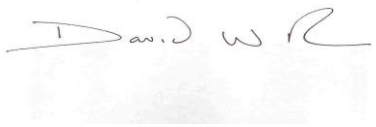
Public Document Pack

# Health and Wellbeing Board

**Wednesday, 9 March 2016 2.00 p.m.**
**The Halton Suite - Select Security Stadium, Widnes**



**Chief Executive**

*Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.*

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

**Part l**

**HEALTH AND WELLBEING BOARD**

*At a meeting of the Health and Wellbeing Board on Wednesday, 13 January 2016 at The Halton Suite - Select Security Stadium, Widnes*

Present: Councillors R, Polhill (Chairman), Philbin, Woolfall and Wright and G. Ferguson, T. Hill, J. Horsfall, M. Larking, A. McIntyre, D. Parr, H. Patel, M. Pickup, J. Rosser, C Samosa, R. Strachan, L. Thompson, S. Wallace-Bonner and S. Yeoman.

Apologies for Absence: S. Banks, A. Marr, Superintendent L. McDonnell, E. O'Meara, D. Sweeney, A. Waller.

Absence declared on Council business: None

**ITEM DEALT WITH**
**UNDER DUTIES**
**EXERCISABLE BY THE BOARD**

*Action*

HWB28 MINUTES OF LAST MEETING

The Minutes of the meeting held on 4th November 2015 having been circulated were signed as a correct record.

HWB29 WELFARE REFORM - HALTON HOUSING TRUST

The Board considered a report from the Director of Halton of Housing Trust, which identified the impact of the Welfare Reforms since 2010. The report identified the changes already introduced and further reforms to reduce the welfare budget. The following welfare changes were highlighted with details on how each had impacted on Trust customers:

- Employment and Support Allowance;
- Personal Independence Payments;
- Universal Credit; and
- Spare Room Subsidy (Bedroom Tax).

Members were also advised that as part of a consortium, Halton Housing Trust tracked the impact of Welfare Reform on up to 100 households for 18 months up to February 2015. The research highlighted the impact that

these changes had, especially on health and wellbeing and detailed how the changes had impacted on claimants within Halton and specifically Halton Housing Trust customers.

Arising from the discussion the Board raised the following:

- Impact of the proposed welfare reforms which would bar 18-21 year olds from claiming housing benefit;
- Fees linked to the Employment Support Allowance; and
- Halton's Child Poverty Action Group would be tasked to adopt a multi-agency approach to identify priorities to address the impact of the welfare reforms on the health and wellbeing of Halton residents.

RESOLVED: That

1) the contents of the report be noted; and

2) further reports be submitted to track the on-going impact of the reforms as they are rolled out further.

HWB30 BETTER CARE FUND QUARTER 2 REPORT 2015/16

The Board considered a report of the Director of Adult Social Services which provided information on the Quarter 2 report for July to September 2015/16 for the Better Care Fund (BCF) that had been submitted to NHS England and progress with the implementation of the BCF, following approval at the Better Care Board on 26th November 2015. A summary of the Quarter 2 report was outlined in the report.

Members were advised that NHS England and the Local Government Association (LGA) were developing the year end reporting guidance and an Annual Report template which would build on the quarterly report. There were currently some outstanding queries around accounting and audit being worked through before these could be finalised and issued. Once finalised, they would be available on the Better Care Fund webpage.

RESOLVED: That the report be noted.

HWB31 BETTER CARE BOARD QUARTERLY UPDATE

The Board considered a report of the Director of Adult Social services which provided an update on the main issue that the Better Care Board had focused on progressing and

monitoring over the past few months. The Better Care Board met on a quarterly basis and its recent work included:-

- One to One Care: St. Luke's;
- Continuing Health Care;
- Falls;
- Minor Adaptations;
- Lillycross Care Home – Widnes; and
- Better Care Fund Review.

In addition, it was reported that the Better Care Board also monitored the activity of the Halton System Resilience Group (SRG). The Halton SRG provided multi-disciplinary strategic direction and guidance across health and social care in relation to non-elective and elective care. It was responsible for ensuring that, locally, there were quality processes in place which were safe and efficient for patients and cost effective. It was reported that over the past few months the SRG had considered issues around:-

- NHS 111 Mobilisation;
- Improving and Sustaining Cancer Performance;
- NHS England – SRG Assurance; and
- Winter Preparation 2015/16.

RESOLVED: That the report be noted.

HWB32 HALTON SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014-15

The Board considered a copy of the 2014/15 Halton Safeguarding Adults Board Annual Report. The report provided a summary of the key actions and priorities the Safeguarding Adults Board had been working towards in the last year. The report also set out the national and local developments on safeguarding adults at risk. During 2014/15, the Safeguarding Adults Board focused on four key priorities:-

1) Promoting the awareness of abuse and the right to a safe and dignified life – particularly among the vulnerable and at risk, but also among staff, volunteers and the wider community.

2) Increasing the contribution from service users and carers, ensuring their views and experienced inform the Board's work and service development. Provide individualised services that kept people safe but permitted informed decisions about risk.

3) Ensuring there was a strong multi-agency approach to the safety, wellbeing and dignity of all adults at risk;

4) Equip employees with the necessary tools and training to safeguard adults at risk and ensure their dignity was respected.

The future priorities for Halton's Safeguarding Adults Board were summarised as follows:-

- Empowerment;
- Protection;
- Proportionality;
- Prevention;
- Partnership; and
- Accountability.

It was anticipated that these priorities would be achieved by ensuring there was a full range of policies, strategies and an action plan in place, that provided a framework within which partner organisations could work together effectively to respond to abuse and neglect.

RESOLVED: That

1) the report be noted; and

2) the Halton Safeguarding Board Annual Report 2014- 15, be approved.

HWB33 HALTON INFANT FEEDING STRATEGY 2016-19

The Board considered a report of the Director of Public Health, which presented a new Infant Feeding Strategy, which outlined Halton's approach to infant feeding over the next four years. The strategy aimed to create a culture and services that supported families and carers within the Borough to make informed healthy choices when feeding their baby and young child, to ensure the best possible health and wellbeing outcomes were achieved.

Further, the strategy would contribute to Halton's Readiness for School indicator. Encouraging parents and service providers to enable infants and young children to breastfeed, be weaned and commence solids at the appropriate ages led to well-developed facial muscles and speech and language skills which in turn resulted in young children being ready for school.

In order to optimise the health of Halton residents the

infant feeding strategy also aimed to achieve the following three overarching outcomes:-

1) Create a culture of breastfeeding in Halton so that the number of infants who were breastfed and the duration of breastfeeding increased;

2) Increase the number of infants who were introduced to solid foods at or around six months of age; and

3) Increase the awareness of parents and the general public of healthy feeding practices for infants and change behaviour accordingly.

A detailed action plan which underpinned a strategy and measured the achievement of the aims and outcomes had been previously circulated to Members of the Board.

RESOLVED: That the Infant Feeding Strategy and recommendations be approved.

*Meeting ended at 3.15 p.m.*

**REPORT TO:** Health & Wellbeing Board

**DATE:** 9th March 2016

**REPORTING OFFICER:** Director of Public Health and Director of Commissioning and Service Planning.

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Integrating Children's Health for Better Outcomes

1.0 **PURPOSE OF REPORT**

1.1 To inform the Board of developments for integrating children's services.

2.0 **RECOMMENDATION: That the Health and Wellbeing Board**

1. **note the contents of this report; and**

2. **note that a paediatrician is available to work in the Halton community from Warrington and Halton Hospital Trust.**

**3.0 Supporting Information**

An Integrating Child Health in Halton Workshop was held on 8th May 2016 with local acute trusts, community trusts, children's services, NHS CCG Halton and public health. The key note speaker was Dr Hilary Cass President of the Royal College of Paediatric and Child Health. The outcome was consideration to pilot an innovative programme of joint working between providers and the placement of a local paediatrician in the local community.

3.1 **Vision**

***Paediatricians, primary care, child health, public health and children's services locality teams working together in the community to improve outcomes for children and young people in Halton.***

**Context**

The shift of healthcare from hospitals into community settings has been a theme running through policy for paediatric health services in the United Kingdom since the Platt Report in 1959 (Ministry of Health, 1959). Based on the philosophy that families' lives should continue as normally as possible when children require medical treatment, National Health Service (NHS) reforms have sought to ensure that children and young people who are ill

receive timely, high quality and effective care as close to home as possible (DoH, 2004). New treatments and technologies in conjunction with a need to reduce demand on acute hospitals (DoH, 2006; Sibbald et al., 2007) have accelerated this initiative, which is also presented as desired by families (DoH, 2004).

Simon Stevens in his Five Year Forward View (2015) has advocated integration stating: *One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the Multispecialty Community Provider.* The Royal Society of Paediatric and Child Health and the Royal Society of Gynaecologists and Obstetricians are both promoting an integrated paediatric care model and women's services model based in a hub. Dr Hilary Cass, OBE, who has just finished a term as President of the RSPCH and is now Paediatric Clinical Lead for Health Education England has recently presented the advantages of this approach at an Integrating Child Health for Improved Outcomes Workshop in Halton and it was well received.

3.2 **Drivers for change**

The UK's child mortality rate is the second worst in Western Europe, with an estimated 5 excess child deaths each day compared to the best performing country (WHO mortality database, 2012). In 2013, local paediatricians, GPs and service users demonstrated that up to 58% of new referrals to General Paediatrics at St Mary's Children's Hospital were avoidable. They also showed that up to 87% of follow up appointments were not in the most appropriate place.

Furthermore, while children make up two-fifths of a typical GP's workload, in some areas of the UK up to 40 – 50% of GPs have little or no formal paediatric training (Department of Health 2010 and The Royal College of General Practitioners).

Across greater Merseyside care for children has changed dramatically and more children than ever are accessing health services via Emergency Departments, Walk-in Centres, Urgent Care Centres and General Practice. Despite this, paediatrics is not a mandatory part of GP training in Liverpool, leaving some GPs deficient in the skills needed to offer broad care for children outside hospital settings (Ryan and Bowers 2015).

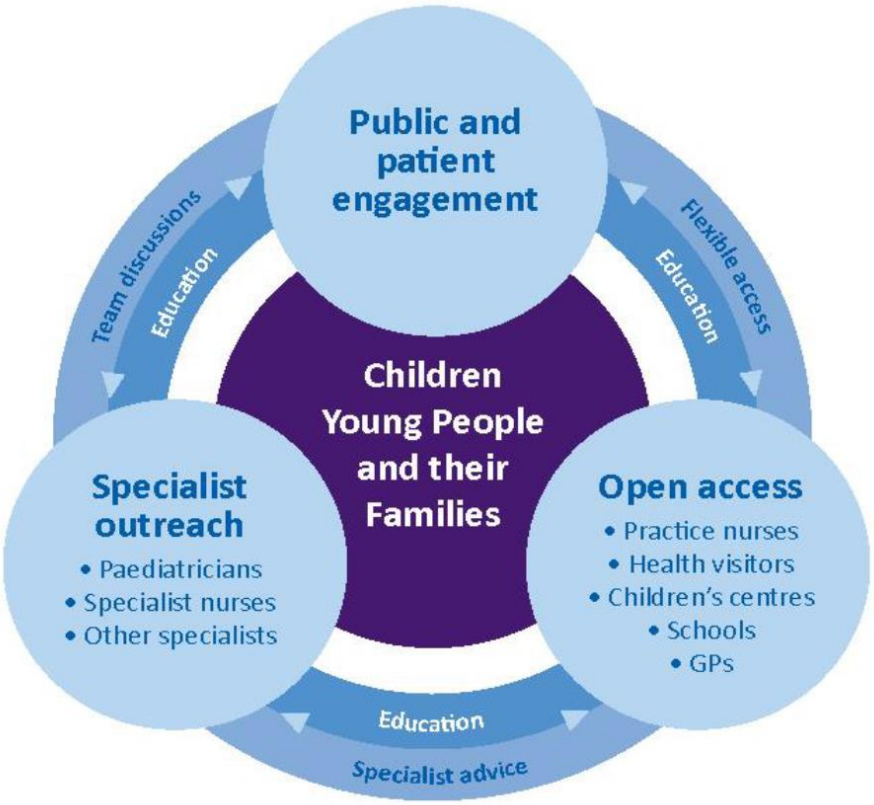
3.3 **Other drivers include:**

- Increasing demand for children's care across all aspects of the health system

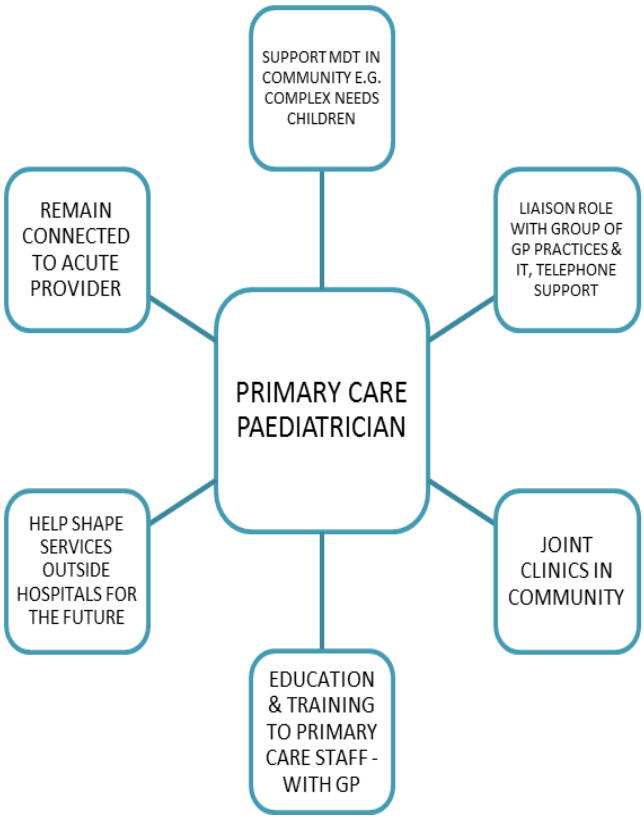
- Rising levels of A & E admissions for children.
- Increasing expectations of an educated population for specialist advice.
- The high and rising cost of hospital based care.
- The need to integrate medical, paramedical, public health and social care for children and improve outcomes.
- GPs are keen to avoid out-patient referrals and Emergency Department attendances for their patients if possible and want to engage with hospital specialists in more non-traditional ways e.g. education sessions, Multi-Disciplinary Team meetings, joint clinics.

### 3.4 Aims and outcomes of an integrated service

- Connects all involved professionals, to encourage shared learning, a 'whole person' approach to care, and increase parent and professional confidence in how child health services fit into primary care.
- Creates better outcomes for children, through coordinated care management, multi-disciplinary teams, and assessment and treatment in the right setting.
- Enhances paediatric skills, confidence and competence across the system.
- Reduces unscheduled care, inpatient admissions and paediatric outpatient referrals through improved out of hospital care, so families can be seen in a familiar setting with professionals they know and trust.
- Enables effective and easier access to specialist paediatric skills in for patients, families and GP surgeries alike.
- Develops specialist pilots (such as respiratory), into a general approach.
- Creates financial savings across the system.
- Development of an intermediate post combining GP and Paediatrician skills.


Public and patient engagement
Flexible access
Education
Team discussions
Education
Children Young People and their Families
Specialist outreach
• Paediatricians
• Specialist nurses
• Other specialists
Open access
• Practice nurses
• Health visitors
• Children's centres
• Schools
• GPs
Education
Specialist advice

3.5 **Example of a model in a GP/Children's Centre Hub**




Example of how the Primary Care Paediatrician could work in the community (Ryan and Bowers 2015)

- **Liaison role**

The PCP would be allocated to a hub of primary care practices and would act as their liaison general paediatrician.

- **Clinics**

They would/ could perform 50% of their Ambulatory clinics in a local children's centre, where families could avail of many other services and other health interventions could be offered e.g. breast feeding advice, nutritional advice.
As a CPD opportunity, a GP from the practice could attend the clinic as an observer.

- **Pathways of Care**

The PCP could work with General Practitioners on further developing integrated care pathways from the community to the acute sector and through to discharge back to the community, building on the work already being done with condition specific pathways (e.g. asthma) and the Map of Medicine.

- **MDT meetings**

Multi-disciplinary meetings would take place on cases so the PCP could

feedback on the referrals, management plan, potential safeguarding issues and development needs of the child and highlight issues such as missed vaccinations or the need for parental support. These may be particularly pertinent to children with complex needs.

- **Education & Training**

The PCP would provide education and training to all grades of staff in the participating practices who are involved in the care of children. This could be a rolling programme but ideally would have input from the practice members to ensure their needs were being addressed.
The PCP could also involve other members of the wider Alder Hey/ Whiston/Warrington team in these sessions as they saw fit.

- **Public Health Promotion**

The PCP would advocate for children's public health and social care issues to remain at the forefront of all Practice agendas.

