Public Document Pack

Health Policy and Performance Board

Tuesday, 8 September 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 Charlotte Gerrard	Labour
Councillor Margaret Horabin	Labour
Councillor Mark Dennett	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Shaun Osborne	Labour
Councillor Carol Plumpton Walsh	Labour
Councillor Pauline Sinnott	Labour
Councillor Pamela Wallace	Labour
Mr Tom Baker	Co-optee (Healthwatch)

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 3 November 2015

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

Part I

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

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 8 September 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: 8 September 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 Social Care Portfolio which have been considered by the Health and Wellbeing Board 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, 13 May 2015 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Philbin, Polhill and Woolfall and S. Banks, P. Cook, B. Dutton, R. Foster, D. Lyon, A. Marr, A. McIntyre, E. O'Meara, D. Parr, N. Rowe, A. Scales, R. Strachan, L. Thompson, S. Wallace Bonner, A. Waller and S. Yeoman

Apologies for Absence: M. Creed, N. Sharpe and Councillor Wright

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB51 MINUTES OF LAST MEETING

The Minutes of the meeting held on 11th March 2015 having been circulated were signed as a correct record.

HWB52 THE TRANSFER OF 0-5'S PUBLIC HEALTH COMMISSIONING RESPONSIBILITIES

The Board considered a report of the Director of Public Health, which provided an update on the transfer of 0-5s public health commissioning responsibilities in relation to mandation and financial arrangements. From 1st October 2015, the Government intends that local authorities will take over responsibility from NHS England for commissioning public health services for children aged 0-5. The workforce would continue to be employed by their current provider, Bridgewater Community Healthcare NHS Trust, whilst the commissioning responsibilities for 0-5 public health services, which included the Health Visiting Service and the Family Nurse Partnership (FNP), would transfer across to the Council.

It was reported that the Government had reached agreement that the following universal aspects of the 0-5 Healthy Child Programme would be mandated in

regulations:

1. The antenatal health promoting visits;
2. New baby review;
3. 6-8 week assessments;
4. 1 year assessment; and
5. 2-2½ year review.

With regard to finance and contracting, NHS England had worked closely with local authorities to jointly agree the finance and contracting picture. The indicative contract value for Halton had been agreed and was based on the anticipated number of Health Visitors who would be in post at the point of transfer.

RESOLVED: That the update be noted.

HWB53 NHS ENGLAND UPDATE

The Board received a quarterly Accountability report submitted by NHS England. The report outlined national and regional context together with specific updates on priorities that the Area Teams were responsible for delivering and how these priorities were progressing. In addition, the report gave an update on NHS England, progress on the Two Year Operational Plans as well as the development of the Cheshire and Merseyside Business Plan for 2015/16.

RESOLVED: That the update report be noted.

HWB54 BETTER CARE FUND QUARTERLY MONITORING REPORT (Q1) - UPDATE

The Board was advised that the Better Care Fund operationalisation guidance and non-elective admissions ambitions had been published and the document set out the monitoring requirements for 2015/16 for the Fund which included:

- Quarterly reporting template;
- Submission points; and
- Annual reporting/year-end reporting.

It was noted that approval was sought for the Quarter 4 report from January to March 2015 which was due for submission to NHS England by 29th May 2015. Details of the submission, including a summary which covered non elective admissions and supporting metrics, were outlined in the report.

RESOLVED: That the Board

1. note the content of the report; and

2. approve the Quarter 4 Better Care Fund Report, detailed in point 4.0 of the report and at the attached appendix.

HWB55 'ONE HALTON' DEVELOPMENT SESSION

The Board received a presentation from Leigh Thompson, Director of Commissioning & Service Delivery, Halton CCG, which advised that NHS Halton CCG had recently launched a new concept and initiative called *One Halton*. This had been done in partnership with a number of local organisations including the Local Authority, NHS providers, voluntary sector organisations and other key local bodies and organisations. The *One Halton* Programme was an overarching framework to deliver a collective mandate for joint action across Halton against a jointly agreed set of strategic priorities. With a focus on primary, secondary and tertiary prevention, it created a holistic way of working in which all local organisations – both statutory and non-statutory – co-ordinated their approach and services to managing the health and well-being needs of local people. Services would be delivered in the optimum locations for people where every resident had consistent access to care. Benefits of the scheme included:

- Whole system approach;
- Shared purpose – the power of everyone behind the same idea/concept;
- Sharing expertise;
- Alignment of organisational plans and priorities;
- Greater opportunity for innovation – with agreed risk sharing; and
- Whole population approach covering all age groups.

As part of the consultation on *One Halton* the Board divided into three groups to discuss six questions around:

Is *One Halton* the right thing to do?

How do we avoid this being just another good idea?

What is the role of the H&WBB in *One Halton*?

What would *One Halton* look like to you as a member of the H&WBB?

How can you accelerate change?

How should the H&WBB through its statutory

responsibilities, provide oversight to *One Halton*?

Each group presented their findings and commented on each question. Leigh Thompson agreed to circulate a discussion document following the consultation workshop and the collective responses to the above set of questions.

It was agreed that progress of the One Halton programme would be presented to the next meeting.

RESOLVED: That the report be noted.

Meeting ended at 4.05 pm

REPORT TO: Health Policy & Performance Board

DATE: 8th September 2015

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Monitoring Report, Quarter 1 2015-16

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 1 of 2015-16. This includes a description of factors which are affecting the service.

2.0 RECOMMENDATION: That the Policy and Performance Board

i) Receive the Quarter 1 Priority Based report;

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

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 1, 2015-16.

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 1: 1st April to 30th June 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 first quarter of 2015/16 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 first quarter which include:

PREVENTION & ASSESSMENT

Winterbourne View

Following the Winterbourne View scandal, the Government pledged to move all people with learning disabilities and/or autism inappropriately placed in such institutions into community care by June 2014. "Transforming Care: A National Response to Winterbourne View Hospital (Department of Health final report) was produced in December 2012 and included an Action Plan with 63 areas to be implemented nationally; areas were identified as the responsibility of the Clinical Commissioning Groups (CCGs) and Local Authorities. A Winterbourne View Concordat Action Plan was developed locally for these specific areas and progress has been monitored regularly through the Winterbourne Strategic Group that meets on a quarterly basis, represented by both HBC and the NHS Halton CCG.

The original Winterbourne View report and pledge to move all people with learning disabilities and/or autism inappropriately placed failed nationally due to various reasons, including: (1) resistance from some of the organisations involved, (2) councils being unsure how to deal with service users who challenge services; (3) limited incentives for organisations to make the changes along with a lack of understanding of how the changes could create cost savings and improve people's quality of life.

Learning Disability (LD) Nursing Team: The team continues to provide support and regular monitoring of LD clients within the borough as well work proactively with families, carers, community organisations and other health professionals. Work this quarter included supporting clients through cancer diagnoses and latterly treatments, ensuring discharged inpatients were settled in their new accommodations and attending the NHS Confederation Conference to discuss reasonable adjustments within acute hospital settings. Community interventions included consultation sessions with the People's cabinet to gather feedback on support needed from LD community in Halton, current services offered and any improvements that could be made. A team member has been part of the group who have produced comics for people with LD across a range of health

topics. The team took part in the Magna Carta event to promote health and rights of people with LD. Close work with the eye health team has resulted in the team giving a presentation to orthoptists and ophthalmologists at Warrington Hospital to raise awareness of learning disabilities and reasonable adjustments. Also, the team have been working closely with GP practice-based pharmacy colleagues regarding medication and guidelines.

Community Multi-Disciplinary Team Development

Recruitment is underway for additional social care practitioners to engage with GP practices and the wider primary care team in Widnes, replicating the existing model in Runcorn. A project lead in social care has been identified to support the wider development of services based around GP surgeries.

Making It Real

The 'Making It Real' steering group meets on a regular basis and their work ensures that our progress towards a personalised community based support is maintained. Dedicated leads have been assigned to take work forward via various task and finish groups. Another 'Making It Real Live' event has been planned to take place in autumn 2015.

Independent Living Fund (ILF)

After an independent review in 2007 the Government acknowledged that the ILF system was inequitable for people and operated outside of care systems operated by the local authority. The Government subsequently decided to close the ILF on 30th June 2015 with the ILF users transferring to the management of the local authority. Although the funding of ILF was to transfer to the local authority, an attrition rate of 5% was to be applied to the overall costs that the local authority would receive.

To address the transfer, senior management team agreed for a project team to be established to review the 51 ILF recipients and produce support plans to reflect any changes that may be proposed. The team reviewed all ILF recipients within timescales and within the proposed budget. In the future any individual who may develop a long term condition will no longer have recourse to ILF for funding and will need to be funded long term from the community care budget.

POET

The Personal Outcomes Evaluation Tool (POET) survey feedback was presented to Communities Senior Management Team and a briefing paper prepared for the Health Policy and Performance Board. Overall, the results were very positive for Halton. Two-thirds of personal budget holders in Halton reported that their personal budget had made a positive difference in 11 of 15 outcome areas surveyed, whilst less than 3% of recipients reported any negative impact. Two-thirds of carers of personal budget holders in Halton reported that the personal budget had made a positive difference in 6 of 8 outcome areas and only 6% of carers reported a negative impact in 1 of the 8 areas (day-to-day stress). We have now registered our interest to be involved in phase three of POET.

COMMISSIONING & COMPLEX CARE SERVICES

Housing

The transfer in ownership of 272 dwellings (predominantly in the Halton Lodge and Runcorn old town areas) from Sanctuary Housing Association to Halton Housing Trust, LHT and Riverside was completed just prior to the financial year end. The new accommodation for single homeless persons at Brennan Lodge (Albert Road, Widnes) opened in June.

Homelessness – Peer Review Process

After successfully qualifying for single homeless funding, the Merseyside Sub Regional Homeless Group (MSRHG) agreed that vulnerable clients with complex needs was a priority. Subsequently, a team will be developed to provide intense support for high complex needs clients. The recruitment process is underway and the service is due to commence early August 2015 for a period of two years.

As part of the Gold Standard, the MSRHG have registered for the peer review. Halton recently completed a service peer review within Sefton and has presented that authority with the overall findings and scores. Halton is due to be reviewed by St Helens, commencing in early September 2015. The review process takes approximately three weeks; the process involves two officers who will visit/assess services and hold discussions with senior management, council members, staff, and providers. Upon completion of the review, the officers will present their findings and award the authority an overall score, with identified improvement recommendations and good practice. The baseline score of 60% must be achieved for the authority to pursue the Gold Standard process.

Homeless – Supreme Court Judgement: Hotak v Southwark

This recent court judgement will impact upon future homelessness assessment and decision making process. Councils will have to widen their criteria for deciding who gets housed and whether someone is vulnerable, by comparing them with an ordinary person if made homeless. It is anticipated that this will lead to a gradual increase in homelessness and temporary accommodation placements; however, the temporary accommodation provision within the district is deemed sufficient to meet the increased needs. Authorities are awaiting further guidance to establish the relevant criteria to be applied to ensure compliance with the priority need judgement.

Mental Health Services

Operation Emblem continues to produce impressive results, with significant numbers of people being diverted into more appropriate levels of intervention and support. This scheme is now being formally independently evaluated.

Mental Health Crisis Care Concordat: this national policy initiative drives local mental health organisations to work together to deliver improvements in services for people who are in mental health crisis. Locally, the main impetus for delivery of the concordat has been led by a pan-Cheshire grouping of all key partners; an action plan has been submitted and delivery of the targets is now being closely monitored by this group. A local plan, which specifically reflects the pan-Cheshire plan, is being agreed in July 2015 by the Halton Mental Health Delivery Group.

Mental Health Outreach Team – GP pilot: For the past eighteen months, this pilot has been working with a small number of local GP surgeries to provide early intervention and

support for people with mental health needs whose care is managed solely through primary care. An internal evaluation suggests that there have been very positive outcomes for the scheme and as a result the Halton Mental Health Delivery Group has agreed in principle to support an extension of the scheme.

Mental Health Act Code of Practice: A revised Code of Practice – a key document supporting delivery of the Mental Health Act – was published earlier in 2015. The considerable changes in the Code required a complete revision of the relevant internal policies and procedures, which has now been completed.

Review of the Acute Care Pathway (ACP): Within the 5Boroughs, the ACP is the term used to describe the ways in which people with complex mental health needs are referred into the 5Boroughs, their needs assessed and then provided with appropriate help, advice, treatment and support, which includes a range of services and support from the directorate. This pathway has been in place for two years, and is now being formally reviewed by an external body commissioned by the joint CCGs across the 5Boroughs. The Borough Council has fully contributed to this review and will be engaged in any service redesign that emerges as a result.

Review of social care mental health services: Designed to complement the review of the ACP, a separate review of all aspects of the ways in which the council mental health social care services – including the social work service, the Mental Health Outreach Team and the pathways into a range of community supports – has been undertaken. A series of reports has been taken to the Directorate's Senior Management Team and will be reported to the Halton Mental Health Delivery Group.

Halton and St Helens Emergency Duty Team

This service, jointly developed between Halton and St Helens Councils, and covering both children and adult services, provides emergency out of hours support to people with social care and housing needs. The service has been in place for 10 years, since when there have been considerable changes in service demand; as a result, a detailed and structured review of the service is being undertaken. In addition, at least one neighbouring local authority has indicated that it wishes to join the partnership, and this is being incorporated into the review, which aims to report in the autumn of 2015.

Supported Accommodation

Vulnerable adults supported accommodation services will be tendered in 2015 and approved by Executive Board in July 2015. A "Direct Award Contract" will be awarded to existing providers from 1st November 2015 to 31st March 2016. As part of the tender process, these services will be remodelled across Halton and based on cost and geographical location. New providers/contracts will then commence from 1st April 2016 with a 3 year plus 1year contract.

Positive Behaviour Support Service

PBSS team continues to develop and expand and are currently working in Halton (children and adults), Knowsley (children and adults), Cheshire East (children) and Sefton (adults). Expressions of interest continue to be received from CCG's and local authorities.

Halton Community Day Services

Halton Community Day Services continues to develop its small businesses and projects engaging all in meaningful day time opportunities. The service is delighted to have picked up the keys to its new venture, 'the Route', and everyone is busy developing this shop to offer a shop mobility service, café, a place to sell our home produced beer, ice cream,

along with fruit and vegetables. One of our partners in this venture, Halton Speak Out, will share an identified space within the shop to promote a number of young entrepreneurs with disabilities and their small businesses as well as supporting and offering consultations to all new up and coming business enthusiasts.

Halton Supported Housing Trust

Halton Supported Housing Trust is busy promoting the Active Support Model to enable tenants to take greater control of their day to day living skills. The outcomes continue to be outstanding where tenants are engaged in all aspects of promoting their independence. As this service works closely with Halton Community Day Services there is a significant change to a more joined up approach to the shared people they support, therefore creating a seamless service and enhancing the Active support model further. The service continues to have strong links with its partners, Halton Speak Out and SHAP advocacy services; joint working has promoted greater opportunities in accessing the local community along with supporting the "Stay Up Late" Campaign.

PUBLIC HEALTH

HPV vaccination

HPV vaccine which protects girls from developing cervical cancer in later life is on target and reaching the England average. Child development is particularly good as the healthy child programme continues to be delivered across Halton, conducting screening, immunisations and health reviews.

Falls Service

The number of older people experiencing hip fractures from falls has decreased from 156 (838.5 per 100,000 population) during 2013/14 to 89 (483.9 per 100,000 population) during 2014/15. This figure is lower than that seen in any year in the published data from 2010/11 onwards. (However, the 2014/15 figure is based on provisional local data and the 2013/14 data is verified published data.) A new falls triage system has seen a reduction in the waiting time for assessment of 6%, this equates to an actual reduction of 163 days and is calculated from an average waiting time from referral to falls service to receiving a service. This has been achieved despite the fact that there has been an 8% increase in the number of referrals into the service.

Alcohol Awareness

An awareness raising campaign on the harms of drinking alcohol during pregnancy was launched in February 2015. It was initially launched with a month long publicity campaign with posters and flyers across the Borough, supported with ongoing social media campaigns and dissemination through the midwives. The full campaign ended on 20th July 2015.

Children and young people's health and wellbeing

The children and young people's emotional health and wellbeing service has been jointly commissioned by the CCG and public health. It has been mobilizing and went live on 1st July 2015. This service will provide therapeutic support to children and families with emotional health difficulties, and will provide workforce training on the recognition and

early treatment of mental health issues. The service also includes an online counselling service.

3.0 Emerging Issues

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

PREVENTION & ASSESSMENT

Care Management

We have developed a "Making a Difference" a strategy for transforming care management in Halton that is aimed at staff and partner agencies. The overall purpose is to provide with a shared vision of the future of care management services and a plan to shape our future, over the next five years. 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. The strategy has been presented to Communities Senior Management Team and the Health Policy and Performance Board and is out for wider consultation.

Thresholds Model

After a period of consultation and a pilot, the implementation of the thresholds model for safeguarding will be implemented from July. Due to the scale and varying needs of adults at risk, it is crucial that all agencies working with adults at risk are involved in the prevention of abuse. However, identifying when safeguarding referrals should be made is not always clear cut. In order to give some clarity to when a referral should be raised with Halton's Integrated Adults Safeguarding Unit, the safeguarding referral "thresholds" have been compiled. This threshold guidance aims to ensure adult protection issues and concerns are reported and investigated at the appropriate level.

Deprivation of Liberty Safeguards

National statistics show that Deprivation of Liberty Safeguards (Dols) case numbers reached record levels from April to June 2015. This is being reflected locally with figures increasing by over 400% on last year. Local authorities must process Dols cases within 21 days for standard authorisations and seven days for urgent authorisations. Due to the pressures within the system waiting lists for assessments are now being held and there is a potential for timescales to be breeched. A prioritisation system has been implemented with the high risk and urgent cases taking priority.

COMMISSIONING & COMPLEX CARE

Housing

The Queen's speech and July Budget have heralded a number of significant changes that will impact on the housing sector which include the following:

- Extension of the Right to Buy to Housing Association tenants.
- Rents for social housing to reduce by 1% for each of the next four years starting in 2016.
- 18–21 yr. olds will not be eligible to claim Housing Benefit if they are not working, with some exceptions for the vulnerable (yet to be defined) and those who were in work in the 6 months prior to application.
- Local Housing Allowance rates frozen for the next 4 years for private rented sector tenancies.
- Tax relief for Buy to Let investments is to be reduced to basic rate, potentially leading to rent increases to recoup costs.
- The Universal Credit cap will be reduced from £26,000 to £20,000, further increasing the risk of the Housing Benefit element being insufficient to cover rent payments.
- Social housing tenants with incomes above £30,000 will be charged a market rent.
- Further planning reforms to remove obstacles to house building.

Halton Community Day Services

After a recent period of consultation, HBC Adult Placement Service and Halton Community Day Services have merged to create one joined-up service. The collaboration is very much in its early stages but hopes to create a seamless service to the people they support.

Halton Supported Housing Network

The Network is currently involved in an efficiency review of the service and on the 4th August will start a month's consultation period regarding a new proposed structure. This will be an anxious time for all and communicating effectively with tenants, staff, carers and other professionals will be important.

PUBLIC HEALTH

Health Visiting and Family Nurse Partnership services

Work continues to ensure the safe transition of the Health Visiting service and Family Nurse Partnership service. These services were previously commissioned by NHS England and will move to the local authority by October 2015. Stage 3 UNICEF baby friendly inspection of Bridgewater Community Health service is taking place in July 2015. The inspection is the final stage of BFI inspections and focuses on the women's experience of community midwifery and health visiting services, and any venue from which the services operate.

Falls Pathway

A pathway for low-level prevention, postural stability and environmental checks has now been incorporated into the overall falls pathway. Plans are being developed to progress this work with information providers in the voluntary sector. Additional training will be available to support this venture.

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 2015-16 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	Q1 Progress
PA 1	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21, 25) March 2016.**	✓
PA 1	Implement the Care Act **(AOF 2,4,10, 21) March 2016.**	✓

Supporting Commentary

PA 1 Monitor effectiveness of Better Care Fund pooled budget:
Governance arrangements are in place and on target to achieve a balanced budget.

PA 1 Implement the Care Act:
Strategic group continues to monitor and oversee. We are on target for full compliance with the requirements of the Care Act.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q1 Actual	Q1 Progress	Direction of travel
PA 1	Numbers of people receiving Intermediate Care per 1,000 population (65+)	80	77	**20.4 (414 referrals)**	✓	↑
PA 2	Percentage of VAA Assessments completed within 28 days	86.8%	85%	**79.3%**	✓	↓
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	95.5%	97%	**98.7%**	✓	↑
PA 6b	Percentage of items of equipment and adaptations delivered within 5 working days – new indicator	89.5%	95%	**93.6%**	✓	n/a
PA 11	Permanent Admissions to residential and nursing care homes per 100,000 population,65+ (ASCOF 2A1) *Better Care Fund performance metric*	600.8	635.1	**177.3 (36 admissions)**	✓	↓
PA 12	Delayed transfers of care (delayed days) from hospital per 100,000 population *Better Care Fund performance metric*	tbc	2235	**407 (vs target 472)**	n/a	n/a
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	tbc	12771.8 Admissions: 16,141 Pop: 126,380	**2206.04 (Apr-May)**	n/a	n/a
PA 15	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric*	823.89	884.2	**Not yet available**	n/a	n/a
PA 16	Proportion of Older People (65 and over)	65.6	70%	**n/a**	n/a	↑

Ref	Measure	14/15 Actual	15/16 Target	Q1 Actual	Q1 Progress	Direction of travel
	who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B1) *Better Care Fund performance metric*					
PA 20	Do care and support services help to have a better quality of life? (ASC survey Q 2b) *Better Care Fund performance metric*	93.3%	91%	**n/a**	n/a	

Supporting Commentary

PA 1 Numbers of people receiving Intermediate Care per 1,000 population (65+):
Q1 figures may be subject to change as some data cleansing is currently taking place which may result in a potential increase in the total number of referrals received. The total number of Intermediate Care referrals is up on the same quarter last year (approximately a 7% increase).

PA 2 Percentage of VAA Assessments completed within 28 days:
We are on target with current progress but the same time last year we had met a higher percentage.

PA 6a Percentage of items of equipment and adaptations delivered within 7 working days:
Performance issues with one of four service providers continue to be managed. At the moment we are maintaining a positive position to meet our target.

PA 6b Percentage of items of equipment and adaptations delivered within 5 working days:
This stretch target has been introduced this year and at present we are making good progress towards achieving it.

PA 11 Permanent Admissions to residential and nursing care homes per 100,000 population, aged65+:
We are currently on course with this target. We are closely monitoring and continuing to on an ongoing basis evaluate the data closely with the performance team.

PA 12 Delayed transfers of care (delayed days) from hospital per 100,000 population:
Data relates to period April to May 2015.

PA 14 Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population:
Performance is within target in that there have been 2788 admissions (compared with planned figure of 3051).

PA 15 Hospital re-admissions (within 28 days) where original admission was due to a fall, aged 65+:
Q1 data will not be available until September 2015.

PA 16 Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services:
This indicator is reported annually around May/June. 2014/15 outturn reports slight performance improvement on 2013/14 outturn.

PA 20 Do care and support services help to have a better quality of life?:
This indicator is reported annually around May/June. However, between 2013/14 and 2014/15, there has been improved performance on clients indicating that their quality of life had improved due to interventions they received from social services.

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q1 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 2016.** (AOF 4)	✓
CCC 1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2016.** (AOF 4)	✓
CCC 1	Continue to work with the 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 2016.** (AOF 4)	✓
CCC 1	The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **Mar 2016.** (AOF 4, AOF 18)	✓

Key Performance Indicators

Supporting Commentary

CCC1 - Services / Support to children and adults with Autism:
Autism Strategy Action Plan is being reviewed in order to align with the Think Autism 2014 National review. Special Education Needs and Disability (SEND) reforms and the Care Act are to be considered in the Autism Strategy 2016 onwards.

CCC 1 Dementia Strategy:
The Dementia Delivery Board continues to oversee the delivery of the strategy and

report progress to the Mental Health Oversight Group. The majority of the actions contained in the strategy have a RAG rating of Green. There are a couple with an Amber rating (due to time scales for delivery, but are not of any concern at this stage), and there are no Red ratings. During Q1 Halton NHS CCG have led on the commissioning of an Admiral Nurse Service for Halton, to be operational by Autumn 2015. The Dementia Delivery Group are also overseeing the review of the Dementia Community Pathway provision, to ensure that it continues to reflect value for money and delivers the evidence based elements of best practice. This review will continue into Q2.

CCC 1 Mental Health:
Both the Acute Care Pathway and the Later Life and Memory services have been in place for some time, with full support from social services. However the joint CCGs across the 5Boroughs have commissioned an independent review of both services, to be reported later in the summer of 2015. In addition, an internal review of the delivery of mental health social care services within the Communities Directorate has been taking place. Both of these reviews will result in action plans which will be delivered jointly with the 5Boroughs to continue service improvement.

CCC 1 Homelessness Strategy:
The homelessness strategy 2014 – 2018 is a working document that captures future change, trends, and demands. A consultation event was held in June 2015 to review the strategy and action plan, which involved both statutory and voluntary agencies to determine the key priorities for next 12 months. The main priorities identified for 2015/16 are Health and Homelessness, and Complex needs. The focus will be around the key priorities, with additional emphasis placed upon achieving the objectives outlined within the St Mungo's report, which will be incorporated within the reviewed strategy action plan.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q1 Actual	Q1 Progress	Direction of travel
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	2.64	3.0	**2.30**	?	
CCC 4	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).	19	11	**9**	✓	

Supporting Commentary

CCC 3 Adults with mental health problems helped to live at home per 1,000 population:
Although this figure has reduced since the end of 2014/15, this appears to be because some aspects of service delivery are not being captured by the data collection processes. Further work is being undertaken to remedy this and report a more accurate figure at the next quarter.

CCC 4 The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years:
The authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients. Halton will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC 5 Number of households living in Temporary Accommodation:
The Housing Solutions Team (HST) has taken a proactive approach to preventing homelessness. Staffing stability within the team has contributed towards the reduction in temporary accommodation placements, resulting in the devised target being achieved. There are established prevention measures in place and the HST fully utilise and continue to promote all service options available to clients. The changes in the temporary accommodation process and amended accommodation provider contracts have had a big impact upon allocation placements. The emphasis is focused on early intervention and empowerment to promote independent living. The improved service process has developed stronger partnership working and contributed towards an effective move on process for clients. The authority will strive to sustain the reduced temporary accommodation provision.

Public Health

Key Objectives / milestones

Ref	Milestones	Q1 Progress
PH 01	Work with PHE to ensure targets for HPV vaccination are maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2016**	✓
PH 01	Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2016**	?
PH 01	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2016**	✓

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 2016**	✓
PH 02	Fully establish the Family Nurse Partnership programme **March 2016**	✓
PH 02	Facilitate the Halton Breastfeeding programme so that all mothers have access to breastfeeding-friendly premises and breastfeeding support from midwives and care support workers. Achieve UNICEF baby friendly stage 3 award **March 2016**	✓
PH 03	Development of new triage service between Rapid Access Rehabilitation Team and Falls Specialist Service. **March 2016**	✓
PH 03	New Voluntary sector pathway developed to support low-level intervention within falls in the borough. **March 2016**	✓
PH 04	Implement the Halton alcohol strategy action plan working with a range of partners in order to minimise the harm from alcohol and deliver on three interlinked outcomes: reducing alcohol-related health harms; reducing alcohol-related crime, antisocial behaviour and domestic abuse and establishing a diverse, vibrant and safe night-time economy. **March 2016**	✓
PH 04	Deliver a local education campaign to increase the awareness of the harm of drinking alcohol when pregnant or trying to conceive. **March 2016**	✓
PH 04	Hold a community conversation around alcohol – using an Inquiry approach based on the citizen's jury model of community engagement and ensure recommendations for action are acted upon by all local partners. **March 2016**	✓
PH 05	Successfully implement a new tier 2 Children and Young Peoples Emotional Health and Wellbeing Service. **March 2016**	?
PH 05	Monitor and review the Mental Health Action plan under new Mental Health Governance structures. **March 2016**	?
PH 05	Implementation of the Suicide Action Plan. **March 2016**	✓

Supporting Commentary

PH 01 HPV vaccinations:
Data is not yet available although indications are that performance is similar to previous years and target is likely to be achieved.

PH 01 Cancer Screening Programmes:
Progress is continuing. Health Improvement Team have undertaken an assessment of awareness/ reasons for failing to respond to Bowel screening test kits, data to be used to inform local targeted activity. Halton will be participating in a Cheshire and Merseyside / CRUK bowel screening awareness campaign. Be Clear on Cancer over 70 breast

screening campaign is being supported locally. Activity will take some time to translate into a noticeable increase in uptake rates.

PH 01 Referral to treatment:
Treatment targets are currently being maintained.

PH 02 Early Life Stages:
The healthy child programme continues to be delivered across Halton, conducting screening, immunisations and health reviews. 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. Work is underway to develop an integrated assessment at 21/2 years, and to agree how we will measure 'readiness for school'.

PH 02 Family Nurse Partnership programme:
The implementation of Halton's Family Nurse Partnership programme is complete and the service is fully operational, and has been recruiting families of mothers under the age of 19 since November 2014. Work to transfer the commissioning of this service from NHS England to Halton Borough Council in October 2015 is underway.

PH 02 Breastfeeding programme:
The hospital and community breastfeeding support continues to be made available across the borough. Stage 3 UNICEF baby friendly inspection is taking place in July 2015.

PH 03 New triage service - Rapid Access Rehabilitation Team and Falls Specialist Service:
This has been completed and is operating well. The new triage service has seen a reduction in the waiting time for assessment of 6% and this has been achieved despite the fact that there has been an 8% increase in the number of referrals into the service.

PH 03 Voluntary sector pathway to support low-level intervention within falls:
Pathway for low-level prevention, postural stability and environmental checks has now been incorporated into the overall falls pathway. Plans are being developed to further develop this with information providers in the voluntary sector. This will be supported by additional training that will be available.

PH 04 Alcohol Strategy Action Plan:
Good progress is being made towards implementing the Halton alcohol strategy action plan. Key activity includes:

- Developing a coordinated alcohol awareness campaign plan.
- Delivery of alcohol education within local school settings (Healthitude, R U Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Ensuring the early identification and support of those drinking above recommended levels through training key staff members in alcohol identification and brief advice (alcohol IBA).
- Reviewing alcohol treatment pathways
- Working closely with colleagues from licensing, the community safety team,

trading standards and Cheshire Police to ensure that the local licensing policy supports the alcohol harm reduction agenda, promoting more responsible approaches to the sale of alcohol (e.g. promotion of Arc Angel and the local pub watch schemes within Halton), promoting a diverse night-time economy.

Working to influence government policy and initiatives around alcohol: 50p minimum unit price for alcohol, restrictions of all alcohol marketing, public health as a fifth licensing objective.

PH 04 Education campaign around alcohol:
An awareness raising campaign on the harms of drinking alcohol during pregnancy has been developed and launched. The campaign includes posters and flyers across the Borough. The campaign also includes PR and social media advertising. Midwives are using a new information leaflet, to provide more information to pregnant women when they book in with the midwife and at Early Bird ante natal sessions. The campaign will be evaluated by further insight work with the targeted audiences in July 2015.

PH 04 Community conversation around alcohol:
The Halton Alcohol Inquiry group have now met for 9 weeks. 11 commentators presented to the group over this period this included the Halton Director of Public Health, and colleagues from Licensing enforcement, trading standards, Young Addaction, Cheshire Police, Drink Wise, Diageo, Beer and Pub Association, University of Manchester.

PH 05 Children and Young People Health and Wellbeing Service:
The children and young people's emotional health and wellbeing service has been jointly commissioned by the CCG and public health. It has been mobilizing and went live on 1st July 2015.

PH 05 Mental Health Action plan:
New governance structures for the Mental Health Action plans are in place and the processes for receiving assurance from each action plan is being implemented. New mental Health posts (one mental health lead and two mental health promotion practitioner) have been agreed and recruitment is underway.

PH 05 Suicide Action Plan:
Good progress is being made towards implementing the Suicide strategy action plan. This work is being overseen by the Halton suicide prevention partnership.
Key developments include:

- Developing a local multi-agency suicide awareness campaign plan
- Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals who interact with known groups at high risk of suicide

Halton being part of a pilot programme across Cheshire and Merseyside to provide a support service for individuals bereaved by suicide. The service became operational on the 1st April 2015 and is called Amparo. Amparo provides support to anyone who has been affected by suicide within Halton.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q1	Current Progress	Direction of travel
PH LI 01	Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population *Published data based on calendar year, please note year for targets.*	179.8 *(2014)*	185.6 *(2015)*	174.0 *(Apr 14 – Mar 15)*	✓	↑
PH LI 02	A good level of child development	46% *(2013/14)*	TBC (Awaiting confirmation of new target definition)		?	n/a
PH LI 03	Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition).	3237.6	3263.9	n/a	?	n/a
PH LI 04	Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population	814.0 (2013/14)	808.4	766.3 (2014/15)	?	↑
PH LI 05	Under 18 alcohol-specific admissions Crude Rate, per 100,000 population	60.5 (11/12 to 13/14)	55.0	n/a	?	↑
PH LI 06	Self-reported wellbeing: % of people with a low happiness score	12.1% *(2013/14)*	11.1%	n/a	?	n/a

Supporting Commentary

PH LI 01 Mortality from all cancers at ages under 75:
The Data methodology for this indicator has changed from previous years making comparison with previous year's data difficult. Although it does indicate continual improvement with a yearly decrease in premature death from cancer over recent years.

PH LI 02 Child development:
The data methodology for this indicator has changed from previous years making comparison with previous year's data difficult. The target will be updated when national data has been published.

PH LI 03 Falls and injuries in the over 65s:
Q1 data unavailable until August 2015.

PH LI 04 Alcohol related admissions:
No data for 2015/16 will be available until September 2015.

PH LI 05 Under 18 alcohol-specific admissions:
There has been an issue with the database where the data is extracted from. Hopefully it will be rectified by August 2015.

PH LI 06 Self-reported wellbeing:
2014/15 data unavailable until September 2015.

APPENDIX 1 – Financial Statements

PREVENTION & ASSESSMENT DEPARTMENT

Revenue Budget as at 30th June 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	6,613	1,620	1,588	32
Other Premises	63	18	6	12
Supplies & Services	420	40	41	(1)
Aids & Adaptations	113	28	24	4
Transport	8	2	2	0
Food Provision	28	7	3	4
Other Agency	22	3	4	(1)
	1,600	0	0	0
Transfer to Reserves				
Contribution to Complex Care Pool	17,330	1,476	1,419	57
Total Expenditure	**26,197**	**3,194**	**3,087**	**107**
Income				
Fees & Charges	-236	-59	-67	8
Reimbursements & Grant Income	-149	-4	-5	1
Transfer from Reserves	-1,001	0	0	0
Capital Salaries	-71	0	0	0
Government Grant Income	-154	-75	-75	0
CCG Contribution to Service	0	0	0	0
Total Income	**-1,611**	**-138**	**-147**	**9**
Net Operational Expenditure	**24,586**	**3,056**	**2,940**	**116**
Recharges				
Premises Support	331	525	525	0
Asset Charges	175	83	83	0
Central Support Services	2,193	0	0	0
Internal Recharge Income	-1,236	9	7	2
Transport Recharges	49	-386	-387	1
Net Total Recharges	**1,512**	**231**	**228**	**3**
Net Departmental Total	**26,098**	**3,287**	**3,168**	**119**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the third quarter of the financial year is £62,000 under budget profile excluding the Complex Care Pool.

Employee costs are currently showing £32,000 under budget profile. This is due to savings being made on vacancies within the department. Some of these vacancies have been advertised and have been or are expected to be filled in the coming months.

Overall income has over achieved by £9,000. Lifeline income is £4,000 higher than anticipated and this trend is expected to continue for rest of the financial year.

COMPLEX CARE POOL

Revenue Budget as at 30th June 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	3,623	460	442	18
End of Life	192	47	47	0
Sub Acute	1,743	376	369	7
Urgent Care Centres	615	0	0	0
Joint Equipment Store	810	4	4	0
Contracts & SLA's	1,197	125	114	11
Intermediate Care Beds	596	149	156	(7)
BCF Schemes	2,546	436	436	0
Adult Care:				
Residential & Nursing Care	18,185	2,586	2,538	48
Domiciliary & Supported Living	10,921	2,048	2,047	1
Direct Payments	4,436	1,476	1,482	(6)
Day Care	523	64	65	(1)
Contingency	518	0	0	0
Total Expenditure	45,905	7,771	7,700	71
Income				
Residential & Nursing Income	-5,018	-740	-734	(6)
Community Care Income	-1,583	-234	-223	(11)
Direct Payments Income	-193	-58	-64	6
Income from other CCGs	-114	-29	-29	0
BCF Income	-9,451	-2,142	-2,142	0
Contribution to Pool	-12,166	-3,042	-3,042	0
Other Income	-50	-50	-47	(3)
Total Income	-28,575	-6,295	-6,281	(14)
Net Divisional Expenditure	**17,330**	**1,476**	**1,419**	**57**

Comments on the above figures:

The overall net expenditure budget is £57,000 under budget profile at the end of the first financial quarter.

Intermediate Care Services includes spend for the Therapy & Nursing Teams, Rapid Access Rehabilitation and Reablement. A number of invoices relating to Intermediate Care Services for the quarter have not yet been received so close monitoring will be undertaken throughout the next quarter to ascertain an accurate position moving forward.

There is a projected underspend on CCG Contracts due to Ship Street void. This underspend may actually increase as remaining tenants might move out.

The budgets across health and social care have been realigned to reflect the expenditure and income in the previous year. The total number of clients receiving a residential care package increased by 0.03% during the first quarter of the financial year, from 604 clients in April to 606 clients in May. However the average cost of a residential package of care reduced from £547 to £541 for the same period.

