to reach the Royal Liverpool site within 45 to 60 minutes, whereas it is unlikely that any of these patients could reach the Bebington site in under an hour.

Public transport links are important since access to private transport, as shown by car ownership, is much less across Merseyside than in other parts of the Cancer Network. This is shown in Table 5 below:

Table 5: Car ownership and percentage of households with a car or van (RAC Foundation, based on 2011 census data)

Local Authority	Rank (out of 348)	Cars/vans per 1000 people	% households with car/van
Cheshire East	76	606	83.9
Cheshire West	135	572	81.4
Warrington	164	546	80.7
St Helen's	240	482	73.3
Wirral	250	476	72
Halton	254	469	73
Sefton	261	462	71.5
Knowsley	315	378	62.9
Liverpool	327	323	53.9

Although it is hoped that public transport would be used to attend the new Cancer Centre in Liverpool it is recognised that many people would still prefer to use private transport. Good car parking is very important for cancer patients and so dedicated free parking would be provided for cancer patients attending the new Cancer Centre in Liverpool, and would continue to be provided at the existing Clatterbridge sites on the Wirral and at Aintree.

Patients who are eligible for Ambulance Transport would continue to have this provided, irrespective of the site attended. In 2013 patient attendances by ambulance at the existing Cancer Centre at Bebington were as shown in Table 6 below:

Table 6: Ambulance attendances at Clatterbridge by principal PCT

PCT	Individual planned patient attendances by ambulance
Liverpool	5828
Halton & St Helen's	4159
Wirral	2154
Knowsley	1922
Sefton	4055
Warrington	2037
West Cheshire	1641
Central & E Cheshire	391

The establishment of a cancer centre in Liverpool is expected to have a beneficial impact on ambulance services since there would be an overall reduction in patient travel times as a result of the opening of a centre in Liverpool.

Inpatient services (including TYA)

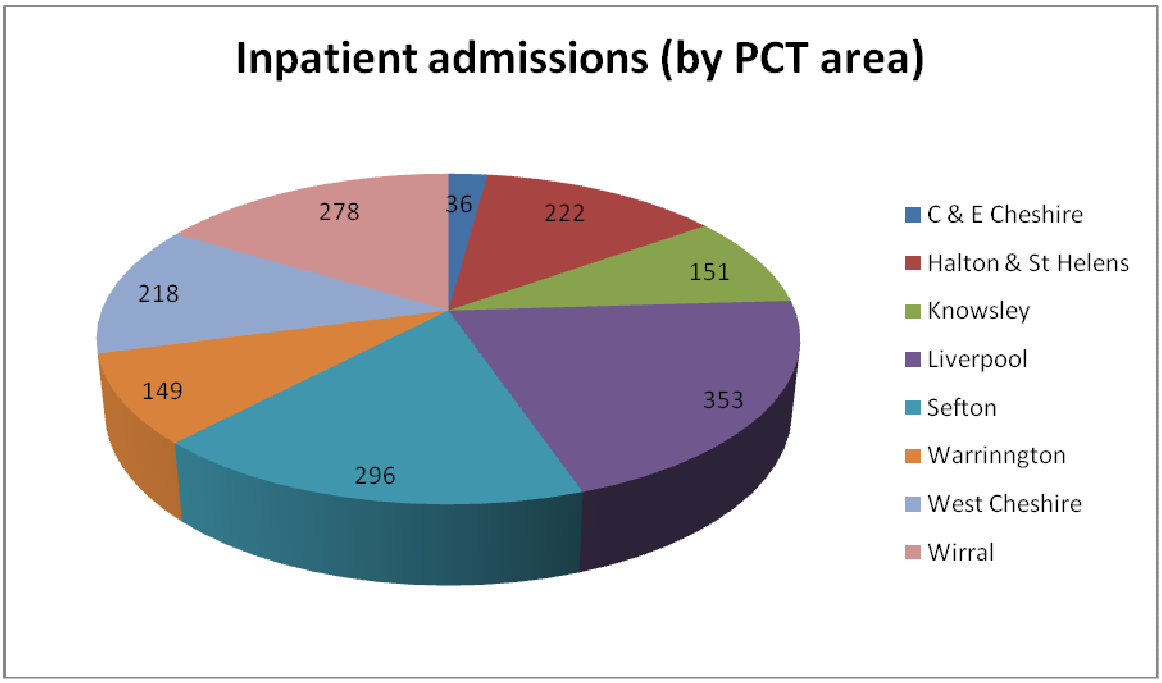
The proposed changes mean that those patients living in West Cheshire and on the Wirral who need to be admitted to an inpatient bed are likely to travel further for their care, as will their visitors. However these are the patients who are the most unwell or who have the most complex needs, and it is these patients whose treatment would benefit most from being admitted to a Cancer Centre which can draw on the facilities and expertise which is only available in a large acute hospital such as the Royal Liverpool.

In practice the greatest impact of this relocation of inpatient services would be on visitor travel time, and so the consultation planned over the summer will aim to explore this in more detail with a view to understanding how the impact of this might be ameliorated. It should also be acknowledged that there would be a beneficial impact on a greater number of people who currently have to travel from Merseyside to the Wirral in order to visit their relatives admitted to the current cancer centre as an inpatient, and who are less likely to have access to a car or to convenient public transport links.

Patients from Wirral and West Cheshire who may currently be admitted to Clatterbridge but who are not receiving chemotherapy or radiotherapy as part of their inpatient care may well in the future be admitted instead to Arrowe Park or the Countess of Chester under the care of the acute oncology team there, meaning that travel time for them, together with their friends and family would be largely unchanged.

The forecast numbers of inpatients by area who would in future be admitted to Liverpool is shown in Figure 5 below (based on a 2018/19 activity forecast)

Figure 5: 2018/19 forecast inpatient numbers by area admitted to the new Cancer Centre in Liverpool for active chemotherapy or radiotherapy treatment



The above figures show the number of forecast inpatient admissions by PCT for patients who need to be admitted in order for them to receive radiotherapy and/or chemotherapy. They exclude any patients who may need to be admitted to a hospital in order to help deal with the side-effects of their cancer but who are not part-way through a course of radiotherapy or chemotherapy.

Those excluded are the 'acute oncology' patients, who at present are usually admitted to their local District General Hospital under the care of the onsite medical team, supported by the local CCC acute oncology service; however, a proportion are admitted to CCC, either directly from clinic or because Clatterbridge is local to them. Work is currently underway to examine the patient pathways for these patients and determine where best they would be cared for in future.

Radiotherapy services

The significant majority of patients from Wirral and West Cheshire receiving radiotherapy services on an outpatient basis would continue to attend the existing Bebington site. However a small number of Wirral and West Cheshire patients, specifically those suffering from the less common cancers, would need to travel to Liverpool for their outpatient radiotherapy treatment. Conversely patients from Merseyside, many of whom currently travel to Bebington, would receive their treatment closer to home. The forecast impact of this on patient numbers, based on activity modelling which has been undertaken to support the Outline Business case, is shown in Table 7 below:

Table 7: Current and forecast place of treatment for radiotherapy patients by PCT (by attendances)[+]

	Bebington				New Cancer Centre in Liverpool				Aintree			
PCT	**12/13**	**%**	**18/19**	**%**	**12/13**	**%**	**18/19**	**%**	**12/13**	**%**	**18/19**	**%**
C & E Cheshire	1,481	1	1251	7	0	0	450	26	4	0	5	0
Halton & St Helen's	6,454	5	262	2	0	0	7,231	55	4807	43	5606	43
Knowsley	3,285	5	0	0	0	0	3,822	57	2,595	44	2928	43
Liverpool	9,615	5	0	0	0	0	10,802	57	7244	43	8018	43
Sefton	6,649	5	0	0	0	0	7,286	53	5616	46	6346	47
Warrington	5,224	7	140	2	0	0	6,086	77	1428	21	1698	21
W Cheshire	10,287	1	11,261	9	0	0	720	6	9	0	10	0
Wirral	14,476	1	14,106	8	0	0	2,269	14	13	0	12	0

[+] CCC activity model

The model above has assumed that some of those Wirral patients who are geographically closer to Liverpool than Bebington would attend the new Centre rather than Bebington in the future. In practice, however, these patients may prefer to have their treatment on the Wirral in which case the proportion of Wirral patients being treated at Bebington in the future is likely to be higher and to come in line with the West Cheshire figure of 94%.

It should be noted that all patients would be given a choice of site, provided this was consistent with the specific treatment they required as a consequence of their type of cancer. In practice this means that almost all patients suffering from the common cancers e.g. breast, lung, prostate, colorectal, could choose which of the three sites they wished to attend for radiotherapy in future.

Chemotherapy and outpatient services

A similar picture to radiotherapy is expected for outpatient chemotherapy and outpatient consultations as a consequence of the proposed changes. Wirral and West Cheshire patients would continue to have their chemotherapy provided at Bebington and to continue to have their outpatient consultations there. However patients who would currently travel to Bebington but who are geographically closer to Liverpool would instead be offered treatment at the planned new Cancer Centre in Liverpool.

Delivery of networked cancer services by CCC

Overall, the Trust remains strongly committed to the philosophy of a networked model of cancer service delivery, providing care as close to the patient's home as

possible and only centralising where access to expertise or specialised equipment requires it if patients are to benefit from the best outcomes.

11. TIMESCALES

The key milestones for the Transforming Cancer Care project are shown in Table 8 below:

Table 8: key project milestones

Milestone	Date
Publication of the Baker Cannon Report	2008
Initial feasibility study	2010-11
Approval to proceed by Merseyside NHS Cluster Board	2011
Development of the Strategic Outline Case	Q3 2012
Pre-consultation public engagement	Q3 2012-Q2 2013
Formal public consultation	July-Sept 2014
Outline Business Case approval	Oct 2014-Feb 2015
Full Business Case approval	June 2016
Construction of the new Cancer Centre in Liverpool	July 2016-July 2018
Refurbishment of Cancer Centre on the Wirral	Sept 2018-Sept 2019

12. STAKEHOLDER INVOLVEMENT

The Consultation Plan for the Transforming Cancer Care project has been produced in tandem with this Case for Change document and is entitled 'Transforming Cancer Services for Cheshire and Merseyside; Communication and Consultation Plan January 2014 to September 2014'. For further information on the consultation process together with stakeholder engagement, please refer to this document.

13. SUMMARY

The Transforming Cancer Care project represents an opportunity to significantly improve the way in which Cancer Care is delivered to the people of Merseyside and Cheshire, areas with some of the very worst cancer outcomes in England. It is hoped that the proposals to deliver these service changes will be endorsed by all stakeholders, enabling the vision of the Transforming Cancer Care project to be realised. The people of Wirral, West Cheshire and Merseyside deserve to have the very best in cancer services.

The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

NHS England

The Clatterbridge Cancer Centre NHS Foundation Trust Transforming Cancer Services for Cheshire and Merseyside

Communication and Consultation Plan January 2014 to September 2014

Jacqueline Robinson
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May 2014

Contents **Pages**

Appendices

1. Introduction

In 2008 the Merseyside and Cheshire Cancer Network (MCCN) commissioned an expert review of the configuration of Cancer Services in Cheshire and Merseyside with the aim of developing recommendations to ensure that services were delivered in the best way to improve outcomes for patients. The resulting report, 'The organisation and delivery of non-surgical oncology services in the Merseyside and Cheshire Cancer Network', made a number of recommendations to improve the way non-surgical cancer services were organised in the MCCN area.

Since then much work has been undertaken to implement the recommendations of this report and the Transforming Cancer Care project represents the culmination of this activity.

- The need to encourage the major expansion of radiotherapy through the development of satellite radiotherapy units closer to the populations served and limiting the size of major centres to a maximum of eight LINACs.

- The decentralisation of chemotherapy requiring a larger clinical workforce with a greater local presence.

- More flexible service delivery models required which were less dependent on a single centre and more served through networks of care.

- The increasing use of multi-modality treatment regimes suggesting that, in the longer term, isolated oncology centres were no longer appropriate.

- The organisation of hospital services in MCCN meant that integrated cancer care was dependent on oncologists to secure the integrity of patient pathways. It was more difficult to achieve this from a remote centre.

- The needs of the network population were high in terms of cancer care but the results were likely to be inhibited by poor accessibility to oncology services as well as by late presentation. Closer alignment of oncology to local providers would shift the balance of leadership in cancer care and would support improving the overall organisation and delivery of care.

- Developing cancer research in Liverpool, an essential component of all cancer care and of medical research, was compromised by the absence of academic oncology leadership. The isolation of the current cancer centre and its distance from surgical oncology and MDTs were factors in the difficulty in addressing this deficiency.

2. Work done to date

Several reports have been produced in order to understand the implications of reconfiguration. These include the *Baker-Cannon* report(1) and the *Ellison-Cottier* report(2). Equality issues, such as whether the reconfiguration would positively or negatively impact on a group with characteristics protected by law, have also been considered(3).

There has been significant pre-consultation activity undertaken on the implications of the proposals contained within the Transforming Cancer Care project. This was conducted within the spirit and guiding principle of "***No decision about me without me"*** which puts patients, service users and their carers at the centre of the decision-making process.

The pre-consultation exercise informed local people about the proposal and sought to find out whether they were in support of the proposed reconfiguration. It was also undertaken in order to help guide the planned formal consultation exercise and development of the business case. Local people were asked a Principal Consultation Question (PCQ):

"After finding out about the plans to develop a new Clatterbridge Cancer Centre for Cheshire and Merseyside, which would be based next to the Royal Liverpool University Hospital, do you think this is a good idea?"

Respondents could either answer *yes*, *no* or *not sure*. Respondents were then asked to provide comments about their chosen answer (*"why do you think this?"*). The data gathered was largely qualitative and therefore has been subjected to an epistemological analytic approach using Nvivo computer software. The survey data comprised 4,164 responses to the PCQ. This data also revealed that 3,755 (90%) respondents left comments to the open question within the survey. The analysis was independently undertaken by John Moores University and the report (Appendix 1) has been made available to key stakeholders as part of the feedback process.

A further Equality Impact Assessment(3) considered the responses to the PCQ in relation to where people lived and further investigates the themes arising from the additional question about why people responded to the question in the way they had.

Results

- 90,000 people engaged
- 114 roadshows
- 96 group sessions with 53 different groups
- 7 District General Hospitals participated
- 12 CCGs involved
- Every area Cancer Support Group engaged
- Every area Healthwatch supported the engagement
- Every area CVS advertised events to support attendance

- Over 40 cancer community champions recruited
- 14,500 visited roadshows
- 4,164 formal written responses

Overall, the process has given The Clatterbridge Cancer Centre a wealth of qualitative information which the Trust is committed to actively reflect within the plans as they develop.

The process has also given the Trust robust evidence and greater confidence that their proposals meet the requirements of its population. It has helped to differentiate the varying concerns of patients, carers and the public and understand these concerns in more depth. It has also confirmed to the Trust the importance of car parking and access and how robustly this must be considered and evidenced within the plans.

The analysis of 4,164 respondents found that those who opposed the reconfiguration were mainly from areas close to the current services ('CH' postcode) but that overall a large majority of respondents supported the proposal.

The emerging themes identified and evidenced (in alphabetical order) were: -

- Accessibility
- Cost
- Good Current Services
- Ill Health
- Loss of Services
- Travel
- Visits

These themes were observed across many responses but with Loss of Services, Cost and Good Current Services being themes particularly pertinent to "No" voters and to a lesser extent, therefore, respondents with a 'CH' postcode.

It is now the intention to use the information gathered from the pre-consultation engagement work to shape a formal public consultation exercise which will be conducted from July-September of 2014.

Therefore there are a number of phases of consultation:-

- **Pre-consultation** as part of the development of recommendations was undertaken August 2012 to February 2013. Feedback on findings from the pre-consultation was undertaken January 2014 to March 2014.
- **Formal consultation** on the actual recommendations for change is planned to commence July 2014 to September 2014.
- **Post-consultation** feedback detailing how the decision is being implemented (dates to be agreed pending outcome of consultation).

3. The Vision for Transforming Cancer Services

Transforming Cancer Care aims to ensure people in Cheshire and Merseyside benefit from easy access to the best clinical expertise, the most advanced treatments and the best facilities for many years to come.

We aim to achieve this through:

1. A new Clatterbridge Cancer Centre at the heart of Liverpool, centrally located for the 2.3m people in Cheshire and Merseyside, and on the same health campus as Royal Liverpool University Hospital, University of Liverpool, CR:UK's Liverpool Cancer Trials Unit and other key research partners.

2. Continuing to provide most cancer services at The Clatterbridge Cancer Centre in Wirral in addition to the new centre on the Liverpool health campus, the satellite radiotherapy unit at Aintree University Hospital and satellite chemotherapy services at seven hospitals across Cheshire and Merseyside.

What would change?

- There would be a new cancer hospital in the heart of Liverpool, closer to the c. 70% of patients who live north of the Mersey.
- Inpatient care would move from Wirral to the new centre in Liverpool. Some complex outpatient treatment would also move, as would the Teenage and Young Adult unit, bringing it closer to Alder Hey.
- For the first time, patients could access cancer surgery, chemotherapy, radiotherapy, intensive care, inpatients, outpatients, and acute medical/surgical specialties together on the same site.
- Seriously ill patients with complex conditions could receive treatment that can't be provided at the moment because there is no intensive care on site at Clatterbridge.
- Cancer experts from different hospitals, the university and key research partners would be together, offering new scope for research. Patients could also access a much broader range of clinical trials.
- The Wirral site would receive further investment so local patients would continue to receive the same high standard of care for the foreseeable future.

What would stay the same?

- The warm, compassionate Clatterbridge care patients value so much would also be provided in the new centre.
- Most Wirral and West Cheshire patients could continue being cared for at the existing centre. They would only need to travel to Liverpool for inpatient care or the more complex treatments. All outpatient chemotherapy would be available at Wirral, as well as radiotherapy for common cancers including breast, prostate and lung.

- The specialist eye proton therapy service – the only one of its kind in the UK – would also remain at Wirral.
- The satellite radiotherapy unit at Aintree (Clatterbridge Cancer Centre Liverpool) would remain, with radiotherapy for common cancers and the specialist stereotactic radiosurgery service for brain tumours.
- The satellite chemotherapy services across Cheshire and Merseyside would also continue.
- Patients – including those from Wirral – would receive an even better quality of care.

4. Aims and Purpose of Communication and Consultation

Under Section 242 of NHS Act 2006, providers of NHS services must make arrangements to secure the involvement of people who use, or may use services in:

- Planning the provision of services;
- The development and considerations of proposals for change in the way those services are provided – where the implementation of the proposals would have an impact on the manner in which those services are delivered, or the range of services that are delivered;
- Decisions to be made by the NHS organisation affecting the operation of services.

The aim of the consultation plan is to ensure that decisions/recommendations are informed and guided by the views of stakeholders and patients, carers, and the public, which will further inform the progress of transforming cancer care across Cheshire and Merseyside.

As a major service provider, The Clatterbridge Cancer Centre is committed to providing the best possible cancer services in order to improve outcomes and reduce health inequality.
Staff are one of the key stakeholders in Transforming Cancer Care. There has been regular staff engagement throughout the pre-consultation period and lessons learnt from their feedback will be built upon. Staff will remain one of the key stakeholder groups throughout consultation and the post-consultation period.

There will be extensive and ongoing communication and engagement through a variety of forums including roadshows, the intranet, noticeboards/newsletters, informal events and more formal involvement of staff representatives in project groups. Staff suggestions for enhancing the proposals for change – both for the new Centre and as part of the Trust's wider organisational development plan – will be very much encouraged and valued.

Clinical engagement and support is an essential element of this project and input from specialist clinicians, clinical commissioning groups, health and wellbeing boards etc, will be sought to ensure their feedback and commentary are considered in the proposals for change.

Local authorities have been engaged since the inception of this proposal and have received regular updates as the plan has progressed through various stages. A request will be made to convene a joint Overview and Scrutiny Committee to allow a collective forum to discuss the proposals, scrutinise the plans, hear from clinical staff involved and view the findings from the patient and public consultation.

This consultation plan seeks to:-

- Outline the objectives for communications and consultation within the project;
- Define the communications and stakeholder consultation strategic approach;
- Define the development of communications and key messages;
- Identify the stakeholder groups (key target audiences);
- Identify the channels of communications for these stakeholders;
- Plan communications and consultation activities;
- Systematically record all engagement aligned to the requirements set out in 2012 Health and Social Care Act and 2006 NHS Act;
- Ensure the consultation activity is aligned to best practice, in particular to:-
  - NHS England guidance as detailed within Transforming Participation in Health and Care September, 2013
  - NHS England guidance as detailed within Planning and Delivering Service Changes for Patients, December 2013
  - Cabinet Office Code of Conduct for public consultations
- Ensure that all phases of the consultation will be composite and will be compliant with the requirements set out in the Four Tests for major service changes;
- Define the means of monitoring feedback and evaluating the success of communications and engagement.

There is an absolute commitment to carry out the work with full engagement from all stakeholders, particularly local patients, carers, providers and staff.

A time-limited group has been established by NHS England Cheshire Warrington and Wirral (CWW) Area Team, to steer the project through the consultation and scrutiny process.

5. Context for Communications & Consultation Activity

This plan supports NHS England CWW Area Team as service commissioners, and The Clatterbridge Cancer Centre NHS Foundation Trust as the service provider, in delivering their communications and engagement responsibilities. There are a number of key specific documents that have informed and shaped the communication and consultation plan which are highlighted in blue below:

Health & Social Care Act 2012

- Duty to promote the NHS Constitution (13C and 14P)
- Quality (sections 13E and 14R)

- Inequality (sections 13G and 14T),
- Promotion of patient choice (sections 13I and 14V)
- Promotion of integration (sections 13K and 14Z1)
- Public involvement (sections 13Q and 14Z2)
- Innovation (sections 13K and 14X)
- Obtaining advice (sections 13J and 14W)

  The duty to have regard to joint strategic needs assessments and joint health and wellbeing
- Section (14Z2) outlines how this legal duty for involvement:
  - in the planning of its commissioning arrangements,
  - in developing and considering proposals for changes in the commissioning
  - arrangements that would impact on the manner in which services are delivered or on the range of services available, and
  - In decisions that affect how commissioning arrangements operate and which might have such impact.
- Section (14v)Duty as to Patient Choice
  - Each CCG (*who will take over from PCT post April 2013*) must in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

Government and Public Involvement in Health Act 2007

- Strategies (section 116B of the Local Government and Public Involvement in Health Act 2007)

NHS Act 2006

- Section 244 of the NHS Act 2006 duty to consult the relevant local authority in its health scrutiny capacity.

Public Sector Equality Duty 2010

Planning and delivering service changes for patients, December 2013, NHS England

Transforming Participation in Health and Care 2013, NHS England

Everyone Counts: Planning for Patients 2013/14, NHS England

NHS Operating Framework for the NHS in England 2013/14

Independent Reconfiguration Panel guidance

- Make sure the needs of patients and the quality of patient care are central to any proposals;
- Assess the effect of the proposals on others services in the area;
- Give early consideration to transport and access issues;
- Provide independent validation of the responses to engagement and consultation.

Rules on service reconfiguration Indicative evidence requirements against the *"Four Tests'*

- Test 1 – support from GP commissioners
- Test 2 – strengthened public and patient engagement
- Test 3 – clarity on the clinical evidence base
- Test 4 – consistency with current and prospective patient choice

6. Specific Stakeholder Engagement Plans

It is vital to involve a wide range of stakeholders in the debate for change. This will ensure that people are informed about the reasons for the proposed changes and they have an opportunity to comment on and influence these plans.

NHS Cheshire and Merseyside Commissioning Support Unit (CMCSU) will work in partnership with Voluntary and Community Sectors (VCS), locality Healthwatch and carer/patient support groups, and build upon its existing networked approach to engaging patients, carers, and the wider public. It will include the use of the community cancer champions model which proved successful during the pre-consultation phase. This approach has been identified as crucial in reaching key stakeholders, including those traditionally hard to reach. Together the CMCSU, The Clatterbridge Cancer Centre outpatient sites and the VCS partners will work to collect views, comments and insight on patient experience and expectations.

Community champions, communities, organisations and patients and will be provided with consistent information and communication materials to share this across the sub-region which is inclusive of key stakeholders in the North and South Mersey regions.

The feedback from this activity will be used to inform the Outline Business Case.

As an early involvement strategy, all of Cheshire and Merseyside Healthwatch organisations, carer groups and VCS have been provided with feedback from the pre-consultation phase and asked for their continuing support in the formal consultation programme. This has been secured and dedicated “cancer champions” awareness events will be held to share the range of activity which is planned and allow people to choose options to volunteer.

A communications and engagement work plan has been appended (see Appendix 3). This will be a fluid plan; as new opportunities arise CMCSU will consider the capacity to add to its exiting programme of work.

Representatives from the community voluntary sector and Healthwatch have acknowledged and valued information regarding the process and have responded positively to our request for a collaboration of approach during the formal consultation period.

Target Audiences

The approach to communication and engagement aims to be comprehensive and robust. Our aim is to work closely with key organisations that can easily communicate with a range of audiences within their networks as follows:-

- Local residents
- Patients and Carers
- Third sector providers
- Voluntary Patient Groups
- Charities
- Hospices
- Hospital Trust Governors and Members
- Hospital Trust Volunteers
- Local Healthwatch Organisations
- Local Council for Volunteer Service network
- NHS England Area Teams for Cheshire and Merseyside
- Cheshire and Merseyside Clinical Senates
- Chairs and Chief Officers of Clinical Commissioning Governing Bodies
- GPs members across Cheshire and Merseyside
- Chairs of Local Medical Committees (LMCs)
- Primary and Secondary Care Trust Communication and Engagement Leads
- Hospital Trust Chief Executive Officers
- Hospital Senior Operational Managers
- Senior Consultant Cancer Clinicians
- Associated Operational Clinicians and staff
- Cancer Networks
- The University of Liverpool
- Local Authority Health Overview and Scrutiny Committees
- Members of Parliament for constituent localities
- Directors of Public Health
- Health and Wellbeing Boards
- Local media

Engagement Channels

Stakeholder engagement will be carried out through a range of channels to promote and explain the purpose and progress of the review, including:

- Senior officer meetings
- Attendance at Health Overview & Scrutiny panels
- Production of patient and clinician DVD to disseminate during the consultation
- Corporate launch events
- 2 Volunteers / Community Champion launch events
- Publicity available at every GP practice

- Local activity at all Clatterbridge Cancer Centre outpatient sites
- Activity at the Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Targeted letters and emails
- Attendance at high volume public events throughout Summer
- Newsletters information within Hospital Trust membership publications
- Internal staff briefings
- Web based consultation information and online survey
- Dedicated phone line
- 10,000 leaflets distributed to cancer centres, community groups
- Coverage on local Radio via live interviews and information on their website reaching the North West and Wales.

A matrix demonstrating reach to respective groups is detailed in Appendix 2.

7. Key Messages

The following key messages will be covered in all communications to all stakeholders:

- The need for change
- Why is this a local priority
- Who it would affect
- What are the benefits
- What this would mean to local people and services
- How it would be implemented
- What are the timescales
- What can you influence
- What are your views on this proposal

8. Milestones

This plan is delivered in the context of a changing NHS. In order to be effective in our communications and engagement we may need to adapt this plan over time to reach our target audiences in the most effective way. Progress against the key milestones will be monitored.

Action plans for communications and engagement are set out in Appendix 3.

References

1. Baker, M.R. and Cannon, R.C. (2008) *The organisation and delivery of no-surgical oncology services in the Merseyside and Cheshire Cancer Network: A feasibility study into the potential for the relocation of non-surgical oncology services from Clatterbridge to Liverpool*, Cancer Taskforce.
2. Ellison, T. and Cottier, B. (2009) *An Analysis of Radiotherapy Services in the Merseyside and Cheshire Cancer Network*, The National Cancer Services Analysis Team.
3. Hennessey, M., McHale, P. and Perkins, C. (2013) *Equality Considerations in the Development of a Comprehensive Cancer Centre*, 2013, Centre for Public Health: Liverpool John Moores University.

Comprehensive Cancer Centre Pre-Consultation: Qualitative Analysis Report

June 2013

CPH | CENTRE FOR PUBLIC HEALTH
LIVERPOOL JOHN MOORES UNIVERSITY

Contents

Executive Summary

Following an independent review into cancer service provision, commissioned by the Merseyside and Cheshire Cancer Network (MCCN) in 2008, The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) are in the process of developing a business case to reconfigure the non-surgical oncology services they provide in line with the review recommendations. In outline, the proposal is for CCC to build a new cancer centre in Liverpool to provide all oncology inpatient services and associated radiotherapy, chemotherapy and outpatient services that the Trust is responsible for. The Trust's Wirral site would be retained and continue to provide outpatient radiotherapy and chemotherapy treatments for Wirral and West Cheshire patients who would find it easier to access the Wirral site rather than Liverpool. CCC will also retain the satellite Radiotherapy facility on the Aintree site and will continue to provide services in the existing clinics in hospitals across the region. This report contains an analysis of responses, by the Centre for Public Health (CPH), to an engagement survey, which was carried out by MCCN as part of the development of the business case.

The survey included a Principal Consultation Question (PCQ) to ascertain whether network residents were in favour of the proposed reconfiguration and the opportunity to record, in their own words their reasons why they were or were not. The data gathered is largely qualitative and therefore has been subjected to an epistemological analytic approach using Nvivo computer software. The survey data comprised 4,164 responses to the PCQ. This data also revealed that 3,755 (90%) respondents left comments to the open question within the survey.

Results

The analysis found that respondents who opposed the reconfiguration were mainly from areas close to the current services ('CH' postcode) but that overall a large majority of respondents supported the proposal.

The emerging themes identified and evidenced (in alphabetical order) were:

- Accessibility
- Cost
- Good Current Services
- Ill Health
- Loss of Services
- Travel
- Visits

These themes were observed across many responses but with Loss of Services, Cost and Good Current Services being themes particularly pertinent to No voters and to a lesser extent therefore, respondents with a 'CH' postcode.

Recommendations

Based on the analysis within this report, it is recommended that:

- the business case records and reflects the reported benefits to the majority of respondents, namely reduced travel for patients and their families and a view that general accessibility using public transport will be improved by locating the service in Liverpool.
- the business case includes a strategy for informing and reassuring those who oppose the proposals that the quality of service will not reduce as a result of reconfiguration.
- the business case makes provision to comment, as far as possible, on the possibility of further service reconfiguration in response to concerns that this may be the start of a programme of service withdrawal.
- consideration is given to how best to further communicate which patients will need to receive their care in Liverpool following reconfiguration and which will continue to be treated at the Wirral site.

1. Background

This analysis has been commissioned by NHS Cheshire, Warrington and Wirral on behalf of themselves and NHS Merseyside.[a] These NHS organisations together with Specialist NHS Trusts, Acute Hospital Trusts and Hospices make up the Merseyside and Cheshire Cancer Network (MCCN)[b].

In 2008, MCCN commissioned an independent review of how cancer services are organised across the region. This showed that benefits could be gained for patients and their families by expanding the services provided by The Clatterbridge Cancer Centre NHS Foundation Trust (CCC). The review recommended the establishment of a comprehensive cancer centre. The establishment of such a centre would involve the reconfiguration of current services such that inpatient services currently provided at The CCC on the Wirral[c] would be located adjacent to the redeveloped Royal Liverpool University Hospital[d] as well as associated radiotherapy, chemotherapy and outpatient services that the Trust is responsible for.

The Trust's Wirral site would be retained and continue to provide outpatient radiotherapy and chemotherapy treatments for Wirral and West Cheshire patients who would find it easier to access the Wirral site rather than Liverpool. CCC will also retain the satellite Radiotherapy facility on the Aintree site and will continue to provide services in the existing clinics in hospitals across the region.

Further work is being carried out in order to develop a business case for the proposed investment. An engagement exercise with the local populations who might be affected by the proposed reconfiguration has been carried out and this report contains an analysis of the responses to that consultation. This engagement exercise was designed to inform local people about the proposal, find out whether they were in support of the proposed reconfiguration and inform the formal consultation exercise and development of the business case. Local people were asked a Principal Consultation Question (PCQ):

> *"After finding out about the plans to develop a new Clatterbridge Cancer Centre for Cheshire and Merseyside, which would be based next to the Royal Liverpool University Hospital, do you think this is a good idea?*"

Respondents could either answer *yes*, *no* or *not sure*. Respondents were then asked to provide comments about their chosen answer (*"why do you think this?"*). This analysis considers the responses to the PCQ in relation to where people lived and further investigates the themes arising from the additional question about why people responded to the question in the way they had.