This description is only an outline of the role the PCP might develop and much of it will be guided by the needs of the community and of the participating practices. In addition to a paediatrician working and driving care from children's centre hubs, other practitioners could be assembled around children in these hubs – developing the infrastructure and creating local 'one stop shops' for children's community care.

## Specialist outreach

The Hub will improve integration between primary, secondary and tertiary care, as well as supporting multi-disciplinary team case discussions between (for example) GPs, paediatricians, health visitors, social care, specialist nurses, midwives and schools.

There could be five outreach activities in participating surgeries, all working in combination:

1 GP-based child health outreach clinics.

2 Joint discussion on referrals and management.

3 Face-to-face education and learning.

4 Email or phone discussion and support.

5 Collaboration with specialist nurses for specific long-term conditions.

## Public and patient engagement

The Hub will embed key principles of co-working, ensuring that, from the beginning, the GP, acute clinicians and patients all work and talk together to make young people's care more seamless.

Children, young people and their families are at the heart of the Hub. They will do more than benefit from it; they will work together with clinicians through three key initiatives:

1 Practice champions.

2 Peer support.

3 Self management.

## Open access

As part of the Hub, open access works in two ways:

- Offered by the GP surgery to patients – same day telephone access to paediatric advice from a GP or Senior Nurse, or a same day appointment for under 16s if needed.
- Offered by specialists to GPs – easy access to a paediatrician through a telephone hotline and email.

Together, these services can significantly reduce use of unscheduled services, help GPs to triage, and – crucially – improve and smooth the family's experience of child health care.

**3.6 Next Steps**

1. Agree a financial plan and work plan for paediatrician in community in Halton.
2. Agree GP hosts and pilot sites
3. Liaise with HEE for recognition as a pilot site

## 4.0 POLICY IMPLICATIONS

4.1 Improved health and wellbeing for children.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 A financial plan to cover the costs of this post will be developed as part of the next steps.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
All of the issues highlighted in this report should contribute towards improving the health and wellbeing of children and young people.

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

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

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

## 7.0 RISK ANALYSIS

7.1 This position is low risk as WHHT already have a paediatrician in place that will take on this role.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 All issues outlined within this report are in line with equality and diversity policy.

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

None within the meaning of the Act.

# Lambeth's Connecting Care for Children is an innovative programme drawing paediatric expertise and community support into primary care, where children's and families' needs are known and can be managed well.

## Did it work the way we hoped it would?

February 12, 2016 by Sarah Montgomery-Taylor

When designing a new service, it is crucial that we fully evaluate it so we can understand if it produced the outcomes desired, and to what extent. We carried out a mixed methods service evaluation for the first year of CC4C with a particular focus on our specialist outreach MDTs and clinics in GP Hubs.

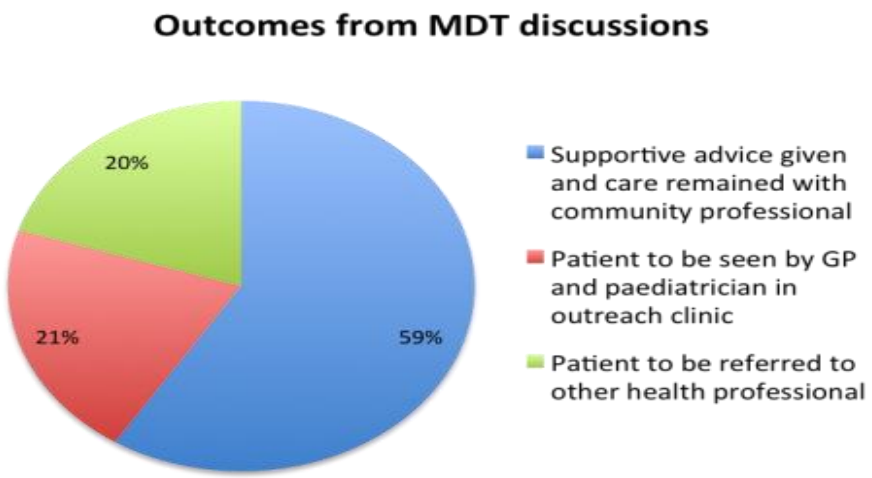
***Measures***

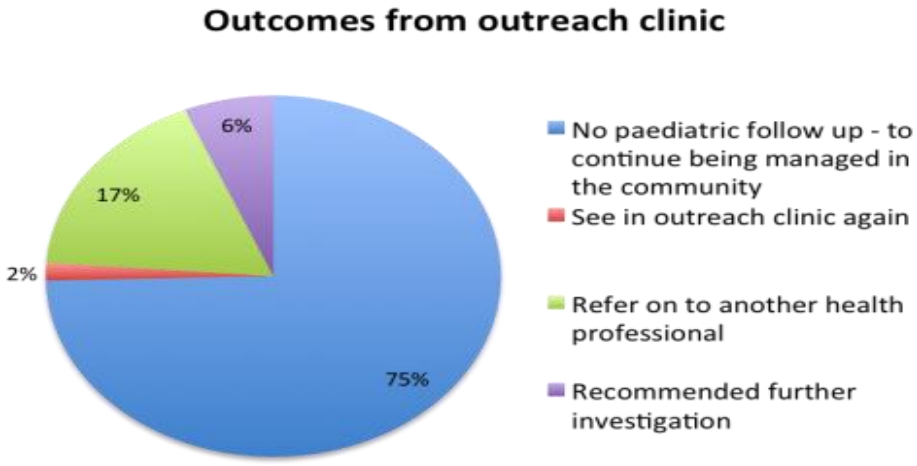
Our outcome measures covered all aspects of the potential impact:

- The service – number of cases discussed or seen in the MDT and the resultant impact on secondary care usage from hospital episode data
- The service users – patient reported experience measures (PREMs)
- The professionals – participant feedback questionnaires from those attending MDTs and clinics

***Results***

*The service:* in the initial 12 months of the pilot 24 MDT meetings and clinics took place. 7-15 professionals attended each MDT meeting and 154 cases were discussed. 126 patients were seen in the clinics. Outcomes of the meeting or clinic were categorised (see figure below).






We then looked at what impact this had on secondary care usage. In one GP Hub, 39% of new patient hospital appointments were avoided altogether and a further 42% of appointments were shifted from hospital to GP practice. In addition, there was a 19% decrease in sub-specialty referrals, a 17% reduction in admissions and a 10% decrease in A&E attenders. Smaller hubs running at lower capacity in early stages of implementation, had less impact on hospital activity.

*The patients*: patients preferred appointments at the GP practice, gained increased confidence in taking their child to the GP and all respondents said they would recommend the service to family and friends. See our previous blog for more details: http://www.cc4c.imperial.nhs.uk/what-do-pts-think/

*The professionals*: 50 professionals, who had attended the Child Health GP Hubs over the first 12 months of the pilot, were contacted by email asking for feedback. Participants 'agreed' or 'strongly agreed' that the Hubs had helped them to: gain knowledge of local services; improve collaboration and professional relationships; and increase professional capability, with the exception of 3 neutral responses regarding professional capability. Interestingly, the development of social capital, which we define as 'trust, reciprocity and collaboration' was the benefit most strongly identified by participants (82% 'strongly agreed').

Appendix 2

**BMJ** Arch Dis Child doi:10.1136/archdischild-2015-308910
Child Health General Practice Hubs: a service evaluation
Sarah Montgomery-Taylor, Mando Watson, Robert Klaber
+ Author Affiliations: Department of Paediatrics, Imperial College Healthcare NHS Trust, London, UK

Published Online First 23 December 2015

**Abstract**

**Objective: To evaluate the impact of an integrated child health system.**

**Design** Mixed methods service evaluation.

**Setting and patients** Children, young people and their families registered in Child Health General Practitioner (GP) Hubs where groups of GP practices come together to form 'hubs'.

**Interventions** Hospital paediatricians and GPs participating in joint clinics and multidisciplinary team (MDT) meetings in GP practices, a component of an 'Inside-Out' change known as 'Connecting Care For Children (CC4C)'.

**Main outcome measures** Cases seen in clinic or discussed at MDT meetings and their follow-up needs. Hospital Episode data: outpatient and inpatient activity and A&E attendance. Patient-reported experience measures and professionals' feedback.

**R*esults*** In one hub, 39% of new patient hospital appointments were avoided altogether and a further 42% of appointments were shifted from hospital to GP practice. In addition, there was a 19% decrease in sub-specialty referrals, a 17% reduction in admissions and a 22% decrease in A&E attenders. Smaller hubs running at lower capacity in early stages of implementation had less impact on hospital activity. Patients preferred appointments at the GP practice, gained increased confidence in taking their child to the GP and all respondents said they would recommend the service to family and friends. Professionals valued the improvement in knowledge and learning and, most significantly, the development of trust and collaboration.

**Conclusions** Child Health GP Hubs increase the connections between secondary and primary care, reduce secondary care usage and receive high patient satisfaction ratings while providing learning for professionals.

**REPORT TO:** Health & Wellbeing Board

**DATE:** 9 March 2016

**REPORTING OFFICER (s):** Director of Public Health and Director of Commissioning and Service Delivery

**PORTFOLIO:** Health and Wellbeing and Children, Young People and Families

**SUBJECT:** Well North Programme

**WARDS:** Borough-wide

## 1.0 PURPOSE OF THE REPORT

This report provides the Halton Health and Wellbeing Board with information on the successful Well North Bid that Halton Borough partners submitted.

## 2.0 RECOMMENDED: That

1) **The Board note the contents of the successful Well North bid and an update on commencement of implementation; and**
2) **Feedback comments to the Director of Public Health and Director of Commissioning & Service Delivery.**

## 3.0 SUPPORTING INFORMATION

Well North is a Department of Health response to the Due North Report which highlighted the disparity in wealth and circumstances between the North and the South of England. The DH Well North team allotted up to £9 million to be available to nine local areas to improve health via innovative approaches.

The well north principles are to:

- Address inequalities by improving the health of the poorest, fastest
- Increasing resilience at individual, household and community levels
- Reducing levels of worklessness.

Well North recognised that for health inequalities to be addressed effectively, interventions must be built on developing community based programmes, which enable, empowerment, control, self-determination and the freedom to lead lives that people have reason to value. Designing such an environment will deliver healthy behaviours and match the emotional needs of people.

The programme must be delivered in wards in the top 10% of Index of Multiple Deprivation and the approach is to develop, test and pilot a set of linked interventions to improve the health of the poorest, fastest, targeting the social life of the social gradient through communities of influence, which support

people from some of the most deprived areas to improve their health, bring the health system and economic growth priorities into closer alignment and build a best practice framework which can be replicated and transplanted.

The Well North methodology will involve co-production between ourselves and the Well North team. Well North will make a £1M worth of investment comprising circa 50% Hub Capacity, including the costs of evaluation and 50% cash. We will need to commit roughly 50% in kind and 50% in cash match. There will need to be access to people and information across our system and we will need to agree capacity in teams and individuals to work on the project.

Halton's successful bid as outlined in Appendix A offered the following:

- An extension of the new One Halton concept with an all-system approach to improve outcomes.
- Development of community assets into Intergenerational Family Centres supporting local communities.
- Multidisciplinary teams too offer services to children, young people and families and older people in the centres and via outreach into the community.
- It will target the 10% poorest people in the Borough including (not exclusively and yet to be agreed) the wards of Ditton, Riverside, Appleton, part of Hough Green & Kingsway in Widnes and Windmill Hill, Halton Castle, Halton Lea, Halton Brook, Mersey, Norton South and Grange in Runcorn. This covers a population of 53,300 (42.3% of the Halton population).
- It will look to support paediatricians and geriatrician outreach into the communities.
- It will support the Cultural manifesto and social/community movement in prevention, self-care and wellbeing.

Next steps

A team of Halton staff from across key agencies and service areas will work with local communities and the Well North team through an initial stage to further define the proposal and intended outcomes for Halton. Initial sessions and visits have already taken place to provide a sense of place for the Well North team and a trip to Bromley by Bow for Halton partners to see a successful Wellness Place based approach in action. A two day workshop will be programmed for May 2016 to develop plans. A further report will be provided at this stage.

## 4.0 POLICY IMPLICATIONS

4.1 The Well North bid highlights the opportunity to be innovative, further develop the One Halton concept and generate extra funding for Halton.

## 5.0 FINANCIAL IMPLICATIONS

5.1 The initiative provides investment in the borough.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES *(click here for list of priorities)*

6.1 **Children and Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and will be addressed via the Well North bid.

6.2 **Employment, Learning and Skills in Halton**
The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

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

6.4 **A Safer Halton**
The Well North bid will play into improvements in the Safer Halton agenda.

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing; Well North recognises the broad context of issues that impacts on residents health & wellbeing including the physical environment.

## 7.0 RISK ANALYSIS

This bid does not present a risk.

## 8.0 EQUALITY AND DIVERSITY ISSUES

The Well North programme will strive to engage with cohorts of Halton's community whom traditionally haven't accessed primary care services.

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

| Document | Place of Inspection | Contact Officer |
|---|---|---|
| Well North Bid | Appendix A | Leigh Thompson |

# Well North Programme

# Site Diagnostic – Part one

# To be returned to Louise Greenall by Thursday 18th June.

Self Assessment (to be completed after initial discussions with Well North Programme staff)

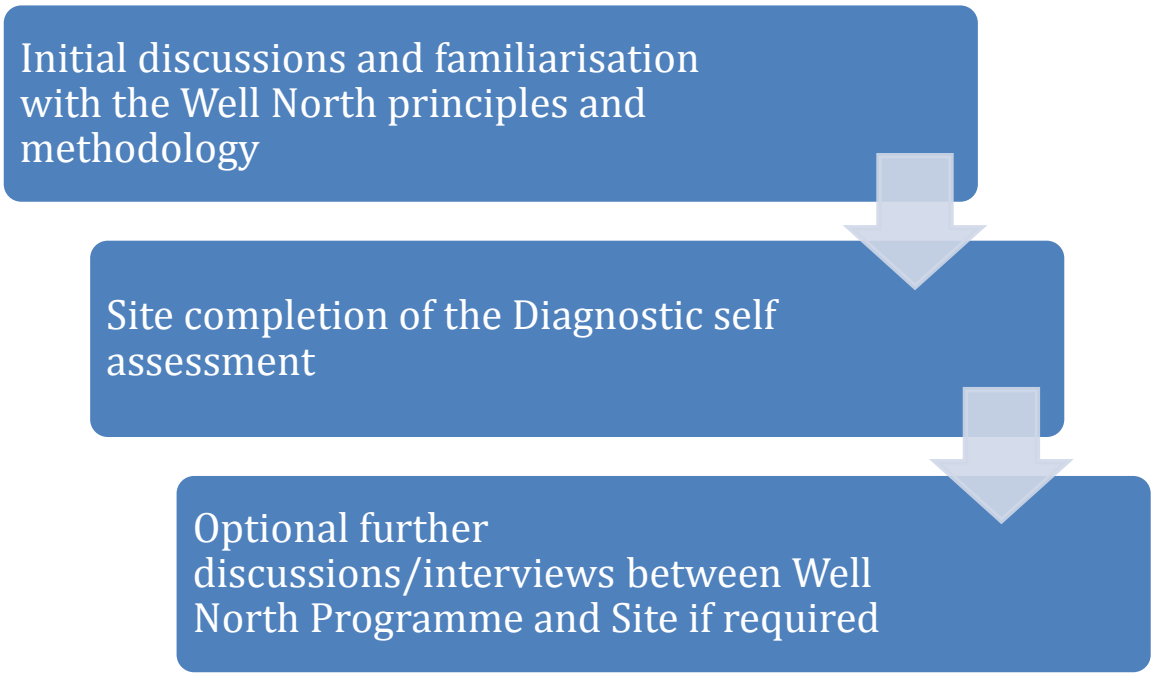
Applicant: One Halton (NHS Halton CCG)

Contact name/details: Leigh Thompson, Leigh.Thompson@haltonccg.nhs.uk, 01928 593724

Date: 29th June 2015

DRAFT 0.2

Diagnostic process




Diagnostic Purpose and benefits

The exercise is intended to support really honest dialogue and shared insight and understanding to support decisions to embark upon a Well North Project.

The diagnostic will allow the Site and the Well North Programme to assess the 'fit' between the site proposition and the Well North methodology and principles, and to consider the commitments required and benefits anticipated. We have considered early learning from the pilot sites and drawn upon selected lessons from healthcare transformation literature.

The three pilot sites have all contributed to the development of this diagnostic.

Key factors include:

1. The **local political system leadership and commitment** for working with the Well North methodology;
2. The relevant **local experiences of transforming services with strong community engagement** (e.g. troubled families, MTDs) and the potential for 'fit' with the Well North methodology, and identification of where value can be added (for the Well North Programme and the site);
3. The **maturity, capacity and capability** of the local system to fully engage with the Well North hub team, the methodology, the philosophy and the evaluation;
4. The ability of the local system to commit appropriate **resources and staff** and to provide timely access to information, people and services
5. The feasibility of the site to participate fully if there are some **gaps and/or development issues;**

6. The potential for **learning**, **added value** (against a range of criteria) for both the site and the Well North Programme and to generate a **return on investment** for the programme, linking to the programme evaluation.