The total number of clients receiving a domiciliary package of care reduced by 1.15% during the first quarter, from 867 clients in April to 857 clients in May. However, the average cost of a domiciliary care package increased from £198 to £202 in the same period.

The total number of clients receiving a Direct Payment reduced by 1.6% during the first quarter, from 379 clients in April to 373 clients in May. The average cost of a DP package reduced from £252 to £250 for the same period.

The Adult Health and Social Care budget will continue to be monitored closely due to its volatile nature.

Capital Projects as at 30th June 2015

	2015-16 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	500	100	35	465
Stair lifts (Adaptations Initiative)	250	60	36	214
RSL Adaptations (Joint Funding)	200	50	17	183
Community Meals Oven	10	0	0	10
Total	**960**	**210**	**88**	**872**

Comments on the above figures:

Whilst the spend to date on Disabled Facilities Grants, Stair Lifts and RSL Adaptations seems comparatively low, they are consistent with that for the equivalent period last year.
Spend for the period April to June 2014 was £98,000, comparable with the £88,000 for April to June 2015. The bulk of the capital allocations for 2014/15 were substantially spent by year-end and this trend is anticipated to continue in 2015/16.

The Community Meals Oven is a new project for 2015/16, and will be spent in full during the year.

COMMISSIONING & COMPLEX CARE DEPARTMENT

Revenue Budget as at 30th June 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,608	1,746	1,700	46
Premises	308	87	82	5
Supplies & Services	1,912	498	500	(2)
Carers Breaks	427	166	164	2
Transport	170	44	40	4
Contracts & SLAs	90	23	21	2
Payments To Providers	3,591	757	757	0
Emergency Duty Team	93	0	0	0
Other Agency Costs	446	87	87	0
Total Expenditure	**14,645**	**3,408**	**3,351**	**57**
Income				
Sales & Rents Income	-284	-129	-134	5
Fees & Charges	-176	-44	-29	(15)
CCG Contribution To Service	-392	-98	-89	(9)
Reimbursements & Grant Income	-648	-78	-75	(3)
Transfer From Reserves	-620	-0	0	0
Total Income	**-2,120**	**-349**	**-327**	**(22)**
Net Operational Expenditure	**12,525**	**3,059**	**3,024**	**35**
Recharges				
Premises Support	174	57	57	0
Transport	450	7	7	0
Central Support Services	1,515	376	376	0
Asset Charges	62	16	16	0
Internal Recharge Income	-2,012	-199	-199	0
Net Total Recharges	**189**	**257**	**257**	**0**
Net Departmental Total	**12,714**	**3,316**	**3,281**	**35**

Comments on the above figures:

Net operational expenditure is £35,000 below budget profile at the end of the first quarter of the financial year.

Employee costs are currently £46,000 below budget profile. This results from savings made on vacant posts, specifically in relation to Day Services. The majority of these posts have now either

been filled, or are in the process of being recruited to. It is therefore not anticipated that the current spend below budget profile will continue at this level for the remainder of the financial year.

Income is below target to date. There is an anticipated shortfall on Fees & Charges income as a result of revised contract arrangements for the homeless hostel. Additionally, income received from the Clinical Commissioning Group is projected to be below target. This income relates to Continuing Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user's care packages, and is out of the direct control of the service. The shortfall is currently estimated to be in the region of £35,000 for the full year. This shortfall is likely to be partly offset by an over-achievement of trading income from Day Services ventures.

At this stage in the financial year, it is anticipated that a balanced budget overall will be achieved for the year. Whilst income is projected below target, this will be offset by in-year savings in other areas, principally on savings on staff turnover above the set target.

Capital Projects as at 30th June 2015

	2015-16 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
ALD Bungalows	200	0	1	199
Lifeline Telecare Upgrade	100	0	0	100
Grangeway Court Refurbishment	360	0	0	360
Halton Carer's Centre Refurbishment	34	0	0	34
The Halton Brew	16	0	0	16
Social Care Capital Grant	413	0	0	413
Total	**1,123**	**0**	**1**	**1,122**

Completion of the first phase of the ALD Bungalows has been delayed due to the original contractor going into liquidation. The contract is currently being retendered, with the building works estimated for completion in November. Spend is now anticipated to be £200,000 in-year, with the remainder being spent in 2016/17.

The refurbishment of Grangeway Court is expected to be completed in-year, although approximately 10% of the capital allocation will be required in 2016/17 for retention payments.

It is expected that all other projects will be completed within the financial year.

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 30th June 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	3,081	757	720	37
Supplies & Services	289	49	46	3
Other Agency	21	21	17	4
Contracts & SLA's	4,193	284	274	10
Total Expenditure	**7,584**	**1,111**	**1,057**	**54**
Income				
Other Fees & Charges	-67	-15	-10	(5)
Sales Income	-26	-26	-18	(8)
Reimbursements & Grant Income	-54	-39	-38	(1)
Government Grant	-8,786	-9	-9	0
Total Income	**-8,933**	**-89**	**-75**	**(14)**
Net Operational Expenditure	**-1,349**	**1,022**	**982**	**40**
Recharges				
Premises Support	166	41	41	0
Central Support Services	2,180	126	126	0
Transport Recharges	21	2	1	1
Net Total Recharges	**2,367**	**169**	**168**	**1**
Net Departmental Total	**1,018**	**1,191**	**1,150**	**41**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the first quarter of the financial year is £41,000 under budget profile.

Employee costs are currently £37,000 under budget profile. This is due to savings being made on vacancies within the department, in particular within the Health Improvement Team. Some of these vacancies have been advertised and are expected to be filled in the coming months. However if not appointed to, the current underspend will continue to increase beyond this level.

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 and Performance Board

DATE: 8 September 2015

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Mental Health Champion Quarterly report

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an update to PPB on mental health related activity undertaken by Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (CCG).

2.0 **RECOMMENDATION: That**

1) **The contents of the report be noted; and**

2) **Members direct any comments/questions to the Director for Transformation.**

3.0 **SUPPORTING INFORMATION**

3.1 It should be noted that Mental Health services in Halton are under huge pressure. Nationally the wait times and need for Mental Health services have risen to an all-time high. Halton is no different and we have a significant challenge to ensure our services (both preventative and treatment) meet National standards. Work is underway to fully review all the adult and older people's provision in line with parity of esteem. This review will be completed in March and will set the scene for the creation of a more effective, responsive service. Our ongoing consultation and co-production of services will continue to help us shape service provision in partnership with users of services. However, huge strides have been taken, and below is an update of changes, updates and innovation underway.

3.2 **Award winning innovation**

Halton's Wellbeing Practice approach has gained National interest, recently winning a National Association of Primary Care (NAPC) award. This and other services offer a preventative approach to mental health, developing strategies for the public to improve their own resilience. The drive is to know incorporate parity of esteem, meaning we meet the psychological requirements of patients

as well as their physical. Work is underway with partners to improve the input of low level mental wellbeing interventions in all primary care settings. Joint work is ongoing with providers of lower level mental health support commissioned by both CCG and HBC to help support achievement of the IAPT waiting times target by March 2016 (See 3.16)

3.3 **Mental Health in GP Practices**

Training is provided to clinicians to enable them to manage mental health within their practice or community services. This training enables the GP or clinician to make best use of the approximately 10 minute consultation and glean vital information about the patient's well-being to ensure correct referral and treatment is provided. This Step One level intervention is a pre requisite for practices to move to a self-referral 'opt in' model of IAPT provision to ensure patients who are referred are prepared to engage with therapy, although the option of referral by GP will remain to ensure risk management is effective.

3.4 **Mental Health Wellbeing Nurse**

In Halton, we have commissioned a Mental Health Wellbeing Nurse Team. This team of Nurses works primarily with the most venerable patients with complex issues. This population rarely utilise health care and therefore many health issues go undetected. The performance is very high, for example the team have picked up on risks associated with heart disease , diabetes etc. offering a truly preventative service. This service currently sits within the IAPT service which was transferred from Bridgewater Community Health Foundation Trust following a procurement exercise. However there are proposals for the service to move within 5BP the new provider to sit with a more appropriate service/team – namely the Health and Wellbeing team who provide a similar service to other boroughs.

3.5 **Service Provision**

Appendix 1 has summary of just some of the service provision across the age ranges, commissioned by Halton CCG and HBC.

3.6 **New Governance Structure**

In order to support delivery of the All age Mental Health Strategy for Halton and the supporting All Age Action Plan, a revised governance structure has been established to ensure robust oversight of delivery. A new Mental Health Oversight Group chaired by the Local Authority Mental Health Champion has been established and the inaugural meeting was on 13 January 2015. This group holds to account the variety of other groups such as the Dementia Partnership Board, the Suicide Prevention group etc. for delivery of their respective elements of the Strategy and Action Plan. The group has subsequently met in April and will meet again on 14th August 2015.

3.7 **Dementia Friendly Communities**

Within Halton we have established a Halton Dementia Action Alliance (Halton DAA) in October 2014. This is in line with national dementia strategy recommendations and is an action of the Halton Dementia Strategy. The Halton DAA will work with services, organisations and individuals across all sectors to promote 'dementia friendly practice', to improve outcomes for people living with dementia and their carers. Current membership includes organisations in primary and secondary care, leisure services, trading standards, commissioned care provision, 3rd sector, CCG and HBC.

Halton has recently (Dec 2014) achieved the 'working towards becoming a dementia friendly community' status through the Alzheimer's Society Dementia Friendly Communities recognition process.

For more information about the Halton Dementia Action Alliance and Dementia Friendly Communities please click on the link below
http://www.dementiaaction.org.uk/

3.8 **Admiral Nurses for Dementia**

Admiral Nurses provide families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member.

An Admiral Nurse service is in the process of being commissioned for the borough of Halton. Following an options appraisal process a hybrid model of the service being hosted by 5Boroughs Partnership mental health Foundation trust, but very much based within a primary and community setting, was selected as bringing the most benefits. Discussions are now ongoing with stakeholders and it is anticipated that the service will become operational from September; recruitment processes allowing.

3.9 **In patient redesign project**

The local provider of the majority of mental health services to the borough, 5 Boroughs Partnership Community Foundation Trust, has developed a revised improved clinical model for inpatient services. This work is on - going and has now been widened to incorporate review of community services to ensure the pathway for mental health services works well. This work will also incorporate the move to borough based services and support the direction of travel for primary care relating to neighborhood hubs. The 5Boroughs footprint review will be completed by end September 2015 and the report will make recommendations on a borough basis which will influence future commissioning decisions. The report will be shared widely with partners when it is delivered.

3.10 **Emotional Wellbeing services for children**

Following a successful tendering process the tier 2 CAMHS service is now provided by 5 Boroughs partnership Mental Health Foundation trust in collaboration with Xenzone (providers of on line counseling resources KOOTH). The service was mobilized from 1st June 2015 and is currently in the process of marketing the new services with schools locally and integrating the Tier 2 service into the Tier 3 service to provide a single point of access for targeted CAMHS services locally

3.11 **The 'Future in Mind' report and Transformational plans for CAMHS, including Eating Disorders**

Following release of the Future in Mind report all CCGs and Partners are required to submit transformational plans as to how they intend to improve CAMHS services for children locally based on the main aspirations of integration of services, timely access and promotion of resilience and wellbeing. Additional funding will be made available. Fortunately the existence of the children and young people's section of the all MH Strategy and Action Plan puts Halton in a good place to submit robust actions plans largely built on existing work which underpins the aspirations of the guidance already.

There will also be specific guidance regarding the provision of a specialised Eating Disorder service which again will attract a share of £30million nationally. A small working group has been established to take forward a proposal working on the current 5BP footprint to ensure the critical mass of population required (500k) is reached.

3.12 **System Resilience Funding**

Halton secured £81k of additional funding from a bid for additional system resilience funding for mental health specifically in the final quarter of 2014/15 which was utilised in increasing capacity in the Alternative to Hospital service and ensuring 24 hour nurse cover to the existing Psychiatric Liaison Service for a time limited period.

3.13 **The Mental Health Crisis Care Concordat**

The Mental Health Crisis Care Concordat was published by Central Government in late 2013. The concordat aims to encourage all services which provide support to people with mental health needs across a wide area to work closely together to reduce the likelihood of people reaching a mental health crisis. This includes health services, the police, housing authorities, social services and the private and voluntary sectors, all of whom are required to sign a pledge to achieve the aims of the concordat, and then develop and implement and action plan.

Locally, Halton has been working closely for some time with partners across the Cheshire footprint. A declaration has been developed and agreed across the partners, and an action plan is in development. Regular meetings are taking place to monitor progress. The overall process is being supported regionally by the Advancing Quality Alliance; a membership body consisting of Mental Health Trusts, CCGs and Local Authorities, and the Association of Directors of Adults Social Services is also actively promoting this work. In order to simplify the approach rather than monitor two separate action plans, it is proposed that actions for the Concordat Action Plan will be incorporated into the All Age MH Strategy Action Plan that is monitored by the MH Oversight Group.

3.14 **Operation Emblem/ Street Triage**

The Operation Emblem Service is currently being externally evaluated to demonstrate the benefits this scheme has brought to the wider system and patients. The evaluation report is due for publication end August 2015 and will inform future commissioning of this service following the pilot phase. Initial reports are very positive and recommendations for ongoing commissioning and expansion of the project are likely.

3.15 **Liaison Psychiatry Service**

The extended Liaison Psychiatry Service was launched within Warrington and Halton Hospitals NHS Foundation Trust in August 2014. This service has been introduced to reduce waiting times in A&E, reduce length of stay and to reduce discharge to institutional care placements. The service has met with some challenges in becoming embedded within the hospital trust and so a workshop was held for senior stakeholders on 9th July. A way forward has been agreed and executive engagement by the Trust has been secured to ensure further roll out of the service.

3.16 **IAPT – Halton Psychological Therapies Service**

The Halton Psychological Therapies service is now provided by 5 Boroughs Partnership NHS Foundation Trust and went live on 1st August 2014. The service was launched with a considerable waiting list, however, action plans and recovery plans are in place to reduce the list and early performance data indicates that the service has begun to increase the access and recovery rates for Halton patients. All initial appointments are now offered within a 2-3 week time fame of referral or 'opt in' by patients.

Due to the higher than expected number of referrals, the service continues to be challenged by the demand compared to the capacity within the service. We have committed both non-recurrent funding £64k and recurrent funding £200k annually to increase the capacity of the service to address any long waits into ongoing therapies. In addition there is a 6 week access target that needs to be achieved by the service by March 2016 and so we are working closely with the service to implement a number of different initiatives to enable a

robust alternative offer for some patients who do not necessarily need a fully IAPT compliant service offer, enhanced training of primary care to enable all practices to move to a self-referral/opt in model, and also working with the service to increase internal efficiencies. In addition a submission has been made for central non-recurrent funding to clear any backlog of patients who may be waiting for ongoing therapies, with the aim of ensuring compliance with the waiting time standard by March 2016. (see 3.2).

3.17 **Mental Health Service Reviews**

There are a number of services which are currently commissioned across HBC and CCG to support individuals with mental health issues in the community and transitioning out of secondary care. These services are; Mental Health Outreach Team (MHOT), Mental Health Social Worker team based at the Brooker Centre, and various third sector providers including: Making Space, SHAP, plus Dane, Mind and Building Bridges.

It has been highlighted that there may be a need to review the service provided around mental health, and understand the current pathways, and patient experience. A small task group has been established and preliminary work has begun on this. (See 3.2)

3.18 **Suicide Prevention Strategy**

The final draft of the suicide prevention strategy will shortly be presented for Board level approval. The public health team have engaged with a wide range of stakeholders in this process and a task and finish group has been formed. The suicide prevention initiatives outlined within the strategy focus on increasing protective factors and reducing risk factors for suicide within Halton.

Key areas for action to prevent suicides include:

- Improving the mental health and wellbeing of Halton residents
- Promoting the early identification and support of people feeling suicidal
- Reducing the risk of suicide in known high risk groups
- Reducing access to the means of suicide
- Providing better information and support to those bereaved or affected by suicide
- Evaluating interventions, data collection and monitoring progress

Key activities linked to the strategy to reduce suicides locally include:

- Developing a local multi-agency suicide awareness campaign plan
- Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals who interact with known groups at high risk of suicide

- Ensuring those identified as being at risk of suicide can access immediate support
- Reducing access to the means of suicide locally
- Continued support of Operation Emblem
- Commissioning a post intervention service to ensure we have effective local responses to the aftermath of a suicide

3.19 **Support 4 Change**

The Warrington Criminal Justice Liaison Service (CJLS) is an integrated, multi-professional and practitioner led mental health service. The service acts as a link between Health, Social Services and all Criminal Justice Agencies in their work with adults who have mental health needs or a learning disability, who find themselves at any stage of the criminal justice system.

In September 2014, additional funding from NHS England was successfully sought/awarded to expand the Support 4 Change service to cover Halton and Warrington. In November 2014 Warrington Borough Council and HBC commenced working together to provide the Support 4 Change service across Halton and Warrington. The magistrates' court covers Halton and Warrington, as does the Probation court staff. Therefore it has previously been confusing for the magistrates and Probation staff to consider recommending a Community Order for one area and not the other.

The aim is to offer intensive, innovative and assertive CJLS support, coupled, where appropriate, with an element of compulsion provided by a formal court order, to engage these offenders and to help them turn their lives around.

Funding for Warrington was originally until March 15 but because of delays in receiving the funding in the first place the pilot only started running in October 2012 so Warrington will tie their work into the pilot in Halton and this will run up until to September 2015.

3.20 **Access targets for Early Intervention in Psychosis for First episode of psychosis**

In addition to the access target around IAPT services there is also a requiring for access to treatment within 2 weeks of referral to an EI service. A task and finish group has been established to work on the implications of achieving this target and the associated additional resource required given there is no 'new funding' being made available nationally.

4.0 POLICY IMPLICATIONS

4.1 The activity outlined has been directed by the overarching Mental Health Delivery Plan and national mandates.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any financial implications associated with the activity outlined has been/ will be highlighted through the appropriate reporting channels.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

Emot

Emotional and mental health and wellbeing is a critical factor in supporting children and young people's social development, behaviour and resilience, educational attainment and achievement and life chances.

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

Good emotional and mental health and wellbeing is a vital factor for children, young people and adults accessing learning and future employment opportunities.

6.3 **A Healthy Halton**

Emotional and mental health services impact directly upon the health and wellbeing of adults, children and young people.

6.4 **A Safer Halton**

Those who do not experience good emotional and mental health and wellbeing are more likely to be subject to a range of risk factors that can impact negatively on community safety issues.

6.5 **Halton's Urban Renewal**

None identified at this time

7.0 RISK ANALYSIS

7.1 Failure to ensure that appropriate services to support emotional and mental health and wellbeing is likely to impact negatively on outcomes and life chances for local residents.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this time

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

None.

Appendix 1 – Examples of Service Provision

Young People

- Universal and Targeted Emotional Health and Well-being, educational sessions in youth clubs and community venues, across Halton.
- Tier 2 Emotional Health and Well-being service to all children and young people aged 5yrs to 19yrs.
- Emotional Health and Well-being service for Children in Care, through Barnardos.
- Young Addaction offer support to children and young people age 10yrs to 19yrs affected by parental mental illness.
- Multi-agency training on mental health, dual diagnosis and self-harm.
- Robust specialist services Tier 3 support for young people with complex issues.

Alternatives for Adults and Children

- Wellbeing Enterprises deliver the NAPC award winning Community Wellbeing Practices initiative to all 17 GP practices in borough. Patients experiencing mild to moderate mental health problems are referred by the GP or health care worker for a personalised wellbeing review, which includes one to one tailored support to identify any social problems at the root cause of mental health distress. The reviews also aim to unlock patient's skills and talents in order to develop a personalised wellbeing plan - in which staff provide ongoing support to help patients to address underlying problems, achieve their goals and to connect with other sources of support available locally.

- The outcomes evidence that 56% of patients report a reduction in their depression symptoms and 64% of patients improve their subjective mental and physical wellbeing levels as a result of their intervention.

- Halton commission wellbeing enterprises to work in partnership with local Mental Health providers (e.g. 5 Boroughs Partnership NHS Foundation Trust) to ensure patients who have been admitted to hospital because of mental health problems also receive wellbeing and social support to ensure they are fully repatriated into their community and receive appropriate community support from their team and other partners.

- Wellbeing Enterprises provides the highly acclaimed 'Ways to Wellbeing' social prescribing programme. Social prescribing is about providing non-medical sources of support to patients with mild to moderate mental health conditions. The team delivers educational and social support groups based on life skills training, cognitive behavioural principles, relaxation classes, sleep hygiene courses, confidence classes and community events that teach people how to stay resilient during difficult times.

- Wellbeing Enterprises CIC have received three years of funding to develop the first, comprehensive wraparound service for children and younger people on waiting lists for CAMHs services because of mild to moderate mental health problems. Children and young people in the borough who are waiting for specialist services will have access to life skills training based on cognitive behavioural principles as well as mindfulness and confidence training as an adjunct to main stay treatment, which it is believed will better prepare younger people for clinical care and will improve outcomes. In addition to this there will be a series of community led projects run by and for children that enable them to share their stories of recovery and to train young people up as peer supporters with a view to creating an informal ecosystem of mental wellbeing support.

Marketing/Prevention and Anti-Stigma

- 'Like Minds for better mental health in Halton' was developed in partnership with the CCG, HBC and PPB to help tackle stigma associated with Mental Health.

- Drawing on the national Time for Change campaign, Like Minds took local people's stories and discussed their experiences with mental health and what they did to help them overcome or work towards overcoming their issues.

- The campaign was launched via a mixed media approach in October 2013, with a second phase focusing on loneliness in the over 55s being launched in October 2014 to coincide with World Mental Health Day.

- To date we have disseminated 10,000 materials across GP surgeries, pharmacies and other community venues. We received mass press coverage in the local media and have delivered approx. 50 training sessions to health professionals, schools and colleges that encompass the Like Minds campaign. We are currently in the process of training all school teachers in self-harm using Sophie's story as a training aide- this to be completed by March 2015.

- The website dedicated to Like Minds www.haltonlikeminds.co.uk has received positive feedback via the online feedback form in terms of changing opinion of mental health and feeling more inclined to talk about mental health than they did before seeing the campaign.

A quote from a member of public on the Like Minds campaign:

"I actually cried reading this, not because I was sad or upset. Seeing stories like this written down made me see where I was back then to where I am now. It was a happy cry, and the last time I cried like that was when my son was born, which made me cry more because I've gotten access to seeing him again. What I mean to say is thank you. I think it's great, I really do".


Like Minds
For better mental health in Halton
My name is David, I'm 30, from Halton View and I've felt suicidal
It's Time to Talk.
For David's full story visit
www.haltonlikeminds.co.uk
Like Minds
For better mental health in Halton
My name is Sophie, I'm 16, from Halton Brook and I used to self-harm
It's Time to Talk.
For Sophie's full story visit
www.haltonlikeminds.co.uk
Like Minds
For better mental health in Halton
My name is Rob, I'm 45, from Halton and I suffer from post traumatic stress
It's Time to Talk.
For Rob's full story visit


Like Minds
For better mental health in Halton
My name is Helen, I'm 31, from Sandymoor and I've suffered from postnatal depression
It's Time to Talk.
For Helen's full story visit
www.haltonlikeminds.co.uk

Loneliness and older people

- The Halton loneliness strategy aims to make Halton a place without loneliness. We aim to achieve this by working with communities and professionals to identify people who are lonely and then tackling that loneliness with a range of interventions.

- These include visits from professionals and volunteers to try and engage the lonely person in activities in the community, simple Skype like devices to enable people to keep in touch with friends and loved ones, linking with existing tele-friending services such as Silverline and Call in Time, and encouraging schools to twin up with local care homes.

- Dementia Navigator Service, for people living with dementia and their carers. Service provides a listening ear, someone who understands, getting to root cause of social issues and providing tailored support to help them improve wellbeing. We also signpost patients to various sources of clinical and non-clinical support.

- NHS Halton CCG and HBC are signed up as a Dementia friendly organisation and action alliance.

REPORT TO: Health Policy & Performance Board

DATE: 8th September 2015

REPORTING OFFICER: Director of Public Health, Policy and Resource

PORTFOLIO: Public Health

SUBJECT: Respiratory Strategy for Halton 2015-2020

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The report presents a new expanded Strategy to address respiratory health for Halton. It identifies key factors influencing respiratory health and provides recommendations for action to prevent respiratory illness, improve identification, treatments and outcomes and ensure provision of appropriate, high quality, primary, secondary and community health and social care services for all ages.

2.0 RECOMMENDATION: That:

i) The Policy and Performance Board note and comment upon the contents of the Respiratory Health Strategy for Halton2015-2020.

3.0 SUPPORTING INFORMATION

3.1 Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer.

There are significant health inequalities in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking.

3.2 The 2014 Halton Respiratory Health Profile[1] details the significant respiratory health issues within Halton. The key issues identified within the health profile include:

[1] http://www3.halton.gov.uk/Pages/health/PDF/health/RespiratoryHealthProfile.pdf

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between the modelled expected number of people with COPD and those known about on GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- The management of patients with COPD and asthma are in line with the North West and England averages
- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

3.3 There has been a significant improvement in the rate of detection of cancers in Halton. Lung cancer represents the greatest proportion of all cancers within Halton (almost 17% of all cancers)[2] and numbers of cases fluctuates unequally across the Borough. Lung cancer represents a significant burden of respiratory illness for the population of Halton.

3.4 Halton has historically high rates of smoking but has seen a significant the reduction of smoking in recent years. The most recent health profile 2015 data shows that the overall smoking rate is 18.4% and is the same as the England average. Other data from the Merseyside Lifestyle Survey suggests that the Smoking rate may be higher than this in areas of deprivation.

3.5 The rate of smoking related deaths is 416 (per 100,000 population), worse than the average for England. This represents 248 deaths per year and is considerable worse than the England average smoking related death rate of 292 (per 100,000 population). Smoking results in considerable respiratory health problems and exacerbates existing conditioned resulting in increases in secondary care usage and poorer outcomes for patients. Halton has seen considerable decline in the numbers of women smoking at the time of delivery, however 19% of pregnant women continue to smoke compared to 12% as an England average. Smoking during pregnancy has considerable consequence to the growth and development of the child, not least a significantly greater likelihood of the child

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2 http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/CensusandStatistics/General_Cancer_Profile_2013.pdf

developing severe asthma in childhood and later life. Further improvements in smoking rates remain a key recommendation within the strategy.

The treatment and management of people with respiratory conditions represent a significant challenge on current health and social care systems

3.6 The strategy presents a single vision for respiratory health across all partners to ultimately improve the respiratory health and well-being of people in Halton, and reduce the impact that respiratory conditions have on people and services across Halton.

Our vision is:
to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.

3.7 In order to achieve the vision, the strategy identifies a set of aims to address every element of the health and care system which impacts upon respiratory health. The strategy aims to;

I. Prevent respiratory ill health

Increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks to poor respiratory health. Ensure that services and agencies activities support activities to prevent poor respiratory ill health.

II. Earlier detection of respiratory diseases

Make sure people are aware of the signs and symptoms of respiratory diseases to encourage positive health seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

III. Primary Care and Community based support

Provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

IV. High Quality Hospital Services

Ensure that pathways and services are in place so that people who need them receive prompt effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.

V. Promoting Self Care and Independence

Ensure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate information, support and interventions to help them manage their own respiratory health issues.

3.8 The strategy provides the evidence and analysis to identify what they key issues affecting the population of Halton are in terms of their impact upon respiratory health for each overall aim. Using this data, in conjunction with key guidance, an assessment of local need and current provisions and gaps, a set of key recommendations and actions are identified in order to achieve each individual aim of the strategy and ultimately improve respiratory health and respiratory health outcomes for people in Halton. The recommendations are covered in detail in the strategy but briefly cover the following areas:

I. Prevent respiratory ill health

- Reduce smoking rates
- Increase appropriate vaccination rates
- Reduce overweight and obesity
- Measures to improve housing quality and warm homes
- Identify opportunities to further improve air quality across Halton

II. Earlier detection of respiratory diseases

- Mechanisms to improve early signs, symptoms and diagnosis of cancer
- Early case finding and rapid treatment access for COPD, Sleep apnoea and Interstitial lung disease
- Ensure risk markers are identified on patient records, known risk occupations etc.
- Consideration of needs of people with learning disability

III. Primary Care and Community based support

- Compliance to appropriate NICE Guidance and Quality Standards
- Pro Active Care programme Local Enhanced Service (2014/15)
- Review provision of pulmonary rehabilitation across Halton
- Establish integrated delivery of respiratory services across Halton
- Improve prescribing, in line with guidance[3], of respiratory medication across primary care
- Improved case finding and rapid treatment access across a number of conditions

IV. High Quality Hospital Services

● Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
● Review arrangements regarding Halton residents admitted to Whiston Hospital with respiratory health problems

V. Promoting Self Care and Independence

● Develop a range of interventions to support self-management
● Further develop and expand the Expert Patients Programme

3.9 The strategy will inform the continuous development of the Respiratory Action Plan which is implemented and overseen by the Respiratory Strategic group, outcomes against which are measured and fed back through to the CCG and the Health and Wellbeing board.

4.0 POLICY IMPLICATIONS

4.1 The strategy addresses some key issues relating to the provision of services to protect respiratory health and for people requiring treatment and support for respiratory illness. As such the recommendations will cover a broad scope of policy areas across the council, CCG and health and care partners.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There may be financial implications in the implementation of recommendations within the strategy which will be assessed and managed within the Strategic Group and through partner agencies for which the implication affects.

5.2 Respiratory health is a significant cause of ill health within the Borough and inequalities exist within the distribution of ill health and services which need to be addressed in order to improve respiratory health across the Borough.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
There are number of respiratory health conditions which affect children to a greater extend. Ensuring that appropriate and high quality prevention, identification and treatment and support services

[3] Pan Mersey Area Prescribing Committee Guidelines
http://www.panmerseyapc.nhs.uk/guidelines.html

are in place is essential to safeguarding the respiratory health of children and young people in Halton.

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

Maximising respiratory health for the population of Halton and limiting the effect that respiratory illness has on an individual, is likely to improve life chances, including employment potential for people in Halton.

6.3 **A Healthy Halton**

Ensuring the health and wellbeing of the population is key priority. Protecting the health of Halton's population is a statutory responsible for Public Health and the Council.

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 *There are no risks associated with the development and implementation of this strategy*

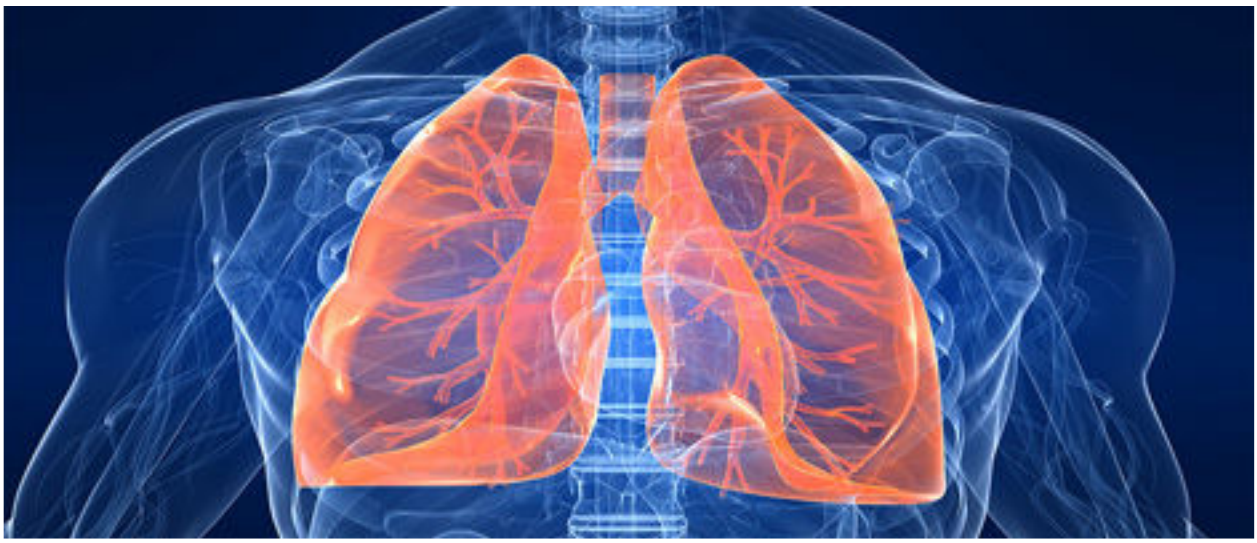
8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 *The strategy is developed in line with all equality and diversity issues within Halton.*

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

None under the meaning of the Act.

Respiratory Health Strategy for Halton 2015 – 2020



HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

myhalton living life well

Foreword

Sadly the impact of respiratory disease has no bounds – from the school child with asthma who wakens in the night and is unable to compete with his peers to the elderly COPD patient with recurrent exacerbations and subsequent admissions. Their suffering is devastating for them and their families and there is a real risk of premature death. The impact of exacerbations and poor control places a further burden on the resources of an already stretched NHS.

There are many excellent therapies and guidance but still the basics of delivering evidence-based and personalised care remains essential for effective timely intervention for these respiratory patients.

This strategy will attempt to fully integrate health and social care aspects on respiratory care and encourage a more equitable service across the Borough incorporating primary, secondary and community services. It will empower local health care & other professionals to deliver the best possible care through better organisation, use of evidence-based care, improved self-management, prevention strategies and appropriate effective therapies and interventions.

The CCG, local authority and health and community partners should all be proud to participate in the initiative to improve the health and social well-being of all respiratory patients and their carers in Halton.

Dr Chris Woodforde, Respiratory Lead GP for NHS Halton CCG

People in Halton, on average, live shorter lives than people in many other parts of the country. Respiratory disease is the third leading cause of death after circulatory disease and cancer. There are significant health inequality in respiratory diseases, people in the most deprived communities in Halton, are twice more likely to die from a respiratory illness than the general Halton population.

Smoking and tobacco smoke is a cause of many respiratory problems and is linked to deprivation, but this is not the only link; working conditions, poor housing, fuel poverty and lifestyle are all associated with respiratory disease and more greatly affect people in poorer communities. Only when all organisations and partners are working together with a single strategic vision, and across all sectors, can we deliver a full range of services to reduce the impact respiratory illness has on the people of Halton. Ensuring that we improve opportunities to delay or prevent the development of respiratory conditions, improve access to appropriate good quality health services, and support people with respiratory problems, and their carers, to confidently manage their condition(s) and achieve the best possible quality of life, are key outcomes of this strategy.

Eileen O'Meara, Director of Public Health, Halton Borough Council

Executive Summary

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer. There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking, all of which are addressed within the scope of the strategy.

The strategy presents a vision for respiratory health in Halton:

Our vision is:

to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.

In order to achieve the vision, the strategy identifies a set of aims across the treatment and condition pathways to improve respiratory health for the people of Halton, identifying the key issues and concerns for each strategic area, identifying the current provision and gaps and making recommendations for action against each. There are numerous recommendations identified in detail at the end of the document which will help achieve the following stated aims:

I. **Prevent respiratory ill health**

II. **Earlier detection of respiratory diseases**

III. **Primary Care and Community based support**

IV. **High Quality Hospital Services**

V. **Promoting Self Care and Independence**

The recommendations will inform the Respiratory Action Plan which will be overseen and monitored by the Respiratory Health Strategy Group in order to assess progress and analyse overall outcomes.

Contents

Strategic Context

Scope of the strategy

This strategy will address the key issues around respiratory health in Halton, it will address a spectrum of respiratory illnesses, causes, treatments and outcomes. While this strategy will aim to provide a broad picture, it cannot address every aspect of respiratory ill health within the one document, a number of related issues are covered in other local Strategic documents, for example, A Cancer Strategy for Halton, 2014-2019[1],identifies specific issues and actions around lung cancer ; A Housing Strategy for Halton , 2013-2018[2] identifies the issues around warm, healthy homes which also impact upon respiratory health; Halton Health and Wellbeing Strategy 2013-2016[3] also provides detailed activity and needs around certain lifestyle issues such as smoking cessation, to which this document will refer.

The Respiratory Strategy for Halton will identify the major respiratory health issues affecting the population of Halton and sets out how Health and Social Care organisations in Halton will deliver on its responsibility to meet the needs of people at risk of developing, or affected by, a wide variety of acute and chronic lung conditions. This is a significant challenge, for individuals and their carers and the whole Health and Social Care.

While the strategy cannot cover the full extent of potential lung and respiratory conditions it will focus on conditions which cause the most significant problems for local people and where illness may be preventable or amenable to treatment and where local action could significantly improve outcomes. The strategy will include the conditions: Chronic Obstructive Pulmonary Disease (COPD); Asthma; Pneumonia; Lung cancer; sleep disordered breathing; Interstitial Lung disorders; bronchiectasis; potentially work related lung disorders and other associated conditions.

Why Do We Need A Halton Respiratory Health Strategy?

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer.

There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

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[1] http://www4.halton.gov.uk/Pages/health/PDF/health/HWB/ACancerStrategyforHalton.pdf last accessed 3.12.14
[2] http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/housing/Halton_Housing_Strategy_2013-18.pdf last accessed 3.12.14
[3] http://www3.halton.gov.uk/Pages/health/PDF/health/Halton_Health_and_Wellbeing_Strategy.pdf last accessed 3.12.14

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking.

The 2014 Halton Respiratory Health Profile[4] details the significant respiratory health issues within Halton. The key issues identified within the health profile include:

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between the modelled expected number of people with COPD and those known about on GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- The management of patients with COPD and asthma are in line with the North West and England averages
- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

In addition, the incidence and mortality from cancer is higher in Halton than in many other parts of the country. Lung cancer represents the greatest proportion of all cancers within Halton (almost 17% of all cancers)[5] and incidence fluctuates unequally across the Borough. While the incidence amongst men has seen a decline since the early 1990s, the incident rate amongst women continues to increase (increasing by 15.43 cancers per 100,000 population, from 1993-95 to 2009-11). Lung cancer represents a significant burden of respiratory illness for the population of Halton.

Halton has high rates of smoking. In 2014, 22.6% of the adult population smoked compared to an England average of 19.5%[6]. Other data suggests that the Smoking rate within Halton may be 30%, and up to 38% in some age groups (the NHS Merseyside Lifestyle Survey identifies that 38% of 25-34 year olds smoke). The rate of smoking related deaths was 416 (per 100,000 population), worse than the average for England. This represents 248 deaths per year and is considerable worse

[4] http://www3.halton.gov.uk/Pages/health/PDF/health/RespiratoryHealthProfile.pdf
[5] http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/CensusandStatistics/General_Cancer_Profile_2013.pdf
[6] Halton health profile 2014 http://www.apho.org.uk/resource/item.aspx?RID=142121

than the England average smoking related death rate of 292 (per 100,000 population). Smoking results in considerable respiratory health problems and exacerbates existing conditioned resulting in increases in secondary care usage and poorer outcomes for patients. Halton also has a considerably higher proportion of women smoking at the time of delivery, with 18.9% of women smoking at delivery compared to 12.7% across England (2012/13). Smoking during pregnancy has considerable consequence to the growth and development of the child, not least a significantly greater likelihood of the child developing severe asthma in childhood and later life.

The treatment and management of people with respiratory conditions represent a significant challenge on current health and social care systems:

- 547 Children aged under 16 years of age presented at Whiston Accident and Emergency in 2013, 56% (305) of these were due to 'difficulty breathing'. 254 of those attending with difficulty breathing (83%) were subsequently admitted.
- CHIMAT data indicates 88 asthma admissions in 2013/2014 across Warrington & St Helens and Knowsley Hospitals.
- The proportion of people dying from respiratory disease in Halton is higher than the North West average and is significantly higher than the England average.
- Fewer people within Halton with existing respiratory illnesses are protecting themselves from the complications of flu. 89.8% of COPD patients received their annual seasonal flu vaccination compared to 92.7% across England as a whole.
- Adult Social Care records show 572 individuals registered with Care First who have asthma or COPD.
- In 2014/15, Halton CCG spend just over £3.4 million on prescribing for respiratory health. This is approximately 15% of the total prescribing spend for Halton CCG.
- The overall spend on respiratory services, prescribed drugs and patient activity for 2013/14 has been estimated to be £5.8 million within Halton.

Our Vision & Aims

We want to improve the respiratory health and well-being of people in Halton, and reduce the impact that respiratory conditions have on people and services across Halton.

Our vision is:

to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.

In order to achieve our vision, this strategy aims to;

VI. **Prevent respiratory ill health**
Increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks to poor respiratory health. Ensure that services and agencies activities support activities to prevent poor respiratory ill health.

VII. **Earlier detection of respiratory diseases**
Make sure people are aware of the signs and symptoms of respiratory diseases to encourage positive health seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

VIII. **Primary Care and Community based support**
Provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

IX. **High Quality Hospital Services**
Ensure that pathways and services are in place so that people who need them receive prompt effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.

X. **Promoting Self Care and Independence**
Ensure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate information, support and interventions to help them manage their own respiratory health issues.

The strategy will inform the development of a comprehensive action plan to oversee the delivery of actions to enable the achievement of the identified aims within the Strategy. The Strategy and Action plan will be overseen by the Respiratory Health Group. The multidisciplinary Respiratory Health Group will oversee and receive assurance from all partners with regards performance towards achieving the action plan objectives and outcomes. The Respiratory Health Strategy Group is accountable to Halton Clinical Commissioning Group's Service Development Committee, a multiagency group consisting of a range of health, public health, social care and voluntary sector providers.

The action plan will be reviewed at least annually and refreshed as required.

Achieving the Aims

i. Preventing respiratory ill health

Health education and disease prevention activities should inform everyday lifestyle choices for the population of Halton. Motivating people to be aware of and take action to reduce their risks of developing respiratory ill health must remain a key focus of activity within this strategy.

Smoking

In Halton:

The average smoking rate in Halton is now the same as the national average at 18.4%

Up to 30% of adults smoke in deprived areas, significantly higher than the Halton Average (18.4%)

19% of pregnant women smoke at the time of delivery, significantly worse than the England average (12%)

There are 416 smoking related deaths per 100,000 over 35 population per year, compared to 292 as an England Average[7]

Reducing the prevalence of smoking will have the greatest impact upon respiratory disease prevention. Improving access to smoking cessation services and encouraging long term quit rates would have a significant impact on reducing prevalence of a variety of respiratory disease, including COPD, lung cancer, adult and childhood asthma amongst others. Increasing work within schools and youth settings and identifying innovative and best practice techniques to prevent young people taking up the habit of smoking will help limit future impacts of respiratory ill health. There is increasing evidence that young people may be using e-cigarettes as a gateway to smoking. Targeting activities towards limiting the increasing usage of e-cigarettes, and working across agencies to limit access and lobby for legislative change could help prevent people in Halton becoming smokers in the near future.

Current data on smoking prevalence varies, with the national Lifestyle survey suggesting that smoking in Halton is the same rate as the national average but other local surveys suggest that as many as 30% of the local population (in the most deprived areas) may smoke.

[7] Halton Health Profile 2014, Public health England http://www.apho.org.uk/resource/item.aspx?RID=142121

Vaccination

In Halton:

In 2013/14, against a national target of 75%

- 73.5% of those 65 years old and over received their annual flu vaccination
- 51.9% of those under 65 but at risk received a flu vaccination
- 38.3% of pregnant women received a flu vaccination

71.2% of those 65 and over had received a Pneumococcal vaccine (national average 68.9%, 2013/14)

Uptake of childhood vaccinations is generally good, with the Halton average uptake for Pneumococcal and Pertussis vaccines by 12 months and Hib vaccine by 24months being above the 95% national target (although there is wider practice level variation)

Next to clean water and sanitation, vaccination is the most effective public health intervention of all time. Vaccinations can prevent respiratory illnesses.

Promoting and improving the uptake of appropriate vaccination programs (Influenza and Pneumococcal) amongst our target populations is essential to reduce in the burden of respiratory illness caused by influenza and pneumococcal infections amongst the most vulnerable people in our communities (the very young, older people and those with existing chronic health conditions). Achieving recommended uptake of influenza and Pneumococcal vaccination (at least 75% uptake amongst all people over 65, those under 65 with an existing health condition, and pregnant women, and achieving a 90% uptake amongst those with COPD), would make a significant contribution to reducing the number of excess winter deaths in Halton.

The uptake of primary Immunisations in childhood is good. Across Halton as a whole, the uptake of primary immunisations including those preventing respiratory diseases Pneumococcal disease, Pertussis (whooping cough) and Haemophilus Influenzae type B (Hib) were above the national target of 95%. There is some variation across GP practices, with some practices reporting 88.9% while others achieved 100% uptakes. Halton Council are working closely with Public Health England to ensure that we maximize opportunities to increase vaccination coverage across Halton.

Obesity

In Halton:

There is a higher percentage of obese adults than the England average.

35.2% of adults in Halton are obese (England average 23%).

Levels of obesity in year 6 children are similar to the national average (20.4% in Halton compared to the England average 19.1%).

Obesity can have a very serious negative impact on the respiratory system, significantly reducing respiratory health. Some of the health effects of obesity on respiratory system include diseases like:-

- Exertion dyspnoea – severe breathlessness as a result of only minor physical activity. This is a common feature among people who are obese.
- Obstructive sleep apnoea syndrome (OSA) – This condition leads to closing or narrowing of the airways during sleep leading to snoring, repeated waking and lack of adequate and restful sleep.
- COPD - a group of lung diseases that block airflow and make breathing difficult. Emphysema and chronic bronchitis are the two most common conditions.
- Asthma – Obese patients are more at risk of asthma exacerbations. The prevalence of asthma is around 38% higher in overweight patients and by 92% in obese patients. Obese patients with asthma also get more acute attacks, need more asthma medication, need more frequent visits to the emergency department (ED), and have more hospital admissions than non-obese patients with asthma.
- Pulmonary embolism – This is a serious condition where a blood clot gets lodged in the blood vessels of the lungs leading to a life threatening medical emergency. Pulmonary embolism may lead to failure and death.

Respiratory illnesses for which obesity can represent a significant cause have a great impact upon the health of people in Halton and the health services across Halton. There are estimated to be 1328 adults with moderate to severe Sleep apnoea.[8] The cost of treating all people with moderate to severe OSA would be £1,092,406 per year. In 2013-14, there were 180 emergency admissions as a result of COPD across Halton. In the same time there were 43 emergency admissions for adults aged 45-74 years of age as a result of asthma.

Encouraging people to lose weight and maintain a healthy weight through a healthy balanced diet and regular exercise is the only way in which the population of health on can stay within a healthy weight range and reduce the likelihood of obesity related respiratory ill health. Halton has a number of services to promote healthy lifestyles, diet and exercise. Current programmes range from interventions in Schools (Food and nutrition awareness, cooking skills, exercise programmes) to Adult Fresh Start programmes to encourage healthy weight loss, provide healthy food skills and supporting regular exercise programmes and opportunities across the Borough and we

[8] British Lung Foundation 2015 OSA Calculator

need to work across partner agencies and the public to a greater extent to ensure that everyone has an equal opportunity to benefit from the services available.

Drugs

In Halton

According to the North West Mental Wellbeing Survey 2012/13

A local schools survey suggests that approximately 5 % of secondary school children had used cannabis in the previous year, which is generally lower than national trends.

In a sample of 500 adults aged 16 and over in Halton 11.3% reported cannabis use

Cannabis use is associated with longer-term damage to the respiratory tract, with an increased risk of chronic bronchitis, asthma and potentially lung cancer. There is also a reported association between cannabis smoking and an increased risk of developing infectious lung diseases such as tuberculosis and Legionnaires disease.

Education to reduce the levels of cannabis use, and prevent young people from using cannabis could help to reduce rates of chronic bronchitis and asthma.

Housing

In Halton

In 2012, 4841 households (9.2% of all households) were in fuel poverty, spending more than 10% of their household income on heating costs. This is not distributed evenly, in some areas within Halton, as much as 26% of households in privately rented accommodation are in fuel poverty.

Halton has seen a general increase in Excess Winter mortality over recent years (although the most recent data is lower than). Nationally, respiratory diseases account for the second highest proportion (32%) of excess winter deaths[9]. Cold homes are a considerable contributor to the excess deaths resulting from respiratory illnesses (particularly exacerbations of COPD) and fuel poverty is a significant cause of cold homes. Damp living conditions are also a major cause of respiratory illness, ranging from allergy to mould resulting in significant rhinitis, wheeze, coughs and exacerbations of asthma and COPD, to increased rates of infections ranging from flu like symptoms to significant lung damage.

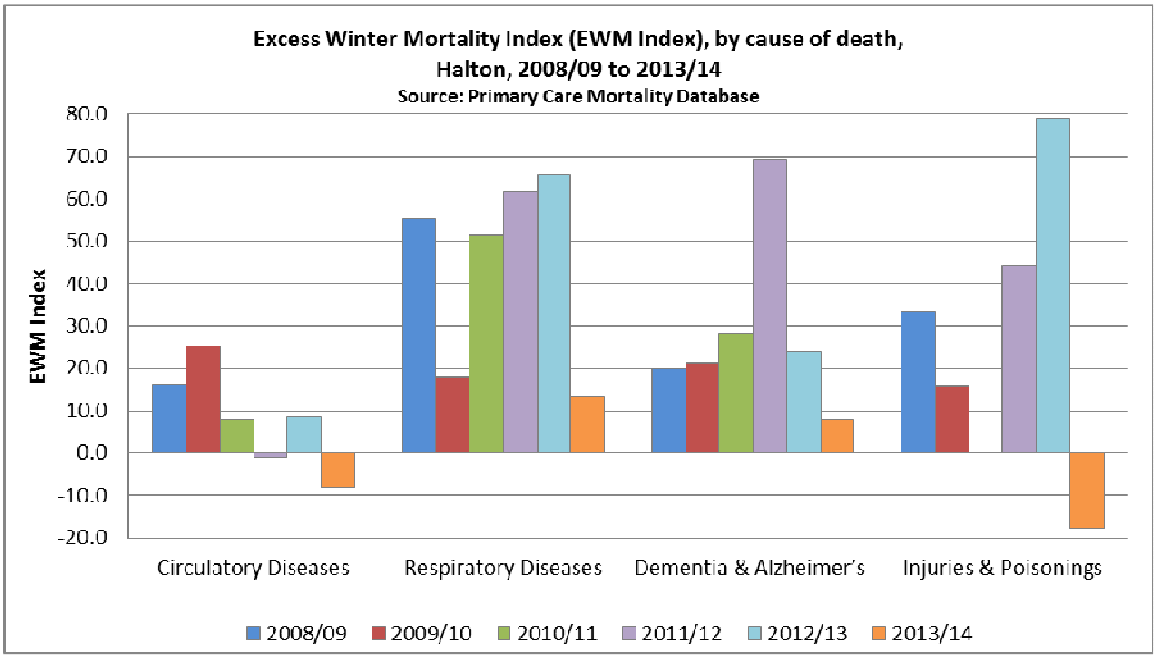
Fuel poverty and cold homes can have severe and life-long effects on children. Studies show that long-term exposure to a cold home can increase hospital admission rates for children and increase the severity and frequency of asthmatic

[9] Office for National Statistics (2010). Statistical bulletin *http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2010-11--provisional--and-2009-10--final-/index.html*

symptoms. Children in cold homes are more than twice as likely to suffer from breathing problems and children in damp and mouldy homes are up to three times more likely to suffer from coughing, wheezing and respiratory illness, compared to those with warm, dry homes.[10] During 2013-14 there were 82 emergency admissions for asthma in children under the age of 14.

Figure 1 shows the proportion of Excess Winter deaths attributable to different causes, in Halton from 2008 – 2014. This shows that respiratory disease generally account for the highest proportion of these deaths,

Figure1: Excess Winter Mortality Index, by cause of death, Halton 2008/09 to 2013/14



During 2011/12 to 2013/14, of all emergency admissions for lower respiratory tract infections in 0-18 year olds, 81.5% were for those under 1 year of age (the England average was 70%) and 79% of these were for acute bronchiolitis. Bronchiolitis can be best prevented by good hygiene and living conditions. Children who are exposed to passive smoking, can suffer more severely with bronchiolitis.

Halton Housing strategy 2013-18 identifies key actions around developing the affordable warmth strategy and promoting energy efficiency and green deals to help

[10] Fact-file: Families and fuel poverty ; Association for the conservation of energy, February 2013 http://www.ukace.org/wp-content/uploads/2013/02/ACE-and-EBR-fact-file-2012-02-Families-and-fuel-poverty.pdf

reduce the local burden, although further multidisciplinary and health involvement would benefit the development and promotion of these interventions.

Environment

In Halton:

Air quality as a whole has improved in Halton over the previous decades.

There are 2 Air Quality Management Areas which regularly exceed recommended emissions levels which can affect health. These are a result of high density traffic flow and congestion.

The environment that we live in can have a great impact upon our respiratory health, both indoor and outdoor environmental factors, predominantly air quality, can significantly influence our chances of experiencing good respiratory health. Breathing fine particles (those produced through burning), high levels of gases such as nitrogen oxide and sulphur dioxide, and low level ozone can all irritate the lungs. In the short term they can cause breathlessness, and exacerbate symptoms of asthma and COPD. In the long term they could lead to reduced lung function, initiation of asthma, and cause scaring and damage to the lung or causes some forms of Interstitial lung disease (a range of conditions which include most commonly Idiopathic pulmonary fibrosis).

Indoor environment

Our indoor environment plays a significant role on our health, particularly so for young children who may spend considerable amounts of their time indoors. Indoor environmental tobacco smoke is the main indoor environmental pollutant to affect peoples, especially children's, respiratory health. Passive smoking is breathing in the smoke from someone else's tobacco. Passive smoking can be either secondary of tertiary; secondary smoking is exposure to smoke from other peoples cigarettes, and tertiary smoking is exposure to residual smoke on persons, clothing and furniture etc. as a result of smoking). The predominant source of passive smoke exposure in children is smoking in the home by parents. The best way to prevent passive smoking in the home is therefore to reduce the prevalence of smoking among parents and would-be parents.[11]

Passive smoking can have a significant impact on health, increasing the likelihood of recurrent lower and upper respiratory infections, recurrent pneumonia, development and worsening of asthma, as well as a significant cause of lung cancer in smokers and none smokers:

[11] Passive smoking and children. Royal College of Physicians 2010.

- Smoking by the mother increases the risk of lower respiratory infections in children by about 60%, and smoking by any household member increases the risk by over 50%. Most of this increase is due to an effect on bronchiolitis, which is about 2.5 times more likely to occur in children whose mothers smoke[12]
- Secondary smoking increases the risk of wheezing at all ages. Again, the effect is strongest for amongst children whose mothers smoke, with increases in risk of 65% to 77% according to the age of the child. The risk of asthma is increased by household smoking by about 50%.[13]

Other indoor environmental factors which can impact upon respiratory health include:

- Mould - Poor quality damp housing and lack of ventilation in humid places such as kitchens and bathroom can lead to the growth of mould. There are many types of mould, many of which harmless, but some people can have allergic reactions to mould or mould spores which can lead to rrespiratory symptoms including persistent sneezing, eye irritation, rhinitis (runny nose), coughing and wheezing, which can be worse in children.
- Pets – fur and feathered pets are sources of allergies. Some people are allergic to certain proteins and substances found in the skin or some secretions (saliva etc) from some animals. Pet allergies can lead to long term rhinitis, coughing and wheezing. Identifying the source of the respiratory ill health can be difficult to detect and can develop even when pets have been present for a long time.
- Dust – dust can harbour mites. Faeces from dust mites are also a very common allergen that can be a significant contributor to the development of asthma and/or triggering asthmatic attacks. Mites accumulate in or on surfaces that accumulate human skin cells or sweat etc. They also thrive in conditions of high humidity and temperature. They accumulate in bedding, pillows, mattresses, carpets and furniture. People are exposed by inhalation and can result in allergic respiratory symptoms as well as asthma.

Ensuring that the environment is clear of potential allergens, when there is a known or likely link (family history) is key to preventing poor respiratory health, and removing/ limiting contact with potential allergy sources where a respiratory allergy symptoms are present is key to preventing ongoing or worsening conditions.

Outdoor environment

[12] Cook DG, Strachan, DP. Health effects of passive smoking
[13] Parental smoking and prevalence of respiratory symptoms and asthma in school age children. *Thorax*1997;52:1081–94.

Outdoor Air pollution is also a key determinant of respiratory health. There are several kind of pollutants which affect health, and are of major concern, these are pollutants for which there are national and international criteria to monitor their levels and limit the impact that they have upon health. The council has a responsibility to regularly monitor, review and assess air quality as part of the Environmental Act (1995) and national Air Quality Strategy.

The Committee on Medical Effects of Air Pollution (COMEAP) estimated that air pollution accounts of 29,000 deaths nationwide every year[14]. The most recent COMEAP Report looks at the proportion of deaths in a local area that can be attributable to particulate pollution. The proportion of deaths attributable to long term exposure to manmade particulate air pollution in Halton is 5.5%, while this still represents a fraction of deaths for which preventive action must be sought, it is reassuring that Halton has no greater risk than many other areas of the country. The average attributable risk across England is 5.6%.[15]

Halton is an industrial area, with a long history of industrial processes. It has had historically poorer air quality than other areas of the country. However, with the reduction in industrial manufacturing, cleaner technologies and closer processes monitoring and permitted processes has significantly improved air quality in Halton over the decades. Halton currently collects data on air quality across the borough to regularly assess air quality. Halton is generally well within national Criterial levels for common air pollutants (particulates, Sulphur dioxide, nitrogen dioxide). However, there are 2 areas which have been identified as Air Quality Management Areas (AQMA) where nitrogen dioxide are above Air quality objective levels, both these areas are in Widnes Town Centre and are associated with high volume traffic flows.

Halton Borough Council in partnership with other agencies is working towards improving transport options, increasing sustainable transport options, cleaner technologies, assessing traffic routes and active travel options (walking and cycling etc.)

Actions for Prevention

Smoking

- Increase the number of people attending Smoking Cessation Services in Halton
- Reduce the proportion of people smoking in Halton

Vaccination

[14] The Mortality Effects of Long Term Exposure to Particulate Air Pollution in the UK. COMEAP Dec 2010

[15] Estimating Local Mortality Burdens Associated with Particulate Air Pollution. PHE, COMEAP April 2014

● Increase the uptake of flu vaccination amongst at risk groups, to achieve national target

● Increase uptake of childhood vaccinations in lowest uptake practices.

Obesity

● Improve uptake to lifestyle advice across the borough

● Increase the proportion of people taking regular daily exercise in Halton

Drugs

● Improve education and awareness of the impacts of cannabis use, especially preventing young people from starting to use cannabis.

Housing

● Increase access to grants and equipment to increase energy efficiency in

People's homes

● Continue to work across the private rented sector to improve housing standards

Environment

● Continue the implementation of the Halton Council Transport Plan to improve traffic flow, reduce emissions and encourage active transport

● Identify opportunities to further improve air quality across Halton

ii. Earlier detection of respiratory diseases

In Halton:

43.1% of lung cancers are detected at early stage 1 and 2.

One and five year survival from lung cancer is higher than regionally and nationally.

2.6% of the population have COPD, but there is a possible 0.79% we don't know about.

Failing to treat the estimated 1328 people in Halton who have Sleep Apnoea could increase NHS costs, social care costs and accidents locally.

Early diagnosis of lung disease delivers significant benefits, particularly in such conditions as asthma, COPD, and lung cancer. There is a need for greater public awareness of the symptoms of such lung diseases, of the risks posed by smoking and by any delay in diagnosing smoking-related lung conditions such as lung cancer and COPD to encourage people to recognise early indications that there may be a problem and to seek medical attention early. In addition, there is a requirement to ensure that primary care are fully aware of the early symptoms of specific conditions and explore appropriate diagnostic tests, and referrals early.

Whilst prevention of ill health remains the primary long term focus to safeguard respiratory health in to the future, significant improvements in health outcomes and mortality can only be made by earlier diagnosis and interventions for respiratory illnesses. There are a number of respiratory conditions that have early signs and symptoms, that can be diagnosed early, or that are more frequently diagnosed late and opportunities may exist for earlier diagnosis. Such conditions include

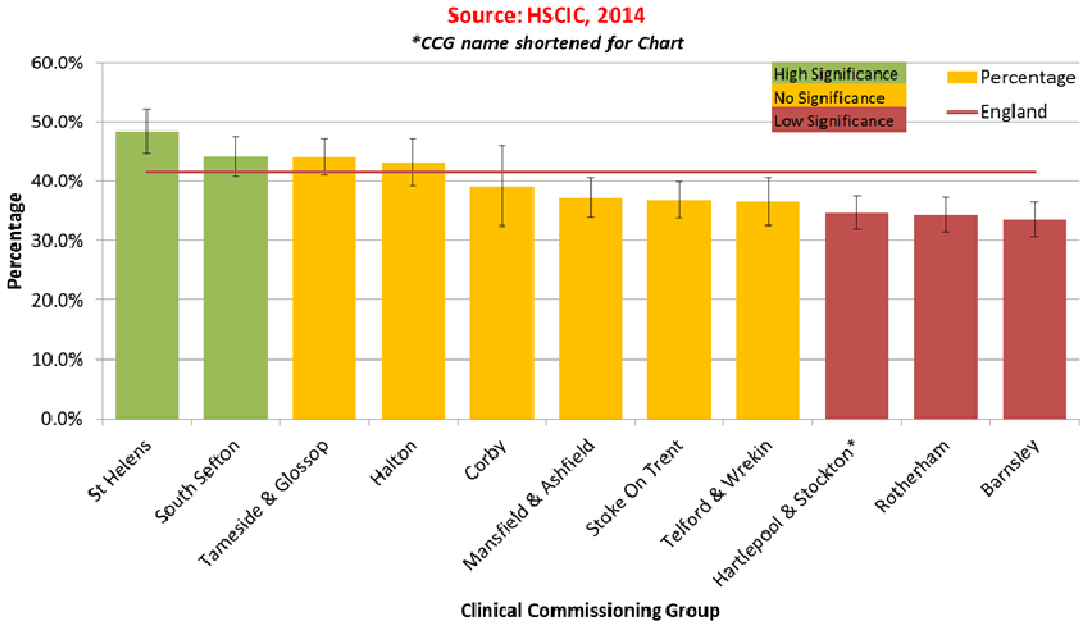
Lung cancer

In Halton, 43.1% of lung cancers were detected at an early stage (stage 1 and 2), where the cancer is much more treatable, has generally had less opportunity to spread and leads to much better outcomes for the patient. This is slightly higher than the England average early diagnosis and is significantly higher than many of comparable Clinical Commissioning Group (CCG) areas as seen on **Figure 2**.

People with lung cancer normally present with common respiratory symptoms (cough, coughing blood and breathlessness). These patients are nearly always seen by a respiratory physician for diagnosis before referral to oncologists and many are admitted as an emergency because the correct diagnosis is not made. This means

that we should put emphasis on early and accurate diagnosis of any unusual respiratory symptoms.

Figure 2: Percentage of lung cancers diagnosed at stage 1 and 2 for Halton and Statistically similar CCGs



Halton has been running a Get Checked public awareness campaign since 2008 which raises awareness about the early symptoms of cancer to the public. From 2008 to date, 'Get checked', in combination with other national awareness initiatives such as Be Clear on Cancer have increased the volume of fast track GP referrals year on year for suspicious breast, bowel and lung cancer symptoms by 24% with an associated increase of cancer diagnosis of 19%. The continuation of the Halton Get Checked campaign and further innovations in delivery are required to further increase awareness of signs and symptoms of lung cancer. These approaches should be backed up with a system approach to ensure that 2 week wait referrals are made appropriately, that system capacity is able to meet any increase in demand in terms of urgent referrals, diagnostics, and treatment and rehabilitation pathways.

COPD

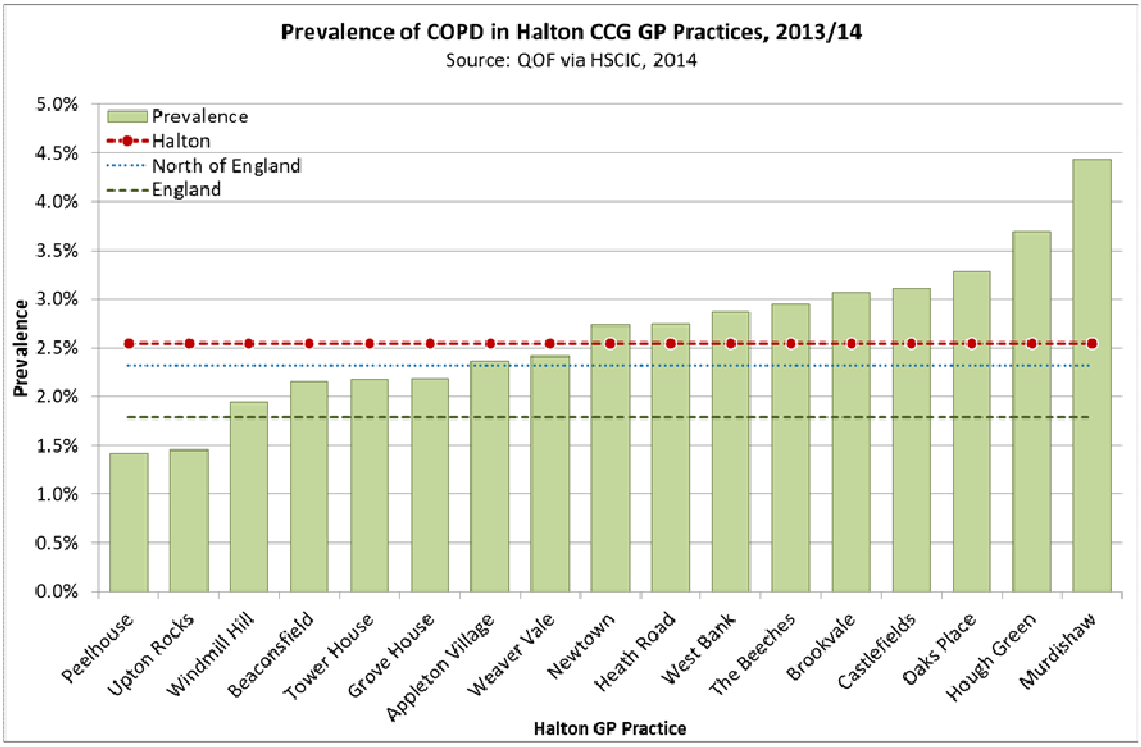
In Halton it is estimated that 3,916 residents over the age of 16 had COPD as of 2010, which is predicted to rise to 4,420 by 2020. The biggest increase is predicted to be in the 65 plus age group.

It is a requirement of the GP contract that practices hold a register of all patients with COPD, data for 2012/13 indicates that 3,210 patients who are registered with practices in Halton have COPD. This represents 2.6% of the registered population.

The prevalence of COPD varies considerably by practice, with some practices experiencing higher than average rates of COPD, and other considerably lower.

Figure 3 below shows the practice variation in COPD prevalence ranging from 1.4% to 4.4% prevalence across the practices.

Figure 3: Prevalence of COPD in Halton CCG GP practices 203/14



Estimates have been made of the number of people that would be expected to have COPD, based on the demographics within the Borough, and these suggest that 3207 people (3.39% of the population)[16] would have COPD. The difference between expected and actual registered cases of COPD suggests that there is a proportion of the population who have undiagnosed COPD. There have been improvements in case finding since 2009/10 closing the gap between the modelled estimated number of people with COPD and those of GP disease registers. But it is important that we continue to actively identify those with undiagnosed COPD. Early diagnosis and treatment initiation for COPD can markedly slow down decline in lung function provide patients with an opportunity to enjoy an active life for longer. Improving public awareness of COPD, including what good respiratory health looks like and signs and symptoms of possible COPD, in addition to wider community, high quality spirometry to assess lung function will help to identify possible COPD patients to enable more rapid diagnosis and earlier treatment plans.

[16] COPD Prevalence Estimates Dec 2011, East of England Public Health Observatory http://www.apho.org.uk/resource/item.aspx?RID=111122

Interstitial lung diseases

Interstitial Lung Diseases (ILD) comprises a large number (over 150) of diverse conditions which primarily affect the lung's smallest airways and alveolar air sacs. Whilst the cause of some ILDs is unknown, there is an overlap with occupational and environmental lung diseases such as Coal and Slate workers' pneumoconiosis, asbestosis and Farmer's lung.

Due to the variety of the illness that comprise ILD, there is no single early diagnosis tool or single set of signs and symptoms, although shortness of breath especially with relatively minor exertion is one common feature. A number of the most common ILD can be related to occupational or environmental factors, and therefore, it is important that a full personal and work history is taken within primary care when a patient presents with breathing problems. In addition, it is also important to ensure that the population are aware of the potential risks so that those who may be in higher risk groups, coal workers, farmers etc. are aware of possible signs and symptoms and encouraged to present early to health services.

Obstructive Sleep Apnoea (OSA)

Due to the risk factors and profile of those who develop OSA, it is possible to predict the likely proportion of a local population who are likely to have OSA. Based on the British Lung Foundation OSA calculator, 1328 people (1.06% of the population) will have OSA. By assessing predicted rates within a population, against known rates, it would possible to identify how many people are likely to have the condition, but remain undiagnosed. However, there are no accurate data on the actual local prevalence of OSA. Locally we need to ensure that we are aware of the population rates of OSA.

The British Lung Foundation estimates that cost of not treating all those with moderate to severe OSA will cost the local health and social care economy will be over £109,000 more per year than the cost of actually treating all people with moderate to severe OSA. In addition, identifying and treating all those with moderate to severe OSA could prevent 157 road traffic accidents every year.

People with symptoms, abnormal tests or screening results should have these addressed locally and/or where appropriate, should be referred for further assessment and management when lung disease is suspected or confirmed.

Spirometry, oxygen saturation measurement and chest radiology are important investigations widely available in both primary and secondary care practice. They can be used to identify at risk groups within case finding strategies which can be most effectively undertaken in local community settings and we must ensure that local spirometry services are robust and accessible.

People with Learning Disability

The Confidential Inquiry into the Premature Death of People with Learning Disability found the most prevalent immediate cause of death in people with learning disabilities was respiratory disorders, followed by heart and circulatory disorders. The report highlights that these deaths are most likely to be amenable to health care interventions. The most common respiratory illness associated with premature death in people with Learning Disability was usually pneumonia.[17]

15.5% of the general population develop respiratory disease and 17% of those die from it. By comparison, 19.8% of people with a learning disability develop the disease but about 50% of these die from it.

Actions for early detection

Cancer

● Ensure that increase the number of appropriate 2 week wait referrers to increase early diagnosis and enable early treatment of lung cancer

● Expand the Get Checked campaign to further increase awareness of signs, symptoms and encourage early presentation for lung cancer.

COPD

● Encourage improved and early case finding to facilitate better management and treatment access

● Develop and implement a Borough wide, inclusive community spirometry service

ILD

● Ensure risk markers are identified on patient records, known risk occupations etc

OSA

● Improve mechanisms for case finding, including access to spirometry and diagnostic tools to ensure rapid access to treatment and management

People with Learning Disability

● Adults with learning disability should be considered a high risk group for deaths from respiratory problems, screening and risk assessment should be included as part of the annual health check for patients with a learning disability.

● People with learning disability should be regarded as a high risk group for the purpose of seasonal flu and pneumonia vaccination programmes even if they do not live in a residential care setting.

[17] Confidential Inquiry into premature deaths of people wioth Learning Disability (CIPOLD) 2013 http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

XI. Primary Care and Community based support

In Halton

- GP practices perform slightly better than the England average for all but 1 clinical indicator for asthma
- GP practices perform slightly better than the England average for all but 1 clinical indicator for COPD
- There is a higher rate of emergency admissions for bronchiolitis than the England average.

Conditions affecting respiratory health are numerous, varied and often complex, requiring a multidisciplinary approach to identification and management offered by many different providers. The route of these approaches invariably lies within primary care. Ensuring that primary care, and the community health approaches are robust and effective will improve outcomes for patients and minimise the health system burden resulting from respiratory ill health.

There are a number of lung conditions where improvements in the delivery of effective primary care and community support care can result in high impact changes to the respiratory health of people in Halton.

Asthma

Asthma is a condition that can affect people of any age. It is an important factor in repeated respiratory infections in children and causes breathlessness in adults. If undiagnosed or inadequately treated it can in the short-term lead to potentially life-threatening exacerbations and in the long-term to irreversible damage to the lungs.

To ensure high quality diagnosis and treatment, it is key that appropriate services are commissioned that enable all practitioners and services to meet the NICE Quality Standards 25 for asthma. The 10 quality statements which will improve care and treatment for people with asthma are:

Statement 1	People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance.
Statement 2	Adults with new onset asthma are assessed for occupational causes.
Statement 3	People with asthma receive a written personalised action plan.

Statement 4	People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.
Statement 5	People with asthma receive a structured review at least annually.
Statement 6	People with asthma who present with respiratory symptoms receive an assessment of their asthma control.
Statement 7	People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.
Statement 8	People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation.
Statement 9	People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.
Statement 10	People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment.
Statement 11	People with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service.

Most people with asthma are managed within primary care. However, some people will require hospital admission. In some instances, increased hospital admissions may result for poor management of the condition which can result in inadequate response and management of exacerbations.

The GP contract requires that practices closely monitor diagnosis, assessment of control and smoking status in young people. For 2012/13, **figure 4** shows that Halton Practices performed better than the England average for asthma diagnosis and assessments of control, but below the national average for recording of smoking status.

Figure 4: Achievement against asthma clinical indicators, 2012/13

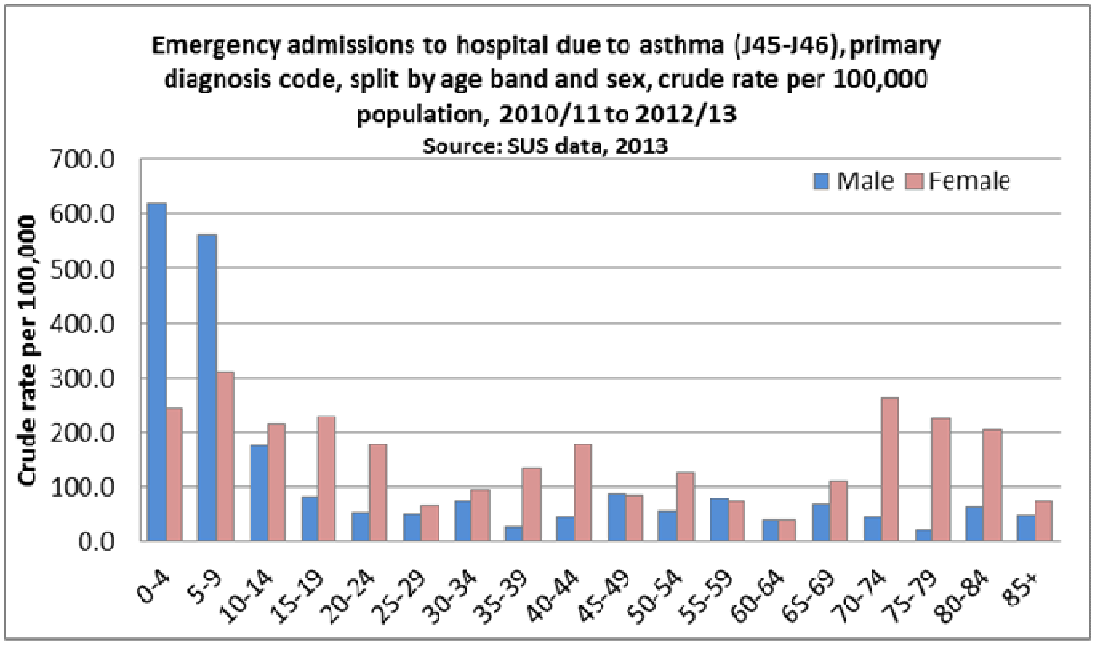
Practice Code	Practice Name	ASTHMA08	ASTHMA09	ASTHMA10
N81011	Beaconsfield	82.6%	79.3%	85.1%
N81019	Castlefields	95.9%	73.4%	87.5%
N81035	Appleton Village	83.1%	71.1%	100.0%
N81037	Beeches	85.5%	62.3%	75.6%

N81045	Peelhouse	89.0%	78.9%	89.4%
N81054	Weaver Vale	94.9%	81.9%	86.8%
N81057	Tower House	97.5%	90.7%	95.7%
N81064	Newtown	82.2%	78.0%	88.5%
N81066	Grove House	95.6%	74.5%	85.5%
N81072	Murdishaw	94.4%	77.2%	87.5%
N81096	Brookvale	81.9%	76.7%	87.5%
N81119	Hough Green	98.1%	74.2%	100.0%
N81618	Heath Road	91.9%	62.1%	100.0%
N81619	Oaks Place	94.0%	75.0%	90.0%
N81625	West Bank	91.4%	89.4%	84.6%
N81651	Upton Rocks	82.8%	78.3%	100.0%
Y02512	Windmill Hill	87.5%	77.9%	83.3%
Halton CCG		**90.5%**	**76.1%**	**88.9%**
Merseyside Area Team		**87.4%**	**76.4%**	**90.6%**
North of England		**87.8%**	**75.4%**	**89.6%**
England		**87.6%**	**74.8%**	**89.3%**

ASTHMA08: The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility
ASTHMA09: The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions
ASTHMA10: The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months

Effective primary care and case management is key to preventing exacerbations and preventing hospital admissions. **Figure 5** shows that the highest rate of admissions is for the 0-9 age groups, this could be admissions as a result of first diagnosis or where management systems are not yet in place, however, for older age group, effective management is more likely to be in place and close monitoring and engagement with primary care and community could potentially reduce emergency admissions.

Figure 5: shows the emergency admissions by age group for Asthma from 2010/11 to 2012/13.



Smoking cessation is an important part of ensuring good respiratory health, for people with asthma (and COPD) it is even more vital that they receive high level support to quit smoking to improve treatment out comes and limit potential serious exacerbations. All people who are on the asthma (and COPD) registers in practice should also have smoking status recorded, and regular (repeated as necessary) offers to engage with smoking cessation services. Encouraging practices to benchmark smoking status and set reduction targets for smoking in these practice populations can have a significant effect on ongoing symptom management.

COPD

COPD is a chronic progressive disease of the airways associated with high morbidity and mortality. It is largely managed in primary care but exacerbations of symptoms often result in acute admission to hospital. Patient and community support groups can improve quality of life for patients living with COPD. Secondary care is involved with providing increasingly more complex interventions such as domiciliary ventilation and assessment for referral to thoracic surgery. As the disease progresses, accessing palliative care services can improve the quality of life of patients with advanced disease.

Adherence to evidence-based guidelines, regular review in primary care, self-management initiatives, long-term oxygen therapy and pulmonary rehabilitation programmes (PRP) can all improve quality of life and reduce hospital admission.

Non-invasive ventilation is cost effective and improves outcomes for selected patients. Optimisation and full integration of COPD care following discharge from hospital improves life for the patient and reduces re-admission rates.

NICE COPD Quality Standards 10 identifies 13 key statements that will improve care and management for patients with COPD, that we must endure appropriate services are commissioned locally and that clinicians are able to meet these standards to maximise care and treatment for COPD patients in Halton. The statements are:

Statement 1	People with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.
Statement 2	People with COPD have a current individualised comprehensive management plan, which includes high-quality information and educational material about the condition and its management, relevant to the stage of disease.
Statement 3	People with COPD are offered inhaled and oral therapies, in accordance with NICE guidance, as part of an individualised comprehensive management plan.
Statement 4	People with COPD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness, frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and comorbidities.
Statement 5	People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.
Statement 6	People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.
Statement 7	People who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.
Statement 8	People with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.
Statement 9	People with COPD receiving long-term oxygen therapy are reviewed in accordance with NICE guidance, at least annually, by a specialist

oxygen service as part of the integrated clinical management of their COPD.

Statement 10 People admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.

Statement 11 People admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.

Statement 12 People admitted to hospital with an exacerbation of COPD are reviewed within 2 weeks of discharge.

Statement 13 People with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.

The GP contract requires practices to manage patients in line with best practice. For COPD this relates to diagnosis, recording of FEV1 (maximal amount of air you can forcefully exhale in one second), influenza vaccination and an assessment of the level of breathlessness a patient is experiencing. For 2012/13, Halton practices showed better than the national average performance on all but one factor. The percentage of COPD patients who received a flu vaccination was below the England average (**Figure 6**).

Figure 6: Achievement against COPD clinical indicators, 2012/13

Practice Code	Practice Name	COPD08	COPD10	COPD13	COPD15
N81011	Beaconsfield	96.9%	89.4%	92.1%	100.0%
N81019	Castlefields	96.6%	87.6%	96.4%	97.2%
N81035	Appleton Village	88.9%	80.5%	97.0%	97.2%
N81037	Beeches	97.1%	85.0%	90.8%	90.0%
N81045	Peelhouse	93.0%	90.0%	91.3%	86.2%
N81054	Weaver Vale	87.4%	95.1%	93.3%	90.0%
N81057	Tower House	97.4%	98.4%	98.6%	100.0%
N81064	Newtown	31.9%	88.1%	96.0%	91.7%
N81066	Grove House	90.6%	93.2%	91.1%	87.5%

N81072	Murdishaw	94.0%	89.1%	97.4%	98.8%
N81096	Brookvale	96.3%	80.9%	90.1%	90.9%
N81119	Hough Green	81.5%	93.9%	94.6%	88.9%
N81618	Heath Road	92.7%	95.1%	95.0%	88.9%
N81619	Oaks Place	94.9%	94.0%	92.0%	85.7%
N81625	West Bank	94.5%	95.6%	97.1%	85.7%
N81651	Upton Rocks	97.6%	92.7%	93.0%	83.3%
Y02512	Windmill Hill	85.7%	87.5%	92.5%	100.0%
Halton CCG		**89.8%**	**89.4%**	**94.2%**	**93.6%**
Merseyside Area Team		**92.4%**	**82.8%**	**91.0%**	**92.0%**
North of England		**92.7%**	**87.9%**	**91.1%**	**91.3%**
England		**92.7%**	**88.4%**	**91.1%**	**91.3%**

COPD08: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March
COPD10: The percentage of patients with COPD with a record of FEV1 in the preceding 15 months
COPD13: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months
COPD15: The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry

COPD is a rare condition before the age of 40. Most people who develop the condition are managed within primary care. However, some people will develop exacerbations of the condition or they may be undiagnosed, which can result in an emergency (unplanned) admission to hospital. **Figure 7** shows the data for 2010/11 to 2012/13 which show that admissions rise from the age 45 onwards for both males and females but that the rate of admissions is generally higher for men than for women.

A number of people with COPD are admitted on more than one occasion during a single year. Research suggests that there are nearly half a million 'frequent flyers' in the United Kingdom and that they cost the health service approximately £2.3 billion a year (2003-4 figures). Assessing the numbers of re-admissions or frequent flyers, does not indicate that the hospital admissions are unnecessary, but we need to

understand the data to ensure that primary care and patient management are maximised to prevent these repeated admissions.

Figure 7: Emergency admissions due to COPD for 2010/2011 to 2012/13

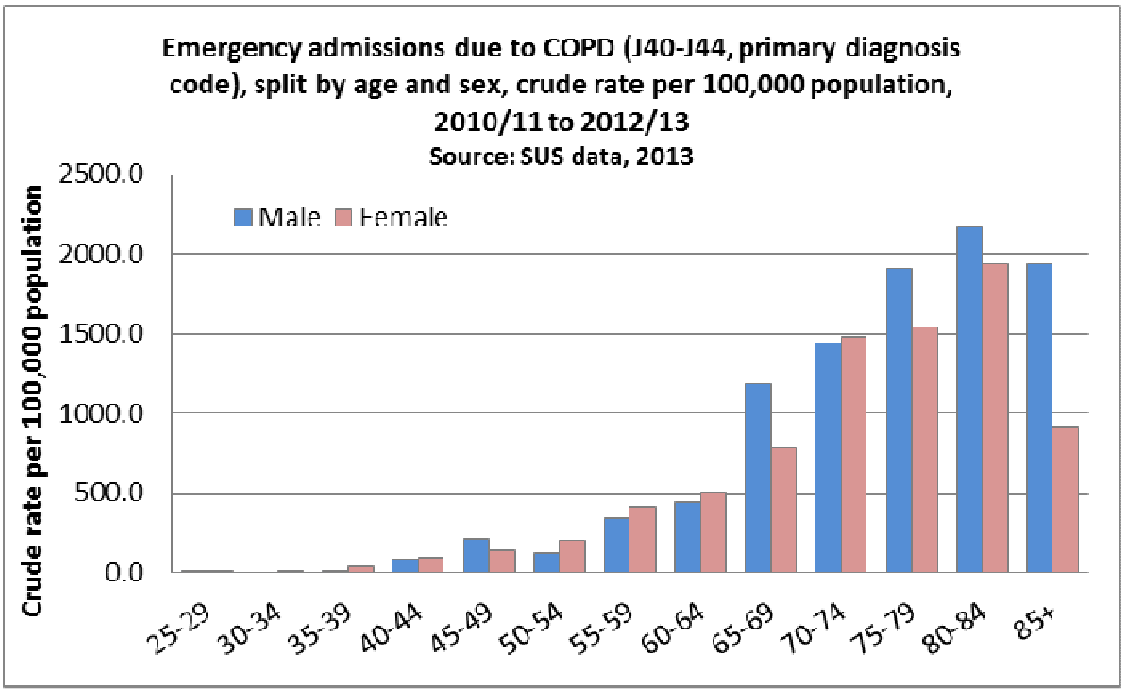
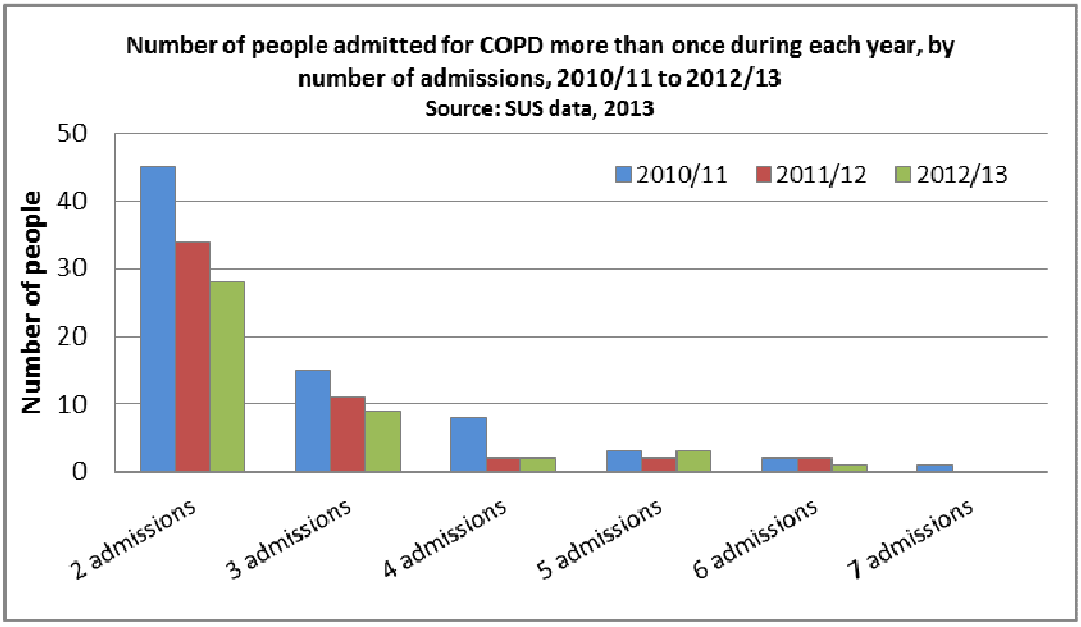


Figure 8 shows the number of patients admitted more than once during a year from 2010/11 to 2012/13. In Halton, most people who were admitted more than once were admitted either 2 or 3 times, with very few people being admitted more than this.

Figure 8: Number of people admitted for COPD more than once in a year



During 2012/13 there were over 100 readmissions due to COPD, however, the number, and percentage of total COPD admissions, has decreased from 2010/11.

	2010/11	2011/12	2012/13
Total number of admissions	452	331	358
Number of readmissions	201	131	112
Percent	44.5%	39.6%	31.3%

Halton Rapid Response Respiratory Team provide services for patients with respiratory illness in the Halton area, assessing conditions such as COPD, asthma, pneumonia, bronchiectasis, interstitial lung disease and lung cancer. The team also has expertise in non-invasive ventilation (NIV) to help support patients with neuromuscular disease, chest wall deformity and OSA. It provides an accessible and responsive service that strives to deliver the highest standards of care possible, to patients with respiratory illness.

Halton Rapid Response Respiratory Team

About this service

The Team offer an award winning service for patients with respiratory illness in the Halton area, assessing conditions such as COPD, asthma, pneumonia, bronchiectasis, interstitial lung disease and lung cancer. The team also has expertise in non-invasive ventilation (NIV) to help support patients with neuromuscular disease, chest wall deformity and obstructive sleep apnoea.

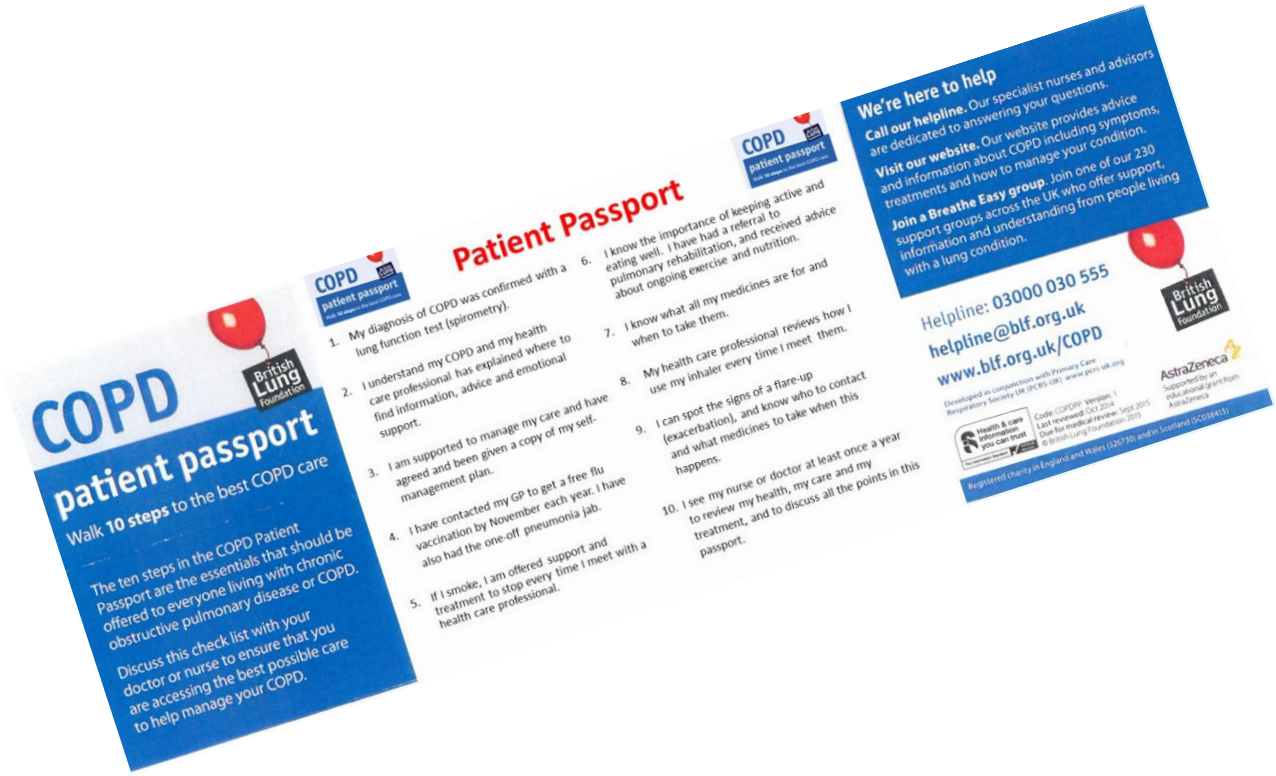
The Team aim is to provide an accessible and responsive service that strives to deliver the highest standards of care possible, to patients with respiratory illness.

The team can be accessed by referral from the GP or hospital and will undertake an assessment to of what you need. Available services and information include:

- Respiratory assessment in your own home
- Pulmonary Rehabilitation
- Long-term Oxygen Therapy
- Ambulatory Oxygen clinics
- Nurse Led Clinics
- Physiotherapy led clinics

Patients are referred to the team either by the GP or the hospital with an aim to seeing each patient the same day or within 24 hours for advice, assessment, support, intervention and supported discharge.

British Lung Foundation's COPD Patient Passport, available through practices and Breathe Easy Groups, helps patients with COPD identify if they are getting the right care and support.



Bronchiectasis

Bronchiectasis is a condition characterised by chronic sputum production and a increased likelihood of developing frequent lung infections, often requiring hospital admission.

There is often pre-existing COPD. People with a suspected diagnosis of bronchiectasis should have the diagnosis confirmed by chest CT (computed tomography).

There has been a steady rise in the number of emergency admissions involving bronchiectasis over the last few years, from 62 in 2011/12, 92 in 2012/13 to 121 in 2013/14. The causes of this are unknown. Primary care management of patients and early identification and treatment of infections could prevent admissions. Physiotherapy has a major role in the management of bronchiectasis and self-help to enable patients to manage signs and symptoms better, helping to reduce infections and hospital admissions.

Halton Oxygen Assessment Service for Long Term Oxygen Therapy

Halton oxygen assessment service was formed in January 2009, following the introduction of the NICE COPD guidelines which recommended that all oxygen assessments should be completed in secondary care.

The service is run by **Senior Respiratory Nurse Specialists**. Our service is based with the Respiratory team at Halton General Hospital in block 4. Our working hours are **Monday-Friday 8.30am to 6.30pm,** our direct telephone number during these hours is **01928 753165.** We are also available on **Bank Holidays** and **weekends** from **8.30am to 6.30pm** on **01928 714567** - please ask for on call staff.

Our initial aim is to provide an up to date assessment for the people who are already on oxygen therapy so that they know what their oxygen needs are. As the service becomes more established and more funding becomes available we are hoping to expand the service and take open referrals. At this time we are limited to completing assessments on individuals with respiratory diseases, unfortunately there is no capacity for the assessment of cardiac related breathlessness at this time.

Referral criteria: Individuals should be considered for oxygen assessment if their oxygen saturations are <92% at rest on room air. To complete the oxygen assessment the individual needs to be stable (i.e. 6 weeks post exacerbation/chest infection).

Interstitial Lung Disease

Interstitial Lung Diseases (ILD) comprises a large number (over 150) of diverse conditions which primarily affect the lung's smallest airways and alveolar air sacs. Whilst the cause of some ILDs is unknown, there is an overlap with occupational and environmental lung diseases such as Coal and Slate workers' pneumoconiosis, asbestosis and Farmer's lung. It is known that some ILDs are caused by cigarette smoke and others may occur as a reaction to medication and yet others occur in association with diseases such as rheumatoid arthritis. Finally, ILDs need to be distinguished from other lung conditions which they sometimes mimic.

Idiopathic pulmonary fibrosis (IPF), the commonest ILD, has shown a greatly increased prevalence over the past 20 years although local prevalence data is not easy to determine as a result of the range of conditions that could be included under the ILD definition.

NICE Quality Standard 79 identifies the set of 5 key statements which will improve the quality and standard for care for people with ILD, these should be adopted locally to ensure best quality of care for patients in Halton.

Statement 1	People are diagnosed with idiopathic pulmonary fibrosis only with the consensus of a multidisciplinary team with expertise in interstitial lung disease.
Statement 2	People with idiopathic pulmonary fibrosis have an interstitial lung disease specialist nurse available to them.
Statement 3	People with idiopathic pulmonary fibrosis have an assessment for home and ambulatory oxygen therapy at each follow up appointment

	and before they leave hospital following an exacerbation of the disease.
Statement 4	Pulmonary rehabilitation programmes provide services that are designed specifically for idiopathic pulmonary fibrosis.
Statement 5	People with idiopathic pulmonary fibrosis and their families and carers have access to services that meet their palliative care needs.

Hospital admissions for ILD increase with age. **Figure 9** shows the admissions per 5 year age group for the period 2011/12 to 2013/14. The higher rates of admission amongst men are likely to reflect the work related nature of some forms of ILD, but the crude rates represent a significant burden on secondary care capacity.

The number of emergency admissions per year for ILD (**Figure 10**) has increased in the last few years. An assessment is needed to identify if this increase is as a result of increasing prevalence. There is also a need to assess if community and primary care management and services achieve quality standards locally to prevent emergency admissions.

Figure 9: Admissions by 5 year age band and sex, 2011/12 to 2013/14

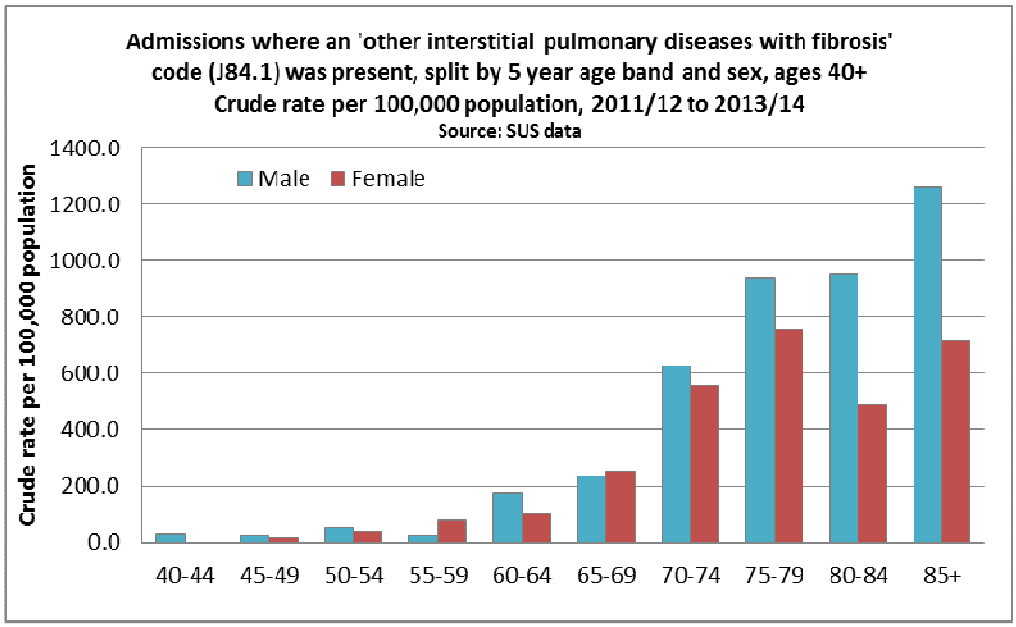


Figure 10: Number of admissions by year

Year	Elective	Emergency
2011/12	31	68
2012/13	33	95
2013/14	21	150

The median survival for IPF is just three years – a prognosis that is worse than many cancers. Lung transplantation is the only treatment proven to improve survival in some forms of ILD.

Ambulatory oxygen therapy (AOT) assessment

AOT allows the patient to leave the home and improves daily activities and quality of life.

The purpose of a formal **AOT assessment** is to:

1. Determine if the patient has evidence of exercise desaturation, which is defined as a 4% drop in SaO2 below 90%.
2. To determine the appropriate flow rate to correct exercise desaturation.
3. To see if an oxygen conserving device is appropriate for that particular patient

Who qualifies for AOT?

Ambulatory Oxygen only indicated in a number of conditions. There are 3 grades of patients who qualify for AOT.

- **Group 1**. On Long Term Oxygen Therapy with low activity level. This group **do not** usually require a **formal** AOT assessment. There flow rate is usually set to their Long Term Oxygen Therapy flow rate.

- **Group 2**. On Long Term Oxygen Therapy but are active.

- **Group 3**. Not on Long Term Oxygen Therapy but demonstrate exercise oxygen desaturation. In this group AOT should be considered only if there is evidence of improvement in exercise tolerance and dyspnoea and the Patient is motivated to use it.

Sleep-Disordered Breathing

Identification and diagnosis of Obstructive Sleep Apnoea is a key challenge. Once diagnoses has been made promotion and provision of lifestyle advice including assessment of weight and measures of obesity, with primary care support and access to community weight management service, smoking cessation and exercise provides a primary approach to reduction in symptoms. Halton Health Improvement Team are able to provide a wide range of lifestyle interventions which would improve outcomes for people with OSA, from diet and exercise based weight management to smoking cessation services and can receive referrals directly from primary care.

Bronchiolitis

Bronchiolitis usually presents with cough with increased work of breathing and it often affects a child's ability to feed. Symptoms are usually mild and might only last for a few days, but in some cases the disease can cause severe illness. There are several individual and environmental risk factors that can put children with bronchiolitis at increased risk of severe illness.

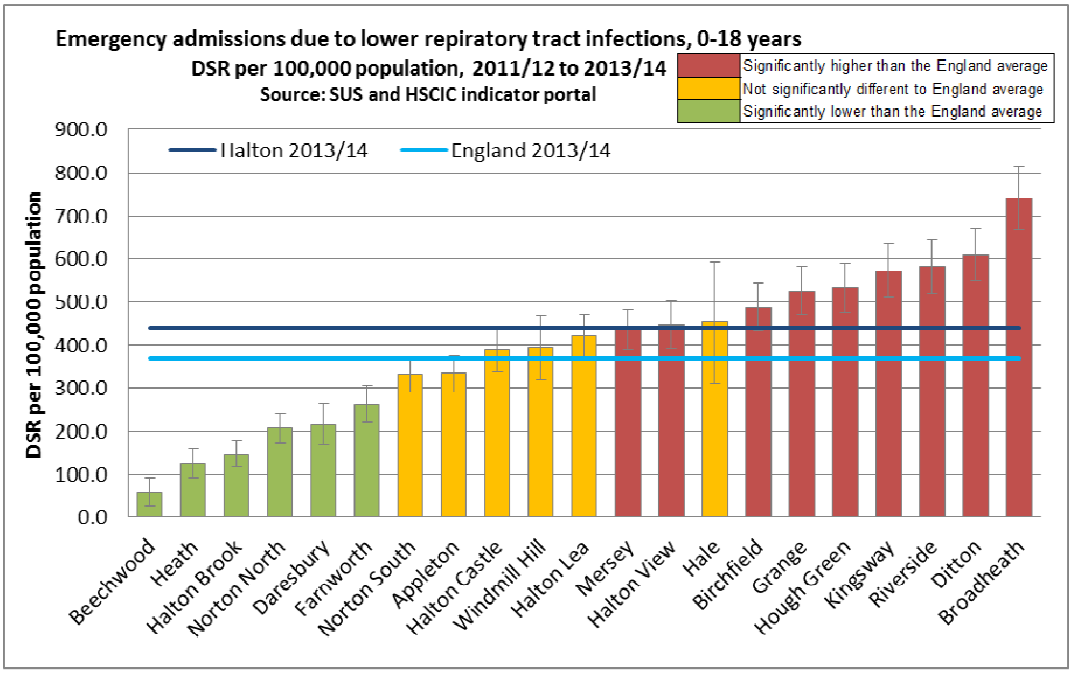
Most children with bronchiolitis present in primary care to a GP. The diagnosis of bronchiolitis is based on clinical assessment showing the presence of various characteristic symptoms and signs. Although bronchiolitis can usually be managed at home, approximately 3% of affected children are admitted to hospital. In 2011/2012 in England there were 30,451 secondary care admissions for the management of bronchiolitis.

The management of bronchiolitis depends on the severity of the illness. In most children bronchiolitis can be managed at home by parents or carers. In mild or moderate cases treatments that improve feeding and reduce the work of breathing could be beneficial. A range of treatments have been trialled, including: inhaled bronchodilators; inhaled corticosteroids; systemic corticosteroids; antibiotics.

Children in Halton are admitted as an emergency admission for lower respiratory tract infections (of which bronchiolitis is the most common) at a higher rate than the England average, and there is significant variation in the rate of admission across different wards within the Borough, which suggests that there could potentially be variations in the primary care management for children with respiratory infections. **Figure 11** shows the variation in emergency admission rate for lower respiratory tract infections for 0-18 year olds between 2011/12 to 2013/14 by ward across Halton. There is little correlation between the variations and the levels of local deprivation, or known lifestyle factors to explain the pattern in variation, which could suggest a potential primary care link (although the data is not presented by practice)

There are 6 wards with significantly higher admission rate for lower respiratory tract infections than the Halton average, and 9 wards are significantly higher than the England average emergency admission rate. During 2011/12 to 2013/14, 81.5% of all emergency admissions in Halton for lower respiratory tract infections were for children under 1 year of age, 79% of these were for acute bronchiolitis; for the rest of England this was 70%.

Figure 11: Emergency Admission due to lower respiratory tract infection in children 2011/12 to 2013/14



NICE are due to publish Guidance for the Diagnosis and Management of Bronchiolitis in Children in May 2015. This guidance needs to be assessed against local services provision and pathways to ensure that local case management and care follow the best practice guidance.

Actions for Primary Care and community based support

General

- Ensure the NICE Guidance and Quality Standards compliance in the recognition, diagnosis and management of respiratory illness and ensure best practice service commissioning.
- Pro Active Care programme Local Enhanced Service (2014/15)
- Review provision of pulmonary rehabilitation across Halton
- Establish integrated delivery of respiratory services across Halton
- Improve prescribing of respiratory medication across primary care

Asthma and COPD

- Implement standardised COPD and Asthma template across primary and secondary case
- Practices to benchmark recording of smoking status for patients on the COPD and asthma registers and set local reduction targets.

● Every patient diagnosed with asthma to receive a personalised action plan and annual review.

ILD

● Recording of occupation, particularly for risk occupations, on primary care records and identify those at possible risk of ILD to red flag early warning signs and symptoms.

OSA

● Maximise case finding against OSA predictor calculator and ensure rapid access to diagnostics.

● Review the pathway for people with OSA

Bronchiolitis

● Rapid review (and application) of NICE Guidance when it is released in May 2015

● Review cause for practice variations in admissions for bronchiolitis across Halton practices

iii. High Quality Hospital Services

Conditions that affect respiratory health are numerous. They are often varied and often complex and need a multidisciplinary approach to treatment and management. In terms of ensuring appropriate high quality hospital services are available, this document will identify were improvements in the delivery can result in high impact changes for respiratory health conditions.

Nurse Led Clinic

The **respiratory nurses** at Halton and Warrington Hospitals run nurse led clinics. These are done in conjunction with **Respiratory Consultants** and are in parallel to their clinics. If the nurse feels the patient is not responding to treatment or needs further advice, they can discuss the patient with the consultant.

Types of patients seen in the clinics are;

- Medication review and optimisation of medication
- Trial of nebuliser
- Post discharge
- To review pulmonary function tests
- To review post discharge
- Review medication change
- To assist in diagnosis, such as asthma
- General monitoring of patients
- Prior to pulmonary rehabilitation
- Following pulmonary rehabilitation
- Following rapid response respiratory team input
- Request from consultant
- GP requests

The clinics run on **Tuesday mornings**, in the Delemere Centre, Halton and **Thursday afternoons**, clinic A, Halton. **Monday afternoon**, OPD clinic Warrington.

Patients can be referred to the clinic by letter to the respiratory nurse, Block 4, Halton General Hospital or respiratory support team, A7/A8 corridor, Warrington Hospital.

Patients cannot self-refer to the clinic, this must be done by a health professional.

Asthma

Asthma is a condition that can affect people of any age. It is an important factor in repeated respiratory infections in children and causes breathlessness in adults. If undiagnosed or inadequately treated it can worsen and in the short-term lead to potentially life threatening symptoms, but in the longer term can lead to irreversible damage to the lungs

Once a diagnosis of asthma has been achieved, information about asthma which is relevant, easy to understand and in an accessible format should be provided to the patient and their family. Those diagnosed should all be provided with an individual asthma management plan including relevant contacts and what to do in the event that their asthma becomes uncontrolled, including training in inhaler technique to support effective self-management strategies for the condition. All patients with asthma will receive treatment appropriate to the severity of their Illness.

With regard to children there is a multidisciplinary asthma pathway in place at St Helens & Knowsley Acute Hospital Trust for children who present at A&E, which incorporates issuing of self-management plans. Follow ups take place with the GP. At Warrington & Halton Hospitals Foundation Trust there is a similar A&E Pathway, which incorporates issuing of an Asthma/Wheeze Management Plan. Follow ups take place in an asthma clinic at Springfield Medical. Asthma UK self-management plans have also been made available to all GP practices for use in annual reviews to ensure those children who do not attend secondary care services also have the choice for robust self- management.

COPD

COPD is largely managed in primary care but exacerbations of symptoms often result in acute admission to hospital. Patient support groups can improve quality of life for patients living with COPD. Secondary care is involved with providing increasingly more complex interventions such as domiciliary ventilation and assessment for referral to thoracic surgery.

As the disease progresses, accessing palliative care services can improve the quality of life of patients with advanced disease. Adherence to evidence-based guidelines, regular review in primary care, self-management initiatives, long-term oxygen therapy and pulmonary rehabilitation programmes (PRP) can all improve quality of life and reduce hospital admission. Optimisation and full integration of COPD care following discharge from hospital improves life for the patient and reduces re-admission rates.

Lung Cancer

Liverpool Heart and Chest Hospital is the local specialist unit for Lung Cancer. It is essential that decisions are made efficiently as a patient identified in primary care, or via a local hospital will often need to be referred to a different provider for specialist treatment.

Timeliness of referrals between trusts for cancer treatments is monitored on a regular basis in line with national cancer waiting time targets. This process allows the identification of any recurrent issues in relation to cancer pathways and allows multidisciplinary discussion to take place to work towards improving them.

From April 2013, diagnostic imaging has been unbundled from the Outpatient tariff (PbR Guidance 13/14), which includes; Magnetic resonance imaging (MRI) scans, Computerised tomography scans (CT), Dexa scans, Contrast fluoroscopy procedures, Non-obstetric ultrasounds, Nuclear medicine and simple echocardiograms. There is local commitment (from the CCG) to working with healthcare providers to explore options for direct access, in particularly direct GP access to diagnostics that will aid with the diagnosis of lung cancer including MRI, ultrasound and chest X-Ray.

Acute respiratory illness

Acute respiratory illnesses are common and include community-acquired pneumonia, acute exacerbations of COPD, asthma attacks and a number of less common conditions. Together these represent a major demand on primary and particularly hospital care.

We need to ensure that we have adequate primary and community provision in place so that we can maximise admission avoidance wherever possible and ensure people can be treated successfully in the community and at home. From secondary care, we need to ensure that early assessment and discharge schemes can be effectively utilised to reduce delays in effective treatment and subsequently the length of hospital stay, thus optimising the use of hospital beds and reducing the considerable costs of such conditions.

Actions for High Quality Hospital Services

General

- Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
- Review current arrangements regarding Halton adult residents admitted to Whiston Hospital with respiratory health problems

- Review current arrangements regarding Halton children & young people admitted to Halton and Warrington Hospitals and ST Helens and Knowlsey Hospitals with respiratory health problems
- Ensure the NICE Guidance and Quality Standards compliance in the treatment and secondary care management of respiratory illness and ensure best practice service commissioning.

iv. Promoting Self Care and Independence

Improving health outcomes for people with respiratory disease not only requires appropriate medical interventions but also enhanced communication, knowledge, skills, and the development of a therapeutic alliance between the patients and the healthcare professional. All patients with respiratory disease and/or their carers should strive to become better informed. Every effort should be made to equip patients, carers and families with the necessary knowledge and skills to improve decision making and thereby improve outcomes.

Education is key to improving awareness of respiratory disorders and associated symptoms, helping achieve an earlier diagnosis and improved self-management.

Having confident and informed respiratory patients at the centre of the decision-making processes will allow them to take ownership of their conditions leading to fewer unplanned primary care consultations, reductions in visits to outpatient departments, reduced hospital admissions and reduced length of stays in hospital.

Individuals with chronic lung disease benefit greatly from a multidisciplinary approach to care and gain the most benefit from this care if delivered in the community, closer to home. This ensures that individuals have two key elements of care: physical and psychological support. These are important, when living with such chronic disease, to help the individual cope with distressing symptoms such as breathlessness, as well as ensuring that respiratory infections are treated earlier to prevent worsening structural damage to the lungs. Professionals involved in supporting individuals with respiratory conditions should be trained in techniques which build self-sufficiency in their clients and address health related behaviours such as smoking and obesity. Pulmonary rehabilitation provides many aspects of this care and should be available locally for all patients with chronic lung disease.

Pulmonary Rehabilitation

Pulmonary rehabilitation is a programme of exercise and education for people with long-term chest problems designed to help patients manage breathlessness due to respiratory conditions. Pulmonary rehabilitation aims to improve patients' exercise tolerance, quality of life, and reduce breathlessness. The service in Halton is provided by Warrington and Halton NHS Foundation Trust’s Rapid Respiratory Team. The programme runs twice weekly for 6 weeks. Each session comprises of 1 hour of individualised exercise and 1 hour of education. Each person receives a resource pack on completion with all aspects of education topics included and encouragement for people to continue with exercises at home after they have completed the course in order to maintain the benefits it produces. There are a number of ongoing exercise classes arranged for pulmonary rehabilitation patients the Halton Health Improvement Team.

- Between March 2012 and December 2013, 420 patients attended Pulmonary Rehabilitation in Halton. 69% at Halton Hospital and 31% at Ditton Community Centre.
- The largest referrers were GPs, Respiratory Consultant (Halton) and respiratory physiotherapists. Of the GPs, Castlefields, Weavervale and Grove House referred the most patients.
- Of those that attended; 171 patients completed at least 9 of the 12 sessions, 64 patients partially completed (<9 sessions), 49 did not attend and 101 were unable to attend due to illness.
- As of June 2015 there were 22 people waiting for an appointment for assessment with a waiting time to assessment of 10 weeks. The service currently sees around 17% of people with respiratory illnesses.

Pulmonary rehabilitation

The programme

Pulmonary rehabilitation is an exercise and educational programme designed to help patients manage breathlessness due to respiratory conditions such as COPD. Pulmonary rehabilitation aims to improve patients' exercise tolerance, quality of life, and reduce breathlessness. For more detailed information about pulmonary rehabilitation there are links to the NHS Choices and British Lung Foundation Websites below.

We run a six-week programme which patients attend twice weekly for two hours. Classes will run every Monday and Friday in Runcorn and Tuesday and Thursday in Widnes.

Pulmonary rehabilitation is available both in Widnes and Runcorn; all sessions are in the afternoon.

Who should be referred?

Patients with a diagnosed respiratory condition with symptomatic breathlessness do well on this course.

Expert Patient programme

The Expert Patients Programme (EPP) is a self-management programme for people living with a chronic (long-term) condition. The aim is to support people by:

- increasing their confidence

- improving their quality of life
- helping them manage their condition more effectively

Local Authority Public Health have just commissioned an extension of the Expert patient programme which will encourage people to live healthy active lives, better manager their own conditions and be able to be more involved in decision making around their care.

Asthma

The children's multidisciplinary asthma pathway at St Helens and Knowsley Acute Trust and Warrington & Halton Hospitals Foundation Trust for children presenting at A&E incorporates self-management plans and guidance on self-care. School nurses also signpost parents/carers to access their GP/Practice nurse for appropriate asthma management as necessary.

Lung cancer

The Runcorn and Widnes Cancer Support Group has been providing numerous support services for a number of years ranging from basic information, to caravan breaks, it offers support and information on the whole range of cancers including lung cancer. Funding for the service has been agreed collaboratively between the CCG, Halton Borough Council and Public Health going forward and the service will continue to receive referrals from a variety of health professionals across the locality including GP's and social services and explore ways to raise awareness of the service across Halton.

Integrated Breathe Easy Project

The British Lung Foundation's Nesta-funded 'Integrated Breathe Easy project' aims to increase self-care opportunities for people affected by respiratory illness. Halton Clinical Commissioning Group is working in partnership with BLF to support the development of two new groups (Widnes and Runcorn). The groups provide peer support and access to a wide range of information that enhances and supports wellbeing. The groups are part of a national project seeking to establish the value of group-delivered self-care due to report in June 2016.

Breathe Easy Widnes	**Breathe Easy Runcorn**
Where: Ditton Community Centre, Dundalk Road, Widnes, WA8 8DF **Date:** First Tuesday of each month **Time:** 12.30pm to 2pm	**Where:** Palacefields Community Centre, The Uplands, Runcorn, WA7 2UA **Date:** Second Wednesday of each month **Time:** 12.00pm to 1.30pm

Patients, Friends, family or carers are welcome to just turn up
There is usually a respiratory healthcare professional in attendance

Breathe Easy groups provide support and information for people living with a lung condition, and for those who look after them.

Groups hold regular meetings, usually monthly, where people can meet and talk to others, share their experiences and learn from each other. Regular speakers can also share information about living with their condition and coping with the emotional aspects of having a lung condition.

They also raise awareness locally about lung conditions, their group and the BLF.

Breathe Easy Case study

"When I returned from Australia I found that I was unable to walk my dogs, walk up slopes or even bend down without getting out of breath. I then caught flu which also affected my chest quite badly. I visited my practice nurse who gave me spirometry and informed me my lung age was 80. I was prescribed an inhaler and told to come back in 4 weeks. My flu got worse. Two weeks later I collapsed and ended up in hospital. I was prescribed antibiotics. I felt down as I used to be so active. Four weeks later when I saw my nurse again she gave me the BLF COPD leaflet and told me that I had COPD. I went home and cried and felt really down again. I read the leaflet which really helped but I still felt panicky. I then went on to the BLF website and found out that there was a Breathe Easy group in Runcorn and the next meeting was imminent. I went along to the Breathe Easy group meeting and haven't looked back. I found BLF information including the BLF COPD passport available and it was so good to meet and chat to other members who have the same condition as me. They gave me advice and tips at that meeting. I took a copy of the COPD passport away and went with my daughter to see my GP who went through each step and explained what it meant. At the next Breathe Easy meeting the community respiratory nurse talked to us about inhalers and inhaler technique. I realised that I had been using mine incorrectly and the nurse showed me how to use it properly. When I visit the chemist they sometimes call me in to ask me about my medications and I had been prescribed a new inhaler. We tried to work out how to use it but I realised that I had been using it incorrectly until the nurse showed me at the Breathe Easy meeting. Next time I am at the chemist I am going to tell them the correct way. I am also waiting to go on a course of pulmonary rehabilitation which I am looking forward to. Sometimes I still feel down but I can honestly say that since joining the Breathe Easy group I have felt so much better and it has changed my life; I know that it is not the end. I have also joined other local groups and realise that I can lead a full life."

Actions for Promoting Self-care and Independence

- Develop a range of interventions to support self-management
- Improve the feedback of patients and carers on their experiences of respiratory services
- Further develop and expand the Expert Patients Programme

Recommendations

There are key actions to be considered in order to achieve each individual aim of the strategy and ultimately improve respiratory health and respiratory health outcomes for people in Halton that are highlighted at the end of each chapter. These actions form the key recommendations of this strategy and are summarised below:

I. Prevent respiratory ill health

Smoking

● Increase the number of people attending Smoking Cessation Services in Halton
● Reduce the proportion of people smoking in Halton

Vaccination

● Increase the uptake of flu vaccination amongst at risk groups, to achieve national target
● Increase uptake of childhood vaccinations in lowest uptake practices.

Obesity

● Improve access and uptake to lifestyle advice across the borough
● Increase the proportion of people taking regular daily exercise in Halton

Drugs

● Improve education and awareness of the impacts of cannabis use especially preventing young people from starting to use cannabis.

Housing

● Increase access to grants and equipment to increase energy efficiency in People's homes
● Continue to work across the private rented sector to improve housing standards

Environment

● Continue the implementation of the Halton Council Transport Plan to improve traffic flow, reduce emissions and encourage active transport
● Identify opportunities to further improve air quality across Halton

II. Earlier detection of respiratory diseases

Cancer

● Ensure that increase the number of appropriate 2 week wait referrers to increase early diagnosis and enable early treatment of lung cancer
● Expand the Get Checked campaign to further increase awareness of signs, symptoms and encourage early presentation for lung cancer.

Chronic Obstructive Pulmonary Disease
● Encourage improved and early case finding to facilitate better management and treatment access
● Develop and implement a Borough wide, inclusive community spirometry service

Interstitial Lung Disease
● Ensure risk markers are identified on patient records, known risk occupations etc

Obstructive Sleep Apnoea
● Improve mechanisms for case finding, including access to spirometry and diagnostic tools to ensure rapid access to treatment and management

People with Learning Disability
● Adults with learning disability should be considered a high risk group for deaths from respiratory problems, screening and risk assessment should be included as part of the annual health check for patients with a learning disability.
● People with learning disability should be regarded as a high risk group for the purpose of seasonal flu and pneumonia vaccination programmes even if they do not live in a residential care setting.

III. Primary Care and Community based support

General
● Ensure the NICE Guidance and Quality Standards compliance in the recognition, diagnosis and management of respiratory illness and ensure best practice service commissioning.
● Pro Active Care programme Local Enhanced Service (2014/15)
● Review provision of pulmonary rehabilitation across Halton
● Establish integrated delivery of respiratory services across Halton
● Improve prescribing, in line with guidance[18], of respiratory medication across primary care

Asthma and COPD
● Implement standardised COPD and Asthma template across primary and secondary case
● Practices to benchmark recording of smoking status for patients on the COPD and asthma registers and set local reduction targets.
● Every patient diagnosed with asthma to receive a personalised action plan and annual review.

ILD
● Recording of occupation, particularly for risk occupations, on primary care records and identify those at possible risk of ILD to red flag early warning signs and symptoms.

[18] Pan Mersey Area Prescribing Committee Guidelines http://www.panmerseyapc.nhs.uk/guidelines.html

OSA

● Maximise case finding against OSA predictor calculator and ensure rapid access to diagnostics.
● Review the pathway for people with OSA

Bronchiolitis

● Rapid review (and application) of NICE Guidance when it is released in May 2015
● Review cause for practice variations in admissions for bronchiolitis across Halton practices

IV. High Quality Hospital Services

General

● Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
● Review current arrangements regarding Halton adult residents admitted to Whiston Hospital with respiratory health problems
● Review current arrangements regarding Halton children & young people admitted to Halton and Warrington Hospitals and ST Helens and Knowlsey Hospitals with respiratory health problems
● Ensure the NICE Guidance and Quality Standards compliance in the treatment and secondary care management of respiratory illness and ensure best practice service commissioning.

V. Promoting Self Care and Independence

General

● Develop a range of interventions to support self-management
● Improve the feedback of patients and carers on their experiences of respiratory services
● Further develop and expand the Expert Patients Programme

The recommendations will be translated in to the Respiratory Action Plan and progressed assessed against these, and current actions by the Respiratory Health Group

How Will We Know Strategy Is Successful?

By 2020 this strategy will have;

I. Embedded respiratory health into a range of preventive programmes and be seeing a decline in prevalence of a number of key preventable respiratory illnesses.
II. Improvements in smoking quit rates and increase number of people referred to smoking cessation services.

III. Increased uptake of flu vaccination amongst those with existing respiratory conditions and amongst those with other on term health conditions, including those with learning disability, to mitigate the effects of flu on general respiratory health.
IV. Improved awareness within the general population of factors that prevent and protect against respiratory ill health, enable earlier identification of problems and health seeking behaviours.
V. Improved the recognition, diagnosis and management of a variety of respiratory illnesses (including COPD, asthma, lung cancer) within primary care.
VI. Developed a range of interventions and support to enable individuals and their carers to better ‘self–manage’ their respiratory condition.
VII. Involved more individuals and their carers in the planning and quality assurance of respiratory health services.
VIII. Improved the pathways between primary, acute, residential, nursing and social care for individuals and their carers.

Contributors

Many thanks to the Halton Respiratory Strategy Group, and other colleagues who have contributed to the development of the strategy.

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Document Summary

Title
Respiratory Strategy for Halton 2015 – 2020,

Date
Produced July 2015

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REPORT TO: Health Policy & Performance Board

DATE: 8 September 2015

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Service Closure Policies and Procedures

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present a suite of policies and procedures that make up the Service Closure Policy within the adult social care market.

2.0 **RECOMMENDATION: That the Board note the contents of the policies and procedures attached within Appendices 1, 2 and 3.**

3.0 **SUPPORTING INFORMATION**

3.1 From April 2015 the Care Act (the Act) required local authorities to help develop a social care market that delivers a wide range of sustainable high-quality care and support services, and places responsibility on local authorities to deliver a duty to ensure that needs are met, including when there is a planned or emergency disruption to services.

3.2 In particular, the Act is explicit in the local authority's responsibility to use market intelligence to have sound market oversight in order to develop a suitable local care and support market, foresee potential risks to disruption to services (i.e. through business failure, withdrawal from market, regulatory compliance etc.) and undertake preventive action to avoid and/or minimise disruption in the event of a care service closure.

3.3 The Act introduces a new role for the Care Quality Commission in overseeing the financial stability of the most hard-to-replace care providers (i.e. providers who deliver across a number of geographical locations), and to ensure people's care is not interrupted if any of these providers fail. It also describes the responsibilities of a local authority if a local care provider fails.

3.4 The Act makes it clear that local authorities have a temporary duty to ensure that the needs of people continue to be met if their care provider becomes unable to carry on providing care because of business failure, no matter what type of care they are receiving.

Local authorities have a responsibility towards all people receiving care. This is regardless of whether they pay for their care themselves, the local authority pays for it, or whether it is funded in any other way.

3.5 **Policy Development**

In line with the new requirements on the local authority, three policies and procedure documents that make up the 'Service Closure Policies' have been developed:

- **An overarching policy in relation to market oversight:** Intelligence gathering, contract monitoring, identifying risks in service continuity, responding to risks, preventing service closure
- **A policy and procedure for responding to a planned service closure:** Covering domiciliary, residential and supported living services. Planned closures may occur for a number of reasons, including business failure, decommissioning or contract default.
- **A policy and procedure for responding to an unplanned service closure:** Covering domiciliary, residential and supported living services, where there is little of no warning of disruption to, or closure of, a service. This may be due to a number of reasons, including fire, flood, disease outbreak, immediate and significant risk of safety.

3.6 The policy and procedure documents provide the protocol to follow in the event of a planned or unplanned service closure, in line with the requirements of the Act, supported by resources such as flowcharts, checklists and templates.

4.0 **POLICY IMPLICATIONS**

4.1 The Act describes the local authority's responsibilities of meeting individual's needs, in particular in the event of business failure or other service disruption.

4.2 Sections 18 and 20 of the Care Act set out when a local authority must meet a person's eligible needs. They place duties on the local authority. If the circumstances described in the sections apply and the needs are eligible, the local authority must meet the needs in question. These duties apply whether or not business failure is an issue. The temporary duty only applies in so far as the local authority is not already required to meet needs.

4.3 Section 19 of the Care Act covers the circumstances where care and support needs may be met i.e. circumstances where no duties arise under section 18 but the local authority may nevertheless meet an adult's needs. In particular, section 19(3) permits a local authority to meet needs which appear to it to be urgent. This is

likely to be the case in many situations where services are interrupted but business failure is not the cause.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Section 4.0 highlights that there may be circumstances where the Council may need to intervene to support vulnerable people. In these events the Council will use the Community Care Budget to support their needs of a temporary basis.

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 suite of policies contained in this report relate directly to the health and wellbeing of individuals who access care and support within the scope of the policies.

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 None identified at this time.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

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

None.

HALTON BOROUGH COUNCIL

Communities Directorate

NHS Halton Clinical Commissioning Group

Provider Service Closure
1) Market Oversight and Management

April 2015

INFORMATION SHEET

Service area	**Halton Borough Council Adult Social Care Communities Directorate.** **Halton Borough Council Integrated Safeguarding Unit** **Halton NHS Clinical Commissioning Group** **Adult Social care Provider Organisations**
Date effective from	TBC
Responsible officer(s)	Quality Assurance Manager
Date of review(s)	TBC
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory for all Halton Borough Council Adult Social Care Staff
Target audience	Halton Borough Council Commissioning Managers Halton Borough Council Quality Assurance Team and Contract Team Halton Borough Council Adult Social Care Teams NHS Halton Clinical Commissioning Group Continuing Health Care Team Adult Social Care Providers Adults who use services, their families and carers
Date of committee/SMT decision	TBC
Related document(s)	Care Act Mental Capacity Act Data Protection Act Human Rights Act Deprivation of Liberty Safeguards Mental Health act
Superseded document(s)	Halton Borough Council Home Closure Protocol 2004

Equality Impact Assessment Completed	Need to do new one
File Reference	

Contents

1.0	POLICY AIM	PRACTICE
1.1	The possibility of interruptions to residential, supported living and domiciliary care and support services causes uncertainty and anxiety for the person receiving services, their carers, family and friends. Interruptions to services can occur as a result of many different factors, including business failure, significant safeguarding issues or quality compliance issues that fail to be rectified.	The associated policies, listed below, should be considered alongside this document. • Provider Service Closure 2. Managing a Planned Service Closure • Provider Service Closure 3. Managing an Unplanned Service Closure
1.2	This policy provides guidance on how Halton Borough Council (HBC) delivers its responsibilities in managing the provider market, so to mitigate disruptions where ever possible, and achieve the best possible outcomes for individuals using services.	
1.3	This policy document (*Provider Service Closure 1.Market Oversight and Management*) is part of a suite of policies that direct : • provider market management, oversight, intelligence and prevention of service disruption for residential and domically providers(through planned or unplanned service closure) • management of a planned service closure (residential, supported living and domiciliary) • management of an unplanned service closure (residential, supported living and domiciliary)	
2.0	**SCOPE OF THE POLICY**	
2.1	This policy details how HBC meets its responsibilities, in relation to the Care Act, in the following areas • Care Quality Commission (CQC) • Market oversight and intelligence • Responding to identified risks in service continuity • Decommissioning • Provider Default • Responsibility of the provider • Responding to economic failure of the provider	
2.2	This policy applies to services in which there are funded and/or self-funding individuals.	
2.3	The aim of this policy is not to replace individual service business continuity plans, nor to stop providers failing, bail out or interfere with commercial decisions. If failure cannot be avoided this policy describes the procedure to	

	be followed to ensure that HBC ensures a well-managed transition.	
2.4	It is a requirement of every HBC commissioned service provider to have a 'tried and tested' Business Continuity Plan that is reviewed.	
3.0	**Care Quality Commission (CQC)**	
3.1	Market oversight is a new regulatory duty for the CQC from April 2015. The purpose of this duty is to protect people in vulnerable circumstances from the effects of a provider failing. The CQC will do this by: • Monitoring financial sustainability and assessing the likelihood of business failure of difficult-to-replace adult social care provider organisations. • Identifying and responding to risks in respect of financial sustainability. • Providing early warnings of business failure to local authorities. • Assisting in coordinating a response in the event of business failure.	The Care and Support (Market Oversight Criteria) Regulations 2014 set out the entry criteria for a provider to fall within the regime.
3.2	Regulations set out the entry criteria into the CQC regime. It will be for CQC to apply those regulations and decide which providers are included. It will include providers who, because of their size, concentration or specialism, would be difficult to replace if they were to fail, and so where the risks posed.	
3.3	The Care Act gives the CQC the power to request information from any care provider they think is likely to fail. The CQC will share this information with the local authority to help minimise the negative effects of the provider failing, and to ensure a smooth process that provides continuing care to individuals.	Further guidance as to how this new CQC regulatory duty will be issued in due course by the CQC. Contact HBC Quality Assurance Team for further information.
3.4	It is proposed by the current Government that CQC will notify authorities with information relating to a provider's potential to fail, if CQC believes the whole of the regulated activity that the provider is registered for is likely to fail, not parts of it. For example, if the financial viability of the whole of the provider business is under question, not just the viability of one of its residential/nursing homes.	
4.0	**Market Oversight**	
4.1	The Care Act 2014 sets out Halton Borough Council's duties to promote the efficient and effective operation of the local care and support services market. The risk of disruption to services can be reduced through commissioning and	Department of Health Care Act Briefing Note 'Managing provider

	monitoring practices. This section describes the mechanisms in place within HBC to gather market intelligence, to identify where there are risks that may lead to service disruption, and what remedial actions may be used.	failure and other service interruptions'
	HBC Adult Social Care Commissioning and Procurement Process	*See* 'Adult Social Care Market Position Statement HALTON' available from HBC Adult Social Care Commissioning Team
4.2	Market intelligence is contained in the *Market Position Statement* which is produced by HBC Adult Social Care Commissioners annually. The Market Position Statement aims to encourage a dialogue with Providers about the development of the local Adult Social Care market.	
4.3	It brings together evidence from a number of sources, including the Halton Joint Strategic Needs Assessment (JSNA) and Commissioning strategies relating to Adult Social Care, as well as Census data, population projection information and evidence from various national papers, strategies and plans, to provide ✓ Strategic Context. ✓ Key Messages and Statistics. ✓ A portrayal of predicted changes in local demographics. ✓ Information about the Size and Structure of the Adult Social Care Market in Halton. ✓ The current position of the three main areas of service provision; Care in Residential and Nursing Care; Care at Home; and Carers. ✓ An indication of Halton Borough Council's future commissioning intentions and work on safeguarding. ✓ Our expectations of Providers and the support we can offer.	
4.4	Commissioning of domiciliary care contract arrangements have to go through a robust procurement process tendering against a specification in which value for money and quality are considered, and adheres to the principals of E.U law on procurement. This process is independent from the Quality Assurance and Commissioning arrangements.	
4.5	Residential care contracts are commissioner led, based on negotiations with providers to meet local needs. During 2015 an accreditation standard for potential future providers will be developed by HBC.	
5.0	**Quality Assurance Monitoring**	
5.1	The HBC Quality Assurance team gather intelligence and information on Providers via quality and contract performance monitoring. This intelligence can be shared with relevant stakeholders in order to build understanding of the market and its potential weaknesses, enabling appropriate action to be taken.	
	Contract	

5.2	Contracted providers who offer services on behalf of HBC must sign up to a contract. All Provider services must be registered with the Care Quality Commission, where there is a regulatory requirement. **Quality Assurance Team checks and monitoring**	
5.3	The aim of HBC Quality Assurance Team is to ensure commissioned care, support and preventative services are contracted, of good quality, monitored, quality assured and safe.	
5.4	The Quality Assurance Team undertake a series of checks, which include: • A review of the latest CQC report, to ensure that the Provider is compliant with the regulatory requirements. • Ensure that there is a business plan and business continuity plan in place • Ensure that annual financial accounts are undertaken	
5.5	The Quality Assurance Team is responsible for the contract management, performance monitoring and quality assurance of all Adult Care Health and Wellbeing commissioned provider services. This responsibility is met by a number of measures which includes contract management performance monitoring and an annual Quality Assurance review. Contract management activities include: • contract administration • annual contract checks • performance monitoring • Contract remedies **Performance monitoring**	
5.6	The team gather intelligence and information on providers relating to key performance indicators which will demonstrate to the Council and providers how they are performing against the contract, and provides early warning of potential risks though the following: • Performance Information Return - Provider self-assessment • Dashboard - Collates risk statuses from CQC, health and safeguarding • Electronic Core Monitoring (domiciliary care) – Monitors provider activity **Scheduled and unplanned monitoring**	
5.7	The Quality Assurance team undertake an annual monitoring visit of all Providers, including consultation with service users and staff.	

5.8	Residential care providers have unannounced monitoring visits.	
5.9	Quarterly contract meetings are held with domiciliary care providers	
5.10	Other professional stakeholders (including CCG Pharmacy, HBC Care Home Team, Infection Control and Environmental Health) also undertake audits and forward findings onto HBC Quality Assurance Team (and Project Lead where there is a Professionals Meeting in place for escalated risk situations).	
5.11	From 2015, the *Hull University Early Indicators of Concern model questionnaire* will be used as part of the HBC quality monitoring process to identify good practice and also where there are specific cultural, leadership or management issues that are risk factors to the organisation. This will enable the Quality Assurance Team to work with providers in employing preventative measures to be taken to address cultural or leadership issues escalating.	
	HBC Risk Matrix – early warning signs	
5.12	Intelligence gathered is weighted by risk considering the category, volume and impact on adults using that service. This is captured on a Risk Matrix and informs the schedule of monitoring visits or meetings.	
5.13	A traffic light system is utilised to benchmark the level of contract monitoring activity that will be required:	
5.14	Green Providers are good. It is estimated that they will need two contract monitoring activities each year. The annual survey and a follow up meeting or visit to evidence progress against any action plan and discuss emerging issues.	
5.15	Amber Providers are adequate. This means that they will have some issues that require improvement and action to be taken but does not identify a significant level of risk. These will have at minimum of three visits annually	
5.16	A red Provider is poor. These are services where there is one serious /significant risk or a range of issues that evidence significant performance or quality failure that requires frequent evidence of improvement through monitoring visit, meeting with the provider.	
5.17	The QAT will undertake a project management approach facilitating a Multi-Disciplinary Team meeting. There is a responsibility to gate keep and streamline the collation, analysis and distribution of information and act as a point of contact.	
5.18	A detailed log of activity is maintained that will provide a chronological	

	oversight of the service and the prevailing issues and progress. Clear roles and responsibilities of MDT (members) is agreed and updated on a regular basis. Support Plans, Emergency Contingencies and/or MDT minutes to be embedded or linked into the chronology/Log.	
5.19	The risk status of a Provider is agreed by the Commissioning Divisional Manager. Sustained failure or heightened risk is discussed with senior operational managers.	
	CQC and HBC Engagement Meetings	
5.20	HBC meet with CQC local Inspection Team on a quarterly basis to share local information, including emerging themes and issues. HBC Quality Assurance Team share performance information and monitoring reports with CQC inspection officers, and will undertake joint Provider visits where emerging issues arise, or when provider compliance issues may lead to CQC enforcement action or threaten the ongoing operation of a CQC regulated service.	
	Provider Forums	
5.21	There are quarterly meetings of all HBC commissioned Registered care providers to enable wider discussion to take place amongst providers in each of the sectors (residential, supported living and domiciliary). This is facilitated by the HBC Quality Assurance Team and provides opportunity to identify and discuss emerging issues across each of the sectors.	
	Safeguarding	
5.22	HBC have a responsibility to identify early warning signs, through Safeguarding issues reported to the initial Assessment Team and 'care concerns' which are reported to the Quality Assurance Team.	
5.23	The Safeguarding lead will escalate risk and convene a multi-disciplinary team to initiate a response, where safeguarding issues have been found to pose a risk to continuity of the service.	
6.0	**Responding to identified risks**	
	Escalating risk	
6.1	The decision to suspend a service must be agreed by an Operational Director	
	Actions to prevent service closure	

6.2	In the event that market intelligence / provider notification highlights that there are significant risk factors that may disrupt service, HBC will convene an Multi-Disciplinary Team (MDT) known as a Professionals Meeting, with stakeholders appropriate to respond to the given situation, which will : • Meet with the provider to develop an action plan to address the specific risk issues identified via Safeguarding and/or the risk matrix. • Within the action plan consideration may be given to: changing the model of service delivery, negotiation with HBC around staffing requirements, issue a new or amended contract. • Identify staffing resources required where staffing is an issue, working with the provider, other providers and HBC to identify a solution. • Ongoing monitoring of the agreed action plan.	
	Partnership working	
6.3	The Professionals Meeting frequency is determined by the Project Lead, but meetings are likely to be required on a fortnightly basis. As the lead authority for any service closure within Halton, HBC take responsibility for identifying meeting membership, organisation of meetings, coordinating and distributing information to and from partners, develop a time line of issues, ensure that information is cascaded to relevant stakeholders.	
6.4	The primary aim of the group is to look at an offer of support to the service in order to maintain continuity where possible, monitor progress, discuss emerging issues, share essential information, agree action and time frameworks and monitor for sustained improvement.	
6.5	The 'time line' document is an evidence/action/outcome document that the group utilise to monitor risk when in the escalation phase. The time line is coordinated by a 'Professionals Meeting Project Leader', identified by the HBC Divisional Manager, and is shared and discussed within the professional meeting. **Please see Appendix 1 Time Line Document**	
6.6	Attendees at the meeting will include representation from all Local Authorities who have individuals using the service at that time, HBC Quality Assurance Team, CQC, Halton CCG Chief Nurse, CCG Commissioners, 5 Boroughs Partnership, Health safeguarding lead, Continuing Health Care Leads, Care Home Liaison Team, Pharmacy, CPNS, District Nurses, GP Practice Manager/s. The chair of the meeting (HBC Divisional Manager) will determine the membership of the group by the nature of the risk and the agencies involved in that service at that time.	
	Emergency Contingency Planning	

6.7	Where risk has been escalated to red there is an Emergency Contingency Planning document that should be completed for the service. **Please see Appendix 2.** This document should be used to outline identified risk and remedial actions. The Professionals Meeting Project Lead, identified by the HBC Divisional Manager, has responsibility for ensuring that the actions are undertaken.	
	Options	
6.8	The Professionals Meeting will, working with the service provider where possible, identify options for next steps to prevent service closure. Evidence from the 'time line' will be used to inform these options. Options may include informing service users and carers where risks have been identified, identifying other support that could ensure continuity of the service, or identifying a 'turn around' team to intensively support the service where this is feasible. A risk plan for each option will be required.	
	Provider offer and charter	
6.9	All providers are required to work collaboratively with HBC to prevent service closure of another provider, where possible. During 2015 a Charter/agreement will be developed for providers to sign up to, indicating their willingness to support HBC in managing a crisis situation with another provider (on a voluntary basis), where it would not pose a risk to the delivery of their core business.	
6.10	In the event of a closure or crisis situation, the providers who have pledged their support to the Charter/agreement will be the organisations initially contacted for assistance to provide a short term solution to avoid, or respond to, a critical situation. Examples of support may include access to beds, staffing, training, equipment, rearrangements of service packages to free up staff/beds. The provider 'offer' would be specific to each situation and dependant on the provider's capacity etc at that point in time.	
6.11	Providers will be required to evaluate what their 'offer' may be when signing up to the 'charter'. The offer framework will be held by HBC Quality Assurance Team.	
6.12	A framework of agreed fees with contracted services is held by the Quality Assurance Team, and HBC will negotiate with each provider the cost of mobilising additional specific support to prevent or respond to a crisis situation.	
7.0	**Provider Default**	

7.1	Withdrawal of HBC contracts are the final stage, once preventative actions have been exhausted. Withdrawal of contract may occur in the following instances: • Where significant and sustained improvement is not seen within 3 months, against the identified requirements in specific areas and against the set time scales. • The provider is unable to demonstrate the *ability* to make identified improvements within the required timescales. • There is significant/immediate risk to safety of adults using the service, staff or others.	
7.2	Notice of default will be provided in writing, outlining the precise manner in which the provider is deemed to be in default, the action required to undertake to remedy the default, a period of 10 days to commence the necessary action.	
7.3	HBC may, itself, provide or procure the provision of the relevant part of the service from a 3rd party, until the breach has been remedied to reasonable satisfaction of the council.	
7.4	HBC may deduct from any sums due or otherwise charged to the provider, the reasonable costs of any service so provided together with relevant administrative costs.	
7.5	HBC can stop or suspend future referrals of service users to the provider until satisfied that the default has been remedied.	
7.6	Termination may create the need to arrange alternative services for existing service users, possibly at short notice. The disruption this creates must be balanced against the Council's/CCG's duty of care to the people it supports. A HBC Divisional Manager will be identified and be responsible for: • Co-ordinating the process with the involvement of staff from departments and agencies • Ensuring that the service provider is notified of the actions to be taken • Ensuring that other agencies are informed.	
8.0	**Decommissioning of a service**	

8.1	The ongoing review of provider services is essential to ensure that they continue to meet any changing local needs, or respond to changes being implemented through national policy.	
8.2	The decommissioning of services is one way in which these challenges can be met so as to ensure they reflect changing priorities and budgets, as well as to effectively deal with poor service performance and / or safeguarding concerns.	
8.3	Decommissioning is generally a result of a longer process of contract management, however, there may be occasions when decommissioning has to take place in response to unanticipated events. Even in these circumstances decommissioning should always be well planned and managed through contract management processes such as provider and commissioner contingency and business continuity plans.	
8.4	Unanticipated decommissioning may take place where: ➢ The current provider is failing to deliver the service. This could be due to poor performance/quality of service or where a provider has breached a contract, for instance as a result of a safeguarding failure; ➢ The current provider seeking early termination where they decide they can no longer provide the service as a possible result of financial difficulties; ➢ The current provider changing the nature of the service they provide without notice to the Council or strategically as part of a business plan review refocusing their core business;	
8.5	A detailed options appraisal will be conducted on the service that is being considered for closure. It is important to fully evaluate the potential impact of decommissioning on demand in other areas of service or sectors. HBC will always take a strategic approach to decommissioning. Any decommissioning plans must include details of alternative service provision, risk mitigation measures and comprehensive impact assessments including equalities impact assessments.	
8.6	For service users, the decision to decommission a service may mean they start to use an alternative provider or that support is provided in a different way. Safeguarding the welfare of current and potential service users must be a key priority throughout the decommissioning process, as the withdrawal of funding or change in the service they receive may have a significant impact on their lives. This may require a phasing out period that is specific to service-users especially where there is very specialist input.	

9.0	**Responsibility of Providers**	
9.1	Providers have a contractual responsibility to notify HBC of any potential risks to business continuity.	
9.2	Risks may include staffing problems, such as an inability to recruit specialist/qualified staff, issues with bed occupancy, financial viability, non-compliance / breach of regulations and potential enforcement actions from CQC.	
9.3	There is a statutory duty of candour on social care providers to report concerns that their staff are mistreating patients under social care legislation to be published this month. This would mean social care providers would have to tell health regulators if they thought their employees might be harming or neglecting service users.	
10.0	**Economic Failure of the provider**	
	Administration and Insolvency	Please refer to the 3rd policy document in this suite of policies, for details of HBC *Duty to meet needs* in the event of business failure :
10.1	An Administrator represents the interests of the creditors of the provider that has failed and will try to rescue the company as a going concern. In these circumstances, the service will usually continue to be provided, and the exercise of Halton Borough Council's *temporary duties* may not be called for.	
10.2	It is not for HBC to become involved in the commercial aspects of the insolvency, but should cooperate with the Administrator if requested.	
10.3	HBC will, insofar as it does not adversely affect people's wellbeing, support efforts to maintain service provision (by, for example, not prematurely withdrawing people from the service that is affected, or ceasing commissioning arrangements).	*Provider Service Closure 3. Managing an Unplanned Service Closure*

TIME LINE

SERVICE:

MONTH:

COMPLETED BY:

Area of Concern	Specific Identified Issue	Actions Required	Outcome
Safeguarding Reports			
Whistleblowing			

Social Worker and/or Professionals Concerns			
Contractual			
Notifications		-	
Strategic/Leadership			
Family Concerns			

Emergency Contingency Planning and Procedures

Overview **Service overview**	
Rationale **Reasons for emergency contingency plan and anticipated outcomes**	
Contingency Actions **Detail actions to be taken**	
Briefing **Details of who has to impellent this plan and have they been briefed**	

HALTON BOROUGH COUNCIL

Communities Directorate

NHS Halton Clinical Commissioning Group

Provider Service Closure
2. Managing a Planned Service Closure

April 2015

INFORMATION SHEET

Service area	**Halton Borough Council Adult Social Care Communities Directorate.** **Halton Borough Council Integrated Safeguarding Unit** **Halton NHS Clinical Commissioning Group** **Adult Social Care Providers**
Date effective from	TBC
Responsible officer(s)	Quality Assurance Manager
Date of review(s)	TBC
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory for all Halton Borough Council Adult Social Care Staff
Target audience	Halton Borough Council Commissioning Managers Halton Borough Council Quality Assurance Team and Contract Team Halton Borough Council Adult Social Care Teams NHS Halton Clinical Commissioning Group Continuing Health Care Team Adult Social Care Providers Adults who use services, their families and carers
Date of committee/SMT decision	TBC
Related document(s)	Care Act Mental Capacity Act Data Protection Act Human Rights Act

	Deprivation of Liberty Safeguards Mental Health act
Superseded document(s)	Halton Borough Council Home Closure Protocol 2004
Equality Impact Assessment Completed	Need to do new one
File Reference	

Contents

1.0	**Aim of the Policy**	**PRACTICE**
1.1	The possibility of interruptions to residential, supported living and domiciliary care and support services causes uncertainty and anxiety for the person receiving services, their carers, family and friends. Interruptions to services can occur as a result of many different factors, including business failure, significant safeguarding issues or quality compliance issues that fail to be rectified.	*The associated policies, listed below, should be considered alongside this document.* • *Provider Service Closure 1. Market Oversight and Management* • *Provider Service Closure 3. Managing an Unplanned Service Closure*
1.2	Every effort should be made to ensure that transition is undertaken with sensitivity to the individual needs of adult, and actions should be taken in consultation with any relevant relatives, friends, advocates or others (e.g. Health) who may be required to or willing to assist in identifying alternative placements.	
1.3	This policy provides guidance on how Halton Borough Council (HBC) delivers its responsibilities in managing a **planned** service closure.	
1.4	This policy document (*Provider Service Closure 2.Managing a planned service closure*) is part of a suite of policies that direct : • provider market management, oversight, intelligence and prevention of service disruption for residential and domically providers(through planned or unplanned service closure) • management of a planned service closure (residential, supported living and domiciliary) • management of an unplanned service closure (residential, supported living and domiciliary)	
2.0	**Scope of the policy**	
2.1	This policy details how HBC and NHS Halton Clinical Commissioning Group (CCG) meets their responsibilities, in relation to the Care Act, in the following area: • Responding to planned residential, supported living or domiciliary service closure – where notice has been given to HBC of an intended closure, or HBC has issued a default notice.	
2.2	This policy applies to services in which there are funded and/or self funding individuals.	
2.3	The scope of this policy is not to replace individual service business continuity plans. It is a requirement of every HBC commissioned service provider to	

	have a 'tried and tested' Business Continuity Plan that is reviewed.	
3.0	**Principals that underpin this policy**	
3.1	In undertaking a planned closure of a service within the scope of this policy, HBC and Halton CCG are committed to the following principles: • Provider market oversight and intelligence is used to foresee closure risks and implement remedial actions to prevent closures, where possible. • Where decision making results in the need to make a planned closure of a service, timescales are appropriate to the adults who use the service, where ever possible. • Ensure that the dignity and welfare of adults who use services is considered at all times. • Communicate decision making in a timely, effective and transparent manner to all stakeholders. • Minimise disruption and distress to adults who use services, promoting familiarity and consistency of care wherever possible. • Where relocation of adults who use services is required, assess the needs of all adults, irrespective of funding arrangements. • Ensure that alternative accommodation takes into account compatibility of each adult's needs to promote positive cohabitation between groups of adults using a supported living service. • Service closures will be managed as a multi-agency project so that all organisations offering some level of care or support to adults, can work towards the common aim of effecting best outcomes and continuity of care. Key players (regulators, receivers/administrators, HBC and CCG commissioners, GPs, Social Workers, residents' representatives, professional associations and other Local Authorities etc.) must therefore be engaged at the earliest possible stage. • Work collaboratively with other organisations and partners to promote effective communication, timely processes and effective use of shared resources. • Ensure that any individual assessments or decision making, meet the requirements of the Mental Capacity Act 2005; particularly the need to assess mental capacity during the closure process and to make decisions on behalf of those lacking mental capacity in their best interests. • Consider equality and diversity issues throughout the closure process, respecting the cultural needs of adults who use the service and using advocates and interpreters wherever necessary. • Develop good practice by monitoring and reviewing the closure	*Care Act 2014* *Halton Borough Council Mental Capacity Act 2005 Policy, Procedure and Practice* *Halton Borough Council data Protection Act Policy, Procedure and Guidance 2011*

	processes used. • Staff will work in accordance with the principles of the Data Protection Act 1998 and information sharing agreements.	
4.0	**Legal responsibilities that underpin this policy**	
4.1 4.2 4.3 4.4 4.5	HBC's mandatory statutory duty to eligible people already receiving the service, is to meet their assessed eligible needs appropriately and safely (to do otherwise would be a breach of statutory duty, potentially enforceable by injunction). HBC has a responsibility towards **all** people receiving care. This is regardless of whether they pay for their care themselves, the local authority pays for it, or whether it is funded in any other way. Leaving a person in a service in which there would be significant risk of harm which may be at risk of breach of contract compliance, CQC notification of serious concerns or closure could lead to a breach of their rights under the Human Rights Act. It is part of the duty of HBC to re-assess someone's needs before a planned move. In reassessment, the law requires best interests of the adults and their families are considered, in compliance with the Choice Rights outlined in Choice Directions and that appropriate consents are observed in accordance with the Mental Capacity Act.	*Care Act* *Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services, England. Department of Health 2012* *Halton Borough Council Mental Capacity Act 2005 Policy, Procedure and Practice*
5.0	**Safeguarding**	
5.1 5.2	HBC and Halton CCG are required to safeguard the needs and welfare of all adults who use services in their area during a transition to another service, regardless of whether they are self or publicly funded and regardless of which local authority has placed them there. Where safeguarding issues or care concerns are identified, the Safeguarding Adults in Halton Interagency Policy and Procedure must be followed.	*Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Guidance 2015*

6.0	**Mental Health Act and Mental Capacity Act Implications**	
6.1	The Mental Capacity Act requires everyone in the first instance to assume that the individual has the mental capacity to make decisions; a person must also be supported to make their own decisions, as far as it is practicable to do so. The Act requires 'all practicable steps' to be taken to help the person. It is a key principle of the Act that all steps and decisions taken for someone who lacks mental capacity must be taken in the person's best interests.	*Halton Borough Council Mental Capacity Act 2005 Policy, Procedure and Practice*
6.2	Consultation with others is subject to obtaining informed consent from adults who use services. Where an adult is unable to consent or make important decisions because of mental incapacity, the Mental Capacity Act 2005's code of practice and regulations will apply to financial, serious health treatment and accommodation decisions. Best interest decision making until then is subject to common law and case law.	*The Human Rights Act 1998 Article 5 for information relating to deprivation of liberty.*
6.3	Adults who lack mental capacity may require an independent mental capacity advocate (IMCA). It is compulsory for the local authority to consider whether an IMCA should be instructed, so it is therefore advisable to give the IMCA service early warning that their service may be required. In respect of adult protection concerns, instructing an IMCA must be considered.	*Mental Capacity Act 2005*
7.0	**Duty On HBC to meet needs of individuals in the event of service closure**	
	Where closure is as a result of business failure	*Department of Health Care Act Briefing Note 'Managing provider failure and other service interruptions'*
7.1	HBC are under a temporary duty to meet people's needs when a provider is unable to continue to carry on their activity because of **business failure**.	
7.2	The temporary duty on HBC to meet needs continues for as long as HBC considers it necessary.	
7.3	The duty applies regardless of whether a person is ordinarily resident in Halton. However, HBC may charge the person for the costs of meeting their needs, and it may also charge another local authority which was previously meeting those needs, if it temporarily meets the needs of a person who is not ordinarily resident in Halton. The charge must cover only the cost incurred by HBC in meeting the needs. No charge can be made for the provision of information and advice to the person.	*There is significant flexibility in determining how needs can be met, as set out in section 8 of the Care Act.*
7.4	The needs that must be met are those being met by the provider immediately before the provider became unable to carry on the activity.	

7.5	The duty applies from the moment HBC becomes aware of the business failure. The actions to be taken will depend on the circumstances, and may range from providing information on alternate providers, to arranging care and support.	
7.6	In deciding on how needs can be met, HBC must involve the person concerned, any carer that the person has, or anyone whom the person asks the authority to involve (this may include best interest assessor or advocates).	
7.7	If the provider's business has failed but the service continues to be provided then the duty is not triggered. This may happen in insolvency situations where an Administrator is appointed and continues to run the service.	
	General duty to meet people's needs, regardless of if closure is triggered by business failure	
7.8	Further to the duty outlined above, sections 18 and 20 of the Care Act set out when a local authority must meet a person's eligible needs. If the circumstances described in the sections apply and the needs are eligible, HBC must meet the needs in question. *These duties apply whether or not business failure is at issue.* How someone pays for the costs of meeting their needs must have no influence on whether HBC fulfils the duty.	*Care Act section 18 & 20*
	PROCEDURE	
8.0	**Responding to notification of a planned service closure**	
	Closure Time Scale and Process	
8.1	To ensure that the best possible outcomes for people are achieved this type of closure needs to have a timescale of three to six months. The exact time scale for closure will be determined by Project Lead in negotiation with the provider and will be influence by the precise nature of the closure.	
8.2	The time scale for a planned closure will be written into the Residential, Domiciliary and Supported Living Contracts.	
8.3	Please refer to Appendix 1 for Planned Service Closure Flow Chart which provides an overview of the process and associated appendices for each	

	stage.	
9.0	**Multi-Disciplinary Team**	
9.1	The closure will be coordinated by a Multi-Disciplinary Team. Appropriate members of the MDT will be identified based on the nature of the planned closure, with the team being established within 24 hours of closure notification. The CCG will have involvement early in process to ensure engagement of NHS commissioned service providers like 5Borough Partnership and NHS Bridgewater Community Trust.	
9.2	In situations where significant risks within the service have already been identified through the market oversight and closure prevention processes (see Policy 1: Market Oversight), there will be an established 'Professionals Meeting' group. The membership of this group is reflective of the professional stakeholders who have any involvement with the service. The group will form the basis of the Project Closure Group, bringing with it information gathered as part of the process that precedes formal closure notification**.** Please refer to Appendix 2 for Initiating the MDT Closure Project Group .	
10.0	**MDT Closure Project Group Responsibilities**	
10.1	The MDT will: • Oversee the safe transfer of adults who are using the closing service to suitable alternative provision. • Liaise with relevant stakeholders including adults who use the service and their carers / families. • Develop and coordinate implementation of a closure project plan. • Develop and coordinate implementation of a Communication plan • Have responsibility for updating and maintaining a key communications log. • Coordinate and report assessments of needs, including health and risk. • Coordinate resources to undertake reassessment and transfer arrangements. • Report regularly on progress and risks. • Ensure that reviews of care are undertaken following transition. • Undertake a de brief on completion of closure to identify any learning from the process.	

11.0	**Provider Responsibilities**	
11.1	In order for HBC to meet its statutory responsibilities in meeting the needs of individuals affected by a service closure, the Provider must ensure that MDT project lead/s receive a list of **all** the adults who use the service, including as much relevant information about the adult as possible. Failure of the service provider to provide all information requested by the MDT, within the time scales determined by the MDT, will constitute breach of contract. If the provider refuses to cooperate and provide information, then CQC have the legal right to request this information from the provider. Please see appendix 3 for a list of information to be provided checklist.	
11.2	The Provider must have in place appropriate measures/safeguards where confidential information is transferred, so not to inadvertently disclosure confidential service user information to any unauthorised party. Likewise, Halton Borough Council will ensure that the transfer of information to stakeholders involved in the closure process will only be transferred in line with the Data Protection Act. Health and social care providers are required to review records on commencement of the care arrangement with the prescribed times in the health and social care frameworks.	
11.3	The Provider must work collaboratively with the MDT Project Team to coordinate and arrange for re-assessments to be conducted for **all** adults who use the service. As part of the assessment process the adults' next of kin, carers and families should be contacted and involved.	
12.0	**Communication about the service closure**	
12.1	Communication about the planned closure to residents and their families/carers, staff, stakeholders (in particular other local authorities where the adult is not normally resident in Halton) and wider public is critical to support the smooth transition to an alternative service.	
12.2	Self-funders and originating local authorities need to be informed at the earliest opportunity about changes to payment arrangements where HBC, or another provider, are required to meet their needs due to service closure.	
12.3	Staff involved in the communication process should be made aware that whilst appropriate communication methods, delivery of information at the appropriate time and availability to answer questions may provide reassurance to adults affected by the transition, the delivery of information may also raise anxiety. Measures should be put in place to ensure that people are supported to understand information provided.	

12.4	A communication plan is to be developed by the MDT Closure Project Lead/s within 48 hours of closure notification. The communication plan must include consideration of appropriate methods, frequency and content of communications. Please refer to Appendix 4' Communications checklist'	
13.0	**Record Keeping**	
	Record keeping responsibilities of the MDT	
13.1	Good record keeping is essential during the service closure process to promote effective communication between staff and organisations, to promote transparency of decision making and to enable the transfer of information to the new service.	
13.2	A MDT Closure Project Log must be maintained by members of the MDT detailing specific actions to be taken, who/when by, progress against those actions and status (active/closed). Key communications with the Service, adults who use the service, public and other stakeholders must be recorded in this log also. Please refer to Appendix 5 for the 'Project Closure Action Plan and Log'	
	Record keeping responsibilities of Service Staff	
13.3	In addition to the Service Activity Log and Finance Log (key communications Log)that the Responsible Manager must maintain, service Staff will need to: • A designated Key Worker (within the service) to keep a record of all care plans, assessments, decision making and movements of adults who use the service. • Keep a log of medicines and ensure these are moved with the adult if this is necessary. • Keep a log of change of GP if this is necessary. • Keep a log of the adults finances and ensure these are moved with them if this is necessary. • Keep an inventory of the adult's belongings, to be signed by them if this is necessary. • Information should be available about each adult who uses the service on the following: registration category of adult who uses the service and identify any change of category, details of relatives, medical history, whether there is a requirement for advocacy to support the adult, details of the adults' needs including those that	

	may require exceptional arrangements or health care provision. Also identify if there are any relatives of adults who may have factors to consider such as own health, whether they are out of borough, etc. • The adult who uses the services' life history book is particularly important for people with dementia, stroke etc etc.	
14.0	**Continuity of Care**	
14.1	Continuity of care is a priority, and where appropriate (depending on the nature of the closure), the MDT will work with the service provider to identify what support may be put in place to promote continuity of care for adults within that setting.	
14.2	The MDT will consider employing support from other services, which will be dependent on each service area's capacity at that time, including: • CPNs • District Nurses • Complex Care Teams • HBC Care Homes Project • Other Local Authorities who are affected by the closure	
15.0	**Assessment & Care Planning**	
15.1	Given the likely complex nature of many of the adults, a multi agency assessment should be undertaken. Social Care and Continuing Health Care (CHC) teams should undertake joint assessments prior to transfer, regardless of whether the adults are in receipt of any health funding. Specialist assessments (i.e. mental health, swallowing) will be undertaken as advised by the initial assessment team. **Staff resource to undertake assessments**	*Halton Borough Council Care Management Policy*
15.2	Halton Borough Council Divisional Manager for Care Planning, along with the Operational Director for Prevention and Assessment, will make a decision on whether Social Work staff will be utilised from teams to respond the assessment demands of a service closure. This decision will be made on the basis of the volume of assessments required within the timescales dictated by the closure process.	
15.3	In some circumstances, where time scales and financial resources allow, agency Social Workers may be sourced to undertake assessments and post transfer reviews.	

15.4	Wherever possible, existing care staff should be utilised during the transition to alternative services, to pass on knowledge of the adults who use the service to new services, handover care plans and summaries, etc. and verbally discuss the adults' care needs.	
	Multi Agency Assessment	
15.6	Given the likely complex nature of many of the adults who use the service, a multi agency assessment should be undertaken. Social care and Complex Care teams should undertake joint assessments prior to transfer, regardless of whether the adults who use the service are in receipt of any health funding. Specialist assessments (i.e. advanced care planning, mental health, swallowing) will be undertaken as advised by the initial assessment team.	
	Best Interest Decisions	
15.7	The best interest decision process must be followed i.e. involvement of family/mental health advocate (where appropriate), decisions may be made, recorded and revisited in line with Halton Borough Council Deprivation of liberty policy.	
	Deprivation of Liberty Safeguarding (DoLs)	
15.8	The residential/nursing home is the managing authority in the Deprivation of Liberty Safeguards. For homes the supervisory body is the local authority where the person is ordinarily resident. Usually this will be Halton Borough Council (where the care home is located), unless the person is funded by a different local authority.	*Halton Borough Council Deprivation of Liberty Safeguards Policy*
15.9	DoLs Authorisations are non-transferable so where a DoLs is in place for an adult who is using the service affected by closure the DoLs would have to be ended. A new DoLs could be applied for by the new setting, if the receiving service felt it was needed.	*Deprivation of Liberty Safeguards Code of Practice*
15.10	The receiving service must be made aware of the existence of the DoL, and for them to consider if a new application is required, based on the person's presentation, when they transfer.	
15.11	A person may need to be deprived of their liberty before HBC can respond to a request for a standard authorisation (for example, in an emergency/unplanned service closure). In these situations the receiving provider can use an urgent authorisation. Urgent authorisations are granted by the managing authority itself (the provider). There is a form that they have to complete and send to HBC Initial Assessment Team. This is then followed by a request for a Standard Authorisation. A Best Interest Assessor will	

	complete the assessments within 7 days.	
15.12	If the closure was anticipated the prospective receiving service could apply for the Standard Authorisation prior to the move. A Best Interest Assessor will then complete the assessments within 21 days,	
	Community Treatment Orders	
15.13	Where residence at a named care/nursing home is a condition of the community treatment order, when managing a transfer from a service to another, all effort should be taken to avoid known factors or situations that heighten the risks associated with the patient's mental disorder. Where it becomes necessary to vary the conditions of a community treatment order (such as place of residence) the responsible clinician must authorise and the adult's care plan updated.	
	Guardianship	
15.14	Section 7 of the Mental Health Act has the power to require a person to live in a place specified by the Guardian (which is usually the local authority). If someone is required to live in a particular place under this piece of legislation, then the guardian has the authority to change the place of residence, such as in the event of a service closure. If legally challenged Halton Borough Council would need to be able to show that it had acted in a way which promoted the person's dignity and choice.	*Mental Health Act 2007 section 17(2a)*
	Restriction Order	*Mental Health Act 2007*
15.15	This is an order under the Criminal Justice part of the Mental Health Act. It is an order made by the courts after someone has committed a serious offence. It can impose residence requirements and these could be that a person has to stay in a particular residential setting. Is an adult with a restriction order where to be affected by a service closure, then the individual's social supervisor (which is usually a social worker) would have to be notified and they in turn would have to tell the Home Office (and thereafter this could go to the Home Secretary).	*Section 7*
	Client Finance	*Mental Health Act 2007 Section 37/41*
15.16	The personal financial arrangements of the adult using the service must be addressed prior to transfer. Please refer to Appendix 6 'Client Finance Checklist'	

16.0	**Self Funders**	
16.1	Halton Borough Council will ensure that self-funding adults are offered the support of a care manager. The self-funding adult is free to decline the support of a care manager, but the following must still be offered. • transport to a new service of their choice • support in moving or transferring personal possessions • accessing the same level of information on the closure process • relevant support to carers and families • details of vacancies within the area • details of local advocacy services • support in contracting with an alternate provider.	
17.0	**Identifying alternative residential placements**	
17.1	HBC Quality Assurance Team will provide a 'bed vacancy list' of in-borough available placements at Care Homes.	
17.2	In consultation with the individual, next of kin, relatives/ friends and carers and any professionals involved, the preferred choice of alternative service should be identified.	
17.3	The needs of groups with protected characteristics must be addressed - i.e. age, ethnicity, religion, disability, mental capacity, sexuality	
17.3	Where possible, adults affected by the closure should not be separated from long-term friends and/or staff.	
18.0	**Identifying alternative domiciliary support**	
18.1	HBC currently hold a contract with 17 external providers for domiciliary support services.	
18.2	If a current provider gives notice on the contract as a whole the packages they are commissioned to provide can be transferred to another contracted	

	provider.	
19.0	**Identifying alternative supported living placements**	
19.1	If a current provider gives notice on the contract as a whole, or an individual service they provide at a particular tenancy/placement; a call-off can be made from the ALD Framework (for both adults with a learning disability or mental health issue); whereby providers who are contracted with the Council can submit a bid for the available work via The Chest procurement website.	
19.2	If due to landlord closing the property the tenancy/placement is no longer available; HBC Quality Assurance Team will provide a 'bed vacancy list' of in-borough available tenancies/placements at Supported Living properties. Where possible the provider can transfer with the service user.	
19.3	In consultation with the individual, next of kin, relatives/ friends and carers and any professionals involved, the preferred choice of alternative service should be identified.	
19.4	The needs of groups with protected characteristics must be addressed - i.e. age, ethnicity, religion, disability, mental capacity, sexuality	
19.5	Where possible, adults affected by the closure should not be separated from long-term friends and/or staff.	
20.0	**Transfer**	
	Arrangements for Transfer – Care Home	
20.1	Where circumstances allow, the date and time that the transfer will be made will be agreed between the new service, the adult, family/ friends, carers, next of kin and the closing service. These arrangements should be confirmed in writing to the adult/ relatives/ friends/ carers/ next of kin and to staff.	
20.2	Once the arrangements for the move have been confirmed then the HBC Adult Social Care practitioners who conducted the assessments in liaison with the service, should make a list of the individual's needs, which would include: medical or clinical arrangements e.g. do they need to change their GP, transport arrangements for the adult, pharmacy and medication arrangements, equipment, aids, arrangements for dealing with the persons finances, arrangements for packing and moving personal possessions, arrangements for leaving the service (e.g. opportunity to say goodbye) and greeting at the new home (by someone familiar where possible).	

20.3	Equipment needs must be considered i.e. decommissioning of equipment in original home and re-commissioning of equipment in receiving service or transport of equipment to arrive/be in situ for the arrival of the person in the receiving service.	
20.4	Where it is possible to do so (dependent on planned/emergency closure and time scales) a visit, or preferably several visits, to a prospective service or supported living environment will be arranged. Having a meal or an overnight stay would be preferable. In the case of people with a learning disability a handover over several days will be arranged.	
20.5	On the day of the transfer communication should be maintained between the HBC Social Worker who undertook the assessment, the closing service and the receiving service, to co-ordinate and confirm departures/ arrivals and handover of property.	
20.6	Where ever possible, care staff should be encouraged to support adults at their new service for an initial settling-in period. This promotes familiarity and consistency of care.	
20.7	The Care Manager will take responsibility for ensuring that any documentation for individual adult is fully developed and accurate, for transfer with that adult to their new service. A transfer letter will be sent with the adult, identifying any critical issues relating to their nursing of care needs.	
20.8	A member of the originating service's management team will contact each of the receiving service providers in the 24 hours before the date of the planned transfer of any individual as a final check to ensure they are fully prepared to accept the adult/s the following day.	
20.9	It will be made clear to the Responsible Manager of any receiving service that they are empowered to refuse the transfer of an adult if they are not happy that all suitable arrangements have been put in place and that the support plans etc are absolutely clear.	
20.10	Transport arrangements will be made by the person designated by the MDT, ensuring that the vehicle is suitably equipped to accommodate the needs of the adult/s who will be accompanied by a carer who knows them and can offer support during the journey.	
20.11	The clothing, possessions and furniture owned by the adults/s should go with them to the new service so that their new environment is as familiar as possible.	

20.12	Where time constrains allow, any adult who is considered not to be physically well enough to move will have their transfer date put back until well enough to transfer to the new service. Appropriate medical involvement will be sought and appropriate staff involved in the assessment and treatment of the person. The Responsible Manager at the originating service on the day of transfer will have the authority to cancel or postpone the move of the adult/s if they have any doubts as all that it is appropriate or safe on that day. They will know that they have the support of senior managers to take this decision	
20.13	Negotiations will take place between the originating service and new providers to ensure that staff familiar with the adult/s can support the adult/s who are transferred for a suitable period of time (during the first week) to ensure smooth transfer.	
	Transfer	
20.14	The Responsible Manager must keep the lead inspector for CQC informed in relation to the work in progress to meet the date of closure.	
20.15	On the day of the transfer communication should be maintained between the assessor, the closing service and the new service, to co-ordinate and confirm departures/ arrivals and handover of property.	
20.16	The Responsible Manager must inform the lead inspector for CQC in relation to the expected time of closure on the given date.	
20.17	On the day of closure of the service the MDT Project Lead/s and Responsible Manager must hold an on-site meeting with the proprietor to complete a closing inventory of the service. This should then be cross checked with the inventory undertaken at the start of the managed period. Any discrepancies must be noted and where possible remedied.	
20.18	The Responsible Manager must discuss and arrange with the relevant health or social care colleagues the removal of any records or equipment provided by either health or social care.	
20.19	The Responsible Manager must arrange for all records kept during the managed period to be removed from the service and transferred to the relevant ASC Locality Team. Records management / data protection / legal obligations need to be considered throughout the process.	
20.20	The Responsible Manager must arrange for any medication remaining within the service to be safely disposed of.	
20.21	The Responsible Manager must handover the keys to the Proprietor and inform the Lead Inspector, CQC by telephone of the time of completion of the managed period.	

	Please refer to Appendix **7** for ' Facilities Management checklist'	
	Arrangements for Transfer – Domiciliary Care	
20.22	Where circumstances allow, the date and time that the transfer will be made will be agreed between HBC, the new service provider/s and the outgoing/closing service provider. The MDT Project Lead/s must liaise with HBC Performance Team for production of a report relating to the amount of packages currently commissioned with the provider (this should be cross checked with the latest Master Service Return (MSR) from HBC Income & Assessment Team). The outgoing /closing provider should also provide a list of all commissioned packages they provide under the contract.	
20.23	A new provider/s should be identified by HBC and communicated to the outgoing /closing provider; providers will need to liaise with each other in relation to TUPE obligations once service user transfer lists have been provided. Staff should be informed by the outgoing /closing provider in relation to TUPE obligations.	
20.24	These arrangements should be confirmed in writing to the adult/ relatives/ friends/ carers/ next of kin by HBC.	
20.25	HBC Care Arrangers will complete new service agreements for the new provider/s and close service agreements for the outgoing /closing provider. This should be done via instruction of the MDT Project Lead/s, rather than Care Management; internal communication should be sent to this effect.	
20.26	Service user Support Plans should be sent from HBC Care Management Team to the new provider/s, to ensure that staff familiar with the service user.	
	Arrangements for Transfer – Supported Living Care Provider	
20.27	The date and time of the transfer will be clearly discussed and agreed between HBC and the outgoing /closing provider and detailed in the tender call-off documentation.	
20.28	These arrangements should be confirmed in writing to the adult/ relatives/ friends/ carers/ next of kin by HBC.	
20.29	Once the tender call-off is awarded to a new provider regular meetings should be held in relation to the transfer.	

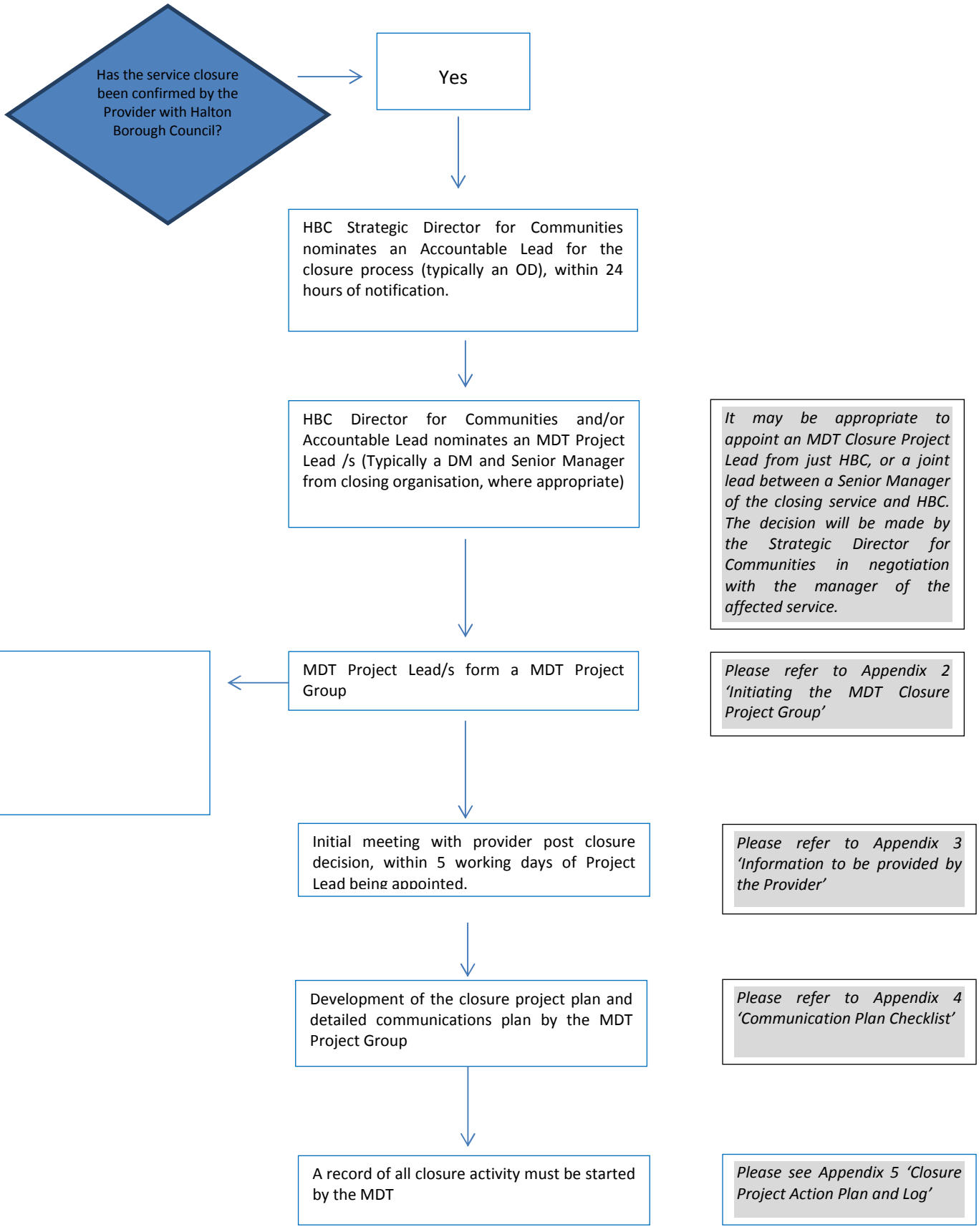
20.30	Turnbull arrangements need to be considered whereby landlord differs from care provider.
	Arrangements for Transfer – Supported Living Landlord
20.31	The date and time of the transfer will be in line with the individual service user's tenancy agreement (notice period).
20.32	As the notice periods may vary many will not allow sufficient time to complete a transfer to a new singular property for the current service user/s; HBC Quality Assurance Team will provide a 'bed vacancy list' of in-borough available tenancies /placements at Supported Living properties. Where possible the provider can transfer with the service user.
20.33	Turnbull arrangements need to be considered whereby landlord differs from care provider.
	Transfer
20.34	Transport arrangements will be made by the person designated by the MDT, ensuring that the vehicle is suitably equipped to accommodate the needs of the adult/s who will be accompanied by a carer who knows them and can offer support during the journey.
20.35	The clothing, possessions and furniture owned by the adults/s should go with them to the new service so that their new environment is as familiar as possible.
	Post Transfer
20.36	A social work review will be undertaken 6 weeks post transfer, to ensure that the individual's needs continue to be met within the new setting. Health reviews will be completed with one month
21.0	**Terminating the MDT Closure Project**
21.1	The MDT Closure Project Lead/s and Accountable Lead should assess each closure situation to determine how long post transfer the project team is required to undertake the post transfer responsibilities. The project plan should be extended accordingly, through negotiation with the new service/s.
21.2	On completion of the post transfer period, The MDT Closure Project Lead/s and appointed Accountable Lead Operational Director must facilitate a debriefing session/s based on feedback from the adults affected, their

	representatives and staff in order to complete a learning report and make any necessary amendments to this document.
21.3	The learning report is to be completed within 3 months of termination of the project and should include: • Outcome of transfers • Lessons to be learned • Any further actions
21.4	The report should be circulated to the HBC Director for Communities Senior Management Team, HBC Contracts Team and Quality Assurance Team and the CCG.

Appendix 1 Halton Borough Council Service Closure Policy

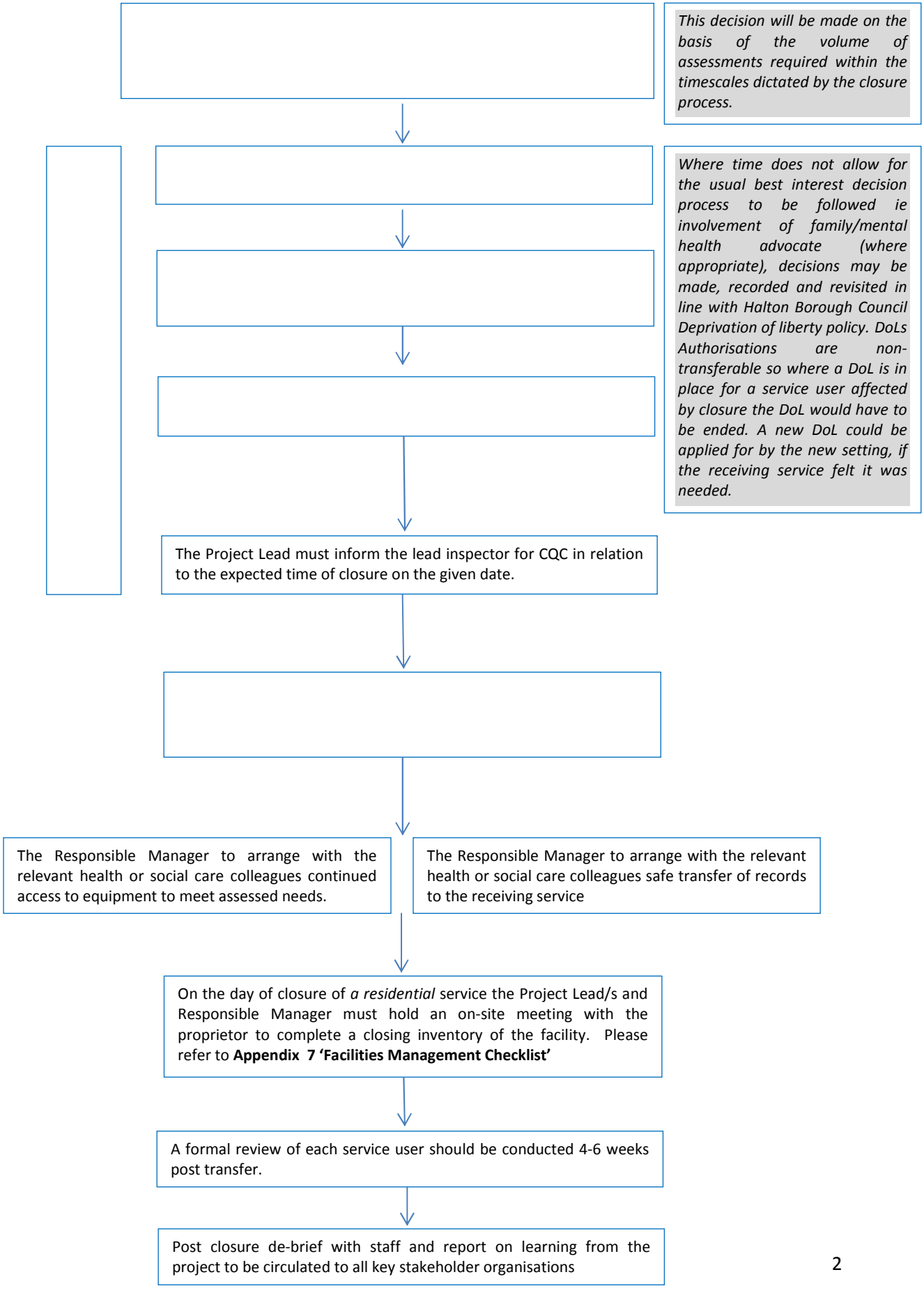
Responding to a Planned Service Closure Flow Chart

Stage 1: Responding to closure notification



Appendix 1 Halton Borough Council Service Closure Policy

Stage 2: Assessment, Care Planning and Transfer



Appendix 5 Halton Borough Council Service Closure Policy

Project Closure Action Plan and Log

Date : ? / ? /20
(dd/mm/yy)

Name of Service :

Address :

Contact Telephone Number/s:

VERSION CONTROL:

REFERENCE

Managed transfer of responsibility – Legal Authority to act under S2: Local Government Act 2000 'Well Being Powers'

OVERVIEW OF PROFESSIONALS INVOLVED IN THE HOME CLOSURE

NAME & DESIGNATION	CONTACT DETAILS
Owner of Service:	
DASS Lead	
Project Lead/s (with responsibility for completing this form):	
CQC Inspector:	
HBC Legal:	
Halton Accountable Lead:	
NHS Halton CCG Lead:	

Appendix 5 Halton Borough Council Service Closure Policy

OVERVIEW OF SERVICE USERS IN THE HOME:

SERVICE USER	DATE OF BIRTH (dd/mm/yyyy)	RESPONSIBLE FUNDING AUTHORITIES: CONTACT DETAILS	NAMED 'OTHER LOCAL AUTHORITY' SENIOR MANAGER: CONTACT DETAILS (Only if Non Halton)	DATE RISK / ASSESSMENT COMPLETED (dd/mm/yyyy)	DATE INVENTORY COMPLETED (dd/mm/yyyy)	TRANSFER DATE (State Actual or Proposed) (dd/mm/yyyy)

Appendix 5 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Risk Plan			
Confirm Actions taken to support provider			
Confirm HBC legal view on closure			
Collate details of all Halton service users			
Confirm reviews requires/ action reviews			
Confirm contract requirements			
Prepare communications briefings (see Appendix 4 Communications Checklist)			
Confirm local voids and vacancies			
Meet with DASS Lead to confirm actions			
Arrange independent advocacy for those who may require			
Inform CQC of decisions			
Schedule meetings with Service owners			
Staffing (on-going)			
Confirm Responsible Manager supervision arrangements			
On-going review of staffing needs of home (care and ancillary)			

Appendix 5 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Responsibility for Commissioning staffing to cover for any shortfall			
Responsibility for rotas, supervision and personnel related queries/actions e.g. leave, sickness			
Out of hours/on call senior management cover			
Finance			
Agreement for Provision of funding stream for managed period			
Staffing			
Food			
Service Users Personal Allowance			
Utilities/services			
Property/buildings insurance			
Petty Cash			
Maintaining existing service			
Inventory to be completed with Proprietor at start of managed period			

Appendix 5 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Proposed agreement between Proprietor and LA re terms of reference for managed period			
Running activity and finance logs (to commence at point of handover until end of managed period)			
Handover of Home related information to include – Staff records, Staff rotas, suppliers of Goods/Services, Insurance cover, any planned facilities maintenance during managed period			
Communication with service users, relatives and other Local Authorities			
Risk assessments for Environment			
Risk assessments for service users			

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Engagement with health professionals e.g. DN/CPN/GP			
Handover of all resident related information e.g. care plans, medication charts, health records, relative contact details			

Appendix 5 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY

IDENTIFICATION OF NEW PLACEMENTS

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Halton Funded Service Users			
Information on local vacancies via placement officer			
Updating Community Care Assessment by Care Managers			
Detailed Community Care Assessment to placement officer			
Inventory of personal effects			
Communication with service user and relations			
Liaison/updating Transfer Coordinator			
Non Halton LA Funded Service Users			
Identification of named manager and communication	Halton Transfer Coordinator		
Updating Community Care Assessment			

Appendix 5 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Identification of vacancies			
Inventory of personal effects			
Communication with Service User and relatives			
Liaison with Transfer Coordinator			
Self-Funding Service Users			
Allocation of Care Manager for completion of Community Care Assessment			
Assistance and advice re placements			
Inventory of personal effects			
Liaison with Transfer Coordinator			
Completion of closing inventory of the home			
Communication with CQC re detail of closure			
On site Closure meeting with Proprietor			

Appendix 5 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Handover of keys			
Responsibility for financial recover and reconciliation			

Appendix 6 Halton Borough Council Service Closure Policy

Client Finance Checklist

General Issues	**Action: Social Worker**
Is the manager, owner or any other staff member the benefit appointee for any of the residents?	
Is the home holding any cash which belongs to any residents?	
Is the home holding any benefit or bank books which belong to any of the residents?	
Is the home holding any valuables on behalf of any resident?	
Does anyone connected with the home have access to any residents' savings accounts?	
Does anyone connected with the home manage the financial affairs for any of the residents?	
Residence Issues	**Action: Social Worker**
What date did the resident take enter the accommodations?	
Was the resident placed by Cheshire or Halton Social Services?	
Did the resident make his/her own arrangements?	
Is another local authority involved?	
Does the resident have protected status?	
Does the resident manage his or her own financial affairs?	
Are all the residents present in the home?	
Benefit and Finance Issues	**Action: Finance Staff**
Is the resident in receipt of benefits?	
Who holds the resident's benefit books?	
Does the resident have an appointee for benefit purposes?	
Does anyone have power of attorney on the resident's behalf?	
Does anyone else manage the resident's financial affairs?	

Appendix 6 Halton Borough Council Service Closure Policy

Financial Assessment Issues	**Action: Finance Staff**
Has the resident had a Cheshire or Halton financial assessment?	
Does the resident pay another authority for the accommodation?	
Does the resident meet the cost of the accommodation from his or her own finances?	
Does a 'third party' make any payments towards the cost of the accommodation?	
Does the resident have any standing orders or direct debits in force to pay for the accommodation?	
Does the resident hold any outstanding invoices for services provided by the home?	
Does Halton hold any outstanding invoices for services provided by the home?	

Appendix 7 Halton Borough Council Service Closure Policy

Facilities Management Checklist

WHAT	ACTION REQUIRED	LEAD PERSON	TIME SCALE	PROGRESS UPDATE
Gather all relevant stakeholders information	Contact/write to • Day Centres • PCT/LCC • SW/GPs • Agencies • Utilities • Community nurses • Transport • Trade directories • Neighbours			
Keys	Collect keys from any key holder			
Signage	Remove all signage			
Credit cards	Cancel any organisation's credit cards			
IT	Inform any IT department • Remove access to network • Phones to be diverted • Computers to be removed			
Insurance	• Inform building and contents insurers if building is to be empty • Liability and indemnity insurance cancelled			
Vacancy rates	Apply for vacancy rates			
Utilities	Take a reading of gas/water and electric. Ask for final phone bill and broad band bill			
Portable and electrical equipment	Remove all small electrical equipment, i.e. TVs music systems, microwaves			
Inventory	Check inventory against any checklists			
Fridges/Cupboards	Empty cupboards and fridges, leave fridge doors open			
Mail	• Inform bands and other			

Appendix 7 Halton Borough Council Service Closure Policy

	correspondents • Inform Royal Mail and have mail diverted to appropriate address			
Medicines	Remove all medicines and record disposal accordingly			
Confidential files	Remove all confidential files and archive according to current legislation			
Stationery	Remove all stationery			
Contractors	Consult services contracts. Inform contractors of termination. Serve notice if required			
Minibus/cars	Cancel insurance/contract			
Rubbish	Remove all rubbish from site/unit			
Cleaning of unit	Cleaners to action			
Petty cash	To be signed off			

HALTON BOROUGH COUNCIL

Communities Directorate

NHS Halton Clinical Commissioning Group

Provider Service Closure
3. Managing an Unplanned Service Closure

April 2015

INFORMATION SHEET

Service area	**Halton Borough Council Adult Social Care Communities Directorate.** **Halton Borough Council Integrated Safeguarding Unit** **Halton NHS Clinical Commissioning Group** **Adult Social Care Providers**
Date effective from	TBC
Responsible officer(s)	Quality Assurance Manager
Date of review(s)	TBC
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory for all Halton Borough Council Adult Social Care Staff
Target audience	Halton Borough Council Commissioning Managers Halton Borough Council Quality Assurance Team and Contract Team Halton Borough Council Adult Social Care Teams NHS Halton Clinical Commissioning Group Continuing Health Care Team Adult Social Care Providers Adults who use services, their families and carers
Date of committee/SMT decision	TBC
Related document(s)	Mental Capacity Act Data Protection Act Human Rights Act Deprivation of Liberty Safeguards Mental Health act
Superseded document(s)	Halton Borough Council Home Closure Protocol 2004
Equality Impact Assessment Completed	Need to do new one

File Reference	

Contents

1.0	**Aim of the Policy**	**PRACTICE**

1.1	In cases where there is an immediate termination of a provider contract or 'urgent' closure of a service within the scope of this policy, there will clearly be limited preparation time, but every effort should be made to ensure that any moves are undertaken with sensitivity to the individual needs of the service user.	The associated policies, listed below, should be considered alongside this document. • Provider Service Closure 1. Market Oversight and Management • Provider Service Closure 2. Managing a Planned Service Closure
1.2	In responding to an emergency, or unplanned closure, paramount consideration should be to ensure that adults' needs continue to be met with the least disruption and stress to them. The actions outlined in this policy and associated appendices are not necessarily sequential (the response required for each emergency closure situation will be assessed given the circumstances and immediacy of the closure), nor are the procedures intended to restrict staff from using their initiative and responding sensitively and imaginatively to unforeseen situations or to particular individual needs	
1.3	This policy provides guidance on how Halton Borough Council (HBC) delivers its responsibilities in managing an **unplanned** service closure.	
1.4	This policy document (*Provider Service Closure 3.Managing an unplanned service closure*) is part of a suite of policies that direct : • provider market management, oversight, intelligence and prevention of service disruption for residential and domically providers(through planned or unplanned service closure) • management of a planned service closure (residential, supported living and domiciliary) • management of an unplanned service closure (residential, supported living and domiciliary)	
2.0	**Scope of the protocol**	
2.1	The possibility of interruptions to residential, supported living and domiciliary care and support services causes uncertainty and anxiety for the person receiving services, their carers, family and friends. Interruptions to services can occur as a result of many different factors, including business failure, significant safeguarding issues or quality compliance issues that fail to be rectified.	
2.2	Transferring from a familiar setting, either as an individual or as part of a group, is likely to be stressful. This is especially so when there is very little or no warning of a disruption to service as in the case of an emergency closure.	
2.3	This policy details how HBC meets its responsibilities, in relation to the Care Act, in the following area:	

	• Responding to an unplanned residential, supported living or domiciliary service closure – where little or no notice of closure has been given to HBC.	
2.4	This policy applies to services in which there are funded and/or self-funding individuals.	
2.5	The scope of this policy is not to replace individual service business continuity plans. It is a requirement of every HBC commissioned service provider to have a 'tried and tested' Business Continuity Plan that is reviewed.	
3.0	**Principals which underpin this protocol**	
3.1	In undertaking a planned closure of a service within the scope of this policy, HBC and Halton CCG are committed to the following principles: • Provider market oversight and intelligence is used to foresee closure risks and implement remedial actions to prevent closures, where possible. • Where decision making results in the need to make a planned closure of a service, timescales are appropriate to the adults who use the service, where ever possible. • Ensure that the dignity and welfare of adults who use services is considered at all times. • Communicate decision making in a timely, effective and transparent manner to all stakeholders. • Minimise disruption and distress to adults who use services, promoting familiarity and consistency of care wherever possible. • Where relocation of adults who use services is required, assess the needs of all adults, irrespective of funding arrangements. • Ensure that alternative accommodation takes into account compatibility of each adult's needs to promote positive cohabitation between groups of adults using a supported living service. • Service closures will be managed as a multi-agency project so that all organisations offering some level of care or support to adults, can work towards the common aim of effecting best outcomes and continuity of care. Key players (regulators, receivers/administrators, HBC and CCG commissioners, GPs, Social Workers, residents' representatives, professional associations and other Local Authorities etc.) must therefore be engaged at the earliest possible stage. • Work collaboratively with other organisations and partners to promote effective communication, timely processes and effective use of shared resources. • Ensure that any individual assessments or decision making, meet the requirements of the Mental Capacity Act 2005; particularly the need to assess mental capacity during the closure process and to make decisions on behalf of those lacking mental capacity in their best	*Care Act 2014* *Halton Borough Council Mental Capacity Act 2005 Policy, Procedure and Practice* *Halton Borough Council data Protection Act Policy, Procedure and Guidance 2011*

	interests. • Consider equality and diversity issues throughout the closure process, respecting the cultural needs of adults who use the service and using advocates and interpreters wherever necessary. • Develop good practice by monitoring and reviewing the closure processes used. • Staff will work in accordance with the principles of the Data Protection Act 1998 and information sharing agreements.	
4.0	**Legal Responsibilities which underpin this protocol**	
4.1 4.2 4.3 4.4 4.5	HBC's mandatory statutory duty to eligible people already receiving the service, is to meet their assessed eligible needs appropriately and safely (to do otherwise would be a breach of statutory duty, potentially enforceable by injunction). HBC has a responsibility towards **all** people receiving care. This is regardless of whether they pay for their care themselves, the local authority pays for it, or whether it is funded in any other way. Leaving a person in a service in which there would be significant risk of harm may be at risk of breach of contract compliance, CQC notification of serious concerns or closure could lead to a breach of their rights under the Human Rights Act. It is part of the duty of HBC to re-assess someone's needs, but this may be done retrospectively where emergency, unplanned closure tie scales do not allow assessment before transfer. In reassessment, the law requires best interests of the adults and their families are considered, in compliance with the Choice Rights outlined in Choice Directions and that appropriate consents are observed in accordance with the Mental Capacity Act.	*Care Act* *Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services, England. Department of Health 2012* *Halton Borough Council Mental Capacity Act 2005 Policy, Procedure and Practice*
5.0	**Safeguarding**	
5.1 5.2	HBC and Halton CCG are required to safeguard the needs and welfare of all adults who use services in their area during a transition to another service, regardless of whether they are self or publicly funded and regardless of which local authority has placed them there. Where safeguarding issues are identified, the Safeguarding Adults in Halton Interagency Policy and Procedure must be followed.	*Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Guidance 2015*
6.0	**Mental Health Act and Mental Capacity Act Implications**	

6.1	The Mental Capacity Act requires everyone in the first instance to assume that the individual has the mental capacity to make decisions; a person must also be supported to make their own decisions, as far as it is practicable to do so. The Act requires 'all practicable steps' to be taken to help the person. It is a key principle of the Act that all steps and decisions taken for someone who lacks mental capacity must be taken in the person's best interests.	*Halton Borough Council Mental Capacity Act 2005 Policy, Procedure and Practice*
6.2	Consultation with others is subject to obtaining informed consent from adults who use services. Where an adult is unable to consent or make important decisions because of mental incapacity, the Mental Capacity Act 2005's code of practice and regulations will apply to financial, serious health treatment and accommodation decisions. Best interest decision making until then is subject to common law and case law.	*The Human Rights Act 1998 Article 5 for information relating to deprivation of liberty.*
6.3	Adults who lack mental capacity may require an independent mental capacity advocate (IMCA). It is compulsory for the local authority to consider whether an IMCA should be instructed, so it is therefore advisable to give the IMCA service early warning that their service may be required. In respect of adult protection concerns, instructing an IMCA must be considered.	*Mental Capacity Act 2005*
7.0	**Duty On HBC to meet needs of individuals in the event of service closure**	
	Where closure is as a result of business failure	*Department of Health Care Act Briefing Note 'Managing provider failure and other service interruptions'*
7.1	HBC are under a temporary duty to meet people's needs when a provider is unable to continue to carry on their activity because of **business failure**.	
7.2	The temporary duty on HBC to meet needs continues for as long as HBC considers it necessary.	
7.3	The duty applies regardless of whether a person is ordinarily resident in Halton. However, HBC may charge the person for the costs of meeting their needs, and it may also charge another local authority which was previously meeting those needs, if it temporarily meets the needs of a person who is not ordinarily resident in Halton. The charge must cover only the cost incurred by HBC in meeting the needs. No charge can be made for the provision of information and advice to the person.	*There is significant flexibility in determining how needs can be met, as set out in section 8 of the Care Act.*
7.4	The needs that must be met are those being met by the provider immediately before the provider became unable to carry on the activity.	
7.5	The duty applies from the moment HBC becomes aware of the business failure. The actions to be taken will depend on the circumstances, and may range from providing information on alternate providers, to arranging care	

	and support.	
7.6	In deciding on how needs can be met, HBC must involve the person concerned, any carer that the person has, or anyone whom the person asks the authority to involve (this may include best interest assessor or advocates).	
7.7	If the provider's business has failed but the service continues to be provided then the duty is not triggered. This may happen in insolvency situations where an Administrator is appointed and continues to run the service.	
	General duty to meet people's needs, regardless of if closure is triggered by business failure	
7.8	Further to the duty outlined above, sections 18 and 20 of the Care Act set out when a local authority must meet a person's eligible needs. If the circumstances described in the sections apply and the needs are eligible, HBC must meet the needs in question. *These duties apply whether or not business failure is at issue.*	*Care Act section 18 & 20*
7.9	How someone pays for the costs of meeting their needs must have no influence on whether HBC fulfils the duty.	
	Meeting urgent needs	
7.10	The local authority may meet urgent needs regardless of whether the adult is ordinary resident in Halton. This means the local authority can act quickly if circumstances warrant.	
7.11	The power in section 19(3) of the Care Act can be exercised in order to meet urgent needs, where service closure or interruption is likely not as a result of business failure, without having first conducted a needs assessment, financial assessment or eligibility criteria determination.	
7.12	All people receiving services in the Halton are to be treated the same. In particular, how someone pays for the costs of meeting their needs – for example, in full by the person themselves – must have no influence on whether HBC fulfils the duty.	
	PROCEDURE	
8.0	**Responding to an unplanned service closure notification**	
	Closure Time Scale and Process	

8.1	On notification of an unplanned closure, the Strategic Director for Communities will be informed immediately by an Operational Director.	
8.2	The exact time scale for managing the closure process will be determined by the Commissioner in negotiation with the provider. Where ever it is possible to delay closure long enough to undertake as much of the 'planned closure' process as possible, this will be done.	
8.3	Factors that will influence the timescale for closure, and therefore the approach to managing each emergency closure situation include: • Factors initiating the closure i.e. fire, flood, risk of disease, risk to safety • Immediacy of the risk to service users, staff and public • Significance of the risk to service users, staff and public • Service provider co-operation	
8.4	In the event that closure is immediate, timescales and process outlined in the protocol and associated appendices may be subject to amendment, omission or done retrospectively. The MDT Closure Project Lead will seek advice from HBC Quality Assurance Team and HBC Legal experts in determining the exact process and timescales on a case by case basis.	
8.5	Please refer to Appendix 1 for Unplanned Service Closure Flow Chart which provides an overview of the process and associated appendices for each stage.	
9.0	**Multi-Disciplinary Team**	
9.1	The closure will be coordinated by a Multi-Disciplinary Team. Appropriate members of the MDT will be identified based on the nature of the planned closure, with the team being established within 24 hours of closure notification. The CCG will have involvement early in process to ensure engagement of NHS commissioned service providers like 5Borough Partnership and NHS Bridgewater Community Trust.	
9.2	In situations where significant risks within the service have already been identified through the market oversight and closure prevention processes (see Policy 1: Market Oversight), there will be an established 'Professionals Meeting' group. The membership of this group is reflective of the professional stakeholders who have any involvement with the service. The group will form the basis of the Project Closure Group, bringing with it information gathered as part of the process that precedes formal closure notification**.** Please refer to Appendix 2 for Initiating the MDT Closure Project Group .	

10.0	**MDT Closure Project Group Responsibilities**	
10.1	The MDT will: • Oversee the safe transfer of adults who are using the closing service to suitable alternative provision. • Liaise with relevant stakeholders including adults who use the service and their carers / families. • Develop and coordinate implementation of a closure project plan. • Develop and coordinate implementation of a Communication plan • Have responsibility for updating and maintaining a key communications log. • Coordinate and report on assessments of need, including health and risk . • Coordinate resources to undertake reassessment and transfer arrangements. • Report regularly on progress and risks. • Ensure that reviews of care are undertaken following transition. • Undertake a de brief on completion of closure to identify any learning from the process.	
11.0	**Provider Responsibilities**	
11.1	Under existing contracts HBC commissioned providers are required to have a business continuity plan in place. Depending on the nature of the closure it may be that the council's or the organisation's business continuity plan/s are initiated, over and above this protocol. For example, if closure is due to a natural emergency (i.e. significant flooding), fire or chemical leak.	
11.2	In order for HBC to meet its statutory responsibilities in meeting the needs of individuals affected by the service closure, the Provider must ensure that MDT project lead/s receive a list of **all** the adults who use the service, including as much relevant information about the adult as possible. Failure of the service provider to provide all information requested by the MDT, within the time scales determined by the MDT, will constitute breach of contract. If the provider refuses to cooperate and provide information, then CQC have the legal right to request this information from the provider. Please see appendix 3 for a list of information to be provided checklist (Dom/Resi/SL).	
11.3	The Provider must have in place appropriate measures/safeguards where confidential information is transferred, so not to inadvertently disclosure confidential service user information to any unauthorised party. Likewise, Halton Borough Council will ensure that the transfer of information to stakeholders involved in the closure process will only be transferred in line	

	with the Data Protection Act. Health and social care providers are required to review records on commencement of the care arrangement with the prescribed times in the health and social care frameworks.	
11.4	The Provider must ensure that each adult has a list of their property in preparation for the move to another provider.	
11.5	The Provider must work collaboratively with the MDT Project Team to coordinate and arrange for re-assessments to be conducted for **all** adults who use the service, where time permits. As part of the assessment process the adults' next of kin, carers and families should be contacted and involved, if appropriate.	
11.6	Where the service closure is undertaken as an emergency and there is not enough time to undertake re assessment and/or instruct an IMCA to support decision making, these should be implemented retrospectively, at the earliest opportunity.	
12.0	**Communication about the service closure**	
12.1	Communication about the planned closure to residents and their families/carers, staff, stakeholders and wider public is critical to support the smooth transition to an alternative service.	
12.2	A communications plan is to be developed by the MDT Closure Project Lead/s within 48 hours of closure notification. The communication plan must include consideration of appropriate methods, frequency and content of communications. Please refer to Appendix 4 Communications checklist' **Safe Communication in the event that a closure is as a result of significant safeguarding concerns**	
12.3	Closing a service in the context of allegations of abuse brings additional requirements around communication. The whole scenario may be more complex because of police investigations. In this case, guidance should be sought by the appropriate Police Authority before communications are circulated, to ensure that any information provided will not jeopardise any possible future criminal investigation.	
12.4	It is imperative that staff members are aware that all records (e.g. emails, notes, diaries and minutes) may be evidence (for the prosecution) or subject to disclosure (to the defense) where a criminal case is pursued. Therefore, detailed contemporaneous notes should be made of all discussions with the service managers and adults using the service.	
12.5	Ideally any discussions should be undertaken with a colleague present who	

	can witness the conversation and countersign notes of the discussion as a true and accurate record.	
12.6	Where it is necessary to communicate via email under no circumstances should the name of individuals or the service be disclosed in the title or body or an email. If it is necessary to communicate this information it should be in a password protected attachment sent via HBC Encrypt email (password is produced by the person receiving the email).	
12.7	For password protected documents, the password should only be disclosed verbally to the recipient i.e. it should not be transmitted in a subsequent email or sent for general use at the inception of the project; in this circumstance it should only be released to project members. The project will be allocated a code name and all documents must have password protection.	
12.8	Face to face and telephone conversation may sometimes be more appropriate than emails.	
12.9	Staff should be cautious when information is requested over the telephone and should always thoroughly verify who they are speaking to.	
12.10	The Freedom of Information Act and access to records procedures must be considered when recording and releasing information.	
12.11	Information needs to be shared with the Care Quality Commission (CQC) throughout the process, particularly about the maintenance of standards of quality and safety during the closure.	
13.0	**The 'managed period'**	

13.1	The MDT Closure Project Lead/s will identify a 'Responsible Manager' to manage the service during the 'managed period', where this is required.	
13.2	The Project Lead/s must discuss with the proprietor whether the financial status of the business might, in anyway, effect the managed period. Where there are concerns in relation to any information shared by the Proprietor the HBC Project Lead/s must share those concerns with CQC.	
13.3	In addition to the Responsible Manager, the Project Lead/s must also identify a transfer co-ordinator to be responsible for the co-ordination and liaison in relation to all transfers of all adults from the service, including those funded by other Local Authorities, CCGs and Continuing Health Care and adults who are self-funding.	
13.4	The Responsible Manager must undertake an inventory with the proprietor of the service in relation to the service's contents and the adults' personal effects. This must be recorded.	
13.5	The Responsible Manager must immediately assess and undertake risk assessments in relation to: ▪ Maintaining the existing service Staffing/risk ▪ Adults' needs/risk	
13.6	As part of the local information sharing protocol , information relating to the closure of a service within Halton is shared with other Local Authorities and CCGs.	
	Financial Resources during the 'managed period'	
13.7	Following the cancellation of the CQC registration, or other relevant enforcement action, it is illegal for the proprietor to undertake any financial management in relation to the service e.g. receive fees, purchase food, pay for repairs to equipment, supplies, staff costs etc. All financial activity must be undertaken by HBC and recorded on the Finance Log.	
13.8	The nominated Responsible Manager of the running of the service within the managed period must begin a Service Activity Log (Appendix 5) and a Service Finance Log (Appendix 6).	
13.9	The Activity Log will relate to the day to day running of the service and cross reference to care notes where appropriate.	
13.10	The Finance Log will relate to daily expenses incurred and other general financial transactions undertaken. All financial transactions in relation to the service must be recorded on the financial log together with receipts where appropriate.	
13.11	A specific Agresso cost centre must be set up to record all transactions.	

13.12	For care homes, the funding stream will be used to provide funding for food, utilities and services, staffing costs and to provide Petty Cash during the managed period.	
13.13	Fees to the proprietor during the managed period must **not** be made by HBC.	
	Recovery of Expenses	
13.14	HBC will endeavour to recoup from the proprietor, any monies spent.	
13.15	The MDT Project Lead/s must identify an appropriate person to establish whether HBC have paid fees to the service in advance of the date of the cancellation of registration, thereby covering fees for the managed period. If this is the case, arrangements must be made to seek reimbursement from the Proprietor.	
13.16	It is the responsibility of any other Local Authority involved to undertake their own process in relation to recovering any monies owed to them for care fees from the Proprietor.	
13.17	HBC must invoice the proprietor for any expenses incurred within the managed period, giving the details for each transaction and relating to an adult including adults from other Local Authorities and those whom are self funding where appropriate.	
14.0	**Staffing**	
14.1	Exact requirements of the number of hours required and the number of health / care staff required to continue to deliver safe and appropriate care must be identified by the Project Lead, in consultation with the appropriate health and social care Senior Manager/s and based on assessment of the needs of adults affected by the service closure.	
14.2	This information must be passed to the Project Lead/s, together with written confirmation from the Accountable Lead that funding will be released to staff the service within the managed period.	
14.3	HBC will source the required care workers from the approved agencies or strategic providers and as per the agreed rates annexed to the pre-placement contract.	
14.4	The information will be communicated back to the Responsible Manager by the Project Lead/s	
14.5	The Responsible Manager shall arrange for a requisition to be raised on Agresso to cover the requirement. If more than one agency is used more than one requisition will be required.	

14.6	The Project Lead will approve the requisition(s) and a purchase order(s) will be issued.	
14.7	The Responsible Manager will review the ongoing staffing needs within the service during the managed period and commission, as required to cover shortfalls.	
14.8	HBC will endeavour to recoup from the proprietor, any monies spent.	
	Transfer of Undertakings Protection of Employment (TUPE)	
14.9	TUPE applies when an undertaking or part of it is transferred from one employer to another where: • all or part of a sole trader's business or partnership is sold or otherwise transferred • a company, or part of it, is bought or acquired by another (if the second company buys or acquires the assets and then runs the business rather than acquiring the shares only) • two companies cease to exist and combine to form a third • a contract to provide goods or services is transferred in circumstances which amount to the transfer of a business or undertaking to a new employer. Please refer to the service's business continuity plan.	
15.0	**Record Keeping**	
	Record keeping responsibilities of the MDT	
15.1	Good record keeping is essential during the service closure process to promote effective communication between staff and organisations, to promote transparency of decision making and to enable the transfer of information to the new service. Even in an emergency response to an unplanned closure, records must be maintained.	
15.2	A MDT Closure Project Log must be maintained by members of the MDT detailing specific actions to be taken, who/when by, progress against those actions and status (active/closed). Key communications with the Service, adults who use the service, public and other stakeholders must be recorded in this log also. Please refer to Appendix 7 for the 'Project Closure Action Plan and Log'	
	Record keeping responsibilities of Service Staff	
15.3	In addition to the Service Activity Log and Finance Log that the Responsible	

	Manager must maintain, service Staff will need to: • A designated Key Worker (within the service) to keep a record of all care plans, assessments, decision making and movements of adults who use the service. • Keep a log of medicines and ensure these are moved with the adult if this is necessary. • Keep a log of change of GP if this is necessary. • Keep a log of the adults finances and ensure these are moved with them if this is necessary. • Keep an inventory of the adult's belongings, to be signed by them if this is necessary. • Information should be available about each adult who uses the service on the following: registration category of adult who uses the service and identify any change of category, details of relatives, medical history, whether there is a requirement for advocacy to support the adult, details of the adults' needs including those that may require exceptional arrangements or health care provision. Also identify if there are any relatives of adults who may have factors to consider such as own health, whether they are out of borough, etc. • The adult who uses the services' life history book is particularly important for people with dementia, stroke etc.	
16.0	**Continuity of Care**	
16.1 16.2	Continuity of care is a priority, and where appropriate (depending on the nature of the closure), the MDT will work with the service provider to identify what support may be put in place to promote continuity of care for adults within that setting. The MDT will consider employing support from other services, which will be dependent on each service area's capacity at that time, including: • CPNs • District Nurses • Complex Care Teams • HBC Care Homes Project • Other Local Authorities who are affected by the closure	
17.0	**Assessment & Care Planning**	
17.1	Given the likely complex nature of many of the adults, a multiagency assessment should be undertaken. Social Care and Complex Care teams should undertake joint assessments prior to transfer, regardless of whether	*Halton Borough*

	the adults are in receipt of any health funding. Specialist assessments (i.e. mental health, swallowing) will be undertaken as advised by the initial assessment team. Where the service closure time scale does not allow for assessment to be done prior transferring, it must be done at the earliest opportunity post transfer.	*Council Care Management Policy*
	Staff resource to undertake assessments	
17.2	Halton Borough Council Divisional Manager for Care Planning, along with the Operational Director for Prevention and Assessment, will make a decision on whether Social Work staff will be utilised from different teams to respond the assessment demands of a service closure. This decision will be made on the basis of the volume of assessments required within the timescales dictated by the closure process.	
17.3	In some circumstances, where time scales and financial resources allow, agency Social Workers may be sourced to undertake assessments and post transfer reviews.	
17.4	Wherever possible existing care staff should be utilised during the closure and relocation process to pass on knowledge of the adults who use the service to new services, handover care plans and summaries, etc. and verbally discuss the adults' care needs.	
	Multi Agency Assessment	
17.5	Given the likely complex nature of many of the adults who use services, a multi-agency assessment should be undertaken. Social care and Complex Care teams should undertake joint assessments prior to transfer, regardless of whether the adults who use the service are in receipt of any health funding. Specialist assessments (i.e. mental health, swallowing) will be undertaken as advised by the initial assessment team.	
	Best Interest Decisions	
17.6	In an emergency closure of a service, where time does not allow for the usual best interest decision process to be followed i.e. involvement of family/mental health advocate (where appropriate), decisions may be made, recorded and revisited in line with Halton Borough Council Deprivation of liberty policy.	
	Deprivation of Liberty Safeguarding (DoLs)	*Halton Borough Council Deprivation of Liberty Safeguards Policy*
17.7	The residential/nursing home is the managing authority in the Deprivation of Liberty Safeguards. For homes the supervisory body is the local authority where the person is ordinarily resident. Usually this will be Halton Borough Council (where the care home is located), unless the person is funded by a different local authority.	

17.8	DoLs Authorisations are non-transferable so where a DoLs is in place for an adult who is using the service affected by closure the DoLs would have to be ended. A new DoLs could be applied for by the new setting, if the receiving service felt it was needed.	*Deprivation of Liberty Safeguards Code of Practice*
17.9	The receiving service must be made aware of the existence of the DoL, and for them to consider if a new application is required, based on the person's presentation, when they transfer.	
17.10	A person may need to be deprived of their liberty before HBC can respond to a request for a standard authorisation (for example, in an emergency/unplanned service closure). In these situations the receiving provider can use an urgent authorisation. Urgent authorisations are granted by the managing authority itself (the provider). There is a form that they have to complete and send to HBC Initial Assessment Team. This is then followed by a request for a Standard Authorisation. A Best Interest Assessor will complete the assessments within 7 days.	
17.11	If the closure was anticipated the prospective receiving service could apply for the Standard Authorisation prior to the move. A Best Interest Assessor will then complete the assessments within 21 days,	
	Community Treatment Orders	
17.12	Where residence at a named care/nursing home is a condition of the community treatment order, when managing a transfer from a service to another, all effort should be taken to avoid known factors or situations that heighten the risks associated with the patient's mental disorder. Where it becomes necessary to vary the conditions of a community treatment order (such as place of residence) the responsible clinician must authorise and the adult's care plan updated.	
	Guardianship	
17.13	Section 7 of the Mental Health Act has the power to require a person to live in a place specified by the Guardian (which is usually the local authority). If someone is required to live in a particular place under this piece of legislation, then the guardian has the authority to change the place of residence, such as in the event of a service closure. If legally challenged Halton Borough Council would need to be able to show that it had acted in a way which promoted the person's dignity and choice.	*Mental Health Act 2007 section 17(2a)*
	Restriction Order	
17.14	This is an order under the Criminal Justice part of the Mental Health Act. It is an order made by the courts after someone has committed a serious offence. It can impose residence requirements and these could be that a person has	*Mental Health Act 2007 Section 7*

	to stay in a particular residential setting. Is an adult with a restriction order where to be affected by a service closure, then the individual's social supervisor (which is usually a social worker) would have to be notified and they in turn would have to tell the Home Office (and thereafter this could go to the Home Secretary). **Client Finance**	
17.15	The personal financial arrangements of the adult using the service must be addressed at the earliest opportunity, whether time constraints do not allow for assessment to be completed prior to transfer. Please refer to Appendix 8'Client Finance Checklist'	*Mental Health Act 2007 Section 37/41*
18.0	**Self Funders**	
18.1	Halton Borough Council will ensure that self-funding adults are offered the support of a care manager. The self-funding adult is free to decline the support of a care manager, but the following must still be offered. • transport to a new service of their choice • support in moving or transferring personal possessions • accessing the same level of information on the closure process • relevant support to carers and families • details of vacancies within the area • details of local advocacy services • support in contracting with an alternate provider.	
19.0	**Identifying alternative residential placements**	
19.1 19.2	HBC Quality Assurance Team will provide a 'bed vacancy list' of in borough available placements at Care Homes. In the event of there not being sufficient number of beds in borough to meet the need of an emergency closure, HBC will work with other providers/Local authorities to negotiate what availability they may have outside of the	

	borough.
19.3	HBC will consult with other Local Authorities outside of borough and negotiate bed occupancy with the relative provider, where there is no in borough alternative.
19.4	In consultation with the individual, next of kin, relatives/ friends and carers and any professionals involved, the preferred choice of alternative service should be identified.
	The Choice Direction and Guidance
19.4	When someone is moved from one residential service to another the four provisions of the Choice Directions still apply - re-accommodating is therefore subject to: 1. **availability** of suitable alternative accommodation. It is not a reasonable choice for an adult to choose to remain where they are when the administrator has made the legally enforceable decision to close down the property or has abandoned the local authority's contract for the adults place in it. 2. **suitability** of alternative accommodation to meet the person's assessed need 3. **the usual rate** paid for such accommodation is acceptable to the new residential care provider. If it is not, and there is no other alternative accommodation for the person, meeting their assessed needs, the commissioning authority has no choice but to pay whatever rate is necessary to get them satisfactorily placed. 4. **choice** has been offered where it is possible and feasible to offer options that enable the adult to make a positive choice based on their preferences and all other conditions in 1, 2 and 3 above can be met.
19.6	In an emergency service closure, a person's first choice may not immediately available, in which case interim placements can be offered.
19.7	It must be ensured that 'assessed need' is a key determinant in selecting and/or funding a care placement. The care setting must be able to meet the assessed needs of the adult. In an emergency closure situation, Adults should not be placed in a setting, even if this is the service of choice, merely because there is a vacancy if the assessed needs can't be met.
19.8	Where the number of people requesting a particular service exceeds the number of places, there will need to be a robust and defensible allocation process in place to manage competing priorities.
19.9	The needs of groups with protected characteristics must be addressed - i.e. age, ethnicity, religion, disability, mental capacity, sexuality
19.10	Where possible, adults affected by the closure should not be separated from long-term friends and/or staff.

20.0	**Identifying alternative domiciliary care placements**	
20.1	HBC currently hold a contract with 17 external providers for domiciliary support services.	
20.2	If a current provider gives notice on the contract as a whole the packages they are commissioned to provide can be transferred to another contracted provider. Please refer to section: Transfer.	
21.0	**Identifying alternative supported living placements**	
21.1	If the unplanned closure relates to the care provider, HBC Quality Assurance Team will provide a 'bed vacancy list' of in-borough available tenancies/placements at Supported Living properties.	
21.2	If the unplanned closure relates to the landlord closing the property, the tenancy/placement is no longer available; HBC Quality Assurance Team will provide a 'bed vacancy list' of in-borough available tenancies/placements at Supported Living properties. Where possible the provider can transfer with the service user.	
21.3	In consultation with the individual, next of kin, relatives/ friends and carers and any professionals involved, the preferred choice of alternative service should be identified.	
21.4	The needs of groups with protected characteristics must be addressed - i.e. age, ethnicity, religion, disability, mental capacity, sexuality	
21.5	Where possible, adults affected by the closure should not be separated from long-term friends and/or staff. Please refer to section: Transfer.	
22.0	**Transfer**	
22.1	**Arrangements for Transfer – Care Homes** Where circumstances allow, the date and time that the transfer will be made will be agreed between the new service, the adult, family/ friends, carers,	

	next of kin and the closing service. These arrangements should be confirmed in writing to the adult/ relatives/ friends/ carers/ next of kin and to staff.	
22.2	Once the arrangements for the move have been confirmed then the HBC ASC practitioners who conducted the assessments in liaison with the service, should make a list of the individual's needs, which would include: medical or clinical arrangements e.g. do they need to change their GP, transport arrangements for the adult, pharmacy and medication arrangements, equipment, aids, arrangements for dealing with the persons finances, arrangements for packing and moving personal possessions, arrangements for leaving the service (e.g. opportunity to say goodbye) and greeting at the new home (by someone familiar where possible).	
22.3	Equipment needs must be considered i.e. decommissioning of equipment in original home and re-commissioning of equipment in receiving service or transport of equipment to arrive/be in situ for the arrival of the person in the receiving service.	
22.4	Where it is possible to do so (dependent on planned/emergency closure and time scales) a visit, or preferably several visits, to a prospective service or supported living environment will be arranged. Having a meal or an overnight stay would be preferable. In the case of people with a learning disability a handover over several days will be arranged.	
22.5	On the day of the transfer communication should be maintained between the HBC Social Worker who undertook the assessment, the closing service and the receiving service, to co-ordinate and confirm departures/ arrivals and handover of property.	
22.6	Where ever possible, care staff should be encouraged to support adults at their new service for an initial settling-in period. This promotes familiarity and consistency of care.	
22.7	The Care Manager will take responsibility for ensuring that any documentation for individual adult is fully developed and accurate, for transfer with that adult to their new service. A transfer letter will be sent with the adult, identifying any critical issues relating to their nursing of care needs.	
22.8	A member of the originating service's management team will contact each of the receiving service providers in the 24 hours before the date of the planned transfer of any individual as a final check to ensure they are fully prepared to accept the adult/s the following day.	
22.9	It will be made clear to the Responsible Manager of any receiving service that they are empowered to refuse the transfer of an adult if they are not happy that all suitable arrangements have been put in place and that the support plans etc. are absolutely clear.	

22.10	Transport arrangements will be made by the person designated by the MDT, ensuring that the vehicle is suitably equipped to accommodate the needs of the adult/s who will be accompanied by a carer who knows them and can offer support during the journey.	
22.11	The clothing, possessions and furniture owned by the adults/s should go with them to the new service so that their new environment is as familiar as possible.	
22.12	Where time constrains allow, any adult who is considered not to be physically well enough to move will have their transfer date put back until well enough to transfer to the new service. Appropriate medical involvement will be sought and appropriate staff involved in the assessment and treatment of the person. The Responsible Manager at the originating service on the day of transfer will have the authority to cancel or postpone the move of the adult/s if they have any doubts as all that it is appropriate or safe on that day. They will know that they have the support of senior managers to take this decision	
22.13	Negotiations will take place between the originating service and new providers to ensure that staff familiar with the adult/s can support the adult/s who are transferred for a suitable period of time (during the first week) to ensure smooth transfer.	
	Transfer	
22.14	The Responsible Manager must keep the lead inspector for CQC informed in relation to the work in progress to meet the date of closure.	
22.15	On the day of the transfer communication should be maintained between the assessor, the closing service and the new service, to co-ordinate and confirm departures/ arrivals and handover of property.	
22.16	The Responsible Manager must inform the lead inspector for CQC in relation to the expected time of closure on the given date.	
22.17	On the day of closure of the service the MDT Project Lead/s and Responsible Manager must hold an on-site meeting with the proprietor to complete a closing inventory of the service. This should then be cross checked with the inventory undertaken at the start of the managed period. Any discrepancies must be noted and where possible remedied.	
22.18	The Responsible Manager must discuss and arrange with the relevant health or social care colleagues the removal of any records or equipment provided by either health or social care.	
22.19	The Responsible Manager must arrange for all records kept during the managed period to be removed from the service and transferred to the relevant ASC Locality Team. Records management / data protection / legal obligations need to be considered throughout the process.	

22.20	The Responsible Manager must arrange for any medication remaining within the service to be safely disposed of.	
22.21	The Responsible Manager must handover the keys to the Proprietor and inform the Lead Inspector, CQC by telephone of the time of completion of the managed period. Please refer to Appendix **9** for ' Facilities Management checklist'	
	Arrangements for Transfer – Domiciliary	
22.22	Where circumstances allow, the date and time that the transfer will be made will be agreed between HBC, the new service provider/s and the outgoing/closing service provider.	
22.23	The MDT Project Lead/s must liaise with HBC Performance Team for production of a report relating to the amount of packages currently commissioned with the provider (this should be cross checked with the latest Master Service Return (MSR) from HBC Income & Assessment Team). The outgoing /closing provider should also provide a list of all commissioned packages they provide under the contract.	
22.24	A new provider/s should be identified by HBC and communicated to the outgoing /closing provider; providers will need to liaise with each other in relation to TUPE obligations once service user transfer lists have been provided. Staff should be informed by the outgoing /closing provider in relation to TUPE obligations.	
22.25	These arrangements should be confirmed in writing to the adult/ relatives/ friends/ carers/ next of kin by HBC.	
22.26	HBC Care Arrangers will complete new service agreements for the new provider/s and close service agreements for the outgoing /closing provider. This should be done via instruction of the MDT Project Lead/s, rather than Care Management; internal communication should be sent to this effect.	
22.27	Service user Support Plans should be sent from HBC Care Management Team to the new provider/s, to ensure that staff familiar with the service user.	
	Arrangements for Transfer – Supported Living	
22.28	If the unplanned closure relates to the landlord, HBC Quality Assurance Team will provide a 'bed vacancy list' of in-borough available tenancies/placements at Supported Living properties.	
22.29	Where vacancies are available in borough, MDT/Project Lead will make necessary arrangements with the current care provider at the closing property to continue to provide the care in a new tenancy.	
22.30	These arrangements should be confirmed in writing to the adult/ relatives/	

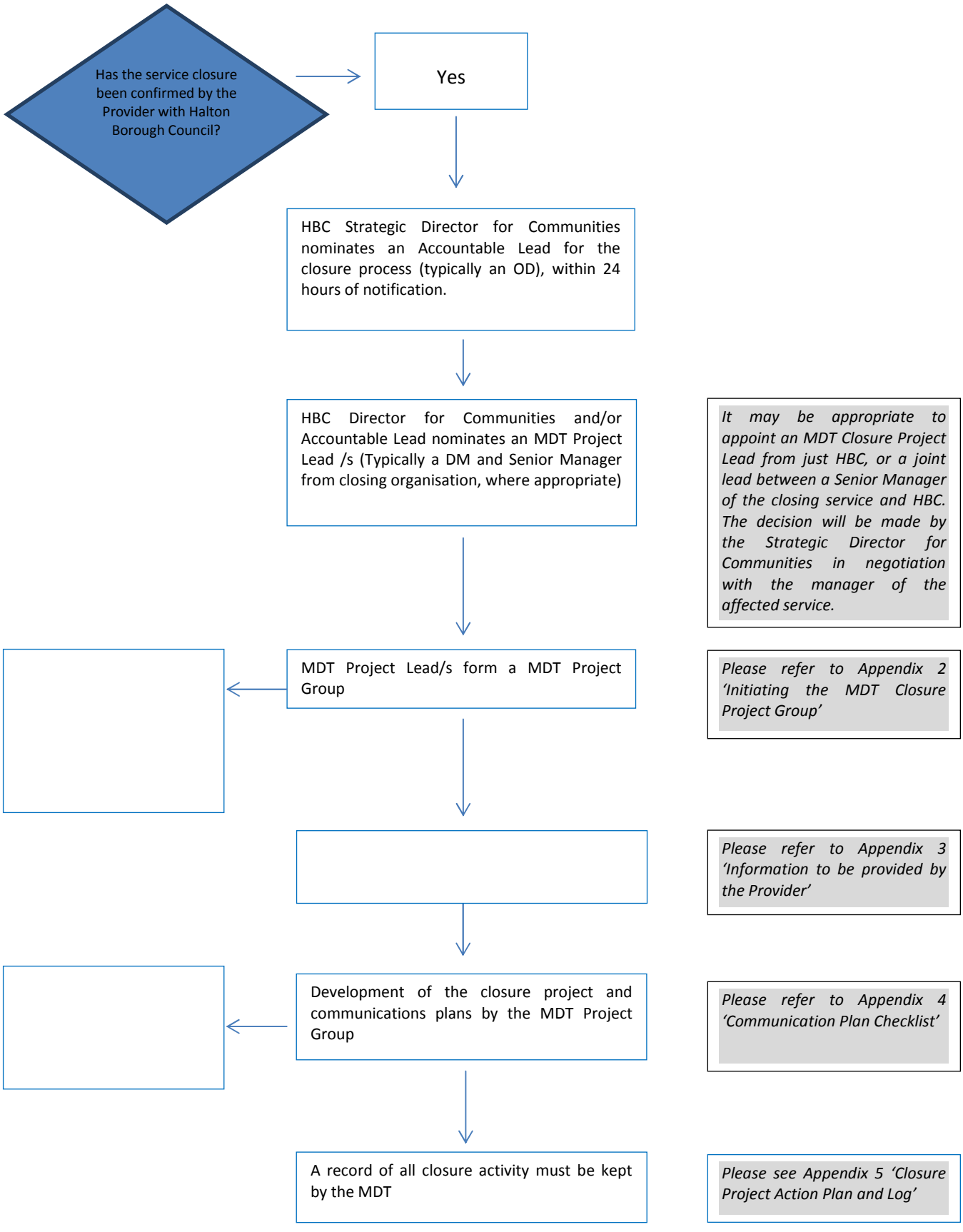
	friends/ carers/ next of kin by HBC.
22.31	HBC Care Arrangers will complete new service agreements for the current provider/s and close service agreements for the outgoing /closing provider. This should be done via instruction of the MDT Project Lead/s, rather than Care Management; internal communication should be sent to this effect.
22.32	If the unplanned closure relates to the care provider, HBC Quality Assurance Team will provide the list of contracted ALD framework providers.
22.33	MDT/Project Lead will make necessary arrangements with a new contracted ALD framework provider and arrange for care to commence at their current property.
22.34	These arrangements should be confirmed in writing to the adult/ relatives/ friends/ carers/ next of kin by HBC.
22.35	HBC Care Arrangers will complete new service agreements for the current provider/s and close service agreements for the outgoing /closing provider. This should be done via instruction of the MDT Project Lead/s, rather than Care Management; internal communication should be sent to this effect.
22.36	Relevant board report to be completed in relation to placing via this method rather than tender due to timescale and circumstances due to the unplanned closure.
	Transfer
22.37	Transport arrangements will be made by the person designated by the MDT, ensuring that the vehicle is suitably equipped to accommodate the needs of the adult/s who will be accompanied by a carer who knows them and can offer support during the journey.
22.38	The clothing, possessions and furniture owned by the adults/s should go with them to the new service so that their new environment is as familiar as possible.
	Post Transfer
22.39	A social work review will be undertaken 6 weeks post transfer, to ensure that the individual's needs continue to be met within the new setting. Health reviews will be completed with one month
23.0	**Terminating the MDT Closure Project**
23.1	The MDT Closure Project Lead/s and Accountable Lead should assess each

	closure situation to determine how long post transfer the project team is required to undertake the post transfer responsibilities. The project plan should be extended accordingly, through negotiation with the new service/s.
23.2	On completion of the post transfer period, The MDT Closure Project Lead/s and appointed Accountable Lead Operational Director must facilitate a debriefing session/s based on feedback from the adults affected, their representatives and staff in order to complete a learning report and make any necessary amendments to this document.
23.3	The learning report is to be completed within 3 months of termination of the project and should include: • Outcome of transfers • Lessons to be learned • Any further actions
23.4	The report should be circulated to the HBC Director for Communities Senior Management Team, HBC Contracts Team and Quality Assurance Team and the CCG.

Appendix 1 Halton Borough Council Service Closure Policy

Responding to an Unplanned Service Closure Flow Chart

Stage 1: Responding to closure notification



Appendix 1 Halton Borough Council Service Closure Policy

Stage 2: Initiating the 'managed period' , where this is required

The MDT Closure Project Lead/s to identify a registered 'Responsible Manager' *for the duration of the 'managed period'.*

↓

The Project Lead/s to identify a transfer co-ordinator

↓

The MDT Project Lead/s, Quality Assurance Manager and the Responsible Manager to complete an inventory with the outgoing service manager.

↓

The nominated Responsible Manager of the service within the managed period must begin a Service Activity Log and a Service Finance Log.

Please refer to Appendix 5 'Service Activity Log' and Appendix 6 ' Service Finance Log'

↓

Responsible Manager to check existing/re assess risk assessments for every service user.

↓

Exact requirements of the number of hours required and the number of care workers/staff required for the service must be identified including the number of existing staff from the service who have agreed to remain working during the managed period.

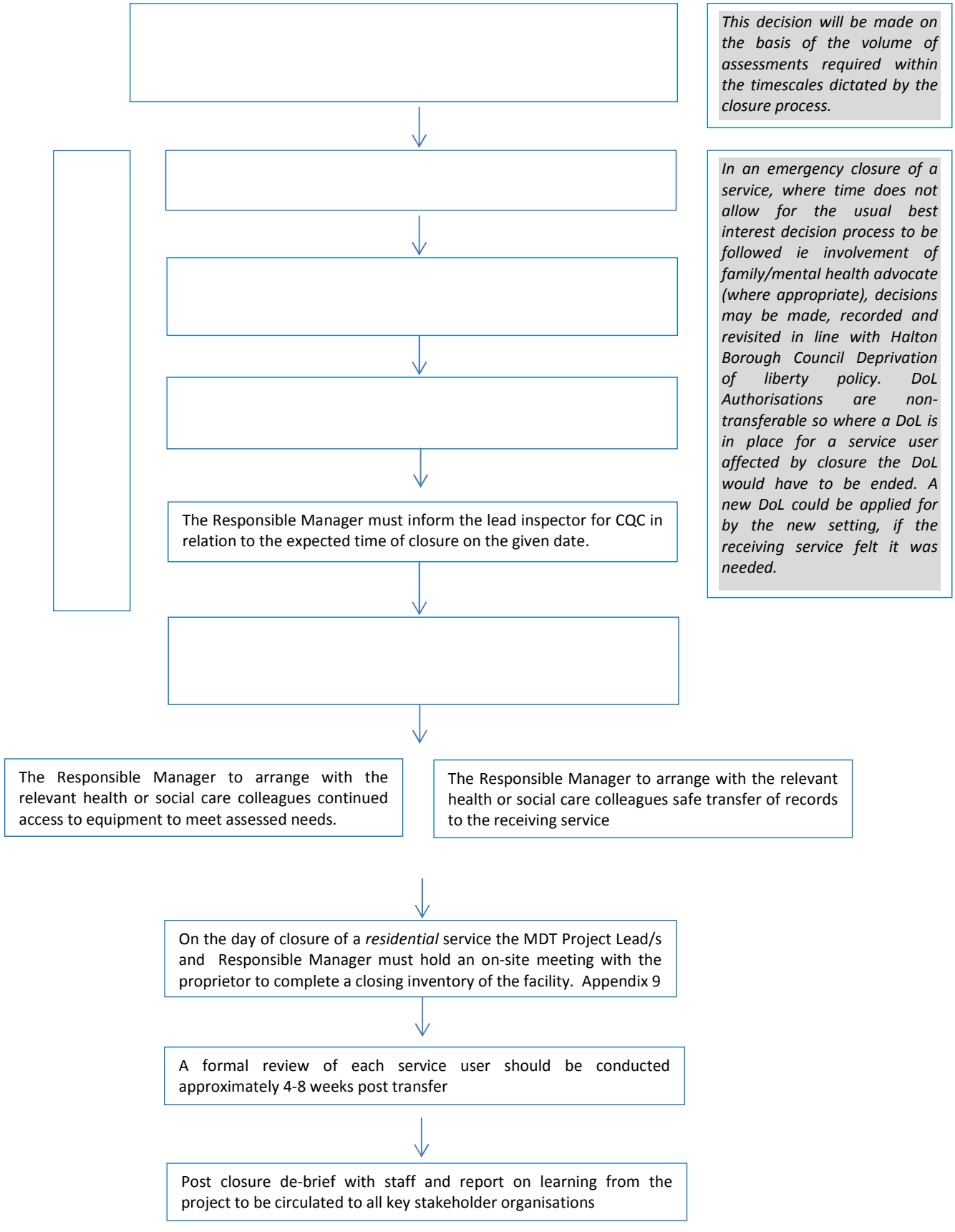
This information must be passed to the Project Lead/s, together with written confirmation from the Accountable Lead that funding will be released to staff the home within the managed period. HBC will source the required care workers from the approved agencies or strategic providers and as per the agreed rates annexed to the pre-placement contract.

↓

MDT to update Project Closure Action Plan and Log, including key communications with the service, service users, public and other stakeholders.

Appendix 1 Halton Borough Council Service Closure Policy

Stage 3: Assessment, Care Planning and Transfer



Appendix 2 Halton Borough Council Service Closure Policy

Initiating the MDT Closure Project Group

The process of initiating an MD, and the associated timescales and responsibilities may change, or be delegated, depending on timescales dictated by the closure (ie Emergency, planned, unplanned but not with immediate effect). This will be the decision of the Accountable Lead

HBC Strategic Director for Communities nominates an Accountable Lead for the closure process (typically an OD), within 24 hours of notification.

→

HBC Director for Communities and/or Accountable Lead nominates an MDT Project Lead /s (Typically a DM and Senior Manager from closing organisation, where appropriate)

→

MDT Project Lead/s form a MDT Project Group

It may be appropriate to appoint an MDT Closure Project Lead from just HBC, or a joint lead between a Senior Manager of the closing service and HBC. The decision will be made by the Strategic Director for Communities in negotiation with the manager of the affected service.

The MDT Closure Project Lead/s should ensure representation from (as a minimum consideration, this list is not exhaustive, and other stakeholders may be included depending on the nature of the closure) :

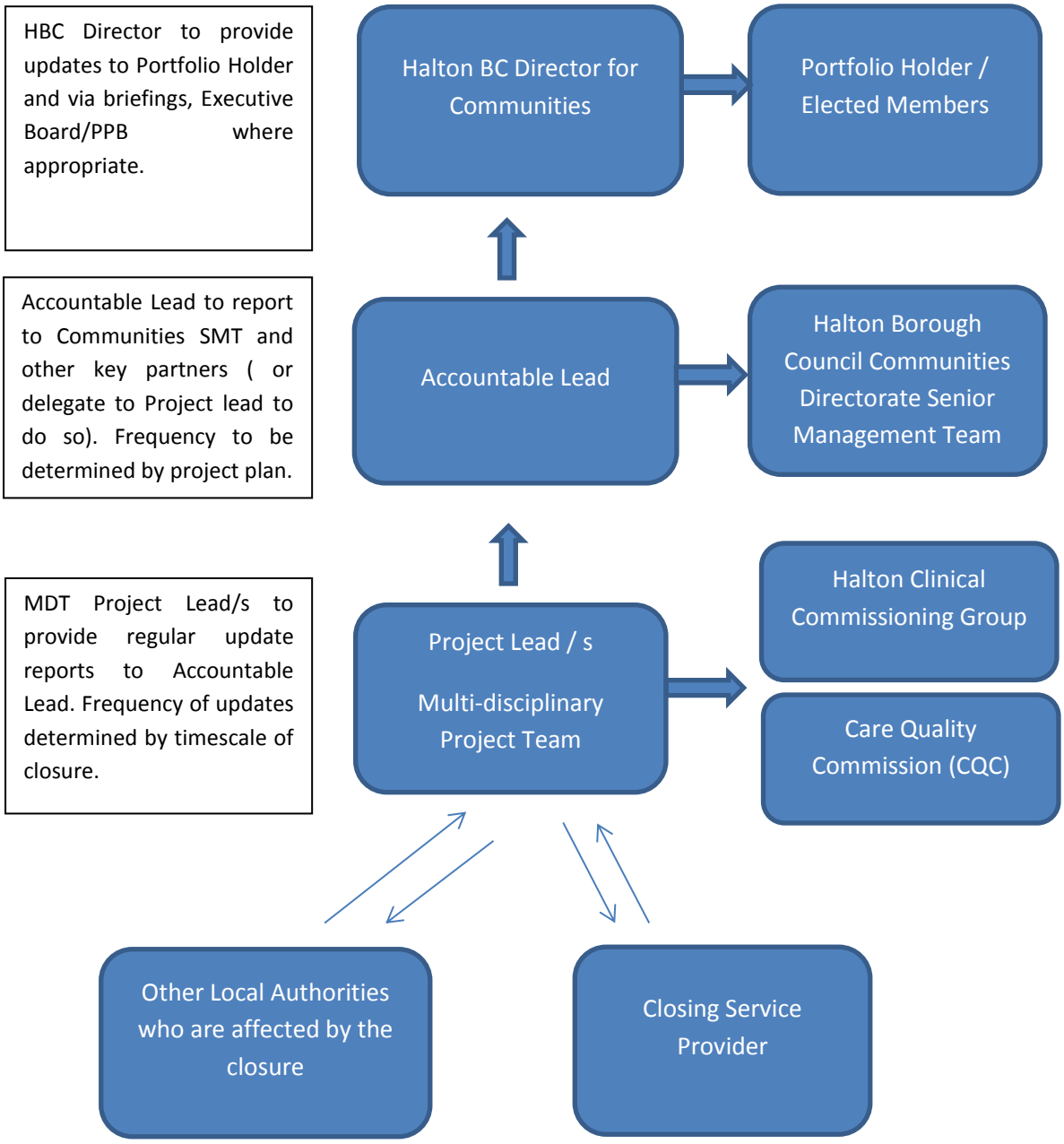
- Service Provider
- HBC Care Management Divisional Manager
- HBC Commissioning Manager/s
- Halton NHS Clinical Commissioning Group
- HBC Quality Assurance
- HBC Safeguarding Unit and Safeguarding Lead for the respective CCG's
- HBC Finance and representatives from the appropriate funding authorities (where appropriate)
- HBC Procurement
- HBC Legal Services
- Human resources from all relevant agencies.
- Detective Inspector/Senior Police Officer (where safeguarding or other criminal activity has been indicated)
- Lead Inspector for CQC
- GP Practice Manager/s
- Continuing Health Care
- A note taker

Other representation may include:

- Fire and Rescue
- Public Health
- HBC Emergency Management
- Other Senior Managers (as appropriate)
- Advocacy Services
- Independent Mental Health Advocates
- Health Colleagues
- Halton Borough Council Communications Staff
- Halton Borough Council Contact Centre Staff

Appendix 2 Halton Borough Council Service Closure Policy

Reporting Flowchart



Appendix 2 Halton Borough Council Service Closure Policy

Key roles

Project Lead/s will have lead responsibility for co-ordinating the relocation of Service Users to an alternative service/s. The Lead/s will manage the Project Team, which will be made up stakeholders.

The Head of the Integrated Adult Safeguarding Unit will have a role in the co-ordination of any potential safeguarding issues. The role will involve advising, directing and consulting with managers and front line staff across a particular area to ensure efficient and effective work within any resulting adult protection investigations.

Care Management Divisional Manager will be responsible for identifying and coordinating resources to undertake assessments.

Care Managers will review those residents who have been allocated to them by the Care Management Divisional Manager, and will work with service users/carers and relatives to find alternative services.

Quality Assurance Team Manager will identify those service users funded through HBC Adult Services, those services funded by other LA's and wherever possible detail on any self-funders within the service. Identify alternative service provision.

Commissioning Manager where a service is decommissioned they would be responsible for identification of suitable alternative service provision.

CQC As the regulatory body they are responsible for regulating the service and standards of service provided. They may also be responsible for giving/receiving information depending on the nature of the closure.

Halton NHS Clinical Commissioning Group responsible for ensuring health needs are identified, considered and met.

Out of hours/on call ASC Senior Management cover must be identified.

Appendix 2 Halton Borough Council Service Closure Policy

MDT responsibilities

Overarching responsibilities of the MDT	**Done**
Undertake the closure of the service, under the direction of the Project Lead/s and Accountable Lead	
Receive progress reports from MDT Members	
Monitor progress against agreed milestones	
Ensure rights of residents and staff are protected	
Coordinate work of key partners	
Provide progress reports in line with reporting flow chart	
Act as an 'information hub' and coordinate all messages to be communicated to service users, staff and the wider community	
Ensure compliance with legislation	
Ensure people can exercise rights	
Involve advocates as necessary and in liaison with social workers	

MDT Actions

MDT Actions	**Status**
Set out the closure timetable	
Agree the communications plan	
Develop the project plan	
Undertake local risk assessments	
Undertake an organisational risk assessment (in the case of the local authority also in respect of the wider market for social care)	
Undertake local risk assessments, looking at the impact of closure of the local community	
Coordinate individual risk assessments, undertaken by social workers and key workers	

Appendix 2 Halton Borough Council Service Closure Policy

Review individual support plans	
Co-ordinate activity for work streams	
Ensure project meets milestones	
Prepare progress reports	
Review the implementation of the communication plan	
Arrange for an Approved Mental Health Practitioner (AMHP) to undertake mental capacity assessment as necessary	
Arrange with the AMHP 'best interest' meetings as necessary	
Ensure involvement of key partners	
Review needs of workforce	
Support re-settlement/relocation of workforce	
Recognise and respond to the emotional needs of workforce	
Meet with the relevant social work manager to ensure all residents are allocated a social worker	
Ensure decisions are taken about who will act as the lead professional	
Make sure an updated assessment is completed so that the new provider has up to date information	
Take steps to inform the local GPs and health workers of the decision and the timetable for closure	

The key worker designated as lead professional for each individual will need to: *Where the resident is publically funded there will be a care co-ordinator/social worker/reviewing officer involved in reviewing and restructuring the care and support plans for each individual*.	
Contribute to the risk assessment for each individual with whom they work	
Liaise with the social work manager or care coordinator of the funding agency where appropriate	
Contribute to revising the care/support plan	
Maintain contact with family/friends	
Arrange medical /nursing assessments where necessary	

Appendix 2 Halton Borough Council Service Closure Policy

Review equipment for moving	
Ensure dietary needs are fully recorded	
Support people to work through the loss of their home	
Support people to visit potential new homes	

Self-funders	
Self funders should be offered a key worker to undertake an assessment and care planning	

[Source: Managing Care Home Closure, Social Care Association, 2011]

Appendix 3 Halton Borough Council Service Closure Policy

Information Exchange Checklist

Once provider closure is confirmed the following information must be sought from the Provider	Responsible MDT Member	Format of information be provided (ie electronic, paper, fax)	Date to be provided	Date provided
Notice Requirements				
Any consultation that has been undertaken (Planned closure) (Residents/Relatives/Advocate)				
Potential staffing implications				
Actions taken to maintain care standards and continuity of care				
Residents Profile (*Names, previous addresses, dob, date of admission, sharing arrangements/friendship groupings, next of kin and relative contact details, appointeeship details, GP details, medication records, copy of care plan, special/complex needs etc).*				
Details of any Staff briefings that have been undertaken				
Name, contact, location, employer of the identified Responsible Service Manager				
Transfer of client information *Residential Service* • Service user social care assessment, health assessment, risk assessments • Inventory of residents' belongings • Transfer of care plans (Including Medication)				

Appendix 3 Halton Borough Council Service Closure Policy

Domiciliary • Staff details (TUPE) • Service user details inc social care assessments, health assessments, risk assessments				
Financial issues • Transfer of appointee function • Identify service users who are publicly funded / Preserved rights / Privately funded / Other local authority residents • Assessed contribution of client details				
Equipment protocol • Service users assessed equipment needs • Who provides equipment • Last equipment service date				
Safeguarding • Any ongoing safeguarding investigations				

Appendix 4 Halton Borough Council Service Closure Policy

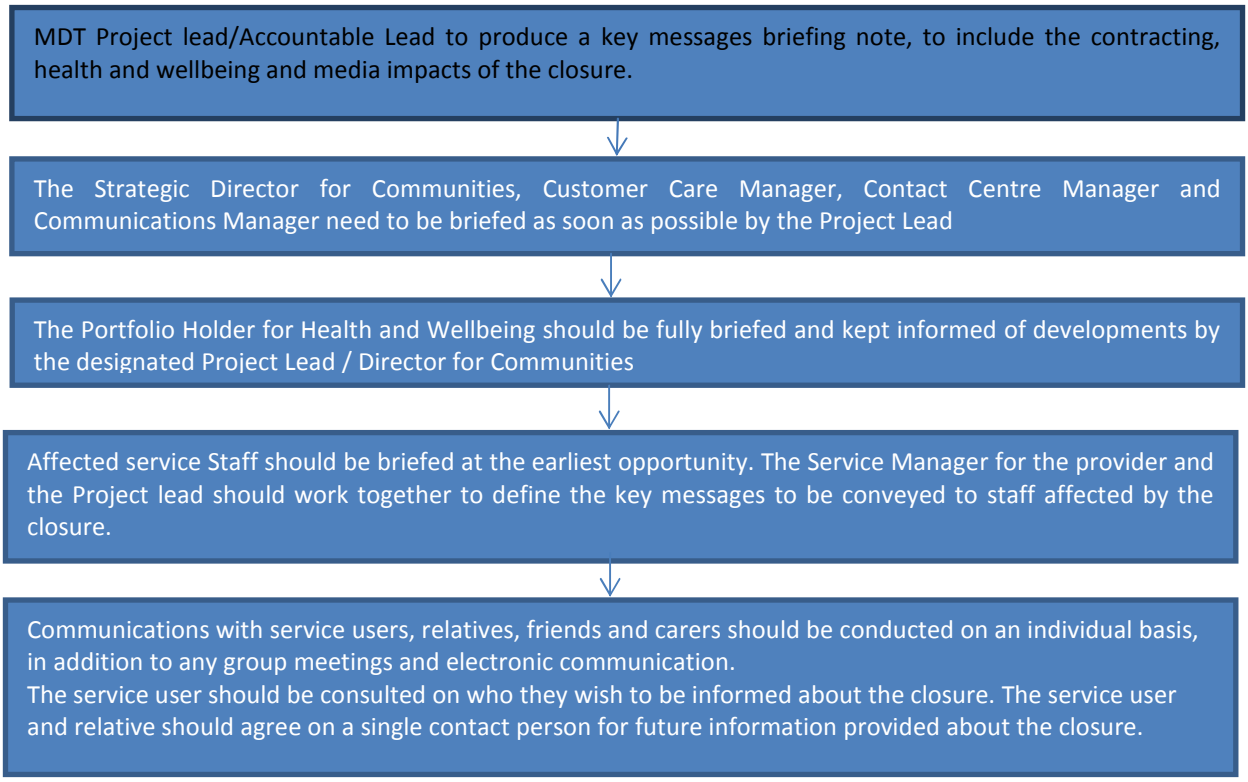
Communications Checklist

The closure timescales will dictate how much of this process scan be followed, but it the principals of the flow chart below should be adhered to. Good communication, at the right time, will aid the transition to alternative services whether in a planned or unplanned situation.

The communication plan should consider the use of approaches such as:

- Home / service newsletter produced as regular intervals
- Large meetings
- Small group meetings
- Individual one-to-one discussions
- Electronic communications including using social networking such as Facebook and Twitter
- Registered manager and/or nominated individual to publicise their availability for personal questions and discussions. This could be 'open door' or planned and bookable times
- Notice boards giving updates, timescales, photos of new options for moves, information about planned moves for people, notice of meetings and contact details of significant people and organisations like CQC.
- A media strategy, including clear protocols for responses to queries and use of media during consultation and subsequently.

Communicating key messages flow chart



It is important to involve staff who know the individual residents / service users well and seek specialist advice if necessary, so that the right decisions are made about what additional information is provided and the methods used, to enable the best outcomes. This is particularly important for those with a learning disability or other cognitive impairment.

Appendix 4 Halton Borough Council Service Closure Policy

Communications checklists

The notification letter/verbal information to be issued to service users affected by the closure should include, as a minimum, the following information:	
Reasons for the decision to close	
Decisions that remain to be taken (about how and when the closure will take place) and what further consultations will take place, in a planned closure situation)	
Process for decision making (this will need to reflect the type of owner and how they make decisions)	
Timescales involved	
People's rights and how they can be exercised(in the case of the local authority owner) options for appeals or representations	
Complaints process	
Proposed arrangements for managing the closure	
Clear detail of when specific information will be available	
Support that residents and families will be provided with.	

Where it has been agreed with the service user affected by the closure, the identified family member/carer should be informed in writing. The letter should include, as a minimum:	
Reasons for the closure	
Reassurances places will be available elsewhere	
Information about vacancies	
Steps relatives will be expected to take	
Who will provide assistance	
The contact person/point	
Messaging should be consistent, open and honest	
Regular updates are advisable	

Appendix 4 Halton Borough Council Service Closure Policy

On-going provision of information	
Inform all service users, family/carers and staff are made aware of the frequency of which information will be provided	
Inform about what format the information will be provided in i.e. letter, social media, meetings, 121	
Inform about the process that service users, family/carers and staff can request information or clarity	

Appendix 5 Halton Borough Council Service Closure Policy

Service Activity Log

Completed By (Registered Manager)	
Name of Service	

Date	**Activity undertaken, relating to closure** ie communication with service users and staff, risk assessments and individual assessments completed, meetings, contractual arrangements, transfer arrangements etc	**By whom**	**Comments**

Appendix 5 Halton Borough Council Service Closure Policy

Date	Activity undertaken, relating to closure ie communication with service users and staff, risk assessments and individual assessments completed, meetings, contractual arrangements, transfer arrangements	By whom	Comments

Appendix 5 Halton Borough Council Service Closure Policy

Date	Activity undertaken, relating to closure ie communication with service users and staff, risk assessments and individual assessments completed, meetings, contractual arrangements, transfer arrangements	By whom	Comments

DAILY FINANCE LOG

Date (dd/mm/yy) :

Name of Service :

Address :

Contact Telephone Number/s:

GUIDANCE

- A separate clearly dated financial log should be kept for each day of the managed transfer period
- If no transactions in or out occurred please state this clearly in the log
- Reference numbers should be in the format specified below and continued sequentially throughout the day's transactions e.g. 22/04/014 – 01, 22/04/014 – 02 etc.
- The reference number should be clearly written on all invoices/bills/individual service users paperwork to cross reference with this log
- To be retained and signed off by the responsible manager

REF NO (Insert) dd/mm/yyyy	**CHEQUE NO.** (If appropriate)	**CASH IN/OUT** (State which)	**IN RESPECT OF**	**BRIEF SUMMARY OF TRANSACTION**	**STAFF NAME AND DESIGNATION** (Please print)	**SIGNATURE**

REF NO (Insert) dd/mm/yyyy	**CHEQUE NO.** (If appropriate)	**CASH IN/OUT** (State which)	**IN RESPECT OF**	**BRIEF SUMMARY OF TRANSACTION**	**STAFF NAME AND DESIGNATION** (Please print)	**SIGNATURE**

REF NO (Insert) dd/mm/yyyy	**CHEQUE NO.** (If appropriate)	**CASH IN/OUT** (State which)	**IN RESPECT OF**	**BRIEF SUMMARY OF TRANSACTION**	**STAFF NAME AND DESIGNATION** (Please print)	**SIGNATURE**

NAME AND DESIGNATION OF RESPONSIBLE MANAGER

Name: ……..
(Please print)

Designation: ……..
(Please print)

Signed: ……..
Responsible Manager

Date seen and signed off: ……..
(dd/mm/yyyy)

Appendix 7 Halton Borough Council Service Closure Policy

Project Closure Action Plan and Log

Date : ? / ? /20
(dd/mm/yy)

Name of Service :

Address :

Contact Telephone Number/s:

VERSION CONTROL:

REFERENCE

Managed transfer of responsibility – Legal Authority to act under S2: Local Government Act 2000 'Well Being Powers'

OVERVIEW OF PROFESSIONALS INVOLVED IN THE SERVICE CLOSURE

NAME & DESIGNATION	CONTACT DETAILS
Proprietor of Service:	
Director of Adult Social Services Lead	
Project Lead/s (with responsibility for completing this form):	
CQC Inspector:	
HBC Legal:	
Halton Accountable Lead:	
NHS Halton CCG Lead:	

Appendix 7 Halton Borough Council Service Closure Policy

OVERVIEW OF SERVICE USERS IN THE HOME:

SERVICE USER	DATE OF BIRTH (dd/mm/yyyy)	RESPONSIBLE FUNDING AUTHORITIES: CONTACT DETAILS	NAMED 'OTHER LOCAL AUTHORITY' SENIOR MANAGER: CONTACT DETAILS (Only if Non Halton)	DATE RISK / ASSESSMENT COMPLETED (dd/mm/yyyy)	DATE INVENTORY COMPLETED (dd/mm/yyyy)	TRANSFER DATE (State Actual or Proposed) (dd/mm/yyyy)

Appendix 7 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Risk Plan			
Confirm Actions taken to support provider prior to closure notification			
Confirm HBC legal view on closure			
Collate details of all Halton service users			
Confirm reviews requires/ action reviews			
Confirm contract requirements			
Prepare communications briefings (see Appendix 4 Communications Checklist)			
Confirm local voids and vacancies			
Meet with DASS Lead to confirm actions			
Arrange independent advocacy for those who may require			
Inform CQC of decisions			
Schedule meetings with Service owners			
Staffing (on-going)			
Confirm Responsible Manager supervision arrangements			
On-going review of staffing needs of home (care and ancillary)			

Appendix 7 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Responsibility for Commissioning staffing to cover for any shortfall			
Responsibility for rotas, supervision and personnel related queries/actions e.g. leave, sickness			
Out of hours/on call senior management cover			
Finance			
Agreement for Provision of funding stream for managed period			
Staffing			
Food			
Service Users Personal Allowance			
Utilities/services			
Property/buildings insurance			
Petty Cash			
Maintaining existing service			
Inventory to be completed with			

Appendix 7 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Proprietor at start of managed period			
Proposed agreement between Proprietor and LA re terms of reference for managed period			
Running activity and finance logs (to commence at point of handover until end of managed period)			
Handover of Home related information to include – Staff records, Staff rotas, suppliers of Goods/Services, Insurance cover, any planned facilities maintenance during managed period			
Communication with service users, relatives and other Local Authorities			
Risk assessments for Environment			
Risk assessments for service users			

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Engagement with health professionals e.g. DN/CPN/GP			
Handover of all resident related information e.g. care plans, medication charts, health records, relative contact			

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
details			

IDENTIFICATION OF NEW PLACEMENTS

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Halton Funded Service Users			
Information on local vacancies via placement officer			
Updating Community Care Assessment by Care Managers			
Detailed Community Care Assessment to placement officer			
Inventory of personal effects			
Communication with service user and relations			
Liaison/updating Transfer Coordinator			
Non Halton LA Funded Service Users			
Identification of named manager and communication	Halton Transfer Coordinator		
Updating Community Care			

Appendix 7 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Assessment			
Identification of vacancies			
Inventory of personal effects			
Communication with Service User and relatives			
Liaison with Transfer Coordinator			
Self-Funding Service Users			
Allocation of Care Manager for completion of Community Care Assessment			
Assistance and advice re placements			
Inventory of personal effects			
Liaison with Transfer Coordinator			
Completion of closing inventory of the home			
Communication with CQC re detail of closure			
On site Closure meeting with Proprietor			

Appendix 7 Halton Borough Council Service Closure Policy

OBJECTIVE	BY WHOM	TIMESCALE	COMMENTARY
Handover of keys			
Responsibility for financial recover and reconciliation			

Appendix 8 Halton Borough Council Service Closure Policy

Client Finance Checklist

General Issues	**Action: Social Worker**
Is the manager, owner or any other staff member the benefit appointee for any of the residents?	
Is the home holding any cash which belongs to any residents?	
Is the home holding any benefit or bank books which belong to any of the residents?	
Is the home holding any valuables on behalf of any resident?	
Does anyone connected with the home have access to any residents' savings accounts?	
Does anyone connected with the home manage the financial affairs for any of the residents?	
Residence Issues	**Action: Social Worker**
What date did the resident take enter the accommodations?	
Was the resident placed by Cheshire or Halton Social Services?	
Did the resident make his/her own arrangements?	
Is another local authority involved?	
Does the resident have protected status?	
Does the resident manage his or her own financial affairs?	
Are all the residents present in the home?	
Benefit and Finance Issues	**Action: Finance Staff**
Is the resident in receipt of benefits?	
Who holds the resident's benefit books?	
Does the resident have an appointee for benefit purposes?	
Does anyone have power of attorney on the resident's behalf?	
Does anyone else manage the resident's financial affairs?	

Appendix 8 Halton Borough Council Service Closure Policy

Financial Assessment Issues	**Action: Finance Staff**
Has the resident had a Cheshire or Halton financial assessment?	
Does the resident pay another authority for the accommodation?	
Does the resident meet the cost of the accommodation from his or her own finances?	
Does a 'third party' make any payments towards the cost of the accommodation?	
Does the resident have any standing orders or direct debits in force to pay for the accommodation?	
Does the resident hold any outstanding invoices for services provided by the home?	
Does Halton hold any outstanding invoices for services provided by the home?	

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Facilities Management Checklist

WHAT	ACTION REQUIRED	LEAD PERSON	TIME SCALE	PROGRESS UPDATE
Gather all relevant stakeholders information	Contact/write to • Day Centres • PCT/LCC • SW/GPs • Agencies • Utilities • Community nurses • Transport • Trade directories • Neighbours			
Keys	Collect keys from any key holder			
Signage	Remove all signage			
Credit cards	Cancel any organisation's credit cards			
IT	Inform any IT department • Remove access to network • Phones to be diverted • Computers to be removed			
Insurance	• Inform building and contents insurers if building is to be empty • Liability and indemnity insurance cancelled			
Vacancy rates	Apply for vacancy rates			
Utilities	Take a reading of gas/water and electric. Ask for final phone bill and broad band bill			
Portable and electrical equipment	Remove all small electrical equipment, i.e. TVs music systems, microwaves			
Inventory	Check inventory against any checklists			
Fridges/Cupboards	Empty cupboards and fridges, leave fridge doors open			
Mail	• Inform bands and other			

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	correspondents • Inform Royal Mail and have mail diverted to appropriate address			
Medicines	Remove all medicines and record disposal accordingly			
Confidential files	Remove all confidential files and archive according to current legislation			
Stationery	Remove all stationery			
Contractors	Consult services contracts. Inform contractors of termination. Serve notice if required			
Minibus/cars	Cancel insurance/contract			
Rubbish	Remove all rubbish from site/unit			
Cleaning of unit	Cleaners to action			
Petty cash	To be signed off			