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[a] These organisations are due for reorganisation under NHS reforms and cease to exist at the time of publication

[b] For a full list of network members, see http://www.mccn.nhs.uk/index.php/about_us_network_organisations

[c] Hereafter referred to as CCC

[d] Hereafter referred to as the Royal Liverpool

2. Extant Literature

Several reports have been produced in order to understand the technical and costing implications of reconfiguration. These include the *Baker-Cannon* report[1] and the *Ellison-Cottier* report[2]. Equality issues, such as whether the reconfiguration would positively or negatively impact on a group with characteristics protected by law, have also been considered[3]. These reports recognise that reconfiguration will have travel implications for those currently living near to the current and proposed sites. The reports conclude that there will be some people who will experience reduced travel as a result of the proposal and some for whom journey time will increase. Overall, the reports find that a majority of future patients will experience reduced travel time based on where the burden of disease lies within the MCCN population. The reports also find that a relatively small population experience direct travel benefits from the current service location and these benefits are no longer realised once the public transport journey time exceeds about 15-30 minutes.

3. Methodology

3.1. Data

This analysis is drawn from survey data taken from a survey sample of 4,164 respondents. Cleaned data revealed that 3,755 (90%) respondents left comments to an open question within the survey. The data presented was predominantly qualitative requiring an epistemological approach and a method based on critical realism.

In order to provide quantitative and qualitative analyse of the data by location, respondents had the opportunity to record their postcode along with their responses. There was a variety of responses gathered with some respondents providing a full postcode, and some only a partial postcode. In a few cases no postcode was given (n=23). In view of this data inconsistency a number of geographies have been prepared to enable analysis to take place (Table 1)

Table 1: Postcode Geography Definitions

	Geography Name	Geography Definition
1	Liverpool Postcodes	Contains all postcodes beginning "L" (Liverpool postal district). It does not including "LL" which is a N Wales postcode district
2	Cheshire Postcodes	Contains all postcodes beginning "CH" (Chester postal district). The CH postcode is the most coterminous postcode for the Local Authority Footprints of *Wirral*, and *Cheshire West and Chester*. The classification of 'Cheshire' used here is purely for ease of presentation and does not include postcodes relating to the Cheshire East Local Authority ("CW" or Crewe postcodes)
3	Manchester Postcodes	Contains all postcodes beginning "M"
4	Warrington Postcodes	Contains all postcodes beginning "WA"
5	Wigan Postcodes	Contains all postcodes beginning "WN"
6	Miscellaneous Postcodes	Contains all postcodes not allocated to geography 1-5 above (Liverpool – Wigan). Examples include "CW" "LL", "PR", "SY", "ST", "SK", "NG" and "VH"
7	Other Area Postcodes	This grouping includes all non-Liverpool postal district (L) or Chester postal district (CH) postcodes
11	Not Known	Either no postcode was provided or location based on classifications above could not be determined

3.2 Methods

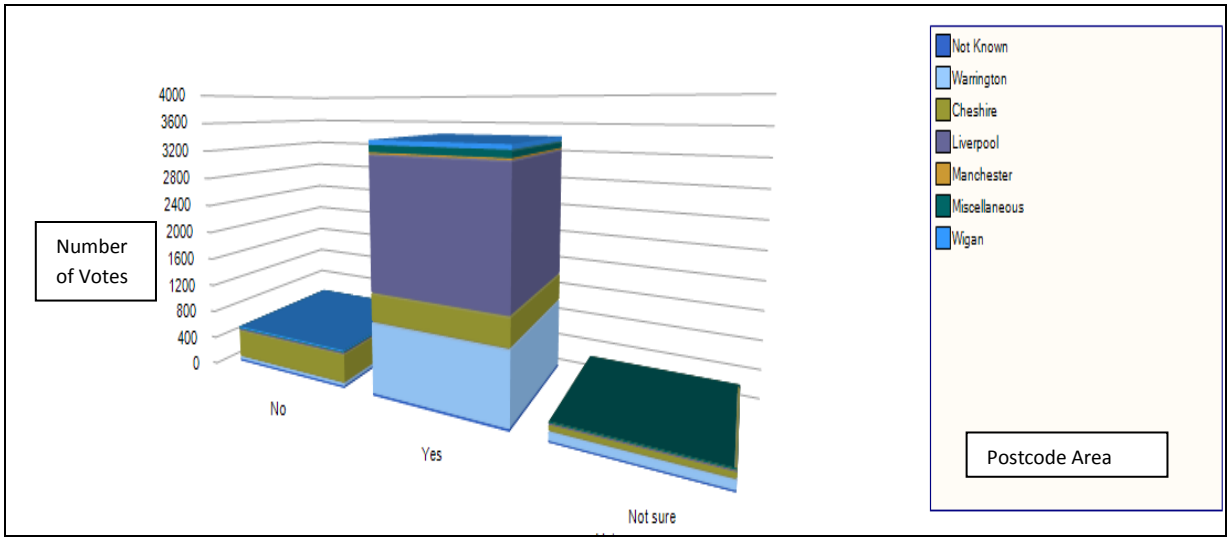
A combination of content analysis and initial evaluation using Computer Assisted Qualitative Data Analysis Software (CAQDAS) package Nvivo 10 was applied to the data. CAQDAS assists in the identification of emerging themes using textual analysis. The data analysed included no missing responses in respect of the overall 'yes, no or not sure' consultation question. However, the optional follow up question responses contained some missing or textual errors. This qualitative analysis is broadly based upon Grounded Theory and uses a process of open coding and axial coding to extract and distil themes from the free text responses[e]. Grounded Theory in its purest form is entirely data directed and presupposes no specific themes from the data. In this scenario, it is clear that there are some constraints on being able to follow a pure Grounded Theory methodology. The pre-consultation builds on the extant literature and is structured on a premise that the reconfiguration will cause a difference of opinion between local groups, most likely with differences observed between groups who live near to the current or proposed sites. In this respect the analysis should be considered semi-inductive, that is to say that the analyst will investigate some expected themes in relation to location.

[e] Grounded Theory involves taking raw data and systematically distilling it to form a theory. Key points in the data are coded and then these codes are combined to form themes and concepts which can be developed into a theory.

4. Key Findings

Analysis of the PCQ shows that significantly more people voted in support of the proposed changes and also that there is a significant difference in the PCQ responses of different locations. Figure 1 illustrates that the number of people who support the proposed reconfiguration is greatest from locations with a Liverpool postcode.

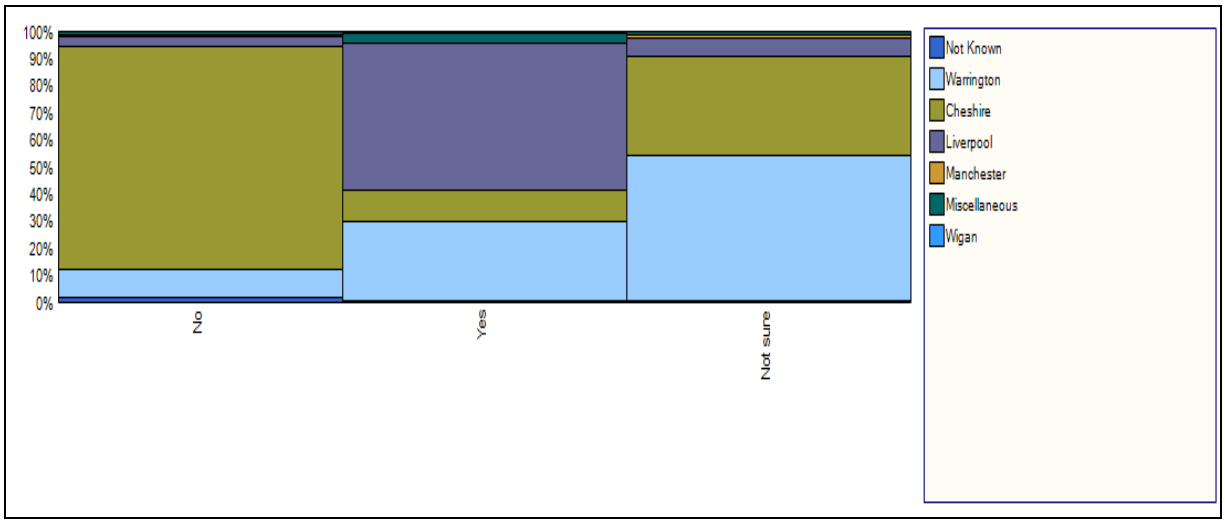
Figure 1: Distribution of Votes by Postcode Area



Source: Engagement survey 2013

Figure 2 shows the percentage of votes cast in the PCQ by each postcode area. Cheshire postoces dominated the No vote with Liverpool Postcodes recording the highest percentage of Yes vote. Warrington and Cheshire postcodes make up the majority of undecided voters.

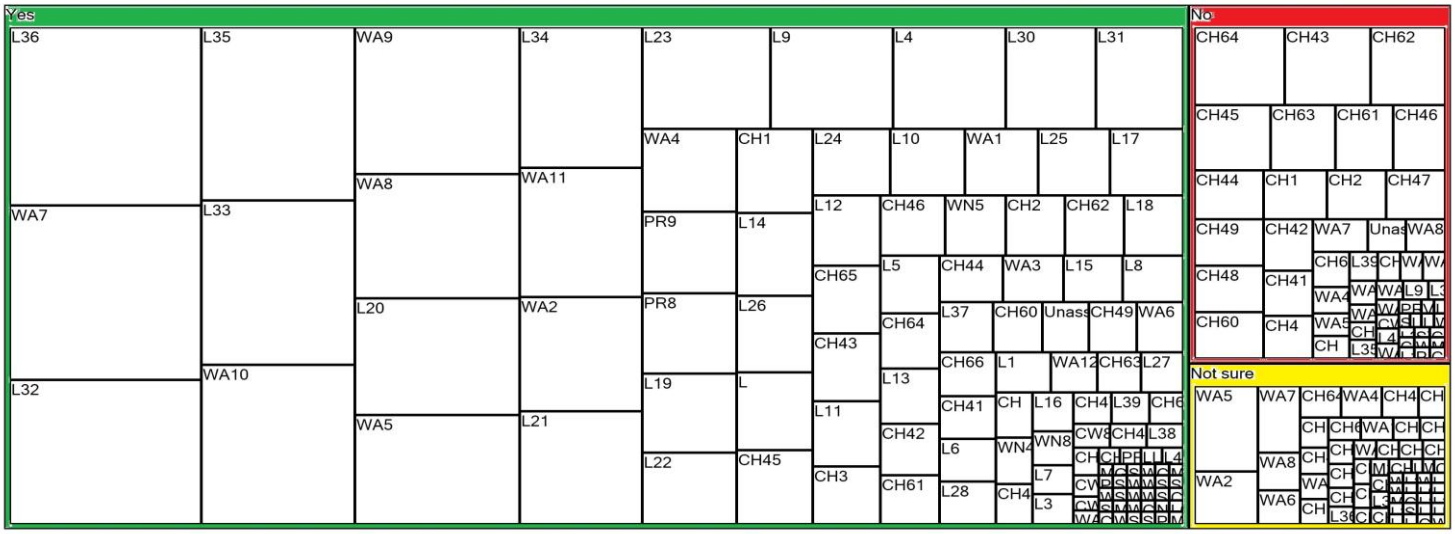
Figure 2: Percentage of No, Yes and Not Sure votes by Postcode Area



Source: Engagement survey 2013

A Tree Map (Figure 3) can be used to illustrate the responses at a lower geography, displaying what proportion of votes came from each postcode. As Figure 3 shows 'No' votes were predominant in CH postcodes with CH64, CH43, CH62, CH45 and CH63 being 'No Hotspots'. Warrington Postcodes made up a substantial proportion of the votes from people who were undecided. 'Yes Hotspots' included L36, WA7, L32, L35 and L33. This report will go on to consider the responses from these postcodes, designated '*Yes'* and '*No'* Hotspots, in more detail (Section 4.4).

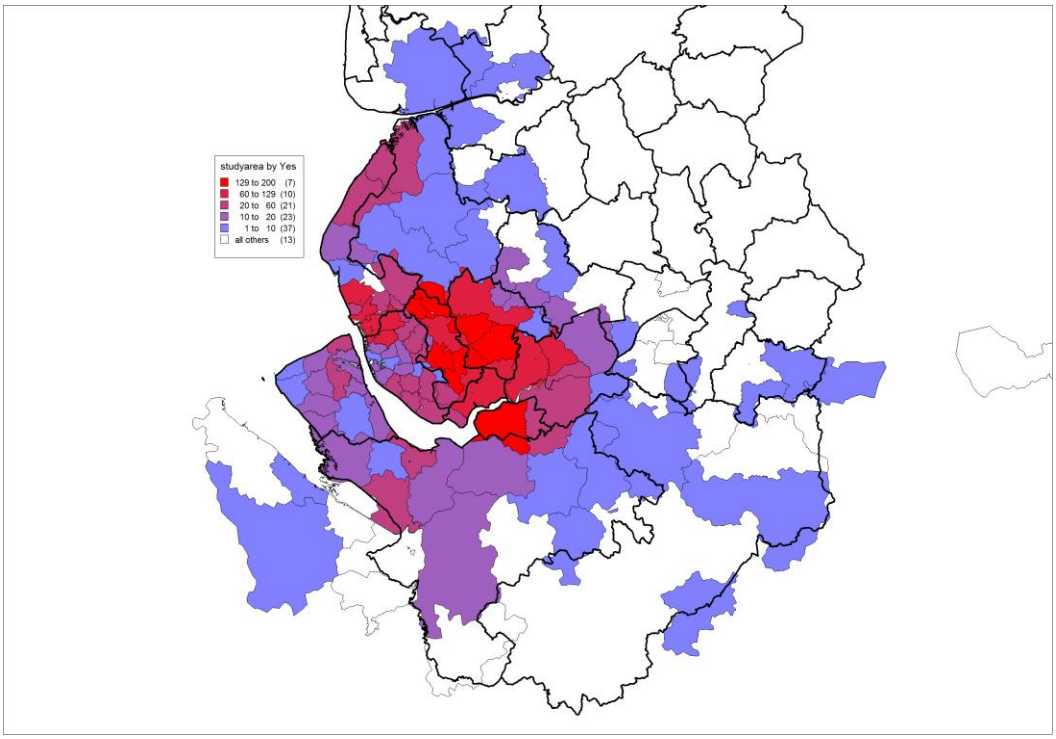
Figure 3: Distribution of Postcodes by Vote



Source: Engagement survey 2013

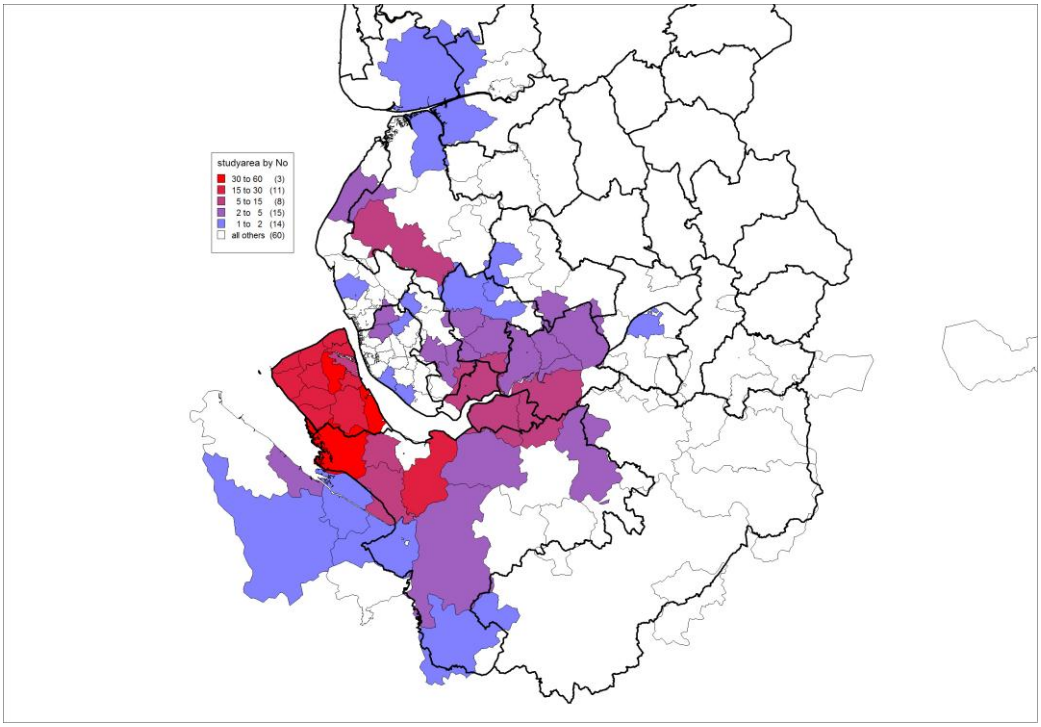
Figures 4 and 5 show how Yes and No votes were distributed across the MCCN footprint.

Figure 4: Map of the Distribution of Yes Votes across the MCCN



Source: Engagement survey 2013

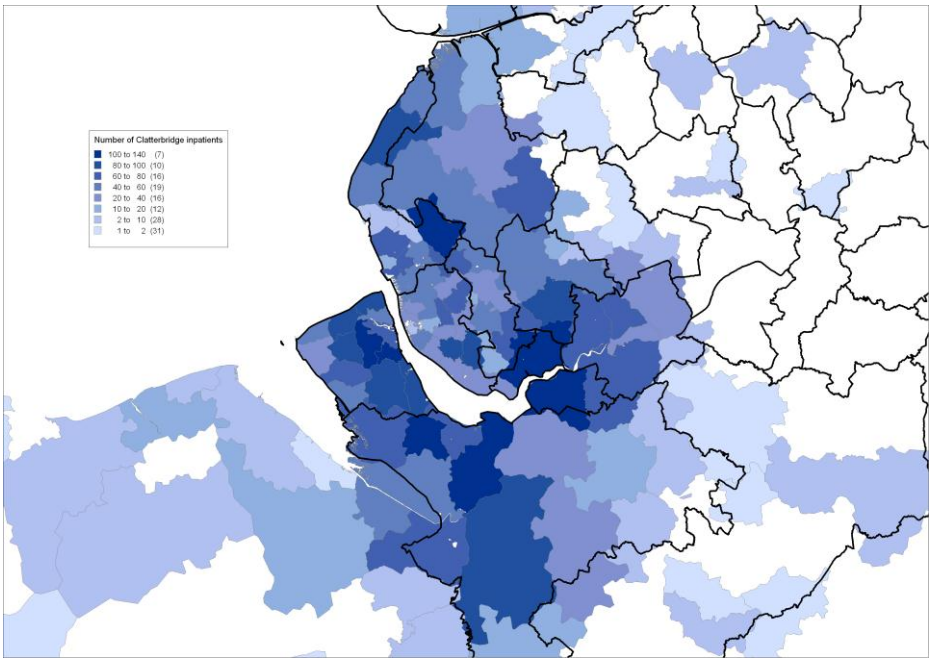
Figure 5: Map of the Distribution of No Votes across the MCCN



Source: Engagement survey 2013

In order to place these responses in some context the current geographical distribution of people attending for in-patient treatment at CCC is shown in Figure 6. Comparing the maps it can be seen that the *No Hotspots* correspond with the areas on the map with high representation in the in-patient treatment population.

Figure 6: Distribution Map of Clatterbridge Inpatients



Source: CCC data 2013

4.1 Emerging Themes

A basic word frequency query was used to identify the words that were most commonly used in people's free text responses (e.g. detailing why they said yes, no or not sure to the PCQ). These words can be visually presented in a tag cloud where the size of the word is proportionate to the number of times it appears[f]. Figure 6 shows the tag cloud for all the responses.

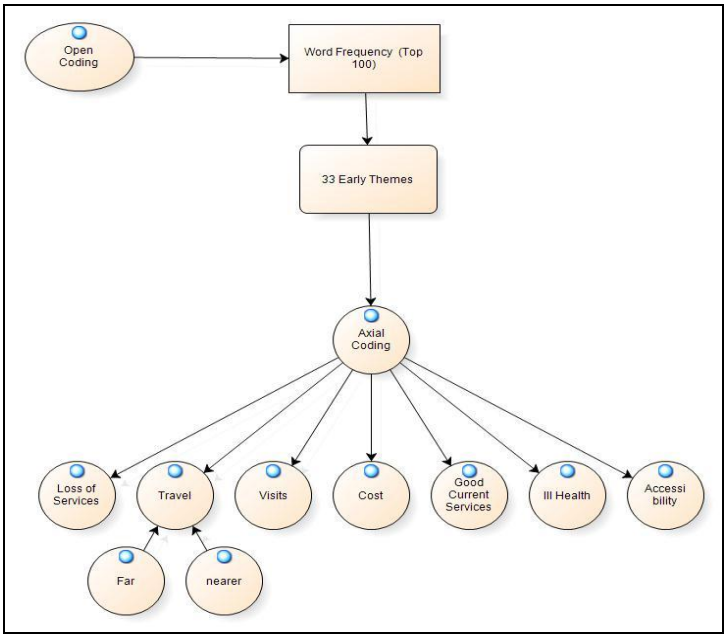
[f] The more often a word appears the bigger it is in the tag cloud

Figure 7: Word Frequency Tag Cloud for All Responses

Source: Engagement survey 2013

This word frequency investigation formed the basisof the open coding. A coding model (Figure 8) shows how themes were distilled from the datatset. In this first round of coding 33 common themes were identified. These included themes (in no particular order) like Idea, Stress, Travel, Links, Distance, Visits, Treatment, Travel, Support and Time.

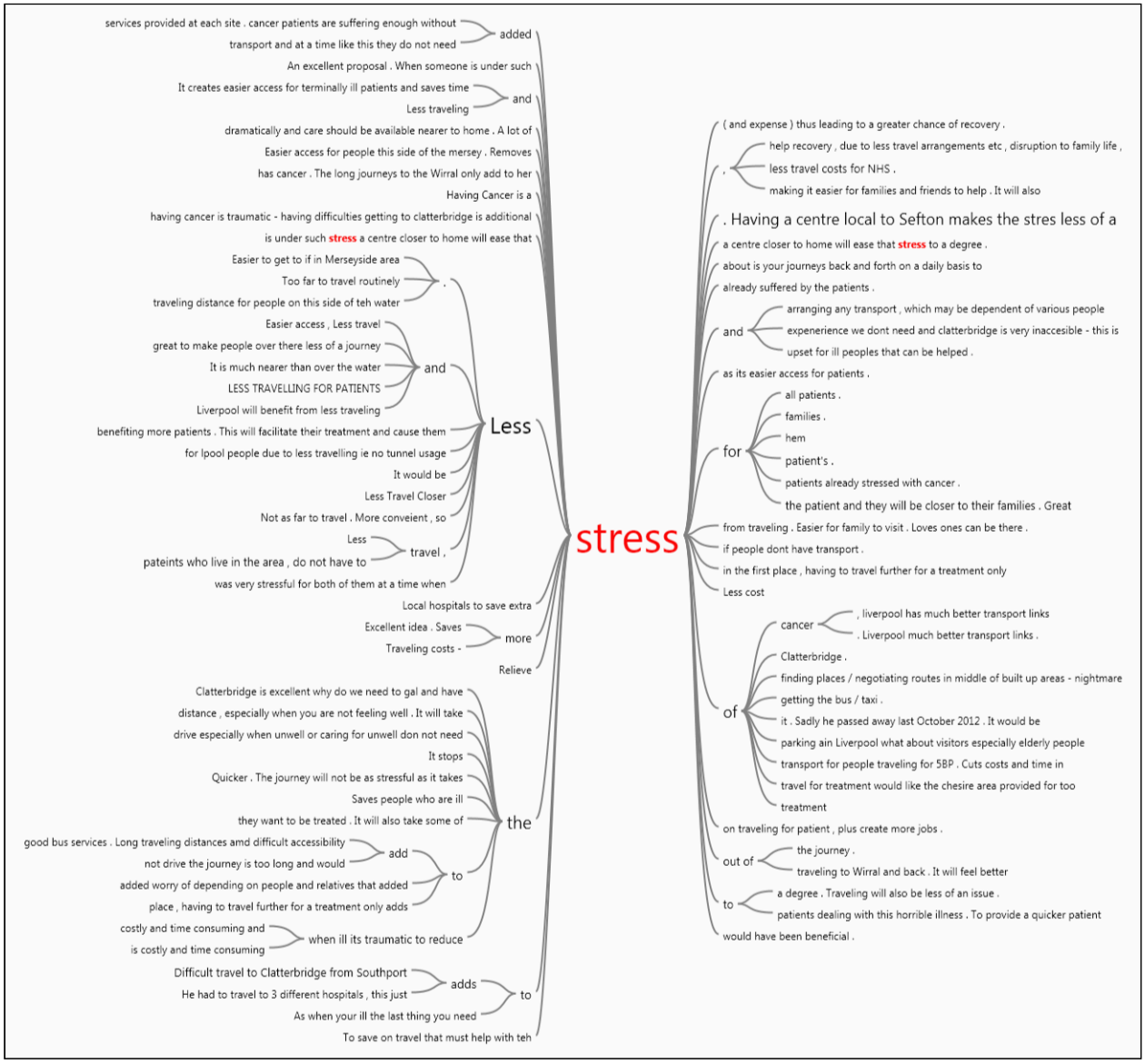
Figure 8: Research Coding Model



Source: Engagement survey 2013

The context of each theme was explored using word trees to understand more about the context that each word was used in. For example, the word “stress” was used 102 times across all the responses. Figure 4 shows the context surrounding the word.

Figure 9: Word Tree of Responses that Include the Word “Stress”



Source: Engagement survey 2013

From this it is possible to see that the word ‘stress’ is most commonly used in the context of travelling to receive treatment. A typical response is provided below:

> *Reference 39*
> *Having Cancer is a **stress** in the first place. Having to travel further for a treatment only adds to the stress.*

Appendix 1 contains more word trees for some of the other ambiguous themes

The 33 initial themes were axially coded or distilled using these methods into 7 main themes emerging from this engagement exercise. These are:

- Accessibility
- Cost
- Good Current Services
- Ill Health
- Loss of Service
- Travel
- Visits.

Having obtained these key themes, it is possible to repeat this exercise for smaller populations than the overall survey sample, such as groups from the same postcode area or those who voted either Yes, No or Not Sure

4.2 Themes per area

The overall PCQ analysis showed that respondents from Cheshire Postcodes and those from Liverpool Postcodes tended to demonstrate different voting behaviours. Analysing and comparing the word frequency of these two groups makes the reasons for their different positions clearer.

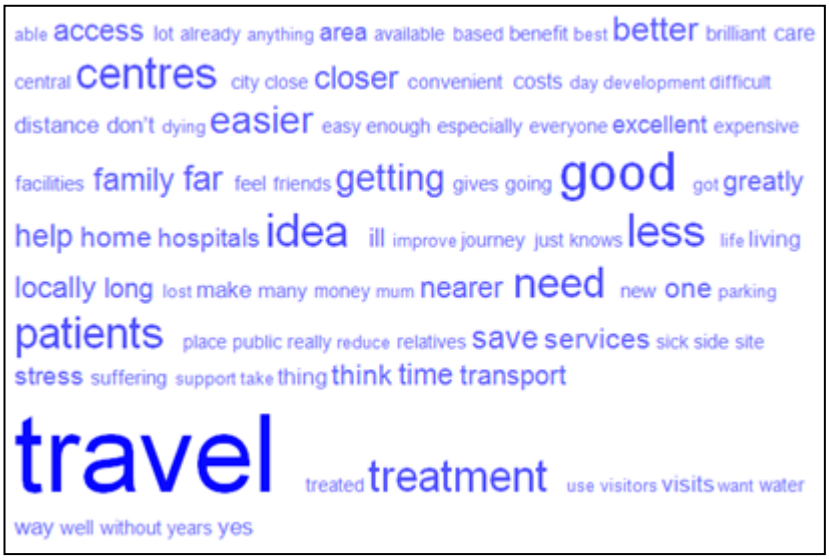
Figure 10a and 10b show the word frequencies for the two postcode areas. While many of the words are similar, suggesting that they have a similar understanding of the proposition and share some of the same views, there are notable differences.

For example, the words Costs, Parking and Tunnel have a greater prominence in responses from Cheshire. The word Tunnel is mentioned 10 times across Liverpool responses but 29 times in Cheshire responses (Table 2).

Figure 10a Word Frequency Tag Cloud for Cheshire Postcode Responses

Source: Engagement survey 2013

Figure 10b Word Frequency Tag Cloud for Liverpool Postcode Responses



Source: Engagement survey 2013

Table 2: Number and percentage of responses that include the word "Tunnel"

	Not Known	Warrington	Cheshire	Liverpool	Manchester	Miscellaneous	Wigan
Number of responses containing "Tunnel"	2	5	29	10	0	0	1
Total number of responses	19	1,008	792	1,776	5	117	38
Percentage of responses which contain "Tunnel"	10.53	0.50	3.66	0.56	0.00	0.00	2.63

Source: Engagement survey 2013

Another theme that emerged with a greater prominence from Cheshire responses was satisfaction with current services – the prominence of words like 'excellent' and 'stay' drew attention to the comments about the 'excellent' quality of current services and the request to let things 'stay' as they are. The following comments were typical of this theme.

Reference 38
I am a patient who has had an ***excellent*** *series of treatments at Clatterbridge Oncology Centre. It is a well organised and pleasant convienent hospital to attend.*

Reference 96
There is already an ***excellent*** *system at clatterbridge which should be further invested in*

Reference 105
As long as the new centre does not replace Clatterbridge, where my father received ***excellent*** *treatment*

Reference 12
Because have used services at Clatterbridge and would like it to ***stay*** *as it is*

Reference 18
Services need to ***stay*** *on the Wirral*

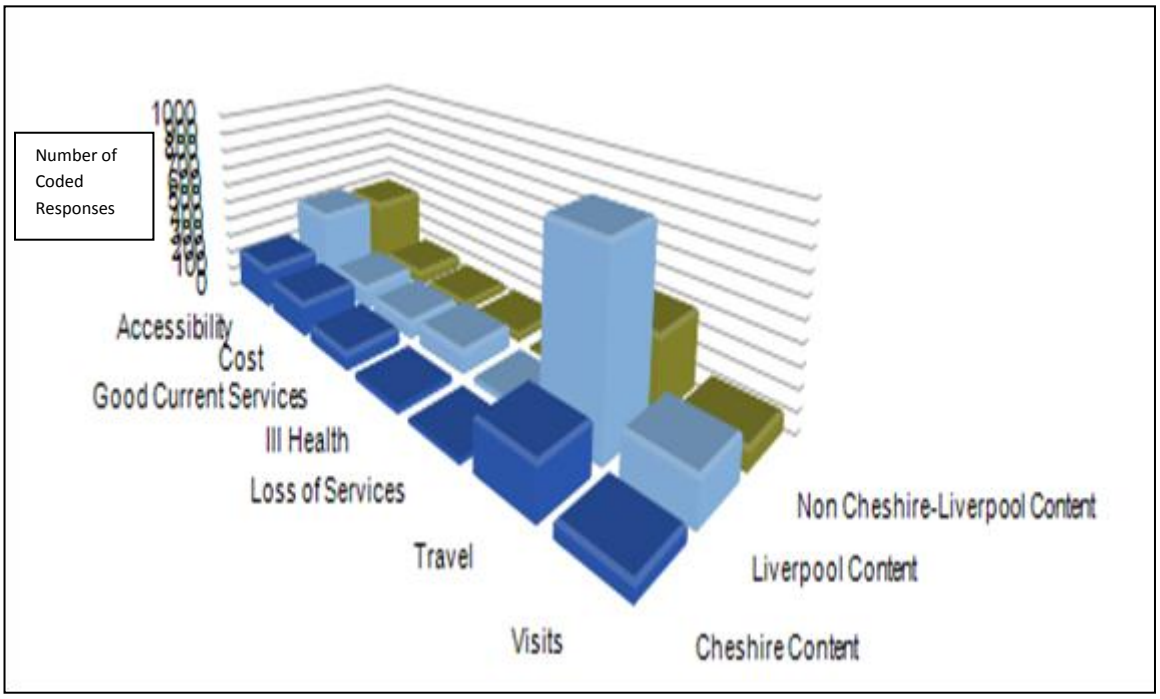
Reference 24
Clatterbridge has such a good reputatuon and should ***stay*** *as it is*

Reference 40
Having been treated at Countess and Clatterbridge would prefer services to ***stay*** *nearby*

Liverpool postcode responses tended to record that a service that 'closer' to home was one reason why respondents had voted the way they had. The number of comments about 'travel' as evidenced by its relative size in the tag cloud reinforces this point. The idea that services should be based near to where the greatest need was echoed in responses from Non Cheshire-Liverpool postcodes (see Appendix 1 for 'closer' word tree)

Figure 11 shows a cross tabulation of the key thematic content by Postcode Area. From this analysis it is clear that the notion of travel and accessibility whilst potentially feeling unwell and issues related to visiting are a common themes for Liverpool postcode respondents and a large majority of respondents overall. Cheshire respondents were raising concerns of cost and pointing out their satisfaction with current services.

Figure 11: Number of Coded Responses by Key Theme and Postcode Area



Source: Engagement survey 2013

4.3 Themes per vote

It should be noted that not everyone in a particular area voted the same way. For example, taking the two postcodes where the number of votes for and against were highest or most polarised (CH64 – 'No' and L36 – 'Yes') it can be seen that voting was not unanimous.

Table 3: Percentage of Respondents from Selected Postcodes voting Yes, No and Not Sure

	% Voting 'No'	% Voting 'Yes'	% Voting 'Not Sure'
Postcode = CH64	63.5	23.8	12.7
Postcode = L36	1.0	98.0	1.0

Source: Engagement survey 2013

In view of this it is appropriate to investigate the themes that emerged from those who indicated support for the proposal and those who opposed it. Using similar analytical methods it can be seen that 'Yes' voters were reporting travel, closeness of services and meeting the needs of family. 'No' voters reported concerns about parking, travel, inconvenience and commented on the excellent quality of current services (Figures 12a and 12b).

Figure 12a: Word Frequency Tag Cloud for Yes Responses

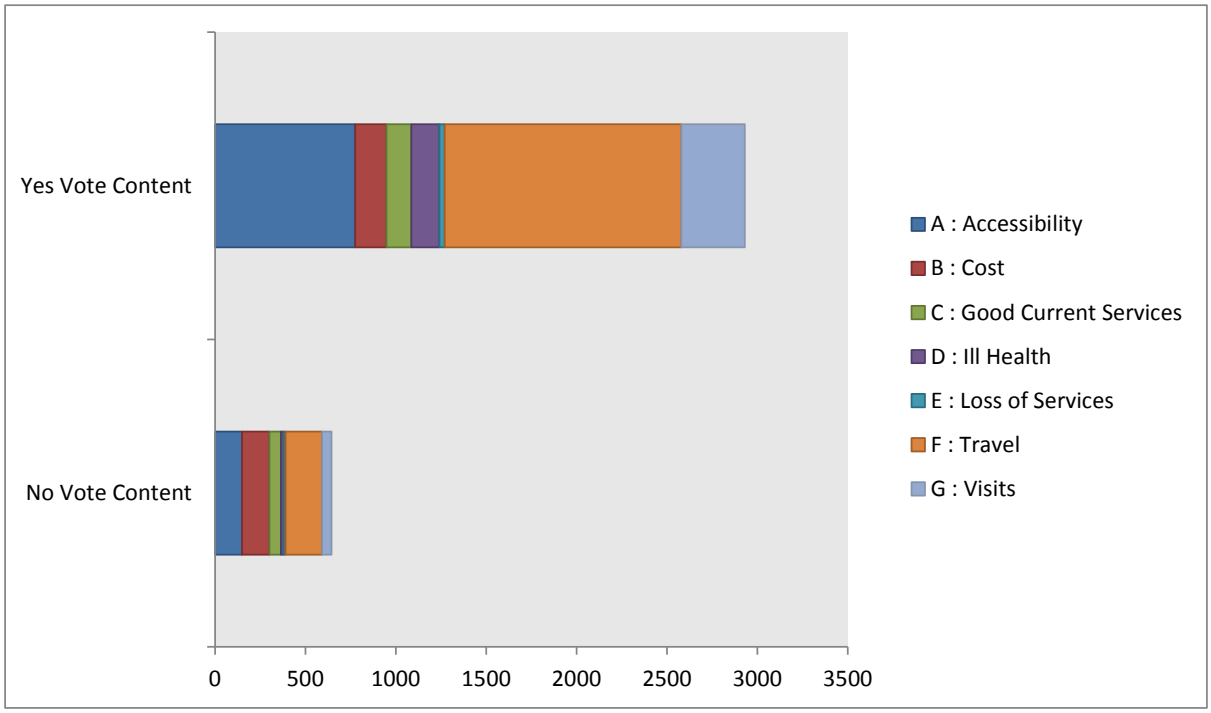
Source: Engagement survey 2013

Figure 12b: Word Frequency Tag Cloud for No Responses

Source: Engagement survey 2013

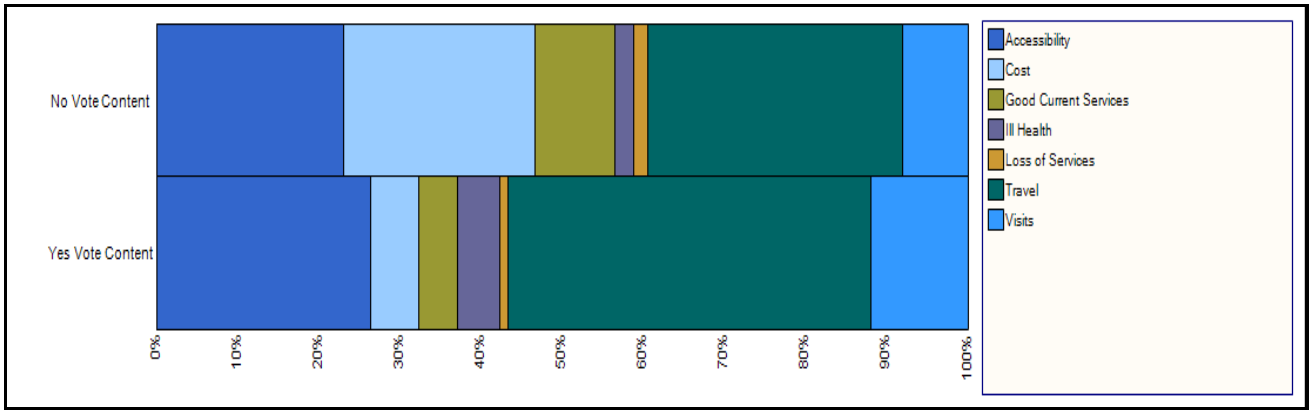
The different perspective of the two groups is also observed in the analysis of the key themes. Figure 13 shows the number of comments made in respect of each theme by the two groups and it is striking that the number of comments relating to accessibility made by the Yes group outnumber all the comments relating to key themes made by the No group. However it is important to ensure that the total number of respondents in each group does not distort the picture – there were many more yes vote responses than no vote responses. For example, the number of 'cost' comments from the 'no' voter group is quite similar to the number made by the 'Yes' group but as Figure 14, which is a presentation of themes as a percentage of comments made by each group, shows there is a greater proportion of 'cost' comments coming from the 'no' voter group. In this respect it is easy to compare which themes were particularly pertinent to each group.

Figure 13: Number of Coded References of Key Theme By Yes/No Vote



Source: Engagement survey 2013

Figure 14: Key Themes Expressed as a Percentage of the Yes and No Votes



Source: Engagement survey 2013

4.4 Key Postcode Analysis

Having identified that there are different perspectives across groups of voters and that these voters were generally split by location (Cheshire/Liverpool), it is worth considering in a little more detail what respondents are actually saying about the key themes. In order to do this, analysis has been focussed on the responses of those areas with the most polarised views. i.e. postcodes that could be described as being 'Yes' or 'No' vote Hotspots.

Figure 15: Number of Coded References by Theme and Vote Hotspot

	A : No Hotspot	B : Yes Hotspot
1 : Accessibility	84	217
2 : Cost	84	45
3 : Good Current Services	38	27
4 : Ill Health	8	40
5 : Loss of Services	5	-
6 : Travel	104	425
7 : Visits	35	112

Source: Engagement survey 2013

The themes are considered in detail below:

4.4.1 Accessibility

The accessibility theme is defined by issues of transport and travel, but more specifically this theme includes references to the availability of public and private transport, parking and congestion. In general, 'No' Hotspot responses recorded that a move would reduce accessibility for them and 'Yes' Hotspot respondents reported that accessibility would be improved because of the transport infrastructure in Liverpool. A detailed analysis of Hotspot

responses showed that 'No' vote responses considered Clatterbridge to be accessible as it was close to the motorway and that Liverpool was inaccessible due to parking and congestion. 'Yes' vote responses focussed on what they believed to be better public transport network to Liverpool.

4.4.2 Cost

Although cost was mentioned in several different contexts, the majority of the cost references were in respect of the **additional** costs of travel, such as parking, taxis and tunnel fares. 'No Hotspot' respondents tended to report that the tunnel costs would be additional to them if the service moved whereas 'Yes Hotspot' respondents reported that taxi fees were currently additional for them.

4.4.3 Good Current Health Services

Comments relating to this theme were made in qualification of a preference to keep services in Clatterbridge. Many respondents spoke of excellent services and the notion of '*if it ain't broke don't fix it*' was expressed.

4.4.4 Ill Health

Respondents who have had personal experience of cancer treatment (either themselves, a friend or relative) reported on the difficulties of travelling when feeling unwell. Respondents from 'Yes Hotspot' postcode areas in particular commented on this issue with 40 'ill health' references being reported against 8 from the 'No Hotspot'.

4.4.5 Loss of Services

The loss of services was a concern for a particular minority of voters. This theme was especially linked with those who reported personal experience of current service provision in 'No Hotspot' postcodes. In some of these cases it was clear that the respondent felt that this might be the thin end of a wedge, resulting in the ultimate closure of services and loss of jobs at Clatterbridge. For example:

> *Reference 2*
> *A devious way of closing the oncology unit at Clatterbridge, which is highly regarded for people in Wirral, Cheshire and N. Wales*

Two respondents made specific reference to the relocation of other health services away from the Wirral.

4.4.6 Travel

Travel is by far the most commented on theme to emerge from the responses. Travel comments are predominantly related to distance. Issues of general transport availability have been collected under the accessibility theme. However, reference to transport 'links' have been recorded within this theme. The majority of those comments relating to travel come from respondents with Liverpool postcodes and reflect the opinion that current provision is 'too far'. Many made reference to the difficulties of travelling when ill. A typical response is recorded below:

Reference 1
Family have been affected by cancer and the travel to Clatterbridge took alot out of them when they were unwell. It was too far.

4.4.7 Visits

Many respondents were clearly able to draw on personal experience of cancer treatment services. Analysis shows that some 75 references were made to parents who had cancer and had used services. Many of these comments were surrounded by reflections on travel and accessibility for the individuals who were receiving treatment but many also commented about the importance of the patient's support network and therefore the need to make it easy to visit. Analysing hotspot responses in respect of this theme, it is clear that the No Hotspot respondents valued the proximity of current services to them and their family, whereas Yes Hotspot respondents reported the difficulty families had travelling to Clatterbridge.

Appendix 3 includes examples of these responses.

5. Summary

The qualitative analysis identifies and evidences the following emerging themes (in alphabetical order):

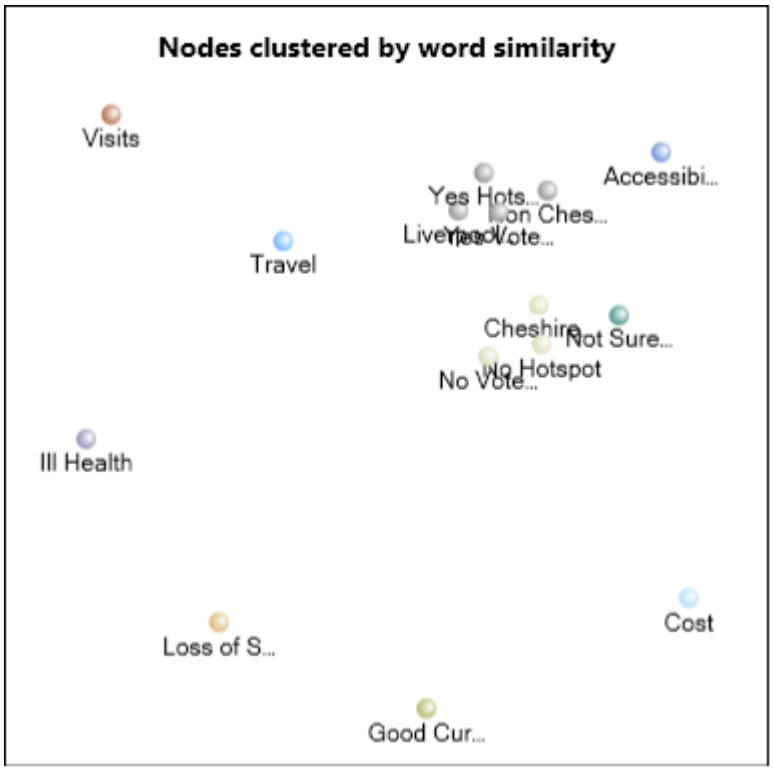
- Accessibility
- Cost
- Good Current Services
- Ill Health
- Loss of Service
- Travel
- Visits

These themes were generally observed across the whole dataset but it is clear that different perspectives exist between those who voted 'Yes' and those who voted 'No'. There was also a geographical dimension to the responses but as Figure 16 shows this was not as strong an association as voting behaviour.

The Cluster Analysis (Figure 16) uses statistical methods to chart the similarity of the words used by the groups selected and the spatial relationship between objects in the chart shows how similar they are. The closer together a group the more similar the content of the responses. From this chart it is possible to see that 'No' votes are the ones most closely

associated with some of the themes like Ill health, Loss of Services , Cost and Good Current Services.

Figure 16: Cluster Analysis of Themes, Votes and Postcode Area by Word Similarity



Source: Engagement survey 2013

Based on the analysis within this report, it is recommended that:

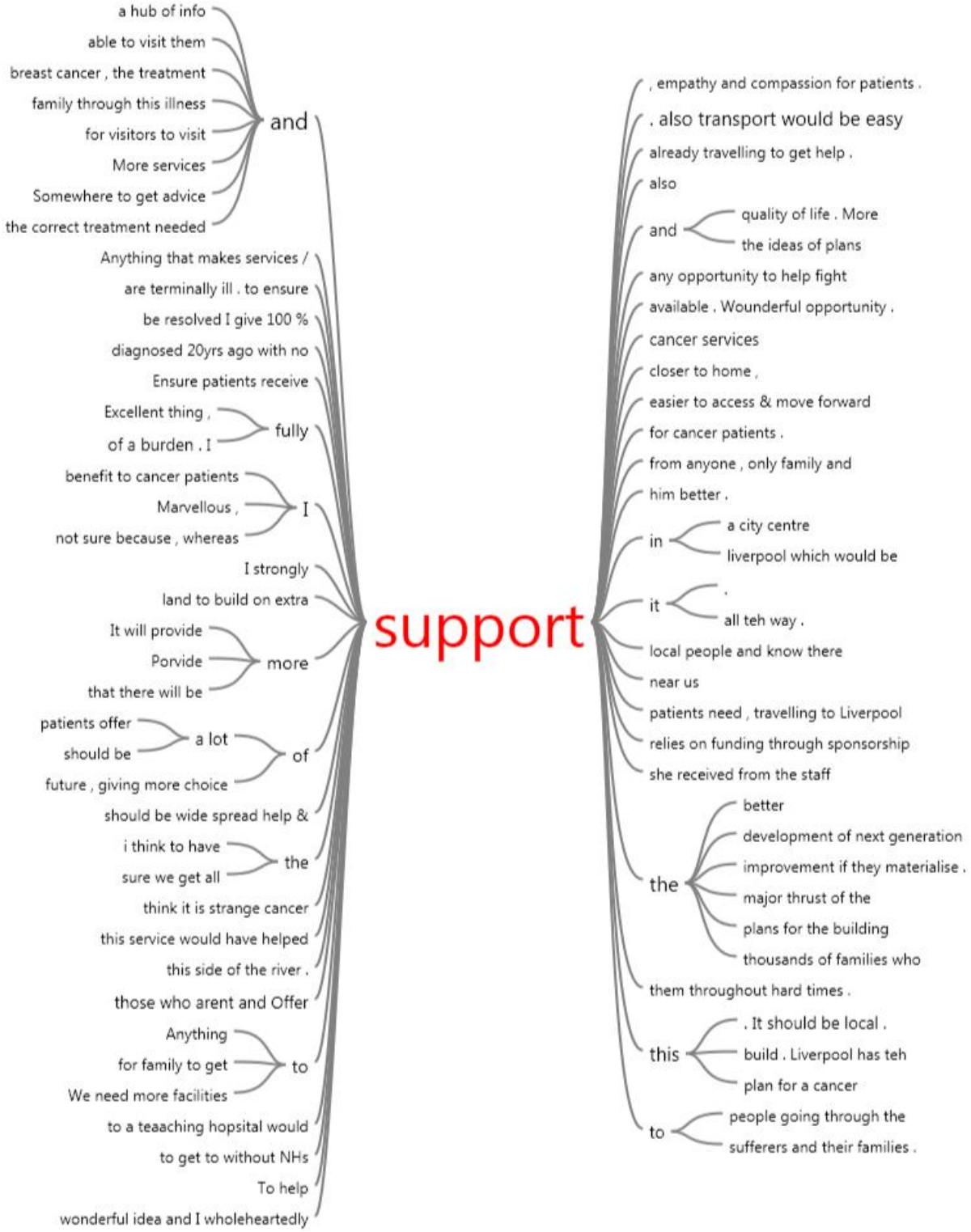
- the business case records and reflects the benefits that the majority of respondents reported, namely reduced travel for the majority of patients and their families and a view that general accessibility using public transport will be improved by locating the service in Liverpool.
- the business case includes a strategy for informing and reassuring those who oppose the proposals that the quality of service will not reduce as a result of reconfiguration.
- the business case makes provision to comment, as far as possible, on the possibility of further service reconfiguration in response to concerns that this may be the start of a programme of service withdrawal.
- consideration is given to how best to further communicate which patients will need to receive their care in Liverpool following reconfiguration and which will continue to be treated at the Wirral site.

6. References

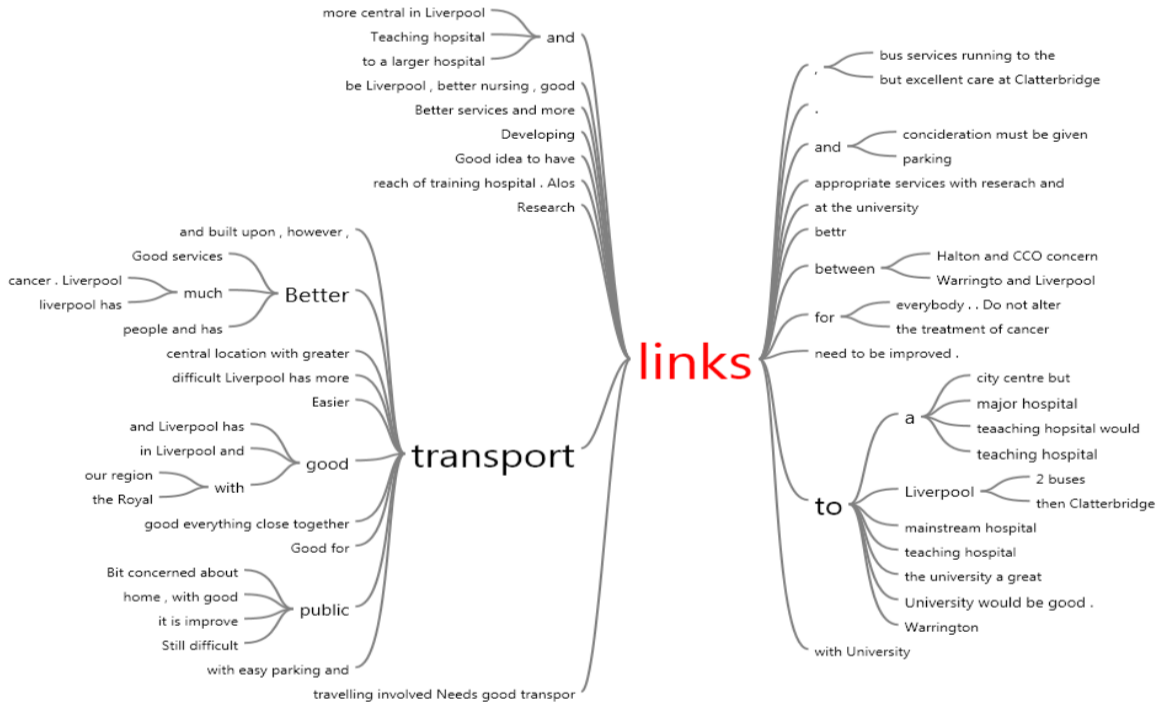
1. Baker, M.R. and Cannon, R.C. (2008) *The organisation and delivery of no-surgical oncology services in the Merseyside and Cheshire Cancer Network: A feasibility study into the potential for the relocation of non-surgical oncology services from Clatterbridge to Liverpool*, Cancer Taskforce.
2. Ellison, T. and Cottier, B. (2009) *An Analysis of Radiotherapy Services in the Merseyside and Cheshire Cancer Network*, The National Cancer Services Analysis Team.
3. Hennessey, M., McHale, P. and Perkins, C. (2013) *Equality Considerations in the Development of a Comprehensive Cancer Centre*, 2013, Centre for Public Health: Liverpool John Moores University.

7. Appendix 1: Word Trees

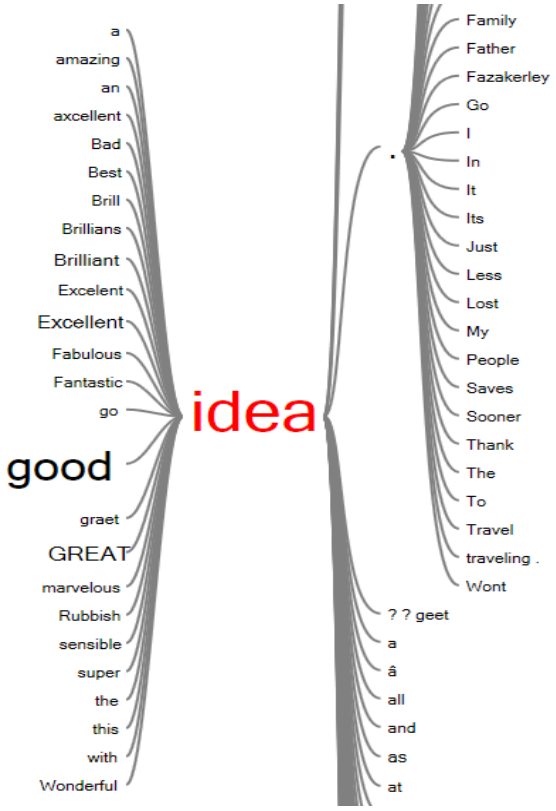
Word Tree of Responses That Include the Word "Support"



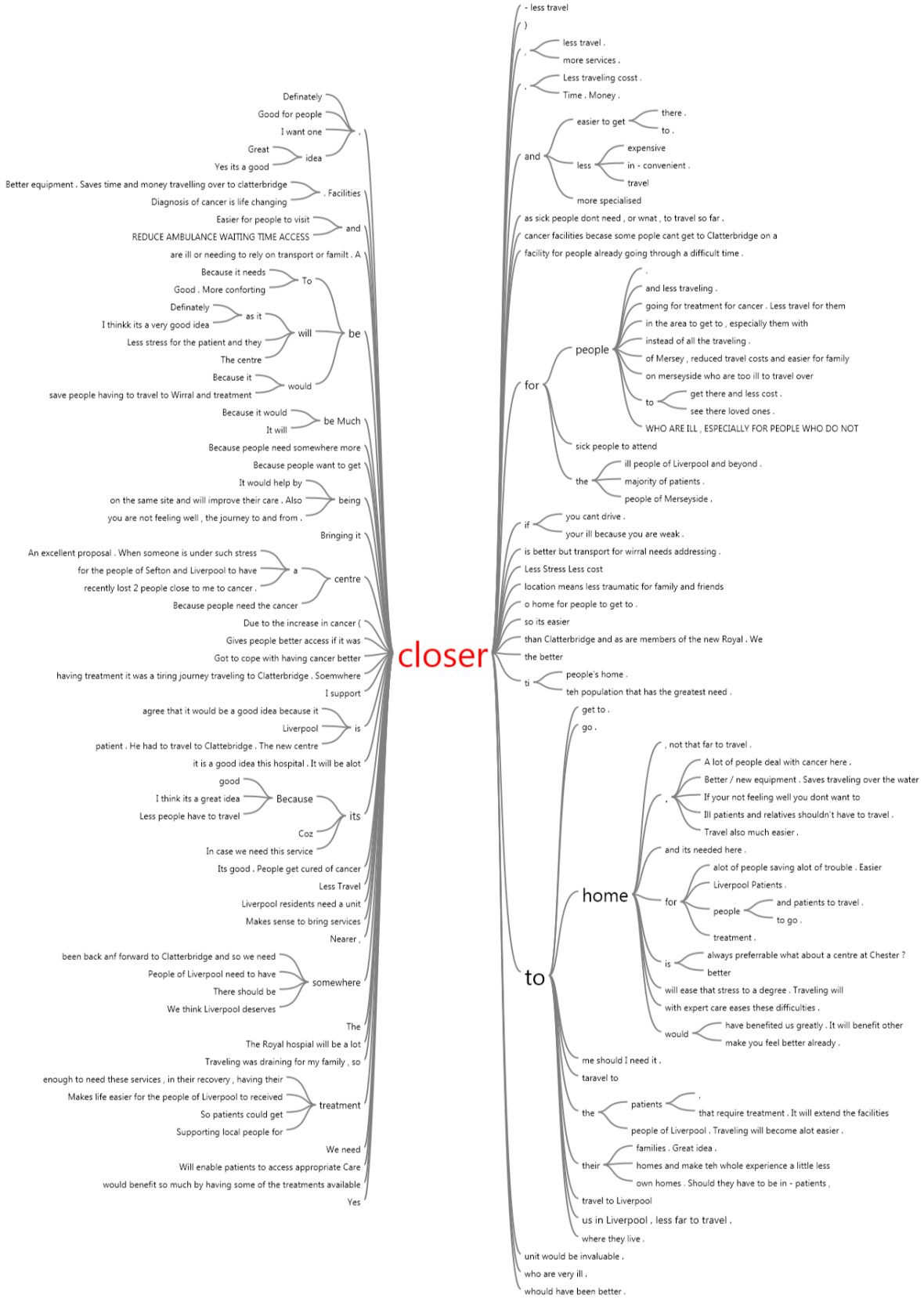
Word Tree of Responses That Include the Word “Links”



Word Tree of Responses That Include the Word “Idea”

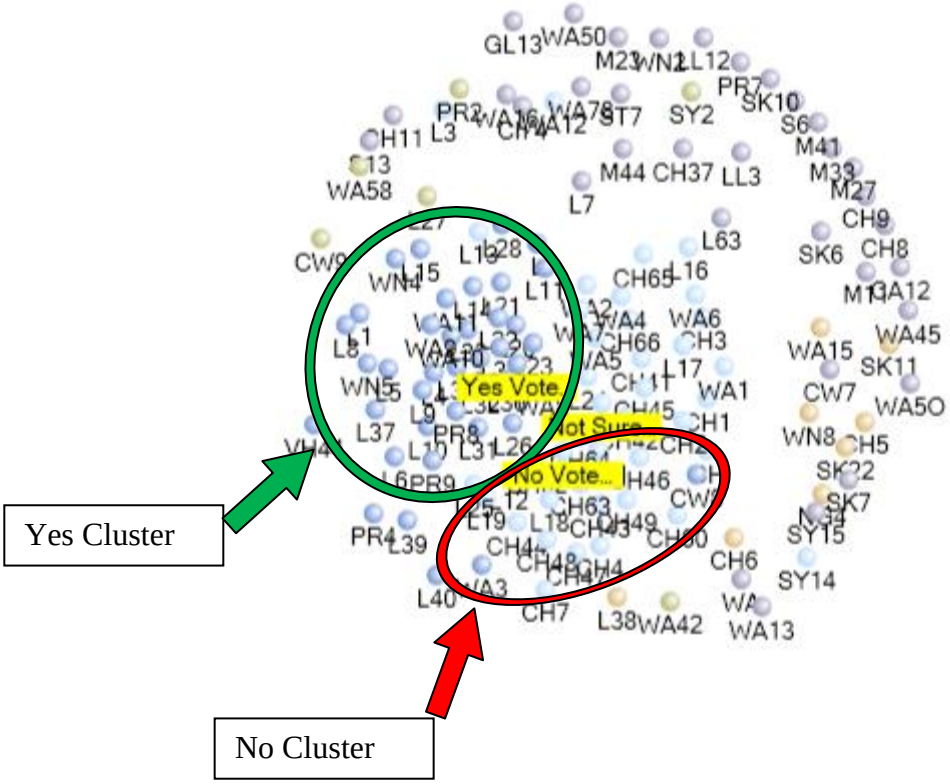


Word Tree of Responses That Include the Word “Closer”

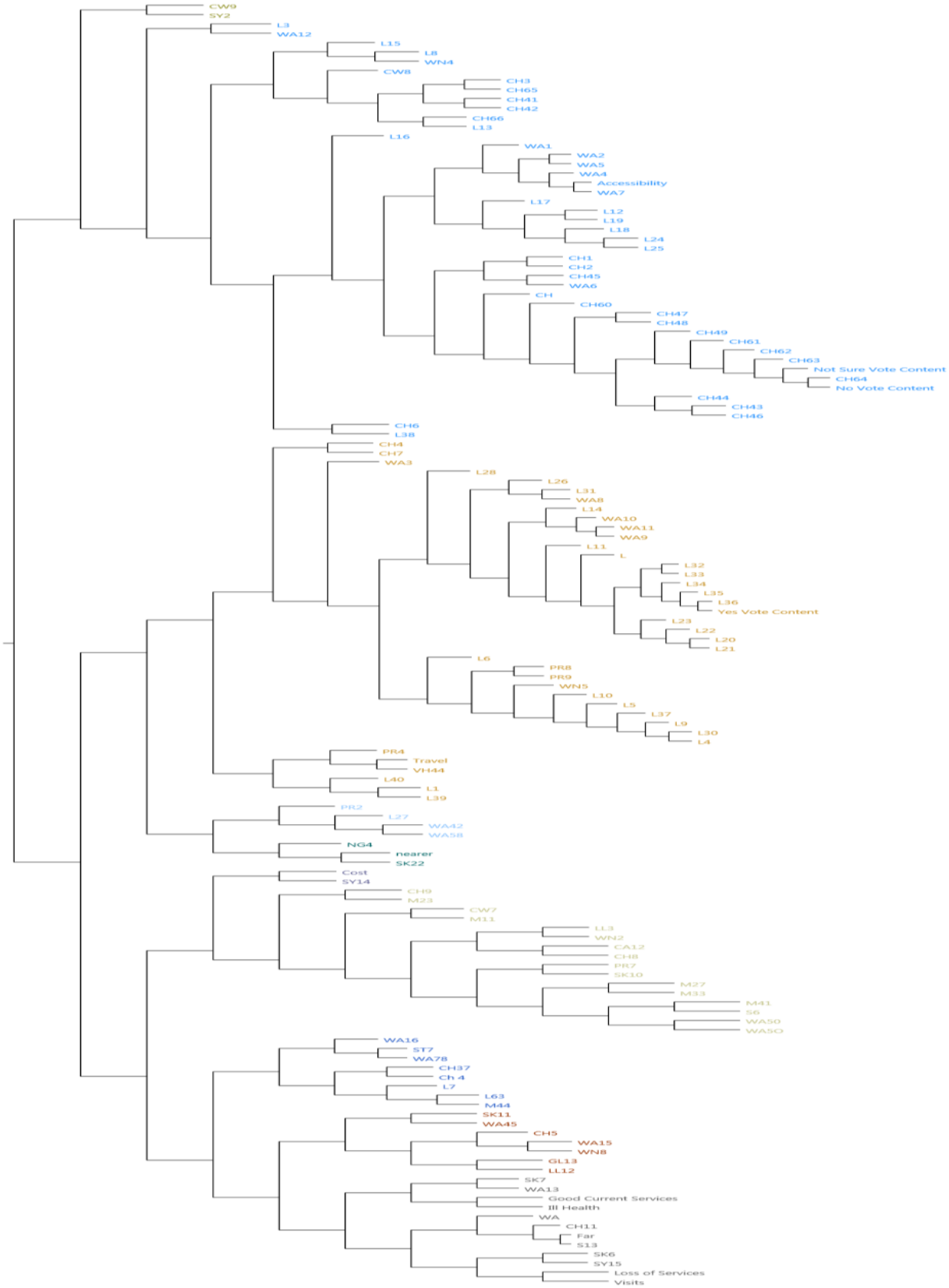


8. Appendix 2: Cluster Analyses

Cluster Analysis: Postcodes Clustered by Word Similarity



Cluster Analysis: Dendrogram of Postcodes, Vote and Themes by Word Similarity



The closer together items are in the tree above, the more similar their word content: For example, the responses the mention 'accessibility' were most similar to responses from WA7 and WA postcodes

9. Appendix 3: Theme Report

Theme Report: "Travel" Theme

Appendix_Travel report (excerpt)

Name	Description	Number Of Coding References	Coded Text	Percent Coverage Of Source
Travel Report		0		
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A centre for the care of cancer patient and for research in to finding cures would be one of the most useful establishments one could hope for. Especially now that so many advancements have been made. Things will get better.	0.02 %
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A centre of excellence seems a good idea, as long as it does not take money and resources from local services.	0.02 %
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A city like Liverpool should have its own centre to ease the burden of travelling to clatterbridge	0.02 %
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A devious way of closing the oncology unit at Clatterbridge, which is highly regarded for people in Wirral, Cheshire and N. Wales	0.02 %
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	a good place to go good bus service and train	0.02 %
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A layman's view. Provided the service currently available at the existing Clatterbridge site is not diminished in any way then the new proposal is an excellent idea otherwise not so. To avoid confusion the Liverpool site should	0.02 %
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A long way from home.	0.02 %

Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A long way to travel when visiting Clatterbridge, so the Royal will be good.	0.02 %
Travel Report	Key Theme. Distilled from references relating to Travel. Includes Stemmed words and synonyms for...Distance, Far, Near, Journey	1,733	A lot more research and treatment is needed to help people with cancer and also to help families come to terms with their diagnosis.	0.02 %

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APPENDIX 2 – CLATTERBRIDGE CANCER CENTRE STAKEHOLDER MAXTRIX MODEL

Stakeholder Group	Level of Interest (1-5)	Level of Influence (1-5)	Communications / Engagement Channels	Methods of Communication/Engagement				
				Meetings	Forums / Events	Briefings / Email / Letter	Newsletter	Local Media
Patient and Public Groups	5	4	• Cheshire and Merseyside Healthwatch	X	X	X	X	X
			• Members of the public		X	X	X	X
			• Previous attendees at pre-consultation sessions		X	X		X
			• Patients	X	X	X		X
			• Patient and carer support groups	X	X	X	X	X
			• Wider Voluntary and Community Sector (including people under protected characteristics and hard to reach groups)	X	X	X	X	X
				X	X	X	X	X
NHS England	5	5	• NHSE Managing Directors	X	X	X		
			• NHSE Specialist Commissioning (Cheshire, Warrington,Wirral)	X	X	X		
			• NHSE Medical Director	X	X	X		
			• NHSE Lancashire (external assurance team)	X	X	X		
Clinical Commissioning Groups	5	5	• NHSE Managing Directors	X	X	X		
			• Cheshire and Merseyside CCG Boards	X	X	X		
			• Cheshire and Merseyside GPs (via CCG Boards communications) members	X	X			
			• Chairs of LMCs (via CCG Boards communications)	X	X	X		
			• Communication and Engagement Leads	X	X	X		

Hospital Trusts	5	4	• Chief Executive Officers • Members of Strategic Overview Group • Clinicians • Non-medical professionals • Senior Operational Managers • Trust Governors • Trust Non Executive Directors • Trust Members • Patient Reference Group Members • Staff members • Trade Union representatives	**X** **X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	**X** **X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	**X** **X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	 **X** **X** **X** **X**	
Political Leaders/ Local Authorities	5	5	• Constituent MPs • Overview and Scrutiny Panels • Elected members • Chief Executive Officers • Healthand Wellbeing Boards • Directors of Public Health	**X** **X** **X** **X** **X** **x**	**X** **X** **X** **X** **X** **X**	**X** **X** **X** **X** **X** **X**	**X** **X** **X** **X**	
NHS Specialist Commissioners	5	5	• NHS England Cheshire, Warrington & Wirral • NHSE England Lancashire Area Team (external assurance)	**X** **X**	**X**	**X** **X**		
Other	4	4	• NHS Gateway • North West Ambulance Service • Strategic Clinical Network • Merseyside and Cheshire Cancer Network • Universities • Charities	**X** **X** **X** **X**	 **X** **X** **X** **X** **X**		 **X** **X**	

			• Hospices					
Communication Channels	5	3	• Local press releases/other proactive media • Radio • Event advertisements • Posters in clinical and community facilities • Hospital Trust and Commissioning Support Unit network					**X** **X** **X** **X** **X** **X**

APPENDIX 3 – STRATEGIC COMMUNICATION AND ENGAGEMENT PLAN

STAGE ONE - STRATEGIC COMMUNICATION AND CONSULTATION PERIOD						
No.	**TASK / RESPONSIBILITY**	**KEY ACTIONS**	**TIMESCALE**	**LEAD**	**PROGRESS RAG RATING**	
1.	**Scope key stakeholders**	Review all work undertaken in pre-consultation and feedback sessions	Jan-Mar 14	CSU	**Completed**	
2.	**Keep CCC staff, patients and members informed**	Articles in CCC magazine 3 x year; monthly Team Brief updates; press releases; staff events etc	Jan-Sep 14	CCC	**Completed (Jan-May); on track for May-Sep**	
3.	**Plan stakeholder events and meetings**	Ensure inclusion of all constituent areas, adherence to equality duties (protected characteristic groups)	Feb-May 14	CSU	**Completed**	
4.	**Ensure adherence to requirements in Health and Social Care Act 2012 (including duties to consult Overview & Scrutiny)**	Keep scrutiny officers appraised of proposal plans to align dates without impact on purdah and that public consultation is 12 weeks with time for OSC consideration as part of its consultation	Jan-Sep 14	CSU	**Work in progress and delivery on track**	
5.	**Overview and Scrutiny**	Joint letter with	May 2014	NHS England	**Completed**	

Green – Completed. Amber = In progress / on track. Red = Not started.

		NHS England to local authority overview and scrutiny committees		and CCC		
6.	**Prepare consultation materials**	Prepare full and summary consultation documents, consultation questions, information film and supporting materials and share with patient reference group for feedback	Apr-Jun 14	CCC	**Work in progress and delivery on track**	
7.	**Consultation website and social media**	Prepare online versions of consultation documents & films, and finalise digital/social media campaign (Twitter, YouTube etc)	May-Jun 14	CCC	**Work in progress and delivery on track**	
8.	**Brief MPs**	Write to MPs to inform them of public consultation (follows ongoing process of meetings and briefings via CCC Chair)	May-Jun 14	NHS England & CCC	**To be actioned – plan in place**	
9.	**Procure and conduct Equality Impact Assessment**	Carry out further analysis on more detailed clinical	Jun-Aug 14	CCC	**Work in progress and delivery on track**	

Green – Completed. Amber = In progress / on track. Red = Not started.

		proposals as recommended by earlier EIA				
10.	**Procure external evaluator**	Academic Health Science Network to support procurement	May 14	CCC	**Work in progress and delivery on track**	
11.	**Advertise consultation**	Book advertising in selected media outlets (print/radio)	Jun 14	CCC	**To be actioned – plan in place**	
12.	**Hold information sessions for key stakeholder partners**	Request support from partner organisations and communities to help steer and disseminate/deliver on consultation activity	Jun-Jul 14	CCC/CSU	**Work in progress and delivery on track**	
13.	**Print and distribute consultation materials**	Print consultation materials and distribute to key sites/venues	Jun 14	CCC/CSU	**To be actioned – plan in place**	
14.	**Media briefings**	Pre-consultation briefings for key media across Cheshire and Merseyside to support communication and publicity	Jun 14	CCC	**To be actioned – plan in place**	
15.	**CCC Governor briefing**	Brief CCC foundation trust Council of Governors	Jun 14	CCC	**Work in progress and delivery on track**	

Green – Completed. Amber = In progress / on track. Red = Not started.

16.	**Begin formal 12 week public consultation Attend Overview and Scrutiny Meetings**	Ensure the plans are flexible to add more activity as new information or public member opportunities arise. Including CCC staff events, Healthwatch, patient groups, public meetings / events etc.	Jul-Sep 14	CSU	**To be actioned – plan in place**	
17.	**Distribute press releases and arrange media interviews / ongoing activity**	Sustained proactive media campaign across Cheshire and Merseyside, publicising consultation and local events	Jun-Sep 14	CCC	**To be actioned – plan in place**	
18.	**Begin consultation with Overview and Scrutiny Meetings**	Support scrutiny officer leading on behalf of Local Authorities for attendance and submission of materials ahead of meetings.	Jul-Nov 14	CCC/CSU	**To be actioned – plan in place**	
19.	**Collate Feedback**	Collate qualitative and statistical feedback information for external review	Sep 14	CSU	**To be actioned – plan in place**	
20.	**Begin external analysis of findings**	Procured organisation to review data and	Sep-Oct 14	TBA – procurement	**To be actioned – plan in place**	

Green – Completed. Amber = In progress / on track. Red = Not started.

		qualitative feedback and write up findings		underway		
21.	**Feedback report produced for Trust**	Analysis report sent to Trust executive team	Oct 14		**To be actioned – plan in place**	
22.	**Feedback report produced for Overview and Scrutiny**	Share findings of consultation with scrutiny committee	Oct 14		**To be actioned – plan in place**	

STAGE TWO- POST CONSULTATION STAGE

No.	TASK / RESPONSIBILITY	KEY ACTIONS	TIMESCALE	LEAD	PROGRESS	
1.	**Receive feedback from Overview andScrutiny Committee**	Provide all documents on request to support scrutiny in its functions	Oct-Nov 14	CCC	Feedback plans dependent on outcomes	
2.	**Share scrutiny findings with CCC Trust Board**	Report scrutiny feedback for consideration and response, as appropriate.	Nov 14-Jan 15	CCC	Feedback plans dependent on outcomes	

Green – Completed. Amber = In progress / on track. Red = Not started.

STAGE TWO- POST CONSULTATION STAGE						
No.	**TASK / RESPONSIBILITY**	**KEY ACTIONS**	**TIMESCALE**	**LEAD**	**PROGRESS**	
		Review/finalise Outline Business Case as appropriate. Inform NHS England and Monitor through the assurance process, as appropriate				
3.	**Feed back findings to all key stakeholders outlined in consultation and ensure range of mediums used to disseminate broadly at using technology where appropriate**	Comprehensive communications plan to feed back results via proactive media, CCC website, presentations to key stakeholders etc	TBC – dependent on outcome of scrutiny	CCC	Feedback plans dependent on outcomes	

Green – Completed. Amber = In progress / on track. Red = Not started.

REPORT TO: Health Policy & Performance Board

DATE: 17 June 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 4 2013 – 14

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to health in Quarter 2 of 2013-14. This includes a description of factors which are affecting the service.

2.0 **RECOMMENDATION: That the Policy and Performance Board:**

i) Receive the Quarter 4 Priority Based report

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

iii) Highlight any areas of interest or concern for reporting at future meetings of the Board

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. In line with the Council's performance framework, therefore, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 4 2013 – 14.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this Report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this Report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

There are no implications for Children and Young People arising from this Report.

6.2 Employment, Learning & Skills in Halton

There are no implications for Employment, Learning and Skills arising from this Report.

6.3 A Healthy Halton

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.4 A Safer Halton

There are no implications for a Safer Halton arising from this Report.

6.5 Halton's Urban Renewal

There are no implications for Urban Renewal arising from this Report.

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no Equality and Diversity issues relating to this Report.

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

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 4: 1st January 2014 – 31st March 2014

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the fourth quarter of 2013/14; for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Prevention & Assessment
- Commissioning & Complex Care (including housing operational areas)
- Public Health

2.0 Key Developments

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

COMMISSIONING & COMPLEX CARE SERVICES

Housing

Following a procurement exercise the contract for the provision of support services to adult victims of domestic abuse has been awarded to the Changing Lives organisation. The contract commences 1st July 2014 for 2 years, with an option to extend by up to 3 further years.

.

Domestic Abuse

The Domestic Abuse tender has been completed, and a new provider will deliver both the Refuge and Community Support Services from 1st July 2014. A contract mobilisation meeting will be held on 29th April 2014.

The refuge remodelling is on target to be completed by May 2014. The first two phases of the remodelling work have now been completed and the first floor now provides fully self-contained units. Phases 3 & 4 will remodel the ground floor accommodation and will also include improvement work on the reception area and provision of new flooring in communal areas.

Adult Social Care Market Position Statement

The Adult Social Care Market Position Statement and Evidence Paper was finalised during the fourth quarter and is now available to Providers and external agencies via the Council's Website.

Alcohol Strategy and Pathway Development

Reducing alcohol harm is a key priority for Halton and it is one of the five priorities identified in the local Health and Wellbeing Strategy. Work commenced during the fourth quarter on the development of a local Alcohol Strategy and Pathway. A multi-agency Workshop took place in mid-January to bring key stakeholders together to facilitate discussions about what local action needs to take place to tackle alcohol-related harm in the Borough. An Alcohol Strategy Steering Group was set up and has met twice since the workshop in early January. A series of sub-groups reporting to the Alcohol Strategy Steering Group have also been set up to focus on specific actions in accordance with a

lifecourse approach. Work on the development of the strategy and pathway is scheduled to run until the launch of the Strategy during Alcohol Awareness Week (mid November 2014).

Quality Assurance Framework Project

Work commenced on a new project aimed at developing a Quality Assurance Framework. Initial work started in January to gather requirements, to define the scope of the project, duration of the project and to determine the members of the project board and project team. The project will operate in a phased approach and will bring together existing and new sources of information to be presented in one place to provide a summary of information relating to the quality of services. In the first phase a Provider Portal has been developed using Sharepoint that will enable sharing of Provider Self-assessment documentation between Social Care Providers and the Council. An electronic Provider Self-Assessment Form has also been developed during this first phase. It is anticipated that the project will run throughout the whole of 2014/15 and progress on the project will be reported via the Complex Care Board.

Mental Health Services

Section 136 Mental Health Act is the legal provision which allows the police to detain anyone they find in a public place who appears to them to be mentally disordered and a risk to themselves or others. Considerable work has been taking place with key partners – the Police, the 5Boroughs and the Clinical Commissioning Group – to develop an agreed policy and procedure across the Cheshire police footprint. This has now been successfully developed and will be singed off by all parties in Quarter 1 of 2014-5.

In addition, there has been a lot of work going on across the North Cheshire area to reduce the number of Section 136 detentions taking place in the area. The Police , 5Boroughs and CCG have worked together to develop a project to attach a community nurse to police operations, and the early indications are that this has resulted in much more appropriate and effective use of the Section 136 powers. This has resulted in a slight reduction in the numbers of overall Mental Health Act assessments that have to be undertaken by the Council's mental health services and Emergency Duty Team.

The Mental Health Outreach Team continues to operate the pilot project aimed at providing earlier intervention and support to people with mental health problems who are known only to primary care services. Over 20 people have now become part of this pilot, and early indications are that positive outcomes are being achieved; for individuals, this is meaning an increase in self-confidence and engagement with a whole range of supports in the community, and it is reported the people are using less medication (by agreement with their GPs) and are attending surgeries less often.

Other developments within the Commissioning and Complex Care Division

A new national performance framework for adult social care, known as SALT (Short and Long Term packages of care) is being fully introduced as from April 2014. Considerable work has taken place to implement these new requirements, both in terms of adapting existing data collection systems and training and supporting staff to use the new system. This will be fully operational within the Directorate by Quarter 1 2014-5.

Emergency Duty Team (EDT): work is continuing through the EDT partnership Board to scope the potential for another Local Authority to join the current partnership arrangement, which is a joint service between Halton and St Helens.

Interface with children's services: as reported in the previous Quarterly Report, the linkages between children's and adults services are strong and continue to develop. Both services are represented on their respective Safeguarding Boards and subgroups, and adults services also contribute to the Children's Trust. In Quarter 4, a joint piece of work, promoted by the Halton Children's Safeguarding Board across adults and children's services began, looking at the way drugs and alcohol services, mental health services and children's services work together

PREVENTION & ASSESSMENT

Learning Disability Nurses

The team continue to work proactively with individuals, their family, carers and professionals such as GPs, allied Health professionals etc.
Progress:

- The team have completed the Royal Society of Public Health level 2
- The team have been consulted on the content of comics for health issues within LD.
- The team have carried out specialist assessments and interventions, primarily in behaviour, epilepsy and dementia
- The team continue to support the psychiatric clinics
- The team have empowered and supported individuals to promote their health and wellbeing.
- The feedback received following interventions from the team/team member is collated and demonstrates the service is meeting peoples' needs.
- A targeted MDT approach has enabled a member of a hard to reach family to have a health check!
- The team are working within the pro-active draft dementia pathway for people with Downs Syndrome, with all clients over the age of 40 having had a baseline assessment completed
- The team worked with the Health Improvement Team to make the FreshStart programme accessible for people with a learning disability. The Runcorn course started at the end of January. Further sessions are planned, plus training for staff groups
- The Women's group was held and completed. New resources were used re: sexual health and it is evidenced that the women's knowledge has increased as a result.
- The walks in the park are continuing. The number attending and walking has increased tenfold! Friendships and relationships are developing within the group.
- Links and pathway development is being made within one of the acute trusts to support the journey of patients with learning disabilities.
- Links within Epilepsy are being developed with Walton Neurological centre and North West forums to support positive epilepsy work.
- Those individuals who are recovering in inpatient services, continue to be monitored throughout their stay via face to face contact with the nursing team. One individual has been supported to be discharged with positive prevention plans to reduce the risk of further admissions.
- Next quarter will be exciting to pilot the Health Equalities Framework!

Community Multi-disciplinary Team's in General Practice
This project brings together GP's, community nurses, social care staff and other health and social care professionals to identify people at high risk of hospital admission and people with complex care needs. The team then work with the individuals to agree a plan of care aimed to improve their overall health and well-being. Running since October 2013 the project will continue in 2014/15. Evaluation of the benefits for individuals forms a central part of the work with the first reports due in the summer of 2014

Care Homes Project
This project has been running since June 2013. A team of health and social care professionals have been working with care homes in the borough to support improvements in the quality of care provided and make it easier for residents of care homes to access health and social care services. A pharmacist has joined the team and will commence reviewing the policies and procedures in the homes as well as working with GP's on reviewing individuals with complex medication needs. An initial evaluation report has been completed and further work is underway with NHS Halton Clinical Commissioning Group, Bridgewater Community NHS Trust and 5 Boroughs Partnerships to provide a long term service

Making Safeguarding Personal Update
Halton joined the Making Safeguarding Personal (MSP) project in November 2013. The intention of MSP is to facilitate person-centred, outcomes-focused responses to adult safeguarding. Since the project commenced 24 cases have now been analysed and of these cases 96% of people involved felt that the investigation was conducted in such a way that they felt in control, informed and involved.

Currently Halton Safeguarding Adults Board receives performance data in relation to safeguarding adults however this data is unable to provide Board members with any real understanding of whether the safeguarding processes in Halton are making a difference for those who are most vulnerable and at risk in the locality. Ongoing work from this project to embed this approach into day to day practice will change the nature of the performance data and will provide Halton Safeguarding Adults Board with a better understanding of people's experiences and thus serve to influence and improve the delivery of safeguarding services in Halton.

As the project moves forward, it is with a generally accepted view amongst the 53 participating local authorities that outcome focused, person centred approaches must be integrated into safeguarding procedures if people are to be supported to live their lives with as much autonomy as possible. It is clear that seeking the person's own definition of a good outcome at the start of a safeguarding process, keeps professionals focused on a person centred approach and leads to better outcomes for the person and their family. As people achieve better outcomes, they are less likely to re-enter the system at a later date, being supported to stay independent for longer and encouraged to utilise their own skills, strengths and natural supports to build a safer future for themselves.

Community Alarm Services
The Community Alarm Service has been audited by the Telecare Services Association – the professional body who regulate providers of Telecare and Alarm Services against the industry quality standards. It has inspected parts of our service against its Code of Practice and the Community Alarm Service has retained accreditation for installation, repair and maintenance, response, referrals and service tailoring at Platinum status and maintained European Standards accreditation for the 5th consecutive year.

The inspection that took place in March of this year was highly commended by the inspector and comments were of a highly organised and high quality service delivered to its service users. The Community Alarm Service continues to see itself as an important partner in the preventative agenda and will continue to support our partners to meet their goals in supporting the community to remain safe and independent in Halton.

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.

'Care and Support for You' has been upgraded to V3, this release has many new exciting features now developed in our LIVE Halton site. The site is currently being update in line with the upgrade. A detailed action plan has been developed and being kept up to date. Progress is underway in attending team meetings and organizing workshops to demonstrate the new look site. This will be subject to review.

PUBLIC HEALTH

A new conversation about Alcohol

An alcohol harm reduction event was held on the 14th January to engage with key stakeholders in Halton. The event included an overview of the national regional and local picture of alcohol harm reduction. A local resident also shared her personal story of the impact of alcohol. The event was very successful with over 60 key stakeholders attending. Partners were asked to identify the key things we should be doing in Halton to reduce alcohol related harm. The information gathered will be used to inform Halton's new alcohol harm reduction strategy.

Presentations are available via the following link:
http://www3.halton.gov.uk/healthandsocialcare/318895/339434/

Halton has successfully applied to participate in a pilot scheme with the Home Office to become a "Local Alcohol Action Area". Such a focus will enable key partners to work together to establish plans to reduce the harm to health from alcohol, tackle crime and improve community safety and also contribute to the stimulation of the local night time economy. The Borough is waiting to hear whether it has been successful.

In addition, the Public Health Team has also:

Commissioned Alcohol Concern to support local activity to promote the "Dry January" campaign. Many Halton people made the commitment to stay sober in January and examine their own relationships with alcohol.

Developed a pilot "social norms" programme to examine young people's relationship with alcohol. Work in underway to develop a Halton wide programme to change the perceived "social norms" through more intelligent presentation of facts, improving self-esteem and emphasising the normalcy of positive health behaviours as a means to promote health and reduce risky behaviour in schools.

Began work to examine the potential role of a "dry room" for Halton.

Alcohol Education and Awareness – YTD 409 Halton School Children and Young People received 1 hour's alcohol awareness education. 252 front line staff have been trained in IBA. January has seen the Launch of the alcohol campaign "Dry January" across the borough of Halton to encourage residents to abstain from alcohol for the month to improve their health.

Sexual Health Services

Sexual Health tender – Work is progressing to go out to tender for a fully integrated Sexual Health service following approval at Executive Board on 12th December. The new service will incorporate Community Sexual Health services, Sexual Health Improvement, genitourinary medicine, Young People's Sexual Health services and the co-ordination of chlamydia screening as part of the National Chlamydia Screening Programme. A specification for the new service, which is due to start from October 2014, is currently being drawn up with a view to advertising the tender in February.
In addition:

Sexual Health Implementation Group – a Sexual Health Implementation Group has been established for Halton. The group is attended by commissioners and Sexual Health providers across Halton and aims to improve the sexual health of people living in Halton and reduce sexual health inequalities through the initiation and implementation of developments relating to service delivery, health promotion/protection and clinical governance.

School Nursing Services

The procurement process to secure a new School Nursing service has begun. Engagement has taken place with a number of stakeholders, including children and young people, Head Teachers and other partners and further involvement will take place in parallel with the procurement to ensure a new contract is in place by Sept 2014 that is fit for purpose and value for money.

Children, Young People and Families

UNICEF Baby Friendly Status Update – Stage two accreditation awarded to Bridgewater January 2013. The baby friendly initiative works with the healthcare system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. Stage two involves assessment of staff knowledge and skills in order to implement best practice. The next twelve months will see us progress towards stage three.

Early Years Activities - 242 children and 91 parents attended an early year's programme and 149 parents/carers attend the 4 week Fit 4 Life programme 100% of those attending reporting an increased knowledge base.

Healthy Schools – 54 schools are engaged on Healthy Schools with 23 having completed the healthy Schools audit to date.

Fit 4 Life – YTD 1115 children and young people were engaged with 98% completion and 86% increased their knowledge of healthy eating and physical activity.

Adults and Older People

IGR Pathway – The Mersey IGR Pathway has been launched at both a sub regional and local level. The aim of the pathway is to identify people at risk of diabetes and refer them to IGR patient education and lifestyle services in a bid to prevent or delay the onset of diabetes. Since the last update the patient education model has been developed and Health Trainers based in the Health Improvement Team have received training on the model. The team supported the CCG in the launch of the Merseyside IGR guidelines and pathway on the 14th January. The Lifestyles service is commissioned by Public Health and is an integral part of this new pathway.

Adult Weight Management Service - Across the adult service YTD 1288 people have been screened and have received a health check. At the end of Qtr. three 632 people were engaged on the weight management "Fresh start Programme" for an initial appointment of which 457 went on to attend the 12 week programme. At the end of Qtr 3 72% of those who had completed the intensive phase of the programme were still engaged at six months with 91% reporting weight loss of 3-5% and 68% reporting >5% at the six month review.

Adult Support Stop Smoking Service – YTD 844 people have set a quit date with 399 successfully quit (NB Data set for Qtr 3 not fully complete until 31st March).

A review of the Council's Stop Smoking service is currently underway and will consider the effectiveness of the current service and the extent to which it is contributes to positive health outcomes.

Early Detection of Cancer – In November 2013, the team promoted Lung Cancer Awareness Month, in conjunction with the Roy Castle Lung Cancer Foundation, the team held events in Widnes Town Centre and Halton Lea shopping centre Runcorn with the MEGA Lungs engaging with over 400 residents. The MEGA Lungs provided visitors with an interactive, educational experience about the respiratory system. The CRUK road show raised cancer awareness for two days at the Asda Runcorn and provided health checks to 30 local residents living in the Halton Area.

NEA Public Health Programme – The Council was successful in receiving up to 12 days of officer support from the environmental charity National Energy Action. The funding will be used to promote awareness of fuel poverty amongst health professionals and the

general public. Officers from NEA are attending Area Forums and are developing a booklet for GPs and other health professionals to support them in identifying those at risk of fuel poverty and referring them for help. A half day awareness-raising session for health professionals is also being planned for March.

Mental Health and Well Being

Mental Wellbeing Survey - A report on the Halton results from the North West Mental Wellbeing Survey was commissioned from the Centre for Public Health, Liverpool John Moores University. This was delivered mid-December and a communications plan is currently being developed to disseminate the results.

Mental Health Promotion – YTD 97 front line staff trained on social prescribing resources for their own face-to-face public interactions. In Qtr. 3 109 young people received suicide prevention training.

Mental Health Strategy – The team have supported the development of the Mental Health strategy to ensure that it includes specific references to promotion and prevention, as well as being focused upon treatment.

CAMHS Event – The team has supported the organisation of an event, in partnership with the C&E team and the CCG, to bring together stakeholders to focus on CAMHS and to begin the process of establishing a new CAMHS partnership group.

Suicide Prevention strategy – Following on from the successful Suicide Prevention Planning event held in 2013 work on developing a suicide prevention strategy for Halton is now underway. The public health team have engaged with a wide range of stakeholders in this process and a task and finish group has been formed.

Drugs Strategy –The team have supported the development of the Drugs strategy to ensure that is includes specific references to promotion and prevention, as well as being focused upon treatment.

Loneliness Strategy – the team have supported the development of the Loneliness Strategy to ensure that it includes specific references to promotion and prevention and is based on best available evidence of effectiveness.

Public Health Evidence and Intelligence

Children's JSNA – work on the new children's JSNA has continued and chapter development is nearing completion. A wide range of commissioners and data analysts from Children & Enterprise, the CCG and Public Health have been involved in this. Regular progress reports have been provided to both the Children's Trust Executive Group and Halton Safeguarding Children Executive Board. A report on initial findings and priorities has been prepared.

Pharmaceutical Needs Assessment (PNA) – Halton continues to lead on the PNA across Merseyside with colleagues from Cheshire also now involved. A standardised

questionnaire has been developed to gather information from every pharmacy on a range of access and service areas. Locally a steering group has been established with representation from the local authority, CCG, Healthwatch, voluntary sector, NHS England and the Local Pharmaceutical Committee. The evidence review element of the work is currently being updated to ensure service commissioning and quality is based on best available evidence of effectiveness.

Child & Adolescent Mental Health Services (CAMHS) Needs Assessment – a rapid needs assessment was completed to support the review of CAMHS services. This details the scale and nature of children at risk of developing mental health problems as well as those in need of services now and into the future across all tiers of provision.

Speech, Language and Communications Needs of Children – a rapid needs assessment has been started (to report November 2013). It is intended to inform and support the review of services across the CCG and Halton Borough Council. This details the scale and nature of children at risk of developing speech, language and communication problems, as well the need for services now and into the future across all tiers of provision.

Health Needs Assessment of Learning Disabilities and Autism amongst children and adults – Halton public health acted as the lead commissioners and project manager for a report investigating the scale, scope and outcomes of children and adults with learning disabilities and autism. This included an easy read version for use with user partnerships. It is currently being used to inform the Self-Assessment Framework submissions.

Health Needs Assessment of Homeless People – The public health team are supporting this work, being led by Liverpool Public Health, across the Liverpool City Region. It has been commissioned from Liverpool Public Health Observatory to investigate the scale, scope and outcomes of homeless people.

Adult Lifestyles Survey - The final report for the Halton results from the Merseyside Lifestyles survey has also been agreed and plans are being developed to disseminate the results.

Health Impact Assessment guidelines – a set of guidelines have been developed by the team, in collaboration with colleagues from Regeneration and from Planning. These are aimed at developers and their agents, to improve the quality of Health Impact Assessments submitted with planning applications, as required under Policy CS22 of the Core Strategy.

Respiratory Health – A Respiratory Health profile has been developed, covering Chronic Obstructive Pulmonary Disease (chronic bronchitis and emphysema), asthma and pneumonia. It covers prevention, identification and management, hospital admissions and deaths. It will support the development of a new respiratory health action plan.

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:-

COMMISSIONING & COMPLEX CARE

Residential and Nursing Care Review
A draft Action Plan was developed towards the end of quarter four defining action needed to take place in regard to a review of Residential and Nursing Care provision within the Borough. It is anticipated that a project team will commence work in Quarter 1, 2014 to progress the actions within the Action Plan, focusing on a review of current provision of Residential and Nursing Care and defining recommendations for future provision of Residential and Nursing Care in the Borough.

Mental Health Services
In November 2013, the Care Quality Commission visited the 5Boroughs Partnership, to assess the quality of the interventions by partners of the process for assessment for admission to hospital under the Mental Health Act. An action plan in response to the visit was developed across all partners within the 5Boroughs, and implementation of the plan is being monitored in Halton by the Mental Health Strategic Partnership Board.

PREVENTION & ASSESSMENT

Transition Planning - Special Education Needs (Disability) (SEN) 2014
The SEN reforms 2014 will be implemented from September 2014 – the reforms will have implications for service delivery across the age range of 0 to 25 yrs. Multi-agency task and finish groups are currently working to adapt systems, processes and to implement the new guidance that will be introduced in September 2014.

Implementation of the Social Care Bill
A project group has been established to look at the implications and requirements of the bill in Halton.

Amethyst Living
Halton Housing Trust (HHT) are currently working with the Community Alarm Service on a project called Amethyst Living. This is a new service which will be offered to HHT residents who do not wish to move into sheltered accommodation offering them a range of services to maintain their independence in the community. Support can be provided in a person's home on a weekly, monthly or quarterly basis, with the provision of a community alarm, access to activities and events held at existing schemes, emergency responsive support

Making It Real
In Care Management Services as part of 'Personalisation' we are taking forward the 'Making it Real' marking progress towards personalised, community based support agenda. This will help check our progress and decide what we need to keep moving forward to deliver real change and positive outcomes with people. We have met with members of the TLAP programme (Think Local Act Personal) and they are helping us facilitate a 'Making It Real Live" event now planned for the 4th June 2014.

PUBLIC HEALTH
No Emerging Issues for Public Health

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 2013/14 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 is undertaken during Quarter 2 and Quarter 4.

COMMISSIONING & COMPLEX CARE

Ref	Risk Identified	Q2 Progress
CCC1 (1)	Not implementing the Local whole system Dementia Strategy	✓
CCC1 (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.	✓

SUPPORTING COMMENTARY:

CCC1 (1) The Dementia Strategy has now been ratified and is the process of being implemented, owned by the Halton Dementia Partnership Board.

CCC1 (2) Both pathways have been fully developed and are fully operational.

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.

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q4 Progress
CCC1	Continue to monitor effectiveness of changes arising from	✓

Ref	Milestones	Q4 Progress
	review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2014.** (AOF 4) **KEY**	
CCC1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2014.** (AOF 4) **KEY**	✓
CCC1	Continue to 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 2014** (AOF 4) **KEY**	✓
CCC1	Develop a new housing strategy, in accordance with Part 7 of the Local Government Act 2003, to continue meeting the housing needs of Halton. Mar 2014. (AOF 4, AOF 18) **KEY (NEW)**	✓
CCC1	Develop a Homelessness strategy for 3-year period 2013-2016 in line with Homelessness Act 2002. March 2014. (AOF 4, AOF 18) **KEY (NEW)**	✓
CCC1	Conduct a review of Domestic Violence Services to ensure services continue to meet the needs of Halton residents. **Mar 2014** (AOF11) **KEY**	✓
CCC2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2014** (AOF 21) **KEY**	✓
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 2014** (AOF 21 & AOF 22) **KEY**	**n/a**
CCC3	Develop a newly agreed pooled budget with NHS partners for complex care services for adults (community care, continuing health care, mental health services, intermediate care and joint equipment services). **Apr 2013.** (**AOF 21 & 25**) **KEY (NEW)**	✓
CCC3	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Groups, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **Mar 2014.** (AOF 21 & 25)	✓

SUPPORTING COMMENTARY

Services for children and adults with autistic spectrum disorder
The Autism Strategy group continues to monitor the progress of the Autism Strategy 2012 – 2016 action plan.

Key milestones have been:

- The funding of an ADHD/Autism Carers worker within the Carers Centre,
- The re-designation of Ashley School

- The implementation of an ASD co-coordinator post for the children's diagnosis pathway.

Autism Self-Assessment Framework submitted to iHals and presented to the Health and Well-being Board (January 2014).

Refresh of the Autism Strategy Action Plan 2014 to reprioritise key areas to reflect local needs and national guidance.

Winterbourne Concordant Action Plan continues to be monitored and work completed in line with the national programme, this includes a task and finish group with a focus on appropriately repatriating individuals placed out of area.

Implementation of Dementia Strategy
Dementia Strategy has now been ratified and is in the process of being implemented through the Dementia Partnership Board. Actions that have had notable progression include the development of a community Dementia case finding/screening programme due to be launched in June 2014. Delivery of a Dementia Direct Enhanced Service has been extened into 2014/15. The dementia business case for delivery of community based care and support is underway.

Implementation of service redesign with 5 Boroughs Partnership
The Acute Care Pathway (for adults with mental health problems) and the Later Life and Memory Service (LLAMS) (for older people with dementia) have both been fully implemented. Social workers are integrated into the new services and play a full part in service delivery. Progress in the Acute Care Pathway is monitored through the Mental Health Strategic Partnership, whilst the outcomes from LLAMS are reported to the Dementia Strategy Group.

Development of Housing Strategy
The 2013/18 Strategy is complete and was approved by Executive Board on 27th June 2013.

Development of Homelessness Strategy
The 2013/18 Homelessness Strategy was approved by Executive Board on 27th March 2014

Review of Domestic Violence Services
During a review of domestic violence services it was highlighted that the current refuge was not fit for purpose. Riverside ECGH secured funding to remodel the refuge into self-contained units, and the improvement work is underway. The first two phases have been completed and all first floor units are now fully self-contained. The remodelling is expected to be completed by May 2014, and will include improvement work to reception and communal areas.

Establishment of Healthwatch
The contract with Healthwatch Halton has been extended for a further year to cover the period 1st April 2014 – 31st March 2015. This follows an initial one-year contract to establish Healthwatch Halton as a new organisation. The extension of the contract will enable Healthwatch Halton to become established further within the local community, providing a representative voice on local health and social care issues for the local residents of Halton.

Update JSNA
JSNA now dealt with by Public Health

Development of Pooled Budget
The established pooled budget continues to be carefully monitored through Complex Care Board and a Better Care Fund submission has now been made to the Department of Health (the Better Care Fund is an important Government initiative to promote integration across Health and Social Care, and has significant resource implications).

Review and Development of Commissioning Strategies
Strategies continue to be reviewed and work is also underway to review the related specifications and contracts that derive from the commissioning priorities. This work will continue throughout financial year 2014/15.

Key Performance Indicators

Ref	Measure	12/13 Actual	13/14 Target	Q4	Current Progress	Direction of travel
CCC 4	Adults with mental health problems helped to live at home per 1,000 population	3.23	3.97	**2.64**	✗	↓
CCC 5	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)	4.0%	5%	**4.01**	✗	↑
CCC 6	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 8).	0	[1.2]	**0**	✓	↑
CCC 7	Number of households living in Temporary Accommodation (Previously NI 156, CCC 10).	6	[12]	**2**	✓	↑
CCC 8	Households who considered themselves as homeless, who approached the LA	5.42	[4.4]	**2.0**	✓	↑

	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).					
CCC 11	Carers receiving Assessment or Review and a specific Carer's Service, or advice and information (Previously NI 135, CCC 14).	18.87 %	25%	**21.29**		

SUPPORTING COMMENTARY:

CCC4 This figure has declined steadily in the past 12 months. The reasons for this have been carefully considered, and are due in part to a change in the population figures, which changed the baseline against which this indicator is measured. However a more significant reason is the successful implementation of the Acute Care Pathway within the 5Boroughs – a multidisciplinary approach specifically for people with severe and complex mental health needs. This means that the social care service is targeted more on people with the greatest levels of need and risk, whilst people with less complex needs are now being supported more though the primary care service. Plans are being developed to provide a greater social work input to the primary care service, to intervene at an earlier stage and prevent people from needing a referral to the 5Boroughs. It is expected that this will increase this performance figure through 2014/15.

CCC5 There is under-reporting of the numbers of people with dementia currently, and in addition there is no absolute requirement to record this information on the Directorate's IT systems. This will be rectified for financial year 2014/15. It is likely therefore that the Q1 figures for 2014/15 will be significantly higher.

CCC6 Halton forms part of the Merseyside Sub Regional, No Second Night Out scheme which is proven to be a successful resource and fully utilised across the Merseyside Authorities. . The service provides an outreach service for rough sleepers and has successfully worked in 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 and facilitate reconnection with neighbouring authorities.

CCC7 The Housing Solutions Team has taken a proactive approach to preventing homelessness. There are established prevention measures in place and the Housing Solutions team will continue to promote the services and options available to clients. The changes in the Temporary Accommodation process and amended accommodation provider contracts has had a big impact upon allocation placements. The emphasis is focused on early intervention and further promotes independent living. The improved service process has developed stronger partnership working

and contributed towards an effective move on process for clients. The Authority will strive to sustain the reduced Temporary Accommodation provision.

CCC8 The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention. 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. The service has achieved an annual prevention target of 4.8 which exceeds target set for 2013/14

CCC11 Although this indicator has not achieved the target figure, the activity this year represents a significant improvement on 2012-13. Carers remain a priority for the Directorate, and a new process of consultation and dialogue with carers from all service areas is now in place. As a part of this, carers are being asked for their views on ways of contacting and supporting "hidden carers" – those people who have not yet made themselves known to the Directorate and who are not therefore accessing the services that may provide them with support. In addition, the Carers Centre continues to attract increasing numbers of previously-unknown carers, and they are working closely with us to encourage these new carers to accept a formal assessment of their needs.

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PA1	Implement and monitor the pooled budget with NHS partners for complex care services for adults (community care, continuing health care, mental health services, intermediate care and joint equipment services). **Apr 2014.** (**AOF 21 & 25**) **KEY (NEW)**	✓
PA1	Engage with new partners e.g. CCG, Health LINks, through the Health and Wellbeing Partnership to ensure key priorities, objectives and targets are shared, implementing early intervention and prevention services. **Mar 2014.** (*AOF1, 3 & 21*) **KEY (*NEW*)**	✓
PA1	Review the integration and operation of Community Multidisciplinary Teams. **Mar 2014.** (*AOF 2, 4, & 21*). **(*NEW*) KEY**	✓
PA1	Develop working practice in Care Management teams as advised by the Integrated Safeguarding Unit. **Mar 2014** (AOF 10) **(*NEW*) KEY**	✓
PA1	Embed and review practice in care management teams following the reconfiguration of services in 2012/13 to ensure the objectives of the review have been achieved. **Mar 2014** (AOF 2, 4). ***(NEW)*** **KEY**	✓

PA1	Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets. **Mar 2014** (AOF 2, AOF 3 & AOF 4) **KEY**	

SUPPORTING COMMENTARY:

Implementation of Pooled Budget
The pooled budget has now been in place for 12 months, and operating effectively. The outturn for 2013/14 demonstrated a small underspend**.**

Engagement with partners to ensure delivery of early intervention and prevention services
Steering group continues to meet on a regular basis.
The sharing of key priorities, objectives and targets have been agreed for Community Multidisciplinary Teams

Develop working practice within care management teams which is advised by the Integrated Safeguarding Unit
Working practice continues to develop including, champions being identified across care management. We are also taking part in "Making Safeguarding Personal 2013-14" a sector-led improvement project. This work aims to facilitate a shift in emphasis from processes to a commitment to improve outcomes for people at risk of harm.
Continue to embed and review practice within care management teams
The care management service has now implemented a new range of streamlined self-directed support documents and resource allocation system, guidance for service users and carers, a programme of training has now been undertaken for staff to roll out this work with a focus on asset based approaches.

Continue to ensure the delivery of personalised quality services through self-directed support and personal budgets
The use of self-directed support and personal budgets is in place across all service areas. As part of 'Personalisation' we will be taking forward the 'Making it real' marking progress towards personalised, community based support agenda. This will help check our progress and decide what we need to keep moving forward to deliver real change and positive outcomes with people. A Making it real Live event facilitated by TLAP is planned for the 4th June 2014.

Key Performance Indicators

Ref	Measure	12/13 Actual	13/14 Target	Q4	Current Progress	Direction of travel
PA 2	Numbers of people receiving Intermediate Care per 1,000 population (65+) (Previously EN 1)	84.35	99	**81.31**		

PA 3	Percentage of VAA Assessments completed within 28 days (Previously PCS15) (Previously PA5 [12/13], PA8 [11/12])	86.73%	82%	**87.69**		
PA 7	Percentage of items of equipment and adaptations delivered within 7 working days (Previously PA11 [12/13], PA14 [11/12], CCS 5)	94%	97%	**96.3%**		

SUPPORTING COMMENTARY:

PA2 The quarter 4 figure for this year was 3 people less than the previous year. The overall numbers increase by 21 compared to 2012 / 13. However the older person population estimate increased by 955 between the 2 years. If the older people population had remained the same as 2012/13 which was 18648, the figure achieved would have been 85%.

PA3 This target has been exceeded.
PA7 The figure achieved has increased on the 12/13 figure of 94%, however, it has fallen just below 13/14 target of 97%. Significant work has been undertaken in this quarter to address some issues and this will be realised going forward

Public Health

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PH03	Work with the public and service providers to raise awareness of the early signs and symptoms of bowel, breast and lung cancer so we can identify it an early stage in the population. **March 2014**	
PH03	Increase smoking quitter rates amongst 16+ age range by working with local Hospital Trusts and the local 'Stop Smoking Service'. **March 2014**	
PH03	Reduce obesity rates in the local population, thereby reducing the incidence of bowel cancer through promoting healthy eating and screening programmes for adults and children via a range of services. **March 2014**	

PH03	Work proactively with GPs, all service providers, Alcohol Liaison Nurses, teachers in schools to reduce the number of people drinking to harmful levels and alcohol related hospital admissions given the rise in pancreatic and liver cancer rates. **March 2014**	✓
PH03	Implement and monitor the new Cancer Action plan to decrease morbidity and mortality from cancer locally. **March 2014**	✓
PH04	Facilitate the Early Life Stages development which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2014**	✓
PH04	Facilitate the Halton Breastfeeding programme so that all mothers have access to breastfeeding-friendly premises and breastfeeding support from midwives and care support workers. **March 2014**	✓
PH05	Working with all service providers, implement the action plan to reduce falls at home in line with the Royal Society for the Prevention of Accidents (ROSPA) guidance as outlined in the new Falls Strategy. **March 2014**	✓
PH06	Implement the alcohol harm reduction plan working with a range of providers including schools, focusing on preventive interventions and behaviour change to target the following vulnerable groups – pregnant women, women with babies and young people under 16 years. **March 2014**	✓
PH07	Implement the Mental Health and Wellbeing Programme in all schools and provide training for GP Practices and parenting behaviour training in the Children's Centres. **March 2014**	✓
PH07	Implement the Mental Health and Wellbeing Action Plan to improve the physical wellbeing of people with mental ill health. **March 2014**	✓

SUPPORTING COMMENTARY:

Raise awareness of Bowel, Breast and Lung Cancer

This is a priority for Halton Health & Wellbeing Board and sits within its underlying action plans. We are making good progress through the roll out of the national Be Clear on Cancer campaign and the team of volunteers that work with local people to deliver the message. We do not yet have easy access to staging data from the local hospitals.

A national ovarian cancer campaign, conducted by Public health England (PHE) was launched on 10th February and ran until 16th March and included TV, radio, posters and press advertising together with adverts on pharmacy bags and GP TV screens and advertising space in the Weekly News and World. GP practices have been supported to conduct the cancer audit.

Increase smoker quitter rates

Halton's smoking rate is just above the national average. Smoking quit rates are seasonal with most people quitting in January. As data is cumulative, we cannot definitively state that we will not meet the target, but given current rates, it seems unlikely. Rate of quitters for 2012/13 did not reach expected targets. This was partly due to population changes from census data but predominantly related to the impact of electronic cigarettes which are impacting upon those achieving quit status (e-cigarettes are not an NHS recognised quit tool).

Reduce obesity rates

We have good Healthy Eating and Weight Management Programmes in Halton. The Fresh Start Programme for adults shows 1,100 patients through per annum with 67% retention of clients at 6 months 90% losing at least 5% of their weight. This is in line with NICE recommended weight loss. There has been reduction in excess weight for year 6 and Reception age children.

Reduce number of people drinking to harmful levels

Halton promoted the Dry January campaign to encourage local people to abstain from drinking.

Halton has been selected as a Local Alcohol Action Area (LAAA). Work is underway to develop a multi-agency action plan to pull together all activity to support a reduction in the harm to health, antisocial behaviour and crime and the diversification of the night-time economy.

A new alcohol strategy and action plan is also in development to expand and develop the work of the LAAA over a longer period.

Work is ongoing with the Whiston Alcohol Liaison Nurse Service to improve the local pathway, to develop better relationships with community services and also improve outcomes for those who regularly attend hospital as a result of drinking. A similar piece of work is due to start soon with the equivalent service in Warrington.

Implement and Monitor new Cancer Action Plan

A Cancer Action Plan that sits beneath the Health & Wellbeing Strategy is in place. This has been monitored by the Cancer Action Team and is currently making good progress with all actions that were expected to be achieved to date on track

Halton has continued to implement the Cancer Action plan. A refreshed and updated action plan will be developed to support local activity.

Facilitate Early Life Stages Development

Universal health visitor service is currently being delivered, and health visitor numbers are increasing in line with department of health guidance. Family Nurse partnership, which is an intensive programme for first time teenage mothers is being commissioned by NHS England, and is due to be operational by October

2014. Work is currently underway looking at access to support for parenting, and is incorporated into the neglect strategy.

Facilitate Halton Breastfeeding Programme
The 'Breastmilk it's amazing' website has been re-launched, and was well received. This has a map showing all the breastfeeding friendly premises in the area. The breastfeeding support team continue to provide peer support across the borough.

Implement action plan to reduce falls at home
Community falls awareness training launched this month as per action plan. Already leading to increase in referrals to falls specialist team

Implement Alcohol Reduction Plan
A social marketing campaign is under development to highlight the dangers of drinking through pregnancy, and encouraging abstinence.

The Healthitude programme is being developed to ensure consistent messages are provided by partner organisations in line with national curriculum requirements.

A social norms programme is being developed to challenge young people's perceptions of alcohol use locally and promote positive behaviour change.

Implement the Mental Health and Wellbeing Programme
A review of all local mental health and wellbeing provision is underway to ensure that there are consistent, high quality services available.

A new Mental Health and Wellbeing strategy has been developed and this will inform the development of a new action plan to meet local need across all ages and levels of need.

Implement the Mental Health and Wellbeing Action Plan
Halton has continued to implement the Cancer Action plan. A refreshed and updated action plan will be developed to support local activity.

Key Performance Indicators

Ref	Measure	12/13 Actual	13/14 Target	Q4	Current Progress	Direction of travel
PH LI 10 (SCS HH8)	16+ current smoking rate prevalence – rate of quitters per 100,000 population (Previously NI 123)	930.4	1263.6	437.4 (Q1-Q3 2013/14)		
PH LI 11 (SCS HH2)	Prevalence of Breastfeeding at 6-8 weeks (Previously NI 53)	17.81%	24%	22.8% (Quarter 3)		
PH LI 14 (SCS	Admissions which are wholly attributable to alcohol AAF = 1, rate per 100,000 population	878.0	1039	949.0		

HH1)				(Jan – Dec '13)		
PH LI 15 New SCS measure Health 2013-16	Excess under 75 mortality rate in people with serious mental illness (NHSOF and PHOF)	850.7 (2010/11)	TBC	Latest data available is for 2010/11	N/A	N/A
PH LI 09 (SCS HH7)	Mortality from all cancers at ages under 75 (Previously NI 122)	142.94 (2012)	125.1	138.6 (Oct '12 – Sep '13)		

SUPPORTING COMMENTARY:

PH LI 10 Halton's smoking rate is just above the national average. Smoking quit rates are seasonal with most people quitting in January. As data is cumulative, we cannot definitively state that we will not meet the target, but given current rates, it seems unlikely. Rate of quitters for 2012/13 did not reach expected targets. This was partly due to population changes from census data but predominantly related to the impact of electronic cigarettes which are impacting upon those achieving quit status (e-cigarettes are not an NHS recognised quit tool)

PH LI 11 The choice to breastfeed is influenced by local cultural beliefs, and as such change takes time. The results for this quarter show improvements. There is always seasonal variation with breastfeeding rates. Data coverage continues to exceed the target of 95%.

PH LI 14 The 2012/13 local rate is provisional data and will be updated nationally in next month. Current quarter data shows an increase in the rate from 2012/13 although it is currently below target.

PH LI 15 No recent data available.

PH LI 09 Halton during the last 12 month rolling period has witnessed a lower rate of mortality from under 75 cancers, than during 2012. Rates are much lower recently than they were during 2009.

APPENDIX 1 – Financial Statements

COMMISSIONING & COMPLEX CARE DEPARTMENT

Not Yet Available

PREVENTION & ASSESSMENT DEPARTMENT

Not Yet Available

PUBLIC HEALTH DEPARTMENT

Not Yet Available

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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

REPORT TO: Health Policy & Performance Board

DATE: 17 June 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Sustainable Community Strategy Quarter 4 year-end Progress Report 2013-14

WARD(S) 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 2014, which includes a summary of all indicators for A Healthy Halton

3.8 The full reports for each of the strategic priorities are reported to the respective Policy and Performance Boards. Additionally the Halton Strategic Partnership Board will receive a report for all measures.

3.9 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 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 Corporate 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	Place of Inspection	Contact Officer
Sustainable Community Strategy 2011 – 26	Municipal Building Widnes	Mike Foy Performance & Improvement Officer

The Sustainable Community Strategy

for Halton

2011 – 2016

Year-End Progress Report

01st April – 31st March 14

Halton Strategic PARTNERSHIP

Healthy Halton

Document Contact (Halton Borough Council)	Tim Gibbs (Divisional Manager Development Services) Municipal Buildings, Kingsway Widnes, Cheshire WA8 7QF tim.gibbs@halton.gov.uk

This report provides a summary of progress in relation to the achievement of targets within Halton's Sustainable Community Strategy 2011 - 2016.

It provides both a snapshot of performance for the period 1st April 2013 to 31st March 2014 and a projection of expected levels of performance to the year-end.

The following symbols have been used to illustrate current performance as against the 2013 / 2014 target 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	2013 / 14 Target	Direction of travel
	HH1*	a) Alcohol related hospital admissions (NI 39) (Rate 100,000 pop.)	✓	↓
		b) Alcohol related hospital admissions – AAF =1 (Rate)	✓	↓
	HH 2	Prevalence of breastfeeding at 6-8 weeks (NI 53)	?	↑
	HH 3	a) Obesity in Primary school age children in Reception (NI 55)	✓	↑
		b) Obesity in Primary school age children in Year 6 (NI 56)	✓	↑
	HH 4	Reduction in under 18 Conception (new local measure definition for NI 112)	?	↑
	HH 5	a) All age, all cause mortality rate per 100,000 Males (NI 120a)	?	↓
		b) All age, all cause mortality rate per 100,000 Females (NI 120b)	?	↑
	HH 6	Mortality rate from all circulatory diseases at ages under 75 (NI 121)	✓	↑
	HH 7	Mortality from all cancers at ages under 75 (NI 122)	✗	↑
	HH 8	16+ Smoking quit rate per 100,000 (NI 123)	✗	↓
	HH 9	Mental Health – Number of people receiving Community Psychological Therapies (IAPT) (New Measure)	Not Yet Available	Not Yet Available
	HH 10	Proportion of older people supported to live at home through provision of a social care package (NEW 2011):	✗	↓
	HH 11	a) Increase the % of successful completions (drugs) as a proportion of all in treatment (over 18)	✓	↑
		b) Increase the % of successful completions (Alcohol) as a proportion of all in treatment (over 18)	✓	↑

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

	2012/13 Actual	2013/14 Threshold	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
a) Alcohol related hospital admissions AAF > 0 (Previously NI 39)	2815.9	3,142	2933.5	2925.1 (Qtr 3)	✓	↓
b) Admissions which are wholly attributable to alcohol AAF = 1 (Rate)	878.0	1039	959.0	949.0 (Qtr 3)	✓	↓

No Chart Available for this indicator as data is not robust.

Data Commentary:

The first indicator measures the cumulative rate of alcohol related hospital admissions per 100,000 population using Hospital Episode Statistics. The 2012/13 rate was calculated using local unverified data. Local data can be utilised as an interim measure.

The second measure provides further detail and relates to admissions which are wholly attributable to alcohol in other words AAF=1. This rate is not released nationally so always uses local data.

The most up to date information available is Qtr 3 (December 2013). It is a rolling yearly rate and includes data from 1st January 2013 to 31st December 2013 and uses local unverified data in the absence of published information.

Performance Commentary:

a) The Q3 2013/14 rate has increased above 2012/13 data, although is still currently below annual threshold.
b) The Q3 2013/14 rate has increased above 2012/13 data, although is still currently below annual threshold.

The national trend has also shown an increase in alcohol related admissions over the last 3 years.

Summary of Key activities taken or planned to improve performance:

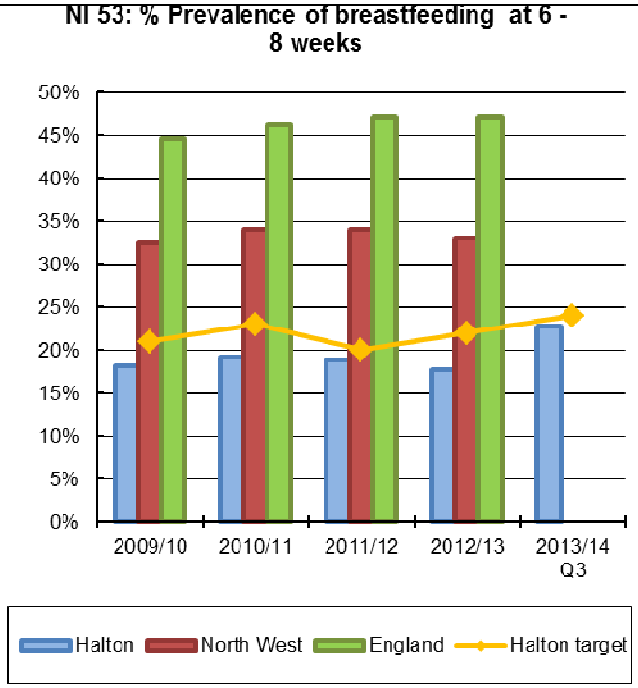
Alcohol harm reduction continues to be a priority area within the Health and Wellbeing action plan. Work is currently underway to develop an alcohol harm reduction strategy and action plan for Halton. This involves engagement of all key stakeholders. A key focus of the strategy will be reviewing pathways related to prevention, early identification, treatment and recovery within Halton

[1] SCS / HH1 is also replicated under Safer Halton as SCS / SH10

in order to reduce alcohol related hospital admissions.

Healthy Halton

SCS / HH2	% Prevalence of breastfeeding at 6-8 weeks (NI 53)



2012/13 Actual	2013/14 Target	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
17.81%	24%	23.7%	22.8% (Qtr 3)	?	↑

Data Commentary:

Good performance is an increase in the percentage coverage and prevalence year on year. Data is available up to Q3 2013/14 (The full years data will be available towards the end of April 2014).
The Q3 data is cumulative for 2013/14 and shows an increase in prevalence from 2012/13.

Performance Commentary:

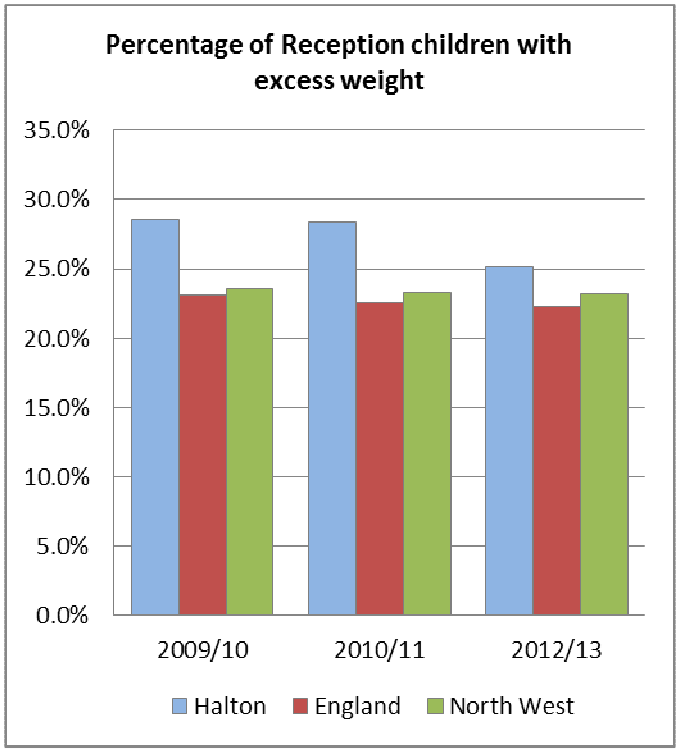
The choice to breastfeed is influenced by local cultural beliefs, and as such change takes time. The results for this quarter show improvements. There is always seasonal variation with breastfeeding rates. Data coverage continues to exceed the target of 95%.

Summary of Key activities taken or planned to improve performance:

Breastfeeding continues to be a priority area within the Health and Wellbeing action plan. The successful achievement of UNICEF's Baby Friendly Initiative stage 2 in November, represents a lot of work by midwives, health visitors and the breastfeeding peer support team to develop a culture and services that support breastfeeding. A breastfeeding celebration event is planned for May, to mark this achievement and develop work further. The Breastfeeding steering group are also developing a local breastfeeding strategy. In March CHAMPs ran a launch event in Halton Lea shopping centre, of the Breastmilk it's amazing website, which was well received and reported in the local press.

Healthy Halton

SCS / HH3a	Excess weight in Primary school age children in Reception (NI 55)



2012/13 Actual	2013/14 Target	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
28.4% (2010/11)	Reduce by 1% per annum based on 10/11 actual		25.1% (2012/13)	✓	↑

Data Commentary:

The excess weight rates in Primary School Age Children in Reception (aged 4-5, as shown by the National Child Measurement Programme (NCMP).

During 2011/12 there was an issue with the Leicester Height Measurement equipment that was used for Widnes school children and it was not known how many children were affected. Therefore 2010/11 has been used instead of the 2011/12 data.

For the purposes of this indicator, children are defined as having excess weight if their body-mass index (BMI) is above the 85th 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 percentage of Reception children with excess weight has decreased by more than 3% between 2010/11 and 2012/13.

Summary of Key activities taken or planned to improve performance:

In 2012/13 the rate of children who are of excess weight in Halton is lower than the rate in 2010/11. Halton has halted the year on year rise in excess weight for Reception children. This is a reduction compared to the National trend and shows Halton is narrowing the gap with England and the North west.

There are a range of programmes in place that encourage a healthy weight in children under 5. The community midwives and the infant feeding team are working to increase the uptake and continuation of breastfeeding, which is directly linked to obesity in later life. Health visitors and the health improvement service also work with families to support healthy weaning which supports good

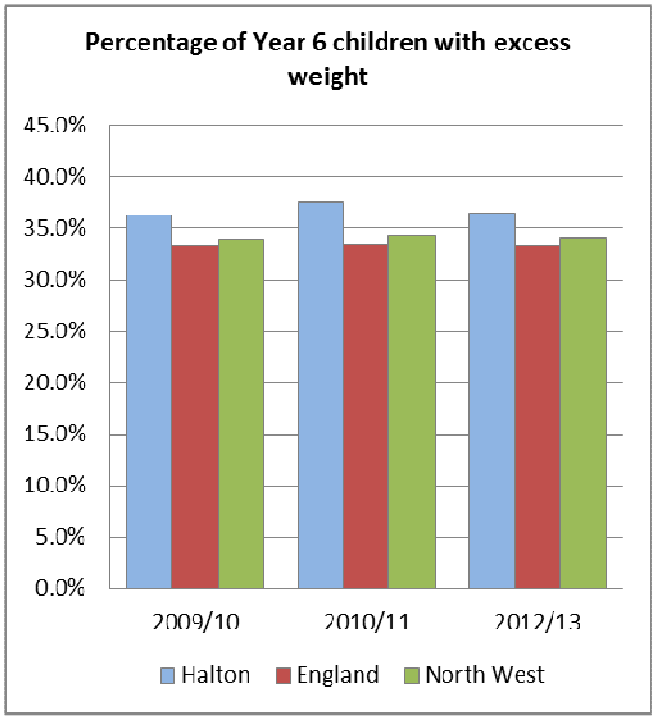
early nutrition, and will impact on children's lifelong eating habits, reducing weight gain and improving health. This is being supported by the national programme of increasing the numbers of Health Visitors in Halton.

The Healthy Early Years Programme (fit for life) is delivered in Children's centres for young families and includes cookery lessons for parents, active tots groups and education and training for parents and service providers.

Children's Centres and Early Years Providers continue to work to meet the Healthy Early Years Standards which include food standards and healthy eating. This award has been further improved and re- launched in September 2013.

Healthy Halton

SCS / HH3b	Excess weight in Primary school age children in Year 6 (NI 56)



2012/13 Actual	2013/14 Target	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
37.5% (2010/11)	Reduce by 1% per annum based on 10/11 actual		36.5% (2012/13)	✓	↑

Data Commentary:

Excess weight rates in primary school age children in Year 6 as shown by the National Child Measurement Programme (NCMP).

During 2011/12 there was an issue with the Leicester Height Measurement equipment that was used for Widnes school children and it was not known how many children were affected. Therefore, 2010/11 has been used instead of the 2011/12 data.

For the purposes of this indicator, children are defined as obese if their body-mass index (BMI) is above the 85th 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 percentage of Year 6 children with excess weight has decreased by 1% between 2010/11 and 2012/13.

Summary of Key activities taken or planned to improve performance:

In 2012/13 the rate of year 6 children who are of excess weight in Halton is lower than the rate in 2010/11. Halton has halted the year on year rise in excess weight for year 6 children. This is a small reduction but compared to the National trend it shows Halton is narrowing the gap with England and the North west.

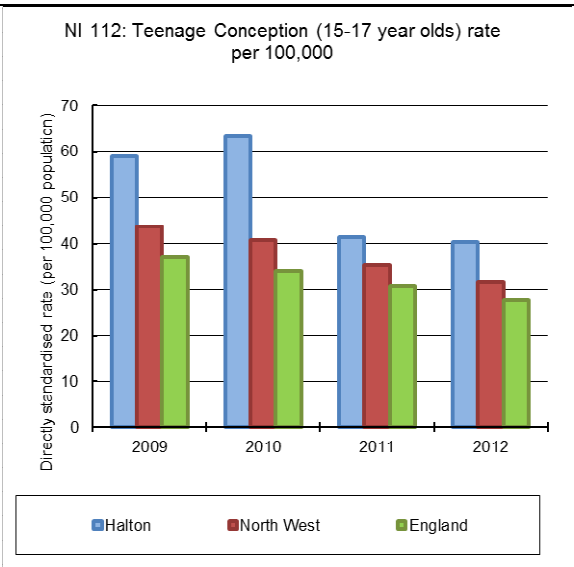
There is an extensive range of programmes available in the schools to encourage a healthy lifestyle and healthy weight. The Fit4Life programme targets schools with the highest obesity rates and has been shown to reduce obesity rates in the schools that engage in the programme.
The range of programmes available to schools includes:

- An extended schools programme on weight management which includes, healthy eating, fun physical activity and healthy cooking sessions across Halton
- A healthy snacks programme in all primary schools across Halton
- Family cook and taste sessions across Halton
- MEND – which is a community based, multi- component, treatment and prevention programme for obese and overweight children and their families
- Fit for Life Academy which incorporates the growth and nutrition clinic and is a community based, multi-component, treatment and prevention programme for very obese children and their families
- Passport to Health – a training programme for all working with children and young people and their families that is designed to motivate individuals to make positive behaviour changes regarding their health focusing on areas of weight management

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 also maintained the Healthy schools programme which 54 schools are engaged in and will also work on reducing rates of obesity through links with the national curriculum.

Healthy Halton

SCS / HH4	Reduction in under 18 Conception (new local measure definition for NI 112)



Please note: figures are now based on a year's worth of data, i.e. figures stated for Q4 2012 are based on the entirety of the 2012 calendar year.

2012/13 Actual	2013/14 Target	2013/14 Qtr 3	2013/14 Qtr 4	Current Progress	Direction of Travel
41.5 (total for year Jan-Dec 2011) (This represents a reduction of -34.44% on 2010)	Reduction of 3%	**40.4** (Jan-Dec 2012) (2.65% reduction)		?	↑

Data Commentary:

2012 figures:
Number of conceptions: **92**
Rate per 1,000 girls: **40.4**

Compared to 2011:
Number of conceptions is **lower than 2012 (97)** and **2010 (142)**

Performance Commentary:

In Halton, the rate of teenage conceptions has reduced greatly from 2010 to 2012, and during 2012 was at the lowest point during the four years since 2009. The reduction from 2011 to 2012 is 2.65%, this is below the target of 3.00%. We are now on the North West average for this indicator.

Summary of Key activities taken or planned to improve performance:

- Facilitated 12 x 18 week Teens and Tot programmes to targeted young people in targeted schools.
- Co-ordinated and increased the number of venues signed up to the condom distribution scheme.
- Offered sexual health awareness training to workers in community and health and social care settings.
- Increased the number of sexual health clinics and made them young people focused.
- Used the VRMZ outreach bus in hotspot areas on Friday and Saturday nights and during school holidays, to provide young people with information and advice on positive sexual health.
- Further developed teen drop-ins in some schools to include information and advice on relationships and contraception.

WHAT DO WE PLAN TO DO NEXT

- Embed and implement young people's services in the community and increase the number of teen drop-ins in schools.

- We will continue to ensure the VRMZ outreach bus provision is accessible to young people across Halton providing universal and targeted sexual health interventions.

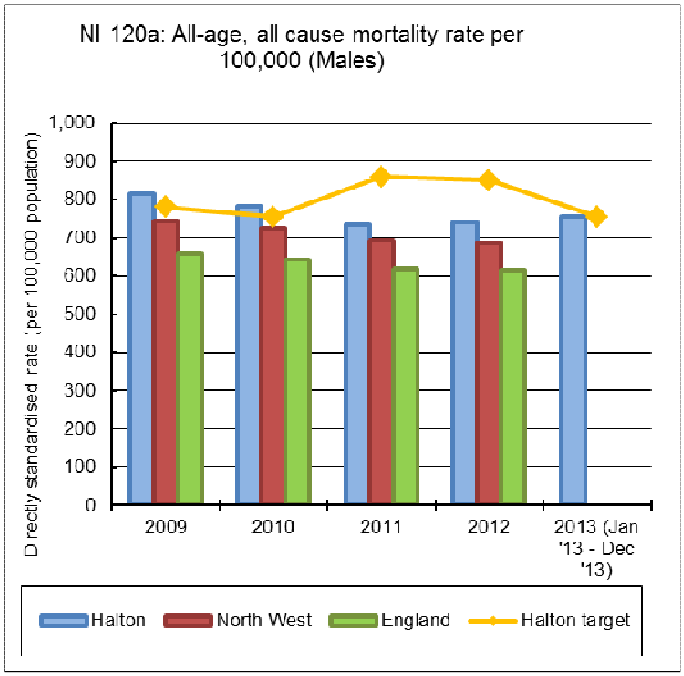
- Continue to support and encourage schools to develop their SRE curriculum, through the Healthitude programme.

- Increase the number of High Schools involved in Teens and Tots programmes

Through the Council's Public Health Department commission a fully integrated sexual health service, which will offer a comprehensive service wherever possible.

Healthy Halton

SCS / HH5a	All age, all-cause mortality rate per 100,000 Males (NI 120a)



2012/13 Actual	2013/14 Target	2013/14 Qtr 3	2013/14 Qtr 4	Current Progress	Direction of Travel
739.6 (Jan 12 - Dec 12)	755.2	754.8 (Jan 13 – Dec 13)		?	↓

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. Rolling 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. All data after 2012 is based on local unverified information, in the absence of up to date published information.

This means that the two sets of data are not comparable as the data from 2012 onwards is still subject to change and could go up and well as down dependent upon the verified information.

Performance Commentary:

In Halton, the rate of all age, all-cause mortality amongst males during 2013 was higher than the rate during 2012. However, currently the rate for 2013 is below the specified target for 2013/14, by 0.4 mortalities per 100,000 population.

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.

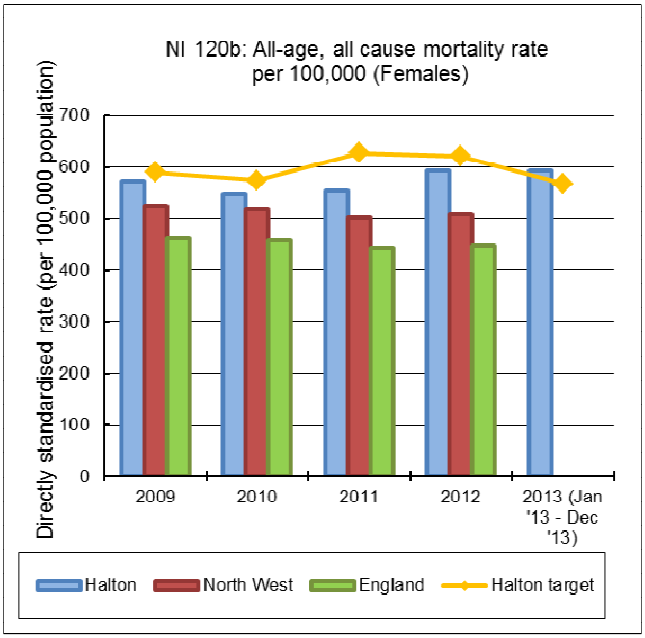
Lifestyle factors contribute to early deaths from the 2 biggest causes of deaths in Halton and therefore there is a continued focus on:

Healthy weight and obesity
Tobacco Control and smoking cessation
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 includes additional checks to identify dementia and use of alcohol.

Healthy Halton

SCS / HH5b	All age, all-cause mortality rate per 100,000 Females (NI 120b)



2012/13 Actual	2013/14 Target	2013/14 Qtr 3	2013/14 Qtr 4	Current Progress	Direction of Travel
594.5 (Jan '12 – Dec '12)	567.9	593.1 (Jan '13 – Dec '13)		?	↑

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. Rolling 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. All data after 2012 is based on local unverified information, in the absence of up to date published information.

This means that the data after 2012 is not comparable to the earlier data. The data 2012 onwards is still subject to change and could go up and well as down dependent upon the verified information.

Performance Commentary:

In Halton, the rate of all age, all cause mortality, during 2013 was slightly below the rate witnessed during 2012. However, the rate during 2013 was still higher than the target set for 2013/14.

Summary of Key activities taken or planned to improve performance:

The three biggest causes of death for females is circulatory diseases, respiratory diseases and cancers.

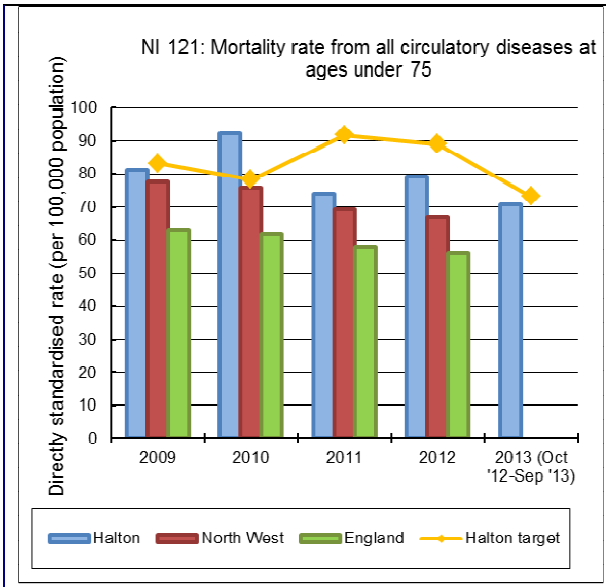
Lifestyle factors contribute to the majority of and in particular to the 3 biggest causes of deaths in Halton and therefore there is a continued focus on:

- 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 Programme. Actions around alcohol is covered in more detail on the Alcohol section

Healthy Halton

SCS / HH6	Mortality rate from all circulatory diseases at ages under 75 (NI 121)



2012/13 Actual	2013/14 Target	2013/14 Qtr 3	2013/14 Qtr 4	Current Progress	Direction of Travel
79.2 (2012 - HSCIC)	73.3	70.9 (Oct 12 - Sep 13)		✓	↑

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. Rolling single year rates are used to enable timely reporting. (The associated national target is assessed using 3 year average figures). All data after 2012 is based on local unverified information, in the absence of up to date published information.

Performance Commentary:

The mortality rate from circulatory diseases amongst the under 75's in Halton was lower during the Oct-12 to Sep-13 period than during any of the years between 2009 and 2012. Besides 2010, Halton has been consistently below the target rate of the borough, during 2009, 2011, 2012, and the most recent 12 month rolling period.
There is a trend towards a fall in the rate of deaths from this condition

Summary of Key activities taken or planned to improve performance:

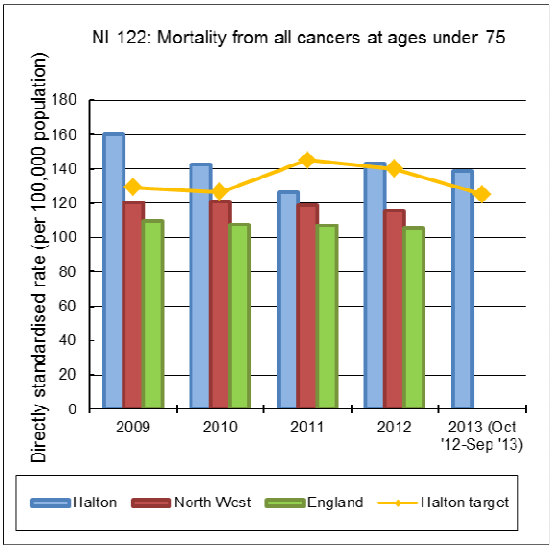
Lifestyle factors contribute to early deaths due to circulatory diseases in Halton and therefore there is a continued focus on:

- 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.
The Quality Outcomes Framework (QOF) programme managed by primary care monitors performance relating to treatment within general practice.

Healthy Halton

SCS / HH7	Mortality from all cancers at ages under 75 (NI 122)



2012/13 Actual	2013/14 Target	2013/14 Qtr 3	2013/14 Qtr 4	Current Progress	Direction of Travel
142.9 (2012 HSCIC)	125.1	138.6 (Oct 12 – Sep 13) Provisional			

Data Commentary:

This is a Department of Health PSA Target.

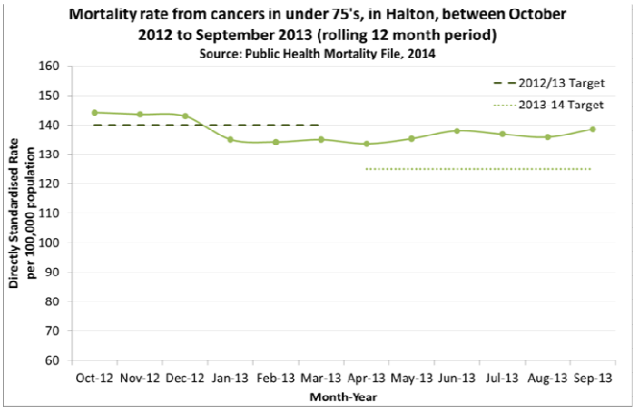
Mortality targets are based on calendar year and not financial year. Rolling single year rates are used to enable timely reporting. (The associated national target is assessed using 3 year average figures). All data after 2012 is based on local unverified information, in the absence of up to date published information. 2009-2012 figures are based on published information from Health and Social Care Information Centre.

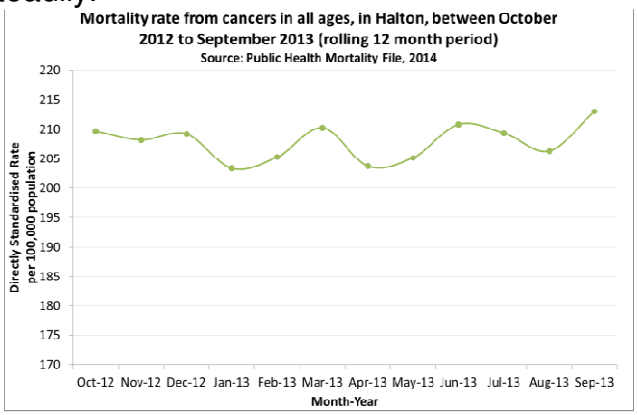
Performance Commentary:

Halton during the last 12 month rolling period has witnessed a lower rate of mortality from under 75 cancers, than during 2012. Rates are much lower recently than they were during 2009.
Cancer remains one of the largest causes of deaths in Halton.

Summary of Key activities taken or planned to improve performance:

The charts show that for people of all ages, and for those under 75, cancer mortality continues to fall steadily.





Lifestyle facts play a big role in the development of many cancers. Early detection through screening plays an important role in ensuring that people can have early treatment or therapy to prevent to onset of cancer.
Existing activities are:

- The national “Get Checked” campaign to improve early detection of breast, bowel and lung cancers
- The Cancer Network continues to support every general practice team in delivering their own cancer action plan
- Three cancer screening programmes are now coordinated by NHS England
- National campaigns to promote early recognition of different cancers
- 2 week referral pathways for specialist appointments where cancer is a possibility
- Audits of cancer diagnosis in primary care

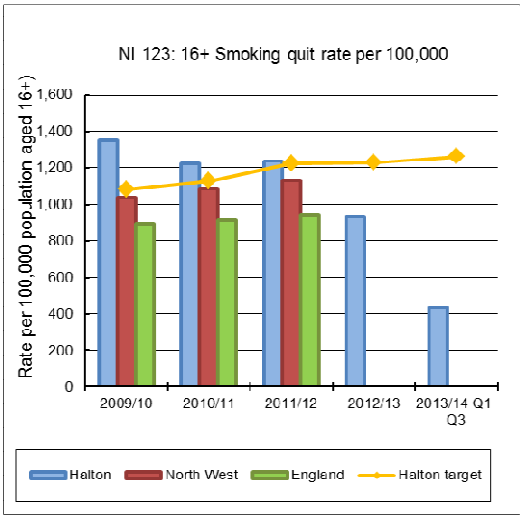
Halton CCG has selected cancer as a priority area, and have a named commissioning manager as lead for cancer. They are launched the local Halton Cancer Action Plan for 2013-14, whilst supporting current initiatives and activities.

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 all those between 60 and 74 years.
Breast cancer screening is now offered to some women aged between 50 to over 70, and is being extended to include those between 47 and 4950 years old. Digitisation of the programme has improved quality.
Cervical screening is offered to all women 25 to 64

Healthy Halton

SCS / HH8	16+ Smoking quit rate per 100,000 (NI 123)



2012/13 Actual	2013/14 Target	2013/14 Qtr 3	2013/14 Qtr 4	Current Progress	Direction of Travel
930.4	1263.6	437.4 (Qtr 1-Qtr 3 cumulative)			

Data Commentary:

This indicator relates to clients receiving support through the NHS Stop Smoking Services. Data is only available for Q1-Q3 2013/14; the rate is cumulative and so it will not be possible to assess the performance against target until the end of Q4. Quitting smoking is seasonal with the majority of quitter stopping in January.

Performance Commentary:

In common with the rest of England the Stop Smoking Service figures have dramatically fallen since the introduction of the E Cigarette. Looking at the rate of current quitters during the first three quarters of 2013/14, it is below half of the rate that would be required to meet the level of 2012/13. Q4 generally witnesses higher numbers of quitters than any other period, however, it is unlikely that Halton will meet the target.

Summary of Key activities taken or planned to improve performance:

Smoking policy amended to include no vaping in public places. Prevention services in schools outline the need to alert children to the dangers of smoking E Cigarettes. A training pack being developed for schools on E cigarettes.

Healthy Halton

SCS / HH9	Mental Health - No. of people in counselling/ day services or on waiting lists. (New Measure)

2012/13 Actual	2013/14 Target	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
9.86% (Achieved across Halton & St Helens)	10.5%	N/A	**Awaiting Information**	**Awaiting Information**	**Awaiting Information**

Data Commentary:

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 as at 2012/13.

Please note that this prevalence is in relation to anxiety and depression only.

Performance Commentary:

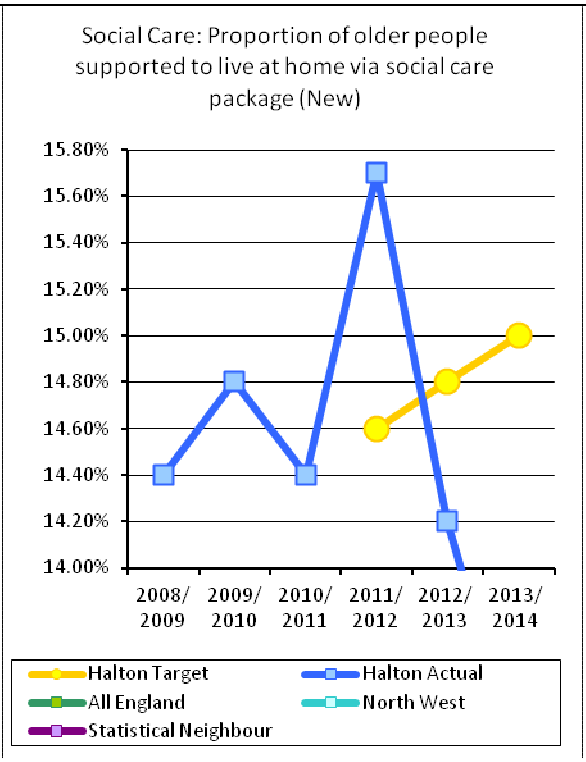
Awaiting Information

Summary of Key activities taken or planned to improve performance:

Awaiting Information

Healthy Halton

SCS / HH10	Proportion of older people supported to live at home through provision of a social care package



2012/13 Actual	2013/14 Target	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
14.2%	15%	13.32%	13.15%	✗	↓

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:

It is expected that the % of older people helped to live at home through the provision of a social care package will decrease due to the increase in the numbers of older people (65+) living within Halton and the introduction of a number of early intervention and prevention initiatives/pathways which impact on the need for social care packages to be introduced. This increase in the numbers of older people etc. was not reflected when the 2013/14 target was set.

Summary of Key activities taken or planned to improve performance:

A number of early intervention and prevention initiatives/pathways have been introduced which have had an impact on this area, as follows :-

- Reconfiguration of Assessment and Care Management provision, including the establishment of the Initial Assessment Team, which has meant individuals are now referred/signposted to community and voluntary sector organisations for support/advice rather than a social care package being put in place.
- Development and implementation of the Falls Strategy, including the revision of the Falls Prevention pathway.
- Introduction of the new Health and Wellbeing Service Model, including the Sure Start to Later Life Service.
- Implementation of the Community Wellbeing Practice initiative across 14 GP practices across Halton.
- Greater investment in Intermediate Care Services.

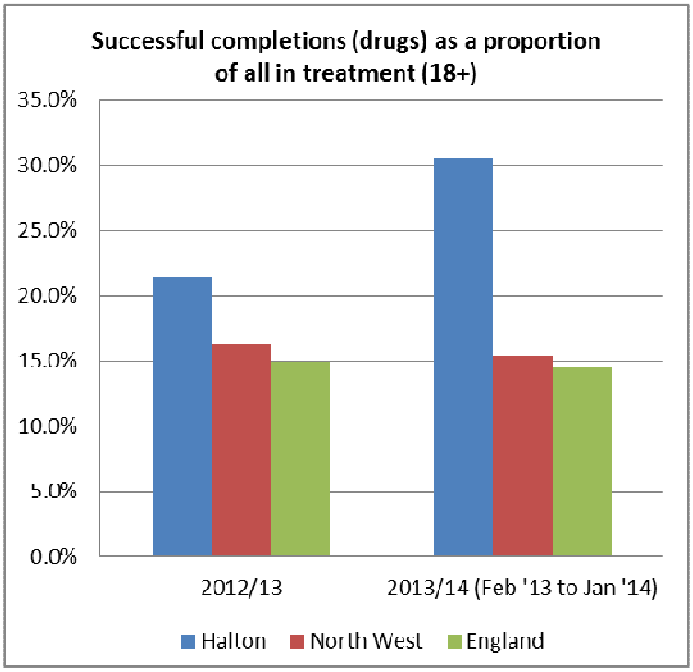
Further planned work expected to improve performance in this area includes

- Integration of Continuing health care nurses within complex care teams (to be implemented next 6 months).
- Implementation of "Making it Real", ensuring that personalisation is more effectively implemented across adult services.

It should also be highlighted that the introduction of the complex care pooled budget (1.4.13) across health and social care will improve outcomes for Halton residents and enable people to remain at home for longer with appropriate support.

Healthy Halton

SCS/ HH11a[2]	Increase the % of successful completions (drugs) as a proportion of all in treatment (18+)



2012/13 Actual	2013/14 Target	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
21.4%	(Above NW average)	26.4%	30.5% (Feb 13 – Jan 14)	✓	↑

Data Commentary:

The new substance misuse service, provided by CRI commenced on 1st February 2012.
Data used for Q2 and Q4 above is a rolling yearly percentage. The latest data (Q4) is for 1st February 2013 to 31st January 2014.

Performance Commentary:

The data is demonstrating an increase in the number of clients accessing the treatment service and an increase in the number of successful completions for all drugs.
Performance for Feb '13 to Jan '14 is better than the 2012/13 end of year figure of 21.4%.
The Halton percentage is statistically significantly higher (better) compared to the North West and England averages.

Summary of Key activities taken or planned to improve performance:

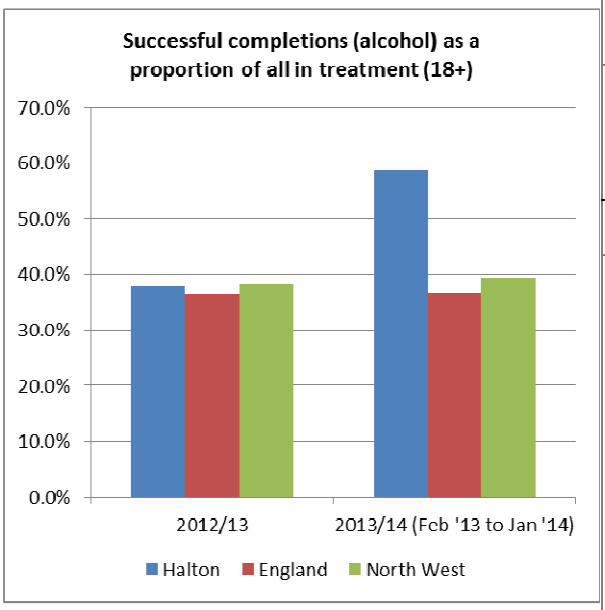
The factors that have contributed to the improving stats are:

- The Foundations of Recovery programme
- Prioritising support and routes out of treatment
- Continued development of peer mentoring programme.
- Recovery event 2013
- Robust case management
- Staff training and robust report processes to improve key performance targets.
- Increase in volunteer programme to support individuals through person journeys of drug treatment.

[2] [2] [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+)



2012/13 Actual	2013/14 Target	2013/14 Qtr 2	2013/14 Qtr 4	Current Progress	Direction of Travel
37.7%	Increasing the % of successful completions	44.0% (July 12 – June 13)	58.6% (Feb 13 – Jan 14)	✓	↑

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.

Data used for Q2 and Q4 above is a rolling yearly percentage. The latest data (Q4) is for 1st February 2013 to 31st January 2014.

Performance Commentary:

The data is demonstrating an increase in the number of clients accessing the treatment service and an increase in the number of successful completions for alcohol.
Performance for Feb '13 to Jan '14 is better than the 2012/13 end of year figure of 37.7%.
The Halton percentage is statistically significantly higher (better) compared to the North West and England averages.

Summary of Key activities taken or planned to improve performance:

Alcohol treatment forms part of the Health and Wellbeing Action Plan. A new alcohol strategy for Halton is in development with multi-agency support.

Work continues with CRI to develop optimal Alcohol pathways which will encourage safe discharge and robust aftercare, in order to maintain treatment gains and avoid repeat admissions.

Work has begun in relation to linking the Community Service CRI into the Whiston Alcohol Nursing Scheme in order to identify people with high need who may re-present to Hospital Accident & Emergency departments and at differing access points within the treatment system.
Work is also underway to better understand the reasons why approximately two thirds of clients

[3] [3] SCS / HH 11b is also replicated under Safer Halton as SCS / SH 7b.

assessed by the Whiston Alcohol Liaison Nursing Scheme who accept a referral to community services do not attend an initial assessment with the community service.

REPORT TO: Health Policy & Performance Board

DATE: 17 June 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing; Community Safety

SUBJECT: Safeguarding Adults update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on key issues and the progression of the agenda for safeguarding 'vulnerable adults' (i.e. adults at risk of abuse) in Halton.

2.0 **RECOMMENDATION: That: The Board note the contents of the report**

3.0 **SUPPORTING INFORMATION**

3.1 The Deprivation of Liberty Safeguards (DoLS) are one aspect of the Mental Capacity Act (2005). The Safeguards are to ensure that people in care homes and hospitals are cared for in a way that does not inappropriately restrict their freedom, and if necessary restrictions are only applied in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to provide appropriate care.

3.2 The recent Supreme Court ruling P v Cheshire West and Chester and P and Q v Surrey Council is significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty.

3.3 A deprivation of liberty for such a person must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under DoLS in the MCA 2005, or (if applicable) under the Mental Health Act 1983.

3.4 The ruling has clarified that there is now a revised test for a deprivation of liberty and two key questions that should be asked are:

- Is the person subject to continuous supervision and control?

- Is the person free to leave?

The focus is not on the person's ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave. The recent judgment is significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty.

3.5 The judgment is important as it holds that a DoL can occur in a domestic setting where the State is responsible for imposing those arrangements. This will include a placement in a supported living arrangement in the community. Hence, where there is, or is likely to be, a deprivation of liberty in such placements that must be authorised by the Court of Protection.

3.6 An action plan is currently being developed to fully scope and address the implications. It is anticipated that this will place an extra burden on the Council in terms of an increase in the number of applications to the Court of Protection and the number of DoLS cases will be significantly greater than previously assumed.

3.7 In November 2013 Halton joined the Making Safeguarding Personal Project, an initiative supported by ADASS and the LGA. This work aims to facilitate a shift in emphasis from processes to a commitment to improve outcomes for people at risk of harm. The key focus is on developing a real understanding of what people wish to achieve, recording their desired outcomes and then seeing how effectively these have been met.

3.8 Councils taking part in this project were tasked with completing an impact assessment statement at the end of the project, providing aggregated measure outcomes and an anonymised case study highlighting how this approach had benefitted the individual involved in the case.

3.9 Halton's level of participation was at bronze level; this being the point that all Councils had to start with. Halton focused on the following two methods to:

- Establish what outcomes the person want at the outset and then a review of the extent to which they have been realised, and
- Gather feedback from people who use services on their experience of the safeguarding adult process.

Currently Halton Safeguarding Adults Board receives performance data in relation to safeguarding adults however this data is unable to provide Board members with any real understanding of whether the safeguarding processes in Halton are making a difference for those

who are most vulnerable and at risk in the locality. On-going work from this project to embed this approach into day to day practice will change the nature of the performance data and will provide Halton Safeguarding Adults Board with a better understanding of people's experiences and thus serve to influence and improve the delivery of safeguarding services in Halton.

4.0 POLICY IMPLICATIONS

4.1 A review of existing policies and procedures will be completed in light of the Social Care Bill.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Safeguarding Adults Board (SAB) membership includes a Manager from the Children and Enterprise Directorate, as a link to the Local Safeguarding Children Board. Halton Safeguarding Children Board membership includes adult social care representation. Joint protocols exist between Council services for adults and children. The SAB chair and sub-group chairs ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

The safeguarding of adults whose circumstances make them vulnerable to abuse is fundamental to their health and well-being. People are likely to be more vulnerable when they experience illhealth.

6.4 A Safer Halton

The effectiveness of Safeguarding Adults arrangements is fundamental to making Halton a safe place of residence for adults whose circumstances make them vulnerable to abuse.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 Failure to address a range of Safeguarding issues could expose individuals to abuse and leave the Council vulnerable to complaint, criticism and potential litigation.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 It is essential that the Council addresses issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its safeguarding policies and plans. Policies and procedures relating to Safeguarding Adults are impact assessed with regard to equality.

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

None under the meaning of the Act.

REPORT TO:	Health Policy & Performance Board
DATE:	17 June 2014
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Care Home Project : Interim Report
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an update to the Board on the work of the Care Homes Project.

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

3.0 **SUPPORTING INFORMATION**

3.1 The Halton Care Homes project has been in operation since July 2013.

3.2 The project aimed to improve the quality of care within homes in the borough through: review of current care practices; analysis of the range and ease of access residents have to health and social care services; identify sustainable ways to improve treatment, care and support.

3.3 The project has identified that the care provided by homes they have worked with has been of a high standard.

3.4 The project has worked closely with the full range of Halton's community health and social care services. A clinical reference group has been supporting the aims of the project and some immediate solutions to issues have been implemented

3.5 The project have group some of the key issues into 7 areas: communication; end of life care; physical care; pharmacy; equipment; primary care utilisation; activities

3.6 Further work is ongoing to identify an appropriate level of clinical support to continue the work of the project

4.0 **POLICY IMPLICATIONS**

4.1 None

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Finances for any future provision will need to be identified.

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

6.1 **Children & Young People in Halton**

Not Applicable

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

Not Applicable

6.3 **A Healthy Halton**

The project has improved the health and well-being of residents in care homes. These gains should be maintained and spread through the implementation of the recommendations and the directing of resources to maintain the project in a similar format.

6.4 **A Safer Halton**

Not Applicable

6.5 **Halton's Urban Renewal**

Not Applicable

7.0 **RISK ANALYSIS**

7.1 Not Applicable

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.

Bridgewater Community Healthcare NHS
NHS Trust

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Halton Care Home Project

Investigation into Unmet Need

Interim Report

March 2014

Jennifer Theodore

CONTENTS

1. Executive Summary

Public concern for the quality and standards in Care Homes (Residential/Nursing) has been much highlighted by the media. Care homes have become increasingly marginalised from health and social services and as a result transparency has been lost and quality standards can be variable (Boseley 2012, BGS 2011, AS 2013). Care home projects have taken place across the country. Some are specialised looking at one area of health such as mental health or strokes, others are more generalised looking at whole system approaches to the way in which Health and Social services provide services for their population such as the projects in Warrington, Manchester and Halton. To avoid overlap and to utilise different skill sets, the Halton care home project has established close links with the 5 borough partnership mental health team and have developed shared objectives and initiatives such as care home training provision, care home managers coffee afternoons and an integrated approach to standardisation of patient transfer forms.

The Halton care home project found that care within all Seven care homes that were visited displayed caring attitudes to the residents that they serve. We found lots of genuinely dedicated members of staff that work incredibly hard to provide good standards of care. The problems that we have identified were mainly due to unconscious omission and we have worked with the care homes to develop safe sustainable solutions.

The Halton care home projects, on-going work has so far identified 7 key issues these include:

- Communication;
- End of life Care;
- Physical Care;
- Pharmacy;
- Equipment;
- Primary care utilisation; and
- Activity

There are several next steps that need to be implemented to create sustainable solutions for the residents of care homes. Some of the solutions needed are relatively simple changes to current services and practices and other ideal solutions involve proposing new models of care which may prove a challenge to implement but worthwhile. System and cultural changes are needed to ensure that the standards required are achieved.

2.1 Rational for care home projects

The needs of the care home population (residential/nursing) have for along time been left unrecognised and unmet by both health and social services. (Boseley 2012, BGS 2011, AS 2013). Concern about the quality of provision that is provided by residential/nursing homes has been much highlighted by the media. While most care homes are trying to provide good quality care for the residents that they serve, it has shown that care homes can be isolated, leading to variation in quality and standards. YouGov public opinion poll commissioned by the charity Alzheimer's Society found that 70% of UK Adults questioned say they would be fairly or very scared of going into a care home.

Care home populations are increasingly frail and make up the neediest population in terms of healthcare, furthermore there is a rapid increase in numbers of older adults choosing to live and die in care homes (Hockley 2010). Research has shown that residents that have been admitted to homes have complex healthcare needs, multiple long-term conditions with significant frailty most of whom have dementia and will die within two years of admission (Katz 2003, BGS 2011). Halton Bough Council (HBC) and NHS Halton clinical commissioning group (CCG) have recognised that there could be potential gaps in services for this very vulnerable client group and therefore have commissioned the Halton care home project to investigate unmet need.

Relevant demographic information for Halton can be found at Appendix 1.

The Care Homes that the project has now had input into are: Widnes Hall, St Patricks, St Lukes Beechcroft, Croftwood, Halton view and Ferndale Mews.

The Care homes have a wide range of services from social services and NHS that provide care for the residents. These include:

- GP's;
- District Nursing;
- Social workers;
- Physiotherapy;
- Occupational therapy;
- Falls;
- Dietician;
- Tissue viability;
- Speech and Language;
- Podiatry;
- Dental;
- Opticians;
- Continence Services.

2.2 National/Regional Context

There is a comprehensive range of other care home projects occurring across the UK. They have some striking commonalities with each other even though they occur in different areas and some times specialising in services from strokes to dementia.

Most care home projects including Haltons found that care homes felt isolated and marginalised from the wider health and social services systems. The projects also highlighted problems in communication and collaboration between the care homes and services.

Some local examples of care home projects are explored below.

2.2.1 Manchester

Manchester developed the Community Health Nursing home improvement programme (Shine 2010).

The team's objectives were:

- To improve communications across organisational and professional boundaries;
- To reduce the number of emergency hospital admissions from care homes;
- To reduce residents length of stay in hospital;
- To increase the percentage of residents with end of life plans;
- To increase the numbers of residents dying in the home; and
- To improve residents' nutritional states.

The programme reported that the first 3 homes achieved a 40% reduction in length of stay of their residents in hospital and 80% of residents had documented conversations about end of life issues. The project members felt that they had succeeded in changing attitudes and improved the way things work within their homes; they also feel that the culture has changed within the care home; they no longer feel that they are working in isolation as they now view themselves as part of a wider multi-disciplinary team.

2.2. Warrington

Warrington developed a year long Care Home Enhancement Project (CHEP); which aim was to use a "preventative approach to enhance health and social care for older adults which could reduce the need for unscheduled admissions into hospital from care homes in Warrington."

They piloted the scheme to 5 care homes across Warrington; after the first 8 weeks one care home pulled out which was replaced by another. They found that a significant reduction in cost could be made by reducing the hospital admissions from care homes. They used the projection of a reduction of 200 admissions per month could save £5,990,400. It is difficult

to understand how these figures were reached and whether this would be an accurate picture of the savings that could be made. They also found solutions to streamline the system and process that could result in better patient care and reduced cost, these include: timely re-banding in the community, appropriate medication changes, reduction in Ambulance call outs, shortened hospital admission, preferred place of care, reduction in GP visits to care homes, reduction in falls and preventable fractures.

They have now finished this project and the NHS Warrington CCG has concluded that there is no further funding for the project. Although the CHEP project has not been rolled out across Warrington they do have an existing GP Liaison team. This team serves residents in care homes who are registered to a Warrington GP. All telephone calls to GP's are triaged through the care home team. The team filter the calls and refer to the right practitioner. The team consists of 4 Specialist practitioners (Former District Nurses), who will visit the homes to assess, and appropriately action sudden detrition in health to confirm or exclude illness when the history of illness is not specific such as chest infection, UTI, Mobility etc.

2.2.3 St.Helens

The care home project in St.Helens commenced on 1st January 2013. The aim is to improve the quality of care, health and well-being of the residents of care homes across St.Helens by supporting existing Care Home Staff with a specialist team of clinicians. The team consists of a consultant Geriatrician, 2 Nurse Practitioners, Advanced Nurse Practitioner and an administrator.

The team go into all the care homes in St.Helens by referral from the GP only. The team offer training and development to the care home staff. They provide advice on managing their resident's long-term conditions. The Consultant Geriatrician will be able to provide advice for that individual's on-going care, although the clinical responsibility remains with the GP. No data or reports are yet available for review.

2.3 Local Context

2.3.1, 5 Borough Partnership (5BP)

The 5BP established a Care home Liaison team in January 2013. This was developed due to national and international concerns about the mental health care being provided to care home residents.

The aims were to:

- Keep residents in their current setting and reduce inappropriate hospital admissions;
- Reduce readmissions to hospital and the length of in-patient stays;

- Respond to urgent referrals within 24 hours and routine referrals within 10 working days;
- Reduce inappropriate 999 calls from care homes;
- Improve the quality of mental health care; and
- Reduce the cost of mental health care.

A dedicated multidisciplinary team was set up. The team provided timely assessments for mental health care.

- From January to May 2013, 703 referrals were received.
- 86% of referrals were assessed within the agreed time frame.
- The team found 83 patients that had a mental health problem that were previously undiagnosed (mainly dementia and /or depression).
- 136 patients had there medication reviewed, which resulted in 60 patients having there medication reduced.
- 223 review of antipsychotic medication took place in 89 cases, the medication was stopped or reduced.
- From January to May 2013, the service cost £583,301 to implement.
- The team estimate that they saved £347,571 on lower admissions; 23% lower on the same time period last year (Jan-May 2012).
- Estimated cost saving from the pharmacy reviews are £11,898.

The care home teams of Halton and 5 BP are taking an integrated approach to many of the tasks and projects surrounding care homes. The two team's compliment each other as the 5 BP team specialise in mental health and the Halton team specialise in physical health and social care. The care home liasion team have now been commisioned by Halton NHS CCG.

2.3.2 Halton Care Home Project

The care home project in Halton, was established in July 2013 and has been extended until August 2014. The projects main objective is to support care home providers to improve the quality of the care for residents and understand how the wider Health and Social Care System works for residents in Halton's care homes. This corresponds with the learning gained from the Francis report.

"People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS." (Francis 2010.)

Firstly the team engaged with a wide variety of stakeholders that have input into the care homes and met the chosen home managers and visited their homes. As care homes work with a wide range of people it is important that we engaged with as many people as

possible. This has developed into a clinical reference group which is multiagency as well as multidisciplinary. We also decided to include the care home managers to strengthen the ethos of collaboration and transparency; this has created an open forum in which to discuss problems and solutions.

The project has now recruited seven care homes. All the patient case files, 410 in total, in each of the care homes have been reviewed. The care homes were visited by the team for a week per month. Each day started and ended by meeting the care home managers discussing any problems/issues that were found, as well as highlighting areas of good practice. Patients and notes were reviewed. Areas needing attention were highlighted as issues to both the care home managers and other agencies as necessary; to gain potential solutions as soon as possible.

It is important to note that all seven care homes that were visited displayed a caring attitude to the residents that they serve. We found genuinely dedicated members of staff that work incredibly hard to provide good standards of care. We were told that some of the staff were paying for courses themselves, to develop there own clinical competencies and have seen numerous small caring acts such as a hug for a resident that was upset, ensuring that the cup of tea was just right, taking time to sit and reassure a resident that was displaying anxious/confused behaviour, even though they were busy. The problems that we have identified were mainly due to unconscious omission. We have worked with the care homes to develop safe sustainable solutions.

3.0 Project Deliverables and Solutions

3.1 Issues Identified

On-going work has so far identified 7 key issues these include: Communication, End of life Care, Physical Care, Pharmacy, Equipment, Primary care utilisation and Activity.

- **Communication**

The team found good evidence of communication between other agencies that visit the home such as Dietician, Speech and Language Therapy (SALT), and the Falls Service. The care homes report good relationships and service from these agencies. **Appendix 2** shows the results of a questionnaire asking care home managers to provide feedback on services that they receive in their home. There seemed to be unnecessary delays caused to some services by the system of asking the GP to forward the referrals. This had been put in place to filter out unnecessary referrals and to inform the GP who was involved in the care. In reality the GP simply passed on the referral causing delay and more work for the GP surgery. Therefore we propose that the Care home refer direct, but inform the GP that the referral has taken place. Services that receive direct referrals have not had large amounts of inappropriate referrals.

The care homes have highlighted that GP surgeries like to be communicated with by different methods; some practices won't take telephone calls from care homes, for example asking if medication has been prescribed only like communication by fax. Others don't want them to fax repeat prescriptions; they have to take them in by hand. Registration of a resident to GP practice has been highlighted as being difficult. Registration at one single GP practice would help to ease the issues. This would provide continuity of care, develop relationships with the home and stop several different district nursing teams going in to the same care home at the same time to do tasks such as insulin's; therefore using multiple nurses when one nurse would be able to complete all the tasks. Better infection control at times when the home has an easily spread infection such a Norovirus and provide transparency residential home, for example 4 District Nursing teams dressing 1 pressure ulcer might not suspect a problem but 1 team dressing 4 pressure ulcers would.

Communication between the acute sector and the care homes have also been highlighted as an area of concern. Accident and Emergency state that they are often unaware of the base line for the patients such as if they usually present as confused or is it a new presentation; These problems can lead to the patient being admitted, while normal presentation is established. The care homes report similar confusion when the patients are discharged of not knowing what has occurred whilst they have been in hospital, as often the patient is unable to tell them, so they are unsure what the management plan for the condition is or if they have been discharged without medication, because it has been purposefully stopped or forgotten. Therefore we have set up a sub-project, which is multi agency and multidisciplinary. On the team are a discharge planning manager, 5 BP care home nursing manager, safeguarding nurse, Care home manager, Community Care Worker social services and clinical nursing lead for the Halton care home project to address this issue

The team decided to look at the information going in to and out of hospital. It was discovered that Warrington had uncovered the same problem and have developed a transfer/ discharge form. We utilized this form as a starting point and discussed with the care homes and A+E. Changes were made such as the addition of a body map, services involved with contact numbers. We also sent the form that needed to be completed for discharge with the resident attending A+E. Warrington's team highlighted the issue of the form being lost. After discussion with North West Ambulance Service it was decided to use a yellow form in a yellow folder to ensure it was as visible as possible; it was also decided to fax a copy of the form to the discharge liaison team so they could monitor the resident whilst in A+E and provide a further copy of the form if necessary.

3 Care homes were chosen in Runcorn to pilot the form, these were Croftwood, Beechcroft and Simonsfield and we decided to use Warrington hospital A+E/UCC. We did a small scale audit before the forms were utilised. The results of the self reporting data for the month of October 2013 from the 3 care homes are as follows:

- 7 admissions to Warrington Hospital in October 2013.

- The care homes reported that all residents were sent to A+E with transfer records.
- 28% of residents were discharged the same month.
- 71% of the admissions needed telephone calls from the care home to A+E post discharge for further information.
- 29% of discharges were discharged home without any information.
- All patients were admitted to a ward; therefore no residents were treated and discharged from A+E.

The form was introduced on the 1/2/14. 7 forms (in one calendar month 28 days) were successfully sent with the resident and faxed to the discharge liaison team. The forms have been completed to varying degrees of success; however all have provided useful base lines for the residents. Two residents were treated and discharged from A+E and discharge information provided. Warrington report that no discharge forms in two years have ever been completed. One completed by a consultant and the other a Staff Nurse which allowed essential information to be provided to the care home upon discharge. Also the Advanced nurse practitionerfrom the 5 borough care home liaison team (mental health) was also contacted from A+E informing her that one of her patients had been brought in to A+E and discussing changes to the medication; this was the first time this has ever occurred and was delighted to be consulted. We will continue to audit the usage of the forms over the next 2 months period and if they continue to be successful we will recommend that they are used by all care homes in Halton transferring to both Warrington and Whiston Hospital A+E. We would also like to discuss the use of the form with other close areas such as Warrington and St Helens.

Care home managers have reported that they feel isolated, not only from social services and NHS but from each other. There is a chance to meet at the provider meetings held at Runcorn Town Hall, but this is a formal format; therefore it was decided, in conjunction with the 5BP care home team, to create informal coffee morning/afternoons that create a relaxed atmosphere and that feels like a safe place to meet, share success and problems and give care home managers the mechanism to support each other. At the time of writing this report two coffee mornings have taken place and the care home managers have reported that they find them very useful. The managers have decided to meet every 2 months and will take it in turn to host.

The resident's care files that we reviewed were very large and unwieldy, therefore difficult to navigate. The amount of information needing to be included to display person centred care is very large. Numerous problems with risk assessments such as Waterlow, Malnutrition Universal Screening Tool (MUST) being completed incorrectly and problems with written communications with frequent meaningless phrases being used such as "settled in lounge" or "un-witnessed fall", plus clearly wrong information being recorded such as wrong name and fields being completed wrongly such as Sex: Unknown, Religion: Ensure. Individual errors were reported through a communication book, to the managers.

However, these problems were so numerous that it was felt that education was needed. Therefore in conjunction with the 5BP care home team it was decided to hold education sessions. We have now completed 2 dates. The days were split into two identical sessions' morning and afternoon. The first training day Halton, the care home team trained on Waterlow and pressure ulcers, MUST, Record Keeping and Documentation. 5BP trained on dementia awareness, and drugs used in dementia. 94 care home staff attended. The second education day, 54 attended and had sessions from safeguarding, falls service, pain in dementia and Behaviours that challenge. The sessions were very well received with good feed back and comments (see appendix 4). The next training day is planned for the 11/3/14 and educational sessions include:- Recognising the Dying Phase, Dementia Friends, Behaviour, Psychological, Symptoms of Dementia and Medication issues in care homes.

Missing or wrong information has been documented on patients notes, for example on one resident's notes it had been recorded that a patient had had a Myocardial Infarction (heart attack), however when the GP summery was obtained, there was no record of this, furthermore they didn't know that their resident had COPD (a respiratory disorder) and had recorded on the case notes that she had no breathing difficulties. The team have recommended that a summary of medical records is obtained for each resident containing current medication, acute medical problems and past medical history, as long as the resident consents or if the patient lacks capacity to consent, it should be obtained in the patient's best interest and documented as such.

- **End of life Care**

The team witnessed a caring attitude to patients in the last few days of life and their relatives. We witnessed arelative providing thanks for the way his mother was being cared for and staff seemed keen to ensure that the patients and relatives were comfortable and had gained timely reviews from professionals such as GP's.

Training on the end of life programme '6 Steps' has started for the homes but due to the end of life facilitator leaving his post, the programme was suspended half way through. The care home team found that care homes understanding of end of life provision has been variable. The care homes report that they have completed 3 steps of the '6 step' end of life course, but as so much time has passed they would like to start the course again.

One home had put best interests about end of life care in place without assessing capacity on that decision; their understanding was that if a patient had a diagnosis of dementia they automatically put in place the best interest, however not being able to do some activities such as cross the road safely, is very different from not having a the ability to decide what you would like to happen when at the end of your life. Therefore this was passed to the safeguarding team to investigate and the new end of life facilitator will work with them, to ensure that capacity issues have been considered and implemented.

Do Not Attempt Resuscitation (DNAR) issues need to be further understood. We have found that some orders have been put in place over two years ago and not been reviewed although on some, indefinite, has been written on them. This is a subject that we have passed to the CCG and Advanced care planner (end of life care) to gain a better understanding, as Government guidance doesn't give clear instructions on reviews and GP's by law, don't need to review. However, most literature indicates that it is good practice, if a DNAR has been in place for two years, questions should be asked, such as was it put in place appropriately and how has the patient changed during that time. Northwest Ambulance Service will request a review after 90 days if a new unified document is registered with them; this is the newly implemented document that can be transferred and used in Hospital. Clear guidelines for the residential/ nursing homes should be developed as they seem to be using it as an advanced life directive, rather than a sensible precaution when it is clear that someone is reaching end of life.

One care home is very keen to be proactive with end of life care planning, however this has resulted in when residents are admitted into the care home, the relatives are being questioned on end of life care planning within 48 hours of admission. It was documented in one resident's notes that the relatives were not ready to discuss end of life plans yet and so the carer would ask them again the week after. This has been passed to the advanced care planner (end of life care), for clarification and advice to care homes on timing for end of life discussions.

Support has been highlighted as issues within the care homes when providing care for residents requiring end of life care. We found that one care home found it difficult to obtain a syringe driver in anticipation of a residents need. The manager has recently negotiated the purchase of a syringe driver with the owners of the care home; this has not yet been received. The district nurses were willing to loan a syringe driver, but after several calls didn't have one available and another district nursing team had to be contacted. This caused significant frustration for the staff in being unable to access the necessary resources in a timely manner. Fortunately on this occasion this didn't impact on patient care.

- **Physical Care**

Several issues with physical care were noted. Some nurses were not confident in dressing wounds. One nursing home had asked the GP for advice and they said that they were told to redress the wound daily. Although the dressing choice was appropriate for the needs of that wound, dressing the wound daily was inappropriate as this increased risk of excoriation of the wound margins, increased risk of infection, and disruption of healing tissue from the wound bed; wound exudate levels were low, therefore daily dressings was not required.

One residential unit Case study detailed in Appendix 5, requested that the care home team's nurse review a resident that appeared to them to be visibly deteriorating. This patient

needed to be reviewed to many multidisciplinary teams to ensure appropriate treatment. The team were able to ensure that this occurred the same day.

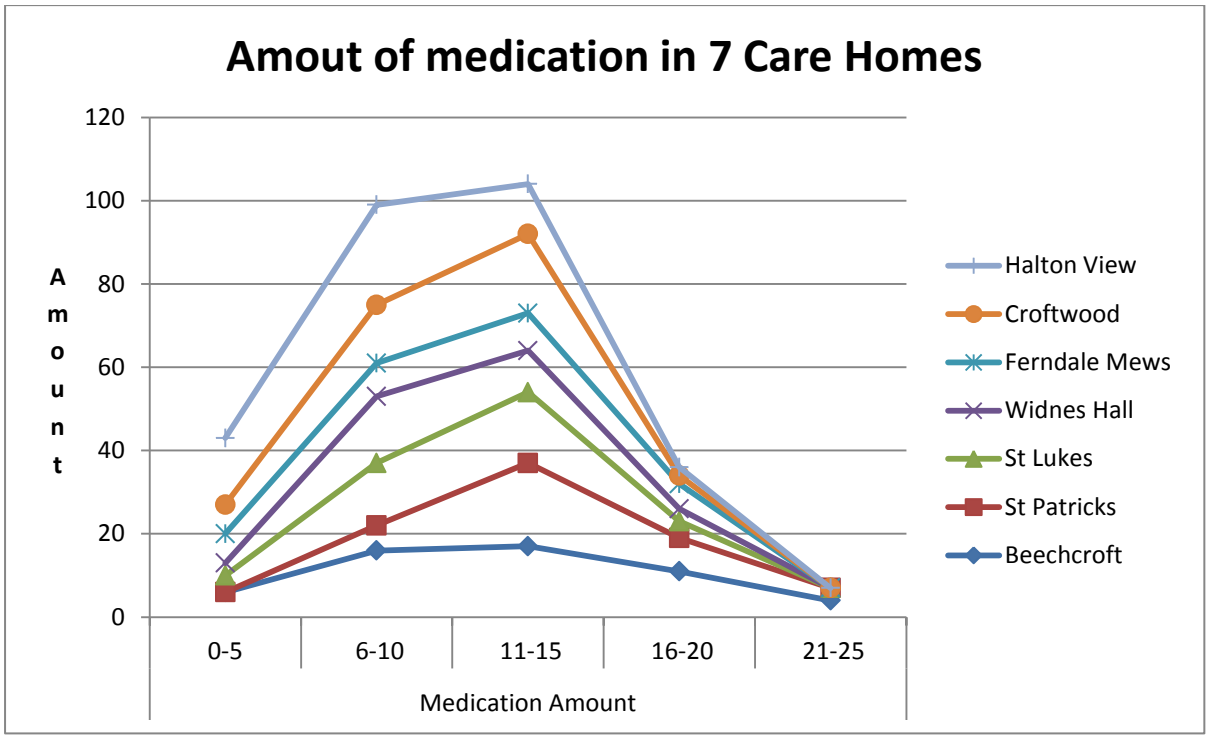
A safeguarding referral was raised for a patient with a false eye. Although the staff had noted that her eye was producing green discharge, they failed to identify that it was false and failed to provide any eye care.

The team found in one care home the optician had prescribed 20% of the resident's verifocals, for most of these residents it was inappropriate as they didn't read or do close work such as puzzles and therefore unnecessary; furthermore research indicates that there is a significant fall risk associated with adults over 65 years wearing Veri/Bifocals (Cambell, 2005). This issue was highlighted to the falls coordinator who has discussed the issue with the optician and has now reached a resolution. Now that the issue has been highlighted, the care home team will go back to all the care homes involved in the project and review the optical prescriptions.

The care home project discovered in two homes that the hairdresser's room and equipment hygiene standards were lacking. Equipment had been put away before cleaning; we found rollers/hairbrushes full of hair and skin. The drawers that they had been put away in also contained skin and hair. In one care home the floor and chair had also failed to be cleaned after use. Public Health Law requires that hairdressers and barbers operate hygienically. The hygiene standards required are listed in the bye-laws made under the local Government Miscellaneous Provisions Act 1982. Furthermore we felt that this preformed well below the standard of dignity and respect required. We advised both managers of our findings. However on return to one of the care homes, although we found the room to be overall cleaner, the equipment used was still in the same unhygienic state. This issue was then passed to Quality Assurance Team. The care home team will now inspect all hairdressing rooms in the 7 care homes involved in our project on return visits.

- **Pharmacy**

The chart below shows the numbers of medications that residents have per Care home.



The team found very high levels of medication amongst the care home residents. 84% of residents have over 6 medications, 50% of residents had over 11 medications, 12 % had over 16 medications and 7 residents were found to have over 21 medications. Polypharmacy starts to be a problem with 5 or over. This high level can produce many polypharmacy problems with drug to drug or disease to drug interactions and the older adult population tend to be more susceptible, due to the reduction in liver and kidney function, that are essential in the processing of drugs in the body. It is important to understand that polypharmacy may sometimes be necessary to control diseases but the residents should have regular medication reviews to monitor and control untoward interactions. The team found no evidence of regular reviews taking place. The problems resulting from polypharmacy can be numerous and systemic. Regular reviews particularly in the older adult population is crucial, because adverse drug reactions can often imitate other problems that are common in the older adult such as confusion, falls, incontinence, urinary retention and depression. These side effects in turn may cause a GP to prescribe further medication to treat them.

A pharmacist and a technician will soon be employed to review all patients in the 4 care homes and the pharmacy teams that are linked with the GP's are starting to look at residents that have over 15 medications. The project team have also requested that pharmacy investigate the use of Homely medications; these are products that can be obtained, without a prescription, for the immediate relief of a minor self limiting ailment. We have found that different homes have different usage and procedures. This needs to be understood and if possible standardised across the Halton care homes. A simple Google

search revealed that other CCG's across the country have recognised potential problems and have developed policies such as Oxfordshire, Gloucestershire and North Kirklees.

The homes also vary in the amount and type of stock that they hold. We found that although one care home use glass ampules, they didn't have any filter needles to filter out any glass shards. It was also found that very limited wound dressing stock was held; one home requested that a wound was assessed. There were no sterile dressing packs or dry dressings to put in place to help prevent infection while a prescription was generated, therefore this could cause further deterioration to the wound. We have asked the Pharmacy team to look into the amount and type of stock that is held.

- **Equipment**

The care homes have good relationships with physiotherapy and occupational therapy. They contract out maintenance and servicing. The care home team found that 16 residents on one unit in one care home had the slings left in place when they had been hoisted into a chair. We also found this practice in another care home on 5 residents. Leaving slings in place, especially on pressure reliving equipment can reduce the effectiveness and any folds or ridges can also cause pressure sores, as well as becoming uncomfortably hot, due to the material not being breathable. The manager explained that they were left in place due to the residents being combative or disease related contractive posture; they were therefore left in place for the protection of the resident and staff from being injured. These were valid reasons to keep the slings in place; however the risk assessments' recognising and supporting the practice had not been completed and the correct type of slings were not being used. The care home project, asked specialist Occupational Therapist (OT) to assess and advise the care home on the use of the slings and type of slings (see report appendix 6). The care homes, after the visit from OT proceeded to produce good risk assessment in the patient's notes and they were made aware of the need to replace some of the slings. The care home team asked to see the Lifting Operations and Lifting Equipment Regulations (LOLAR) reports for the slings in one care home due to the much worn nature of one of the slings; this was refused by the care home manager. This issue was then passed to the Quality Assurance Team.

The team also asked the Specialist OT to review a patient who had poor sitting balance in a chair; the lady was almost lying sideways and was unable to access drinks or reposition herself. The OT advised the Care home of a better chair to use, but couldn't find one that was perfect as the lady was small; therefore advice was provided detailing the correct size chair.

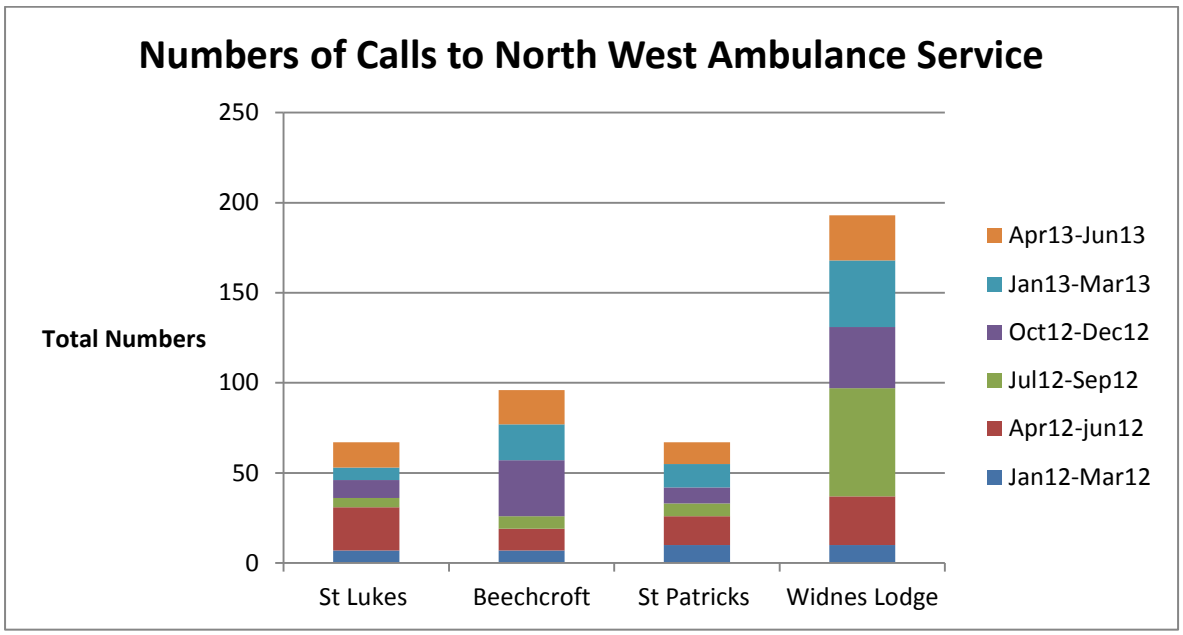
All air mattresses that we observed had been set on the wrong level for the weight of the patients. Having the setting set incorrectly can cause further problems with pressure. We found 5 set at the wrong level in one home, after discussing it with the care home manager it was decided to implement a chart with the patient's weight and the setting for the bed to

be checked each week to ensure that they remain correctly set. The same care home had also identified in residents notes that some of the residents should be using pressure reliving cushions. However when we located the residents in the lounge we found that they were not using cushions, furthermore they didn't have enough cushions for all the residents that needed them. We requested that the care home put this in place.

- **Primary care utilisation**

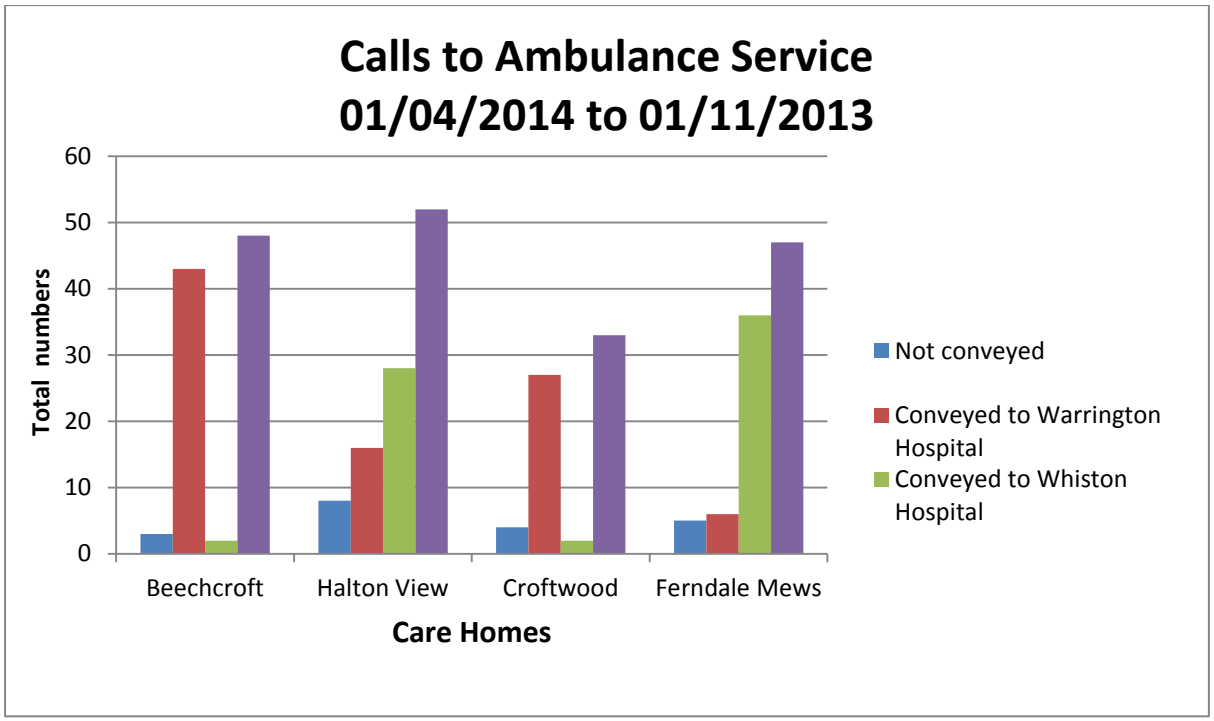
Whilst we have some data on the access to acute, primary and community care services we do not have a clear understanding of the use. Improving interventions in the community can prevent pressure on the rest of the healthcare system.

This chart below shows the number of 999 calls to the ambulance service over given time periods. It is important to note that the population size of each care home is different. Other variables that will have an effect are types of resident (nursing/residential) progression of disease and presence of nursing staff in the care home.



As patient identifiers weren't available with this data, it is difficult to know if all the patients were conveyed to hospital. Also, what happened to the patients in terms of length of stay, discharges and those that were readmitted; however, an audit of the care homes being involved with the previously discussed patient transfer form (see appendix 7) will provide further information and a clearer picture.

During phase two, NWAS were able to provide information on how many residents were conveyed to hospital.



- **Activity**

There was a lack of activity in all the care homes we visited. The team only observed one care home having regular activity; regular and additional programmes of activity are necessary for resident's wellbeing. One to ones observed were not utilised to the full capacity and often just involved sitting in front of the television with the resident that they were tasked to care for. Physical activity such as yoga for the more capable residents and Chair based exercises would be useful and training for care home staff to be able to provide these sessions for their residents. Exercises for the brain need to also be catered for such as bingo, board games, animal therapy, crafts along side the usual aromatherapy, beauty therapy etc. Education for residents (for those cognitively able) and care staff on bone health, healthy diets and smoking cessation advice for those willing and able to participate would be helpful. Quite a few of the care homes have offered rooms and venues for meetings.

The project approached the Health and Wellbeing Service Steering board to see if any of the members had any ideas and resources to aid in further enrichment activity. It proved to be a very favourable meeting with several people coming forward with offers to help.

We have started working with the intergenerational project (health improvement team) linking care homes with schools for mutually beneficial activities; it is starting with a pilot at one of the care homes we have suggested and a school the health improvement team have approached. Furthermore, the health improvement team have offered to work with two of the care homes, that have residents with some of the most challenging needs, to provide

some training to the staff on activities and/or to provide some resilience training for the staff.

We will be looking to find further activity solutions for the care homes as this seems to be the area that needs vast improvement. Sadly the activity co-ordinator is often used as a carer when care homes are short staffed and therefore leaving any planned activity abandoned.

4.0 Conclusions

4.1 Next Steps

There are several next steps that need to be implemented to create sustainable solutions for the residents of care homes. Some of the solutions needed are relatively simple changes to current services and practices and other ideal solutions involve proposing new models of care and difficult cultural changes. These are summarised below:-

- Streamline referral process of direct referrals to professionals.
- All residents should have a GP summary detailing past medical history, current problems and medication, providing the residents consent or following the principles of best interest.
- Create a rolling care home training programme, utilising multi agency and disciplinary teams.
- Invest in individual training for some of the care home staff, such as tissue viability, and V150 prescribing, so that they can prescribe dressings, laxatives, Catheter equipment. Although the initial outlay would have some cost, this would be off set by the improved quality and the reduction in community professional time. This would provide the means for the care homes to have further skills to care for their residents. It would reduce the pressure on tissue viability service and the GP's prescribing the dressings. It would also provide recognition and skills for the nursing staff and hopefully improve retention levels. Care home nursing staff should be at a similar skill level to community nursing staff, to be able to care for this very vulnerable population.
- It should be contracted that the nursing homes providing end of life care should have there own Syringe driver and should have on going education and training to support the use.
- Improve communication between Care Home and hospital using standardised patient transfer forms.
- Proactive reviews:
    - Pharmacy, reviewing medication 6-12 monthly.
    - Mental Health; all residents to be reviewed by the mental health team on admission to the care home and yearly.

    - Physical Health; reviewed by a dedicated care home nurse, Physiotherapist O.T. and Doctor on admission to the care home and 6monthly.
- Change the way we consider Care Homes. Ensure that processes that would be put in place for someone in their own home are the same that would put in place in care homes.
- Improve transparency, by ensuring the Care Homes feel comfortable and confident in when and how to seek advice and help.
- Ensure that other adverse incidents such as pressure sores (grade 2 >) are analysed using route cause analysis, so that lessons are learnt and incidences are recorded and reduced.
- Create a more embracive culture between social and healthcare. Utilise meetings such as the, clinical reference group referenced earlier in this report.
- Create meetings, such as the coffee morning to allow care managers to provide support to each other to reduce isolation.
- Encourage registration at one single GP practice.
- Place a larger focus on activities within the home.
- Larger clinical input into the reviews of quality standards within the Care homes.
- The creation of one integrated care home team to liaise between all the agencies and professionals to ensure that the needs of the care home population remain clearly in focus.

4.2 Conclusion

Care homes arguably care for the most vulnerable population in this country. The homes have become marginalised from the relative safety of Social Services and Health. System and cultural changes are needed to ensure that the standards required are achieved. It is no longer an excuse to stand by because they are private companies and hope that the standards are reached. Failure to provide good quality care for an individual is not just an indictment on that care home but a shared failure of the health and social care system that should have provided and ensured the quality of care for that individual. It is anticipated that the developments already undertaken in addition to those outlined will provide Halton with transparent, collaborative, quality services that the vulnerable care home population require and deserve.

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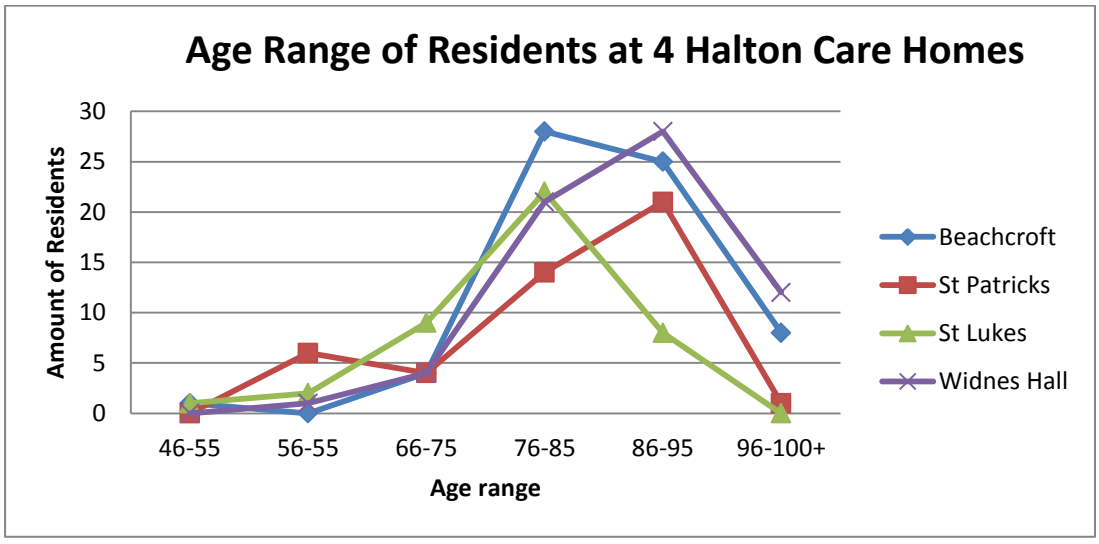
www.northkirkleesccg.nhs.uk/wp-content/uploads/2013/07/Kirklees_homely_remedies_protocol__care_homes_.pdf

Appendix 1: Halton Care Home Demographics.

In Halton 2012 there was estimated to be is 19,600 Older Adult (over 65 years). There is estimated to be a population increase in Older Adults of 33% from 18,600 in 2011 to 24,700 in 2021 (Halton.gov). This also corresponds with a rise in life limiting illness in this population from 10,782 in 2012 to 13,300 in 2020 (poppi). Care Home provision is not spread equally across the area Widnes has 67% and Runcorn 33%. In Halton there are 716 beds, in 16 care homes there are approximately 8% of beds that are vacant each week. This breaks down into categories depending on the needs of the population, Residential beds 297 Nursing 84 and Dementia/EMI (Residential and Nursing) 412 these are approximations as some of the beds are interchangeable depending on the individual need of the person.

There are 12 providers that serve the Care home population these are:

Company Name	Number of Care Homes in Halton	Number of Beds
CIC	2	88
HC-One LTD	3	157
Minster Group	1	41
Hill Care	2	122
Madeline McKenna	1	23
Four Seasons	1	44
Ideal Care homes	1	66
Cartref	1	24
Ryan Care	1	15
Lily Cross	1	60
Trewan House	1	44
Norton lodge	1	32



Appendix 2: Results from care home managers questionnaire regarding services that they receive into the home.

Name of Service	St Luke's Care Home	Widnes Hall Care Home	Beechcroft Care Home	St Patrick's Care Home
Dietitian	Referrals usually via GP, usually very good	Fax, GP, Telephone, usually good		Fax form to dept. - Usually good reponse time
Falls Team	Referrals usually made via the phone or fax, usually very good	Fax, GP, Telephone, usually good		Fax form to dept. - Usually good reponse time
SALT	Referrals usually made via fax/phone, no problems	GP referral usually good		Fax form to dept. - Usually good reponse time
GP-general	Calls via telephone vary from good to very poor	Usually good		Telephone rquest usually same day
GP - review on admission to home	Calls via telephone vary from good to very poor	Average		Telephone rquest usually same day
GP review on discharge from hospital	Calls via telephone, review usually within one week	Average		Telephone rquest usually same day
Equipment	Do Not Request Equipment	Equipment good		Purchase own equipment, no problems
Mental Health	Phone, referral via fax, GP, generally good response	Usually good		Telephone request response variable due to case worker
Social Worker	Phone, referral via fax, GP, can vary depending on Social Worker availability	Average		Telephone request response variable due to case worker
Support/Care plan	Completed in house, or can come after admission			Named nurse responsilble and action taken
Out of Hours	Phone - out of hours GP form, can vary up to 3 hours plus	Average	`	Telephone request, can be a time lapse before visit
Hospice	Phone/email, response time very good	Not applicable		Not used at pesent
CHC	Phone/email	Usually good		Telephone request, variable response time
OT	Via GP or Kate Dutton if required	Via GP, variable		Requested by GP, usually good response time
Physio	Via GP or Kate Dutton if required	Via GP, variable		Requested by GP, usually good response time
Pharmacy	Phone/fax, generally quite good	Usually good		Requested by GP, usually good response time
Other - Continence Service	Phone, fax/email, varies due to re-faxing because of fax problems			Fax referral, can take up to six weeks
Are you aware of:	**Record use i.e. often, sometimes, now aware of them**	**If no why not? What are the barriers? Do you use an alternative?**		
Frat/Frac	Aware but have our own forms	Aware but use own policy		Not aware
Oral assessment tool	Aware but have our own forms	Aware but use own policy		Forms part of pre-admission plan
MUST	Yes in use - Generally done monthly or if required sooner will be done e.g. some residents on fortnightly weights.	Yes, routinely		Yes - Weekly or monthly depending on the score
Waterlow	Yes in use - Generally done monthly or if required sooner will be done e.g. some residents on fortnightly weights.	Yes, routinely		Yes - Weekly or monthly depending on the score
LCP	Yes - working to GSF as required	Yes - working to GSF as required		Yes - GP ,family members, and staff involved
Any other comments				
Do you refer all Falls to CQC? Evidence	No - only those as per CQC guidelines	Witnessed falls are recorded		No only those with srious injuries as per CQC guidelines
Do patients on 4 or more meds. get a review?	Residents meds. are reviewed but not all residents are reviewed routinely.	Occasionally		Meds are under constant review by MHT
Falls register - what does it capture	Unit, time and type of accident/incident			When and how and preventative actions
Audit of 999's - actions?	None undertaken	In place		Audited
Records of incidents reported to safeguarding.	Always recorded	Monthly		All incidents are recorded and logged with CIC quality

Appendix 3: Feedback from the training day.

MUST, Waterlow and Documentation training - Thursday 10th October 2013							
1. Poor 2. Below Average 3.Satisfactory 4. Good 5. Excellent							
MORNING SESSION						**TOTALS**	
	1	2	3	4	5		
ENVIRONMENT	NIL	NIL	10	20	1	31	
CONTENT	NIL	NIL	13	21	2	**36**	
RELEVANCE	NIL	NIL	11	18	6	**35**	
AFTERNOON SESSION							
	1	2	3	4	5		
ENVIRONMENT	NIL	NIL	6	11	10	27	
CONTENT	NIL	NIL	2	12	12	26	
RELEVANCE	NIL	NIL	2	12	8	22	
GENERAL COMMENTS							
1. Handouts?							
2. Very good has been interesting							
3. Too much reading from slides							
4. Very repetitive							
5.Too much to take in							
6. Lots of jargon							
7. Funny in parts -enjoyed it							
8. Interesting better with handouts							
9. Very interesting							
10. Learnt more and feel more confident							
11. Very interesting and useful - Thankyou							
12. Very well presented/ very useful							
13. Could have shown comparison of pressure ulcers							
14. Very interesting							
15 Very well presented							

28/11/13 Falls and Safeguarding					
1 poor- 5 excellent					
	1	2	3	4	5
How did you rate the overall venue?			4	7	12
How did you rate the overall presentation?			1	6	16
How accessible was this presentation to you?			1	3	19
How did you rate the experience, knowledge and skills of the presenter?				2	21
How did the presentation suit your learning needs?			1	5	17

Very Interesting
Very well presented and informative
Very good presentation
Very well presented key points were given and explained well in a short time.
I enjoyed Paula's session it is very important to remember any vulnerable adult can be at risk of abuse in any form financial, sexual emotional ect

Appendix 4

Case Study

The team was requested to review this lady by a social worker, who was concerned that Mrs A had lost weight.

The care home reported that she was very withdrawn and spent most of the day lay on her bed in her room.

On examination it was found that she had lost 8.4% weight in one month. She stated that she had pain to her sacrum, lower back and hip. This was very painful and not being controlled. These areas were examined and a grade two pressure sore was found to her sacrum which was dressed with a temporary dressing.

The care home had referred her to a dentist as she had painful gums and didn't want to use her dentures the dentist has tried to visit last week but the care home reported that She was busy and unable to see the dentist.

The care home noted that she struggled with diet and therefore were giving her a mashed diet.

The team referred her to:

- GP for pain management and to review weight loss.
- District Nursing Service for wound management and Pressure reliving equipment. Bloods.
- Dietician for weight loss.
- Speech and language to assess swallow and food consistency.
- Dentist.

We requested that the Care Home provided an enriched diet and to weigh her weekly.

Discussing with the GP surgery it was also noted that she had had two previous pelvic fractures following a fall therefore, a referral to the fall prevention service was all so completed. The GP surgery also noted that a pelvic mass has been found but as she had moved out of the area for a short time before moving back in. The referral to the consultant and follow up appointments had been lost. Therefore the GP followed up on this.

Appendix 5: Report from the specialist Occupational Therapist.

Bridgewater Community Healthcare NHS
NHS Trust

Halton and St Helens Division
Occupational Therapy for Assistive Technology

Occupational Therapist Report

Report on a joint visit with Jenny Theodore and Donna Pickavance to St Patricks Nursing Home, Crow Wood Lane, Widnes on 7th August 2013.
Reason for visit: To provide advice and information on suitable slings for residents who have slings left in situ.

St Patricks has a number of residents requiring hoisting who remain sitting on their slings in specialist seating during the day. Not all slings are suitable for leaving in situ, and could be detrimental to the user's skin integrity and comfort. Slings designed to be left in the chair are made of either a very fine soft fabric like parachute silk or a 'comfort' fabric which is soft, breathable and has a 2 way stretch so that it moulds around the user and does not wrinkle into stiff folds. These slings are often called 'All-day slings' or 'in-seat slings' Polyester slings are not ideal to leave in situ as the fabric is not breathable and the user can become very hot and sweaty. They ruckle up easily into uncomfortable folds, causing discomfort and risk of pressure areas. Mesh slings are usually used when bathing and showering. They are breathable so are slightly better than the polyester for leaving in situ, but still ruckle and cause discomfort.

A brief visual check was made of the residents in the Ashley Unit who were sitting on slings. The majority of residents were sitting on general purpose polyester or mesh slings, some of which were very worn and should be replaced. We saw one person sitting on a parachute silk sling.

We also looked at the information contained in the Moving and Handling Risk Assessments. Although they specified the hoist and the size of sling, they contained few other details to ensure the correct equipment and techniques were used. E.g. did not specify the type of sling, which loops to use, whether it is left in situ or removed.

Recommendations:
Ideally, all slings left under residents whilst in their chairs should be designed for this purpose. As it is not feasible to replace all the slings currently in use, more specific individual risk assessments would identify those at highest risk of injury or discomfort and detail the appropriate equipment and techniques to use to reduce risks to an acceptable level.

I recommend that the worn slings are replaced immediately with more suitable 'all day' slings, then the remaining slings replaced as appropriate when possible. As 'All-day' slings will be more comfortable and supportive, they may cause less distress when hoisting for some of the residents.

Helen Reed, Dip COT,
Occupational Therapist, Halton Independent Living Centre.

Appendix 6:Audit for care homes regarding transfer and discharge information.

Audit Data for Care home pilot October 2013

How many admissions to Warrington Hospital in October?
How many residents were discharged from Warrington hospital in October?
How many residents, in October, went with transfer records to Warrington Hospital?
How many residents that went in to Warrington Hospital October, have not been discharged?
How many discharged in October, form Warrington Hospital were admitted in a previous month?
How many discharges, in October, from Warrington Hospital, did you receive written information for, when the resident returned home?
How many discharge information contained all the essential information?
Did you have to make any phone call to the hospital to gather more information?
If phone calls were needed, how many phone calls did you make?
How many admissions were generated by a GP?
How many emergency admissions?
Numbers of rapid discharges?
In those residents that were admitted in October, to Warrington Hospital, how many had a previous admission in the preceding 4 weeks?

REPORT TO:	Health Policy & Performance Board
DATE:	17 June 2014
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Health Policy and Performance Board Annual Report : 2013/14
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health Policy and Performance Board's Annual Report for April 2013 - March 2014.

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

3.0 **SUPPORTING INFORMATION**

3.1 During 2013/14, the Health Policy and Performance Board has examined in detail 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 associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with 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 2013 - March 2014

As Chair of the Health Policy and Performance Board (PPB), I am conscious of the massive changes that have taken place in how we receive our Health Services over the past few years. The remit of the Board is to scrutinise the Health and Social Care Services provided to the residents of the Borough; we also have a responsibility to scrutinise Hospital Services, including Mental Health Services.

We receive reports on a regular basis from all those who provide services to our residents and as a Board we take the opportunity to scrutinise the services provided by such providers as Warrington and Halton Hospitals Foundation NHS Trust, St Helens and Knowsley Teaching Hospitals NHS Trust and the 5 Borough's Partnership.

We take our responsibilities very seriously and as such choose at least one Scrutiny Topic to focus on each Municipal year.

This year, our Scrutiny Topic was focused on Mental Health. We undertook this work with a view that the outcome would be to promote more emphasis on prevention and more importantly we were looking to help develop a policy of 'No Stigma for Mental Health Illness' within Halton.

In order to progress this work effectively, we formed a joint scrutiny group looking into Mental Health Services i.e. the Health PPB and Children, Young People and Families PPB; two Policy Boards working successfully together.

My appreciation for all the hard work done on this Topic must go to Councillors Joan Lowe, Mark Dennett, Geoff Logan, Sandra Baker, Pamela Wallace, Margaret Horabin, Pauline Sinnott, Geoff Zygadllo and Kath Loftus. My thanks also goes to Pauline Hignett, from the Children, Young People and Families PPB, who joined

myself and Margaret Horabin in visiting the schools where we provide education services for Children with Autism related problems.

A big thank you must also go to Emma Bragger, our Policy Officer on the topic group, for all the work and many extra hours spent on this project and I would also like to extend my thanks to Partners for their time and for the contributions they made to this work.

I would like to extend my thanks to NHS Halton Clinical Commissioning Group too, for their support and involvement with the Health PPB this year and to Dave Sweeney, Operational Director Integration for his support on the Mental Health Scrutiny Topic.

As usual, 2013/14 has proved to have been a very busy, challenging and interesting time for us all.

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

During 2013/14, John Chiocchi was Halton Healthwatch's co-opted representation on the Board and we would like to thank John for his valuable contribution. John has now left the Board and has been replaced by Tom Baker.

The Lead Officer for the Board is Sue Wallace-Bonner, Operational Director, Prevention and Assessment - Communities Directorate.

Responsibility:

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 2013/14. 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 2013/14.

GOVERNMENT POLICY- NHS AND SOCIAL CARE REFORM

NHS Halton Clinical Commissioning Group (CCG)

As part of NHS Halton CCG's authorisation requirements, Simon Banks, Chief Officer of the CCG, presented the Board with the CCG's Integrated Commissioning Strategy for 2013-15 and their Operational Delivery Plan for 2013-14.

Simon highlighted for the Board that the Strategy and associated Operational Plan was in line with the planning guidance published by NHS England in *Everyone Counts: Planning for Patients 2013/14* (December 2012), the *NHS Outcomes Framework* and the *NHS Mandate*, as well as the CCG's local priorities which had been developed via engagement with local people and GP member practices.

Francis Inquiry

The Board were presented with details of the key findings and recommendations from the second Francis Inquiry (*Francis 2 High Level Enquiry*) following on from the first published in 2009, which detailed 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.

The Board were provided with details of the actions being delivered locally to ensure the quality and safety of health care provision for our local population as a result of Francis and the Board have been receiving subsequent update reports in relation to local activity.

Social Care Bill

The Care Bill outlines the most significant change in Adult Social Care in decades with changes to underpinning legislation, eligibility criteria, funding, changes to the status of Adult Safeguarding and a host of other associated areas which are likely to

impact across all Council Portfolios. New requirements, duties and responsibilities will be implemented from April 2015 with full implementation planned for April 2016.

The Board have been kept informed of developments so far and will continue to be kept informed of developments/implications on an on-going basis.

Sector Led Improvement

As the Government have decided to reduce the burden of nationally imposed inspection and assessment regimes, such as the Care Quality Commission's inspection of Adult Social Care and the Comprehensive Area Assessment, a new approach to improvement, being overseen by the Local Government Association and with the support of Government, has been developed; details of which were presented to the Board in September - Sector Led Improvement (SLI).

Details were also provided about how SLI was being specifically developed in the Northwest (NW) region. The approach being adopted in the NW celebrates success and excellence, sharing best practice and provides support and / or intervention from within the sector where needed.

An SLI Local Authority Analysis has recently been undertaken across the North West region and it was reported to the Board that in Halton's Local Authority report, no risks were identified. The Board were pleased to hear that areas of good practice had been noted which includes a good service balance with low reliance on residential care. Halton were also found to have made good progress on personalisation and has a comprehensive approach to early response for service users.

Care Quality Commission (CQC) – Inspection Processes

Over the past twelve months, the Board have received updates in relation to the changes undertaken by CQC in how they inspect acute trusts, mental health hospitals and community services.

The new inspection regime involves significantly larger inspection teams which will include clinical and other experts, and trained members of the public.

The teams will spend longer inspecting hospitals and community locations.

In November 2013, the Care Quality Commission (CQC) paid an announced visit to the 5Boroughs Partnership NHS Foundation Trust, to examine the operation and use of the Mental Health Act 1983.

There were some positive overall findings from the inspection which included Community support being described as very good and the ward environments having improved considerably.

There were some issues highlighted for consideration and action and these are being progressed and the Board will be kept informed of how these develop.

SERVICES

Urgent Care

As part of an extensive consultation exercise, in June 2013 Members were presented with details of the options being considered to develop a local response to Urgent Care with Halton. Three options were presented to the Board, with the option of the creation of an additional Walk in Centre plus a Clinical Decision Unit at Halton Hospital Site and the maintenance and expansion of services at the Walk in Centre at Widnes being supported.

It is anticipated that the development of Urgent Care facilities in Halton will provide the following benefits:-

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

It is anticipated that the new facility will be open from September 2014 and the Board is watching this development with keen interest.

5Boroughs Partnership NHS Foundation Trust – Service Redesign

In September 2013, the Board received a presentation from the 5 Boroughs Partnership updating the Board with regards to the local progress being made in implementing two service developments within the Trust: the Later Life and Memory Service (LLAMS) and the Acute Care Pathway (ACP), since initial details of the developments were presented to the Board back in January 2012.

The ACP was developed specifically for people with significant mental illnesses, and arose because of concerns expressed by patients and carers about the transfers of care between the complex range of community services (inc. GPs) and the hospital. As a result of these concerns, the 5Boroughs took the opportunity to fully review, with their partners, the structure and type of service they deliver, with the ACP as the final outcome.

The LLAMS service is for all older people with memory problems, and provides specialist assessments, treatment and support. This, too, has followed from an internal review of services and subsequent redesign, in full partnership with key stakeholders, including Halton Borough Council (HBC).

Complex Care

On the 1st April 2013, HBC and NHS Halton CCG commenced a Joint Working Agreement for the management of a Pooled Budget between the two organisations

covering spend on service packages in areas such as Adult Social Care, Equipment Services, Intermediate Care and Continuing Healthcare.

The Board were provided with details outlining how the pooling of these funds will ensure high quality, safe, efficient and effective health and social care services which will be commissioned and provided in the most appropriate and timely way, in order to meet the health and social care needs of people in the Borough.

The pooled budget for 2013/14 is approximately £32million and the Board will continue to receive updates in relation to the effects the pooling of resources are having on the outcomes for Service Users.

POLICY

Falls Strategy 2013 - 2018

Following on from the extensive work undertaken by the Falls Scrutiny topic group in 2012/13, in September 2013 HBC's and NHS Halton's CCG joint Falls Strategy was presented to the Board.

Falls continues to be a particular risk in Halton (1 of the 5 priorities identified with Halton's Health and Wellbeing Strategy) due to higher levels of falls in older people, as well as higher levels of hospital admissions due to falls.

The Strategy aims to identify the areas that need to improve in Halton to reduce the number of falls and as such contains a comprehensive action plan to ensure that the Strategy is appropriately implemented.

Safer Halton Partnership Drug Strategy 2014 – 2018

The National Drug Strategy 2010 changed the focus of drug service delivery from maintenance of individual's dependent misusing drugs to enabling and promoting recovery.

Following extensive consultation with a range of partner agencies, service users, carer groups and voluntary agencies, the Board were presented with Halton's Drug Strategy which provides a focus on Halton's strategic objectives and priorities linking them to a drugs service action plan that will become the focus of the work of the Substance Misuse task group with Halton.

Halton – A Place without Loneliness

HBC, for many years, has been at the forefront of initiatives to prevent and alleviate social isolation. However, it was clear that a focus on social isolation alone may not combat the pain of loneliness felt by so many older citizens.

As a result, extensive work has taken place to develop the strategic approach to the prevention of loneliness in Halton; the results of such being presented to the Board in November 2013.

The Board was very pleased to be able to endorse this approach and it was noted that HBC would be one of the first Local Authorities to adopt a strategic approach to combating loneliness.

Halton Dementia Strategy
There can be no doubt about the current and the future challenge posed by dementia.

The revised local dementia strategy, 'Living well with dementia in Halton' looks at the progress that has been made since the original strategy was published in 2010, as well as identifying some key actions that need to be completed over the next 5 years.

The Board endorsed the implementation plan contained within the Strategy which outlines the key actions for future development in improving the outcomes for people with a dementia diagnosis, their families and carers.

Mental Health and Wellbeing Commissioning Strategy for Halton
Mental health problems are the single largest cause of ill health and disability in the Borough. Halton's Health and Wellbeing Board has recognised this by including "Prevention and early detection of mental health conditions" as one of its 5 priorities.

The strategy, Halton's first integrated strategy for Mental Health and Wellbeing in the Borough bringing together commissioning intentions of Public Health, the CCG, Children's Services and Adult Social Care, presented to the Board adopts a life course approach which recognises that the foundations for lifelong wellbeing are already being laid down before birth, and that there is much that can be done to protect and promote wellbeing and resilience through early years, into adulthood and then on into a healthy old age.

The Board recognised that only a sustained approach across the life course will equip Halton to meet the social economic and environmental challenges it faces and deliver the short and long term benefits needed.

Housing Adaptation Policy
As a result of an increase in ramp requests raised with the Contact Centre by residents who had independently purchased mobility scooters, where an Initial Assessment Team assessment of access to the residential property had not been undertaken, in November the Board received a report and associated proposed amendments to the ramps section of the Housing Adaptation Policy.

The revisions now provide clarification on eligibility for ramp installation and make it easier for the Contact Centre to make initial decisions on people's potential eligibility.

SCRUTINY REVIEWS

Mental Health

Halton identifies good mental health as a priority and as such sought to examine the breadth and quality of mental health promotion and prevention services and resources available locally, with a view to developing a joint intergenerational prevention and promotion campaign to tackle mental health stigma locally. The scrutiny topic was commissioned by the Health Policy and Performance Board and representatives from the Children, Young People and Families PPB. Mental health promotion was a specific area selected as there were already significant pieces of work being undertaken, in relation to mental health treatment services. These included 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.

National and local evidence demonstrates that failure to ensure that appropriate services to support emotional and mental health and wellbeing is likely to impact negatively on outcomes and life chances. Failure to provide effective mental health prevention and promotion services across the life course could result in an increase in the need for specialist services thus leading to potentially increased costs to the Council.

The Topic Group were instrumental in the development of a local anti-stigma campaign, Like Minds (http://www.haltonlikeminds.co.uk/) which takes the stories of local people's journey through mental health, providing links to a range of local support services. The campaign was launched in October 2013 and the campaign resources are now available for use by any organisation to use at events or meetings, to facilitate debate around mental health.

PERFORMANCE

During the course of the year the Board received priority based quarterly monitoring reports and was 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:

- Provider Quality Accounts;
- Adult Social Care Annual Report 2012/13;
- Adult Social Care Customer Care Annual Report 2012/13; and
- Public Health Annual Report 2012.

WORK TOPICS FOR 2014/15:

Care at Home Provision in Halton

As people get older, they are increasingly likely to need care at home.

In 2010/11, nationally an estimated 543,000 service users received home care of which 81 percent were aged 65 and over,[1] and as our population ages, more people will inevitably need care at home in the future.

This topic will focus on the quality of Services provided to those who are supported to live at home within Halton. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population. In addition, the topic group will examine the access to other services e.g. Health Services that individuals supported to live at home have.

Cancer Services

It is anticipated that the Board will become involved in joint scrutiny arrangements with other Local Authorities across the North West during 2014/15, regarding proposed changes in respect of Cancer Service provision across the Region.

At the time of writing this report, the Board are still waiting for further details from the Clatterbridge Cancer Centre NHS Foundation Trusts regarding the proposals.

Report prepared by Louise Wilson, Development Manager – Urgent and Integrated Care, Communities Directorate

Email: louise.wilson@halton.gov.uk Tel: 0151 511 8861

[1] Health and Social Care Information Centre - Community Care Statistics 2010-11: Social Services Activity Report, England (2012)

REPORT TO: Health Policy & Performance Board

DATE: 17 June 2014

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Scrutiny Topic 2014/15 : Care at Home Provision in Halton

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To present the Board with details of the Care at Home Provision Scrutiny topic as outlined in the attached topic brief.

2.0 **RECOMMENDATION**

RECOMMENDED: That the Board

i) Note contents of the report;
ii) Approve the Topic Brief outlined at Appendix 1; and
iii) Nominate Members of the Board to form part of the Scrutiny Topic Working Group

3.0 **SUPPORTING INFORMATION**

3.1 As people get older, they are increasingly likely to need care at home.

In 2010/11, nationally an estimated 543,000 service users received home care of which 81 percent were aged 65 and over, and as our population ages, more people will inevitably need care at home in the future.

Within Halton, the older people age group (65+) are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025.

3.2 This topic will focus on the quality of Services provided to those who are supported to live at home within Halton. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population. In addition the topic group will examine the access to other services e.g. Health Services that individuals supported to live at home have.

3.3 Subject to agreement by Board to accept the topic brief; this report seeks nominations from members of the Board to form a member led scrutiny working group.

4.0 **POLICY IMPLICATIONS**

4.1 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.

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**
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 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.

TOPIC BRIEF

Topic Title: Care at Home Provision in Halton

Officer Lead: Marie Lynch – Divisional Manager

Planned Start Date: July 2014

Target PPB Meeting: March 2015

Topic Description and Scope:

This topic will focus on the quality of Services provided to those who are supported to live at home within Halton. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population. In addition the topic group will examine the access to other services e.g. Health Services that individuals supported to live at home have.

Why this topic was chosen:

As people get older, they are increasingly likely to need care at home.

In 2010/11, nationally an estimated 543,000 service users received home care of which 81 percent were aged 65 and over,[1] and as our population ages, more people will inevitably need care at home in the future.

In terms of increases in the number and proportion of older people in the UK population, the percentage of persons aged 65 and over increased from 15 per cent in 1985 to 17 per cent in 2010, an increase of 1.7 million people. By 2035 it is projected that those aged 65 and over will account for 23 per cent of the total population.[2]

Within Halton, the older people age group (65+) are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025.[3]

Nationally, Councils with Adult Social Services responsibilities purchased or provided 200 million contact hours of home care during 2010-11, an increase of 13 per cent on 2005-06 and the percentage of contact hours provided by the independent sector (private and voluntary sectors) has been steadily increasing over the past few years, with 72% of hours being provided back in 2005-06 to 87% being provided in 2010-11.[4]

Studies show that older people would prefer to stay at home until it is impossible for them to do so rather than move into residential care and that the benefits of home care are enormous, both to individuals and to the state. Home care provision also costs less than a place in residential or nursing care. In 2008-09 the average weekly cost to local authorities for an older

[1] Health and Social Care Information Centre - Community Care Statistics 2010-11: Social Services Activity Report, England (2012)

[2] Office of National Statistics (ONS) - Population Ageing in the United Kingdom, its Constituent Countries and the European Union (2012)

[3] ONS - Population Projections 2010

[4] Health and Social Care Information Centre - Community Care Statistics 2010-11: Social Services Activity Report, England (2012)

person in residential and nursing care was £497. In contrast, the average weekly cost of home care was £145.[5]

Key outputs and outcomes sought:

- An understanding of existing Care at Home provision in Halton.
- An understanding of the role that partner agencies play in the provision of care provided to those living at home.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to services to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.

Which of Halton's 5 strategic this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member led scrutiny review of Care at Home provision.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council/Health Services, partner agencies and contracted providers to examine current provision.
- Desk top research in relation to national best and evidence based practice.

Agreed and signed by:

PPB chair ……. **Officer …….**

Date ……. **Date …….**

[5] Equality and Human Rights Commission - Close to Home : An inquiry into older people and human rights in home care (2011)