   The diagnostic process will provide the following benefits:

- For the Well North Hub, Board and investors – the diagnostic will contribute to a transparent and robust 'due diligence' process for site selection, and supports prioritisation and sequencing decisions. The diagnostic is a useful tool to demonstrate that sites have fully considered and thought through the degree of commitment needed.
- For the Well North Hub team and the site – creates the ability to have a dialogue about how and where the Well North methodology could add value and ROI and align with local developments. This dialogue will form part of the local collaborative agreement;
- For the sites – identifies where there is flexibility to bring in planned or ongoing local initiatives into the Well North methodology;
- For the Well North evaluation – the diagnostic assessment forms part of the site baseline, and contributes to the overall evaluation of 'what works where and why';
- For the sites – the diagnostic assessment can inform the local OD (organisational development) plan to support achievement of the project;
- For all parties – the diagnostic is a key way of using lessons learned from earlier sites about the pre-conditions for success – it enables all parties to understand the factors that help and hinder progress from the offset;

**Guidance.**

If you feel you have covered a point please don't feel the need to repeat any text, simply signpost back. We are not seeking operational levels of detail, or lengthy script, but rather key, summarised information that will sufficiently paint a picture about your proposition and local context, and can be expanded upon in discussion.

**Sections.**

1. Your proposition
2. Your commitment to the Well north Philosophy
3. System Leadership and Collaboration
4. Local Commitment and Resources
5. Horizon scanning – opportunities and risks
6. Transformation Case Study
7. Governance
8. Learning

1. **Your proposition**

**Well North is an opportunity to do something really differently. Please describe your proposition expressing your ambition, your appetite for learning, for breaking down barriers and being willing to push through challenges and complexity to deliver better outcomes.**

Please summarise your local proposition for joining the Well North Programme, describing

- Scope of proposition in terms of population and geography. Are there any specific demographic challenges with the proposed community you propose to focus on? E.g. ageing, ethnicity
- The fit between the Well North methodology and your local ways of working – for example which elements of the methodology are familiar and which elements would be different for you.
- What differences in outcomes would you be seeking?
- What are you seeking to learn ?
- Any connections and alignments to other local projects or workstreams that are relevant?

In February 2015, NHS Halton CCG engaged with local statutory and non-statutory partners to launch the One Halton concept. One Halton emerged following the production of a General Practice Strategy for Halton. Within it, a new care model was described, the ethos, principles and structure of which the Five Year Forward View labelled as a Multispecialty Community Provider (MCP) model, or an integrated health and social care delivery model with a focus on out of hospital community provision.

This care model would also see local services and health and social care teams wrapping around a series of 'community hubs', embracing the vibrant voluntary and community sector in Halton.

Well North presents an incredibly well timed opportunity to rapidly implement part of the overall One Halton vision, where we want to develop a new innovative model, placing services and clinical expertise in the community changing our Childrens Centres to Intergenerational Family Centres that reach into the community and are part of the community as a family network and older peoples support, somewhere easily accessible and local. This would see a range of existing local services working in a more connected way, joining up around older people and families with the possible introduction of care navigators. This would include the local Well Being services, Social Care in Practice (SCIP) services, the Health Improvement Teams, GPs, Paediatricians, social workers, youth workers, health visitors, voluntary sector organisations and a range of other providers working as a Multidisciplinary Team, offering joint services in the Centres themselves but also providing out-reach services, going out into the communities, finding and working with families and individuals most at need and enable them to improve their own and their communities health. Supporting the development and evolution of community networks will better enable the sustainability of the programme.

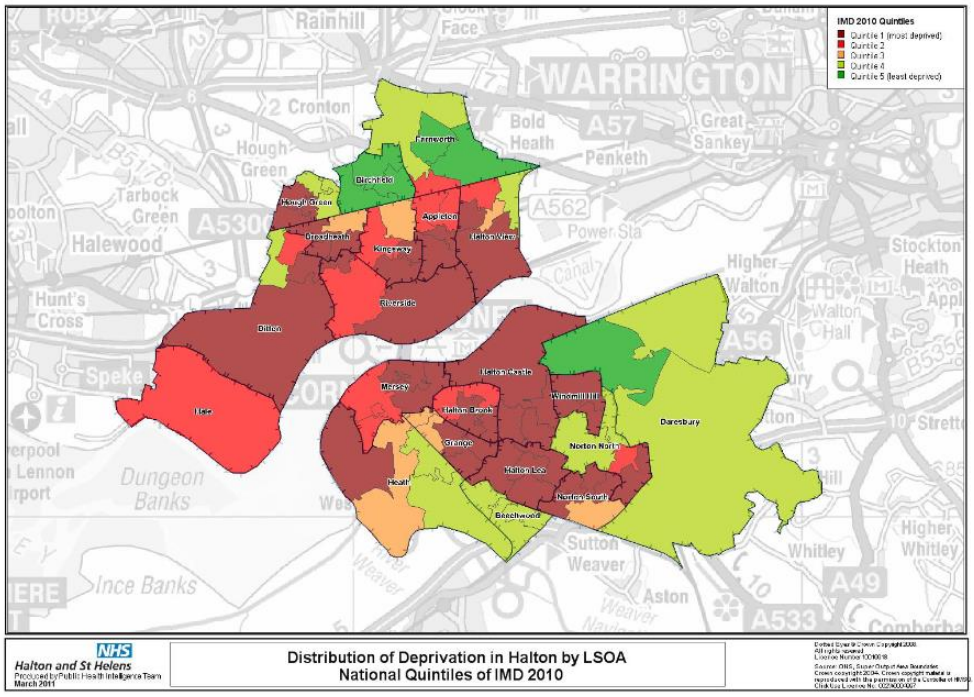
Halton recently invited Dr Hilary Cass, OBE, who has just finished a term as President of the RSPCH and is now Paediatric Clinical Lead for Health Education England, to present the advantages of this approach at an Integrating Child Health for Improved Outcomes Workshop and it was well received by the acute trusts, including Alderhey as well as GPs, the Council, local children's providers and the public. We now have a commitment to this model including working to develop hybrid Paediatrician/GP roles.

All of this approach will be underpinned by our real focus on early detection and prevention across all aspects of the health and social care system, making every contact count, offering value with every intervention.

We know from analysis of the Halton population with Professor Chris Bentley, a national Health Inequalities lead, that to make a difference we need to target a cohort of 40% of the population that he identified as situated in our poorest areas and not currently accessing available services.

We will therefore focus on our poorest areas (those who are in the 10% most deprived communities nationally) and those not currently accessing available services. These population groups are across Halton and if we look at the spread of the 40% we will really target Central Widnes and Central Runcorn. These include the wards of Ditton, Riverside, Appleton, part of Hough Green & Kingsway in Widnes and Windmill Hill, Halton Castle, Halton Lea, Halton Brook, Mersey, Norton South and Grange in Runcorn. This covers a population of 53,300 (42.3% of the Halton population)

A lot of these people are likely to already have underlying and existing long term conditions. We want to find these people and work in partnership with them to provide the best possible services and care, in localities that are suitable and convenient for them and their families and carers.



We are highly confident that the programme of work will deliver a range of positive outcomes including:

- Enabling local people to look after themselves;
- Connects all involved professionals, to encourage shared learning, a 'whole person' approach to care;
- Creates better outcomes for children families and older people, through coordinated care management, multi-disciplinary teams, and assessment and treatment in the right setting;
- Train staff to work in completely different ways in different settings;
- Development of new roles that are hybrid between hospital consultants and GPs;
- Work in areas of greatest deprivation and improve outcomes for the poorest members of society;
- Reduce mortality;
- Creating sustainable and positive change;
- Work with children and adults with complex needs and or disabilities;
- Demedicalise conditions;
- Utilising community assets;
- Work with local people to evaluate the success and impact;
- Enhances paediatric skills, confidence and competence across the system;
- Reduces unscheduled care, inpatient admissions and outpatient referrals through improved out of hospital care, so families can be seen in a familiar setting with professionals they know and trust;
- Enables effective and easier access to specialist paediatric skills for patients, families and GP surgeries alike;
- Develops specialist pilots (such as respiratory), into a general approach;
- Creates financial savings across the system; and
- Development of an intermediate post combining GP and Paediatrician skills.

Finally, the approach we have adopted to date fully aligns with the evidence-based Well North Methodology. Starting with detailed analytics, coupled with strong engagement, the programme of work has emerged and is underpinned by robust system-wide governance with all local system leaders already acting as champions for the changes needed. Working in partnership with Well North and the benefits they bring, including evaluation, economic analysis and access to leadership programmes for the clinical and emerging future leaders in Halton, we believe this proposition can and will be highly effective and make a real and sustainable difference for people in Halton living in the most challenging circumstances.

## 2. Commitment to the Well North Philosophy

**Please describe how your proposition aligns with the Well North principles and methodology and how you and your collaborators will demonstrate that you are committed to the philosophical approach.**

**6**

We believe our proposition completely aligns with the Well North principles and methodology. We started this process by commissioning Professor Chris Bentley to undertake a detailed analysis on the health inequality challenges across Halton. Using this evidence base and incredibly powerful case for change (including known demographic and work force changed), we undertook wide engagement with professionals, partners and the public to co-design what the key principles of the future services in Halton should look like:

- Commissioning and delivering consistent high quality care for every local resident;
- Care continuity for patients with Long Term Conditions;
- Reducing unwarranted variation;
- Strong local clinical leadership;
- Embracing the opportunity to offer services at scale, delivered locally to individual people;
- High levels of population and patient engagement;
- Commissioning and contracting for outcomes and improved experience, not inputs or processes;
- Services working in greater collaboration in the community as multi-disciplinary teams of care professionals working together;
- Improving access to all services and better coordination of care pathways;
- Focus on prevention;
- Supporting the aspirations of parity of esteem and the crisis care concordat.

From this, the integrated health and social care in the community model emerged (or MCP).

Developing this shared purpose across all stakeholders in Halton is the foundation of the entire One Halton programme. Professionals, partners and the public have collectively constructed and designed this through comprehensive engagement. We have listened to the public and patients to gain insights and not make assumptions about what is important to them through wide ranging engagement including Halton CCGs Radio Phone In Programmes, Halton People's Health Forum, Local Area Forums and workshops. They have enthusiastically contributed and showed real desire and commitment to be part of this programme moving forward. The public asked to be involved from the very outset in co-designing and co-producing new services, and they have been.

Using these principles, the care model emerged that focussed on increasing resilience of services and people in their own homes and in their local communities. We have commissioned additional services from a number of local voluntary sector organisations to support engagement and communication with the public.

It is a collective approach that has brought us to this point. All local organisations and leaders working in partnership, building on the existing integrated approach and energy already in place in Halton that brings the commitment and desire to make the improvements for the people of Halton as we pioneer a new approach to make a real difference.

## 3. System leadership and collaboration

**System leadership - meaning working across different organisations and leading change with influence - will be a key part of Well North and crucial to that will be the meaningful engagement of communities. In this context can you tell us who your system leaders will be at different levels and how you will encourage them to work together?**

*Note _ there will be an opportunity for the system leaders from applying sites to participate in a one day confidential, joint system leadership think tank and development session. This would be used as an opportunity to identify challenges for your propositions and to explore your system leadership role within these. Please indicate if you would be willing to commit to this programme.*

| |
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| Please describe your approach to system leadership for your proposition, including visible leadership, political support and active collaboration.<br><br>To underpin the delivery of the One Halton transformational programme, a governance structure has been established with a Programme Board overseeing and leading the process. This group provides visible leadership, collaboration and political support. The principles and concept of One Halton are supported and endorsed by the Health & Well Being Board. The Chair of the HWBB, the leader of the council, is a member of the Programme Board. The Programme Board is made up of CEOs, Chief Officers and Clinical Leaders from across the acute, community, mental health and out of hours providers, from the CCG, Local Authority and Public Health, from the voluntary sector, Healthwatch and housing association as well as representatives from the local community.<br><br>We see the Programme Board as the ideal governance base for the Well North programme of work given its inextricable alignment to the wider One Halton programme.<br><br>We would be very interested in accessing the joint system leadership think tank and development sessions to support the One Halton programme. |
| Willingness to attend a System Leadership session with other sites? What would you most want to achieve from such an event? What would you contribute?<br><br>We would absolutely want to be part of System Leadership session and the inclusivity opportunities to learn and share from and with others. We believe such events present an ideal opportunity to talk about how things have worked well and how things have been challenging. It also presents the opportunity to understand how different health economies, each with their own individual attributes, are approaching the transformational challenge and we will use these to try and identify ways in which we can be more efficient and effective.<br><br>We will bring candour, challenge and willingness to contribute and will ensure we provide and present a full cross-section of the system leaders involved, including those from statutory organisations but also clinical leaders and those from the voluntary sector too, as we believe strong local collaboration between statutory and non-statutory organisations, |

working in partnership across our communities presents a massive opportunity to do things differently for our population.

Are there any known risks to the continuity and consistency of system leaders within the first 12 months of the programme?

There are no known risks to continuity at the time of writing this. In fact, the CCG and Local Authority have both made investments in the local Voluntary Sector to ensure sustainability of leadership and input.

## 4. Local Commitments and resources.

**The Well North methodology will involve co-production between yourselves and the Well North team. Well North will make a £1M worth of investment comprising circa 50% Hub Capacity, including the costs of evaluation and 50% cash. You will need to commit roughly 50% in kind and 50% in cash match. There will need to be access to people and information across your system and you will need to agree capacity in teams and individuals to work on the project. Please describe the commitments and resources that you will be committing and the enablers that you already have, for example information sharing protocols.**

Like elsewhere across the NHS, organisations across the borough of Halton have financial challenges and pressures both in the current year and in their outlook. This has been one of the factors that has led to the integration of the CCG and Local Authorities and the innovative approaches and programmes of work that have been jointly developed to date. As such, we would look to commit resources across four fronts:

- System leadership – both in Halton and across the system (if required)
- Staff resources – staff in Halton to work with the Well North team to work with the local communities and implement the new services and systems
- Utilisation of existing finances in a new and innovative way – we will work with the Well North team to identify where services or resources require investment and we will use existing or allocated resources, in a flexible and accessible way to make these investments. This will come from a variety of sources, across a range of organisations but the flexibility and accessibility of this will be managed by the One Halton Programme Board, ensuring any changes are focussing on the benefit to local people and families.
- New/additional finances – we will look to create a 'pot' of finances that can be used to pump prime initiates, where the Well North investments and contributions cannot meet the needs. We will look to work innovatively and creatively to identify the funding to support this, given the challenges outlined above. That said, we will commit to identifying an amount, in agreement with the Well North team.

The staffing commitments we will make include:

- The One Halton PMO will support this scheme and ensure it aligns fully with other

programmes of work being undertaken;

- Our clinical champions will be heavily involved in supporting, leading and contributing to the successful delivery of this scheme;
- Our analytical teams will work with the Well North analytical teams to ensure we have the very best data and information available to inform decision making
- The expertise in our Public Health team will be available to support the analysis and interpretation of data, working with the Well North team to forecast and predict where maximum impact and return on investment will be realised.
- We are developing robust and effective links with local sporting organisations (including Widnes Vikings rugby league team and Liverpool and Everton ladies football teams) as partners to support innovation and creative solutions. We would be happy to share the learning and opportunities this presents elsewhere.

We have also laid a number of strong foundations with a number of key enablers, including:

- The on-going development of a system-wide shared IT platform to enable the sharing of patient information across all parts of the system
- The development of data sharing systems and documentation to support and underpin this
- The establishment of the Halton Strategic Asset Management Group, designed to coordinate the transformation of local estates across the whole borough.

**5. Horizon scanning –external and local opportunities and risks.**

Please could you indicate anything known or anticipated that may impact upon your Well North proposition. These could be events that could provide leverage, justification or added value for your proposition. For example, infrastructure developments; inward investment. Equally, there could be events that could potentially distract or provide significant challenge. For example major restructuring, changes to local employment market. For any significant examples please summarise the intended approach to maintain resilience and support for the Well North Project.

| **Political, Social, Economic, Technological, Environmental or Legal Events that potentially impact upon your proposition** | **Anticipated nature of impact and proposed action** |
|---|---|
| Technological – development of shared IT platform | Huge opportunity to improve communication and coordination across team and to significantly improve the information flow and awareness of patients across the system |
| Environmental – the construction of a 2nd | The new Mersey Gateway Bridge presents |

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| bridge across the river Mersey to connect Halton further | opportunities and challenges. In the medium term it will provide better access for the people of Halton. In the short term it means delays to crossing the river Mersey. We will counteract this by ensuring we mirror services across both sides of the bridge. We already do this with all services we offer. We also tailor services to meet the needs of the different communities that live on either side of the bridge |
| Social/Economic – more rapid implementation of One Halton programmes | Positive impact if successful with Well North bid as the public have been engaged in helping to shape this programme. Securing additional funding will enable more rapid implementation of elements of the work programme and demonstrate commitment and desire to the local people. |
| Economic - local organisations financial challenge | These challenges will not stop the partners and system leaders across implementing the One Halton programme and Well North programme of work. We will be creative, innovative and integrated in our approach to managing these challenges, ensuring we continue to focus on improvements for the local people of Halton |
| Political - Devo-Manchester | Following the devolution announcement for Manchester, discussions are now taking place across the NHS system and it is possible this could affect Halton in the future. The nature of the impact of this is unknown but would likely be significant. |
| Social –change the model of Halton's Children's Centres and improve outcomes. | A change in the model of Children's Centres to Intergenerational Family & Older People's Centres offers local people a local centre where they can go to meet others, find information and advice on self help, organise local activities, engage in activities.<br><br>It also allows service providers to meet local families and older people in a non medical setting offering a real opportunity for staff, including hospital consultants, to work as an |

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| | MDT realising a whole person approach to care. |

**6. Transformation Case Study Example**

To provide a sense of your transformation and collaborative experience and lessons please summarise below ONE relevant case study of a whole systems transformation.

| | |
|---|---|
| Name of transformation and timescale | Inspiring Families / Troubled Families 2012 - 2015 |
| Rationale for the transformation?<br><br>What were the drivers? | In 2012, Halton started the process on how to redesign the way that services in Halton work with families facing multiple problems (troubled families) through in the first instance the creation of a multi-agency family support Service.<br><br>The approach was transformational and developed new ways of working that would contribute to reducing demand for public services thereby delivering a sustainable reduction in costs in the future. This included setting up and delivering new evidence-based models of service and training the workforce to deliver on achievable outcomes. |
| Who were the leaders?<br><br>Are they involved in Well North?<br><br>How is tacit knowledge and organisational memory going to be used for the Well North Project? | The leaders were from across our Local Strategic Partnership. These strategic leads are linked into the Well North project.<br><br>Well North will benefit from the existing partnership structures and the links that have already been made with the community.<br><br>The data and performance systems that have been built will be available to support the analysis and interpretation of multi-agency data streams and this can be used to further enhance the Well North Project.<br><br>Some of this intelligence includes local and national findings based on the use of a national cost calculator tool that evidences where maximum impact and return on investment will be realised. |
| How were staff involved? | Through the set up and development of the programme |

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| Extent and nature of community engagement?<br><br>E.g. systematic part of service design/ through elected members etc. | The programme looked to focus on families that required high Intensive Support with a whole family approach. This involved working with individuals and families in their own home and in their community.<br><br>With Partners we worked to ensure the delivery of family plan objectives, as well as engaging with them to source and commission services where gaps were identified.<br><br>Partners were involved in supporting structural changes around the developmental of information sharing protocols, core workforce training packages, developmental of family assessments. |
| What were your results? | We now have:<br><br>• children benefiting from schooling<br><br>• families and communities benefiting from less crime and ASB<br><br>• people and the public purse benefiting from family members getting into work<br><br>• all the wider improvements in family functioning, health and wellbeing<br><br>By the end of the programme Halton has achieved 100% payment by results (PBR) for the full 375 families. Of the 375 families worked with:<br><br>• 338 families have achieved the ASB, Youth offending and or Education Governmental targets.<br><br>• 313 families were claiming benefits at the start of intervention (80%). A total of 122 families (40%) have, during intervention, come off benefits and moved into continuous employment. |
| What went well?<br><br>What were your strengths? | The service transformation objectives of the programme has helped support our local drive to redesign services to further develop our early intervention and integrated family focused working.<br><br>Inspiring Families helped to develop and implement a performance management system that could identify, track and monitor outcomes of individuals and families against given criteria. |
| What didn't go well?<br><br>What were your | The national criteria to give more flexibility to give the Council and its partners a better opportunity to identify and work collaboratively to identify those families who will most benefit from an integrated, whole family approach.<br><br>Organisational barriers with regard to process and paperwork with regard to the recording of activity and outcomes as we sometimes |

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| barriers? | missed the opportunity to address the critical issues facing individuals and families by looking only at one person at a time rather than considering the needs of the whole household. |
| Did the transformation result in any scale or replication?<br><br>Has it been sustained? | Halton has further develop its Early Intervention Model to include co-ordinated, evidence based interventions leading to good outcomes for children and families such as Strengths and Difficulties Questionnaire (SDQ) and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) a nationally recognised tool for measuring well-being.<br><br>The model focused on a common outcome based approach that included a key worker or case management approach to improve integration, co-ordination, prioritisation of interventions<br><br>Developing the partnership workforce is a continued feature with a standard set of core competencies around the skills of the workforce to identify underlying causes and problems, rather than simply the presenting nature of demand |
| What reflections and lessons would you bring forwards into the Well North Project? | Being able to show change with families by comparing actual outcomes with families 'before' and 'after' you have worked with them.<br><br>Being smarter about making the case for investment by showing local commissioners how services are benefiting them and saving them money. |
| Is there a documented Evaluation or Lessons Learned Document that you could share? | There is a National Impact Study in place and through our performance management system we had collected local information and case studies that evidence real change. |

**7. Governance**

**Describe how you will meet the requirements for Governance of the Project. Please outline who will be the lead and how they will exert leadership across the system; how you will engender engagement of partners sat/not sat at the table?**

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| The lead for the Well North Programme will be Leigh Thompson, Director of Service Delivery at NHS Halton CCG and the One Halton Programme Director.<br><br>Leigh has developed the One Halton governance approach to ensure engagement and |

communication is at the heart of everything we do.

There are three main committees – a Programme Board, a Steering Group and an Advisory Group.

The Programme Board is set up to secure, via partnership working, the provision of system leadership and meaningful engagement in the development of the One Halton Programme. This aims to secure sustainable, high quality services which meet patient needs and optimise the health of the borough, delivering organisational sustainability.

The Steering Group is set up to oversee, on behalf of the One Halton Programme Board, that appropriate and timely decisions are taken to ensure the successful delivery of the One Halton Programme. It will ensure that the programme successfully engages the right people and organisations, and that the best evidence and facts are always used for decision making, so that solutions will be reached which can be effectively implemented.

Finally, the Advisory Group will be crucial to the Programmes success. It will add value, scrutiny and insight. It will influence the programme, working groups and phasing of delivery.

It will ensure that the programme and working groups are inclusive of the patient's voice and ensure that relevant individuals and or organisations are included in the relevant working groups.

The membership of the Advisory Group is made up of representation from Healthwatch, the voluntary sector, housing, AHSN, estates providers including NHS PS, Health Education North West and our IT provider.

We believe this approach will bring focus, leadership and structure but also challenge, openness and wide engagement.

We would propose that the Well North scheme dovetails into this existing governance approach.

**8. Learning**

**What contribution are you willing to make to optimise the learning for the Well North Programme, within your project and with other projects? How do you feel honest and open sharing across projects can be facilitated effectively?**

We would be both willing and keen to establish a learning network with other localities involved in the Well North programme. For this to be a success, we would all need to commit to investing in the approach and ensuring the right staff are available. For example, we may want to establish a clinical leaders learning network and we would therefore ensure our clinical leaders are encouraged and able to attend.

We would also be happy for the independent evaluation of our programme to be shared

fully with other localities, and in return, we would want to see evaluation of their schemes, considering things like approach, structure, success, engagement, impact and sustainability.

We would be happy to agree to attend and present at a number of regional and/or national events to talk about both the programme itself but also the work we will have undertaken locally. This would be something we would look to support both during and after the completion of the programme.

Finally, we would be happy to host a 'learning conference' in Halton, inviting other localities involved or thinking about getting involved, system thinkers and political leaders to consider what's been successful and to help shape further thinking and potentially even policy.

**REPORT TO:** Health & Wellbeing Board

**DATE:** 9 March 2016

**REPORTING OFFICER:** Chief Officer NHS Halton CCG

**SUBJECT:** Delivering the Forward View: Planning Guidance 2016/17- 2020/21

1.0 **PURPOSE OF REPORT**

1.1 The purpose of this report is to provide the Board with a briefing on the NHS Planning Guidance 2016/17- 2020/21. A full copy of the guidance is attached to this report (please see Appendix 1).

2.0 **RECOMMENDATION : That the Board**

**1) Note the contents of this report; and**

**2) Agree that the Council works collectively with Halton CCG and One Halton delivery partners to develop a local 5 year Sustainability and Transformation Plan with accompanying 12 month operational plan and contribute to the wider Cheshire and Merseyside footprint Sustainability and Transformation Plan**

3.0 **SUPPORTING INFORMATION**

3.1 The national health and care bodies in England have come together to publish shared NHS Planning Guidance for 2016/17 – 20/21, setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

3.2 As part of the new planning process, NHS organisations have been asked to develop two plans:

1. A wider health and care system 'Sustainability and Transformation Plan', covering the period October 2016 to March 2021; and
2. A plan by organisation for 2016/17.

In additional Halton has agreed with its health and wellbeing partners to produce

The guidance is backed by £560 billion of NHS funding, including a new Sustainability and Transformation Fund.

**Place-based planning**

3.3 The guidance indicates that planning by individual organisation will increasingly be supplemented with planning by place for local populations. Producing a Sustainability and Transformation Plan (STP) on a larger geographical footprint will encourage this joint approach and will involve five things:

(i) Local leaders coming together as a team;
(ii) Developing a shared vision with the local community, which also involves local government as appropriate;
(iii) Programming a coherent set of activities to make it happen;
(iv) Execution against plan; and
(v) Learning and adapting

Success will also be dependent on having an open and engaging dialogue that harnesses the input of all partners including clinicians, patients, carers, citizens, the community and voluntary sector and local government through Health and Wellbeing Boards.

As a truly place-based plan, the STP must cover all areas of CCG and NHS England commissioned activity. It must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting locally agreed health and wellbeing strategies.

On the 29th January it was confirmed that Halton will form part of the Cheshire and Merseyside STP footprint

**Access to future transformation funding**

3.4 For the first time, the local NHS planning process will have significant central money attached to it. In order to reduce bureaucracy and to help with the local join-up of multiple national initiatives, the STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. They will consider:

(i) The quality of plans, particularly the scale of ambition and track record of progress already made
(ii) The reach and quality of the local process, including community, voluntary sector and local authority engagement
(iii) The strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and
(iv) Confidence that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

3.5 **Content of STPs**

Annex 1 of the document sets out a list of "national challenges" to help local systems set out their ambitions for their populations. The list of questions includes the objectives set out in the Mandate, however, local areas are urged not to "over-interpret" the list as a narrow template for what constitutes a good local plan. The most important task is to ensure a clear overall vision and plan for the area.

Local health systems also need to develop their own system wide local financial sustainability plan as part of their STP.

3.6 **Agreeing "transformation footprints"**

The STP will be the umbrella plan, with a range of delivery plans underneath it, some of which will necessarily be on different geographical footprints. The first critical task was for local systems to consider their transformation footprint. This was submitted on the 29th **January 2016**, for national agreement. Local authorities were engaged with these proposals. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver services, transformation and public health programmes required and how it best fits with other footprints. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. The document stresses that the footprint may adapt over time and it is preferred that partnerships focus their energies on the content of plans rather than have lengthy debates about boundaries.

Further guidance on the planning process, including timetable, is

now finalised. It is anticipated that the full draft of the operational plan be submitted by the 2nd March 2016, and the final draft by 11th April 2016. The 5 year Cheshire and Merseyside STP should be completed by end of June 2016. There is no expectation that the local Halton STP be submitted to NHS England. By spring 2016, information will be made available on roadmaps for national transformation initiatives.

NHS England has also stated that they would like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest.

**National "must dos" for 2016/17**

3.7 NHS England with the other national NHS organisations has identified nine must-do priorities for local health economies.

1. Produce a **sustainability and transformation plan** and decide the geographical transformation footprint it will cover (see below).
2. **Return secondary providers to aggregated financial balance**, delivering savings through the Carter productivity programme, caps on agency spending, and CCGs reducing variations.
3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.
4. Achieve waiting time targets for **A&E patients and ambulance response times**.
5. Improve and maintain performance against the **18 week referral to treatment target**.
6. Deliver the **62 day cancer waiting time target**, including the 2 week referral and 31 day treatment targets, and make progress in one year survival rates.
7. **Achieve and maintain new mental health waiting time targets**, and continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.
8. Improve care for people with **learning disabilities**, including improved community services and reducing inpatient facilities.
9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. Providers are required to publish **avoidable mortality** rates annually.

The guidance also sets milestones for areas meeting the clinical

standards for providing seven-day services, leading to complete coverage across the country by 2020. Access to out of hours care should be enhanced through better integration and redesign of NHS minor injuries units, urgent care centres and GP out of hours services. Areas should work to reduce avoidable NHS deaths by increasing consultant cover on hospital wards and improving access to diagnostic support at weekends.

NHS England is also extending the vanguard programme, looking for areas to trial two new approaches:

- secondary mental health providers managing care budgets for tertiary mental health services
- the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working on either of these approaches should let NHS England know by **29th January 2016**.

## 4.0 POLICY IMPLICATIONS

4.1 As a local area Halton will need to develop a local 5 year Sustainability and Transformation Plan (STP) that contributes to the wider Cheshire and Merseyside 5 year STP and a 12 month operational plan that demonstrates:

(i) How we intend to deliver the nine “must dos” and other requirements of the Mandate.

(ii) How we answer the triple aim in each area of better health, transformed quality of care delivery and sustainable finance- specifically referencing the questions outlined in Annex 1 of the guidance (see Appendix 1)

(iii) How we align and deliver a sustainable and transformation plan

4.2 All matters set out within this report have direct implications for the health and wellbeing priorities.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The development of a 5 year Sustainability and Transformation Plan for Halton and accompanying 12 month operational plan should contribute towards reducing the health inequalities gap, reducing the care and quality gap and closing the finance and efficiency gap. In real terms, this should result in improved health and wellbeing outcomes for Halton residents.

## 6.0 RISK ANALYSIS

6.1 Working collaboratively to address local health and wellbeing priorities should have a positive impact on improving health locally therefore negating any minor risks involved.

## 7.0 EQUALITY & DIVERSITY ISSUES

7.1 This report is in line with Equality and Diversity policy.

**REPORT TO:** Health & Wellbeing Board

**DATE:** 9 March 2016

**REPORTING OFFICER:** Operational Director, Education, Inclusion and Provision

**PORTFOLIO:** Health & Wellbeing

**SUBJECT:** Complex Dependency/Early Intervention

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The report summarises the arrangements for the introduction of a Multi-Agency Front door as part of Complex Dependency Early Intervention model in Halton.

2.0 **RECOMMENDATION: That the Board note the progress to date in implementing a multi-agency front door and recognise the benefit of a defined route to services through a single point of access by a dedicated multi-agency team.**

3.0 **SUPPORTING INFORMATION**

3.1 One of the key aims of the Complex Dependency Early Intervention project is to create a single, multi-agency front door for identification and assessment of complex individuals, children and families.

3.2 To deliver a multi-agency front door in Halton the process and practice of the current Contact and Referral Team (CART) have been reviewed. Through the implementation of the revised front door the aim is to provide a proportionate, timely and co-ordinated partnership approach to children, families and vulnerable adults. This approach should lead to a more appropriate allocation of resources to those children, families and vulnerable adults that require additional support due to them having multiple and complex needs.

3.3 For the new arrangements to be effective partners have to commit to the following principles:

- A graduated approach to offering support at the lowest level, in keeping with early intervention principles;

- Professionals to be proactive in the provision of early support and to work in partnership to achieve this; and
- Professionals to implement appropriate frameworks and methods to ensure that support is at the right level and is SMART.

3.4 The above principles are critical in order to prevent escalation of needs and to reduce the requirement for specialist services. Through improving our expertise and processes at the front door it should be possible to ensure that children, families and vulnerable adults are supported on the correct pathway and that resources are more efficiently allocated.

3.5 The development of the model in Halton has been led by the Early Intervention Operational Group a partnership group chaired by the Complex Dependencies Co-ordinator. It has been informed by best practice and feedback from quality assurance i.e. audit, practitioner and family feedback. A dedicated Business Analyst has been working on mapping and identifying functions and processes that need to be undertaken within the new integrated team. As a key part of this work a toolkit is being developed for use by professionals.

3.6 The new integrated team will be known as I-CART and there will be a soft launch of the new approach at the end of March 2016. I-CART will be located on the first floor of Municipal Building alongside the contact centre and adult service front door. During March joint training and workforce development will be provided to the team.

3.7 Although a number of key roles have been identified within the initial team the experience of other areas is that once the team is up and running opportunities for more partners or services to contribute to strengthen the approach are identified. The membership of the core initial team is as follows:

**Safeguarding**

- Halton Borough Council Principal Manager
- Halton Borough Council Practice Lead
- Social Workers x 5 (1 part time)
- Halton Borough Council Business Support x 3 (1 part time)

**Early Intervention**

- Halton Borough Council Principal Manager
- Halton Borough Council Senior Early Intervention Officer
- Halton Borough Council Family Worker x 2
- Halton Borough Council Practice Manager – Adult Secondment
- Health Secondment
- Police Secondment
- Education Welfare Officer Post

3.8 In addition, it is anticipated that staff from the Domestic Abuse Service will have a presence in the front door as well as Cheshire Fire Service.

3.9 There will be a range of common duties that will be required of the professionals within the I-CART and these will include:

- Gathering information with regards to the present level of need for a child, family or vulnerable adult;
- Checking multiple data systems for past and present agency involvement in order to lead on and contribute to the front door contacts/assessments e.g. 360;
- Making decisions around support requirements to improve outcomes;
- Contribution to team development;
- Supporting the review of new systems and processes and making suggestions for improvements;
- Presenting information on a concise manner, implementing SMART outcomes;
- Representing substantive service and the new service as appropriate;
- Offering advice and training to multi-agency professionals;
- Adopting reflective practices and contributing to action learning; and
- Supporting continuous quality improvement.

3.10 The three main outcomes which could take place after

contacting the I-CART team where the cases sit below Level 3 are as follows:

- Information advice and guidance is provided to the requester and where appropriate another suitable professional to takes the IAG further;
- There is escalation to acute services; and
- There is progression to a 360 profile for further assessment.

3.11 For those families who qualify for a 360 profile there are three further possible outcomes from this multi-agency triage approach and these are as follows:

- Professionals continue with a multi-agency plan with specific agreed objectives;

- The case is send to the Working Together Meeting as it has been confirmed that the family has multiple and complex issues, which require further support from that multi-agency network;

- Cases are stepped-up to level 3 support i.e. safeguarding procedures.

3.12 A new early intervention performance framework is being developed which will include measures to assess the timeliness of decision making, number of referrals and repeat referrals, categories of referral and quality of decision making.

3.13 Through the introduction of I-CART the aim is to see less inappropriate and repeat referrals, closer partnership working and clearer accountability, supported by information sharing protocols and pathways, improved confidence from those who access the service, identification of possible gaps in service and cost benefits.

## 4.0 POLICY IMPLICATIONS

4.1 The current Information Sharing Agreement has now been revised and reissued to partners for approval. This will ensure the safe and proportionate multi-agency information sharing required of partner agencies as part of the information gathering process which leads to effective decisions around support for children, families and vulnerable adults.

## 5.0 FINANCIAL IMPLICATIONS

5.1 Complex Dependency funding has been secured for twelve months to support a Principal Manager role, the Adult, Health and Education secondment positions. Funding has also been approved to contribute towards the costs of the police secondment. The project

funds the costs of the Complex Dependency Co-ordinator and the full cost of the Business Analyst post. The Troubled Families budget is being used to support the Cheshire Fire Service post.

5.2 In addition, to the pump prime funding for staffing, Complex Dependency monies have been used to develop the accommodation and IT and access training for the workforce.

5.3 Each service/partner is now developing plans to continue to fund the posts currently supported by Complex Dependency grant.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

The vision for the new approach is that all children and families in Halton thrive and achieve, and are kept safe. Those children and families who need extra help and support thrive and achieve well are able to get that help quickly and easily and that all those working with children and families work well together to support families that next extra help.

### 6.2 Employment, Learning & Skills in Halton

A key focus of the complex families early intervention programme is to address worklessness within families.

### 6.3 A Healthy Halton

A range of health partners are committed to contributing to the new approach.

### 6.4 A Safer Halton

Children and families are supported at the lowest safe level of needs and supported to build resilience and make full use of universal services.

### 6.5 Halton's Urban Renewal

None identified.

## 7.0 RISK ANALYSIS

7.1 The revised approach to aim to support agencies and partners to provide the right support and signposting to prevent needs from escalating and reaching crisis.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The Complex Dependency Early Intervention model aims to provide a more joined up approach across agencies and services that tackle the causes of crisis for children, families and vulnerable individuals and ensure more support is available for those families already in a state of crisis.

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

| **Document** | **Place of Inspection** | **Contact Officer** |
|---|---|---|
| DCLG Guidance on Phase 2 Troubled Families Programme | Rutland House | Ann McIntyre Operational Director Education, Inclusion & Provision |
| Complex Dependency Bids | Rutland House | Ann McIntyre Operational Director Education, Inclusion & Provision |
| Best Practice Overview for Front Door Arrangements Complex Dependency Model | Rutland House | Ann McIntyre Operational Director Education, Inclusion & Provision |

| | |
|---|---|
| **REPORT TO:** | Health and Wellbeing Board |
| **DATE:** | 9 March 2016 |
| **REPORTING OFFICER:** | Chief Officer NHS Halton CCG |
| **PORTFOLIO:** | Health and Wellbeing |
| **SUBJECT:** | Summary of CQC Inspection Reports of GP Practices |
| **WARD(S)** | Borough-wide |

## 1.0 PURPOSE OF THE REPORT

1.1 This report presents a summary of the outcomes of the first wave of CQC inspections of general practices in Halton undertaken in September 2015. Of the eight practices inspected, seven received an overall rating of good, and one an overall rating of outstanding.

## 2.0 RECOMMENDATION: That the Board note the good outcomes of the first wave of CQC inspections of GP practices in Halton.

## 3.0 SUPPORTING INFORMATION

3.1 The Care Quality Commission (CQC) monitors, inspects and regulates services that provide health and social care, including general practices. They do this by:

- Registering people that apply to them to provide services.
- Using data, evidence and information throughout their work.
- Using feedback to help reach judgements.
- Inspections carried out by experts.
- Publishing information on judgements.
- Taking action when services are judged to need to improve or to make sure those responsible for poor care are held accountable for it.

3.2 There are five questions CQC asks of all care service which are at the heart of the way they regulate and they help them to make sure they focus on the things that matter to people.

The five questions are:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?

- Are they well-led?

3.3 There are four ratings that are given to health and social care services: outstanding, good, requires improvement and inadequate.

| | |
|---|---|
| Outstanding | The service is performing exceptionally well. |
| Good | The service is performing well and meeting our expectations. |
| Requires improvement | The service isn't performing as well as it should and we have told the service how it must improve. |
| Inadequate | The service is performing badly and we've taken action against the person or organisation that runs it. |

3.4 Between 3rd September 2015 and 22nd September 2015 eight general practices in Halton received a CQC inspection. All the reports have now been published and this paper provides an overview of those reports. A summary of the findings from the five key questions for each practice can be found in Appendix 1, tables 1-8. Appendix 2 highlights the key themes from each of the five questions.

Seven practices received an overall rating of 'good' and one practice received an overall rating of 'outstanding'. In general the inspectors found the practices to be good for providing well-led, effective, caring and responsive services.

The remaining nine practices will receive their inspection visits between January and March 2016.

4.0 **POLICY IMPLICATIONS**

The reports will be used to inform the review and monitoring of the quality, safety, effectiveness and impact on health outcomes of general practice services.

5.0 **FINANCIAL IMPLICATIONS**

5.1 None identified.

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

6.1 **Children & Young People in Halton**

The report will support the priority to improve the health and wellbeing of children and young people by focussing on the care provided by GP

practices.

6.2 **Employment, Learning & Skills in Halton**
The report will help to support maintaining a healthy workforce by focussing on the care provided by GP practices.

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

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 **RISK ANALYSIS**

7.1 Practices that receive a poor rating are at risk of providing inadequate levels of care to its patients. No practice received an overall poor rating.

8.0 **EQUALITY AND DIVERSITY ISSUES**

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

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**
.
Appendix 1 attached.

**Report Prepared by:** Julie Holmes, Commissioning Manager, NHS Halton CCG
**Contact:** julie.holmes@haltonccg.nhs.uk

**Appendix 1**

**Table 1: Beaconsfield Surgery – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| Good | Are services safe? | Requires improve-ment | The practice is rated requires improvement for providing safe services as there were insufficient records of appropriate recruitment checks. The practice was able to provide evidence of a good track record for monitoring safety issues. The practice took the opportunity to learn from incidents, to support improvement. There were systems, processes and practices in place that were essential to keep people safe including medicines management and safeguarding. |
| | Are services effective? | Good | The practice is rated good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Data showed patient outcomes were at or above national averages. Staff worked with other health care teams and there were systems in place to ensure information was appropriately shared. Staff had received training relevant to their roles. |
| | Are services caring? | Good | The practice is rated good for providing caring services. Information from various patient surveys demonstrated patients were treated by clinicians with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect. Staff helped people and those close to them to cope emotionally with their care and treatment. |
| | Are services responsive to people's needs? | Good | The practice is rated good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements from feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Information about how to complain was available. Learning from complaints was shared with staff. |
| | Are services well led? | Good | The practice is rated good for being well-led. It had a clear vision and strategy. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and had an active PPG. Staff had received inductions and attended staff meetings and events. |

**Appendix 1**

**Table 2: Beeches Medical Centre – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| Good | Are services safe? | Good | The practice is rated as good for providing safe services. Staff were aware of procedures for reporting significant events and safeguarding patients from risk of abuse. There were appropriate systems in place to protect patients from the risks associated with medication and infection control. We found that the recruitment practices should be improved by recording an assessment of the physical and mental fitness of staff. An up to date fire risk assessment needed to be made available to ensure the on-going safety of the premises. |
| | Are services effective? | Good | The practice is rated good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared. Staff had received training appropriate to their roles. |
| | Are services caring? | Good | The practice is rated as good for caring. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients felt involved in planning and making decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with Privacy. |
| | Are services responsive to people's needs? | Good | The practice is rated good for providing responsive services. Services were planned and delivered to take into account the needs of different patient groups. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. |
| | Are services well led? | Good | The practice is rated good for being well-led. It had a clear vision and strategy. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The practice was aware of future challenges. |

**Appendix 1**

**Table 3: Brookvale Practice – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| ☆ Outstanding | Are services safe? | ● Good | The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. We noted that the recruitment practices should be improved by recording an assessment of the physical and mental fitness of staff. |
| | Are services effective? | ☆ Outstand-ing | The practice is rated outstanding for providing effective services. The practice proactively engaged patients to promote their well-being. The practice had run several events to raise patient awareness of health conditions and promote good health. For example, a talk was given to patients about mammography screening to improve mammography uptake. This event was held in the evening to promote attendance. A health promotion evening was held were male patients were invited for a range of health checks such as blood pressure, body mass index (BMI) and glucose monitoring. This event was well attended and helped to identify several patients who required follow up. The Fit for 15 campaign was introduced this year to increase the cardiovascular screening of patients aged 18 and over. In the last 12 months the practice had completed 478 health checks compared with 253 the previous year. The practice had strategies in place to identify long term conditions early and therefore improve patient care. For example, to identify patients at risk of chronic obstructive pulmonary disease (COPD) Spirometry was offered to smokers aged 35 and over. This strategy has been in place for a number of years and this work gained recognition with a prize from the International Primary Care Respiratory Group. A project was undertaken to encourage male patients over 65 to request aortic aneurysm screening (the national programme offers this to patients who are 65 years of age, patients older than this have to request this screening). Patients were informed about this testing via practice website, waiting room TV, consultations and mailshots. Patients were invited to the practice to discuss to discuss this screening prior to referral. Results showed that 118 scans had been requested and as a consequence six patients with aortic aneurism and an incidental cancer diagnosis had been identified. The practice had a very good skill mix which included two nurse clinicians and a nurse practitioner who were able to see a broader range of patients than the practice nurses. In addition the practice had four practice nurses and a health care assistant which allowed for greater capacity for monitoring and reviewing patients' health. The practice provided examples of audits to demonstrate that audit and quality improvement was central to the operation of the practice. The practice had been recognised by the RCGP Mersey faculty having won prizes for an audit of diabetes care and an audit of peripheral vascular disease. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Data showed patient outcomes were at or above national averages. Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared. Staff had received training appropriate to their roles and there was a clear commitment towards staff learning and development. |
| | Are services caring? | ☆ Outstand-ing | The practice is rated outstanding for providing caring services. The practice provided a range of services to demonstrate that patients were provided with a caring service. The practice had close links with the Halton Carers Association and a representative from the association attended practice meetings such as the avoiding unplanned admissions to hospital and palliative care meetings so they were able to identify any support needed by carers. A carer's register was maintained. Information publicising services for carers was available in the waiting area and on the website. Text messages were sent to carers notifying them of events and useful information.<br>For example, carers had recently been sent a text message about a non-means tested allowance available to them for breaks. Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. A Christmas present or hamper was provided to older patients with no family. The practice had signed up for the |

**Appendix 1**

| | | | |
|---|---|---|---|
| | | | Safe in Town scheme and provided a safe haven for vulnerable people (vulnerable people were able to come to the practice and the person's carers would be contacted). In 2014 the practice was awarded a grant to develop a community garden at the practice. Patients worked to create the garden which provided exercise and reduced social isolation. Patients' views gathered at inspection demonstrated they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Staff helped people and those close to them to cope emotionally with their care and treatment. |
| | Are services responsive to people's needs? |  Outstand-ing | The practice is rated outstanding for providing responsive services. Services were planned and delivered to take into account the needs of different patient groups. For example, extended hours services were provided Monday and Tuesday morning and evening and from 09:00 to 13:00 on Saturdays. Home visits were undertaken to housebound patients and patients that were hard to engage. The nursing team dedicated two days per week to home visits which included long term condition reviews and immunisation. The effectiveness of this approach was shown in data demonstrating flu vaccine uptake for 2014 was higher than neighbouring practices with a similar patient population. Quality and Outcomes Framework (QOF) Performance for diabetes assessment and care was higher than the national averages. There were longer appointments available for people with a learning disability and Saturday morning clinics were offered to patients with a learning disability to encourage attendance. One-stop clinics were provided to encourage uptake for health monitoring services related to specific conditions. There were disabled facilities, hearing loop and translation services available. Chairs for bariatric patients were provided in the waiting area. In response to a high number of patients being illiterate alerts were placed on staff computers to indicate assistance may be required. The practice referred patients to Wellbeing Enterprise Services, a social enterprise to support people to achieve happier, healthier and longer lives. Patients could be referred for support with a number of issues, including, debt management, housing, social isolation. A report from this service showed that patients who were referred by the practice benefitted from the interventions provided. For example, by experiencing a reduction in their symptoms of depression and improving their general well-being. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided |
| | Are services well led? |  Good | The practice is rated good for being well-led. It had a clear vision and strategy. Governance arrangements were underpinned by a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on and had an active PPG. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice was aware of future challenges. |

**Appendix 1**

**Table 4: Grove House Practice – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| Good | Are services safe? | Good | The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. We saw good examples of joint working with midwives and health visitors who were based in the same building, and with school nurses. Staff shared locally acquired knowledge to keep vulnerable patients safe, especially were this could affect decisions on the future care arrangements of vulnerable patients. |
| | Are services effective? | Good | The practice is rated as good for providing effective services. Staff worked with multidisciplinary teams, which involved staff from care providers and voluntary organisations that could contribute to the long term, effective care and support of patients. Clinicians worked with SCIP workers to provide more holistic treatment of patients, where social factors were significant contributors to some patients' health problems. Data showed patient outcomes were in line with the average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. |
| | Are services caring? | Good | The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. We saw particularly how clinicians strived to provide continuity of care by use of a buddying system within the practice. This was particularly important to those patients with complex needs, their carers and their relatives. Staff worked with all stakeholders to ensure that patient care was compassionate and focused on the needs of the individual. |
| | Are services responsive to people's needs? | Good | The practice is rated as good for providing responsive services. Where data showed the practice could improve on positive scores for patient satisfaction, we saw plans in place to address this. Urgent appointments were available on the same day. We saw the practice respond to examples of social isolation of patients and the way this affected the health of the local population. To address this the practice had built up a matrix of almost 600 voluntary organisations, many of which were invited to a 'market day' at the practice to reach out to more isolated patients, offering support and well-being services. Practice clinicians worked on a daily basis with SCIP workers, to support vulnerable patients and tackle the root cause of complex health problems of some patients. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the Patient Participation Group (PPG). Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders. |
| | Are services well led? | Good | The practice is rated as good for providing well-led services. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff. Teams worked together across all roles. Governance and performance management arrangements had been reviewed and took account of current models of best practice. The practice had succession planning in place, which was reviewed to ensure that the skills set of clinicians kept pace with the demands of the practice population and the practice desire to offer more integrated care. There was a high level of constructive engagement with all staff. Staff we spoke with spoke of high levels of satisfaction in their role. The practice worked with |

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| | | | the wider health care community to deliver care that met the needs of patients. We saw examples of how this was promoted and supported by the leadership team as critical to delivering services that truly addressed patients' health issues. The practice gathered feedback from patients and it had an active Patient Participation Group (PPG) which influenced practice development. |

**Appendix 1**

**Table 5: Oaks Place Surgery – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| Good | Are services safe? | Requires improvement | The practice is rated as requires improvement for providing safe services as there were areas where it should make improvements. The practice was able to provide evidence that they monitored safety issues. However, there was limited evidence of shared learning taking place or that lessons learnt had led to effective change. The practice had a recruitment system in place that ensured appropriate checks on permanent and temporary staff were undertaken. The practice advertised that chaperones were available, however due to staffing levels this facility was unworkable. There was no system in place to effectively monitor the cleanliness of the practice. There was system in place to monitor uncollected prescriptions to ensure vulnerable patients were receiving their medication. However records viewed during the inspection identified that the system was not always being followed by the staff team. |
| | Are services effective? | Good | The practice is rated good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Data showed patient outcomes were broadly in line or above national averages. Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared. Staff had received training appropriate to their roles. |
| | Are services caring? | Good | The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. |
| | Are services responsive to people's needs? | Good | The practice is rated as good for providing responsive services. The practice offered pre bookable and same day appointments and also offered telephone consultations to determine whether a patient needed to be seen by a GP or could be offered advice or sign posted to a more appropriate service such as a pharmacist. There were limited systems in place to monitor patient access. For example, monitoring the use by patients of the urgent care and walk in services situated in the building to determine the effectiveness of the service provided to meet patients' needs. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. The practice did not carry out an annual complaints audit to identify themes and to monitor the effectiveness of the complaints process as a driver of improvement. The practice does not have a website. |
| | Are services well led? | Good | The practice is rated good for being well-led. The practice had recently changed from a GP partnership to a single handed GP. The lead GP had identified areas for improvement in the clinical and administration staffing levels and had taken steps to resolve these issues. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. However, further work was needed to ensure proactive work took place to remove or minimise risks identified. Self-employed and locum GPs received external appraisals, in house induction and were invited to staff meetings. |

**Appendix 1**

**Table 6: Peelhouse Medical Centre – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| Good | Are services safe? | Good | The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated within the practice and with external professionals and members of the patient participation group (PPG) to support improvement. The premises were clean and tidy. Safe systems were in place to ensure medication, including vaccines were well managed. Prescription pads stored in office cabinets would benefit from risk assessments to help improve security when cabinets were left open for staff access. There were sufficient numbers of staff. Recruitment checks were carried out and recruitment files were well managed. |
| | Are services effective? | Outstanding | Practice rated outstanding for providing effective services. Practice proactively engaged patients to promote their well-being. The practice had strategies in place to identify long term conditions early and therefore improve patient care. For example, to identify patients at risk of chronic obstructive pulmonary disease (COPD). The practice monitored its performance data and had systems in place to improve outcomes for patients. Staff routinely referred to guidance from the National Institute for Health and Care Excellence (NICE.) Patients' needs were assessed and care was planned and delivered in line with best practice and national guidance. An advanced nurse practitioner saw a broader range of patients and monitored the effectiveness of their unplanned admissions strategy of patients identified at risk and in managing their in-house warfarin clinic. |
| | Are services caring? | Good | The practice is rated as good for caring. Patients' views gathered at inspection demonstrated they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Staff helped people and those close to them to cope emotionally with their care and treatment. Data from the National GP Patient Survey published July 2015 showed that patients rated the practice as comparable and exceeded in several aspects of care compared to local and national averages. Some staff had worked at the practice for many years and understood the needs of their patients well. |
| | Are services responsive to people's needs? | Good | The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Services were planned and delivered to take into account the needs of different patient groups. The practice referred patients to Wellbeing Enterprise Services, a social enterprise to support people to achieve happier, healthier and longer lives. Patients could be referred for support with a number of issues, including, debt management, housing, social isolation. The practice had good facilities and was well equipped to treat patients and meet their needs including access to disabled facilities, hearing loop and translation services. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff. |
| | Are services well led? | Good | The practice is rated as good for being well led. It had a clear vision and strategy. Governance arrangements were underpinned by a clear leadership structure with delegated roles and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on and had an active PPG. Staff had received inductions, regular performance reviews and attended staff meetings and events. |

**Appendix 1**

**Table 7: Upton Rocks Primary Care – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| Good | Are services safe? | Good | The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed. Some follow-up of outstanding compliance matters was required. |
| | Are services effective? | Good | The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. |
| | Are services caring? | Good | The practice is rated as good for providing caring services. Data from the NHS England GP Patients Survey, showed that patients rated the practice the same or sometimes lower than others locally and nationally for several aspects of care, particularly in relation to GP care. More recent data, for example from the Friends and Family Test, showed patients would recommend the practice to others. Patients said they were treated with compassion, dignity and respect. Scores in relation to treatment by the practice nurses were good. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. |
| | Are services responsive to people's needs? | Good | The practice is rated as good for providing responsive services. It reviewed the needs of its local population and when necessary, engaged with the NHS England Area Team and Clinical Commissioning Group to meet the needs of patients. Patients said they found it easy to make an appointment with a named GP, and said if they needed an appointment to be seen on the day, this was made available to them. The practice information leaflet gave details of how to make a complaint. We saw that complaints were responded to in line with the complaints policy of the provider. The practice has a branch surgery which it operates from one day each week. This had been kept open in response to patient demand. We did note that although the practice had a GP presence for the extended hours surgery on Monday of each week, there was no GP presence for most of the surgery opening hours on Monday of each week. The arrangement in place was that the GP was 'on call' and if patients needed to see the GP, staff would telephone and request the GP attend the surgery. An advanced nurse prescriber was routinely available throughout the day. |
| | Are services well led? | Good | The practice is rated as good for being well-led. There was a corporate vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor quality and identify risk. The practice proactively sought feedback from staff and patients. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. |

**Appendix 1**

**Table 8: West Bank – summary of findings from five key questions**

| Overall Rating | Question | Rating | Findings |
|---|---|---|---|
| Good | Are services safe? | Good | The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. |
| | Are services effective? | Good | The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. |
| | Are services caring? | Good | The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. |
| | Are services responsive to people's needs? | Good | The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. |
| | Are services well led? | Good | The practice is rated as good for being well-led. It had a clear vision and strategy. Staff knew the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. |

Appendix 1

**Table 9: Common themes from the five key questions**

| Question | Rating | Key Themes |
|---|---|---|
| **Are services safe?** Six practices were rated as 'good' and two as 'required improvement'. | Good | • Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.<br>• Lessons were learned and communicated widely to support improvement.<br>• Risks to patients were assessed and managed.<br>• Safe systems were in place to ensure patients protected from risks associated with medication. |
| | Requires improvement | • Recruitment practices should be improved by recording an assessment of the physical and mental fitness of staff. |
| **Are services effective?** Six practices were rated as 'good' and two as 'outstanding'. | Good | • Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely.<br>• Patients' needs were assessed and care was planned and delivered in line with current legislation.<br>• Staff had received training appropriate to their roles. |
| | Outstanding | • The practice proactively engaged patients to promote their well-being.<br>• The practice had strategies in place to identify long term conditions early and therefore improve patient care.<br>• The practice skill mix included nurse clinicians and nurse practitioners which enabled them to see a broader range of patients than the practice nurses. |
| **Are services caring?** Seven practices were rated as 'good' and one as 'outstanding' | Good | • Staff treated patients with kindness and respect, and maintained confidentiality.<br>• Patients said they were treated with compassion, dignity and respect.<br>• Patients felt involved in planning and making decisions about their care and treatment. |
| | Outstanding | • The practice provided a range of services to demonstrate that patients were provided with a caring service, e.g. the practice had close links with the Halton Carers Association and a representative from the association attended practice meetings so they were able to identify any support needed by carers. A carer's register was maintained. Information publicising services for carers was available in the waiting area and on the website. Text messages were sent to carers notifying them of events and useful information.<br>• A Christmas present or hamper was provided to older patients with no family. |
| **Are services responsive to patient's needs?** Seven practices were rated as 'good' and one as 'outstanding'. | Good | • The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.<br>• Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.<br>• Learning from complaints was shared with staff and other stakeholders.<br>• The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the PPG. |
| | Outstanding | • Home visits were undertaken to housebound patients and patients that were hard to engage. The nursing team dedicated two days per week to home visits which included long term condition reviews and immunisation.<br>• There were longer appointments available for people with a learning disability and Saturday morning clinics were offered to patients with a learning disability to encourage attendance.<br>• One-stop clinics were provided to encourage uptake for health monitoring services related to specific conditions.<br>• In response to a high number of patients being illiterate alerts were placed on staff computers to indicate assistance may be required. |

| | | |
|---|---|---|
| **Are services well led?** All eight practices were rated as 'good'. |  Good | • Practice had a clear vision and strategy.<br>• Governance arrangements were underpinned by a clear leadership structure and staff felt supported by management.<br>• The practice had a number of policies and procedures to govern activity.<br>• There were systems in place to monitor and improve quality and identify risk.<br>• The practice proactively sought feedback from staff and patients, which it acted on. |

| | |
|---|---|
| **REPORT TO:** | Health and Wellbeing Board |
| **DATE:** | 9th March 2016 |
| **REPORTING OFFICER:** | NHS England |
| **PORTFOLIO:** | Health and Wellbeing |
| **SUBJECT:** | Transforming Care: Implementation of National Plans across Cheshire and Merseyside |
| **WARDS:** | Borough Wide |

## 1.0 PURPOSE OF THE REPORT

The purpose of the report is to update Halton Health and Wellbeing Board on the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities

## 2.0 RECOMMENDED: That

1) **the report be noted; and**
2) **the Board support the implementation**

## 3.0 SUPPORTING INFORMATION

The Transforming Care programme is a national programme of work, aimed to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

## 4.0 POLICY IMPLICATIONS

The work on learning disabilities in Cheshire and Merseyside is a response to the Winterbourne View Review: Concordat: Programme of action (2012) and Transforming Care for people with Learning Disabilities – Next Steps, July 2015). The five areas in the Transforming Care programme are:

**Empowering individuals** – giving people with learning disabilities and/or autism, and their families*, more choice* and say in their care.

**Right care in the right place** – ensuring that we deliver the best care now, including a new approach to *care and treatment reviews*, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning.

**Regulation and inspection** – tightening regulation and the inspection of providers to *drive up the quality of care*.

**Workforce** – developing the *skills and capability* of the workforce to ensure we provide high quality care.

**Data and information** – making sure the *right information is available* at the right time for the people that need it, and continuing to track and report progress.

The actions identified within the programme, are key deliverables to

## 5.0 FINANCIAL IMPLICATIONS

The actions identified within the programme will be delivered through existing resources identified within each partner's budget, with a plan for finances to move to a pooled arrangement for service provision. There will be financial support via a national budget pool to progress some of this work; the amount and process for access to funding is still yet to be agreed, but there is a local agreement that a project management office function be established to drive delivery.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
The outcomes of this programme will be the continuation of in-provision for people in times of deteriorating health or crisis and conjunction with the development of high quality services closer to enable people to liver independent lives closer to their friends, family and carers.

6.2 **Employment, Learning and Skills in Halton**
None as a result of this report

6.3 **A Healthy Halton**
The outcomes of this programme will be the continuation of in-provision for people in times of deteriorating health or crisis and conjunction with the development of high quality services closer to enable people to liver independent lives closer to their friends, family and carers.

6.4 **A Safer Halton**
None as a result of this report

6.5 **Halton's Urban Renewal**
None as a result of this report

## 7.0 RISK ANALYSIS

In the delivery of Transforming Care programme through the introduction of new care models and removal of beds, there is an associate risk of Judicial Review or referral to the Secretary of State due to the scale of change. Therefore the delivery of the programme requires strategic commitment from all stakeholders. Operational risks are outlined more fully within the report.

## 8.0 EQUALITY AND DIVERSITY ISSUES

In the delivery of Transforming Care programme through the commissioning strategy and operational plans, NHS England and key partners (Department of Health, Local Government Association, Association of Directors of Adult Social Services, Care Quality Commission and Health Education England will be required to ensure that it is compliant with the duties upon public bodies under the Equality Act 2010.010.

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

None under the meaning of the Act.

NHS England

# Transforming Care: Implementation of National Plans across Cheshire and Merseyside

**January 2016**

# Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Version number: 1

First published: December 2015

Prepared by:
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Chief Nurses and Directors of Quality Cheshire & Merseyside CCG's.

Classification: OFFICIAL

## 1. Purpose of report

The purpose of this report is to update Cheshire and Merseyside Health and Wellbeing Boards with regard to the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities.

## 2. Background

As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout peoples' lives.

Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

Next Steps (July 2015) set out clear expectations that six organisations - NHS England, Department of Health (DH), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQQ) and Health Education England (HEE) - would work together more effectively, to drive forward change.

There is now a single shared Transforming Care programme that recognises the scale of the change required, and ensures that we address the underlying causes of why so many people remain in, and are continuing to be placed in, hospital settings.

The five areas in the Transforming Care programme are:

- **Empowering individuals** – giving people with learning disabilities and/or autism, and their families*, more choice* and say in their care.

- **Right care in the right place** – ensuring that we deliver the best care now, including a new approach to *care and treatment reviews*, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning.

- **Regulation and inspection** – tightening regulation and the inspection of providers to *drive up the quality of care*.

- **Workforce** – developing the *skills and capability* of the workforce to ensure we provide high quality care.

- **Data and information** – making sure the *right information is available* at the right time for the people that need it, and continuing to track and report progress (Appendix 1).

## 3. National Transforming Care Programme 2015 - 2019

Next Steps (July 2015) set out a clear ambition for a radical re-design of services for people with learning disabilities. A draft service model has been recently published,

which sets out nine overarching principles which define what ‘good’ services for people with learning disabilities and/or autism whose behaviour challenges should look like.

These principles will underpin how local services are redesigned over the coming months and years – allowing for local innovation and differing local needs and circumstances, while ensuring consistency in terms of what patients and their families should be able to expect from local decision-makers.

The establishment of six Fast-Track areas, announced by Simon Stevens at the NHS Confederation conference will ‘test; the draft Service model during the summer of 2015.

NHS England have continued to seek the views of clinicians, commissioners, providers, people with learning disabilities and/or autism who have a mental health condition or display behaviour that challenges (including offending behaviours) and their families, ahead of the publication of a final version published in autumn 2015. This will help to support commissioning intentions and financial planning 2016/17.

In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 18 months, allowing the closure of inpatient beds and facilities.

Friday 30 October 2015 saw a key milestone in the Transforming Care programme with the publication by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) of; ‘Building the right support: A national implementation plan to develop community services and close inpatient facilities and a ‘New Service Model’ (2015).

Taken together, these documents have asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019.

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

While local areas will be able to design bespoke services with those who use them, the national plan (2015) also sets out the need for:

- Local councils and NHS bodies to join together to deliver better and more coordinated services

- local housing that meets the specific needs of this group of people, such as schemes where people have their own home but ready access to on-site support staff
- a rapid and ambitious expansion of the use of personal budgets, enabling people and their families to plan their own care, beyond those who already have a legal right to them
- people to have access to a local care and support navigator or key worker, and investment in advocacy services run by local charities and voluntary organisations so that people and their families can access independent support and advice
- pooled budgets between the NHS and local councils to ensure the right care is provided in the right place
- Using the nine principles set out in the 'New Service Model' (2015) TCPs should have the flexibility to design and commission services that meet the needs of people in their area

There is also an expectation as part of the national Transforming Care programme of work for:

- A 10% reduction in in-patient admissions using the pre 31.3.15 cohort of patients as the baseline, by 31 March 2016 and,
- Care and Treatment reviews (CTRs) for all people in an inpatient bed to become 'business as usual'.

## 4. Transforming Care Partnerships (TCPs)

Cheshire & Merseyside have had an historic Learning Disability Network that has undertaken much work from the Winterbourne View Recommendations over the past 3 years. Discussions through this network resulted in an agreed consensus to progress developments via one Transforming Care Partnership or unit of planning across the Cheshire & Merseyside footprint to ensure commissioning at scale, with three geographical collaborative commissioning delivery hubs as outline below.

| **Cheshire and Merseyside Unit of Planning** | | | |
|---|---|---|---|
| **Hub** | **CCGs** | **Local Authority** | **Total Population** |
| Hub 1<br>Cheshire | Wirral<br>West Cheshire,<br>East Cheshire,<br>South Cheshire<br>Vale Royal | Wirral<br>West Cheshire &<br>Chester<br>East Cheshire | 1,078,886<br>Population |
| Hub 2<br>Mid<br>Mersey | Halton<br>St Helens<br>Warrington<br>Knowsley | Halton<br>St Helens<br>Warrington<br>Knowsley | 701,952 Population |
| Hub 3<br>North<br>Mersey | South Sefton<br>Southport &<br>Formby<br>Liverpool | Sefton<br>Liverpool | 786,383 population |

This approach builds on:

- existing CCG/LA collaborative commissioning arrangements
- current clinical pathway service delivery
- joint purchasing arrangements between some CCGs
- joint CCG/LA arrangements, including governance for joint decision-making
- excellent CCG/Provider working relationships
- provider financial viability and clinical sustainability

NHS England has proactively facilitated the bringing together of local delivery hubs and local discussions have already commenced

**4.1 Cheshire & Merseyside Transforming Care Board**

In response to the national programme (Building the right support, 2015) a Cheshire & Merseyside Transforming Care Board has been established; with Alison Lee, Accountable Officer, West Cheshire CCG as Senior Responsible Officer for this programme of work and Sue Wallace-Bonner, Director of Adult Social Care Halton Council as Deputy Chair. There are current discussions underway with the North West Confirm and Challenge service user group to establish a co-chair position.

The Board are undertaking 2 pieces of work in the first instance. The first is to establish the population need to enable commissioning of high quality services moving forward. We have commissioned a Joint Strategic Needs Assessment across Cheshire & Merseyside to inform current work programmes in partnership with Public Health England and Liverpool John Moore's University.

The second is a look back exercise to evaluate were we have come from in terms of bed usage and models of care and where we need to get to as a health and social care economy.

It is recognised that Cheshire & Merseyside have already undertaken a significant amount of service improvement in this area and recognising the journey so far is significant when reviewing in-patient provision. To this end the Board will:

- Undertake a retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work there will be a look at:

    - The trend analysis and identify complementary activity within local NHS in patient provision in assessment and treatment units.

    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.

    - Performance as measured in the LD Self-Assessment Framework over this period.

- Developing a model of care for the coming 3 years, 2016-2019, for LD services for Cheshire and Merseyside that builds on the strengths identified in the retrospective study that draws on Government Policy and the NHS 5 Year Forward View (NHS England 2015).

The target completion date for this work is January 2016.

It is expected that the TCPs will now follow the same programme of work as the six national fast track sites. Therefore the programme plan of transformation will include:

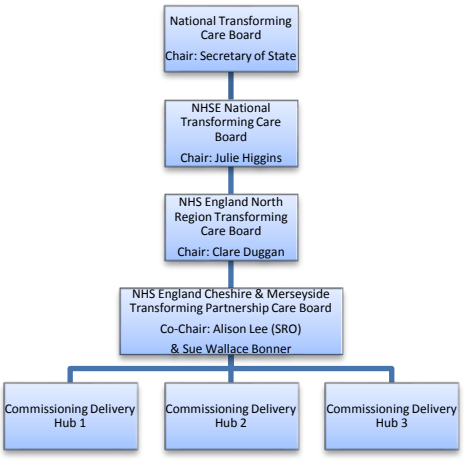
- Development of local plans that support the development of new models of care and long term bed closures, underpinned by a robust learning disability joint strategic health needs assessment.
- Rapid expansion and improvement in community provision, encompassing a range of supported living options and housing with accompanying care and support, to enable the transfer of people from inpatient facilities.
- Any use of in-patient services must be based on robust assessment of an individual's needs. People that do require in-patient care due to the severity of their condition should have the highest quality of care and an agreed plan to return to their community placement as quickly as possible.
- Repatriation of out of area placements

**4.2 Governance arrangements to support delivery**

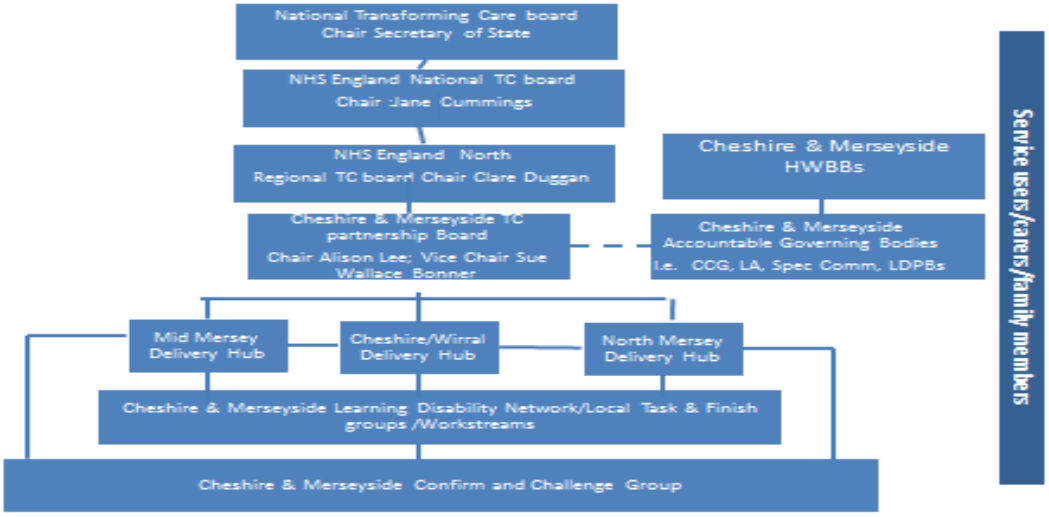
There is a well-established Cheshire & Merseyside learning disabilities network with CCG, LA, Provider and service user representation. This group will now undertake task and finish work on behalf of the board. One of the current strategic work themes is, 'Safe and Responsive services' for which a full work plan has been developed. However it is envisaged that this work plan will be captured and continue as part of the Cheshire and Merseyside Transforming Care Board which will hold partners to account for delivery of the National Implementation programme (2015).

There will be financial support via a national budget to progress some of this work; the amount and process for access to funding is still yet to be agreed nationally, but there is local agreement that a project management office function be established to facilitate the work programme locally.

The **national governance structure** to support delivery of the national plan is outlined below:



As NHS England is not a Governing body the suggested **local governance structure** to support delivery of the national plan is outlined below:




### 4.3 National and Local Focus 2016 – 2019

The expectation is that the non-fast track areas (Cheshire & Merseyside being one of them), will start to mobilise using the learning from the fast track areas and begin collaborative working to enable the system to realise the start date of April 2016 for:

- A reduction in in-patient admissions using the pre 31.3.15 cohort of patients of 10% by 31 March 2016
- Long term learning disability bed closures in
    - Assessment and Treatment beds
    - Locked Rehabilitation beds
    - Neuro Psychiatry beds

  (Forensic beds, low, Medium and High secure are being led by Specialised Commissioning)
- Development of new models of care.

#### 4.3.1 Care and Treatment reviews

Care and Treatment reviews (CTR) are offered to all patients who are or have been an inpatient for 6 months or longer and patients have a right to request these at any time. More recently the expectation is that patients should be offered a CTR prior to admission or alternatively within two weeks following admission and then 6 monthly thereafter.

Cheshire and Merseyside CCGs and 3 main LD NHS Providers (Merseycare, 5 Borough Partnership and Cheshire Wirral Partnerships NHS Mental Health Trusts) are fully engaged in the CTR process and have pooled clinical resource to enable delivery in a consistent manner. Pathways Associates/North West Training and

Development Team provide Experts by Experience (service users, families and carers). There has been local proactive development of local operational models to ensure CTRs are 'business as usual' from September 2015. The patient stories of individuals who have had Delayed discharges have been collated which is useful in detailing some of the challenges in the system and will be considered in the new service models.

As of December 2015:

- 135 CTRs have been undertaken across CCGs for CCG commissioned services.
- There are 5 patients who have a delayed discharge; the main reasons being accessing an appropriate community provider, no local care package availability and requirement for housing adaptations to be undertaken.
- The use of the pre admission / blue light CTR protocol has avoided 4 hospital admissions during the period October-December 2015

**Specialised commissioning**

CTRs are also undertaken for patients in forensic/secure commissioned services. The aim being to progress the patient along the secure/forensic pathway into CCG commissioned services or community settings.

To aid progress NW Specialised Commissioning team have established quarterly meetings with local commissioners to ensure the number of Cheshire and Merseyside patients moving along the secure/forensic pathways of care into CCG commissioned placements is planned and funded for.

As of December 2015 the number of Cheshire and Merseyside patients in Specialised Commissioned services is outlined below:

| CCG | Stepdown | LSU | MSU |
|---|---|---|---|
| East Cheshire | | 1 | 0 |
| West Cheshire | | 3 | 0 |
| Halton | | 0 | 4 |
| South Cheshire | | 2 | 0 |
| Vale Royal | | 0 | 0 |
| Warrington | | 2 | 1 |
| Wirral | | 1 | 2 |
| Knowsley | | 1 | 1 |
| South Sefton | 1 | 4 | 3 |
| Southport | | 0 | 0 |
| St Helens | | 3 | 2 |
| Liverpool | 1 | 5 | 4 |
| Totals | 2 | 23 | 17 |

*(Data source NHS England Specialist Commissioning Tracker Dec 2015)*

### 4.3.2 In patient reduction & bed closure programme

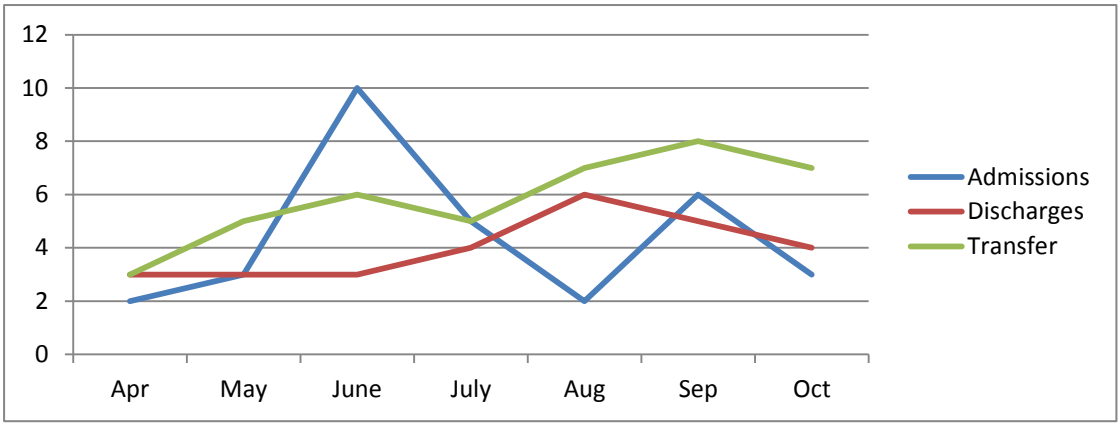
**In patient reduction**

One of the main responses to the Winterbourne View Concordat (2012) was the requirement to discharge patients from in patient settings if clinical safe to do so. The National Transforming Care board set a national discharge trajectory of between 10% - 13% for patients currently in an inpatient setting as of 31.3.15 to be achieved by 31. 3.16

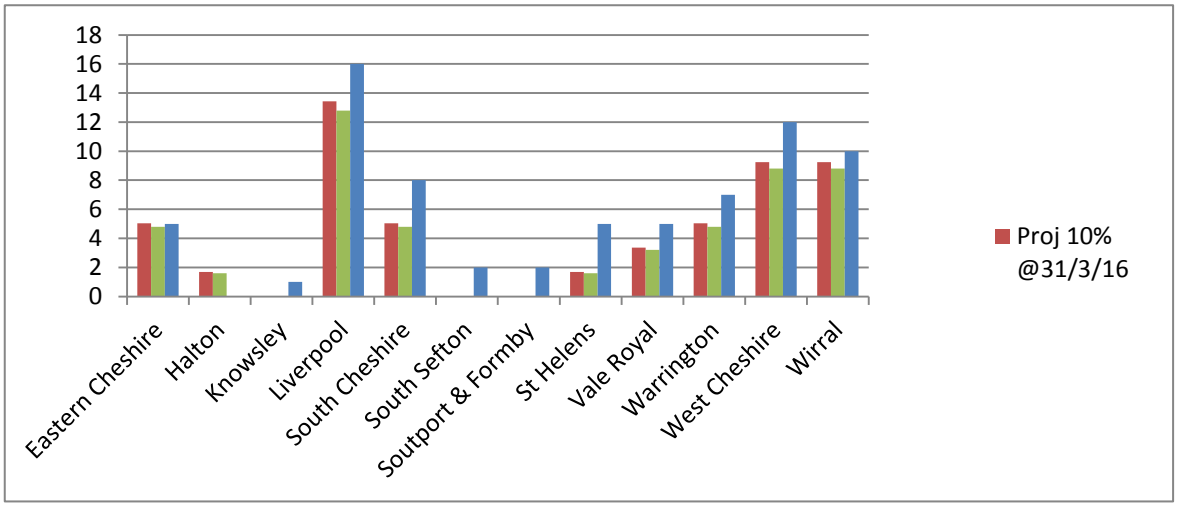
Progress to date for Cheshire and Merseyside's discharge trajectory is outlined below;

| Team / CCG | Baseline@31/3/15 | April | May | June | July | Aug | Sep | Oct | Nov | Proj 10% @31/3/16 | Proj 13% @31/3/16 | Diff to P1 | Diff to P2 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| North of England | 994 | 928 | 950 | 969 | 970 | 979 | 954 | 959 | 947 | 893 | 861 | -66 | -98 |
| Cheshire & Merseyside | 64 | 56 | 61 | 66 | 73 | 69 | 71 | 68 | 73 | 54 | 51 | -19 | -22 |
| Eastern Cheshire | 6 | 5 | 5 | 5 | 5 | 6 | 6 | 5 | 5 | 5 | 5 | 0 | -0 |
| Halton | 2 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 2 | 2 |
| Knowsley | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | -1 | -1 |
| Liverpool | 16 | 15 | 16 | 15 | 17 | 17 | 17 | 16 | 16 | 13 | 13 | -3 | -3 |
| South Cheshire | 6 | 7 | 7 | 8 | 8 | 6 | 7 | 6 | 8 | 5 | 5 | -3 | -3 |
| South Sefton | 0 | 0 | 0 | 1 | 2 | 1 | 1 | 1 | 2 | 0 | 0 | -2 | -2 |
| Soutport & Formby | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 2 | 0 | 0 | -2 | -2 |
| St Helens | 2 | 1 | 2 | 2 | 4 | 4 | 4 | 5 | 5 | 2 | 2 | -3 | -3 |
| Vale Royal | 4 | 4 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 3 | 3 | -2 | -2 |
| Warrington | 6 | 4 | 6 | 6 | 6 | 6 | 7 | 7 | 7 | 5 | 5 | -2 | -2 |
| West Cheshire | 11 | 9 | 9 | 12 | 11 | 10 | 11 | 12 | 12 | 9 | 9 | -3 | -3 |
| Wirral | 11 | 9 | 10 | 11 | 13 | 12 | 11 | 9 | 10 | 9 | 9 | -1 | -1 |

*Data source: HSCIC Assuring Transformation dataset & NHS England TC Tracker Dec 15*




*Data source: NHS England TC Tracker Dec 15*




*Data source: NHS England TC Tracker Dec 15*

### 4.3.3 Bed closure programme

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million populations
    - Cheshire & Merseyside target = 25 – 37 (CCG beds)
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million populations
    - Cheshire & Merseyside target = 50 – 62 (specialised beds)

The Cheshire and Merseyside Transforming Care board are currently undertaking the following baseline exercise which will help inform commissioners of bed activity as the new models are care are developed:

- A retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work look at:

    - The trend analysis and identify complementary activity within local NHS in patient provision with assessment units.

    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.

The detail from the baseline report will be available January 2016.

## 4. Potential risks that may prevent delivery

| Risk | Risk Level | Mitigating Actions |
|---|---|---|
| Lack of robust baseline data | Medium | • Commissioned LD JSNA to understand robust population based needs<br>• Timescales for completion of LD JSNA not in line with timescales for service development<br>• Commissioned look back exercise of bed state |
| Requirement for Efficiency savings | High | • Work with CCG/LAs to ensure funds are ring fenced for LD service development & delivery<br>• Bids for capital funds available for adaptions etc. via NHS England |
| Viability of Providers | High/medium | • Providers to develop models of care that ensure trust viability<br>• Providers to commence discussions with legal teams regarding consultation<br>• Commission at scale to ensure viability of providers |
| Delayed discharges / transfers | High | • Work with LAs to ensure robust process in place to move patient to suitably commissioned supported living placements<br>• Map current provision of commissioned services and benchmark against LD profile |

| Risk | Risk Level | Mitigating Actions |
|---|---|---|
| | | • Commissioners to hold providers to account in ensuring planned discharge date for individual on admission |
| Lack of sustainable community LD teams /services | High | • Commissioners to collaborate to develop strategic provider / preferred provider frameworks with commissioning collaborations need to be as local as possible<br>• Work with commissioner to understand what community services are current commissioned – mapping & identifying 'what goods look like' to support shaping of future local service models<br>• Development of bids to 'double run' services |
| Disruption to natural patient pathway/flows | Medium | • Clinical Leadership<br>• Clear communication |
| Limited personalised social care | Medium | • Mapping of housing providers and social care providers<br>• Establish market place |

## 5. Service Change Assurance

The scale of change being envisaged (introduction of new care models and removal of beds may be considered a significant change, with associated risk of Judicial Review or referral to the Secretary of State.

To mitigate these risks NHS England with key partners (LGA, ADASS, Service users etc.) has a role in assuring the service change proposal before progress to the next stage. The assurance would need to be tailored to the specific circumstances and scale of the proposal. Details of assurance process are outlined in the document below:

9) Transforming Care Assurance Process Flo

## 6. Next steps

Following local discussions at the Regional Transforming Care engagement workshop (9 November 2015) the following areas were identified as essential to support delivery of the national implementation plan:

- Clear governance structures
- As the national plan is reflective of all age ranges, further mapping of stakeholders to ensure all relevant stakeholders engaged in local development work i.e. Children's commissioners, CAMHS etc.
- Review of current community learning disability team (CLDT) specifications
- Review of out of area patients and development of repatriation programme
- Mapping of current social care/housing providers with CCG & LA commissioners with the potential to develop a social care framework
- Hold social care provider forum to establish current and potential services on offer
- Consideration of interim residential placements for current in-patients cohort with delayed discharge

- Development of ‘Step up Step Down beds’ to support crisis management building on what models that are nationally/regionally evidenced to support local developments
- Establish a provider forum
- Strength the ‘at risk register’ development’s with all stakeholders: including development and agreement of data sharing agreements
- Strength local authority involvement in work programme via ADASS leads
- Pooled budgets
- Hold a local stakeholder dialogue event

**7. Cheshire & Merseyside Stakeholder event**

A local stakeholder event was held on 16 Dec 2016 at Daresbury Park Warrington to understand the local ‘ask’ of the National Transforming Care programme across the Cheshire & Merseyside footprint.

Over 85 delegates attended the event, with representation from health, local authority, social care, NHS providers, Healthwatch, advocacy, housing, and experts by experience and family members.

Members of the National Transforming Care Programme (NHS England and LGA) outlined the national ‘ask’ and timescales for mobilisation and delivery. As Senior Responsible Officer for this programme of work, Alison Lee, Accountable Officer, West Cheshire CCG endorsed the progress and work to date in this field across Cheshire & Merseyside, but also acknowledged the challenge ahead.

Moving into their relevant delivery commission hubs, the stakeholders started to work together to:

- Describe the vision for services for people with a Learning disability/autism or behaviours that challenge living in Cheshire & Merseyside?
- Established the strengths and weakness of current LD service provision in their locality
- Identify any key stakeholder that are missing and need to be involved
- Describe what does success look like
- Identify some local quick wins, and
- Begin to prioritise services developments for Years 1, 2 and 3
- Give thought to how the delivery hubs will progress locally

Details from the event have been collated and shared with stakeholders present (Appendix 2). NHS England will now utilise the detail from the event together with the findings of the retrospective reviews to develop a strategic plan for Cheshire & Merseyside which will be shared with the 3 delivery hubs and relevant governing bodies.

**8. Conclusion**

It is recognised that Cheshire & Merseyside have already undertaken a significant amount of work with regard to service provision for people with learning disabilities and/or autism, and/or behaviours that challenge.

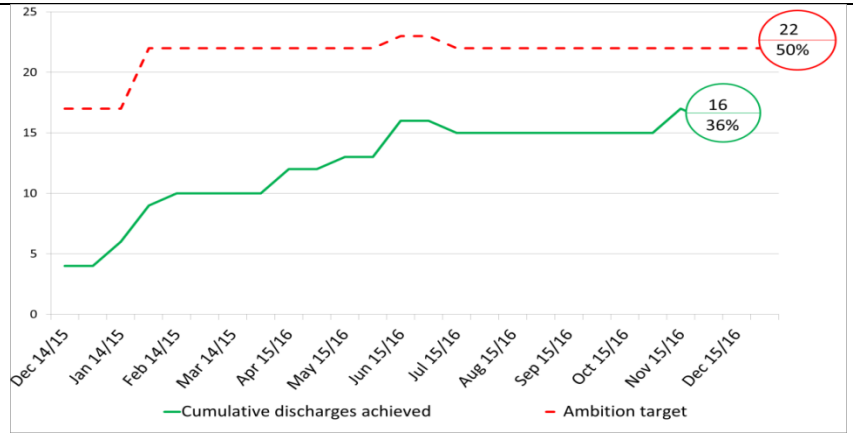
Telling the story of the journey so far is significant when reviewing in-patient provision to ensure we have adequate support for people who require it in times of deteriorating health or crisis. Alongside this the development of high quality services closer to home will enable people to live independent lives closer to their friends, family and carers.

The Cheshire & Merseyside Transforming Care Partnership Board will strive to delivery that national priorities locally, ensuring this is done in a co-productive manner with the patient's voice at the centre of the service model. Cheshire and Merseyside Health and Wellbeing Boards are asked to note the content of this report and support its implementation as a high priority area of work.

ENDS

**Appendix 1. Cheshire & Merseyside Local Progress 2015/16**

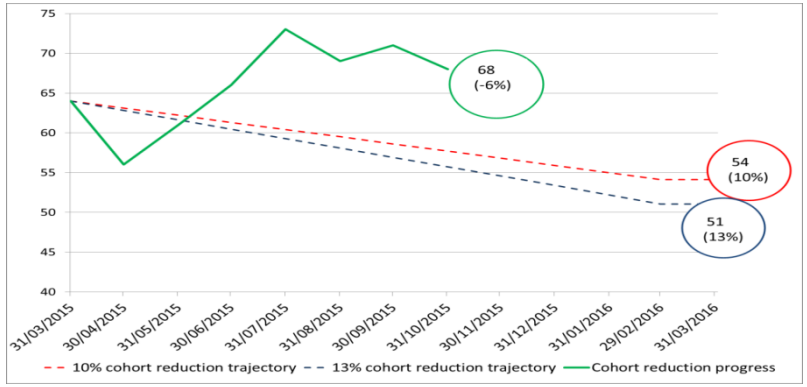
| | |
|---|---|
| **Empowering Individuals** | Empowering people with learning disabilities and their families to have greater rights and say in their care, underpins the Transforming Care programme. We have been working with partners across the health, local authority and voluntary sectors to strengthen the collective voice of individuals with learning disabilities and their families, to ensure greater personalisation, increased choice about care, and greater influence over service design and delivery.<br><br>An important milestone this year was the public consultation issued by the Government, 'No voice unheard, no right ignored', to strengthen the rights of people with mental health issues, learning disabilities and autism, so they can live independently, be included in their community, and make choices about their own lives. Locally we continue to work closely with Pathways Associates in:<br><br>• Developing an expert hub of clinical reviewers and experts by experience to undertake Care and treatment reviews<br>• ensuring we are asking whether people are getting support from advocacy through the revised approach to Care and Treatment<br>• Reviewing Assuring Transformation data to gather information that tells us what sort of advocacy a person is receiving.<br>• Developed a Co-production workstream to ensure the voice of the service user/Family carers is heard locally, regionally and nationally<br><br>As a result of the work undertaken local we have successfully presented our methodology and how we have utilised the LDSAF validation process to improve and drive forward quality for people with LD locally at 2 national workshops run by IHAL. The workshops were held in June 2015 in Manchester and Bristol. Wirral CCG presented how this work at been used strategically at a local level to drive forward a joint action plan. As part of this they have streamlined processes, integrated stakeholders and worked towards joint ownership.<br><br>**Governance: Co-production Sub Group of the Cheshire & Merseyside Transforming Care Board.** |
| **Right Care, Right Place, Right Time** | The national ambition is to discharge 50% of patients from an inpatient facility at 1 April 2014 to the community by 31 March 2015; and to carry out care and treatment reviews for any patients in that cohort who have not got a discharge date and are in a low secure setting.<br><br>Cheshire & Merseyside position at November 2015: |




50% discharge ambition: Currently on trajectory to achieve discharge ambition of 65% by Q4 leaving 15 inpatients from the 31 March 2014 cohort with discharge dates during 2016/17

There is a renewed focus on reducing hospital admissions from the 2013/14 baseline by 10% during 2015/16, reducing length of stay and tackling delayed discharges. This will require a focus on developing community based provision locally. Improving the patient experience and outcomes is a key factor to drive this initiative.

Cheshire & Merseyside position at November 2015:




10% discharge ambition: despite an increase in admission numbers over summer months (due to CCG's has found patients who were out of area) now on a downward trend and confident that the 10% ambition will be achieved by end of Q4. Current focus on 3 CCGs with highest admission rate: West Cheshire, Wirral and Liverpool CCGs.

**Governance: Commissioning Hubs of the Cheshire & Merseyside Transforming Care Board.**

| | |
|---|---|
| **Regulation & Inspection** | NHS England has established an Enhanced Quality Assurance Programme (EQAP) with the specific role of making sure people are safe and monitoring the quality of care reviews. EQAP will seek the firmest assurances that patients have clear care plans and are receiving the support they need and deserve.<br><br>CQC is working to ensure that its assessment methods are fully adapted to ensure robust inspections of hospital and community learning disability services.<br><br>The CQC is further developing the work on registration, to ensure that:<br>• Applications by any service provider to vary their 'service type', that describes the services that they offer, are only agreed when the new 'service type' accurately reflects a changed model of care. This will also ensure that any inappropriate models of care for people with learning disabilities do not continue after the 'variation' has been agreed; and<br><br>• new applications are only agreed when the application reflects the agreed model of care for people with learning disabilities, which is currently being defined by the Transforming Care programme and outlined in the new Service Model for commissioners<br><br>**Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.** |
| **Workforce** | Since the publication of Next Steps (July 2015), Health Education England (HEE) has been working with its Transforming Care partners, including Skills for Health and Skills for Care, to ensure that workforce development and planning supports the wider service re-design across health and social care.<br><br>Work to date will includes the development and testing a new Learning Disability Skills and Competency Framework that outlines the competencies that staff needs to have, to fulfil certain roles, to ensure that we have the right skills in the right place. This Framework will be rolled-out in January 2016.<br><br>**Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.** |
| **Data and Information** | Health and Social Care Information Centre (HSCIC) is the national electronic information data analysis system for the Assuring Transformation Clinical Platform. All local CCGs are registered with HSCIC and actively submitting data.<br><br>Local CCG/LA leads are also required to submit fortnightly data to NHS England via the local Transforming Care tracker. This enables the local monitoring of CTRs, admissions, in patient length of stay and progress being made towards individual, anticipated and planned discharge dates. Work is currently ongoing between NHS England Transforming Care analytical team and HSCIC to enable all clinical data fields to be submitted via one clinical portal on HSCIC system. It is |

| | |
|---|---|
| | envisaged that the NHS England TC tracker will cease in December 2015.<br><br>**Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.** |
| **Learning Disabilities Mortality Review (LeDeR) Programme** | The new Learning Disabilities Mortality Review (LeDeR) Programme has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and will run from 2015 – 2018. The Programme has been established as a result of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). The aim of the Programme is to make improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities, through national and local reviews of deaths. There will be a phased roll-out of the programme across the 12 NHS Clinical Senate geographical areas of England from January 2016, following a piloting phase in autumn 2015. Once known, dates for C&M will be disseminated locally.<br><br>**Governance: Health Inequalities Sub Group of the Cheshire & Merseyside Transforming Care Board.** |

**Appendix 2**

**Transforming Care Stakeholders event 16 December 2015 Daresbury Park Hotel Warrington**

**Cheshire Delivery Hub**

| Who's missing? |
|---|
| • Family Carer's<br>• Carer's<br>• CCG's<br>• Eastern Cheshire CCG's<br>• Educational Sector<br>• Employment Services |
| **Overall Vision for People with Learning Disabilities** |
| • Care in the community / Closer to home<br>• Safety<br>• Proportionate risk taking<br>• Right care, Right Treatment, Right time.<br>• Own front door (Housing)<br>• Working together (CCG, LA's, Independent Sector)<br>• Forums<br>- Culture change<br>- Workforce development<br>- Market shaping<br>• 'Nothing about us without us'.<br>• Honest<br>• Self-Advocacy<br>• Community Development<br>• Leading 'own' support (Self/peer advocacy)<br>• 'Good Lives' – People leading<br>• Sharing Data<br>• Working with service users.<br>• Reducing Barriers.<br>• Stream less Services / Transitions.<br>• Sharing Resources<br>- Useful tools<br>- More co-production<br>• Gaps in service (Autism)<br>• Good Communication<br>- Person centered.<br>• Culture Change<br>• Right People?<br>- Employers<br>- Children's Services |
| **Shared Vision** |
| • Meeting needs at times of crisis<br>- Appropriate planning<br>- Step up/step down beds<br>- Person led<br>• Individuals taking control of care planning<br>• Safe happy and well<br>• Supporting services to meet peoples neds<br>• Individuals More in control of own budgets |
| **What could be improved?** |
| • Patient voice being heard. |

- 24/7 support for service users in the community
- Transparency
- Patient-led care
  - Managing own budget
- Contingency planning
  - Crisis support
- Employment Service Users
  - Autism/LD
  - Opportunities
  - Improving quality of life, achieving goals.
- Involvement of employment and children's service and stakeholder groups.
- Care within home – Not sending out of area / secure units etc.

**What does success look like?**

- Working alongside service users - Closer collaboration.
  - Getting the best out of the services.
- Transparency
  - Between Services
  - Available Services
  - E.g. Development of land
- Shared Vision
- Meeting needs
  - Times of crisis
  - Appropriate planning step up / step down
  - Person-Led
- Individuals taking control of care planning.
- 'Safe, Happy and Well'
- Supporting services to meet person's needs.
- More In control of own budget (Service users)

**What's Working Well?**

- Local area coordinator's scoping available services – Individualised.
- Person – centred planning
- Improved communication – Hospitals / GP's
- Lots of work with Hospitals
  - Reasonable adjustments
  - GP Training
  - Health Champions (Training)
- Caring (CQC)
- Effectiveness (CQC)
  - Communication / Staff and carers
- Service users key role in recruitment.
- Service users assessing services
- Fewer people LD in assessment

**What keeps you awake at night?**

- Safeguarding issues – Problematic providers.
- Quality of service provision – Leadership
- Sending service users out of area
- Isolation
  - No support company

**How are you going to progress locally?**

- Out of area
  - Jan 16 meeting CCG's service users
- Single plan
  - Commissioner led
  - Strategic group set up
  - Joining commissioners / joined-up commissioners.
- Strategic Visions
  - Work streams working to same vision.
  -

Mid Mersey delivery Hub

| Overall Vision for People with Learning Disabilities |
|---|
| • Gaps in provision need to be addressed such as post diagnostic services – for people with Autism / Asperger's.<br>• Clarity of responsibilities of health provider 5BP<br>• Better planning around transition and people coming through the service.<br>• Involvement of voluntary sector to meet needs – potentially?<br>• Housing / Builders being on board with transitional planning (Affordable housing)<br>• Smarter intelligence and how we collate information of people coming through the transitional system.<br>• Greater involvement of people of all ages including younger people.<br>• Greater support for parents to understand the transitional process.<br>Positive communication with people from birth. |
| What could be Improved |
| • Autism Post Diagnostics (decisions making) what will be decided when<br>• Transitional Process<br>• Reasonable adjustments process, explaining to people (Staff as well as service users)<br>• Embedding reasonable adjustments in general practice.<br>• Educating the wider population around learning disability awareness – Autism and Aspergers Syndrome.<br>• Community Cohesion / resilience? |
| Gaps within the Process |
| • No Children's Service representation.<br>• Ensuring the right cohort of people are involved ( E.g. LD Social Work)<br>• We need to ensure all professionals are communicated with. (E.g. GP's/CCG's)<br>• Strategic Planning and building positive relationships with housing providers.<br>• Ensuring people receive the right care in the right setting –<br>-Improving transitional processes<br>-Partnerships is second<br>-Care particularly elder carers |
| What Does Success Look Like? |
| • Seamless Services<br>• Establishing what is important to the individual<br>• Co-ordinated support through the journey (navigation role) |
| What is Working Well? |
| • Cohesive approach and relationships.<br>• Good advocacy<br>• Integration<br>• Co-production (Partnership boards)<br>• Voluntary sector involvement to develop groups<br>• Learning Disability Pathway<br>• Skill up the workforce (Educate workforce)<br>• Positive behaviour support working well in some areas.<br>• PBS not a short term solution for crisis – Community teams generally pick VW's?? up. |
| What keeps you awake at night? |
| • Impact on family carers, particularly older family carers / significant others.<br>• Needs to be more communication between professionals. |

North Mersey Delivery Hub

| Who's missing? |
| --- |
| • Sefton Local Authority<br>• Liverpool City Council<br>• Autism Initiatives<br>• Options<br>• Natural Breaks<br>• People First<br>• Sefton and Liverpool Partnership<br>• Education |
| Overall Vision for People with Learning Disabilities |
| • