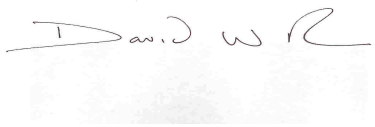
Public Document Pack

Health Policy and Performance Board

Tuesday, 9 June 2015 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Joan Lowe (Chairman)	**Labour**
Councillor Stan Hill (Vice-Chairman)	**Labour**
Councillor Sandra Baker	**Labour**
Councillor Mark Dennett	**Labour**
Councillor Charlotte Gerrard	**Labour**
Councillor Margaret Horabin	**Labour**
Councillor Martha Lloyd Jones	**Labour**
Councillor Shaun Osborne	**Labour**
Councillor Carol Plumpton Walsh	**Labour**
Councillor Pauline Sinnott	**Labour**
Councillor Pamela Wallace	**Labour**
Mr T Baker	**Co-optee (Healthwatch)**

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, 8 September 2015

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

Part I

Item No.			Page No.
1.	**MINUTES**		
2.	**DECLARATIONS OF INTERESTS (INCLUDING PARTY WHIP DECLARATIONS)** Members are reminded of their responsibility to declare any Disclosable Pecuniary Interest or Other Disclosable Interest which they have in any item of business on the agenda, no later than when that item is reached or as soon as the interest becomes apparent and, with Disclosable Pecuniary interests, to leave the meeting during any discussion or voting on the item.		
3.	**PUBLIC QUESTION TIME**		**1 - 3**
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In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 9 June 2015

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: 9 June 2015

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 Wellbeing Portfolio which have been considered by the Health & Wellbeing 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, 11 March 2015 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Philbin and Polhill (Chairman) Philbin, Woolfall and P. Cook; M. Creed; B. Dutton; K. Fallon; G. Ferguson; A. Marr; A. McIntyre; E. O'Meara; D. Parr; M. Pickup; N. Rowe; M. Sedgewick; N. Sharpe; R. Strachan; D. Sweeney; L. Thompson; A. Waller; S. Wallace-Bonner and S. Yeoman

Apologies for Absence: Councillor Wright and S. Banks, D. Johnson and D. Lyon.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB43 MINUTES OF LAST MEETING

The Minutes of the meeting held on 14th January 2015 having been circulated were signed as a correct record.

HWB44 PRESENTATION - DELIVERING IMPROVED HEALTH AND WELLBEING THROUGH THE WIDNES VIKINGS RUGBY CLUB - JAMES RULE, WIDNES VIKINGS

The Board received a presentation from Mr James Rule, Chief Executive of the Widnes Vikings, which illustrated how the Vikings were working with the local community and schools to promote health and wellbeing. Members were shown a dvd which highlighted some of the work the Club was carrying out in the community to encourage fitness and healthy eating, involving other agencies such as Halton CCG, Halton Borough Council, schools and Halton Housing Trust and included:

- the recent world record attempt for the most number of people exercising in a fitness video;
- raising the profile of prostate cancer;
- fit for Life programme;
- launch of a new rugby shirt for Magic Weekend which will be held in Newcastle to raise money for the

Bobby Robson Foundation; and
- tackling Cyber bullying.

Mr Rule advised the Board that Widnes Vikings had received recognition for its work with the community by receiving the Super League Club of 2014 award.

Members were advised that a future initiative being explored by the Club included providing health checks at the Stadium for men aged between 40-60 years.

RESOLVED: That the presentation be noted.

HWB45 GENERAL PRACTICE STRATEGY

The Board considered a report of the Chief Officer, NHS Halton CCG, which advised that, NHS England had stated their ambition for general practice services to operate at greater scale and be at the heart of a wider system of integrated out-of-hospital care. This would require a shift of resources from acute to out-of-hospital care. These ambitions were congruent with NHS Halton CCG's 2 Year Operational Plan and 5 Year Strategy and also with the Better Care Fund delivery plan developed with Halton Borough Council.

Members' were advised that NHS Halton CCG had submitted a formal expression of interest to undertake co-commissioning arrangements for general practice services in the borough to NHS England and was awaiting a response. If approval was received, from 1st April 2015, responsibility for the commissioning of general practice services in the borough would be delegated to NHS Halton CCG. It was noted that NHS Halton had worked with general practice and other partners in the borough to develop a Co-Commissioning Strategy for General Practice Services in Halton.

In addition, it was noted that the final draft of the Strategy for General Practice Services in Halton would be presented for ratification to the NHS Halton CCG Governing Body on 5th March 2015. A copy of the strategy had been previously circulated to Members. It was anticipated that the strategy would impact on how general practice services, and/or out of hospital services in the borough, were commissioned and delivered.

The Board discussed the national shortfall of GP's and the work that was being carried out with the Royal College and locally with the Cheshire and Merseyside Local

Workforce Group to address the issue.

It was noted that a presentation entitled 'One Halton' would be brought to a future meeting of the Board. | Chief Officer NHS Halton CCG

RESOLVED: That the Board note the report and accompanying documentation.

HWB46 HEALTHY HALTON PERFORMANCE REPORT Q3 2014/15 & HEALTH AND WELLBEING PRIORITIES 2015/16

The Board considered a report of the Director of Public Health, which presented the progress of key performance indicators, milestones and targets relating to Health in Quarter 3 of 2014/15. The report also set out information relating to the Annual Review of Health and Wellbeing Strategy priorities. In 2013 the Board agreed the Health and Wellbeing Strategy for 2013-16 which outlined the following five key priority areas:

- prevention and early detection of cancer;
- improved child development;
- reduction in the number of falls in adults;
- reduction in harm from alcohol; and
- prevention and early detection of mental health conditions.

Whilst these priorities were agreed for 2013-16, the Board agreed to conduct a brief Annual Review to ensure that they were still fit for purpose. The first review took place in April 2014 as part of a public consultation event. The event concluded that the five priorities were still relevant and that work should continue under each of the five priority action plans. The Board were requested to consider if the five priorities continued to be fit for purpose for 2015/16.

RESOLVED: That

1. Quarter 3 Priority based report be received; and

2. the Health and Wellbeing Board priorities, as set out in the report, were agreed to be still relevant for 2015/16.

HWB47 BETTER CARE FUND

The Board considered a report of the Halton CCG, which sought approval on the changes to the original targeted reduction in 2015 Non-elective activity as submitted

in the Halton Better Care Fund (BCF) Plan. It was noted that one of the schemes embedded within the BCF which would have provided a significant amount of this reduction was the development of the Urgent Care Centres. However, the delays in opening the Widnes site and analysis of the initial Quarter 4 data suggested that the reduction expected in 2014/15 would not take place and non-elective activity would be similar to 2013/15.

It was noted that the impact of missing the target for 2015 had already been factored into the CCG budget for 2014/15 there was no impact on the 2015/16 budget.

In addition, the Board noted a letter from NHS England which advised that the resubmitted BCF Plan had been classified as 'Approved'.

RESOLVED: That the Board note the positive assurances of BCF (see Appendix 1) and approve the reduced planned reduction in non-elective activity to meet NHSE Governance and Timescales (see Appendix 2).

HWB48 PREGNANCY AND ALCOHOL SOCIAL MARKETING CAMPAIGN

The Board considered a report of the Director of Public Health, which sought to highlight a new social marketing campaign to educate women of the harm that drinking alcohol in pregnancy could cause, in order to reduce alcohol related harm to the unborn baby. It was reported that each year in Halton:

- around 1600 women became pregnant;
- of these women around 1300 (80%) were drinking before pregnancy; and
- of these women around 800 (60%) would give up drinking during pregnancy

Members were advised that current activity in Halton to reduce alcohol consumption during pregnancy included:

- all pregnant women were advised of safe drinking guidelines;
- Halton midwives and health visitors had been trained in the early identification and support of pregnant women who misused alcohol. This included when and how to refer to local treatment services; and
- there was the dedicated Alcohol and Substance Misuse Liaison Midwife who co-ordinated anti- natal care services for pregnant women identified as

misusing alcohol.

In addition the Halton Alcohol Strategy (2014-19) identified the need to improve general awareness and understanding of safe drinking levels during pregnancy. The Action Plan recommended developing an awareness campaign aimed at the general population to increase awareness of the danger of drinking during pregnancy. Following baseline research, the campaign was launched at the end of February, with a big bang outdoor media approach with billboards, supermarket posters at entrances, bus sides and internals.

The campaign also included social media advertising and messaging using the #boozefreebump to use on all social media communications. Further, midwives would use a new information leaflet, to provide more information to pregnant women when they book in with the midwife and at early bird and anti-natal sessions. Posters and fliers would also be distributed to all GP surgeries and in community locations across the borough.

The campaign would be evaluated by further work with the targeted audiences in July 2015; this would be compared to the previous work to establish changes in attitude/behaviour. Alongside this a sample of women would be identified at booking in stage and followed through to birth to establish attitude and behaviour change after exposure to the campaign messages.

RESOLVED: That the Board support the campaign aims:

- To bring about a change in attitude and behaviour, towards drinking alcohol in pregnancy; and

- To reduce the risk to the unborn baby due to drinking alcohol in pregnancy, and subsequently improve child development.

HWB49 HALTON BOROUGH COUNCIL AND NHS HALTON CLINICAL COMMISSIONING GROUP: REVISED JOINT WORKING AGREEMENT

The Board considered a report of the Strategic Director, Communities, which sought approval for the revised Joint Working Agreement between Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (CCG), which now incorporated the Better Care Fund for 2015/16. During 2014, partners within Halton worked

collaboratively, within the national guidance and framework to develop Halton's Better Care Fund. It was agreed that the Better Care Fund should be incorporated into the existing pooled budget arrangements between HBC and NHS Halton CCG.

The Board had previously approved Halton's Better Care Fund Plan in January 2015. It was noted that the Joint Working Agreement had now been revised to reflect the following changes:

- the Complex Care Board was renamed the Better Care Board;

- the Executive Commissioning Board was renamed the Better Care Executive Commissioning Board; and

- the budget schedule for 2015/16 had been revised to incorporate the addition of Better Care Fund allocation for 2015/16

RESOLVED: That

1. the contents of the report be noted; and

2. the revised Joint Working Agreement attached to Appendix 1 be approved.

HWB50 MATTERS ARISING

The Board was advised that there had been recent incidents involving members of the public waiting over 50 minutes for an ambulance to arrive in an emergency. It was agreed that on behalf of the Board a letter would be sent to the Ambulance Service expressing concern at the recent delays in providing an ambulance in an emergency. Cllr Polhill

On behalf of the Board, the Chairman thanked Kate Fallon for her service and wished her well for her future retirement.

Meeting ended at 3.25 p.m.

REPORT TO:	Health Policy & Performance Board
DATE:	Tuesday 9 June 2015
REPORTING OFFICER:	Chief Officer, NHS Halton Clinical Commissioning Group (CCG)
SUBJECT:	To share engagement and involvement work of NHS Halton CCG; and joint involvement with HBC and partners in gaining views from local communities.
PORTFOLIO:	Health & Wellbeing
WARD(S)	Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To share the range of engagement we are undertaking and how we are using local people's views to influence commissioning decisions and to highlight good practice and joint working in engagement and consultation

2.0 **RECOMMENDATION**

RECOMMENDED: That the report and presentation be noted.

3.0 **SUPPORTING INFORMATION**

3.1 NHS Halton CCG is committed and has a duty to engage widely with local people to ensure that we commission services in line with local peoples need. Promoting opportunities, wellbeing and good health for people locally is a key target within the Joint Strategic Needs Assessment and NHS Halton CCG 2 year plan and 5 year strategy. This update report provides an overview of just some of the projects and programmes to continually engage people locally both in their own health and the work of NHS Halton CCG and partners over the last financial year 2014/2015.

3.2 A Presentation of events and projects is attached to the report.

4.0 **POLICY IMPLICATIONS**

4.1 In line with NHS Halton CCG's Consultation and Engagement Strategy. Engagement events are co-designed with support and advice through local volunteers on the Halton People's Health Forum Steering Group. Governance is maintained in line with legal and best practice guidance within the terms of reference belonging

to the joint Consultation Steering Group

5.0 **SAFEGUARDING IMPLICATIONS**

None

6.0 **FINANCIAL/RESOURCE IMPLICATIONS**

6.1 Within Halton CCG resources.

7.0 **OTHER IMPLICATIONS**

7.1 None

8.0 **RISK ANALYSIS**

8.1 Need to ensure Halton people's voices and experiences are heard

9.0 **EQUALITY AND DIVERSITY ISSUES**

9.1 It has not been appropriate, at this stage, to complete a Equality Impact Assessment (EIA)

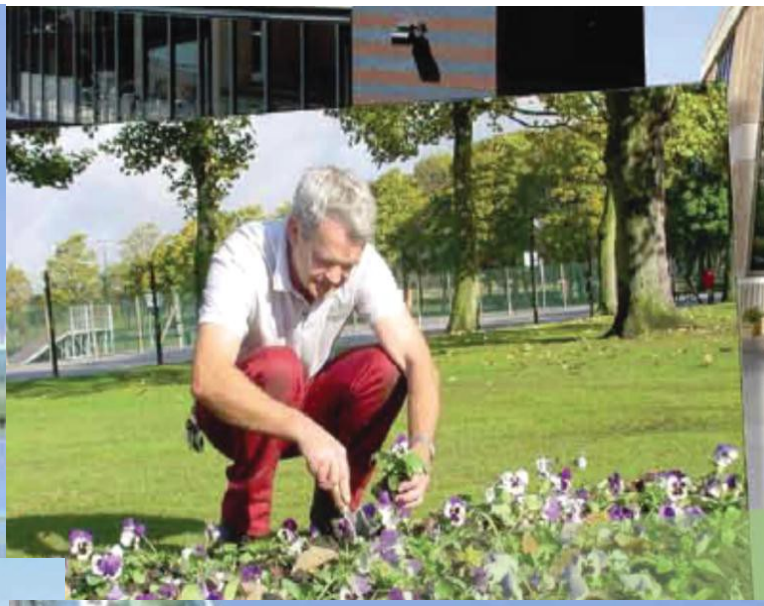
10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None under the Meaning of the Act

Halton Clinical Commissioning Group

Consultation and Engagement Strategy 2015-2016

Reviewed January 2015



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1. Introduction

NHS Halton Clinical Commissioning Group (CCG) represents each of the 17 GP Practices in the borough of Halton.

The CCG is responsible for planning NHS care in Halton, working with local health care providers to ensure that services meet the needs of all our patients.

In April 2013, the CCG became the new statutory body responsible for the local health budget. The CCG is clinically led by GPs and other healthcare professionals. It is formed and built on a membership model, with the aim of ensuring high quality, cost effective services within a sustainable healthcare system.

NHS Halton CCG is committed to engaging widely with local people to ensure that we commission services in line with local peoples need. Promoting opportunities, wellbeing and good health for people locally is a key target within the Joint Strategic Needs Assessment and the CCG 2 year operational plan and 5 year strategy.

2. Our Vision and Values

As an organisation we recognise that it is essential that we develop our Vision and Values, and share these with our key stakeholders, which include our staff, member practices and the public.

During out first Commissioning Event in February 2012 we commenced consultation with key stakeholders and the public on our Vision and Values, which resulted in an overarching Vision of:

"To involve everybody in improving the health and well-being of the people of Halton"

This Vision is supported by our set of Values which are:

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

Openness: We will undertake to deliver all business within the public domain unless there is a legitimate reason for us not to do so.

Caring: We will place local people, patients, carers and their families at the heart of everything we do.

Honesty: We will be clear in what we are able to do and what we are not able to do as a commissioning organisation.

Leadership: We will be role models and champions for health in the local community.

Quality: We will commission the services we ourselves would want to access.

Transformation: We will work to deliver improvement and real change in care.

3. Our Approach to Consultation and Engagement

The 2010 NHS White Paper "Liberating the NHS" signalled significant change for the NHS and detailed at the very heart of the strategy is the importance of public involvement with the emphasis being on "No decision about me without me".

The statutory guidance supports two distinct new legal duties on NHS Commissioners as defined in the Health and Social Care Act 2012. NHS Halton CCG remain committed to working with local people, finding out what the local people think and involving them in planning local health services. The duty to involve the public under section 242 of the NHS Act raised the bar for the way NHS organisations are expected to consult and engage with people and respond to the feedback received. The Health and Social Care Act 2012 strengthens this expectation

Section 242 of the National Health Service Act 2006 places a duty on NHS Trusts, CCG's and NHS England to make arrangements to involve and consult patients. This duty strengthens accountability to local communities, speeds up change and creates a more patient responsive service.

The consultation for NHS Halton CCG requires evidence of "meaningful engagement with patients, carers and communities". This means that the CCG must show how it ensures inclusion of patients, carers, public, communities of interest and geography, health and wellbeing boards and local authorities and how the views of individual patients and practice populations are translated into commissioning intelligence and shared decision-making.

Definition

There is no one definition of consultation, but in essence it means the act of asking a person or group for their views on a proposal or issue before a decision is taken.

In this Strategy the CCG has taken a broad view of what should be included.

The first is for commissioners to promote the involvement of patients, carers and members of the public in planning, managing and making decisions about their own care and treatment (Individual Involvement) through:

- **Friends and Family Test (FFT)** - For example, the capture, collation and analysis of patient experience insight including FFT.
- **Information for patients** – For example, ensuring targeted support to enable patients to be more in control of their health.

- **Personalised care planning** - For example, when a person is eligible, having the option of a personal health budget.

- **Shared decision making** - For example, involvement in decisions about individual episodes of care and/or longer term care.
- **Self-care and self-management** - For example, providing support to better manage health and prevent illness.

The second relevant statutory duty in the Health and Social Care Act 2012 covers public involvement in terms of (Collective Involvement)

- **Planning of commissioning arrangements** - For example, local commissioning intentions, which will need to include consideration of allocation of resources, review on current needs assessment and involvement to inform service specifications.
- **Development of proposals for change** - For example, major service reconfigurations, service redesign, pathway remodelling and local level service changes.
- **Decisions affecting the operation of commissioning arrangements** - For example, changes to the way the CCG delivers its function.

NHS Patient Experience Framework

In October 2011, the then NHS Commissioning Board agreed on a working definition of patient experience to guide the measurement of patient experience across the NHS. This framework outlines those elements which are critical to the patients' experience of NHS Services;

- Respect for patient-centred values, preferences, and expressed needs, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making
- Coordination and integration of care across the health and social care system;
- Information, communication, and education on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion
- Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings

- Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances
- Welcoming the involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers
- Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions
- Access to care with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

This framework is based on a modified version of the Picker Institute Principles of Patient-Centred Care, an evidence based definition of a good patient experience. When using this framework the NHS is required under the Equality Act 2010 to take account of its Public Sector Equality Duty including eliminating discrimination, harassment and victimisation, promoting equality and fostering good relations between people.

NHS Halton CCG has made a firm commitment to not only fulfil the requirements of the NHS Constitution and the 2010 NHS White Paper, but to really embrace the principles of „no decision about me without me", making this a reality for the people of Halton and is determined to develop a culture of openness, transparency and honesty.

This strategy not only reflects the requirements of the NHS constitution and the CCG"s statutory obligations which will be aligned to the recently legislated changes outlined in the 2012 Health and Social Care Act, but goes much further building effective engagement into all the work of NHS Halton CCG.

Patient Experience

Much has been written about the impact of the report from the Francis Inquiry. The failings described in the reports into care delivered by Mid Staffordshire Hospital have brought into sharp focus the need to monitor and manage more rigorously the performance and quality of services delivered and the experience of patients and their families accessing those services.

As commissioners we want to ensure that patients feel that they are included in their care. We know that our providers are committed to providing excellent quality services and look to continuously improve the quality of their services.

NHS Halton CCG fully recognises the importance of patient experience data. NHS Halton CCG will work collaboratively with provider organisations to proactively capture patient experience data and put in place mechanisms to analyse this information so that it can be used to effectively inform the planning and commissioning decisions of the CCG.

NHS Halton CCG will continue to utilise the established Talk2Us patient experience programme which is already widely publicised and provides a means for people to provide their patient experience feedback through a variety of channels. Through this programme the CCG will continue to actively seek patient stories, the experience of patients, either through a pathway of care or a one-off contact.

The monitoring of patient experience however, must go beyond hospital care services and also include community, primary and integrated care service delivery.

Everyone counts, Planning for Patients 2013/14 – section on “Listening to patients” requires:

- Rights for patients set out in the NHS Constitution are delivered
- NHS will move to provide access to routine healthcare services seven days a week
- Real time experience feedback from patients and carers is in place by 2015
- Friends and Family Test identifies whether patients would recommend their hospital to those with whom they are closest.

PALS

The Patient Advice and Liaison Service offers confidential advice, support on information on health related matters. They also provide a point of contact for patients, families and their carers. PALS provide additional help in many ways, which include;

- Advice on health related topics
- Help resolve concerns or problems when using the NHS
- Advice on how to get more involved in healthcare

Collective Engagement through Patient Participation Groups

NHS Halton CCG has been developing its existing mechanisms and expanding its engagement links with patients and the public. GP practice Patient Participation Groups (PPGs) are one of the many ways in which we engage with patients.

NHS Halton CCG has 17 GP practices all of which are active in the recruitment drive for new members of the public to engage with the practice on health related matters.

This model of engagement provides the CCG with feedback through individual PPGs to clearly understand local issues. Each PPG varies in size, how it functions and what activity it undertakes. Each PPG is invited to send patient representatives to participate in Halton People's Health Forum and the PPG Plus where wider collective views are shared and solutions explored.

Halton Peoples Health Forum (HPHF) steering group, which is made up of general public volunteers, come together to support and give direction around public events. All of our public events include representatives from GP practices, local health forums, Halton Healthwatch, community groups, local residents, third sector providers and local councillors. Our plan is to continue to keep this good relationship by using a range of engagement and consultation events to ensure that this work is built upon and that feedback from local people is reflected in the commissioning plans for the future.

3.1 How Patient feedback informs CCG decision making

Listening and Acting on Feedback

Key items from the Halton People's Health Forum and any patient experience data will be collated and reported to the Quality Committee and will scrutinise patient experience data and agree on actions to improve and steer the development of quality improvement across the health economy.

We will work with our providers and colleagues in the third sector to enhance our capabilities around the collection of patient experience feedback and ensure that the data being presented for review at the Quality Committee is well rounded and from a diverse range of clinical areas.

The patient feedback received through the various channels is communicated to:

- Clinicians/local GPs
- Quality Committee
- Governing Body
- Halton Local Authority Health Policy and Performance Board (OSC)

This feedback is then considered and taken into account for future commissioning plans.

3.2 How does the CCG ensure Consultation Governance when Commissioning Services

The structure below illustrates the way in which we gather patient experience data via a range of routes and how this data is utilised in order to influence the CCG decision making process.

The Halton Consultation and Engagement Steering Group ensures that there is an inclusive, integrated and consistent approach to consultation and engagement of Halton's population in the development and implementation of NHS Halton Clinical Commissioning Group's (CCG) commissioning plan and any other work which may require consultation, this will include wider consultation from Cheshire and Merseyside

The Group will provide a level of scrutiny across the consultation and engagement process. The Group will be directly responsible for:

- Producing an annual engagement plan which will be agreed at the start of each financial year (based on NHS Halton CCGs commissioning intention, but also considering all CCG activities) to ensure adequate engagement with patients and the public of Halton in the planning and delivery of health care services.

- Providing expert opinion and direction on the levels of consultation required for each project / commissioning intention and methodology required, including:
    - Intended audience and type/method of consultation
    - Legal requirements
    - Cost
    - Timescales
    - Preparation/planning
    - Expected outcomes

- Ensure all statutory requirements and including the Public Sector Equality Duty are met, including taking 'due regard' for the elimination of unlawful discrimination. Advanced equality of opportunity and fostering good relations.

- Evidence of consultation and engagement is robust, including the recording of information (for example within Halton Hub) and ensuring completion of end of project reports for each finished consultation or engagement activity

Patient experience feeding into NHS Halton CCG governance structure and the Commissioning Plan

4. Consultation and Engagement Objectives

The strategy is built around four key objectives, with clear aims and identified desired outcomes, as detailed below:

Objective One

"To continue to build meaningful engagement with our public, patients and carers to influence the development of services and improve the health and wellbeing of people in Halton"

This will be achieved by:

- Using the most appropriate means of consultations for the specific audience.
- Ensuring the public voice influences and is directly involved in the decisions made by NHS Halton CCG.
- Using a wide variety of methods and innovative approaches to engagement.
- Working closely with „hard to reach" groups to ensure they have a voice.
- Using patient experience data and information to work with provider organisations and patients
- 'Closing the loop' by reporting on the impact of public feedback on NHS Halton CCG's commissioning decisions
- Learning from good practice and tried and tested examples of engagement

Outcomes of this objective:

People in Halton feel they have had the opportunity to give their views and have been involved in the decisions made by the CCG around the development and delivery of local health care services.

Objective Two

"To ensure that the CCG is clearly visible as the leader of the local NHS and to instil confidence, with patients, public, provider and partner organisations in the CCG as an effective commissioning organisation".

This will be achieved by:

- Developing and promoting the profile of NHS Halton CCG
- Developing and maintaining proactive media relations
- Ensuring effective management of reactive media attention

- Ensuring internal and external audiences are aware of CCG developments as well as issues facing NHS Halton CCG
- Providing consistent and timely messages internally and externally to various audiences
- Working collaboratively with partners and other NHS organisations in and around
- The status of the Consultation Steering Group is consultative, and the group will act
    - in an advisory capacity to the CCG. The Consultation Steering Group does not have
    - devolved responsibility but will provide:
        - ✓ Recommendations to the Quality Committee and the Project Lead of the level and type of consultation required. Assurance to the Quality Committee that the CCG is meeting its consultation requirements

Outcomes of this objective:

Stakeholders are confident that NHS Halton CCG has successfully taken the lead, with responsibility for commissioning healthcare services and is operating in the interest of the people of Halton.

Objective Three

"Develop a culture within the CCG that promotes and facilitates open consultation and engagement, with all stakeholders."

This will be achieved by:

- Developing and maintaining proactive media relations
- Developing internal two-way consultation channels with staff and CCG practice members
- Ensuring internal and external audiences are aware of service developments and successes
- Ensuring internal and external audiences are able to feedback information on successes and achievements through accessible routes
- Making language meaningful to staff, public and patients in all consultations
- Ensuring that the CCG Operational Delivery Plan informs and is linked to all of our engagement work.

The outcomes of this objective will be:

CCG Governing Body members, staff and constituent practice members understand their role and what is expected of them in terms of consultation and engagement. They will also have the support they need to ensure effective relations with the media.

There will be good staff retention rates and staff will feel they can express their opinions and judgement and will see that their contribution is valued.

The public feel informed; are aware of how they can feedback to NHS Halton CCG; are confident to discuss issues and that they will be acted upon.

Objective Four

"Continue to develop effective consultation channels to ensure that local people have the information they need to enable them to access the right care at the right time, helping them to look after themselves and improve their health and wellbeing."

This will be achieved by:

- Working with member practices, providers and partners to ensure that public information is accurate and up-to-date
- Working closely with our community groups, including seldom-heard groups to ensure that messages and information are being received and are understood
- Working collaboratively with providers and partners to ensure that messages are consistent and timely
- Ensuring that all information is fully accessible
- Continuously scoping new and innovative ways of communicating, making best use of new technologies and digital consultation
- Regularly testing out the effectiveness of consultations.
- Making language meaningful for staff, public and patients in all consultations.

The outcomes of this objective will be:

The people of Halton will be well informed and will have a good understanding of local services and what is available to them. People will have the information they need to help them to improve their own health and wellbeing. Reduction in inappropriate use of services, reduction in DNA"s and increased use of self-care.

4.1 Action Plan

In order to achieve our objectives, a detailed action plan has been developed. This is currently being developed and will be agreed through the CCG‟s Quality Committee. This action plan will describe the consultation and engagement activity and the resources required over the next three years to ensure that the CCG progresses successfully and becomes a high- performing commissioning organisation. The Halton People's Health Forum will also be key to the development and delivery of the action plan and will be involved directly in the process. The plan will provide clear timescales and will be monitored by the Quality Committee which will provide assurance to the Governing Body.

It should be noted that this will be a working document as it is recognised that we are working in a dynamic environment which is continually changing, therefore the action plan will change and has to be flexible to meet potential changes.

5. Methods – tools, systems and processes

In line with our Equality and Diversity responsibilities, the CCG will ensure that it actively engages with a broad range of local people and community groups, including those people and community groups defined in the Equality Act 2010 as having protected characteristics, which are:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation
- Marriage and Civil Partnership

NHS Halton Clinical Commissioning Group will utilise a mixture of approaches, as detailed below to communicate and actively seek out the views of the people of Halton and we will ensure that our methods are evidence based and work for our intended audiences.

- Events, including partnership engagement events, national events.
- Focus groups
- Community forums
- Meetings (internal and external)
- Workshops strategies, plans, reports and other formal publications
- Written consultations
- Face-to-face, interpersonal consultations
- Meeting papers and minutes

- Newsletters
- Comics and animation
- Briefings
- Website / Intranet (Halton Hub)
- Online Social Media
- Press releases
- Paid media and advertising campaigns

The CCG will also ensure that all information is accessible and that processes are in place to provide information in differing formats on request (e.g. large print, other languages, Braille or audio).

5.1 External - Regional Consultations

Commissioning Support Unit colleagues will be supporting or leading regional consultations as they lend themselves to wider area consultations. However any topics that reaches out to Halton local people will still have to come to our consultation steering group and committees.

Patients and the Public

In all consultations to patients and the public, staff should remember to use plain English and keep their writing and speaking free of jargon and abbreviations.

General consultation with the public will be facilitated via established routes i.e. the media, public events and the attendance at various network meetings.

In order to ensure clarity of message and public understanding around the recent NHS organisation changes and creation of CCG"s we have developed a suite of key messages, which should be used consistently throughout all our consultation with the public (see Appendix A).

The first parts of our Governing Board meetings are held in public to demonstrate openness and transparency in our decision making.

We will also utilise the Annual Public Meeting as a means to promote the CCG and encourage engagement in the business of the CCG.

We will work collaboratively with partners and providers to have a presence at a range of events and forums.

We will utilise the existing consultation mechanisms within our partner and provider organisations, for example Halton Borough Council's Inside Halton magazine and we will, where appropriate work collaboratively with provider organisation to utilise their mechanisms.

Publications and literature

We will only produce printed publications and other material such as leaflets and flyers when absolutely necessary and we will utilise existing mechanisms within health, the Local Authority, provider and community publications to communicate key information. We will where possible only produce documents and publications in electronic format, and will
ensure that when we do so they are fully accessible.

When there is a need to produce information in relation to specific programmes of work, this is likely to be low volume and will be produced locally wherever possible.

Events

We will plan a programme to deliver and publish the recommendations from the Consultation Steering Group, where required in line with our statutory obligation to undertake public consultation. We will also utilise existing planned events, including events hosted by our partners and providers to communicate key messages and to take advantage of any PR opportunities.

E-consultations

We will develop and maintain our electronic consultation mechanisms - managing web content and providing content for use on partner and provider sites. We will also utilise social media, Facebook, Twitter etc. and will continue to further develop our e-consultation capabilities.

Communicating with our Partners and Providers

We will utilise existing meetings and forums to communicate with our partners and providers. To provide key updates and ensure consistency of messages and information relating to the CCGs business, we will develop and implement a high level “spotlight” brief, which will be issued each quarter to all external stakeholders and published on our website.

Members of Parliament

Political support for the CCG is important in raising and maintaining our profile and creating awareness. MPs will be regularly briefed on successes and issues within their local constituency.

Face to face meetings with the CCG Chief Officer and Chair will ensure that relationships with our MPs are maintained and that they are provided with information first hand. We will also ensure that ad hoc briefings are prepared in relation to emerging issues and therefore minimise the risk of MPs being misinformed.

We will also continue to ensure that we respond quickly and effectively to requests from the Ministerial Briefing Unit in relation to parliament questions and will continue to monitor activity around local issues, Parliamentary Questions and responses. This information will be shared with board members.

An annual audit among our staff and practice members to ascertain feedback and views on our consultations will inform future developments. All consultations will encourage feedback on an on-going basis from our staff and members to ensure they remain effective.

We will also be working to integrate staff that we work with from the Local Authority into our consultations, inviting them to our weekly staff brief sessions and sharing our emails with them.

Consultation with members of the Governing Body

It is crucial that members of the Governing Body are kept up-to-date of key developments, media coverage and issues. Local consultations support will provide a fortnightly consultations update, which will include all media activity to all Governing Body members and senior officers and where required will liaise with them on key issues.

Consultations with our constituent practices

We will further develop our fortnightly CCG e-newsletter to communicate key information to constituent practices. We will also look to further develop this e-newsletter to fit the needs of staff and encourage two way consultation and feedback.

We will continue to support the facilitation of events and where required co-ordinate briefing sessions with constituent practices on behalf of the CCG Governing Body.

We will develop Halton Hub as a secure online platform that will provide a means to share information with practice members and to enable members to communicate with each other.

We will continue to hold monthly Practice Manager Meetings with our constituent practices, seeking to inform, engage and capture feedback. This will be supported by Annual Practice Visits where we will seek feedback to key questions.

6. Stakeholder Analysis

6.1 Stakeholder Matrix

The matrix outlined in Appendix C provides the detail in terms of the stakeholder groups, focusing on consultation and engagement processes for each of the audiences.

We capture patient experience data from the various groups, focussing particular effort on diverse and vulnerable groups as identified within the Joint Strategic Needs Assessment (JSNA). These groups include:

Black Minority Ethnic (BME)

Halton has a BME population (non-white descendants) of approximately 2.4%. This equates to around 3,000 people residing in the Halton Borough. These communities experience access issues due to barriers such as language and cultural issues. Another significant barrier is a lower level of awareness of early warning signs for cancer among this group.

There is also a community of migrant workers, particularly from the EU accession countries of Eastern Europe, who are now settling in the area with wider family networks.

Older Citizens:

There are around 18,400 people aged 65 years and over residing in Halton (according to the 2011 Census population figures). It is important that services are commissioned and procured to meet the complex needs of older citizens, to consider the relationship with disability, for example dementia, and to support them to live in their own homes for longer.

It is estimated that 1,082 people aged 65+ were suffering from some form of dementia in 2010 in Halton (Source: POPPI).

Disability, Long-Term Conditions and Mental Health:

The Department of Work and Pensions estimates that nine million people in the UK are disabled and have difficulty carrying out day-to-day activities. The Equality Act 2010 protects those with long-term conditions including cancer, diabetes, COPD, CVD and dementia. It is also essential that we make services accessible for, and consider the needs of people with mental health conditions. It is estimated that in 2010 there were around 12,000 people in Halton, aged 18-64 years, who suffered from a common mental disorder (Source: Adult psychiatric morbidity study, 2007). In November 2010, 8.9% of the total population of Halton were claiming Disability Living Allowance. For physical disability, the number of people aged 18-64 predicted to have a moderate physical disability in 2012 in Halton is 5972. (Source: PANSI, 2012)

For learning disability, the number of people aged 18-64 years predicted to have a learning disability in 2012 in Halton is 1808. (Source: PANSI, 2012).

Children and Young People:

Advancing the health needs of children and young people requires tailoring services to meet the needs of boys and girls of different age groups. In particular, those services most relevant to this group such as teenage pregnancy, sexual health, and alcohol and weight management.

The teenage pregnancy (under 18) rate in Halton was 43.9 per 1,000 girls in 2012, a reduction of 11.3 compared to 2011 (Source: ONS). The percentage of obese children in Reception and Year 6 also increased between 2009/10 and 2010/11. The Reception percentage increased by 1.1%, whereas the Year 6 percentage increased by 2.2%. (Source:

NHS IC). This data shows that intervention in early years is a key priority that will enable us to tackle health inequalities in Halton.

Gender:

Men and women display different behaviours in relation to accessing services. Life expectancy varies between men (75.5 years) and women (79.6 years) and they experience different illness and conditions, so appropriate and targeted services are essential (Source: ONS, 2008-10). For example, it is important that women receive appropriate and targeted gynaecological services. It is a key priority to ensure that men access appropriate prevention services to reduce unhealthy lifestyle behaviours.

Lesbian, Gay, Bisexual and Transgender (LGBT):

A disproportionate number of this community experience mental health issues. These communities face disadvantages in relation to access and health outcomes. According to the Integrated Household Survey 2010/11, around 1.5% of the population in the North West are said to be LGBT (Source: ONS, 2011).

We are aware of a low number of trans people in Halton at the moment. Statistically, Trans people comprise approximately 1-2 per cent of the general population, but the statistics do differ in more welcoming situations and environments. Not all Trans people are 'out' as Trans and some people may not have come to the realisation that they are Trans. The more approachable we make the subject (via leaflets and posters in GP offices for example) the more people will make themselves known.

Religion/Belief:

Religion and belief is extremely important to many patients in all aspects of their lives. Particular consideration of religion and beliefs needs to be taken when commissioning end of life services.

As well as the groups identified above, we also continually engage with the groups identified within the stakeholder matrix below through various mechanisms, including

our Talk To Us Patient Experience Programme, Halton People's Health Forum, Patient Participation Groups and specific focus groups in relation to commissioning intentions to ensure patient experience data is captured and acted upon.

Stakeholder Group	Groups Identified	Engagement & Consultation Priorities
All stakeholders including patients and the Public		• Reputation management and public affairs • Campaigning for health priorities • Managing the brand and the market • Awareness of key health messages • Engagement and involvement in decision-making • Access to health services messages
Vulnerable groups	• Travellers • BME • Young / Old • Work / economic migrants • Disable / non disable • Asylum Seekers & Refugees • Transgender and Transsexuals • Gender	• Through CCG"s extensive reach via its community engagement team and tailored engagement tools, including focus groups • Consultation through partnerships with community organisations. • Use of interpretive tools– translation clarity of language etc.

Key partners	• Halton Borough Council • Warrington & Halton Hospital Foundation Trust • St Helens and Knowsley Hospitals Trust • 5 Borough Partnership • Bridgewater Community Trust	
Other partners	• Healthwatch • Third Sector • Local Involvement Networks • Faith Groups • Resident Groups • Department of Health • National NHS England Area Team • Neighbouring CCGS & Local Authorities	• Reputation management • High quality, timely information to support partnerships • Effective engagement and involvement • Consultations to support their organisation development • Consultations about access to services
Influencers	• Local MP"s • Councillors	• Reputation management • Timely, regular briefings – written and face to face to build awareness and support the objectives
NHS partners	• Acute and Specialist Trusts • All other providers • NHS England North • Department of Health	• Reputation management, particularly
Independent contractors	• GP"s and practice staff • Pharmacists • Dentists • Optometrist • Local professional Committees	• Timely and consistent consultations • Effective clinical engagement to build awareness and support for strategic objectives and delivery • Reputation management

Other NHS and related partners	• NHS Direct • Health Protection Agency • Workforce Confederation • Healthcare Commission • NHS Alliance • NICE • Business Services Authority	• Reputation management • Awareness of key messages • Effective engagement and involvement

7. Risk Assessment

There are several risks attached to the success of the consultation and engagement strategy, as detailed in Appendix B and C. Consideration has been given to these risks and the successful implementation of the consultations strategy will contribute to the mitigation of all the risks identified:

- Negative media attention around health reforms and the "privatisation" of the NHS
- Political spotlight drawing NHS finances in to the political debate locally and nationally
- Confusion due to the amount of information being communicated at any one time via provider and partner organisations or due to conflicting messages from different NHS organisations or other stakeholders.
- Individual concerns that are lost in the general mix.

8. Implementation and monitoring

8.1 Roles and responsibilities

Effective consultation and engagement is everyone's responsibility and the Governing Body, staff, including clinicians and practice staff all have a key role in promoting the work of the CCG, the services which it commissions and in raising awareness of health campaigns and initiatives.

The consultation and engagement leads will ensure that the CCG Governing Body and staff are well informed and supported to do this.

Key responsibilities

The local consultations support, provided by the Cheshire and Merseyside Commissioning Support Unit will be responsible for:

- Developing and managing the operational delivery of the consultation and engagement strategy and action plan
- Providing the CCG Governing Body with progress reports ensuring that the board is made aware of any significant issues which will impact on the effectiveness of the strategy and any risk in terms of achieving the objectives
- Providing strategic input to the work of NHS Halton CCG, providing strategic advice on consultation and engagement requirements
- Identifying, planning for and responding to emerging issues which may have a detrimental impact on the reputation of the CCG and / or the NHS brand
- Handling of all consultation, including crisis consultations in relation to serious and untoward incidents
- Handling of all consultation, including media activity in relation to major incidents as part of emergency planning arrangements. (this includes on call out of hours support)
- Handling of reactive media activity, ensuring appropriate response and timely escalation of issues and where required co-ordinate responses with consultation leads from partner and provider organisations
- Oversight of all proactive media activity, and, where required co-ordinate media activity with consultation leads from partner and provider organisations
- Oversight of all regulatory and non-regulatory consultation
- Supporting commissioning leads and CCG senior officers with practical consultation support, including the development and implementation of consultation plans

The Engagement and Involvement Manager will be responsible for:

- Delivery of all engagement operational activity identified in the consultation and engagement action plan
- Acting as the first point of contact for community and third sector groups in relation to public engagement activity
- Alerting the consultations lead with information around any emerging issues in relation to engagement activity which may impact on the organisations reputation
- To be the CCG representative at a variety of third sector and community group meetings and present updates as and when required
- Attend a variety of public events across the borough

- Development of a membership based approach with constituent practices
- Providing engagement support to lead commissioners
- Supporting the development of the patient experience programme and ongoing monitoring of patient experience information, including Patient Opinion and patient choices
- Supporting the development and facilitation of Halton People's Health Forum
- Supporting the ongoing development of Patient Participation Groups

NHS Halton CCG Governing Body will be responsible for:

- Taking the lead and fronting media activity, both in relation to proactive and reactive issue
- Lead on the delivery of high level consultation to staff, constituent practices, partner and providers
- Alerting the consultations lead with any emerging issues
- Supporting the CCG by attendance and involvement in public events

NHS Halton CCG Clinical Leads and staff will be responsible for:

- Alerting the consultations lead with any emerging issues
- Providing updates to the consultation lead for inclusion in briefings

8.2 Budget and resources

Much of the activity can be delivered at minimal or nil cost through use of existing mechanisms and channels of consultation and engagement, although there will be resource requirements in terms of people's time.

As part of the development of the detailed operational work plan, any activity in relation to specific areas of work will be fully costed and submitted for approval before any activity is commissioned.

The CCG has a Service Level Agreement with Cheshire and Merseyside CSU to provide an end-to-end consultations service.

Supported by the CSU Consultations Head of Service and Locality lead we will continue

to look to work collaboratively with our partners, providers and neighbouring CCGs to ensure that we are making best use of our opportunities to maximise our consultations resource capacity.

9. Evaluation

It is important for us to monitor and benchmark performance of consultation and engagement activity so that we can ensure that the activity is appropriately tailored and targeted to the relevant audiences, messages and method. The following criteria are suggested as being ways in which we should be able to track performance:

- **Formal and informal feedback from stakeholders, to include;**
  - Patient experience feedback and patient surveys
  - Levels of awareness of the work of NHS Halton CCG
  - Public perceptions of ability to get involved and influence the future shape of these services
  - High level 360 degree feedback – practice members, partner and provider organisations.
- **Formal and informal feedback from employees**
  - Views sought through team meetings, staff briefings and other engagement events
  - Staff survey
  - Halton Hub feedback
- **Number of attendees at engagement and consultation events**
  - Internal audiences
  - External audiences
- **Favourable media coverage**
  - Media evaluation
- **Political temperature**
  - Positive political support vs. level of political noise (MP letters, Parliamentary Questions etc.)
- **Halton Hub**
  - Online platform in which the Engagement & Involvement Manager and colleagues can record the CCG‟s engagement activity with local people and communities.
- **All NHS Trusts**
  - Early adopters for Friends & Family Test
  - Maternity services

APPENDIX A

WHAT CAN YOU EXPECT

- No decision about me without me" is the principle behind the way in which patients are treated – patients will be able to make decisions with their GP about the type of treatment that is best for them. Patients will also have more control and choice over where they are treated and who they are treated by.

They will be able to choose their:

  - GP
  - Consultant
  - Treatment
  - Hospital or other local health service

- Patients will be able to get the information they need, such as how well a hospital carries out a particular treatment, to help them decide on the best type of care. If patients are unhappy with their local hospital, or other local services, they will be able to choose another one to treat them.

- Patients will be able to rate hospitals and clinics according to the quality of care they receive, and hospitals will be required to be open about mistakes and always tell patients if something has gone wrong.

- Patients will have a strong collective voice through a national body, Healthwatch and in their communities through arrangements led by local authorities.

What does it mean for the public?

- The public will be able to have more influence over what kind of health services should be available locally. They will also have greater opportunities for holding to account local services that are not performing well.

- They will be able to get more information about how their local health services are performing, such as how well their local hospital carries out a particular operation or treatment.

- There will be more focus on preventing people from getting ill – the Public Health Service will pull together services locally to encourage people to keep fit and eat more healthily.

How will the new health and care system be run?

- Local authorities will be responsible for local health care priorities, while central government will have much less control over health services.

- The NHS will be measured by how successfully it treats patients – for example, whether it improves cancer survival rates, enables more people to live independently after having a stroke or reduces hospital acquired infection rates.
- NHS England - an independent and accountable organisation has been established to:
    - lead on the achievement of health results
    - allocate and account for NHS resources
    - lead on improvements in quality
    - promote patient involvement and choice.
- NHS England will also have a duty to promote equality and tackle inequalities in access to healthcare.
- Monitor will become an economic regulator to promote effective and efficient providers of health and care, encourage competition, regulate prices and safeguard the continuity of services
- The role of the Care Quality Commission will be strengthened as an effective quality inspectorate covering both health and social care. Healthwatch will represent the views of patients, carers and local communities.

APPENDIX B

STAKEHOLDER MATRIX

Keep satisfied: ***but not so much that they become bored with messages:*** • Warrington & Halton Hospitals NHS Foundation Trust (WHHFT) Members • 5 Boroughs Partnership NHS Foundation Trust (5 BP) Members • Bridgewater Community Healthcare NHS Trust (BCH) Members • St Helens & Knowsley NHS Trust (SHK) Members • NHS England • Local Medical Committees • Local Pharmacy Committees	**Manage Closely**: ***these are the people to fully engage and make the greatest efforts to satisfy***. • CCG Governing Body and Staff • Media • WHHFT – Board • 5 BP Board • BCH Board • Local Authority Exec Committee • MPs • Local Council Members • Local Overview and Scrutiny Committee • Health and Wellbeing Board • Halton Healthwatch • Third sector and patient support groups (via local CVS organisations) • Halton People's Health Forum • Patient Participation Group members • Member Practices
Monitor: ***do not bore with excessive consultation:*** • Other NHS Staff (providers) • Local Social Enterprises • Local Chambers of Commerce • Housing Trusts and other public sector organisations	**Keep informed:** ***and engage to ensure no major issues are arising*** • Patients, their carers, families and the general public

Low

Low High

INTEREST

Red – High Power, High Interest – fully engage and satisfy

Orange – High Power, Mod Interest – inform, seek approval and satisfy

Blue – Mod Power, High Interest – inform and engage

Green – Low Power, Low Interest – monitor and inform

APPENDIX C

SWOT ANALYSIS

Having reviewed our situational analysis, a number of areas have been identified as being "weaknesses or threats":

Strengths	Weaknesses
Established board with high level of strategic expertise and a varied skill set. Skilled consultation and engagement resource, which is flexible and has the ability to scale up when required. Effective Clinical Engagement Effective engagement with practice members Excellent staff engagement	Continuously changing environment
Opportunities	**Threats**
Continue to further enhance clinical engagement between provider and commissioner organisations. Enhance robust working arrangements with partners and providers	Resource within local media organisations – lack of "named" health link. Political challenge Loss of public and clinical engagement and confidence. Diverse and competing demands on time to undertaken the necessary work.

This document can be made available in a range of alternative formats including various languages, large print, Braille and audio cassette. To discuss your requirements please ring 0800 389 6973.

Ky dokument mund të jetë në dispozicionin tuaj në një varg të formateve alternative përfshirë gjuhë të ndryshme, të shtypura, Braille dhe audio kaseta. Për të diskutuar kërkesat tuaja, ju lutemi thirrni në 0800 389 6973 (Albanian)
يمكن توفير هذه الوثيقة في العديد من الاشكال بما في ذلك مختلف اللغات، بخطوط كبيرة، بكتابة بريل او على شريط كاسيت. لمناقشة متطلباتك الرجاء الاتصال على الرقم 0800 389 6973 (Arabic)
এই দলিলটি বিভিন্ন ফরম্যাটে বিকল্পমূলক ভাবে পাওয়া যাবে যার মধ্যে অন্তর্ভুক্ত আছে বিভিন্ন ভাষা, বড় ছাপা, ব্রেইল পদ্ধতি ও অডিও ক্যাসেট। আপনার প্রয়োজনের ব্যাপারে আলোচনা করার জন্য অনুগ্রহ করে ০৮০০ ৩৮৯ ৬৯৭৩ নম্বরে ফোন করুন। (Bengali)
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Engagement with the public

- Engagement with over 5,000 people
- 17 Patient Participation Groups (PPG)
- Halton People's Health Forum
- Chamber of Commerce
- LD North of England events
- Childrens Take Over Day
- Big Learning Disability Health Day
- Bright Spark Day

Halton Clinical Commissioning Group

Halton People's Health Forum

Involving everybody in improving the health and wellbeing of the people of Halton

PPG Plus

Urgent Care - Catch 22 & Halton Speak Out

Annual General Meeting

Working with our schools

NW Vintage Rally

Citizenship World Record Day

Feedback

CAMHS tier 2 service. Young people said they wanted:

- Increased access with an on-line option
- Be seen in non-clinical venues
- To see the same person so that they didn't have to keep telling their storey

We Did:

- Two young people on the procurement panel.
- Online live 121 counselling sessions and chat room forums relating to popular mental health areas of discussion i.e. self-harm.
- Range of venues with an option to meet at home if necessary
- Health professional will have access to their records, meaning they won't have to tell their stories again.

Future Developments

Experience Led Commissioning (ELC) is a new approach to planning and buying healthcare services. It is built around the idea that if we listen to and deeply understand people's experiences, we will design better, more person-centred services that deliver better care for people in across Halton.

How are we going to implement this approach ?

1) 4 co-design events – that Halton peoples health forum will support.

2) Include ELC in the Terms of Reference for Halton Peoples Health Forum and develop internal systems to capture the populations experience, which in turn will support current and future commissioning

3) Continue to deliver core engagement events which will include an element of ELC

REPORT TO:	Health Policy & Performance Board
DATE:	9 June 2015
REPORTING OFFICER:	Operational Director, Commissioning & Complex Care
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Performance Management Reports, Quarter 4 2014-15
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 4 of 2014-15. 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. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 4, 2014-15.

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 to 31st March 2015

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 2014/15; 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:

PREVENTION & ASSESSMENT

Care Act Implementation: Final plans have been put in place to implement the Care Act in Halton. Training has taken place across a range of services and has been extended to partners. These "bite-size" learning sessions offered a total of 357 places and focussed on six different areas of the Care Act. In addition, two major areas of redesign have now been drafted:

- The development of an Advocacy Hub, to offer improved access to advocacy and developing coherent, well-supported low-level advocacy in the borough.
- An information network that will have at its heart an information charter that organisations will sign up to which helps them to move away from basic signposting and now offers a consistent navigation system that ensures services carry out, follow-up, and offer individuals the right level of support to access all of the help they need.

Keyring Community Living Network: The Keyring model is a network of vulnerable people who need some support including mutual support to live safe and fulfilling lives in the community with an emphasis on enablement rather than dependence on high levels of support. Implementation is now underway and a full evaluation will be undertaken at the end of Year 2. The Keyring pilot network is now established in Widnes and plans are in place to develop a satellite service in Runcorn. Halton Housing Partnership has offered support in sourcing accommodation and community venues for drop in sessions.

Learning Disability (LD) Nursing Team: The team has been instrumental in the development of a new learning disability pathway at Warrington Hospital as well as attending at learning disability pathways at other NHS trusts. Working with GP surgeries, there has been some improvement in increasing LD health checks completed by GPs, with approximately 50% of health checks being completed. Regular monitoring of patients within the inpatient ward continues. The team has also been supporting the transition process from inpatient setting to community. Training and outreach work (prevention and promotion) carried out by the team included personal hygiene and cervical screening

sessions and support to sexual health services. Joint working with sexual health services and MacMillan has supported clients' understanding of contraception and terminal conditions respectively. Other community work involved dental desensitisation being carried out to improve clients' health and wellbeing. Training within the team included bespoke medication training and cancer screening. Some members have signed up as "Health Champions" and will undertake further training for this role.

Winterbourne View Two Years on and Transforming Care: Next Steps: At the end of January 2015, the Winterbourne View Two Years On and Transforming Care: Next Steps was published by Association of Directors of Adult Social Care (ADASS), Department of Health (DH), Local Government Association (LGA) and NHS England. The Winterbourne View Two Years On is a collective progress report from partners across the health and care system. Transforming Care: Next Steps sets out the plans for the next stage of this work. All partners have agreed on the need for a single programme with a single plan, building on the recommendations of Winterbourne View – A Time for Change. Any outstanding actions from the original action plan and concordat will be carried forward into the Transforming Care programme. The new publications reinforce the Health and Wellbeing Board's leadership role by ensuring that there is a strong integrated local health and care commissioning and housing support, and use of pooled budgets.

Learning Disability (LD) Beds and Out of Borough placements: LD inpatient bed usage continues to be monitored, with four admissions in 2014/15 compared to ten admissions in 2013/14. The multi-disciplinary team approach has provided a robust community response reducing the need for inpatient admissions. The out of borough cohort continues to be monitored, with four individuals repatriated to Halton in the past financial year. The Barkla Bungalow project continues to be developed as part of Halton's offer to reduce the out of borough cohort in 2015/16.

Telecare Services Assocation (TSA): Halton Community Alarm Service was inspected by the Telecare Services Association and has, for the fifth year on the run, achieved platinum and European accreditation. Continued accreditation will help to assure service users, their families and carers that they are in receipt of a quality service they can rely on.

COMMISSIONING & COMPLEX CARE SERVICES

Operation Emblem: Between December 2013 and February 2015, there were 120 incidents which previously would have been dealt with using Section 136; this figure reduced to a total of 10 detentions (92% reduction). Of these, 9 went on to be further detained for treatment and assessment under the Mental Health Act. Prior to this project, only around 25% of people detained under Section 136 were subsequently further detained under the Mental Health Act, suggesting that more people are being routed away from mental health services; the interventions have been much more targeted towards people who really need help and treatment, and a more effective use of resources. Accident and Emergency services are being used less, and police and social work time are being better used. As a result of this success, the project has been rolled out to cover the entire Cheshire area.

Mental Health Crisis Care Concordat: In addition to the work done last quarter by the inter-agency group (Councils, Clinical Commissioning Groups, Mental Health Trusts and Police across Cheshire), Halton mental health services have developed their own action plan, which closely references the wider Cheshire plan but recognises local conditions. This action plan will be monitored and delivered by the Halton Mental Health Oversight and Mental Health Delivery Groups.

Mental Health Outreach Team – GP pilot: Previous monitoring reports have referenced the development of this pilot scheme, which links the Outreach Team to a small number of local GP practices, with the intention of intervening at an earlier stage in people's mental health condition. This pilot continues to show positive results and plans are being developed to roll this out more widely into Halton.

Halton and St Helens Emergency Duty Team (EDT): Since the establishment of this partnership, there have been considerable changes in services delivery, national and local requirements for social care services across children's and adults services, levels of service demand and the way in which partner agencies work. Therefore, a detailed review of out of hours emergency social care services is being undertaken by the EDT Steering Group. A report should be available by the end of the summer 2015.

Homelessness: The Merseyside Sub Regional Homeless Group (MSRHG) successfully qualified for single homeless funding. All six authorities agreed that vulnerable clients with complex needs were a priority. A service developed to provide intense support to clients with high complex needs will commence early May 2015 and run for a period of two years. As part of the Gold Standard, MSRHG have registered for the peer review. Each authority will review a number of services within the group. The peer review is due to commence April 2015 and Halton services will be reviewed in August 2015.

Halton has subscribed to the Pan Merseyside Bond Scheme, which will be managed and delivered by Whitechapel, Liverpool. The scheme will assist vulnerable clients not meeting the local authority homelessness criteria to get help from Whitechapel in securing alternative accommodation within the private rented sector.

PUBLIC HEALTH

Halton has made excellent progress with child obesity for school age children and has reduced the excess weight level so it is less than 1% above the England average. Halton has excelled with immunisation and this is now above the England rate with over 95% of children vaccinated. The Healthy Child programme is making good progress with a new School Nurse Service commissioned and a Family Nurse partnership in place overseen by a statutory board. Work continues to reduce Under 18 alcohol admission rates locally. Alcohol health education sessions have been delivered in all local schools and will continue. Uptake remains good for HPV vaccination with latest data for 2013/14 showing uptake of all 3 doses at 90.9%, above target and slightly higher than the England average. Tier 2 mental health services for children and young people have been commissioned and the service has just started.

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:

PREVENTION & ASSESSMENT

Employment Tribunal Case – Sleeping Night Support: A recent Employment Appeal Tribunal case '*Esparon t/a Middle West v Slaikovska'* suggested sleeping night support should be paid at the national minimum wage rate. The current sleeping rates are £33 per night shift. This appeal presents a considerable financial risk for the Council and Halton Clinical Commissioning Group's pooled budget arrangements with sleeping support predominately being used in supported accommodation for vulnerable adults. A re-tender exercise of the supported accommodation services will take place in 2015. The implications of the Esparon Case will be considered during the re-tender of services. Colleagues continue to investigate the authority's responsibilities and liaise with provider services.

COMMISSIONING & COMPLEX CARE

Mental Health Act Code of Practice: The new Code of Practice has now been published and contains a number of changes and developments. All Council policies and procedures are being amended to take this into account and key staff in mental health services are receiving training in relation to this.

Review of the Acute Care Pathway (ACP): The review of the ACP is now being taken forward by all of the Clinical Commissioning Groups within the footprint of the 5Boroughs; an external consultancy has been appointed and the review is scheduled to conclude in autumn 2015.

5Boroughs Trust: From April 2015, 5Boroughs will introduce a more borough-based approach to the delivery of their services. This new approach will ensure more effective engagement in local strategic and operational planning processes. In July 2015, the 5Brooughs will be inspected by the Care Quality Commission, as part of CQC's national programme to review all mental health services. The Council will support the 5Boroughs' preparation for this inspection.

PUBLIC HEALTH

Early child development and the readiness for school indicator indicate that Halton has considerable challenges in this area. Public Health and Children's Services are working together to address this issue. We are conducting an in depth analysis across the Borough. Despite making progress with school age obesity levels obesity in the early years remains a concern. A new Healthy Weight Strategy is being developed to address this issue.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2014 – 15 Directorate Business Plans.

Progress concerning the implementation of all Directorate high-risk mitigation measures was reported in Quarter 2 and Risk Registers are currently being reviewed for 2015/16 in tandem with the development of next year's Directorate Business Plans.

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.

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PA 1	Fully implement and monitor the effectiveness of the complex care pooled budget **March 2015.** (**AOF 2,3,4,10,21)**	✓
PA 1	Continue the integrated provision of frontline services including multidisciplinary teams, care homes, safeguarding services and urgent care **March 2015** (**AOF 2,3,4,10,21)**	✓
PA 1	Develop a Care Management Strategy to reflect the provision of integrated frontline services for adults **March 2015** (**AOF 2,3,4,10,21)**	✓
PA 1	Work within adult social care to focus on preventative service to meet the needs of the population **March 2015** (**AOF 2,3,4,10,21)**	✓

PA 1	Develop an integrated approach to the delivery of Health and Wellbeing across Halton **March 2015** (**AOF 2,3,4,10,21)**	✓
PA 2	Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets **March 2015 (AOF 2, 3,4,10,21)**	✓
PA 2	Continue to review the quality of commissioned services and continue to develop the role of the integrated safeguarding unit **March 2015 (AOF 2, 3,4,10,21)**	✓

Supporting Commentary

PA 1 Complex care pooled budget: The pooled budget has been fully implemented.

PA 1 Integrated provision of frontline services: Community health and social care teams continue to integrate around GP practices and hubs. The successful bid for the Prime Ministers challenge money for primary care will further support the developing model of health and social care delivery as will the remodelling of mental health services to a borough based approach.

PA 1 Develop a Care Management Strategy: The Care Management Strategy has previously been presented to SMT it is in a final draft and will now follow a period of consultation. It will be presented to the HPPB in June.

PA 1 Work within Adult Social Care focussing on Preventative Services: The Initial Assessment team continues to work closely with Sure Start/Bridge Building teams, and Telecare. Training has been delivered on the new Care Act to reinforce better signposting and capturing information that ensures positive outcomes for people using services.

PA 2 Personalisation/Self-directed Support: Effective arrangements continue to remain in place for 'Personalisation' across adult social care. A steering group has been established and will continue to progress the 'Making it Real' agenda. A co-production approach has been adopted to work with people who use services and their support networks.

PA 2 Integrated Safeguarding: A care and safeguarding dashboard is being developed to enable professionals to receive up to date information across the Halton footprint for commissioned services and safeguarding.

Key Performance Indicators

Ref	Measure	13 / 14 Actual	14/15 Target	Q4 Actual	Q4 Progress	Direction of travel
PA 2	Numbers of people receiving Intermediate	81.31	82	**80.0**	✗	↓

Ref	Measure	13 / 14 Actual	14/15 Target	Q4 Actual	Q4 Progress	Direction of travel
	Care per 1,000 population (65+)					
PA 3	Percentage of VAA Assessments completed within 28 days	87.69%	85%	**86.8%**	✓	↑
PA 7	Percentage of items of equipment and adaptations delivered within 7 working days	96.3%	97%	**95.5%**	✗	↓

Supporting Commentary

PA 2 Numbers of people receiving Intermediate Care per 1,000 population (65+): The total number of Intermediate Care referrals are up on the same quarter last year and overall are slightly up on 2013/14. However there was a 3.6% increase in the 65+ population estimate (20306). Had this population figure remained the same as 2013/14 (19603), the outturn would have been 82.8.

PA 3 Percentage of VAA Assessments completed within 28 days: Target has been achieved.

PA 7 Percentage of items of equipment and adaptations delivered within 7 working days: Three of the four service providers have achieved the 97% target. There have been issues with the fourth contract which is coming to an end in 2015/16. We are undertaking a procurement process to find a new service provider.

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q4 Progress
CCC 1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2015.** (AOF 4)	✓
CCC 1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2015.** (AOF 4)	✓
CCC 1	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 2015** (AOF 4)	✓

CCC 1	The Homelessness Strategy be kept under annual review to determine if any changes or updates are required. **Mar 2015. (AOF 4, AOF 18)**	✓
CCC 2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2015 (AOF 21)**	✓
CCC 3	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 2015. (AOF 21 & 25)**	✓

Key Performance Indicators

Supporting Commentary

CCC1 Services / Support to children and adults with Autism: Autism Self-Assessment 2015 has been completed and formally submitted on behalf of Halton Borough Council and Halton Clinical Commissioning Group. The Autism Strategy Action Plan is to be reviewed to align with the Think Autism 2014 National review. £18,500 grant funding has been allocated to support safely accessing social media and employment focused based support with Community Services.

CCC 1 Dementia Strategy: During Q4 the focus has been on achieving the diagnosis rate target of 67% by end of March 2015. As at mid-March 2015, the diagnosis rate was 69.5%. Preparation for the commissioning of a Halton Admiral Nurse Service has taken place, including planning a consultation event for early April 2015 and meetings with existing community pathway providers. Further work will be undertaken into Q1 2015/16 with community pathway providers to maximise opportunities for collaborative working to reshape the pathway (where appropriate) in readiness for the Admiral Nurse service and to ensure quality services that continue to meet the needs of people living with dementia, and their carers. The Dementia Action Alliance (DAA) is now well established, with 17 active members. There was a successful Halton DAA event held in conjunction with Halton Carers Centre, attended by over 120 participants; 50% of participants were people living with dementia or their carers.

CCC 1 Mental Health: The effectiveness of the Acute Care Pathway (ACP) is being reviewed by the combined Clinical Commissioning Groups across the 5Boroughs. A report will be due in the autumn of 2015. The pathway for older people with mental health problems – the Later Life and Memory service – has also been fully developed and implemented, and is again fully supported by the council social work service.

CCC 1 Homelessness Strategy: The homelessness strategy 2014 to 2018 is a working document that captures future change, trends, demands and is due to be reviewed in June 2015. During the past 12 months a number of priority actions within the strategy plan have been successfully completed to ensure the service is fully compliant with the legislation. The focus has been around improving the performance and monitoring of the service, with further emphasis to develop prevention initiatives for vulnerable complex needs client groups. The main priority for 2015/16 will be on Health & Homelessness, meeting the key service objectives outlined within the St Mungo's

report, and incorporating these within the reviewed strategy action plan.

CCC 2 HealthWatch: Healthwatch continues to develop and events for local residents are scheduled. Discussion with partner Councils related to advocacy took place to ensure the best possible service is delivered. More cost effective arrangements are now in place.

CCC 3 Review and development of commissioning strategies to align with Public Health and Clinical Commissioning Groups: Work in this area is progressing as scheduled. The Integration Agenda continues to move towards greater alignment around governance, work schemes, and performance management. For example, new Governance arrangements for Mental Health and other work streams have been put in place.

Key Performance Indicators

Ref	Measure	13 / 14 Actual	14 / 15 Target	Q4 Actual	Q4 Progress	Direction of travel
CCC 4	Adults with mental health problems helped to live at home per 1,000 population	2.64	3.5	**2.64**	✗	⇔
CCC 5	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6).	0	1.2	**0**	✓	⇑
CCC 6	Number of households living in Temporary Accommodation (Previously NI 156, CCC 7).	11	12	**19**	✗	⇓

Supporting Commentary

CCC 4 Adults with mental health problems helped to live at home per 1,000 population: Although the target for this year has not been reached, this figure represents a small improvement on the previous quarter's performance, and a reversal of a previous downward trend. This improvement has arisen because of a reconfiguration of some of the work within the mental health service.

CCC 5 The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years: Halton has approached the street pastors and are striving towards developing an outreach service to tackle rough sleepers within the district. The authority will continue to aim to sustain zero

tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC 6 Number of households living in Temporary Accommodation: Many authorities across the country have seen an increase in homeless presentations. During the last 12 months there have been a number of contributable factors that have led to the increase, for example, welfare reform, benefit cap and sanctions, which have placed additional pressure upon the authority to provide temporary accommodation. The introduction of Universal Credit had a small impact upon homelessness, as the process has resulted in clients experiencing disruption to benefits and financial hardship. It is envisaged that this process may affect more clients in the future, whereby, affordability is a contributable factor to the loss of their settled accommodation. Consequently, this will place additional pressure on the service and increase demand for the temporary accommodation provision.

Public Health

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PH 01	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 2015**	✓
PH 01	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 2015**	✓
PH 01	Meet the target for the take up of HPV vaccination in girls 11-13, to reduce cervical cancer rates by working proactively with the School Nursing Service and GPs. **March 2015**	✓
PH 01	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 2015**	✓
PH 02	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 2015**	✓
PH 03	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 2015**	✓
PH 05	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 2015**	✓

Supporting Commentary

PH 01 Raise awareness of Bowel, Breast and Lung Cancer: We are in the process of updating the Health and Wellbeing Cancer Action plan and exploring additional opportunities to expand programmes, including opportunities to increase participation in National Bowel Cancer Screening. 43.1% of cancers were detected early (stage 1 or 2) in 2012, slightly higher than the England average.

PH 01 Reduce Obesity Rates: A range of weight management services have been delivered for children and adults on an individual or group level, such as the fresh start programmes, active play and introduction to solid food parties. The Halton Healthy Weight management care pathways for children and adults have been reviewed and the tier 3 service is in the process of being re-commissioned.

PH 01 Reduce Cervical Cancer Rates: Uptake remains good for HPV vaccination. The latest data for 2013/14 shows uptake of all 3 doses at 90.9%, above target and slightly higher than the England average. Changes to the national schedule for HPV vaccination (reduction from 3 to 2 dose schedule) may provide further opportunities to improve uptake locally.

PH 01 Reduce the number of people drinking to harmful levels: An alcohol harm reduction strategy for Halton has been developed. The strategy was developed in partnership with colleagues from health, social care, education, voluntary sector, police and the community safety team. The strategy sets out actions across the life course to reduce alcohol related harm and reduce hospital admissions. Locally, good progress has been made in reducing under 18 admission rates. Alcohol health education sessions continue to be delivered in all local schools. Key activity includes:

- Alcohol health education sessions delivered in all local schools.
- Community outreach work to educate young people about alcohol, offer advice and support and promote alcohol free local activities for young people.
- Local awareness campaign around the dangers of drinking alcohol during pregnancy.
- Training key staff such as midwives, health visitors, Early Years' staff and people who work with children and young people in the early identification and support of those who misuse alcohol.

PH 02 Facilitate Early Life Stages development: A new school nurse service has been commissioned and this service is a key part of the Healthy Child pathway. The Healthy Child programme continues to be delivered across Halton, conducting screening, immunisations and health reviews. The Family Nurse Partnership team is working closely with first time teenage mothers in the borough. Work continues to ensure the safe transition of the Health Visiting service and Family Nurse Partnership to be commissioned by the local authority by October 2015. Halton Health in the Early years group is developing action plans to ensure the delivery of the 'high impact areas' that have been recommended by the Department of Health.

PH 03 Falls Reduction Action Plan: The falls business case has now been completed in draft and is going through the relevant decision making boards. This document is an addition to the existing falls strategy that continues to be implemented successfully. Training and exercise programmes have both been redesigned in quarter 4 to increase capacity; this has been done through the Healthy Living Team.

PH 05 Mental Health and Wellbeing Programme: The children's mental health service has now been commissioned, and will be delivered by 5 Boroughs Partnership NHS Trust. This service will deliver training on health and wellbeing in schools. The Health Improvement team continue to provide the Healthitude programme in schools and colleges. The parenting programme Triple P also continues to be delivered by the Health Improvement team

Key Performance Indicators

Ref	Measure	13/14 Actual	14/15 Target	Q4	Current Progress	Direction of travel
PH LI 01 (SCS HH 7)	Mortality rate from all cancers at ages under 75 (previously PH LI 04 [2013/14],NI 122)	145.1 July 13 to June 14	140	130.8 2014 Provisional	✓	↑
PH LI 02	A good level of child development	37%	40%	46% (2013/14)	✓	↑
PH LI 03 New SCS Measure Health 2013-16)	Falls and injuries in the over 65s (Public Health Outcomes Framework) (previously PH LI 06 [2013/14])	2,850.4 (Jan 13 – Dec 13)	2,847	2942.5 2014 (Provisional)	✗	↓
PH LI 04	Admissions which are wholly attributable to alcohol AAF=1, rate per 100,000 population.	947.5 (2013/14)	1,038	916.2 (Q3 2014/15	✓	↑
PH LI 05	Mental Health: Self-reported wellbeing (previously PH LI 08, 2013/14)	N/A	69%	N/A	N/A	N/A

Supporting Commentary

PH LI 01 Cancer Mortality rates: There has been a very positive in-year reduction in the mortality from cancers. There needs to be some caution in interpreting a downward trend from an in-year improvement and continued progress against the Cancer Action plan will solidify a downward direction of travel.

PH LI 02 Child Development: The annual measure of child development has shown an improvement in the number of children reaching a good level of development by school age. There has been a lot of work in this area, for example piloting an integrated assessment between education and health, and parenting programmes that contribute to this improvement. Further work is underway to better understand the strengths and weaknesses of Early Years provision in Halton, and identify how greater improvements can be made.

PH LI 03 Falls and injuries 65+: There has been an increase in the numbers of people presenting, mainly due to changes in practice and improved triage in the system; this change presents are more efficient method of capturing information and ensuring that a fall is recorded as a fall. A business case is being developed to support the existing falls strategy and consider the gaps and potential risks in the existing service.

PH LI 04 Alcohol admissions: The number of admissions which are wholly attributable to alcohol saw a reduction in Q3 2014/15 and is now lower than the 2013/14 rate.

PH LI 05 Mental health self-reported wellbeing: No data available yet.

APPENDIX 1 – Financial Statements

Statement from Financial Management team

The Council's 2014/15 year-end accounts are currently being finalised. The year-end position for each Department will therefore be made available via the Intranet by 30th June 2015.

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:	9th June 2015
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Health Policy and Performance Board Annual Report : 2014/15
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 2014 - March 2015.

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 2014/15, 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 2014 - March 2015

As Chairman of the Health Policy and Performance Board I am very pleased to report on the work of the Board for 2014/15.

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.

I am proud to announce that Councillor Mark Dennett a member of the Health Policy and Performance Board was selected by the Board to take on the responsibility of Mental Health Champion for Halton. Mark gave his first report to the Board in January 2015; we were very impressed with his report and pleased to hear that Mark chairs the Council's Mental Health Strategy Board.

We take our responsibilities very seriously and as such choose at least one Scrutiny topic to focus on each Municipal year.

This year we have scrutinised the services to older people who receive Care in their own home. We looked closely at those providing that care, received reports from various providers and also interviewed a number of our residents receiving Care at home, with their permission of course.

Regional Scrutiny of Health is a new responsibility for the Board and if there is a substantial change in the way in which Health Services are provided we have a right to be consulted and take part in the Joint Scrutiny of that service. Over the last twelve months we were involved in a Regional Scrutiny exercise with Liverpool, Sefton, Chester West and Chester, Wirral, Knowsley, St Helens and Warrington Council's, all looking at how our Cancer Treatment Services will be delivered in the near future.

Clatterbridge Hospital are extending the services to us all, a new build will be established in Liverpool City Centre, one of the new services will be a Critical Care Unit, which will be a big improvement.

The new Clatterbridge Hospital will be built next to the new Royal Hospital and close to the Liverpool University's which is a plus both for the students studying Cancer research, and staff and Patients at the new hospital.

Parking will also be free; I am pleased to say, for Visitors and Patients receiving Care in this new hospital.

A big thank you must be expressed to all members of the Halton Health Scrutiny Board for all the dedicated work done over the last year. Thanks 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.

We would also like to thank Simon Banks and his team at the NHS Halton Clinical Commissioning Group (CCG) and Sue Wallace Bonner for all the help and support given to the Board over the past year too.

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 Marjorie Bradshaw
Councillor Martha Lloyd Jones
Councillor John Gerrard
Councillor Pauline Sinnott
Councillor Pamela Wallace

During 2014/15, Tom Baker was Halton Healthwatch's co-opted representation on the Board and we would like to thank Tom for his valuable contribution.

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 2014/15. 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 2014/15.

GOVERNMENT POLICY- NHS AND SOCIAL CARE REFORM

Care Act

In May 2014, the Care Bill received Royal Assent and became the Care Act 2014. Some elements come into effect from April 2015; others come into effect from April 2016.

The significance of the Care Act should not be underestimated as it replaces much of the legislation that has governed Adult Social Care since 1948.

To oversee the implementation of the Care Act in Halton, the Council have established an overarching Care Act Strategic Group chaired by Operational Director Prevention and Assessment. The strategic group in turn oversees six sub-groups each working to their own implementation plan that includes working towards completion of reviewing relevant documents, policies, considering training and workforce development, charging and cost implications as well as understanding and identifying potential risks.

In January and March 2015 the Board received detailed reports outlining progress towards implementation which provided the Board with the necessary assurances that Halton were on track with the required changes that were required by April 2015.

NHS Five Year Forward View

Following the publication of the Five Year Forward View in October 2014, which sets out a vision for the future of the NHS, the Board received a report from Simon Banks, Chief Officer of NHS Halton Clinical Commissioning Group (CCG), outlining how health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The Forward View has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts also contributed to its development.

As part of the report presented, the Board was provided with details of Halton's response to the NHS led strategic view. This response will ensure that there is congruence with the CCG's 5 Year Commissioning Strategy, 2 Year Operational Plan, Halton's Better Care Fund and other initiatives that are shared with partners across the borough.

Primary Care Co-Commissioning

In January 2015, the Board received a report outlining NHS England's 'Next Steps towards primary care co-commissioning'. The document presented to the Board outlines how NHS England aims to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy. The Board were provided with details as to the level of primary care co-commissioning NHS Halton CCG wished to undertake with NHS England.

SERVICES

Community Wellbeing Practices

The Board received an interesting update in relation to the Community Wellbeing Practices (CWP) initiative which provides a wraparound service for all 17 GP practices in the borough to ensure patients whose needs are predominantly psychosocial in origin are identified and provided with effective community based interventions.

The Board were interested to hear how the CWP initiative has continued to provide three core services for patients and the public over the last 12 months, as follows:-

- *The provision of psychosocial support* - such as life skills training, community events and a comprehensive, fully integrated social prescribing programme;
- *A community navigation service* - a holistic wellbeing assessment in conjunction with a community brokerage service to link patients to support provided by the wider voluntary, community and social enterprise sector (VCSE); and
- *Asset based community projects* - empowering patients and the public to play a lead role in designing and delivering community based activities that improve wellbeing. Working with VCSE partners the CWP initiative have empowered young people to run their own wellbeing projects linked to GP

practices, enabled patients to run their own hobby and interest groups and encouraged volunteers to play an active role in the CWP initiative as community champions.

Improving Access to Psychological Therapies (IAPT)

In November 2014, the Board received a presentation from Mr Paul Campbell, Clinical Psychologist from the IAPT Service, regarding the main principles behind the service, how the service operates and current performance.

The Halton model developed, implemented and presented to the Board had been based on the Award winning Wigan service provided by the 5 Borough's Partnership. This service was recently identified as being in the top ten services in the country with regard to quality. The model used a self-referral system that improved access to talking therapies for clients and had the highest recovery rates in the North West. The Board is hopeful that this success will be replicated within Halton.

POLICY

A strategy for General Practice services in Halton

During 2014/15, the Board received regular reports/information regarding the development of Halton's GP Strategy, with the final Strategy being presented to the Board in March 2015.

General Practice is often described as the cornerstone of the NHS. The basic delivery model of General Practice has evolved over time but not radically changed. There have been seismic shifts and environmental pressures in health and social care in recent years that have challenged the sustainability of General Practice.

The Strategy presented to the Board recognises the challenges General Practice services face but also seeks to address them within Halton by building upon the foundations of the good work that are already in place.

The Strategy looks at how we can continue to improve the quality, capability and productivity of our General Practice services through a collaborative approach with key stakeholders and, most importantly, with our wider population.

The principle approach throughout the development of the Strategy has been about engagement with local practices, NHS England, providers and partners and the public and a range of patient groups. Initially NHS CCG worked to develop a shared understanding of the problem that needed to be solved and then worked on co-designing and co-producing what a sustainable model of General Practice should look like for Halton.

Commissioning Strategy for Adult of Working Age Living with Physical Disability in Halton

In Halton the number of working age adults reporting that their activity is limited by illness or health problems is significantly higher than nationally. Projections show that numbers of people living with more than one long term condition will increase and potentially this will limit the activity of more people.

As such in September 2014, the Board received 'Choice, Control and Inclusion' the Commissioning Strategy for Adult of Working Age Living with Physical Disability in Halton. The integrated strategy brings together the commissioning intentions of Public Health, the Clinical Commissioning Group, and Adult Social Care. The Board were pleased to see how this holistic approach will strengthen informal support and through effective prevention and early intervention minimise the need for more formal care.

Commissioning Strategy for those living with Sensory Impairment in Halton

Halton's ageing population means by 2020 there will be more than a 20% increase in numbers over age 65 living with hearing impairment and a similar increase for those living with visual impairment. Both are contributing factors to falls in older people and many over 65's will experience loss in both senses. 50-70% of sight loss in the older population is avoidable or treatable.

As with the above Strategy, 'SeeHear', the Commissioning Strategy for those living with Sensory Impairment takes an integrated approach to improve the quality of life for Halton residents living with sensory impairment and brings together the commissioning intentions of Public Health, the Clinical Commissioning Group, and Adult Social Care.

The holistic approach undertaken will again strengthen prevention and early intervention and help minimise the impact that people living with sensory impairment has on daily living.

SCRUTINY REVIEWS

Care at Home Provision in Halton

The Care at Home Provision scrutiny review focused on the quality of services provided to those who are supported to live at home within Halton. The review examined the effectiveness of a selection of social care and health services in meeting the needs of the local population.

The scrutiny group sought evidence via presentations from a number of sources that enable people to remain living well within the community and provide care at home, in addition to undertaking visits to services. Contributors to the review included those

from Sure Start to Later Life, Community Nursing, Halton Borough Council Quality Assurance Team, Lifeline/Community Warden Service, Enablement Team and Extra Care Housing.

As a result of the review the Board has made a number of recommendations, including that:-

- Adult Social Care to be consulted on/contribute to any developments in the provision of telehealth to help people maintain independence.
- The Sure Start to Later Life Service should continue to have an important role in delivering personalised wellbeing outcomes.
- The Council's Quality Assurance Team to have an increased role in market oversight, supporting quality improvements and preventing provider failure as a result of the Care Act.
- The role of staff in supporting tenants within extra care schemes to be made explicit in the contract between the provider and the prospective tenant.

Cancer Services

The Transforming Cancer Care Project was established by the Clatterbridge Cancer Centre. The aim of the review was to ensure that services were delivered in the best way to improve outcomes for patients. A key issue addressed as part of the review was consideration of the geographical location of the specialist Cancer Centre on the Clatterbridge hospital site.

As outlined earlier on in this annual report a Joint Health Scrutiny Committee was established across Merseyside and Cheshire to consider the proposals. The Committee reviewed all the materials presentation and considered a number of factors including:-

- Case for change;
- Patient perspectives;
- Frontline staff perspectives;
- Financial Issues;
- Project Management; and
- Clinical Case for Change.

An analysis of responses to the formal public consultation conducted was also considered by the Committee.

As a result of the review the Committee agreed the proposals to develop a new Cancer Centre in Liverpool adjacent to the redeveloped Royal Liverpool University Hospital. The Committee also agreed that they would set up a further Joint Scrutiny Committee for Cheshire and Merseyside in order to monitor the project over the next few years.

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.

INFORMATION BRIEFING

During 2014/15 the Board introduced an information briefing bulletin that is sent out to all Board members in advance of each of the Board meetings.

The introduction of the Information Briefing is a way of trying to manage the size of the agendas of the Board meetings better, as the Board found that many reports going to Board were only being presented for information. As such, including these reports/information now into the Information Briefing it allows the Board to focus more on areas where decisions etc. are needed.

Members have the opportunity to review the information in the briefing and return any questions, comments or concerns they wish to discuss further to Committee Services who in turn collate and forward through to the Chair of the Board for consideration and response.

Areas that have been included in the Information Briefing over the last 12 months have included:-

- Provider Quality Accounts 2013/14;
- Social Care Bill – Progress towards implementation;
- NorthWest Ambulance Service (NWAS) - 5 year plan;
- Customer Care Annual Report 2013/14; and
- Healthwatch Annual Report 2013/14.

WORK TOPICS FOR 2015/16:

Discharge from Hospital

Discharge planning is a routine feature of the Health and Social Care system and consists of the development of an individualised discharge plan for the patient prior to leaving hospital, with the main aim of improving a patient's outcome.

Planning for discharge helps reduce hospital length of stay and unplanned/emergency readmissions to hospital, relieves pressure on hospital beds and improves the co-ordination of services following discharge from hospital.

This topic will focus on the quality of the Discharge planning process and associated pathways to those Halton residents who have been admitted to the local Acute

Trusts for both elective and emergency care. 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.

Report prepared by Louise Wilson, Development Manager – Urgent and Integrated Care, Communities Directorate

Email: louise.wilson@halton.gov.uk Tel: 0151 511 8861

REPORT TO: Health Policy & Performance Board

DATE: 9 June 2015

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Community Nursing Service

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide feedback on issues discussed at the Health Policy and Performance Board in March 2015 following presentation of the Care at Home Scrutiny Review 2014/15, with respect to the Community Nursing services in Halton.

2.0 **RECOMMENDATION: That the Board:**

1. **Note the contents of the report; and**
2. **Acknowledge the steps taken to ensure the community nursing service has capacity to provide a safe and efficient Community nursing service.**

3.0 **SUPPORTING INFORMATION**

3.1 As part of the Care and Home Scrutiny Review 2014/15 report that was presented to Board on 10th March 2015, the review took into account current Community Nursing Services and as part of the review Members received a presentation from the Clinical Manager of Halton Community Nursing and the Service Manager for Adult Community Nursing the Community Nursing services regarding the service that is currently delivered in Halton.

The presentation given as part of the review focused on such areas as current staffing levels, referrals, quality and safety aspects and patient feedback.

3.2 When the report was presented at Board in March, Members expressed concerns about a perceived lack of capacity within the Community Nursing service.

3.3 In order to provide Members with appropriate assurances, the following is an update on the posts affected and the actions taken to ensure a safe workforce is in place:-

- A Band 7 evening service District Nurse sister returned from long term sick leave week commencing 12th April 2015 on a 4 week phased rehabilitation return to work programme.

- A vacant 0.4 FTE Band 5 Community Nurse post has been recruited to and a start date is expected to be confirmed imminently following the completion of recruitment checks.

- 2 x 0.4 Band 5 post interviews took place on 28th April 2015 and recruitment checks for the successful candidates have commenced.

- A Band 7 District Nurse sister left the Trust on the 26th April 2015; however she will be remaining on the nurse bank for night duties. The post is being advertised and, until it has been recruited to, the Trust has taken on a very experienced agency nurse working 2 to 3 nights per week who is interested in applying for the post.

- There are no capacity issues in the District Nursing Out of Hours Service. Staff within the service occasionally report issues when the evening staff have to hand over patients if they have been delayed with an end of life patient which impacts on their workload. This is because the community nursing service prioritises end of life patients and this has been discussed and agreed with staff.

4.0 **POLICY IMPLICATIONS**

4.1 None associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None associated with this report.

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

6.1 **Children & Young People in Halton**
None associated with this report.

6.2 **Employment, Learning & Skills in Halton**
None associated with this report.

6.3 **A Healthy Halton**
This report relates directly to the health and wellbeing of individuals who access care and support within the community.

6.4 **A Safer Halton**
None associated with this report.

6.5 **Halton's Urban Renewal**
None associated with this report.

7.0 **RISK ANALYSIS**

7.1 None identified at this time.

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.

REPORT TO: Health Policy & Performance Board

DATE: 9 June 2015

REPORTING OFFICER: Chief Officer, NHS Halton CCG

PORTFOLIO: Health and Wellbeing

SUBJECT: Information Management & Technology (IM&T) Strategy 2015-18

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Board with the 2015-2018 IM&T strategy for Halton.

2.0 **RECOMMENDATION: That Members of the Board:**

i) Note the contents of the strategy
ii) Note the Year 1 priorities within the strategy

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

The development of the document was carried out in collaboration with a number of key stakeholders including:

- St. Helens and Knowsley Teaching Hospitals NHS Trust (StHK)
- Warrington and Halton Hospitals NHS Foundation Trust (WHHDF)
- 5 Boroughs Partnership NHS Foundation Trust (5BP)
- Bridgewater Community Healthcare NHS Trust (BW)
- Halton Borough Council (HBC)
- St Helens and Knowsley Health Informatics Services (HIS)
- Voluntary sector
- Academic Health Science Networks (AHSN)
- Strategic Clinical Networks (where applicable) (SCN)
- Police Services
- Urgent Care 24 (UC24)
- North West Ambulance Service (NWAS)

The above stakeholders were invited to a number of engagement

sessions and meetings to ensure that we could understand the wider healthcare economy priorities and how these align with our local priorities in Halton so that we are not duplicating efforts and are making the best use of our local resources.

Following engagement with stakeholders the strategy aimed to identify what both our local priorities are in relation to IM&T and also the wider healthcare economy priorities which span a number of organisations and which are likely to span the life of the strategy.

The workstreams were identified by first specifying the need that was not currently being met and then identifying the possible solutions that could meet this need. Their potential impact on outcomes and also their ease of implementation was also mapped.

The strategy was presented to the CCG Service Development Committee in February 2015 and was approved via the Governing Body in March 2015. The workstreams are now being developed into a number of detailed project plans to be progressed over the coming months.

3.2 **Strategic context and Governance**

A number of workstreams within the IM&T strategy are also part of and have been influenced by a number a wider strategic CCG programmes currently being undertaken:

- Prime Ministers Challenge Fund
- Strategy for General Practice
- Emerging 'One Halton' programme

In addition a number of workstreams have been identified as a priority across a number of stakeholders. In order to ensure that these are progressed effectively, they have also been incorporated into the Health Informatics Service (HIS) operational workplan and will be monitored via the HIS Operational Group, who provide IM&T support for the CCG and a number of out neighbouring CCG's.

Locally, we have a Halton IM&T working group who will be responsible for monitoring the progress of the strategy implementation, including both the local priorities and also oversight of the wider health economy projects via feedback from the HIS Operational Group. The IM&T group will provide quarterly updates to the Information Governance Committee.

3.3 **Current position and next steps**

The identified workstreams within the IM&T strategy are now being planned in collaboration with the relevant stakeholders and detailed project plans being developed. These will form a monitoring

dashboard that will be discussed monthly at the IM&T working group and form the basis for the quarterly IG Committee report.

4.0 **POLICY IMPLICATIONS**

4.1 In line with NHS England, 2014, *Five Year Forward View*.

4.2 In line with NHS England, *Prime Minister's Challenge Fund: Improving Access to General Practice*, NHS England, 2014.

5.0 **FINANCIAL IMPLICATIONS**

5.1 Within existing CCG resources.

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

6.1 **Children & Young People in Halton**

None

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

None

6.3 **A Healthy Halton**

Embedding IM&T into existing practices and across organisations will ensure that clinicians have access to the appropriate and necessary clinical information when required which will both improve and support the clinical management of a patient, with the aim of improving health outcomes for our population.

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 A number of the priorities identified within the strategy require cross-organisational working. As such there is a risk that competing organisational priorities may result in delays to implementation.

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.

NHS Halton Clinical Commissioning Group IM&T Strategy Report

2015-2018

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Executive Summary

NHS Halton Clinical Commissioning Group (HCCG) has a clearly stated intention to use transformational technologies (Priority Area 4 HCCG Five Year Strategy) to meet the needs of its patient population, users and staff; the CCG also sees Information Technology (IT) as a method for maximising the benefits from change.

This report highlights the system needs and proposed technologies that can be used to improve patient care, reduce barriers to communications and improve access to information. The needs and technologies referred to in this document have been identified and developed via extensive engagement, designed to understand the operational issues and barriers in relation to information management. This document outlines potential solutions to the issues identified as part of the engagement work, some of which are direct technological solutions are some of which are the supporting processes that need to be in place.

Two of the proposed solutions have been assessed and prioritised as having the greatest potential impact on service provision:

1. Interoperability between clinical systems
2. The Integrated Clinical Environment (ICE)

The deployment of these solutions is dependent on an associated relative ease of change. In this regard interoperability and ICE are assessed as being the high impact solutions that can be implemented and used by a wider group of staff over the life of the strategy.

The scope for deployment of all the solutions is wide and based on HCCG's expressed desire for transformational change and service development. The solutions outlined in this document can be applied to all care sectors:

- Primary
- Community
- Secondary
- Mental Health and
- Social Care

Adopting new, or expanding existing technologies to additional groups of staff and users will make a major contribution to all of the CCGs patient-centred Priority Areas, as well as realising the benefits of harnessing transformational technologies to bring about improving healthcare delivery.

Stakeholders are asked to note the contents of this strategy document and support the development and extension of the key priority areas over the next year, and to support the proposals for the use of IT to enable healthcare provision, across the CCG, over the subsequent 2 years, until 2018.

Stakeholders

Due to the wide ranging role that technology can play in health and social care delivery, this strategy has taken a health economy approach and as such will be shared with our wider stakeholder group, who have also been engaged in this process. This includes:

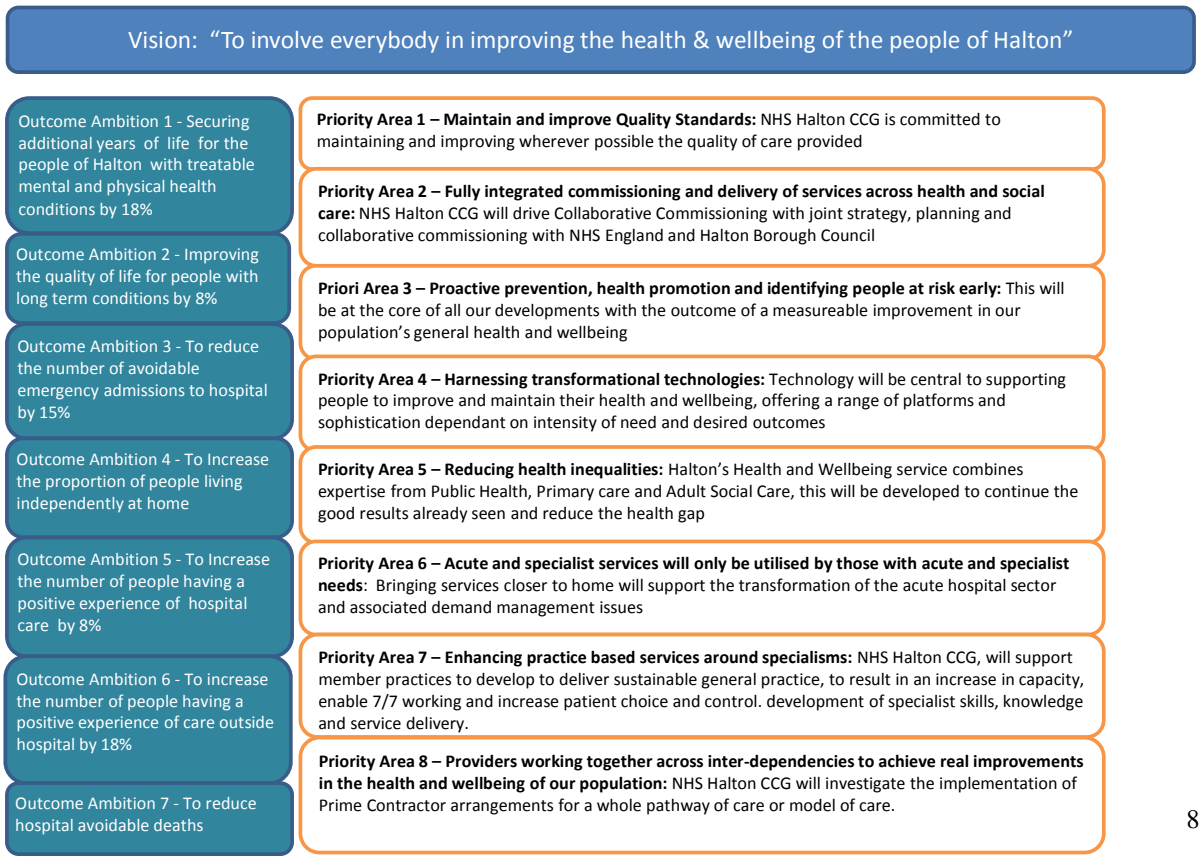
- St. Helens and Knowsley Teaching Hospitals NHS Trust (StHK)
- Warrington and Halton Hospitals NHS Foundation Trust (WHHDF)
- 5 Boroughs Partnership NHS Foundation Trust (5BP)
- Bridgewater Community Healthcare NHS Trust (BW)
- Halton Borough Council (HBC)
- St Helens and Knowsley Health Informatics Services (HIS)
- Voluntary sector
- Academic Health Science Networks (AHSN)
- Strategic Clinical Networks (where applicable) (SCN)
- Police Services
- Urgent Care 24 (UC24)
- North West Ambulance Service (NWAS)

There are a number of priorities identified in this strategy document that will be reflected in local organisational policies as such it will be necessary to establish cross organisational steering groups in order to manage the governance required for projects of this scale.

Background

NHS Halton CCG set out a five year plan and operational strategy in 2014. To achieve health improving outcome ambitions, the CCG has defined 8 Priority Areas for action; Priority Area 4 makes specific reference to making best use of technologies that will transform, improve and maintain health and well-being.

Having completed the 'Five Year Strategy and 2 Year Operational Plan 2014-2019' in October 2014, there was a need to develop the IM&T strategy bearing in mind NHS England's six characteristics of a high quality sustainable health and care system; this ensures a local and national context for the IM&T solutions that comprise the strategy.



NHS England's six characteristics of a high quality sustainable health and care system are:

1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step-change in the productivity of elective care
6. Specialised services concentrated in centres of excellence (as relevant to the locality)

And as integrated care is a central feature of current health planning and direction, this early strategy work has been based on consultation with a multi-disciplinary team of staff drawn from across both health and social care.

Wider Considerations

Strategy for General Practice

Over the last 12 months, NHS Halton CCG has been developing a strategy for General Practice in partnership with local practices, clinicians, public, partners and providers. We have undertaken extensive engagement to develop the strategy and from this, a new model of care has emerged that brings all providers of health and social care, statutory and non-statutory, together to focus on improving out of hospital care and the wider preventative agenda.

This work emerged as we recognised that the demands on General Practice on out of hospital care, have never been greater, and our out of hospital workforce is changing, particularly as significant numbers of GP principals are nearing retirement age. There is also the need to extend and improve access to services and at the same time ensure a focus on prevention.

The driving concept of the new approach is to strengthen services in the community, wrapping them around local people; ensuring needs are met through an integrated health and social care delivery model. Essential to this is that the future model of General Practice fits in to the overall system.

The proposed model will see GP practices working better together in a more integrated way. As well as working better together, practices will also work even more closely with Community, Mental Health and Wellbeing, Social Care, Urgent Care, Children's Services, the Voluntary, Community and Social Enterprise (VCSE) sector and Pharmacy services all wrapped around Community Hubs. This concept resonates with NHS England's Five Year Forward View and the description of a Multispecialty Community Provider (MCP).

We must ensure that the use of information and information technology to improve patient care, access to care, the patient experience, delivery of clinical outcomes, health record keeping and value for money should be, and will be, a fundamental part of all future of General Practice.

Therefore, using and embracing technology to improve communication and interoperability of systems between practices and providers is essential, as is the development and use of Assistive Technologies to support the self-care agenda.

The overarching IM&T strategy needs to support this direction of travel and promote and encourage the use of technologies to realise the full potential of the new model of care.

Medicines Management

Information Management and technology is an integral part of medicines management and any IM&T element will need to interact with other clinical systems particularly those within Primary Care. NHS Halton CCG currently utilise the ScriptSwitch system which interoperates with GP clinical systems to assist with prescribing decisions and adherence to local guidance. We are contracted with this system until 31st March 2015. The intention is to extend this contract to allow a review of the requirements of this service and explore new technologies and solutions or additional functionality within the current system to match our specification.

NHS Halton CCG also currently utilise Webstar. Webstar is designed to help commissioners manage the administration of our minor ailments service within community pharmacy enabling focus on services rather than administration. This contract expires on 31st March 2016. It will be necessary over the next 12 months, to review our service requirements to ensure that we are adopting the most appropriate solution. There may also be opportunities for collaborative working with our Local Authority team to gain some economies of scale.

External Funding

In order to support the workstreams identified within the strategy, NHS Halton CCG have identified a number of potential funding streams that align with the strategic direction which include the Prime Ministers Challenge Fund and NHS England capital schemes. These potential funding opportunities will be confirmed in Q1 2015/16 and if successful, will be used to support a number of the programmes below, in particular:

- Interoperability
- Mobile working
- Patient centred media
- Predictive and Preventative Care Technologies

Process and approach to the solution proposals

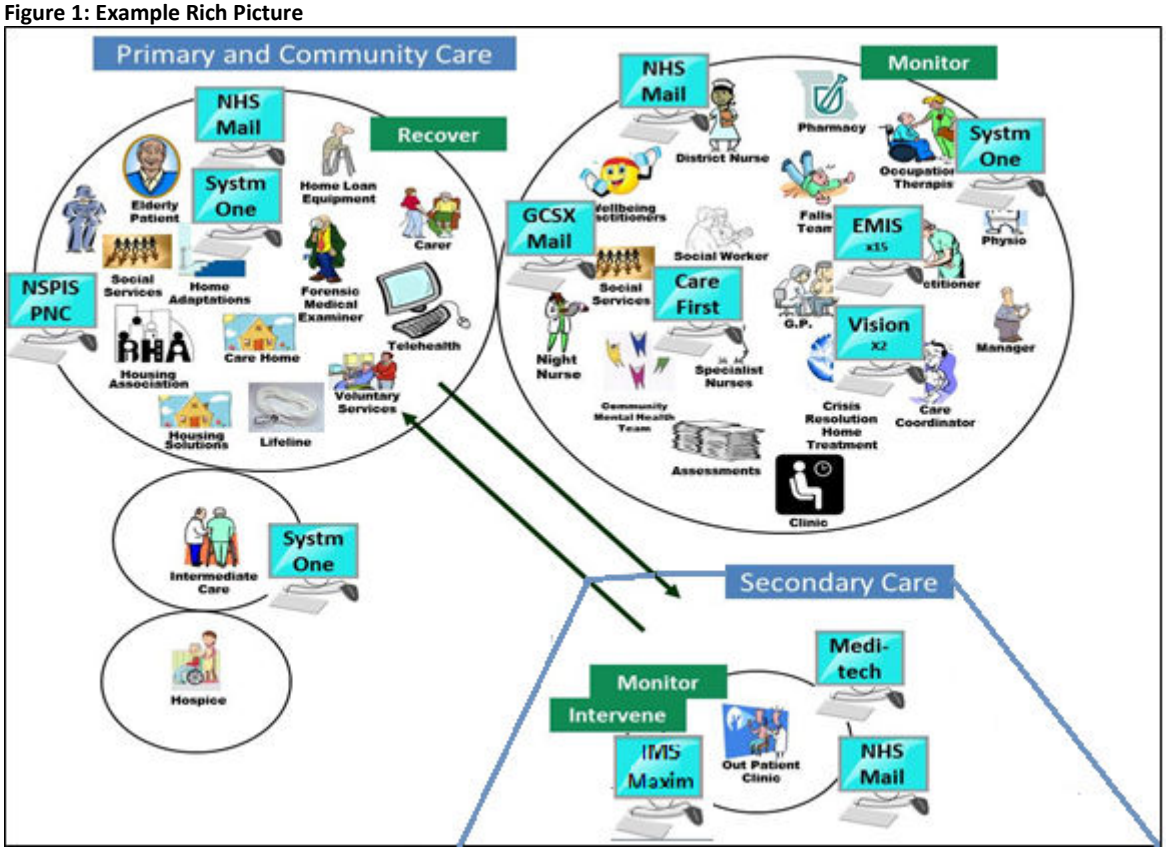
To engage with stakeholders as part of the IM&T strategy development, two workshops were held, one in October 2014 and a follow-up event in November 2014. The workshops were attended by staff from all sectors of the health and care community.

The workshop groups were tasked with defining problems and opportunities for improvement through six care streams; Present, Diagnose, Prepare, Intervene, Recover, and Monitor. Attendees were divided into three over-arching pathways to build a ‘Rich Picture’ for each of the following settings:

- Planned Care
- Unplanned Care and
- Mental Health

The groups constructed a picture and considered current working problems and solutions in terms of People, Process and Technology. This report focuses of the technology elements of their thinking.

Figure 1: Example Rich Picture



Key Problem Domains

During the IM&T strategy workshops, nineteen key problem domains were described. Upon review, it was established that the problems span five of the six key care phases; presentation, diagnosis, preparation, recovery, and monitoring. No problems were identified which related exclusively to the intervention phase although it is likely that improvements in other areas would have positive influence on this area. The problem domains were groups into phases and settings of care for further analysis:

Figure 2: Key Problem Domains

Presentation and Diagnosis (Primary and Community care):
1. Information sharing 2. Access to services 3. Access to information 4. People 5. Patient 6. Duplication 7. Technology
Recovery and Monitoring (Primary and Community)
8. Patient flow 9. Access to information 10. Technology 11. Resources

12. Information sharing: Discharge 13. Access to information: Discharge
Diagnosis and Preparation (secondary, planned care):
14. Information sharing: Handoff to acute 15. Access to information
Recovery and Monitoring (Secondary, planned care):
16. Access to Information: Discharge
Presentation, Diagnosis and Preparation (Secondary, unplanned and planned entry routes)
17. Handoff to acute (services) 18. Access to information: Handoff to acute 19. People

Below is some further verbatim feedback the workshop sessions; they too can be categorised as problems relating to communications and access to information, and access to services.

Figure 3: Narrative from workshop sessions

Service User identified problems:
"I know the police will respond straight away so in future they are my first port of call." "I have to tell my story over and over as I am handed off through the service."
Referrer concerns:
"The Mental Health pathway is so complex and dense (and is only one of many) it is not possible to fully understand choice." "Social and domestic referral services are not as well identified as clinical referral services." "Access to GPs can be problematic and cause crises requiring police intervention." "GPs find it difficult to refer because of the time it takes to write/phone for referral." "Social perception of available care does not match reality." "Mental health issues present in subtle ways (repeat calls to police) and so can be difficult to identify." "As a referrer I have no assurance that what I am asking to happen will happen consistently." "There are too many access points causing multiple referrals for a single person." "The lines of communication between professionals are too formal and process-bound to nurture or develop good relations and share information." "There are no informal networks through which decision support can be gained, what would you recommend?" "Crises occur due to referrals to secondary care which are not appropriate and cause lengthy waiting lists."
From Service Providers:
"Referrals can keep bouncing back and forth if they are sent to the wrong place." "There is no single view available for all stakeholders." "Patient journey relies on the good will of the staff that make the pathway work."
Problems relating to referral methods:

"Sending info from a secure system to a secure system is difficult because not all staff have secure email across organisations." "No one single view to all stakeholders means small pieces of the jigsaw can't be put together." "Response targets are fixed and for some it is too long causing unnecessary crises and police intervention."
Regarding assessments:
"Secure mail systems are more difficult to access (because they are secure) and so people tend not to use them."
General observations:
"So many people and organisations [are] involved who don't have all the information causes communications just to other providers for info." "Inconsistent relationships between staff [using the care] pathway has an impact on quality of service, better relationships [will provide a] better service."

These observations and comments by staff can be broadly summarised as problems relating to:

- Inter-disciplinary communications, including access to information
- Access to services by patients and healthcare professionals

Interdisciplinary communications and access to information were identified as being acute in all but the Intervene phase of care. Notably communications are most challenging at the points of patient care transition; between services and providers and at the point of discharge.

In relation to access to services, particularly for patients, there is also a need to ensure that we are effective utilising the way technology can improve our communications with patients to give them increased ownership of their healthcare. There are a number of programmes already in progress which aim to address this need, for example patient online access which aims to promote and support the programme of self-care and it is necessary to build on this platform as part of this IM&T strategy, the intentions for which are detailed below.

It is also clear from the key problem domains that there is huge potential to improve IM&T function within primary and community care. Primary care rely on a number of systems and processes to support their daily functions making it essential that they are efficient and practical with its use and the necessary support is available where needed. This will also ensure that they are utilising best practice and sharing learning across the health economy.

Proposed solutions

The workshops culminated in proposed solutions to each of the problem areas identified above and in some cases one solution was able to address a number of issues. The solutions were considered in terms of:

- **Need/outcome:** What need is this solution addressing and what is the expected outcome?
- **People:** What is required of staff and/or patients
- **Process:** The process or processes that need to be followed
- **Technology:** The supporting and assisting information technology that will enable staff to meet their obligations and execute the process

The range of 19 IT-related solutions proposed is outlined below:

Figure 4: Proposed workplan

Need	Solution	Outcome(s)
To be able to share relevant health and social care information across settings, initially prioritising the sharing of end of life data sharing in line with national requirements.	Interoperability technical solution (e.g. Clinical Portal) to be informed by business case. Hospice transition onto electronic patient system	• Improved patient pathway via more effective handovers • Reduced duplication • Increased opportunity for shared care
Inability for staff teams to efficiently order appropriate tests	Increased access to Integrated Clinical Environment (ICE)	• More efficient service for patients • Increased efficiency for staff, in particular community nursing teams
Variation in utilisation of supporting technology	Increased training and support to be provided as part of IM&T support contract	• Improved productivity and efficiency • Potential to increase direct patient contact time.
Opportunity for earlier discharges, improved access to services and to support mobile working	Telehealth Telemedicine Assistive technology Embed technology into the discharge checklist	• More accessible services for patients • Potential for reduced length of stay in hospital care • Improved efficiency for staff • Improved patient quality of life
Standardised route of referral and standardised supporting	e-Referrals Standardised referral form for all services	• Improved pathways into secondary care • Reduced patient delay

documentation to streamline referral process	Electronic assessments Culture of forward referrals	
Ability for staff to be mobile when visiting various care settings, including Care Homes	Smart card and supporting hardware facilities to allow access to patient systems Reliable Wi-Fi, and devices Bring your own device (BYOD)	• Increased efficiency whilst undertaking mobile working • Improved access to necessary clinical information • Future opportunities for shared care/GP coverage
Improved electronic communications to patients	Multimedia including: email, Text, Skype, VizBuzz, Facebook (Patient-centred Media), patient online access	• Better informed population and use of healthcare resources
Robust and secure information sharing across settings	Shared technology/controlled infrastructure Develop shared care agreements	• Improved patient care via sharing of key health and social care information
Appropriate IM&T support and guidance	Review IM&T support and supporting functions including Information Governance.	• Robust workplan in place • Appropriate levels of support and guidance available
Increased IM&T functionality within primary care	Docman workflow, Utilisation of the Hub, Spine, NHS.net	• More efficient primary care services
Provide access (view only) to cross-sector systems. Role based for easy access	Smart card and supporting hardware facilities to allow access to patient system	• Improved pathways or care across organisational settings • Improved access to necessary data
Access to up to date prescribing guidance and advice within primary care Streamlined prescribing processes	Review of current specification requirements of and options appraisal of available technologies	• Clinically appropriate prescribing decisions • Cost effective prescribing • Efficient prescribing process from the patient perspective • Reduced administration

This list of solutions demonstrates that staff see a great deal of value and benefit from using IM&T, in some cases without having to invest in new technology. Proposals such as improving the Docman workflow, making better use of Spine service and the NHS.net and Bring Your Own Device are good examples of pragmatism.

Appendix 1 of this report documents the corresponding care stream, problem and proposed solution.

Two solutions were repeatedly identified as contributing towards a number of problems and thus appear to have the potential to make the greatest impact on the current situation; the solutions are:

- Interoperability between clinical systems
- Integrated Clinical Environment

Defining the greatest impact solutions

Interoperability between clinical systems

Identifying an interoperability solution to be delivered locally, connecting any healthcare system within a healthcare economy is a key priority. This will give users secure access to the whole-life health records. By mobilising this data via an interoperability solution, healthcare providers are able to deliver safer, more efficient care, based on a fuller understanding of a patient's medical records. There are currently a number of providers within the local health economy that have deployed an interoperability solution, the learning from which should be incorporated in the planning of this project. In additional there is a national focus on data sharing in relation to End of Life records and the requirement for increased coverage across England of an Electronic Palliative Care Coordination System (EPACC's) so it is intended that palliative care would be the initial focus of the interoperability agenda, taking into account the local hospice transition onto an electronic patient administration system.

Providing access to primary care records from Mental Health services (such as the Child & Adolescent Mental Health Service and Substance Misuse Teams) and acute services (such as Outpatients and Pharmacy) and at primary and community health units (such as the Urgent Care Centres and community nursing service) will allow clinical staff the opportunity to better assess patient care needs and contribute to improved outcomes, based on the diagnosis, care and medication records.

A key element of the interoperability agenda is to ensure a mechanism by which data can be linked and as such it will be a requirement for all Providers to ensure the use of NHS number as the prime identifier. It is also acknowledged that the planning for this programme will need to incorporate a number of stakeholders and it will be more realistic for this to be part of the wider health economy IM&T strategy for which NHS Halton CCG are engaged with via the current IM&T support contract and neighbouring CCG's.

Clinical portals would also be a consideration within this workstream as they are virtual electronic patient records, with information being presented within the portal as an assimilation of available information from other clinical information systems. Users have an authenticated single sign on and are able to view information and access other IT systems, based on their role and permissions.

The contents of clinical portals varies but a portal developed for NHS Halton CCG, in cooperation with primary, secondary, tertiary, community and mental health services could provide a point of access to many other software applications, as well as providing users with up-to-date information about a patient (information such as blood results, pending appointments, discharge summary information, single assessment scores).

The options for this will be explored via an options appraisal working collaboratively with neighbouring CCG's as appropriate.

Integrated Clinical Environment (ICE)

ICE, provided by Sunquest, is a portfolio of products that enables pathology and radiology requesting and reporting. ICE is used within primary and secondary care services and is central to GPs making pathology and radiology requests online, and being able to see the results.

Benefit from providing ICE to a broader range of staff, particularly in primary and community services, is that information sharing will be easier; all users, with appropriate access rights, will be able to view the latest patient pathology and radiology orders and results, acting on them to provide the most appropriate level of care.

Prioritising solutions for deployment and considerations

Although the 2 solutions above appear to present the greatest impact and opportunity to resolve operational problems, their priority for implementation is affected by the relative ease by which they can be implemented.

There is also a need to consider the supporting arrangements and infrastructure which sit under not just the 2 key priorities but also the other solutions identified above. This will be key in ensuring that robust Governance arrangements and an over-arching Information Sharing Agreement are in place. In order to provide assurance for providers these will be developed jointly seeking support from our Local Medical Committee's (LMC). This need has been incorporated into the Year 1 planning outline below.

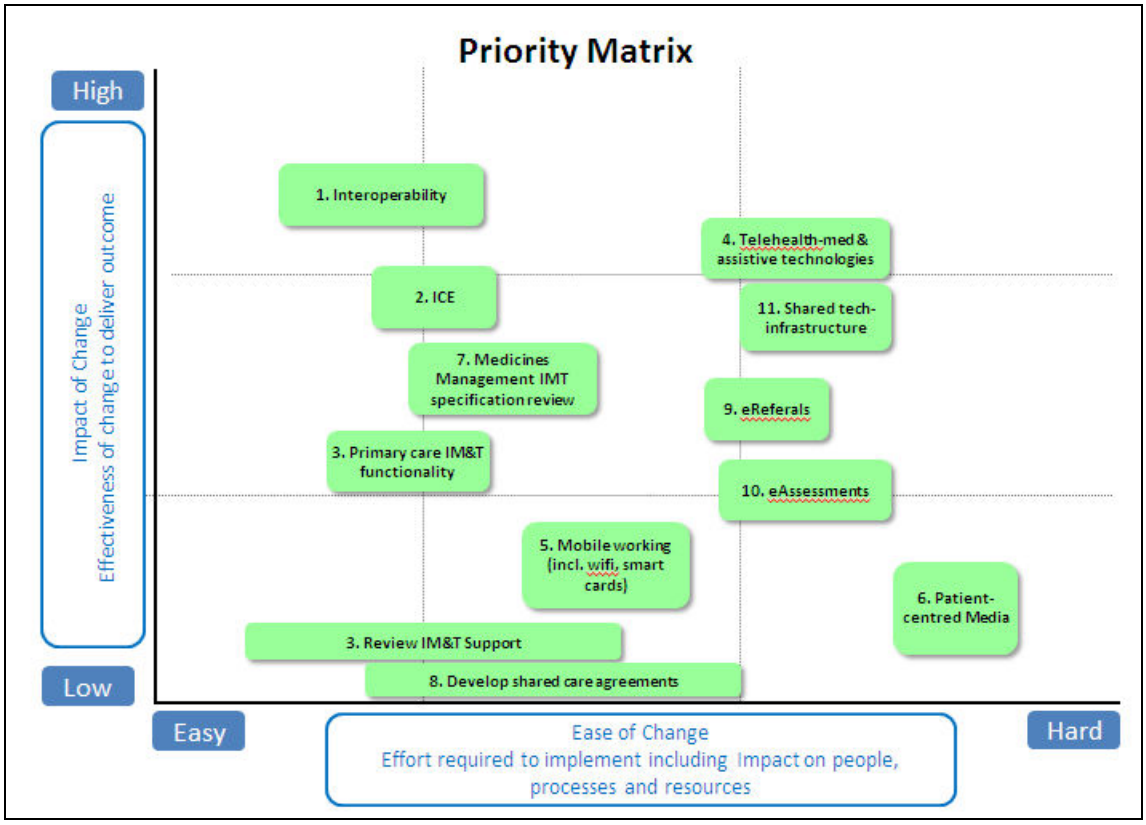
In addition an IM&T Strategy Group will need to be established or incorporated into existing structures to develop plans in relation to each of the solutions identified within this report, with particular focus on the Year 1 deployment recommendations, and define work streams to deliver the solutions. It will also be necessary to consider and plan for the corporate governance necessary to meet the strategy, building on governance work already in place at the CCG

Priority Matrices

The Priority Matrices below illustrate the solutions impact against the ease of implementation.

Figure 5: Prioritising high impact solutions

Figure 6: Prioritising all solutions (numbers correspond to 3 year planning below)



A number of dependencies became apparent when reviewing the solutions; for instance allowing the use of staffs own devices (BYOD) can only be enabled once a reliable Wi-Fi network has been established. Similarly eReferrals and eAssessments may only be fully achievable once a technology platform, such as SharePoint has been set-up. As such the below pages provide a proposed 3 year plan in line with the interdependencies and what is achievable.

Year 1 Planning

In relation to the 2 key priority areas, ICE is an existing solution and there are technical solutions available to support interoperability; with agreement to the benefit and use of each solution, these provide the earliest opportunities to use the technology to improve patient care. They will also contribute to the national priority of managing access to A&E services and avoiding unnecessary admissions in line with the Five Year Forward View.

The use of both solutions by a wider group of staff could be affected by the end of 2015 pending the appropriate information sharing agreements developed and agreed by all relevant parties as outlined above.

It is envisaged that a clinical portal may take longer to develop; specifications will need to be defined and a commercial partner found to build, configure and test the product. A proposed implementation date is March 2017.

Whilst the interoperability and ICE technological solutions are being brought into wider use it is proposed that a number of other solutions can be initiated in Year 1 based on the solutions identified in Table 3 (page 10), some of which will span the life of the strategy due to the complex nature of the projects. These have been highlighted below.

1. **Interoperability** (project brief above) – this will be developed in a phased approach and will span the life of the strategy.

2. **Integrated Clinical Environment (ICE)** (project brief above)

3. Review of current levels of **IM&T support** and need for further training to encourage more efficient use of technology, utilising current IM&T performance reports to inform primary care IT support SLA to increase levels of **functionality within primary care**. This should include (but is not limited to):
    - Docman workflow,
    - Halton Hub,
    - Spine,
    - NHS net,
    - Electronic patient prescribing (EPS)

4. Undertake review of current schemes and programmes being undertaken in relation to **telehealth and assistive technologies**, building on work undertaken by HBC and select

appropriate solutions for further rollout or exploration in addition to horizon scanning of what else is available across the region and through the Innovation Network.

5. Improved **mobile working** via:
    - Implementation of secure router into care homes to provide Smart card access to EMIS for mobile GP working
    - Extend reliable Wi-Fi and devices so that mobile working allows staff to make connections to clinical and social care systems when office bound and out in the community
    - Further develop SharePoint opportunities
    - Investigate BYOD as a real option

    This programme will span the life of the strategy via a phased rollout plan; however a number of elements will be scoped and progressed within Year 1, namely extending Wi-Fi and secure routers in care homes.

6. **Patient centred media -** Improved electronic communications to patients utilising existing multimedia including messaging services, Skype, VisBuzz, Facebook (Patient-centred Media), patient online access

7. **Medicines Management IMT specifications review –** During 15/16 a review will be carried out in relation to supporting Primary care prescribing and the associated administration. This will inform the commissioning decisions for 16/17.

8. Lastly, as part of the Year 1 solutions, the CCG will develop robust **shared care agreements**. These agreements will be useful in not only managing patient care and contributing to the commissioning and provision of integrated care but also defining or refining the IM&T strategy, within and beyond this three year view

Year 2 Planning

In year two (16/17) we propose that these solutions are focused on; they have a medium impact on the health economy and appear harder to implement; by moving them into year 2 of the strategy additional time is provided to lower barriers and increase the chances of operational and deployment success:

9. Develop **eReferrals** to support multidisciplinary working and integrated care provision and as part of this programme work towards developing a standardised referral form for all services

Year 3 Planning

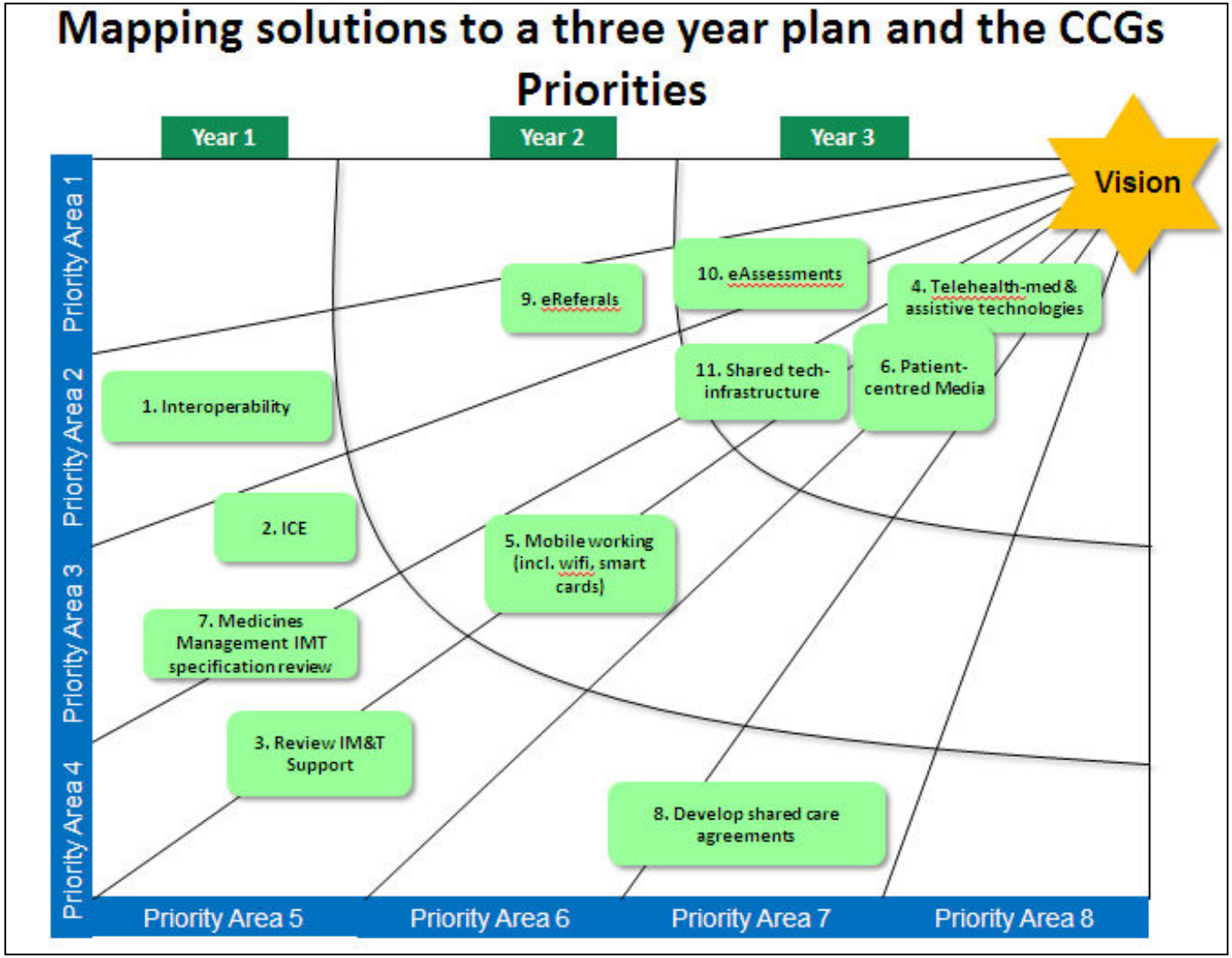
In the third year of the IM&T strategy (17/18), or sooner if practicable, we propose the harder to implement or dependent elements of the strategy be brought into use:

10. Implement **eAssessments**, building on the benefit of eReferrals

11. Providing information via a secure **shared technical infrastructure** will be important as services integrate care and need to share information on secure and common technology platforms. An infrastructure that connects primary, secondary, community, mental health and social care services will allow the information to be shared more freely whilst protecting it from misuse

Deploying the Year 1 solutions, increasing the use of existing technologies and developing shared care agreements will help the CCG to achieve the Priority Areas and Outcomes set out in the 'Five Year Strategy and 2 Year Operational Plan 2014-2019', October 2014. Driving the interoperability agenda will enable the CCG to share, and users to open, patient and service user information. In turn this will assist improved patient and service user management and the provision of improved quality standards, the delivery integrated services, the promotion of health and enable staff to identify people at risk of ill-health. In short, the technology will link to the CCGs Priority Areas.

Figure 7: Mapping the proposed solutions to the CCGs Priority Areas and a 3 year plan



Appendix 1 – Suggested work streams to bring the Year 1 solutions into use

Interoperability and increased functionality of ICE are intended to provide users with up-to-date patient information. As such, and in the first instance, it is likely that the same groups of clinical staff will want access to both applications. With this in mind it is proposed that the programmes are viewed as “opposite sides of the same coin”, allowing the same team of staff to bring both into use, by a wider group of users, at the same time.

The advantages of this approach include:

1. Joined-up thinking about the benefits the applications will bring users and the patient care they manage
2. No duplication of effort; a possible consequence of two change and implementation teams working separately
3. Reduced training time for users – both applications can be introduced at the same time
4. Maximising the benefit to users – assuming that both applications go live with the new users on the same day, clinicians will be able access primary care notes and records, see pathology and radiology results and, if appropriate, request pathology and radiology tests and examinations
5. Maximising the preparation, consultation time and output-outcome collations from the work streams; simply, the same work streams can be used simultaneously to define, plan and complete the tasks necessary to achieve the applications go lives

With this latter point in mind the following work streams are proposed:

1. Project Management
2. Transformation and benefits realisation
3. Governance and information management
4. Technical infrastructure and set-up for deployment
5. Training
6. Finance management

An example plan for these work streams is shown on the next page.

Example work stream plan to deliver the MIG and ICE to a wider group of users in 2015-16

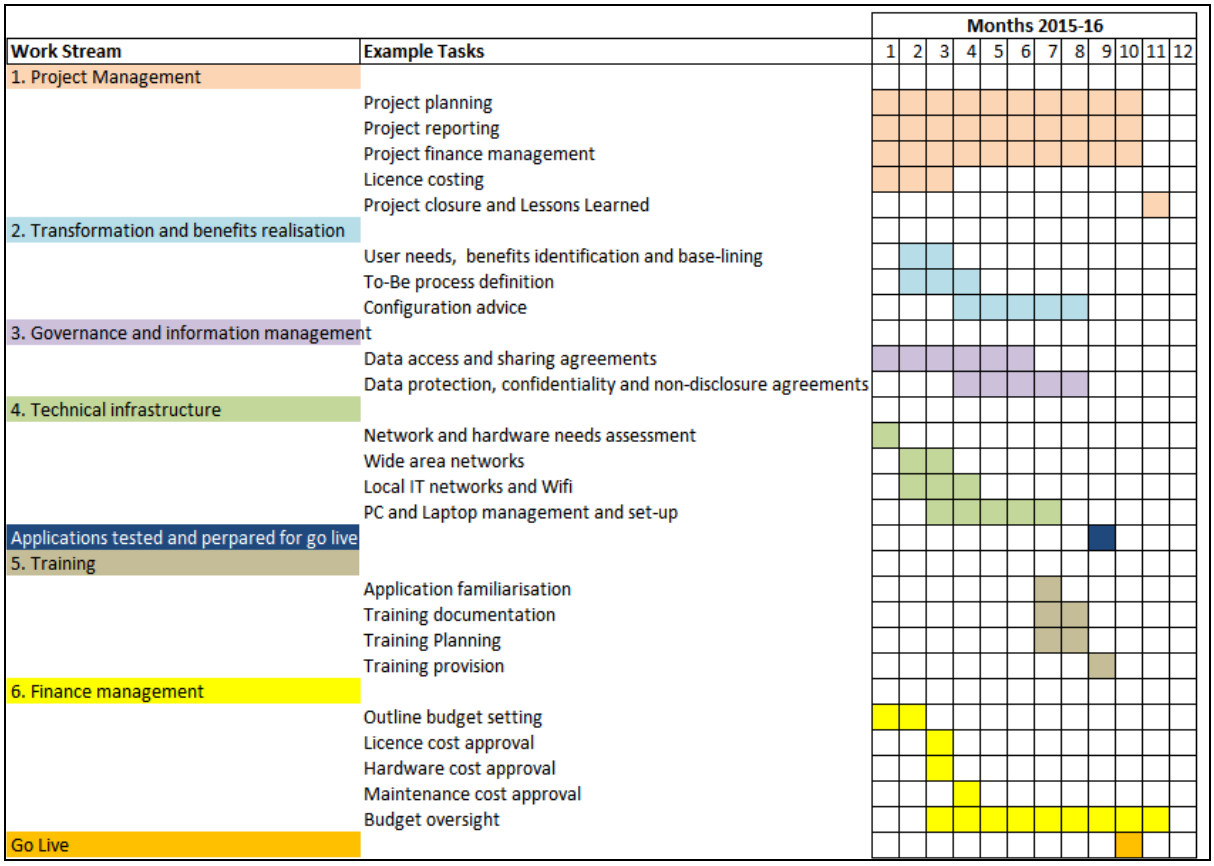


Figure 2: Example work stream plan

REPORT TO: Health Policy & Performance Board

DATE: 9 June 2015

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Urgent Care/System Resilience : Update

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To present the Board with an update report in relation to the Urgent Care/System Resilience agenda within Hatlon, including an update on the Urgent Care Centre developments.

2.0 **RECOMMENDATION**

RECOMMENDED: That the Board Note contents of the report and associated Appendix.

3.0 **SUPPORTING INFORMATION**

Background/Context

3.1 Halton's Urgent Care Working Group (UCWG), formally the Urgent Care Board, was established at the end of 2012. The Group had been responsible for providing multi-disciplinary strategic direction and guidance across the Urgent Care system within Halton and for overseeing all significant service changes required to deliver Urgent Care across the Halton Health Economy, by ensuring that patients could access high quality emergency and follow up care and preventing patients from reaching crisis point so that they need to access emergency care. The Group was also responsible for reviewing and responding to the full range of appropriate data concerning the local urgent care system ensuring that for Halton, patient focussed and cost effective processes were put in place to monitor and react to areas of concern, thus avoiding unnecessary escalation.

3.2 Building on the successful work of the UCWG and following the release of the NHSE guidance 'Operational resilience and capacity planning for 2014/15' Halton have worked to transform the UCWG into a System Resilience Group (SRG) which now has delegated responsibility from NHS Halton Clinical Commissioning Group (CCG) and Halton Borough Council (HBC) for the regular planning of service delivery and the associated capacity planning to ensure delivery across the Halton health economy, in elective and non-elective care. As such the Terms of Reference for the SRG reflect the emphasis on year round resilience and the prominence of a whole system approach, which is mirrored in the membership. The SRG is also the forum where wider considerations such as planning, patient experience, chronic conditions and

home care is discussed.

System Resilience Group

3.3 Formally established in July 2014, the SRG now provides multi-disciplinary strategic direction and guidance across health and social care in relation to non-elective and elective care, taking into account the wider context as laid out by national guidance, such as avoiding inappropriate delays, Children's services and caring for patients with chronic conditions.

3.4 The SRG is also responsible for ensuring that locally there are quality processes in place which are safe and efficient for patients and which are cost effective.

3.5 As such, the membership of the SRG is designed to be reflective of the whole system of health and social non-elective and elective care within Halton, and is outlined in ***Appendix 1.***

3.6 One of the first tasks for the newly established SRG was to produce an Operational Resilience and Capacity Plan with main partners, such as NHS Halton CCG, HBC, local Acute Trusts; St Helens and Knowsley Teaching Hospitals NHS Trust and Warrington and Halton Hospitals NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, 5 Boroughs Partnership NHS Foundation Trust, North West Ambulance Service NHS Trust and NHS England.

3.7 The Plan outlined Halton's SRG response to the need to undertake a whole system approach for operational resilience and the schemes, using nationally allocated non-recurrent funding for operational resilience, to help manage increases in activity etc. within the system.

3.8 The numerous schemes identified:-

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

3.9 These schemes coupled with close operational management of services and work with all providers provided additional capacity within the system to manage the changes in demand whilst maintaining the quality of care for Halton residents.

Winter 2014/15

3.10 During winter 2014/15 additional resources were made available from the Department of Health. In Halton the SRG agreed to focus the resources on preventing attendances and admissions and reducing length of stay. Additional capacity was procured into the 2 acute trusts, community beds, community care packages, North West Ambulance Service and the two discharge teams. System monitoring during this period enable resources to be directed where required. Acute pressure across the system during Christmas and New Year continued through the first 4 months of the year.

The key measure of performance agreed was the national standard (4 hour A&E

Target) for all types of A&E attendance at the Halton population level. This did not go below 93.9% during the period.

SRG Performance Dashboard

3.11 The monthly SRG Performance Dashboard which has been introduced within Halton covers all the key indicators for both non-elective and elective care. This dashboard is actively considered by the SRG at every meeting and as a result of the data/information/trends presented this has led to a number of additional pieces of work/'deep dives' being undertaken to examine in more detail areas of concern and necessary action taken if appropriate. Latest available SRG Dashboard is attached at ***Appendix 2.***

3.12 An example of this has included work to explore the significant increase in recent delayed transfers of care. Following closer examination this dip in performance related to a large number of delays at 5 Boroughs Partnership (5BP). This has now been addressed through close work between NHS Halton CCG, HBC and 5BP. As a result the situation as at the end of February 2015 has seen a significant decrease in the number of Mental Health delays at 5BP. This situation will continue to be closely monitored by the SRG to ensure that any future remedial action that may be required is taken as necessary.

3.13 Another example of a 'deep dive' is the current work taking place, involving a number of partner organisations, to explore why the readmission rates at 30 and 90 days are so high for Halton patients. It is anticipated that this work will be concluded shortly and then necessary action can be taken to improve performance in this area.

3.14 On the basis of the performance being reported, the SRG has also received reports from partner organisations outlining areas of concerns/issues that need to be addressed, an example of this is in respect of NWAS ambulance response times. The SRG received details of the plans that NWAS are putting in place to address the poor performance and this continues to be closely monitored. As a result of the SRG proactively monitoring performance in this area we were also able to implement a Respond and Refer Car Scheme in Halton to support winter pressures, with the main aim being to increase referrals of low acuity patients to alternate care pathways and reduce A&E attendances, hence improve patient outcomes.

Note: It should be noted that the North West CCGs commission Paramedic Emergency Services from NWAS via NHS Blackpool CCG as the Lead Commissioner and work is underway to review the current contract.

Also following completion of the NHS 111 North West Procurement process it has been confirmed that the preferred provider is NWAS in partnership with out of hours GP provision - FCMS and Urgent Care 24 (UC24). Work is now taking place with the three organisations to ensure a phased implementation of the service during October and November 2015.

3.15 Information from the SRG Performance Dashboard, along with a range of soft data is also actively monitored by the Health and Social Care System Resilience Team. The Team consists of Senior and Operational Managers from NHS Halton CCG and HBC,

plus the Clinical Lead for Urgent Care from the CCG.

3.16 This information helps the team proactively provide leadership, operational input/support, ensure appropriate communication and direct resources into the Urgent Care System to respond to particular pressures in the system. An example of this is that an additional 6 Intermediate Beds were put into the system in November 2014 as part of winter planning however it was evident from information being received that additional capacity was required at the beginning of January 2015 and as such we were able to provide an immediate response to this by putting in a number of additional beds into the system.

3.17 Urgent Care Centre (UCC) Developments

3.17.1 **Runcorn UCC**

Runcorn UCC has been operational since 9th February 2015 and is open from 7am until 10.30pm (accepting patients up until 10pm), 365 days a year.

Work is ongoing between Warrington and Halton Hospitals NHS Foundation Trust and UC24 to recruit the necessary numbers of GPs to ensure that there will be a GP presence at the UCC 8am – 10pm, 7 days a week. However at the moment the GP provision at the Unit is still being provided by locum GPs via UC24. The locum GPs are currently being provided from 9am – 5.30pm, Monday to Friday.

It is anticipated that we will have full GP provision at the Runcorn UCC from July 2015 and there will be arrangements in place to rotate GPs between the Runcorn and Widnes UCC as the GPs will be provided by UC24 for both Centers.

In addition to minor injuries/illnesses, the UCC have introduced an additional 16 clinical pathways (covering adults and children) for patients that can be treated at the UCCs; examples of these include:-

- Suspected Deep Vein Thrombosis
- Suspected Pulmonary Embolism
- Asthma
- Exacerbation of COPD
- Rib Injury
- Headache in Adults
- Abdominal Pain
- Syncope (Collapse)
- Low Risk Cardiac Chest Pain (Non-Pleuritic & Non Traumatic)

Diagnostic services are in operation at the Runcorn UCC, as outlined below:-

- Pathology – The UCC have access to a range of tests (some at Point of Care) and arrangements are in place with Halton and Warrington Pathology labs to provide results of tests within 90 minutes from 9am – 10pm, 365 days of the year.
- X-Ray - The X-Ray facilities at the UCC are available, operating from 8am to 8pm, 7 Days a week. Once additional staff are in post, X-Ray at the UCC Runcorn will extend to 10pm.

- Ultrasound – Ultrasound facilities are also available at the UCC Runcorn 9am – 5pm (Monday to Friday) and at the weekends via Warrington General Hospital.

If GPs are concerned about a patient and they believe that the Runcorn UCC can provide the appropriate assessment, diagnostic tests, treatment and discharge for the individual, then they can contact the Nurse Co-ordinator at the Unit directly to discuss a referral.

There has already been instances where episodes of care for patients have been able to be completed within the Unit when previously they would have had to have been signposted or transferred to other services.

Local GPs now receive discharge letters from the UCC electronically, every hour, on the hour, to enable GPs to receive this information as close to real-time as possible.

The service has already received a large number of positive feedback from patients and clinicians.

3.17.2 **Widnes UCC/Healthcare Resource Centre (HCRC)**
Work commenced on the site at Widnes on 4th February 2015.

There are a number of phases to the planned work at the HCRC site which is seeing the redevelopment of the current Walk in Centre on the ground floor to the new Widnes UCC, and the redevelopment of the rooms on the 2nd floor to clinical space which once complete will see a number of services currently located on the Ground Floor moving into the 2nd Floor; these services include Sexual Health, UC24, Windmill Hill and Podiatry.

It is anticipated that works on the Widnes UCC part of the redevelopment will be completed by the end of June 2015 and once completed Members will be given the opportunity to visit the UCC.

Works have commenced on the development of extra car parking facilities on Moor Lane (across the road from the HCRC). Once completed it is anticipated that this will generate some 100+ extra car parking spaces and staff from the HCRC will start to park there, which will mean that the spaces at the HCRC will primarily be used for patients visiting the Centre. Moor Lane car park will also be used as an overflow car park for patients. It is anticipated that the completion of the Moor Lane car park will coincide with the completion of the works to the Widnes UCC.

Once works are completed and the new Widnes UCC is operational, it will operate under the agreed Service Delivery Model as does the Runcorn UCC.

In addition to being able to assess/treat minor illnesses and injuries, as with the Runcorn UCC the Widnes UCC will be staffed by a team of on-site integrated healthcare professionals who will be able to provide care to those presenting at the Centre will a range of other conditions, through the development of the necessary competencies of the staff team and the clinical pathways, examples of which are outlined earlier in this report.

The aim, as with the Runcorn UCC, will be to get the Widnes UCC Kite Marked with Northwest Ambulance Service (NWAS) from 8am until 9pm, 365 days per year.

4.0 POLICY IMPLICATIONS

4.1 As part of the UCC development, work has taken place to operationalise the agreed UCC Service Delivery Model which has meant the need to develop associated Standard Operating Procedures for use within both Centres.

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**
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.

Appendix 1

Halton's System Resilience Group: Membership

Membership of Halton's System Resilience Group outlined below:

- Operational Director (Prevention and Assessment), HBC - **Group Chair**
- Director of Transformation, NHS Halton CCG – **Group Vice Chair**
- Divisional Manager for Urgent Care, HBC
- Head of Planned Care, NHS Halton CCG
- Head of Finance, NHS Halton CCG
- Development Manager for Urgent Care and Integrated Care, HBC
- Transformational Change Manager, NHS Halton CCG
- Consultant in Public Health, HBC
- Clinical Lead Urgent Care, NHS Halton CCG
- Clinical Lead Children, NHS Halton CCG
- Contract Clinical Lead, NHS Halton CCG
- Assurance and Delivery Manager, NHS England
- General Manager for Adults, Bridgewater Community Healthcare NHS Trust
- Chief Operating Officer (plus clinical representative), Warrington and Halton Hospitals NHS Foundation Trust
- Director of Service Modernisation (plus clinical representative), St Helens and Knowsley Teaching Hospitals NHS Trust
- Divisional Director for Adult and Secure Services, 5 Boroughs Partnership NHS Foundation Trust
- Director of Operations and Performance, UC24
- Service Development Manager, Northwest Ambulance Service
- Associate Director, Health Services Commissioning, NHS Warrington CCG
- Chair, Halton HealthWatch
- Representative, Halton Housing Trust
- UCAT Representative, North West Commissioning Support Unit

NB. The SRG may invite other officers to attend the Group in line with agenda items.

System Resilience Performance Dashboard - February 2015

HALTON BOROUGH COUNCIL

Halton NHS Clinical Commissioning Group

	Performance Indicators	Operational Standard/ Plan	Lower Threshold	Baseline	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Accident & Emergency																	
A&E Attendances - Type 1 (Average per day) *(Ref 1)*				13/14 ave per day	2394 (85.5)	2767 (89.3)	2590 (86.3)	2750 (88.7)	2568 (85.6)	2846 (91.8)	2499 (80.6)	2595 (86.5)	2711 (87.5)	2623 (87.4)	2705 (87.3)	2604 (84.0)	2535 (90.5)
	Type 1 A&E at Warrington (Average per day) *(Ref 2)*				1038 (37.1)	1228 (39.6)	1064 (35.5)	1186 (38.3)	1068 (35.6)	1189 (38.4)	1053 (34.0)	1084 (36.1)	1156 (37.3)	1085 (36.2)	1077 (34.7)	1069 (34.5)	1022 (36.5)
	Type 1 A&E at Whiston (Average per day) *(Ref 3)*				1161 (41.5)	1313 (42.4)	1333 (44.4)	1323 (42.7)	1276 (42.5)	1421 (45.8)	1202 (38.8)	1293 (43.1)	1323 (42.7)	1316 (43.9)	1406 (45.4)	1339 (43.2)	1302 (46.5)
Narrative	Although the total number of A&E attendances fell in February compared to January the numbers attending per day increased and February was the busiest month for type 1 A&E attendances for Halton patients since July 2014. The activity increase was particularly acute at Whiston where February saw the largest daily average of Halton patients since reporting to the SRG began, activity at Warrington also saw an increase to the highest level since October but slightly below February 2014																
Whiston	Percentage of patients who spent 4 hours or less in A&E (type 1 &3) TRUST (IN MONTH figure) *(ref SIT REP)*	>=95%	>=94%	96%	94.0%	94.7%	94.0%	92.2%	95.8%	96.5%	96.4%	95.6%	94.7%	93.2%	91.4%	91.9%	93.0%
Whiston	Percentage of patients who spent 4 hours or less in A&E (**type 1 only**) TRUST (IN MONTH figure) *(ref 9)*	>=95%	>=94%		92.3%	93.6%	94.0%	92.6%	95.8%	96.5%	96.7%	94.7%	94.7%	91.6%	89.4%	89.9%	91.3%
Warrington	Percentage of patients who spent 4 hours or less in A&E(type 1 & 3) TRUST (IN MONTH Figure) *(ref SIT REP)*	>=95%	>=94%	95.5%	94.9%	97.0%	94.5%	92.8%	94.9%	91.0%	93.8%	93.3%	93.0%	91.2%	83.7%	84.1%	81.9%
Warrington	Percentage of patients who spent 4 hours or less in A&E (**type 1 only**) TRUST (IN MONTH Figure) *(ref 7)*	>=95%	>=94%		95.4%	96.4%	93.4%	91.2%	93.9%	90.0%	92.3%	91.9%	91.9%	89.7%	81.4%	81.6%	78.7%
Narrative	The 4 Hour A&E target of 95% has been missed by both Whiston and Warrington A&E departments in February, if the type 3 activity at the respective trusts is included then although performance against the target improves the target is still missed. Warrington has missed the 4-hour A&E target every month so far in 2014/15 and Februarys figure is the lowest 4-hour performance so far. Warrington has had significant problems in recent months affecting its capability to move people quickly through the system. D&V and Norovirus led to two ward closures as well as intermediate care units leading to discharges being delayed and ultimately a backlog building up in A&E. In addition the D&V affecting the wards also affected staff and significant staff sickness during this time also made operational conditions difficult.																
% of Type 1 A&E attendances where referral source is GP *(Ref 11)*				4.1%	4.7%	5.1%	5.3%	4.9%	4.8%	4.7%	4.8%	5.3%	5.5%	6.6%	7.8%	7.2%	7.7%
Narrative	The proportion of A&E attendances where the GP has made a referral remained above 7% in February and accounted for 7.7% of all A&E attendances. This should be looked against a 13/14 average of 4.1%. For comparison during 2012/13 the average GP referral rate across the country was 5.8% with the North West having the lowest referral rate of 4.4%.																
(%) Conversion rate - A&E type 1 attendances admitted to hospital *(Ref 14)*		28%		36.2%	37.1%	37.0%	37.4%	36.7%	35.5%	35.7%	36.1%	35.9%	38.8%	37.5%	39.2%	38.6%	39.1%
Narrative	The National Audit Office report "Emergency admissions to Hospital - Managing the demand" October 2013 - highlighted that 26% of patients attending a type 1 A&E department were then admitted. For Halton residents this figure is approximately 39%. The likelihood of an A&E attendance becoming an admission for a Halton registered patient is higher at Warrington (43%) than St Helens (37%) The impact of the urgent care centres in Halton will probably have the impact of increasing the conversion rate as only the most acute patients will be attending the type 1 A&E and are therefore more likely to be admitted.																

	Performance Indicators	Operational Standard/ Plan	Lower Threshold	Baseline	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Non-Elective Emergency admissions - (based on Admission method 21 - 'Accident and emergency or dental casualty department of the Health care Provider)																	
No. of patients discharged following admission via A&E *(ref 24)*				935	875	911	936	978	873	1034	882	894	1025	928	980	973	945
Narrative																	
% of patients discharged following admission from A&E with zero length of stay *(Ref 28)*		<=33.3%	<=37%	32.8%	30.2%	32.8%	35.2%	34.7%	35.3%	36.3%	35.2%	36.8%	34.7%	35.8%	34.5%	31.6%	33.7%
Narrative	January saw the lowest percentage of patients discharged with a zero day length of stay so far in 2014/15 and below the baseline figure for 2013/14																
Emergency Re-admissions 30 days *(corp perf rpt 14)*		15.5%	15.6%	15.6%			305 (21.3%)	278 (17.0%)	256 (16.4%)	305 (17.4%)	253 (16.3%)	284 (16.8%)	325 (17.4%)	300 (16.9%)	210 (16.5%)	198 (13.1%)	
Narrative	A multi-organisational Task and Finish group - acute, NWAS, HBC, CCG and clinicians have been tasked with reviewing the current position with a view to initiating appropriate measures for improvement. Although February data is not available the readmission rate in January was very low.																
Alcohol related Hospital Admissions - (based on first completed hospital episode data where AAF = 1 i.e. 'Alcohol specific admissions' only)																	
Wholly attributable admissions (ref 17)					93	103	72	107	91	99	90	96	102	90	87	86	83
Warrington and Halton Hospitals NHS foundation trust (ref 18)					40	48	26	60	47	50	35	35	45	33	34	37	26
St Helens and Knowsley Hospitals Trust (ref 19)					37	38	34	36	33	36	38	38	42	43	38	42	44
Wholly attributable admissions - Male (ref 20)					57	71	43	67	54	68	60	65	71	56	63	58	55
Wholly attributable admissions - Female (ref 21)					36	32	29	40	37	31	30	31	31	34	24	28	28
Wholly attributable admissions with a zero length of stay (ref 22)					39	45	32	59	40	47	44	45	40				
Wholly attributable admissions - average length of stay (days) (ref 23)					5.2	2.2	3.5	1.6	1.9	2.8	2.8	4.2	2.4				
Urgent Care Centres																	
Total non type 1 A&E					3641	4304	4144	4308	4080	4171	3598	4056	3705	3535	3632	3617	3314
Type 3 & Type 4 (ave per day)					130	139	138	139	136	135	116	135	120	118	117	117	118
(34b) Halton Patient Attendances - HCRC walk in centre (Widnes) Type 4					2646	3070	2942	3079	2799	2892	2523	2790	2610	2558	2804	2753	2417
(34b) Halton Patient Attendances - Minor Injuries Unit (Runcorn) Type 3					995	1234	1202	1229	1281	1279	1075	1266	1095	977	828	864	897
Ratio of Type 3 /4 attendances at MIU or HCRC to Type 1 attendance at Whiston or Warrington					1.66	1.69	1.73	1.72	1.74	1.60	1.60	1.71	1.49	1.47	1.46	1.50	1.43
Narrative	Whilst increases in type 1 activity have been witnessed, activity at the MIU and WIC has reduced, February saw the smallest number of type 3/4 attendances as a ratio to type 1 attendances, falling to 1.43 :1																

	Performance Indicators	Operational Standard/ Plan	Lower Threshold	Baseline	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Out of Hours																	
	Total number of Halton calls completed on Adastra (% variance from 13/14 activity) *(ref 57)*	0%-7.5% from 13/14 base	7%-15% from base	13/14 actual	1559	1788	1775 (+5%)	1938 (+14%)	1472 (+4%)	1465 (+13%)	1556 (+4%)	1312 (-2%)	1489 (+13%)	1637 (+11%)	2210 (+17%)	1929 (+18%)	1587 (+2%)
Narrative	RAG banding has been introduced, this shows the % variance to the number of calls recorded in 2013/14. this highlights that almost every month in 2014/15 has been busier than the corresponding month in 2013/14 and that December and January were exceptionally busy months having 17% more calls compared with the corresponding month in 2013/14.																
Ambulance - NWAS																	
	The number of category A (red 1) calls resulting in an emergency response arriving at the scene of the incident (% within 8 minutes) *(ref 83)*	75%	none		25 (64.00%)	38 (68.42%)	30 (76.67%)	42 (76.19%)	27 (55.56%)	36 (75.0%)	44 (81.82%)	35 (68.57%)	40 (77.5%)	36 (63.9%)	61 (63.93%)	37 (67.6%)	40 (92.5%)
	The number of category A (red 2) calls resulting in an emergency response arriving at the scene of the incident (% within 8 minutes) *(ref 86)*	75%	none		540 (75.0%)	624 (74.4%)	606 (77.6%)	573 (74.0%)	562 (73.3%)	589 (68.1%)	567 (73.0%)	558 (75.5%)	637 (73.9%)	612 (69.9%)	743 (60.16%)	664 (60.4%)	606 (61.9%)
	The number of category A (red 1& 2) calls resulting in an emergency response arriving at the scene of the incident (% within 8 minutes) *(ref 83-88)*	75%	none	613 (76.7%)	565 (74.5%)	662 (74.0%)	636 (77.5%)	615 (74.1%)	589 (72.5%)	625 (68.5%)	611 (73.6%)	593 (75.0%)	677 (74.2%)	648 (69.5%)	804 (60.4%)	701 (60.8%)	646 (63.8%)
Narrative	The most urgent (Red 1) calls achieved the target in February for Halton patients, the larger volume but still urgent calls (Red 2) saw an slight improvement in performance but still significantly below target and a reduction in activity compared to March but higher than the corresponding month in 2014, mirroring the pattern seen in A&E attendances.																
	Turnaround times (Average) (mins) Whiston	<15	<30	27.68	27.31	26.36	27.25	26.36	27.36	27.32	28.25	28.12	28.6	31.2	32.4	32	27.4
	Turnaround times (Average) (mins) Warrington	<15	<30	23.90	22.45	22.28	22.38	23.47	23.21	25.03	25.1	24.58	25.5	26.2	32.5	30.6	32.1
Narrative	Ambulance turnaround times improved again in February at Whiston and the average turnaround time is back below 30 minutes and the lowest since July 2014. At Warrington, average ambulance turnaround times increased in February and remain above 30 minutes.																
Delayed Discharge Transfers - Halton GP registered patients - Snapshot taken last Thursday of the Month																	
(158 & 159)	Number of delayed discharge transfers & (Days)			6.6	7 (245)	5 (268)	14 (257)	6 (235)	9 (196)	4 (225)	6 (239)	2 (145)	5 (133)	7 (223)	9 (280)	11 (317)	8 (296)
Narrative	Halton reported a high number of delayed transfers of Care in January, there were a total of 317 days during the month and 11 patients were reported at the snapshot on the last Thursday of the month. This performance relates to a large number of delays at 5BP. These have now been addressed through close work between the CCG, HBC & 5BP. The situation as at the end of February has seen a decrease to 2 patients now delayed at 5BP although an increase in patients delayed at Warrington was witnessed.																
Intermediate Care Services - Halton Borough Council																	
	Numbers referred to Intermediate care				143	127	145	117	126	137	103	121	140	124	134	171	147
Narrative																	

	Performance Indicators	Operational Standard/ Plan	Lower Threshold	Baseline	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Referral To Treatment Times																	
Admitted (Halton Registered Patients)		90.0%	89.0%	92.7%	93.9%	94.2%	94.3%	95.2%	95.6%	92.5%	91.5%	93.4%	93.7%	94.0%	94.9%	94.8%	95.1%
All Patients Warrington Trust (TRUST LEVEL)		90.0%	89.0%	91.7%	92.8%	93.4%	92.6%	93.2%	93.6%	90.7%	90.3%	92.0%	92.1%	92.7%	93.0%	92.9%	92.2%
All Patients St Helens Trust (TRUST LEVEL)		90.0%	89.0%	93.8%	93.7%	93.6%	94.3%	96.0%	96.7%	94.7%	94.0%	95.6%	96.6%	96.0%	97.0%	96.9%	95.7%
Non-Admitted (Halton Registered Patients)		95.0%	94.0%	98.0%	98.0%	98.1%	98.3%	98.5%	98.8%	97.7%	97.9%	97.9%	97.8%	97.2%	98.3%	97.4%	98.3%
All Patients Warrington Trust (TRUST LEVEL)		95.0%	94.0%	97.8%	98.1%	97.9%	98.0%	97.6%	98.5%	97.8%	97.7%	98.1%	97.6%	97.0%	97.5%	97.0%	97.3%
All Patients St Helens Trust (TRUST LEVEL)		95.0%	94.0%	98.0%	98.2%	98.6%	98.6%	98.7%	98.5%	98.4%	98.5%	99.0%	98.4%	98.3%	98.6%	98.1%	98.4%
Incomplete (Halton Registered Patients)		92.0%	91.0%	95.5%	94.8%	95.4%	95.7%	96.0%	95.8%	95.6%	96.2%	96.1%	95.7%	96.2%	95.6%	95.0%	95.1%
All Patients Warrington Trust (TRUST LEVEL)		92.0%	91.0%	93.2%	94.4%	94.7%	94.5%	94.6%	94.9%	94.9%	95.3%	94.9%	94.5%	94.3%	94.0%	93.5%	93.9%
All Patients St Helens Trust (TRUST LEVEL)		92.0%	91.0%	96.2%	96.5%	97.0%	97.6%	97.7%	97.7%	97.6%	98.2%	98.5%	98.1%	98.2%	98.0%	97.4%	97.8%
Narrative	RTT targets have been met at both CCG and Trust level for all three headline measures.																

REPORT TO: Health Policy & Performance Board

DATE: 9 June 2015

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Making a difference A strategy for transforming Care Management in Halton 2015-2020

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report presents to Policy and Performance Board Making a difference: A strategy for transforming Care Management in Halton 2015-2020

2.0 **RECOMMENDATION: That:**

i) Health Policy and Performance Board note and comment on A Care Management Strategy for Halton 2015-2020 and supporting evidence paper

3.0 **SUPPORTING INFORMATION**

3.1 Making a difference: A strategy for transforming Care Management in Halton 2015-2020 has been developed within a range of national and local policies and themes including the Care Act 2014. The Act places additional responsibilities on the Council through the 'wellbeing principle' and the wider focus on the whole population in need of care rather than just those with eligible needs or who are funded by the state.

3.2 Implementation of the Care Act has significant implications for the roles of the Adult Social Care workforce as the way people access the care and support system changes and demand increases for assessments and support plans from self-funders and carers.

3.3 The strategy sets out a framework to build on our existing care management model and construct a professional, skilled care management service that is fit for purpose and responsive to this future demand

3.4 The framework incorporates the pivotal areas and objectives of the LGA "Standards for Employers of Social Workers in England". In addition it aims to change culture and embed strengths (asset)

based approaches into working practice to further advance personalisation so that Halton residents are able to achieve outcomes consistent with the Making It Real progress markers.

3.5 Implementation of the strategy action plan requires Workforce Capacity Planning and this is underway supported by Skills for Care as one of their pilots. The project will explore how social workers are deployed, how many will be needed (for the expected increase in assessments) and how assessments are undertaken. This will then inform the right mix and numbers of social workers and community care workers with the right skills and knowledge to implement care and support reform.

3.6 The strategy recognises the local ambition for greater integration of health and social care as set out in the Better Care fund plan and the development of community hubs described in NHS Halton CCG A strategy for General Practice services in Halton 2014/15-2019/20.

3.7 The action plan will be delivered through the newly established Professional Capabilities Forum (page 23 of the strategy) chaired by the Principal Social Worker (Divisional Manager Care Management and Assessment). The Strategic Director and Operational Director Prevention and Assessment will form the “Professional Leadership” and have an overview of progress in implementing the strategy.

3.8 Making a difference has been shared with staff and NHS Halton CCG for comment and Executive Board will be asked to endorse the strategy later this month.

4.0 POLICY IMPLICATIONS

4.1 Making a difference is the Council’s response to meeting its statutory duties relating to assessments and support planning for the local population with care needs regardless of how they are paid for.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The strategy action plan highlights resources required for implementation. A key area of focus is the workforce capacity planning to determine the skill sets needed and numbers of staff at each level to respond to the predicted increase in demand for assessments. The aim is as far as possible to achieve this transformation within existing resources.

6.0 IMPLICATIONS FOR THE COUNCIL’S PRIORITIES

6.1 Children & Young People in Halton

The strategy encompasses young people transitioning to adult social care.

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

6.3 **A Healthy Halton**
Effective social care interventions help individuals to maintain and improve their health. The Wellbeing Principle set out in the Care Act underpins the strategic approach.

6.4 **A Safer Halton**

This Strategy adopts the approach that everyone accessing services has the right to live safely and freely from harm. Social work professionals will support a person to understand the risks and benefits associated with a situation. Ultimately the person's wishes will be respected even if they wish to remain in a situation that may cause them harm.

All service provider agencies commissioned to deliver personal care are CQC registered, monitored by the Quality Assurance Team and must comply with Halton Safeguarding Adults policies and procedures.

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

7.0 **RISK ANALYSIS**

7.1 The strategy continues the transformation of care management services and as with any process of change is likely to meet resistance from staff affected. This will be controlled through change management processes including actions agreed at the Professional Capabilities Forum, Action Learning Sets for Social Workers and Occupational Therapists and individual supervision meetings.

During the implementation of the strategy monthly Team Performance reports will be reviewed to ensure response times to referrals and reviews are being maintained.

One of the biggest threats to successful implementation of the strategy is capacity to progress the identified actions. Any delays or barriers will be escalated to the Professional Leadership for consideration (see 3.6 above)

A full risk assessment is not required.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment (EIA) is not required for this report

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF**

THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
Care Act 2014	Runcorn Town Hall	Sue Wallace-Bonner

Halton Borough Council
Communities Directorate

Making a difference:

A strategy for transforming Care Management in Halton

2015 to 2020

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Foreword

We are delighted to introduce this strategy for transforming care management in Halton that is aimed at staff and partner agencies. The overall purpose is to provide a shared vision of the future of care management services and provide us with a plan to shape our future, over the next five years. We would like to acknowledge the input many of you have made in participating in developing the strategy I am sure many of you will recognise your contributions to the strategy as you read through it and I would like to take this opportunity to thank you.

We are all aware of the pressures on health and social care and the need to address increasing demand arising from demographic changes, financial pressures, national policy, major legislative reforms and local priorities. The introduction of the Care Act brings care and support legislation together into a single act with a new well-being principle at its heart. It has introduced major reforms to the legal framework for adult care. We need a future vision of assessment and care management services that is responsive to these challenges whilst maintaining high quality, effective and safe practice.

In advancing integrated care we will be embedding our multidisciplinary teams and working to build on and extend our GP partnerships. Working together, we will be developing integrated processes and systems where possible to provide seamless services. We are developing a framework that will enable us to construct a working model of a professional multi-disciplinary care management service that is fit for purpose to absorb increased future demand on services and offer better co-ordinated and integrated interventions.

The strategy sets out our vision, aims and priorities for assessment and care management services. It aims to assist us to progress modern models of social care which builds on looking at strengths based approaches to support vulnerable adults to live independently in their own communities. It is a working document which sets out how we will implement our priorities with a dynamic action plan that is already taking shape and takes us forward. It fully endorses coproduction and offering personalised services to promote active citizenship, and harness mutual support.

A recent review undertaken by the Local Government Association (LGA) identified, one of the key motivating factors that encourage individuals to join the social care profession in particular, is wanting to make a difference to people's lives. In my role as Principal Social Worker, I have recently spent time meeting with a range of practitioners including social workers, occupational therapists, community care workers, a common theme has been, talking about why we came into our professions. We have held events, including, "Building Common Ground" with Occupational therapists and "Social Work Matters Forums" with Social Workers. What I find fascinating is, that we all share a lot in common in the reasons we come into the social care as a vocation. I myself came into social work over some twenty years ago; my reason for doing so is very much the same as those who are experienced in the job also, as well as our

newly qualified younger recruits, we all want to make a difference as we touch people's lives. This resonates so much with us that "Making a difference" seemed to be the fitting strapline for this strategy. We hope you find it informative and motivating.

Marie Lynch

Principal Social Worker/Divisional Manager Assessment and Care Management

Dwayne Johnson

Strategic Director, Communities

Introduction

This Care Management strategy has stemmed from the growing need to identify a future vision of assessment and care management services that are fit for purpose to meet the many challenges at national and local level whilst maintaining high quality, effective and safe practice. Some of the key areas include demographic changes, the Care Act, Personalisation, budgetary constraints, the Integration agenda and a shift in focus to Well-being and Prevention. Cultural and attitudinal changes both at a strategic level and in professional practice are required and we need to understand the processes and architecture as well as the workforce implications to take this forward.

We are all aware that Halton's population aged 65+ will increase by a third over the next 10 years many of whom will be living with multiple long term conditions. Similar increases will be seen across all ages in the numbers of people living with three or more health conditions whether physical or mental or both[1]. Mental health problems are the single largest cause of ill health and disability in the Borough and deprivation across the Borough is widespread and remains a major issue and determinant of health.

Failure to respond effectively to these challenges is reflected in the numbers of people admitted to hospital in an emergency and at least one fifth are estimated to be directly avoidable in some way.[2] Many of these admissions relate to long term conditions and emergency readmissions. Emergency hospital admissions of Halton residents have reduced though remain high. Rising numbers of older people will increase pressure on unplanned hospital activity and we are aware that falls related hospital admissions amongst those aged over 65 is a priority to be addressed.

Potentially the impact of multi-morbidity will be disabling for many people. Prevention, delaying onset and slowing progression of long term conditions can happen through improved public health messaging and targeting, personalised care planning, information and supported self-care. Effective management of a condition can slow progression having a positive impact not only on people's lives but on reducing health and social care costs.

1 Fulfilling potential – Building understanding (ODI 2013)
2 Transforming Primary Care (DH 2014)

Our vision, aims and priorities

Our vision in Halton Borough Council is that:

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

Halton's Strategy is focussed on a partnership approach across Health and Social Care on prevention of ill health and poor emotional wellbeing, supporting people to remain independent at home and to manage their long-term conditions, wherever possible avoid unnecessary hospital admissions and in situations where hospital stays are unavoidable ensure that there are no delays to their discharge. This Care Management Strategy will support these aspirations and a whole system integrated approach to local health, care, support and well-being.

The shared plans of Halton Borough Council and NHS Halton CCG for further improving and integrating health and social care services in the Borough are set out in the Better Care Fund (BCF) submission to the Department of Health. This will be achieved by working more closely together through a single pooled budget arrangement to meet assessed health and social care needs. To further develop assessment and care management services and our multi-disciplinary approach to deliver the vision for Halton and meet our statutory responsibilities we have constructed a working model for care management in Halton ***"The Making a Difference Model".***

Through the model we aim to have seamless services across health and social care which are responsive to need and minimise delays by developing and supporting:-

i. **Locality based care management teams aligned with GP practices**
Building on our current configuration we will support implementation of the proposed GP led delivery hub model to strengthen the capacity of the teams, and provide for greater opportunities to work more closely to deliver integrated care and better outcomes and health gains for people in the community.

ii. **Integrated processes and systems where possible**
By sharing relevant information, resources and risk we can avoid duplication, improve outcomes and build resilience and sustainability into the local health and social care system.

iii. **An appropriate care management response to improve support in the community**
Integration will be around pathways of support, care and treatment requiring timely care management interventions to support individuals and families at home avoiding unplanned hospital admissions and facilitating speedy, safe discharges and minimising readmissions.

iv. **Maximise prevention and early intervention**

We will improve quality of life for people with social care needs and their families building on available informal support to prevent, postpone and minimise the need for formal care. A shift in resources is required from high cost complex care to more preventative interventions. We will be proactive in recognising opportunities for health promotion and make effective use of telehealth and telecare to support independence and early detection of health problems.

v. Personalised and co-ordinated care and support for all

We will offer access to personalised, timely, evidence-based interventions and approaches that empower people to remain in control of their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

vi. Effective safeguarding for both adults and children

We believe that everyone accessing services has the right to live safely and freely from harm and will support a person to understand the risks and benefits associated with a situation. Ultimately the person's wishes will be respected even if they wish to remain in a situation that may cause them harm.

vii. A well led proficient working environment that values, encourages and supports staff in their personal development

We want care managers to be able to continue their professional development and adopt "strengths based" working practices that are person centred, innovative and creative.

In aspiring to meet our aims we have identified **five strategic priorities:**

1. **Health and wellbeing of individuals in our community**
2. **Supporting Independence**
3. **Managing complex care to support individuals to remain at home**
4. **Maintaining high quality, personalised care management services**

All of the above underpinned by:

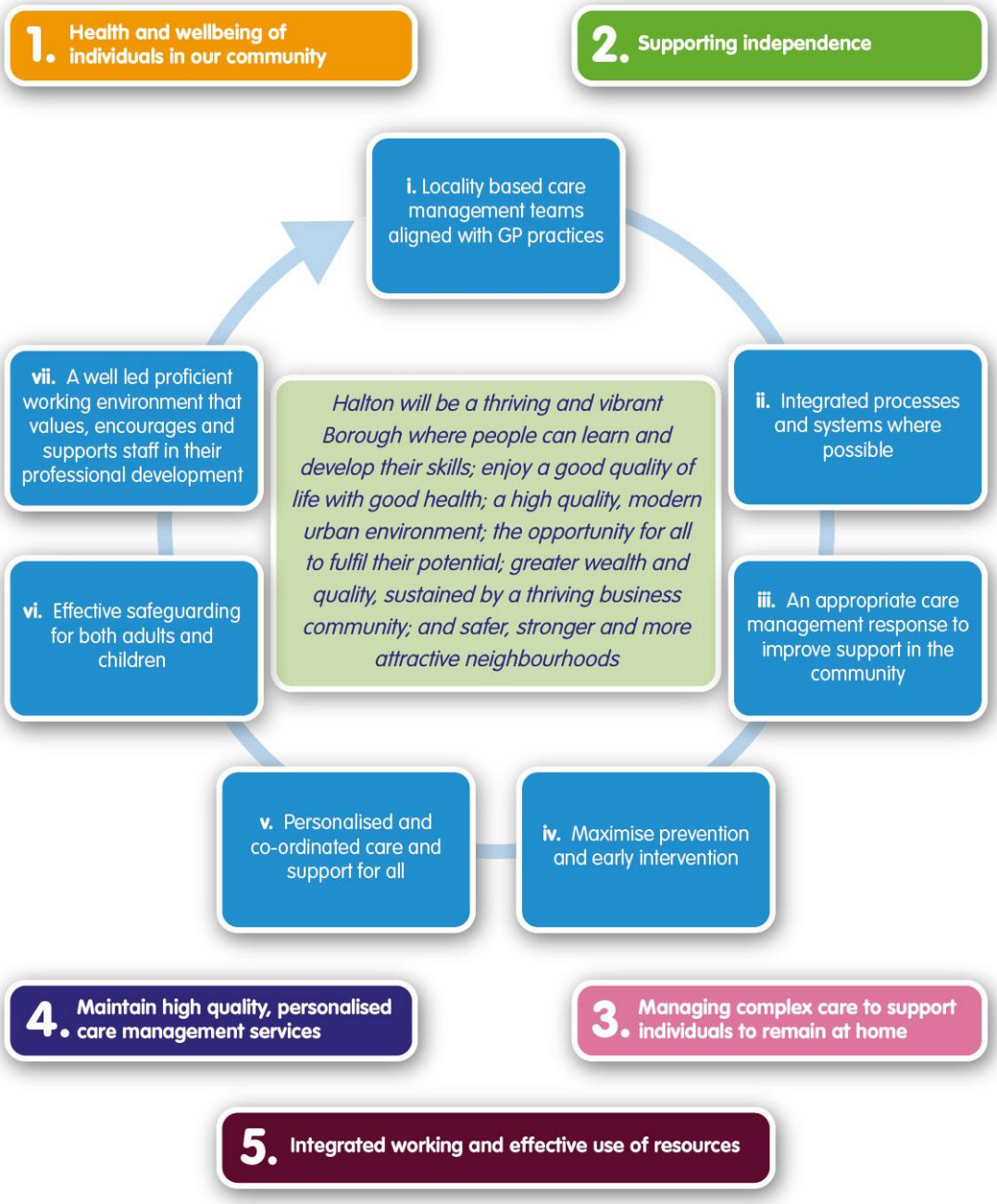
5. **Integrated working and effective use of resources**

The priorities set out in the strategy support the cultural shift to an integrated, strengths (asset) based focus for meeting individual need steering away from the traditional, narrow focussed deficit based model which looks only at vulnerabilities and how this fits with eligibility and service entitlements undermining the resilience of people. The emphasis will be on effective personalised social care intervention with an understanding of what's important to the person, what they can do and at what they have the potential to do with a little help leaving an individual better informed and connected and more confident, supporting the individual's unpaid relationships, informal networks and natural support networks.

We will work with local people and with partner organisations including NHS Halton CCG, service providers and the voluntary sector to ensure that the people of Halton with health and social care needs experience accessible, co-ordinated, integrated and high-quality services to support them to remain safe and well at home. We will embrace the concept of Making Every Contact Count (MECC) to improve the health and wellbeing of people with support needs by using all opportunities to encourage them to make healthier choices to achieve positive long-term behaviour change.

The Making a Difference Model

This model will enable us to construct a working model of a professional, multi-disciplinary care management service that is fit for purpose, able to absorb increased future demand and offer better co-ordinated and integrated interventions.



What are our drivers?

We have already identified the need to respond to increasing demand and financial pressures arising from demographic and legislative changes. Local issues to be addressed are summarised below.

People and Community

- Aging population
- Increased numbers of people with multiple long term conditions
- Highest levels of depression in the North West
- Higher than average numbers of people falling
- Access to urgent care and numbers of unplanned hospital admissions

Workforce Capacity and Competency

- Capacity building required to meet legal responsibilities and future demand
- Greater awareness of impact of prevention, early intervention and reablement services
- Professional standards and competencies
- Appropriate use of professional skills across teams
- GP Strategy and 7 day working
- Appropriate out of hours response for Halton

Policy and Systems

- Personalisation - Making It Real
- Impact of resource information portal
- Help to develop support plans and a range of brokerage approaches
- Access to systems and information for staff working in the field
- Consistency and transparency in all interventions
- Integrated systems, policies and pathways
- Self assessment and self funders

The major legislative reforms we are facing stem from The Care Act 2014 which consolidates existing good practice and policy into statute. There is renewed focus on responsibilities, duties and processes which:

- Reduce demand for formal services
- Adopt preventative and person centred approaches

- Ensure vulnerable adults are safeguarded
- Encourage citizen led commissioning and service delivery
- Supported by skilled social workers with a broader remit to include community development, safeguarding , prevention, early intervention and interpersonal support

Further more detailed explanation of the implications of the Act and other national drivers can be found in the accompanying evidence paper.

Health and Social Care Integration

National policy is directing us to work collaboratively with health partners. The College of Social Work and the Royal College of General Practitioners jointly affirmed partnership between social workers and general practitioners as critical to the development of person centred care and in addressing the looming financial crisis facing both the NHS and social care.[3]

Both Colleges acknowledge that successful partnerships do not happen by chance and differences in funding, professional cultures, training, governance and accountabilities, all need to be recognised, understood and worked through to ensure that the right partnerships are in place and do the right things where it matters, in practice. The report demonstrates through evidence and case studies how GP's and

[3] GPs and Social Workers: Partners for Better Care Delivering health and social care integration together October 2013

Social Workers can work together as local leaders to make integration in local communities a practical reality.

In Halton we are acutely aware of working within scarce resources and that over the next five years Halton Borough Council, NHS Halton CCG (CCG) and our partners face significant financial challenges which are driving us to do things differently and transform all aspects of health, social care and wellbeing. The Better Care Fund (BCF) effective from April 2015 has been established to be shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more collaborative approaches and integrated services for older and disabled people. In Halton we have embraced this through a joint working (Section 75) agreement and pooled budget arrangement for Complex Care. We recognise that by overcoming the boundaries between health and social care and jointly designing and delivering services with NHS Halton CCG we can improve outcomes and quality of life for individuals, carers and the wider community.

GP Strategy

In response to 'A Call to Action'[4] and to inform the challenges facing general practice and provide a sustainable future for membership practices, NHS Halton CCG has begun working with its member practices and key stakeholders to undertake a review of its services and their sustainability. To meet the increasing challenges faced, there is a need to reshape the range of services offered within general Practice, thereby enhancing the sustainability of practices whilst preserving the local roots of general practice that are valued highly by patients.

A strategy for General Practice services in Halton 2014/15-2019/20 describes how NHS Halton CCG is working with its partners and the public to develop and commission standardised high quality General Practice that balance the benefits of organisational scale with preservation of the local nature of general practice.

The following ten principles are emerging and considered fundamental to the future design, configuration, commissioning and delivery of local General Practice:

1. Commissioning and delivering consistent high quality care for every local resident;
2. Reducing unwarranted variation;
3. Strong local clinical leadership;
4. Embracing the opportunity to offer services at scale, delivered locally to individual people;
5. High levels of population and patient engagement;
6. Commissioning and contracting for outcomes, not inputs or processes;
7. Services working in greater collaboration in the community as multi-disciplinary teams of care professionals working together;
8. Improving access to all services and better coordination of care pathways;
9. Focus on prevention;

[4] http://www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf

10. The CCG playing a greater role in contracting services through co-commissioning General Practice with NHS England.

To achieve this, it is proposed that a new model is established with community services centred on people, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together, in a much more integrated way with Community, Mental Health and Wellbeing, Social Care, Urgent Care and Pharmacy services all wrapped around local delivery points.

It is proposed that the model will see services and teams aligned to community 'hubs'. Each 'hub' will determine how to best configure itself to meet the needs of its local population. This includes service delivery, governance, population engagement, performance management and strategic planning. It is recognised that in certain circumstances, it will be advantageous to continue to commission and deliver services across the whole borough of Halton, however, this will be for each 'hub' to determine and influence.

Principles of Integration

This strategy and the accompanying action plan considers the interconnections of the proposed model for GP practice and the implications of this for adult social care in terms of the required skills mix.

The purpose of integrated working is to improve the quality of care and support by keeping the individual, not the organisation or particular profession, as the driving force behind care and support. At a strategic level, integration creates a more seamless experience for individuals.

To support the cultural shift in practice that enables workers to understand each other's roles and contributions, and to build support networks around individuals, Skills for Care have developed 6 principles for integrated care and support which been used to inform our strategic planning. Further detail can be found in the Evidence Paper.

Other influences

The Local Government Association "Standards for employers of Social Workers in England" and The College of Social Work Professional Capabilities Framework are additional important influences that we must embrace and use to sustain high quality outcomes for service users, their families, carers and the wider community.

Consultation

In developing this strategy the views of staff working in the Assessment and Care Management Division, as well as partners across the health and social care sector have been sought and influenced the actions for developing care management services over the next five years. It is important to stress that whilst this strategy covers a five year period it is dynamic and responsive to further national and local policy changes.

Halton Assessment and Care Management Services

This service offers an 'Initial Assessment Team' (IAT), a dedicated multi-disciplinary duty function team, responsible for all referral, screening, signposting and initial assessments. In addition, there are two Operational teams dealing with complex work, (one in Widnes and one in Runcorn). The teams are now integrated with Social workers, Occupational therapists and Continuing Health Care Nurses with additional support from the Integrated Safeguarding Unit. Additional developments could look at closer working with District nurses

This model of service delivery was developed as there was and remains an increasing requirement for joint working between health and social care to be facilitated to ensure the population's health inequalities and needs are being addressed. Growing research, data and evidence supports the establishment of multi-professional health and social care teams to address the needs of high risk people within the community.

The aims of the model are:

- To meet the needs of as many people as possible at first contact with the Initial Assessment Team (IAT) which provides universal advice, guidance and acts as a single point of access to all adults with adult social care needs;
- To facilitate people to undertake assessments and support plans with limited social services input;
- To provide a focus throughout all processes on prevention and re-enablement, to promote independence;
- To offer locality based care management services aligned with GP Practices and wherever possible and appropriate, co-located with other professionals;
- To create generic teams covering defined localities helping all adults in the local community according to demand.

As outlined earlier, demographic changes and new legal duties will increase demand for assessments and reviews. Current capacity within the service is summarised in Part Four of the evidence paper. Modelling based on Local Government Association guidance suggests that Halton will need additional care management requirements. Further capacity will be needed if all carers' assessments are conducted in-house rather than through the Carers Centre.

Although community mental health assessment and care management services remain as part of the 5 Boroughs Partnership NHS Foundation Trust, many aspects of this strategy and action plan including continued professional development and workforce planning are inclusive of this service area.

Workplace Champions

Our experience of the success of the End of Life Care "Key Champion" role suggests that this is an exemplary approach that may be worth extending to promote best practice and develop staff knowledge and expertise in other areas. It can also be used to effect and embed cultural change within working

practice. The “key champion role” is an identified social worker holding a generic social work post within Complex Care who has specialised their knowledge and skills with a dedicated interest in the nominated area. Activity and dissemination of knowledge will typically include:

- Keeping up to date with and share best practice across social care, care providers, District Nurses, nationally and regionally
- Acting in a link role between care providers and care management staff
- Identifying areas where care managers feel they have training needs

Adult Safeguarding

Adult Safeguarding is an integral part of assessment and care management services supported by the Integrated Adult Safeguarding Unit which works across health and social care. The Unit assists and advises care managers on safeguarding referrals for adults aged 18 plus who may live in the community, receive domiciliary care in their own homes or reside in a residential or nursing home. The Unit will support investigation of complex safeguarding referrals for any domiciliary or residential providers in the Borough and providers outside of the Borough, where appropriate. The Unit also holds the coordinating role for dealing with Deprivation of Liberty Safeguarding requests to the authority and undertaking Best Interest Assessments both in and out of Borough.

The Unit contributes to the safeguarding of adults across the Borough by:

- Providing support to the Halton Safeguarding Adults Board and its sub groups
- Ensuring key linkages with the Domestic Violence Coordinator and services
- Ensuring key linkages with Children’s safeguarding
- Supporting the development of effective Interagency Safeguarding Adults Policies and Procedures
- Lead on prevention by responding to those cases that do not meet the threshold for a safeguarding investigation
- Supporting the local authority and its partner agencies to:
  - Fully embed safeguarding adults policies and procedures and thus deliver consistent and robust outcomes for vulnerable adults
  - Monitoring the effectiveness of the delivery of their safeguarding adults activity
  - Providing advice and support regarding individual safeguarding adults cases

The Unit is an example of best practice and provides effective safeguarding for adults. Through its continued involvement with the Making Safeguarding Personal project, the care management service will continue to move towards a more person centred approach to safeguarding, with the focus being on the outcomes the adult at risk would like to achieve following the safeguarding process and to then assess to what extent those outcomes have been achieved.

Workforce Culture and Development

Cultures are complex and difficult to define but in its simplest terms a work place culture has been described as: *"The way we do things around here*" (Bower 1966). As a basis we need to have in place a culture that focuses on greater collaboration between workers, emphasis on partnership working and problem solving through collective responses and be a friendly and caring place to work.

> "*A positive workplace culture is essential in adult social care to provide high quality flexible care and support it not only addresses productivity and the health and wellbeing of staff, but also look to improve outcomes for those who need care and support services".* (Sharon Alllen, CEO Skills for Care).

Where services are integrated ADASS believes that positive work place cultures can support the work force to develop a common vision and shared values. Such cultures also develop trusting and collaborative work practices. Positive workplace cultures bring the following benefits:

- Improved quality
- Stable skilled workforce reduces costs
- Greater resilience in times of change
- Improved reputation and market share

The Hedgehog Concept

In relation to developing a positive work place culture, Skills for Care have developed a "Culture for care" toolkit which will be used to form part of our action plan. There are a number of tasks and group exercises to help us identify, giving a flavour of this is what is described as our organisation's 'hedgehog', which entails, discovering what it is that we do better than anything else. The 'hedgehog' concept uses the parable of the clever, devious fox and the simple hedgehog. The fox keeps coming up with new ideas to eat the hedgehog, but the hedgehog handily defeats him by doing his one trick: rolling into a thorny ball. It is now a concept used widely as an organisational development tool. The hedgehog concept highlights the importance of:

- organisations knowing what they're good at
- keeping strategies simple but effective
- pursuing these strategies with drive and determination.

Most people work best when they believe in and are committed to the service they are providing, so it is important to identify what these things are.

What do we do well? (And equally important—what we do not do well)

In order to build on good practice we can support future planning by identifying our workplace 'hedgehog', to identify answers to the following questions from the circles below:

What do we, the workforce, care passionately about?

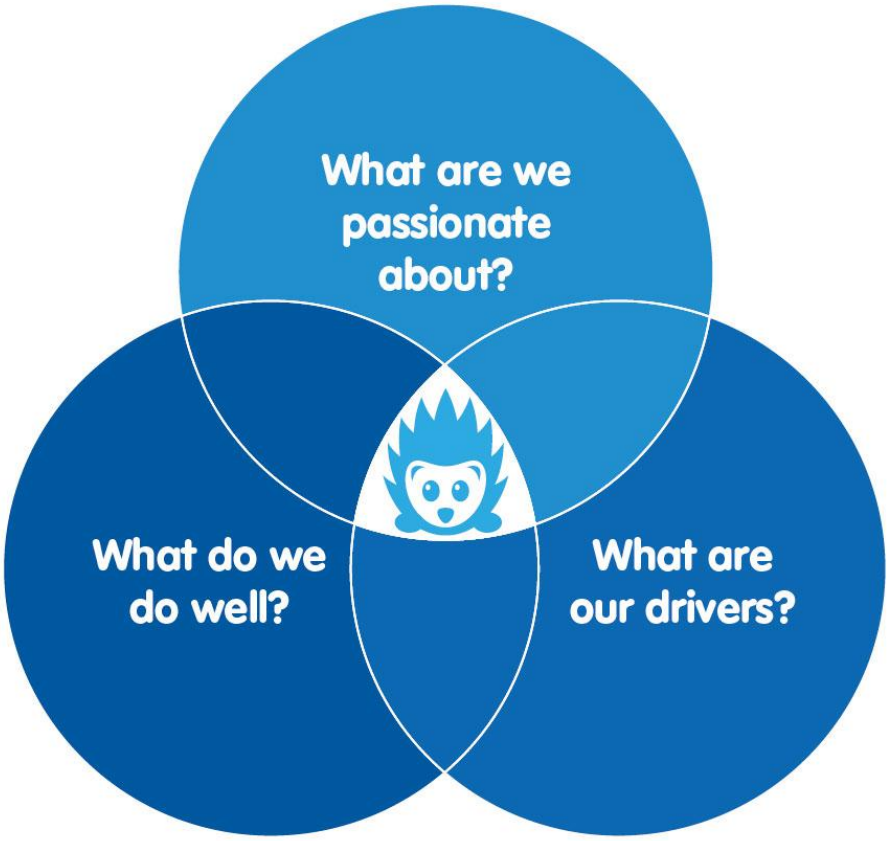
This may be small scale or very focused, for example it could relate to how we support people to use assisted living technology, how we ensure mealtimes are a positive and dignified experience for all, or maybe you have a great induction for new staff.

What are our drivers? How do we measure success?

We might include factors such as reputation, workforce health and wellbeing, or customer satisfaction.

Our Hedgehog

(devised by Jim Collins, in his book "Good to Great")



Workforce integration[5] (Skills for care)

People with care and support needs want care provided in ways that make sense to them, that reflects their lives, their needs and their wishes. This is best achieved through integrated working, with practitioners working together to support individuals, their families and carers. Skills for Care have developed six principles to support practitioners, managers and organisations to think through what is meant by integration, and in particular, how workforce development can contribute to its introduction and implementation and sustainability.

In summary the principles relate to implementing successful integrated working and we will use these to shape our approach to developing our care management service:

> **Principle 1**: Successful workforce integration focuses on better outcomes for people with care and support needs.
>
> **Principle 2:** Workforce integration involves the whole system.
>
> **Principle 3:** To achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities.
>
> **Principle 4:** A confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active and engaged communities is at the heart of workforce integration.
>
> **Principle 5**: Process matters—it gives messages, creates opportunities, and demonstrates the way in which the workforce is valued.
>
> **Principle 6:** Successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies give each of these attention, creating the circumstances in which all can thrive.

A fuller explanation of the questions managers and staff need to explore and the principles of integration can be found in the evidence paper.

Workforce Capacity Planning

To help us prepare to meet the increase in demand for assessments arising from demographic changes and new responsibilities under the Care Act we are working with Skills for Care to help us plan and think about the care management and social worker workforce. Areas being explored include how social workers are deployed, how many will be needed (for the expected increase in assessments) and how assessments are undertaken. This will help us to work out whether or not we have the right mix and numbers of social worker and community care workers with the right skills and knowledge to implement care and support reform. Identification of workforce capacity gaps or surpluses will enable us to begin early transition planning. An Adult Social Care Workload Management system is being developed. A caseload weighting tool is under development that will be aligned to the supervision policy and ties to the professional capability Framework.

[5] http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-integration/principles-of-workforce-integration.pdf

Further detail on the Skills for Care Workforce Model can be found in the accompanying evidence paper.

Workforce Development

The Local Government Association (LGA) has published “Standards for employers of Social Workers in England” to sustain high quality outcomes for service users their families and carers. The eight standards are grouped into three focal areas within the diagram below:

1. **Enabling employers to provide a well led professional environment**
2. **Enabling social work professionals to maintain their professionalism**
3. **Enabling social work professionals to practice more effectively.**

The standards for employers set out shared core expectations of employers which will enable social workers in all employment settings to work effectively. These expectations are being incorporated within self-regulation and improvement frameworks for public services and used by service regulators (Ofsted, CQC). This document sets out what social workers should expect from their employers and we will use these standards to assess our performance and identify areas needing more focus to ensure we retain our professional service and aid retention and recruitment of our workforce.

Social Work Leadership

Our proposed approach regarding leadership is to follow up on discussions with Skills for Care to undertake work which utilises the 'Social work leadership toolkit'.

The refreshed toolkit has been influenced by sector feedback and now includes:

- A 360 degree development tool for social work managers mapped to the Professional Capabilities Framework.
- References to the relevant social work professional and leadership frameworks, including the College of Social Work's Professional Capabilities Framework (PCF).
- New online resources to support social work leaders develop confidence and capability across the nine PCF domains, helping them to be effective in existing and emerging roles and settings.

The new resources include:

1. Leading an ethical social work business
2. Leading an improving service
3. Leading in a professional context
4. Leading with less
5. Scenarios to depict how these resources can be used by different organisations

This 'Social work leadership toolkit' provides tools and resources to support the development of social workers across the experienced, advanced and strategic levels of the PCF. Aspiring managers and leaders, front line managers, advanced social work practitioners and other social workers at a strategic level can be supported by this toolkit. It will also be useful for non-social work professionals who manage or are accountable for the social workers within their service. Further explanation and a link to the toolkit can be found in the evidence paper.

Care Management Professionals

The College of Social Work Professional Capabilities Framework (PCF) sets out the expectations of social workers themselves and is intrinsic to the implementation of the Standards for Employers. The PCF has been developed to help social workers be supported to do the best job they can at all stages of their profession. The evidence paper contains more description of the PCF.

In Halton we are committed to supporting and encouraging staff to continue their professional development and progression. We will look at the current structure of care management professionals within Communities Directorate and develop a concise progression policy aimed at recognising National frameworks and standards for Social Workers and Occupational Therapists. Training requirements regarding experienced social workers are likely to identify the necessity for safeguarding, mental capacity, best interest assessor and deprivation of liberty training as mandatory. Experienced social workers as part of their career progression will undertake supervision of less experienced staff.

There will also be Action Learning Sets for Social Workers and Occupational Therapists to share and promote good practice and support problem solving.

Occupational Therapy

We will be developing a specific Professional Capability Framework for Occupational Therapists based on the College of Occupational Therapists (COT) guidance[6] as a starting point. It states that, Occupational Therapists are living and working in a time when service-user needs are paramount. Drivers are focused towards continuing professional development (CPD) and lifelong learning (LLL) to ensure a competent and capable workforce that can plan and carry out evidence-based interventions. The COT Strategic vision and action plan for lifelong learning (2004) stated a commitment to support a culture of lifelong learning as being a continuum within academic, work and social environments. The plan is informed by the need for diversity and inclusivity and a culture where the achievement of learning is valued, and where creativity and flexibility enables and facilitates transformational learning.

The Post qualifying framework (PQF) has been developed as a means by which occupational therapists can be guided to meet the evolving needs of their professional roles. The framework lists statements that identify capabilities expected to be demonstrated for all levels of occupational therapists within practice, management, education and research. Any learning opportunity taken can be mapped against these statements in order to consider relevance to professional and organisational needs. In addition, the framework will help to determine learning needs applicable to the role development aspirations of the therapist, helping him/her to make plans and engage in development opportunities that could be perceived as being relevant to the chosen role. Issues of preceptorship, supervision, appraisal and personal development planning have been closely linked to ongoing professional development at all stages; this enables the integration of professional, career and workforce development issues. The PQF has been developed to support and meet the learning needs of all members wherever they work.

The Role of the Social Worker in Adult Mental Health Services

The College of Social Work7 states that Social workers have a crucial part to play in improving mental health services and mental health outcomes for citizens. They bring a distinctive social and rights-based perspective to their work. Their advanced relationship-based skills, and their focus on personalisation and recovery, can support people to make positive, self-directed change. Social workers are trained to work in partnership with people using services, their families and carers, to optimise involvement and collaborative solutions. Social workers also manage some of the most challenging and complex risks for individuals and society, and take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the rights of different parties. This includes, but is not limited to, their vital role as the core of the Approved Mental Health Professional (AMHP) workforce. Yet the role and priorities of social workers in mental health in recent years have often not been well defined. Their status and authority within multidisciplinary settings has sometimes been undermined, and opportunities to realise professional

[6] The Post Qualifying Framework: A resource for occupational therapists (COT 2004)

[7] The voice of Social Work in England

potential have been underdeveloped. The question now is: How can social work play an even greater part in improving adult mental health services and achieve better service user, family and community outcomes?

This strategy will need to recognise, The College of Social Work (TCSW) high ambition for the future impact of social work within mental health and the proposed five key areas of practice that should frame the deployment and development of social workers in mental health as follows:

1. Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority.
2. Promoting recovery and social inclusion with individuals and families.
3. Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.
4. Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship.
5. Leading the Approved Mental Health Professional workforce.

These areas of practice should shape role descriptions, continuing professional development (CPD) opportunities and curricula, and social work leadership in all adult mental health work contexts. The Professional Capabilities Framework (PCF) should be used to guide the development of increasingly effective practice, in breadth and depth.

Non-Registered Social Work Staff

Within our Workforce Plan, there will be development and particular focus upon the role of the non-registered social worker officer in the future, linking to national and regional developments towards a "Qualification Credit Framework." Skills for Care are developing a Level 4 Diploma in Social Care and confirm that the Learning and Development modules are nearly finalised, but awaiting final confirmation of the Regulations and Guidance. Skills for Care have some initial proposals and there may be connections to national workforce development but the North West region are working collaboratively to prioritise this, and ensure all plans are Care Act compliant. Early agreement has identified jointly procuring the production of materials for staff once the Skills for Care modules are available, e.g. printing costs. The role of 'trusted assessor' in partnership with the NHS will also be developed.

Action Learning Sets

The Assessed and Supported Year of Employment (ASYE) along with other reforms following the Social Work Reform Board has, among many other things, thrown renewed focus on developing reflective and analytical practice. The emphasis is on needing to support our staff through 'critically reflective action learning' this can contribute to their professional activity, thereby improving the outcomes for people who need care and support and their professional social work staff. Action learning facilitation is the proposed approach to take with staff, towards individual and organisational practice development, which takes the

challenges of both professional work and organisational change as the vehicles for learning. Working in small groups, people tackle important or problems and learn from their attempts to change things. We are working with Skills for Care to promote, Action Learning facilitation as a useful support package for NQSWs undertaking the ASYE and experienced social workers.

Implementing our priorities

National policy for Adult Social Care places emphasis on Prevent, Reduce, Delay the need for formal care. This is underpinned by integrated approaches which put the person at the centre and focus on context, possibilities and outcomes rather than processes and tasks. In line with national policy, the Council and NHS Halton CCG are working collaboratively to move towards greater integration of services to improve quality of care and ensure effective use of finite resources.

We believe that our priorities can be achieved by:

- **Promoting prevention and early intervention to reduce risk of more costly interventions**
- **Integrated approaches and MDT working to ensure responses are appropriate**
- **Strong leadership and professional accountability**
- **Supporting and promoting good practice and continued professional development;**
- **Having the right mix of skills to meet current and future demand**
- **Adopting 'strengths based' approaches in assessments**

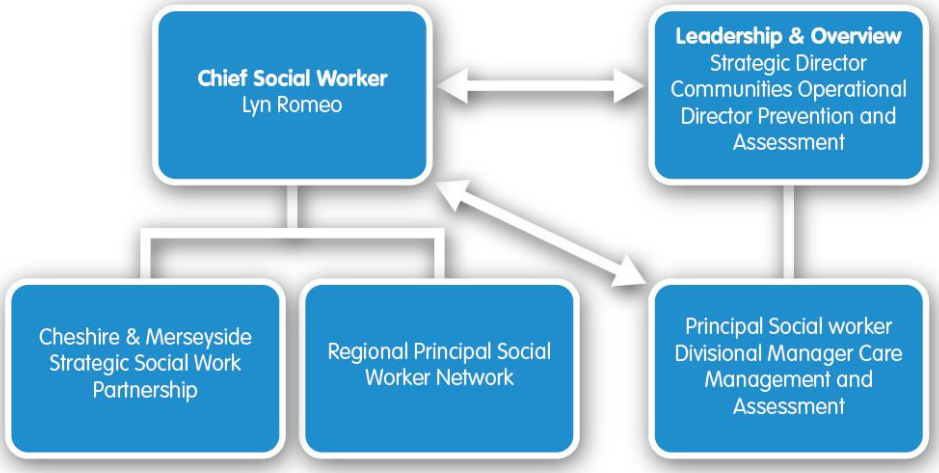
Halton's Professional Capabilities Framework

The Department of Health has set out the social workers vital role in personalising care and support and has established the role of Chief Social Worker (CSW) for an adult who works collaboratively with the Children's counterpart to provide leadership in the profession to drive forward the improvement and reform programme. There is now an expectation that local authorities will appoint a Principal Social Worker (PSW) to use their strategic influence across organisations and develop partnership arrangements. This role will also be the professional lead to ensure accountability and maintain quality across the profession. The Chief Social Worker will lead the national network of PSW's.

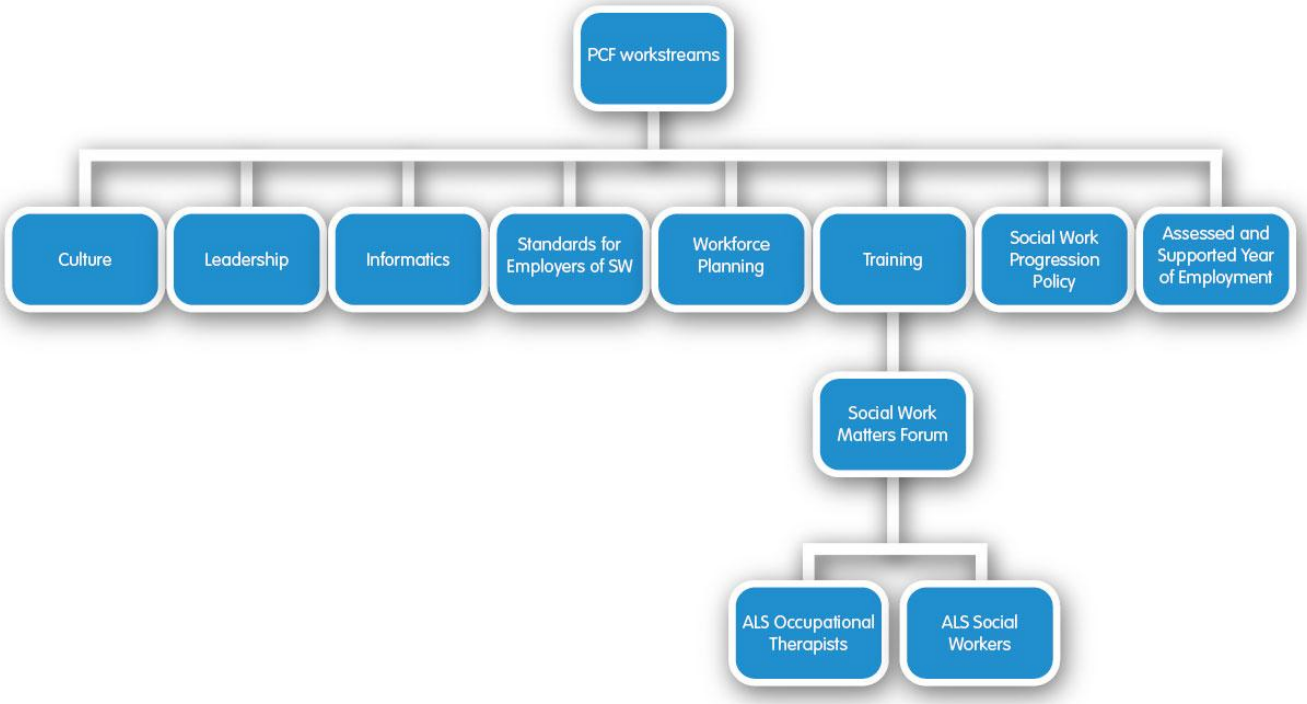
In Halton, the role of PSW is held by the Divisional Manager Assessment and Care Management Services. To support this role the "Professional Capabilities Forum" has been established which provides strategic leadership and overview as well as progressing the following areas of work to support delivery of this care management strategy:-

- Culture
- Leadership
- Informatics
- Standards for Employers of Social Workers
- Social Work Progression Policy
- Training requirements
- Workforce Planning
- Assessed and Supported Year in Employment (AYSE)

Professional Capabilites – Leadership and Overview



Professional Capabilites Forum – Workstreams



This Professional Capabilities Forum chaired by the Principal Social Worker will take responsibility for delivering our action plan through the task and finish groups. The Forum will report on progress and any blockages to the Professional Leadership (Strategic Director and Operational Director) who will keep an overview.

This forum will ensure that Social Workers are able to meet the expectations of them and continue their professional development for progression through the different levels of the National Performance Capability Framework.

A Strengths Based approach

There are increasing budgetary pressures across the health and social care system nationally accompanied by increased demands for services due to changing demographics. The risk for care management in focusing on Fair Access to Care, although highly relevant, potentially leads to a practice where assessment and eligibility is set up to focus exclusively on eligible needs and how services alone can meet those needs, this is known as a 'deficit approach'.

Instead of looking only for an individual's problems, vulnerabilities and at what he or she cannot do, the care management service in line with the Care Act will focus upon need and take a strengths-based approach looking first for what individuals and those close to them can do and at what they have the potential to do with a little help. The strength based approach has two key objectives:

1. Effective social care intervention which leaves an individual better informed, connected and more confident.
2. Every intervention supports the individual's unpaid relationships and informal networks of support and avoids undermining key relationships or isolating the individual from their natural support networks.

To embed a strengths based approach, we need the route towards support to start with an easy-access conversation with someone whose job is to inform, empower and connect people, with services as the last not first resort. This kind of support to plan is so vital to this transformation it should be embedded in the self-directed support process refocusing emphasis on existing information, advice, navigation, advocacy and brokerage providers. This creates a shared purpose between individuals and communities: to help people to help themselves and each other and to reduce the risk of increasing dependence.

This strategy supports the approach that, instead of undermining the resilience of people by only seeking to understand their eligibility and service entitlements, we should start by understanding what's important to them, what they want to do and the strength and nature of their social networks. The key question should then be '*how can these strengths be best supported"*? That's when personal budgets and a wider range of services should come into play.

Co-production

Co-production is potentially a transformative way of thinking about power, resources, partnerships, risks and outcomes; a meeting of minds coming together to find shared solutions. In practice, co-production involves people who use services being consulted, included and working together from the start to the end of any project that affects them. When co-production works best, people who use services and carers are valued by organisations as equal partners, can share power and have influence over decisions made.

Co-production is not a new concept in Halton; it has been around for a number of years and the term is often used at an 'individual' level to refer to the personalised and self-directed support developed in conjunction with health and social care professionals and funded through direct payments or individual budgets leading to:

> …..everyone having choice and control over the shape of their support, along with a greater emphasis on prevention and early intervention.

There is a distinction to be made between this individual co-production (personalisation) and collective co-production where people work together on community issues.

Coproduction offers a route away from a passive consumerist model of personalisation towards one of active citizenship, equality, and mutual support. By transforming the relationship between professionals and people and effectively using the assets that are abundant within the Halton community we can improve people's quality of life and wellbeing.

How will we know if we have been successful?

The Overarching Outcome for this Strategy is:

Seamless services across health and social care which are responsive to need.

This will be achieved by focussing efforts on delivering against the five priorities to achieve the following outcomes:

- **Health and social care practitioners work across boundaries offering high quality personalised care management support**
- **A sustainable and innovative assessment and care management service**
- **Individuals and families share power with professionals and influence decision making**
- **Care managers have career progression and are able to maintain their proficiency**
- **Resources are identified and used to maximum benefit to achieve value for money and excellence in care and support**

It is important to ensure that the implementation of this strategy continues to deliver an effective care management service. There are a number of national audit tools and resources produced by the LGA, ADASS and Skills for Care that we can use for self-assessment to identify areas that need greater focus such as the Skills for Care Social work leadership toolkit and the:

LGA Standards for Employers of Social Workers

There are eight standards - Standard 1 covers the requirement to have a 'clear social work accountability framework' and highlights the social work 'health check' as an important tool in supporting and delivering effective social work. It is a key element of Standard1:

> "All employers should: complete, review and publish an annual **'health check' or audit** to assess whether the practice conditions and working environment of the organisation's social work workforce are safe, effective, caring, responsive and well-led"

We can also use recognised measures already being collated to monitor the benefits arising from the priority actions and the targets summarised below have been set as a measure of our success.

This strategy also supports delivery of the local Better Care Fund targets and progress in implementing the action plan will be overseen by the Better Care Board which is accountable to both the NHS Halton Clinical Commissioning Group's Governing Board and Halton Borough Council's Executive Board.

	Priority	Target to measure success	2015/16 to be agreed 2014/15 baseline
1	Health and wellbeing of individuals in our community	Emergency admissions (all ages) for acute conditions that should not usually require hospital admissions (cumulative rate per 100,000) Emergency readmissions (all ages) within 30 days of discharge from hospital (cumulative)	1794 15.5%
2	Supporting independence	Number Receiving Self-Directed Support	78%
3	Managing complex care to support individuals to remain at home	Admissions to permanent residential and nursing care age 65+per 100,000 population Admissions to permanent residential and nursing care age 18-64 per 100,000 population Adults helped to live at home per 1,000 population: Learning Disabilities Physical and sensory disabilities Mental health	636.6 15.2 4.00 8.00 3.50
4	Maintain high quality, personalised care management services	Adults and older clients receiving a statement of their needs and how they will be met Adults and older clients receiving a review as % of those receiving services	97% 80%
5	Integrated working and effective use of resources	Reduction in number of people out of Borough Adults and older clients receiving a review as % of those receiving a service	32 2013/14 baseline 80%

PRIORITY 1: HEALTH AND WELLBEING OF INDIVIDUALS IN OUR COMMUNITY	
Emergency admissions (all ages) for acute conditions that should not usually require hospital admission **Baseline 2014/15 (rate per 100,000) 1794** **Emergency readmissions (all ages) within 30 days of discharge from hospital** **Baseline 2014/15 15.5%**	
Why is this a priority? In Halton we have seen recent improvements in some health conditions and we wish to build on this success to deliver better health outcomes and health gains both mental and physical.	**What do we want to achieve?** **We want people with care and support needs to have:** • Greater awareness of benefits of good health • Improved mental health and wellbeing • Improved physical health • Better self-management of long term conditions (LTC) • Reduced need for unplanned hospital admissions • Improved access to information and advice to self-manage their condition, keep healthy, active and well

	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
1a	**Make Every Contact Count:** Identify opportunities to incorporate health promotion into care management interventions Develop skills, knowledge and confidence of care managers to converse with service users and encourage active self-management of LTC including mental ill health	Improved self-reported wellbeing Slow progression of conditions Avoid unplanned hospital admissions Improved self-reported wellbeing	April 2016 Ongoing	• Health Improvement team input • Training • Support from health professionals	Divisional Manager Assessment and Care Management With Public Health
1b	**Care Act:** Include the Wellbeing Principle in the training programme for staff	Improved feeling of wellbeing among those with care and support needs.	April 2016	• Training	Professional Capabilities Forum

PRIORITY 2: SUPPORTING INDEPENDENCE

Number Receiving Self-Directed Support
Baseline 2014/15 78%

Why is this priority?

Adults of all ages with care and support needs aspire to participate in every aspect of life – home and family, community life, education, training, employment and volunteering. They want the opportunity to participate fully in society and be valued for their contribution.

Having choice and control in their lives is key to people improving their health, maintaining independence and relationships within families and retaining lifestyles.

Halton is committed to empowering people to take control of the decisions made regarding their needs and avoid or move away from dependency on formal care.

What do we want to achieve?

People with care and support needs:

- Have choice and control over their lives
- improve or maintain their mental wellbeing
- are active members of their community
- are financially stable and able to access benefit advice and support

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
2a	Implement the Making It Real action plan to support personalisation and give people control	Co-ordinated personalised health and social care People with support needs in control of their lives	Ongoing	These are identified in the Making it Real action plan	Operational Director Prevention and Assessment
2b	Develop a self-assessment process that self-funders can access	Support approaches to self-assessment Minimise demand for assessments	April 2106	• Staff time • ICT Support	Divisional Manager Assessment and Care Management
2c	Review impact of preventative services and early interventions on demand for assessments and build on successes to further minimise future demand	Maximise independence Minimise demand for care managers assessments	December 2015	• Staff time • Training	Divisional Manager Assessment and Care Management
2c	Promote the benefits to public and professionals of strengths based approaches to assessment of need.	Effective interventions which support a person's informal networks	Ongoing	• Training • Forums and Making it Real events	Divisional Manager Assessment and Care Management
2e	Review adequacy of available information and advice on meeting and preventing need for those not eligible for support to meet new duties of Care Act.	Effective signposting to avoid escalation of need Individuals in control of identifying their low level needs	July 2015	• ICT systems • Publications • Voluntary Sector support	Care Act Implementation Group

PRIORITY 3: MANAGING COMPLEX CARE TO SUPPORT INDIVIDUALS TO REMAIN AT HOME

Admissions to permanent residential and nursing care age 65+ per 100,000 population Baseline 2014/15 636.6

Admissions to permanent residential and nursing care age 18-64 per 100,000 population Baseline 2014/15 15.2

Adults helped to live at home per 1,000 population: Baseline 2014/15 - Learning Disabilities 4.00, Physical and Sensory disabilities 8.00, Mental Health 3.50

Why is this priority?

Increases in life expectancy means people are living longer with disabilities and multiple long term conditions. Evidence shows that those with complex physical and mental health and care needs are at high risk of unplanned admission to hospital. This is distressing and disrupting for them and their families. By improving community based support for those with complex physical health needs these unplanned admissions can be reduced and admission to long term care avoided.

What do we want to achieve?

- Maximise independence and good quality of life
- Younger adults working towards achieving their aspirations
- Equal access to Health Improvement and Health Promotion initiatives
- Access to the right support to avoid unplanned hospital admissions
- Those with complex and on-going care needs retain control over how they are cared for and how they approach end of life
- Those with care and support needs feel safe, respected and maintain their dignity
- Carers are supported to maintain their caring role

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
3a	Explore NMDS and local intelligence e.g. User feedback surveys to benchmark local performance and identify any issues to be addressed.	Effective and responsive care management delivery to reduce unplanned hospital admissions and readmissions	April 2016	• Staff time	Divisional Manager Assessment and Care Management
3b	Explore opportunities to create further Workplace Champions to promote best practice and develop staff knowledge across integrated teams	Best practice remains current across multi - professionals	April 2016	• Staff time • Network links	Professional Capabilities Forum
3c	Ensure any changes in working practice continue to prioritise the safety of vulnerable adults	People accessing services remain safe Safeguarding referrals/Care Concerns are minimised	Ongoing	• Regular Monitoring reports across health and social care	Integrated Adult Safeguarding Unit
3d	Continue to progress Making Safeguarding Personal project	Outcomes focussed approach embedded across IASU and care management	Ongoing	• Staff time	Integrated Adult Safeguarding Unit

PRIORITY4: MAINTAIN HIGH QUALITY PERSONALISED CARE MANAGEMENT SERVICES

Adults and older clients receiving a statement of their needs and how they will be met
Baseline 2014/15 97%

Adults and older clients receiving a review as a percentage of those receiving services
Baseline 2014/15 80%

Why is this a priority?

Personalisation and integration present a real opportunity to:

- **Reposition social work and social workers at the heart of integrated, personalised health and social care**
- **Refocus on social work interventions that make a difference to the lives of the most vulnerable people in society including promoting recovery for those with mental illness**
- **Develop innovative, person-centred approaches in social work practice, using evidence of what works**
  (Chief Social Worker)

Traditional models of support begin by exploring eligibility and entitlement to services which can undermine the resilience of people. By adopting a strengths based approach people who use services, their families and the wider community contribute their in-depth knowledge of their requirements and how best to meet them to assist in the design, commissioning and provision of support and services rather than being passive recipients of services.

What do we want to achieve?

- Strong leadership of the assessment and care management service
- social care professionals and people who use services work in equal partnerships towards shared goals;
- people who use services and carers having an equal, more meaningful and more powerful role in services;
- people who use services and carers are involved in all aspects of a service – the planning, development and actual delivery of the service;
- power and resources are transferred from managers to people who use services and carers;

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
4a	**Leadership** Establish lines of accountability for social work delivery	Clarity in local levels of responsibility and links to regional and national networks	January 2015	• Staff time	Operational Director Prevention and Assessment
4b	**Workforce Capacity Planning** As part of the Skills for Care pilot review essential multi-professional assessment and care management functions and determine where these are best carried out and by	People with care and support needs will have access to high quality assessment and care management interventions. Capacity to meet increases in	September 2015	• Staff time • Service reconfiguration within existing resources • Possible new investment dependent on	Divisional Manager Assessment and Care Management

	whom.	demand for assessment including Best Interests/DOLS		national funding	
	Adopt a Caseload Weighting Tool appropriate to Halton to support allocations policy	Effective allocation policy and targeting of registered and approved staff	September 2015	• Staff time	Principal Managers Complex Care
	Develop performance measures to monitor caseload, referrals and unscheduled reviews	Managers will be alerted to pressures in the system	March 2016	• Staff time	Professional Capabilities Forum
	Identify the skills mix and resources required within care management to support the proposed GP hub model	Seamless services	Dependent on final GP model	Reconfiguration of existing resources	Divisional Manager Assessment and Care Management
4c	**Workforce Culture and Development**				
	Use LGA Social work Standards Audit tool to self-assess the practice conditions and working environment of the social work workforce	Snapshot of where care management services are now and priorities for development	September 2015	• Staff time	Professional Capabilities Forum
	Participate in Skills for Care pilot to embed Integrated working into the culture of care management	Positive workplace culture with a common vision and shared values.	April 2016	• Champions for Change	Divisional Manager Assessment and Care Management
	Develop staff skills to work collaboratively with health professionals	First response is the most appropriate response	April 2016	• Training • Progression policy	Professional Capabilities Forum
4d	**Professional Capabilities**				
	Develop Professional capabilities framework for OT based on COT post qualifying framework	Effective and motivated practitioners	April 2015	• Staff time	Professional Capabilities Forum
	Review job	Job descriptions	April 2015	• Staff time	Divisional Manager

	descriptions against TCSW PCF and OT PCF	reflect PCF experienced practitioner levels		• HR input	Assessment and Care Management
	Ensure registered professional competency by identifying staff training needs and opportunities for CPD	Effective and motivated practitioners	Ongoing	• Training budget • Mentoring • Champion roles	Professional Capabilities Forum
	Develop a competency framework for non-registered staff	Retention of a quality care management service	April 2016	• Staff time	Professional Capabilities Forum
	Develop a clear progression policy which links to national professional competency standards	Professional workforce with clear career pathways	April 2016	• Staff time	Professional Capabilities Forum
	Ensure our delivery model reflects the LGA "What to expect as a Social worker?"	Retention of a quality care management service	Ongoing	• Staff time	Professional Capabilities Forum
	Develop partnerships with educational institutions to support students and practice placements	Succession planning and effective recruitment.	September 2016	• Staff time • Training • Mentoring	Professional Capabilities Forum

PRIORITY 5: INTEGRATED WORKING AND EFFECTIVE USE OF RESOURCES

Reduction in number of people out of Borough
2013/14 baseline 32

Adults and older clients receiving a review as a percentage of those receiving services
Baseline 2014/15 80%

Why is this priority?

Both the Council and Clinical Commissioning Group face significant funding reductions accompanied by increased pressures on the system arising from increased life expectancy and increased numbers of people living with multiple long term conditions. Closer integration between health and social care to deliver better, more joined up services are key to addressing these challenges and building sustainability into the system to keep people out of hospital or avoid long term care.

What do we want to achieve?

- People with complex needs enabled to remain independent in their local community
- Utilise Better Care Fund to integrate and join up pathways for those living with complex needs
- Compliance with national minimum eligibility thresholds
- Cost effective and efficient approaches to meet new legislative requirements
- Achieve value for money

REF	ACTION	SUCCESS MEASURES AND OUTCOMES	TIMESCALE	RESOURCES	RESPONSIBILITY
5a	Review EDT out of hours service to determine the model to support GP 7 day working and Urgent Care Strategy	Seamless service transitions	March 2016	Staff time Redirection of existing finance and staff resources	Divisional Manager Mental Health Services and Divisional Manager Systems Resilience
5b	Work with Public Health and CCG to develop a Making Every Contact Count approach	Improved Health and Wellbeing across the Borough	March 2017	• Possible reconfiguration of existing resources	Public Health
5c	Ensure that fieldworkers have full access to systems and information to fulfil their role and avoid repeated calls	Effective interventions	March 2016	• ICT Systems	Divisional Manager Service Improvement
5d	Review assessment and support planning tools and develop alternative access to assessments for care and support.	Cost effective approaches to manage increased demand for assessments	March 2016	• Staff time • ICT Systems	Professional Capabilites Forum

Halton Borough Council
Communities Directorate

Making a difference:

A strategy for transforming Care Management in Halton

2015 to 2020

Evidence Paper

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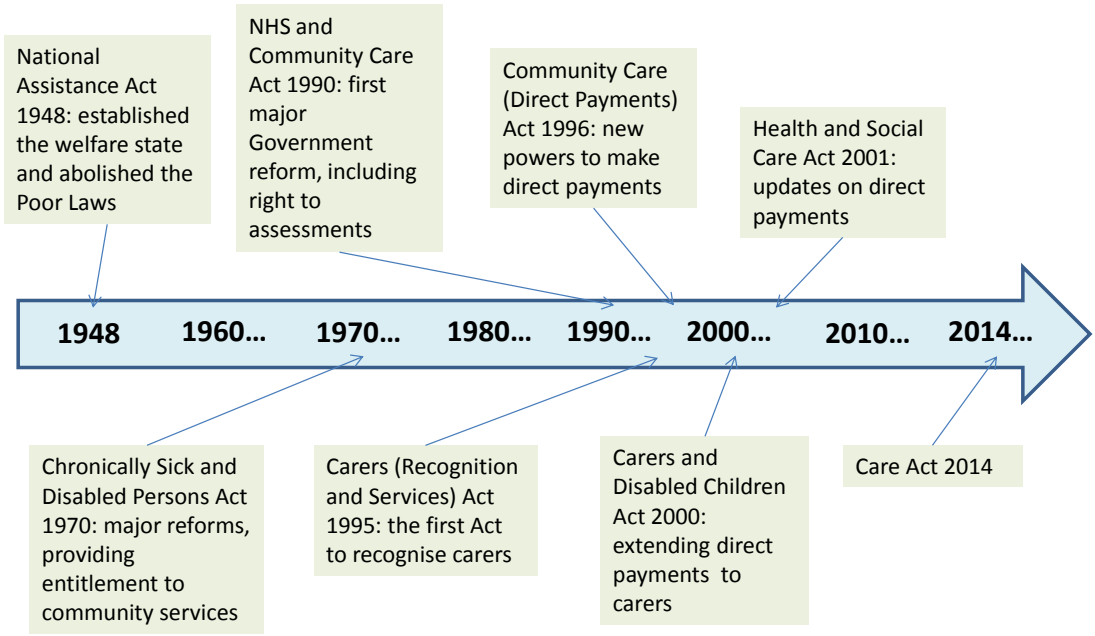
Part 1: National Policy Context

The Care Act 2014 represents the biggest change in Adult Social Care in over 60 years and consolidates numerous previous laws. The Act is reforming legislation and promotes a change in culture and practice through new duties for local authorities and partners and new rights for users and carers.

A brief history of care and support law

Around 30 Acts of Parliament over more than 60 years:



The following is a brief summary of the Care Act in relation to the Care Management Strategy. Building on the white paper Caring for Our Future (DH, July 2012) care and support reforms within the Act come into effect from April 2015. Adult Social Care in Halton and our partners now have a wider focus on the whole population in need of care, rather than just those with eligible needs or who are funded by the state.

The “wellbeing principle” which enshrines people’s needs and desired outcomes is now at the heart of the care and support system accompanied by a shift in the local authority’s legal duty to the concept of ‘meeting needs’ recognising that everyone’s needs are different and personal to them rather than a one size fits all approach. Further, the Care Act gives carers enforceable rights to their own assessment.

Definition of Wellbeing

Statutory guidance defines wellbeing as relating to the following nine areas:

i. Personal dignity (including treating of the individual with respect)
ii. Physical and mental health and emotional wellbeing
iii. Protection from abuse and neglect
iv. Control by the individual over day-to-day life (including over care and support provided and the way it is provided)
v. Participation in work, education, training or recreation
vi. Social and economic wellbeing
vii. Domestic, family and personal relationships
viii. Suitability of living accommodation
ix. The individual's contribution to society

Through the introduction and further development of personal care budgets and direct payments, users can now look forward to enhanced choice, more involvement, and more say over their particular assessed care needs. The Act includes a statutory requirement for local authorities to collaborate, cooperate and integrate with other public authorities e.g. health and housing.

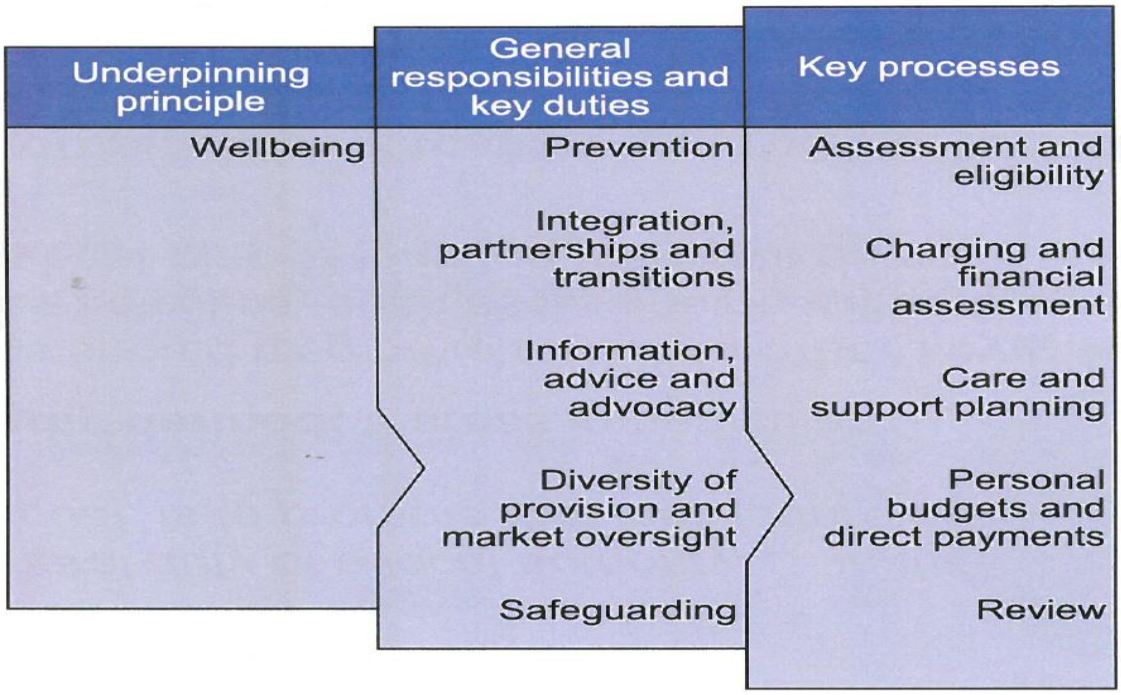
Emphasis is now on **Prevent, Reduce, Delay** the need for formal care and there must be a system in place through the Council or independent sector to provide information and advice on care and support and independent financial advice to all when they need it. Access to independent advocacy to support decision making is also a requirement.

The Act gives the local authority the lead role in co-ordinating local safeguarding activity and for protecting adults with care and support needs from abuse or neglect. This will ensure clear accountability, roles and responsibilities for helping and protecting adults with care and support needs who are experiencing, or at risk of, abuse or neglect as a result of those needs.
If the local authority has a duty to meet a person's needs, it must help them decide how their needs are met through the preparation of a care and support plan or support plan for carers.

A personal budget will from part of the care and support plan or support plan. Where a person, including carers, has a personal budget, they can have a direct payment. Those with eligible needs who are not supported by the authority (e.g. self-funders) will still have an independent personal budget (IPB) to record the notional cost of meeting their eligible needs. Fair Access to Care (FACS) will be replaced by a national eligibility threshold.

Implementation of the Care Act in April 2015 will have significant implications for the way the Council does business and the roles of the adult social care workforce. There will be changes to the way that people access the care and support system and increased demand for assessments and support plans.

The Framework of the Act and its statutory guidance



Mental Capacity Act

The Mental Capacity Act (MCA 2005) created a framework to provide protection for people who cannot make decisions for themselves. The Act contains provision for assessing whether people have the mental capacity to make decisions, and procedures for making decisions on behalf of those people who lack mental capacity, as well as measures to ensure that vulnerable people are safeguarded. It applies to anyone whose mental capacity to make decisions is affected by what the MCA refers to as "an impairment of, or a disturbance in the functioning of, the mind or brain" which may be long or short term. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. The MCA is supported by a Code of Practice and has been further enhanced through the Mental Health Act 2007 to include the duty of access to Independent Mental Health Advocates and Deprivation of Liberty Standards. (DOLS)

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 and aim to make sure that people in care homes and hospitals are cared for in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home or hospital only deprives someone of their

liberty 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 look after them.

A recent Supreme Court ruling[1] has clarified that there is now a revised test for a deprivation of liberty. This ruling has significant implications for social care practice which are considered further in Part 4 Assessment and Reviews.

Transforming Care: A national response to Winterbourne View Hospital

In December 2012, following its investigation of the failings, the Government published its full response to the criminal abuse uncovered at Winterbourne Hospital and practices observed in other settings. The review exposed concerns regarded as:

i. Inappropriate placements
ii. Inappropriate care models
iii. Poor care standards

A programme of action ensued with stretching timescales across the whole health and social care system to improve care for people with challenging behaviour. The report sets out a revised model based on the work of Mansell[2] along with roles and responsibilities across the health and social care system including regulatory bodies.

National policy has stressed the importance of personalisation and prevention which are now embedded in the Care Act 2014. The findings from Winterbourne support this approach as well as stressing the importance of ensuring that services are available locally that can deliver a high level of support and care to people with complex needs or challenging behaviour.

Francis Inquiry

The Francis Inquiry report was published in February 2013. It examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report makes 290 recommendations, including:

- openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers
- improved support for compassionate caring and committed care and stronger senior leadership across the health and social care sector

[1] Supreme Court ruling P v Cheshire West and Chester and P and Q v Surrey Council

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

Many of the messages are relevant in social care settings. In particular, people who are vulnerable (such as those dependent on care in hospital wards, residential or domiciliary settings) should be treated with dignity and compassion whilst they, their families and staff should be encouraged to raise any concerns they may have.

Information: To Share or not to Share

This document published in September 2013 is the Government Response to the Caldicott Review and accepts all 26 recommendations to improve governance practices for sharing information across health and social care.

People using health and social care services are entitled to expect that their personal information will remain confidential. They must feel able to discuss sensitive matters with a doctor, nurse or social worker without fear that the information may be improperly disclosed. These services cannot work effectively without trust and trust depends on confidentiality. However, people also expect professionals to share information with other members of the care team, who need to co-operate to provide a seamless, integrated service. So good sharing of information, when sharing is appropriate, is as important as maintaining confidentiality. All organisations providing health or social care services must succeed in both respects if they are not to fail the people that they exist to serve.

The term used to describe how organisations and individuals manage the way information is handled within the health and social care system in England is 'information governance'. In 1997 the *Review of the Uses of Patient-Identifiable Information*, chaired by Dame Fiona Caldicott, devised six general principles of information governance that could be used by all NHS organisations with access to patient information giving priority to discouraging the uploading of personal information on to information technology systems outside clinical control. The issue of whether professionals shared information effectively and safely was not regarded as a problem at the time.

NHS organisations responded by appointing 'Caldicott Guardians' to ensure that information governance was effective. The practice spread to other public bodies, including local authorities and social care services, and the remit of the guardians was extended to provide oversight of information sharing among clinicians.

Over recent years, there has been a growing perception that information governance was being cited as an impediment to sharing information, even when sharing would have been in the patient's best interests. In January 2012 the *NHS Future Forum* work stream on information identified this as an issue and recommended a review *"to ensure that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care".* The Government accepted this recommendation and asked Dame Fiona to lead the work, which became known as the Caldicott2 review.

The Health and Social Care Information Centre (HSCIC) has published guidance providing simple rules that complement the revised Caldicott principles to help everyone working in health and care to follow good information governance practice in their daily work. A further document, the Confidentiality Code of Practice also to be published by the HSCIC is awaited.

Integrated Care and Support: Our Shared Commitment (2013).

In May 2013, the Government announced its biggest ever commitment to making co-ordinated health and care a reality through publication of this framework document on integration. Signed by 12 national partners (National Collaboration for Integrated Care and Support) it sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

For health, care and support to be 'integrated', it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered.

> I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me.
>
> *Definition of integration developed by National Voices*

The Collaboration which includes the Department of Health published plans that aim to see them working together nationally and locally and included:

- An ambition to make joined up and co-ordinated health and care the norm by 2018;
- The first ever agreed definition of what people say good integrated care and support looks and feels like;
- New 'pioneer' areas around the country and
- New measures of people's experience of joined up care and support.

In addition ten shared commitments at both national and local level aim to address:-

- Pursuing a common purpose;
- National resources for local ambition;
- Providing practical tools to localities;
- Integrating information; and
- Accelerating learning across the system.

Better Care Fund (formerly Integration Transformation Fund)

Government believes that*:*

> *"to improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs."*[3]

Nationally a £3.8 billion pooled budget for health and social care services has been established to be shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. Access to this funding is based on a plan agreed between the NHS and local authorities that will deliver on national conditions:

- Protecting social care services;
- 7-day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional

Payments will be made based on performance related to:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service-user experience

[3] Spending Review 2013, HMT

Part Two: Professional Standards and Capabilities

Chief Social Worker for adults

The Chief Social Worker for Adults Lyn Romeo works collaboratively with the Chief Social Worker for Children and Families. Together they work from the Office of the Chief Social Worker to:

- support and challenge the profession to ensure that children and adults get the best possible help from social workers
- provide independent expert advice to ministers on social work reform, and the contribution of social work and social workers to policy implementation more generally
- provide leadership and work with key leaders in the profession and wider sector to drive forward the improvement and reform programme for social work
- challenge weak practice to achieve decisive improvements in the quality of social work
- provide leadership to the network of principal social workers

Principal Social worker Role

The role of Principal Social Worker (PSW) is currently held in Halton by the Divisional Manager Assessment and Care Management services. This role remains relatively undefined, within the professional capability framework and there appears to be variations in the role within local authorities. However being involved in the national network, which is supported by the college of social work, the Office of the Chief Social Worker, Skills for Care, ADASS, North West Employers Organisation (NWEO) and partaking in the Cheshire and Merseyside Partnership regional peer group should offer opportunities to be able to influence things nationally. University of Central Lancashire (UCLan) have agreed to provide expert knowledge and experience to support the group on all things related to Social Work education and research and Skills for Care have also identified a lead officer which will be invaluable as the new developments emerge.

Some key aspects of the developing role are as follows:

- Professional leadership role
- Lead, motivate and inspire social workers
- Promote social work role
- Liaise and develop professional networks locally, regionally and nationally
- Influence strategic decision making
- Users and carers and outcomes at the heart of this role
- Monitoring and auditing of quality of the Social Work service
- Undertake organisational health check annually
- Implement and monitor employer standards

The Key focus of practice improvement for the PSW role

- PSWs – 'vital impact on quality of social work in this country'
- Championing good practice – challenge to improve
- Quality assurance role – beyond auditing
- Bring reflective practice into the working environment
- Evidence practice - impact and outcomes
- Importance of CPD
- Courage to work differently/collaborate/ work across boundaries

Standards for employers of Social Workers

The Local Government Association (LGA) has set out "Standards for employers of Social Workers in England"[4] The standards were developed by Stakeholder partners across the sector 2009 and 2012 as part of the Social Work Reform Board, building on existing guidelines for employers of social workers, the Professional Capabilities Framework for social workers held by The College of Social Work, the evolving Career Framework, and the Health and Care Professionals Council regulatory requirements.

The LGA says:

> *"Good social work can transform people's lives and protect them from harm. In order to achieve consistently high quality outcomes for service users and their carers, social workers must have and maintain the skills and knowledge to establish effective relationships with children, adults and families, professionals in a range of agencies and settings, and members of the public. We can use the Standards, along with an appropriate supervision framework to help drive recruitment and retention".*

The eight standards are expectations that are being incorporated within self-regulation and improvement frameworks for public services and used by service regulators (Ofsted, CQC). The Standards apply to all employers of social workers and relate to all registered social workers employed within an organisation, as well as managers and social work students. The purpose of the Standards is to sustain high quality outcomes for service users and their families/ carers/communities.

All employers providing a social work service should establish a monitoring system to assess their organisational performance against this framework, set a process for review and, where necessary, outline their plans for improvement. Employers should ensure their systems, structures and processes promote equality and do not discriminate against any employee.

All aspects of the Standards are equally important, just as the National Professional Capabilities Framework (PCF) is holistic in nature in order to effectively set out the expectations of social workers themselves. The PCF is intrinsic to the implementation of these Standards for Employers.

[4] http://www.local.gov.uk/documents/10180/6188796/The_standards_for_employers_of_social_workers.pdf/fb7cb809-650c-4ccd-8aa7-fecb07271c4a

National Professional Capabilities Framework (PCF)

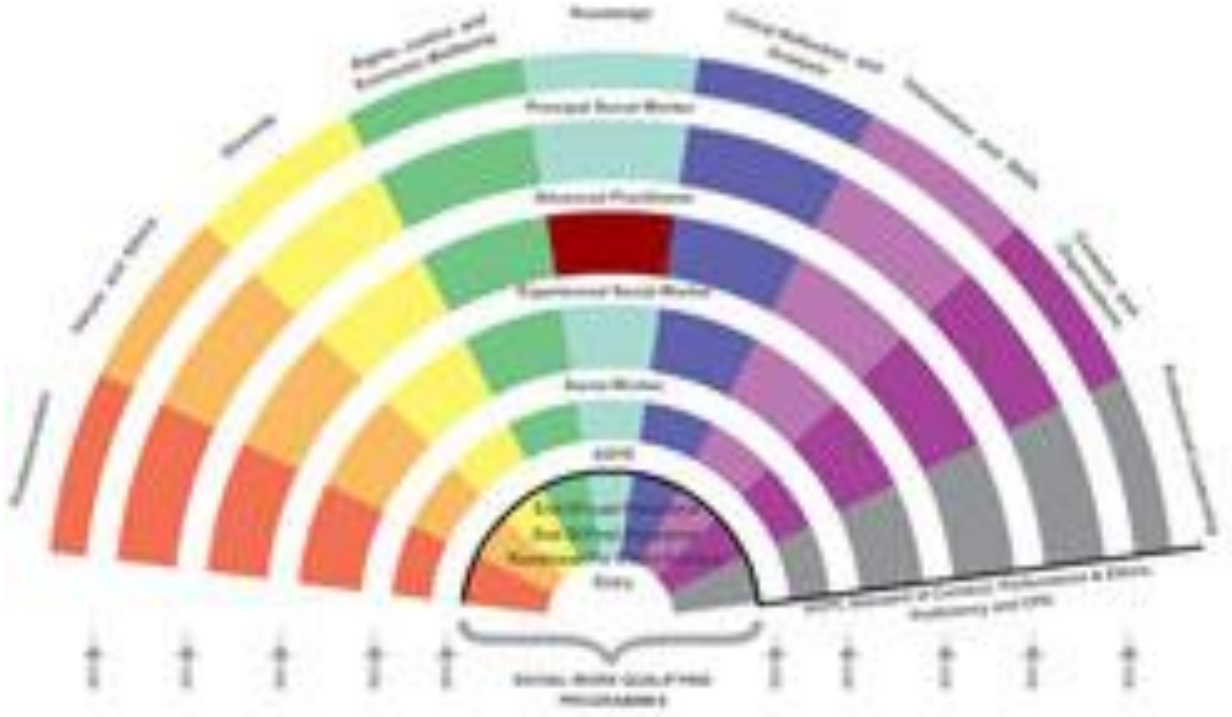
The national “Professional Capabilities Framework” is an overarching professional standards framework, developed by the Social Work Reform Board and now owned by The College of Social Work (TCSW). The PCF applies to all social workers in England - in all roles and settings, including independent social workers which has been developed to help social workers be supported to do the best job they can at all stages of their profession.

The College of Social Work has launched a series of social work toolkits to help support the implementation of a suite of reforms that are galvanising improvements throughout the profession. The six toolkits are designed to direct social workers, social worker employers and education providers through the steps required to implement a series of recent practice developments aimed at strengthening professionalism and improving the public image of social work.

The PCF:

- Sets out consistent expectations of social workers at every stage in their career
- Provides a backdrop to both initial social work education and continuing professional development after qualification
- Informs the design and implementation of the national career structure
- Gives social workers a framework around which to plan their careers and professional development.

Professional Capabilities Framework ”PCF”[5]



[5] http://www.tcsw.org.uk/pcf.aspx

Part Three: Integrated Working and Workforce Planning

The principles of workforce integration[6] (Skills for care)

Workforce integration is about working together to meet people's needs and enabling people with care and support needs to live as independently as possible. Its purpose is to improve the quality of care and support by keeping the individual, not the organisation or particular profession, as the driving force behind care and support. Adopting an integrated approach enables workers to understand each other's roles and contributions, and to build support networks around individuals. At a strategic level, integration creates a more seamless experience for individuals.

There are six principles that help in thinking about and discussing integration, these principles address some specific workforce related questions:

- How can workers who are being asked to work in a team with people from different professional backgrounds be supported to deliver real change?
- What is the role of workforce development in developing strategies to steer the path to workforce integration?
- How can workforce development opportunities be shaped to ensure that the goal of integrated care and support with people at its heart is paramount?
- What is the role of workforce development in ensuring that resources are identified, developed and used to their maximum benefit in achieving value for money alongside excellence in care and support?
- How can managers at all levels ensure that workers are involved, engaged and listened to, and create opportunities for learning and sharing across boundaries as well as within teams?
- How can individual workers best be supported to equip themselves to grow as practitioners so that they become confident, knowledgeable and capable of contributing to and delivering high quality integrated services and co-produced care?

Principle 1: Successful workforce integration focuses on better outcomes for people with care and support needs.

Developing a common goal around better outcomes for people with care and support needs creates a single vision to underpin transformation. It is easy to lose direction or get pulled by competing priorities, but continually refocusing on the purpose of the care and support being provided brings everyone back together. Integrating the workforce, including the range of different practitioner skills, around the needs of each individual being supported will result in better use of resources, and support that is tailored to that person's needs. The views and experiences of people with care and support needs, and of family or friends

[6] http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-integration/principles-of-workforce-integration.pdf

carers, are an integral part of developing new ways of working. Creating person-centred provision is not just about workforce reconfiguration. It is about how the team operates around the individual, working together to achieve best outcomes.

Principle 2: Workforce integration involves the whole system.

Bringing together frontline workers without integrating all of the systems that support and enable those workers is not sustainable. It will create conflict and practical difficulties, and make the workers feel unsupported. Integrating resources, responsibilities and control creates a clear message that each organisation is committed to the transformation. Integrating resources will minimise duplication, and help ensure that every part of the system is working effectively. Bringing in new service arrangements will disrupt some long established informal networks; building new ones should be viewed as a priority. The system should be viewed in a non-hierarchical way, each person in the system carries some responsibilities, and all are mutually dependent upon each other for success.

Principle 3: To achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities.

Change and transition can be debilitating if it is perceived to be threatening. Workers need to feel safe, valued and supported. Their anxieties should be freely aired and responded to. Where job roles change, workers can feel de-skilled. Identifying and meeting learning needs should be part of any strategy employed. Safe environments enable people to innovate, take risks, build new models and ways of working, and share learning to enhance practice. A balance needs to be struck so that workers can maintain their sense of professional identity at the same time as working across boundaries that are increasingly blurred. To achieve this, roles, responsibilities and accountability need to be clearly described. Workers, who feel their perspectives and skills are recognised and valued by their colleagues and across organisations are more likely to feel confident, motivated and engaged with the changes. Professional supervision and the opportunity to manage continuing professional development need to be incorporated into any new arrangements.

Principle 4: A confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active and engaged communities is at the heart of workforce integration.

The most valuable resource in any organisation is the workforce. Attending to workforce issues, identifying learning needs, addressing issues of professional identity and recognising infrastructure issues such as employment arrangements, gives a clear message about the value placed upon workers. Successful implementation of integration depends upon workforce issues being addressed from the beginning. Workforce issues cannot be added at the end, they need to influence discussion and decision-making, and need to be included in the process of resource allocation. An environment in which workers feel safe and confident to raise questions, express concerns, talk about their experiences and make suggestions for service improvement based on their experience and relationships with people they support will create trust and help them and colleagues to feel supported. Acknowledging and valuing the expertise that workers bring to their changing workplace environment will make them feel valued and listened to. Creating a

learning environment that draws on the experiences of workers will maximise innovation and appropriate risk-taking, and support the development of new models and ways of working. People learn in different ways and at different paces, and are affected by change to varying degrees. The design and implementation of integrated strategies needs to reflect this, so that things are paced appropriately, with individual workers' needs identified and met in a range of ways. 'Champions' play an important role in the implementation of any transformation and having champions at every level will help in implementation. Motivated and enthusiastic workers should be identified, nurtured and encouraged to take on this role.

Principle 5: Process matters—it gives messages, creates opportunities, and demonstrates the way in which the workforce is valued.

Give attention to the process, it is by getting this right that ownership, commitment and trust will be developed and the likelihood of sustained success will be increased. Good communication, keeping everyone informed and appropriately involved in decision making, is the foundation of an effective strategy. Begin by looking for the resources and experiences that are already there, as building on these demonstrates that individuals' contributions are valued. Create opportunities for people to learn from each other. The ways in which senior workers behave and act should mirror the co-operative, open and motivated approaches that will be expected of frontline workers.

Principle 6: Successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies give each of these attention, creating the circumstances in which all can thrive.

Informal networks are critical to workers, providing them with information, support, ideas and quick responses. Reconfiguring services will interrupt existing networks. Opportunities need to be created to ensure that new relationships can thrive. The ways in which different professional groups and organisations relate to each other will change with integration. This can feel threatening and create insecurity. The needs of each professional group need to be attended to, to enable a continued sense of professional identity and to ensure continuing professional development. At the same time, members of newly created teams and services should have the opportunity to share understandings, perspectives, priorities and limitations so that everyone feels comfortable in their role, and with the roles of others. The new ways of working that emerge with integration may create specific learning needs to enable individuals to work effectively. These need to be identified and attended to. There is richness in the diversity created within integrated teams and organisations; facilitated opportunities should be created to exploit this, so that people can learn together as new approaches evolve.

Skills for Care

The Department of Health has set out the social workers vital role in personalising care and support. This will become more important as part of an integrated response focused on context, possibilities and outcomes, rather than processes and tasks:

- Personalisation reflects social work values: **respect for the individual** and **self determination** are at the heart of social work

- Social workers have a central role in **maximising better outcomes** for people:
- Promoting **independence and choice** – working alongside individuals and their families - independent living, inclusion and well being
- **Empowering people** to shape their own lives and their care and support
- **Putting people at the centre** – working it out together – equal and creative relationship between people who use services and social workers
- **Supporting positive risk-taking** through good assessment and management of risk and information about possibilities
- **Working with other professionals** to ensure responses are appropriate and sensitive to the needs of the individual
- **Strengths-based approaches** – helping to build independence and reduce the risk of more costly interventions
- **Reflection, supervision and Continuous Professional Development** to challenge and improve personalised and quality social work practice

Personalisation of services and the national drive to move to a more integrated approach present a real opportunity to:

- Reposition social work and social workers at the heart of integrated, personalised health and social care
- Refocus on social work interventions that make a difference to the lives of the most vulnerable people in society
- Contribute to shaping the social care market to achieve the best outcomes for people using services

The Professional Capabilities Framework reinforces this approach setting out expectations for social workers to:

- Apply critical thinking, augmented by creativity and curiosity
- Identify, distinguish, evaluate and integrate multiple sources of knowledge and evidence, including:
- Practice evidence and experience
- Service user and carer experience
- Research-based, organisational, policy and legal knowledge
- This will become more important as part of an integrated response focused on context, possibilities and outcomes, rather than processes and tasks.
- Personalisation presents further opportunities for innovative, person-centred approaches in social work practice, using evidence of what works - including:
    - Outcome based approaches to assessment, care planning and review
    - Motivational interviewing
    - Attachment-based strategies for working with adults
    - Making Safeguarding Personal

- Strengths-based approaches
- Micro-providers/ Innovative use of Personal Budgets

The Workforce Capacity Plan

Since 2011 the National Minimum Data Set for Social Care has collated information on all adult social workers employed in the statutory sector. Nationally this tells us that the number of registered social worker jobs over this period has been relatively stable. More than 1 in 3 of these social workers is aged 50 or over which may have implications for continuity planning. The ASYE registrations in 2013-14 was around 1,000 and data suggests that the proportion employed in the non-statutory adult social care sector (i.e. private, voluntary and health) nay be increasing.

'Skills for Care' has been tasked by the Department of Health to support local authorities across the country with workforce capacity planning to help them prepare for the implementation of the Care Act. This model below has been developed to implement workforce reform in the context of the Care Act which will require significant change to workers roles and practice to meet new legal expectations.

The model puts the person at the centre of workforce capacity planning emphasising the role of workforce capacity planning in improving outcomes for people with care and support needs and their carers. Prevention, integration and wellbeing all need to be considered throughout the development of the plan and co-production can be an important part of workforce capacity planning.

The Act sets out the general responsibilities of local authorities describing their broader care and support role towards the local community. In relation to the Act, the workforce needs to have the capacity and capability to work in the context of:

i. **Well-being principle:** a new statutory principle designed to embed individual well-being as the driving force behind care and support.

ii. **Prevention:** the local authority's role in preventing, reducing or delaying the need for care and support. This is a general duty that applies in relation to all local people – including applying equally to carers and those with care needs.

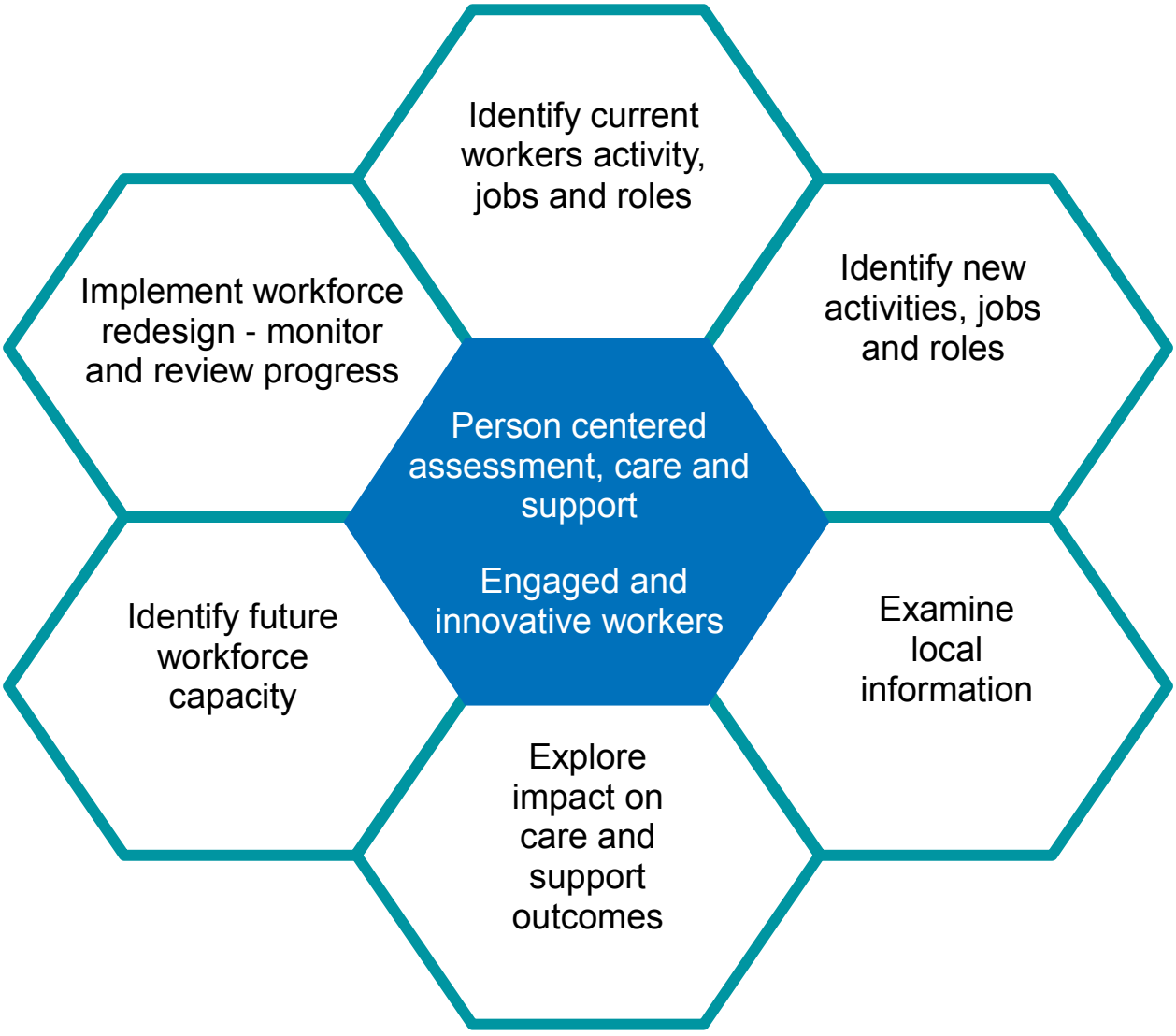
iii. **Integration:** a duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services, such as housing. Improving outcomes for people and communities.

iv. **Information & advice**: broad, high-level requirements for what local authority information and advice services should include to enable people to understand how the care and support system works, what services are available locally, and how to access those services.

v. **Promote diversity and quality of services:** local authorities will be required to promote the diversity and quality of local services, so that there is a range of high quality providers in all areas. This includes local authorities fostering an effective care and support workforce.

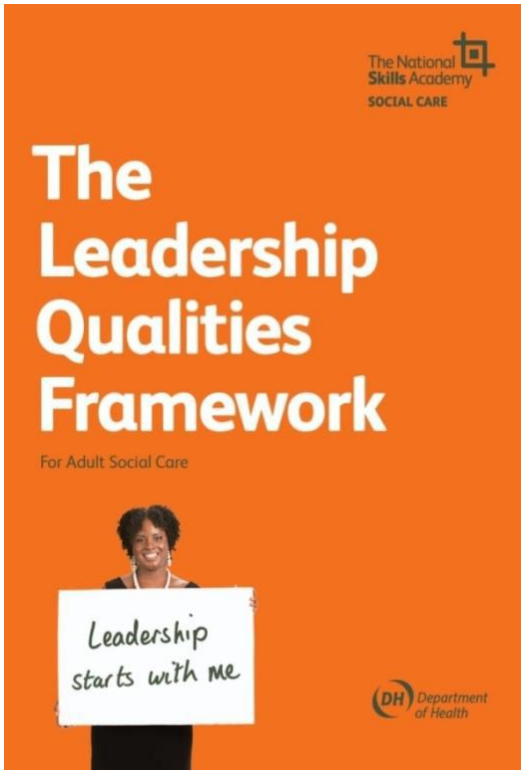
vi. **Co-operation**: local authority and other authorities which have functions relevant to care and support will be required to co-operate. There will be a specific duty to co-operate in relation to individual cases, where the local authority can request co-operation from one of the partners (or vice versa) to help with a specific issue to do with a carer or an adult who uses care and support. These provisions include a duty on the local authority to ensure cooperation between its officers responsible for adult care and support, housing, children's services and public health.

Skills for Care Workforce Reform Model



Social workers as leaders, and leadership from social work:

The 'Social work leadership toolkit'[7] is a refreshed version of the frontline social work managers' framework originally developed by Skills for Care and The National Skills Academy for Social Care. New material and additions to the toolkit have been developed in collaboration with a number of wider stakeholders including The College of Social Work and Learn to Care.



How can it be used?

- Front line social work practitioners (those working at the 'Experienced' PCF level) who aspire to be managers can use it to understand the skills and knowledge required to move into a management role and to support identification of their development needs.

- Front line social work managers (those already working at the 'Advanced' PCF level) who are either new to management or in a new role can use the framework to identify their development needs.

- Established social work managers may use it to maintain and improve their skills and work effectively in a changing context.

- HR, professional development staff and commissioners who want to understand the development needs of social work managers and other professional social work leaders may find it helpful as part of a restructure or workforce re-design process.

- Senior managers, including strategic social work managers (working at the 'Strategic' level of the PCF), who wish to change their service by supporting social work managers and professional leaders to work in different ways or take on different responsibilities.

- Training providers and awarding bodies who are seeking to develop and accredit programmes to meet the needs of social workers.

What is the Structure?

The 'Social work leadership toolkit' works as a coherent whole for those who wish to understand the underlying principles and be guided through the process of developing a social work leadership framework linked to the profession's own 'Professional Capabilities Framework.'

To meet the needs of a range of differing audiences each section of the toolkit are "searchable" allowing users to go directly to specific information using the clickable sections.

[7] http://www.swltoolkit.co.uk/

The 'Introducing the Social work leadership document (2013)' provides a background and overview of the methodology and process used in the development of this toolkit. It contains a number of the models which could be useful to those who are seeking to draw learning from a range of projects.

Each section provides examples of best practice, links to useful tools and research evidence. All the materials are intended to support individuals and organisations plan and implement effective social work leadership development programmes and activities.

Part Four: Assessments and Reviews

Qualified Social Workers

The Audit Commission[8] argued the case for local authorities making significant financial savings by having less qualified staff, rather than experienced social workers to carry out assessments and reviews. By this means, they estimated that local authorities could save £180m annually.

However, to raise the debate, the College of Social Work (TCSW)[9] considered this strategy to be fraught with danger and could even "increase the risk of harm and bring higher costs later". Removing qualified staff from conducting simpler assessments could result in critical elements of risk, vulnerability and need being missed by a less experienced assessor, which would be picked up and acted upon by a qualified Social Worker.

The TCSW further argue that SWs are uniquely prepared by their education, experience and training to foster the social capital that makes active citizenship in thriving communities a genuine possibility. Service users quite often have to have their needs teased out, interpreted and met creatively from the social assets of the family and local community. This asset-based approach requires a deep knowledge of individual, family and community interaction that goes beyond the assessment and the care package, but looks at the inclusion of individuals. Hence as social care theory and legislation continue to develop, social workers will have a central role not only with assessment, planning and review but also with: community development, safeguarding, prevention, early intervention and interpersonal support.

Halton Spend on Assessment and Care Management

Year	£000	% of Total spend on Adult Social Care
2012/13	£4,693	13.5
2013/14	£4,397	12.4

The percentage of Adult Social Care spend on Assessment and Care management is a little higher than the Audit Commissions suggested target of 10% (based on 2010/11 figures) but well below the 17% of high spending authorities. The report recommends that authorities should undertake benchmarking of care management costs with other authorities of a similar size and circumstances.

[8] Reducing the Cost of Assessments and Reviews, Audit Commission August, 2012

[9] The Business Case for Social Work with Adults, December, 2012

Halton assessment and care management capacity (April 2015)

Posts	Complex Care and Initial Assessment Teams	Mental Health Team
Principal Manager	3	1
Practice Manager	5	1
Social Workers	22.5	11
Carers Assessor		1
SW Community Care Workers	21.5	
Occupational Therapists including Accessible Homes	6	
OT Community Care Workers	10	
CHC Nurse Assessors	4	
Vision Rehabilitation Officers	2	
Social Care in practice Community Care Workers (funded by CCG)	3	

It is imperative that assessments and reviews of the needs of vulnerable people are robust as poor assessments increase the risk of harm and bring higher costs later. In making savings in assessments and reviews, each council must monitor service quality and outcomes for people. Some measures of efficiency will provide an indication of quality, such as the time taken to provide for needs and financial assessments.

The Audit Commission's analysis evidenced that low-cost councils achieve broadly the same levels of service quality as high-cost councils. This suggests that councils that spend more on assessments and reviews can make savings without sacrificing service quality, or putting vulnerable people at higher risk. Suggestions on how Councils can reduce their spending on assessments and reviews include:

- redesigning the care pathway to provide information at an early stage to reduce the potential demand for formal assessments;
- reducing overheads, by streamlining the administration supporting assessments and reviews;
- reviewing the grade mix of staff providing assessments and reviews; reviewing pay rates to find savings, but without risking recruitment and retention;
- matching staffing more closely to workload; and
- looking for opportunities to collaborate with other councils to reduce overheads and costs.

Referrals, Assessments and Reviews in Halton

Activity within Assessment and Care Management has increased significantly in 2014/15 compared to 2013/14 and further increases are anticipated with the implementation of the Care Act and recent case law relating to Deprivation of Liberties. Numbers of completed assessments completed are showing a significant increase and includes a 70% increase in the number of Carers Assessments undertaken.

Referrals, Assessments and Reviews

Year	Referrals	Assessments (Including Carers Assessments)	Reviews	Vulnerable Adult Abuse Investigations (including ISU)
1/4/2012 to 31/3/2013*	3,784	2.114	1,476	1,217
1/4/2013 to 31/3/2014	4,930	2,149	1,975	1,473
1/4/2014 to 12/12/14 (extrapolated to 31/3/15)	5,525	3,921	1,916	1,718
Percentage increase 2013/14 to 2014/15	12.1%	82.5%	-3%	16.6%

***Data loaded on Carefirst 5 1/4/12-28/5/12 is incomplete due to structural changes. In view of this 2013/14 has been used as the baseline for comparison

Assessments and reviews completed by Mental Health Team

Team	01/04/2012 - 31/03/2013	01/04/2013 - 31/03/2014	01/04/2014 - 12/12/2014 extrapolated to 31/3/15	% change 13/14 to 14/15
Comprehensive	39	54	81	50
Reassessment/unscheduled review	19	26	34	30.8
Review	328	259	194	-25.1
total	**386**	**339**	**309**	**-8.8**

Worker Average Case Load

01/04/2012 - 31/03/2013	01/04/2013 - 31/03/2014	01/04/2014 - 12/12/2014
43	64	45

The 2014/15 figure is indicative at this stage and will be amended at year end.

The average worker case load is the number of assessments and reviews completed divided by the number of workers. This does not necessarily reflect the type of cases a worker would pick up, e.g. only Social Workers complete safeguarding, whilst a reviewing officer would have a larger case load than a Social Worker or Community Care Worker with more complex cases. Most carers' assessments are completed by IAT and as they offer short term intervention have a quicker throughput of cases.

New responsibilities – Care Act 2014

The new duties under the Care Act will increase demand for assessments and reviews arising from requests by self-funders and carers. The 2011 Census asked whether you provided unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age and for how many hours per week. Overall numbers had changed little from 2001 but the numbers providing more than 20 hours of care each week had increased by 5% and now represents a third of all unpaid carers with 8% providing more than 50 hours per week. As a result of the Act councils must assess carers' needs for support and the duty to promote wellbeing now applies to carers, including parent carers of under 18s, in addition to service users.

This is being considered as part of Workforce Capacity Planning work streams along with the professional development of care managers who will need to incorporate the nine areas of the "wellbeing principle" into assessments of need (outlined in Part 1).

Deprivation of Liberty Safeguards (DoLS)

Recent clarification by the Supreme Court (the Cheshire West ruling) on the test for DoLS has lowered the threshold for DOls assessments resulting in a significant increase in the number of people requiring an assessment for protection under DoLS with serious implications for both social care practice and the wider health and social care system. The Association of Directors of Adult Social Services (ADASS) has predicted that the Cheshire West ruling will see DoLS assessments rise from just fewer than 10,000 last year to a predicted 94,000 by the end of 2014/15 financial year at an extra cost of at least £88 million to Local Authorities.

Estimated maximum number of assessments required in Halton to address new ruling

Setting	Numbers
Residential and Nursing Homes – based on total no of beds in the Borough	837
Hospitals (assuming approx. 30 per week)	1560
Hospice	12
Supported Living	185
Respite (based on figs for shared care vouchers)	79
Estimated no of potential assessments required	**2,673**

In Halton for the year 2012/13, 50 DoLS assessments were undertaken. In the six months April to September 2014, 87 assessments were completed representing a 28% increase. In December 2014 Halton has 19 trained Best Interest Assessors working alongside their current Social Worker role. The increase in assessments has impacted upon the care managers who are also Best Interest Assessors

taking them away from their care management role. These figures represent only the most urgent of cases and do not represent the cases who are in a stable situation in residential and nursing homes who meet the 'acid test' but have yet to be assessed. DoLS authorisations require statutory reviews at least once every 12 months and therefore this demand will be on going.

It has been proposed that the main vehicle for initiating a DoLS assessment for cases within residential and nursing homes will be via the care management review processes. This will provide us with a managed procedure maximising our resources and a stepped approach to future annual DoL reviews. Potentially this will require additional 35 – 40 DoLS assessments per month (based on current reviewing cycles).

Strengths (Asset) Based Approach

Halton as are other local authorities are examining ways of maintaining the same level of service through alternative ways of working. One approach is to commission services in a way that identifies and makes use of the strengths already existing within communities, as a means for sustainable development (Asset Based Commissioning [ABC] and Asset Based Community Development [ABCD]).

Nationally numerous Local Authorities have adopted the ABC/ ABCD approach (Nelson, Cambell and Emanuel, 2011). Locally, various authorities in the North West are making progress using asset based approaches in the widest sense. Liverpool since early 2011 has been using the ABC approach to help involve and engage communities to improve their heart health in a particular neighbourhood, as a means of achieving long-term improvements in local health.

Making It Real

Think Local Act Personal (TLAP) is the sector wide commitment to transform adult social care through personalisation and community-based support. Over 30 national organisations worked together to come up with a way of checking how things are going with changes. The result is 'Making it Real', a framework that highlights the issues most important to the quality of people's lives. It helps the sector take responsibility for change and publicly share the progress being made. It is built around "I" statements, that express what people want to see and experience; and what they would expect to find if personalisation is really working well.

Of note 'Making it Real' framework features prominently in the 'Integrated Care and Support: Our Shared Commitment' May 2013, to coincide with Norman Lamb's announcement around integration. An extract from the document as an example of this is as follows:

> "*We have already started to use the Narrative to inform our national work to support local initiatives. For example, we are developing the "I" statements as indicators for measuring people's experience of integrated care and support and are looking for them to be used at the local level to ensure*

integrated care and support is developed around the needs of the individual. We are looking for Health and Wellbeing Boards with commissioners and providers to come forward to test how the "I" statements can be used in practice to deliver better-coordinated care and support across local health and social care systems.

We expect local and regional organisations to adopt the Narrative and use it to support the planning, commissioning, and delivery of better-coordinated care and support tailored around the individual. The Narrative is intended to be used flexibly at a local level. We therefore encourage localities to develop and adopt "we" statements setting out what you will do in order to make the "I" statements a reality for your patients and service-users.

In implementing the Narrative, we encourage localities to adopt a three-step process, in line with Making it Real, ensuring:

1. Co-production with patients and people who use services

2. Board level commitment

3. Production of an action plan, and sharing this publicly.

In order to ensure coherence, the organisations in our national collaborative and TLAP will work closely together to align the implementation of the Narrative and Making it Real. It is also of note that there will also be significant linkages into the Integration Transformation Fund and this work would be required to be reported back as part of this agenda.

Halton Borough Council and NHS Halton CCG have signed up to Making It Real in 2014

Making Every Contact Count

Making Every Contact Count (MECC) is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change. To do this organisation need to build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals. Doing this will improve health and wellbeing amongst service users, staff and the general public and reduce health inequalities. Enabling and empowering the public requires staff through their interventions to:

- promote the benefits of healthy living across the organisation
- ask individuals about their lifestyle and changes they may wish to make, when there is an appropriate opportunity to do so
- respond appropriately to the lifestyle issue/s once raised
- take the appropriate action to either give information, signpost or refer individuals to the support they need.

There are a range of toolkits and resources to support implementation of these approaches at

http://www.makingeverycontactcount.co.uk/

Part 5: Self Directed Support and Support Brokerage

Self-directed support is about the person having informed choices about the way they are supported. Many people will be able to plan and organise this themselves whilst others may need some help from “support brokers”

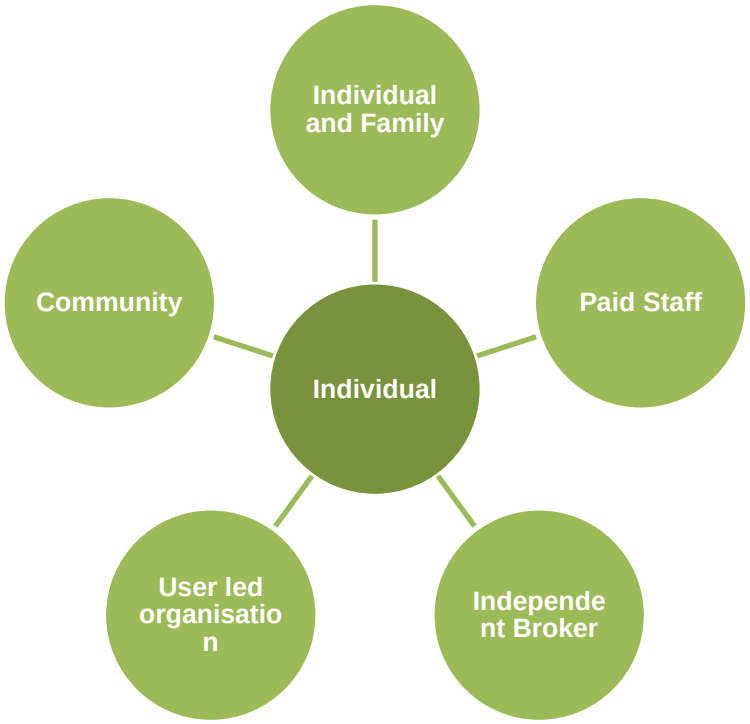
There is growing consensus that support brokerage has a number of functions covering a range of activities or tasks that people may need when directing their own support. The Department of Health provides the following list which offers a framework to understand the range of support encapsulated within the term support brokerage:

Functions of Support Brokerage

1. Information, Advice and Guidance - having the right information and advice to make decisions.
2. Facilitation and Enablement - support to navigate and work through the process of self-directed support.
3. Researching what is available - knowing what’s available locally.
4. Technical Advice - drawing on specialist advice where necessary e.g. legal and employment advice
5. Planning - developing Support Plans - exploring how best to organise support that suits the person.
6. Coordinating supports and resources - setting up support systems and longer term management arrangements.
7. Negotiation and mediation - support to resolve conflicts or disputes to ensure the right outcomes for the person.
8. Advocacy - support to be heard and represented if needed.

There are a range of people and agencies that can fulfil the functions of support brokerage represented below. In all cases the starting point should be the individuals brokering their own support before seeking the assistance of others.

Brokerage approaches



There are a number of different models for support brokerage based around either local authority provision or independent/voluntary sector provision. More information on these can be viewed at:

http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/Informationandadvicecasestudies/

In Halton we are continuing with our existing model of brokerage whilst monitoring which models embracing. In Wigan, for example, a model where brokerage is provided by Social care staff working within the Council as a separate function has been implemented. The assessment and resource allocation functions have been separated from the support planning and brokerage functions.

Brokerage is separated from the responsibilities of Social Work staff within the Council. Social Workers continue to assess and agree the resource allocation but do not draw up a support plan or organise the support which is actioned by other social care staff.

This model creates a new service incorporate existing functions i.e. Direct Payments Team, Central Commissioning Team (Care Arrangers) and can be created within existing resources so is cost neutral. The following analysis of this model was completed by Wigan:

Advantages of Brokerage provided by the Local Authority as a separate function

Service User Outcomes

Exercising Choice

- Individuals are able to build a relationship with one organisation.
- Provides an opportunity to match the service user choice of a broker with staff with different expertise, knowledge and skills.

Keeping Safe

- Social Workers could still be accessed quickly to respond to a crisis and unexpected changes in need. Support systems are already in place to protect vulnerable adults.
- Some regulation and accountability, protecting vulnerable people against inefficiency and bad practice and provide a route for complaint.

Organisational

Workforce

- Could create a new team using existing workforce.
- Local Authority Social Care staff are already experienced in some of the brokerage functions
- The skills and expertise of the current workforce are retained and developed.
- There are no TUPE implications for in house but would be TUPE for contracted services.
- May offer opportunities for staff re-deployment from decommissioned service areas.
- This has been an approach that has been done before as it mirrors the current approach around Direct Payments Teams.

Financial

- Could be easier than other options to collate information regarding the market
- Could ensure cost effective approaches in arranging support.
- May reduce costs associated with the possible workforce changes as more people may choose not to use traditional services.

Partnerships

- Information could be more easily collected and shared to inform an emerging area of practice.

Reputational

- Could maintain the regulatory and accountability role, protecting vulnerable adults against inefficiency and potential poor quality provision.
- Social Care workers may have very good trusting relationship with people that are worth building on.

Disadvantages

Service User Outcomes

Exercising Choice

- Council staff providing brokerage may have too much power which is not in keeping with some of the principles of a personalised approach.
- People are unable to choose the organisation that helps them to arrange their support.
- Staff may lack creativity in planning how needs can be met and choose traditional service options.
- Internal brokers may prioritise in-house services or particular providers. A change in practice may not be realised.

Keeping Safe

- The willingness of internal brokers to develop more innovative support packages varies and the duty of care may act as a barrier to the pursuit of independence and control.
-

Organisational

Workforce

- Training and development of workforce required.

- Staff may not want or be able to carry out new roles.
- Significant changes at a time when change agents may not be in place to lead.

Financial

- Some staff working on brokerage type activities may not be required to the same degree. So some staff, in some situations, would be placed at risk.
- May not deliver efficiencies.

Partnerships

- Local Authority staff may be less able to negotiate creative or cost effective solutions due to historical relationships.

Reputational

- May not achieve the strategic shift in thinking and practice.
- Third sector may challenge if they are affected in order to afford this option.

Risk Description	Consequence	Impact	Probabilit	Possible actions to control the risk
1. Lack of available change agents to lead service development.	Challenge to change could delay implementation			• Capacity to take forward changes needs to be fully scoped and resourced.
2. Service users may be dissatisfied with a break in the Personalisation Pathway.	May lead to an increased number of customer care complaints.			• Handover points in the pathway need to be managed effectively to ensure good response times and clarity for all around roles and responsibilities.
3. This option may not realise any efficiency savings as staff re-deployment could be costly.	Increased budget pressures.			• Financial reduction achieved through reduced Social Work resource. • Streamline resources to maximise efficiencies.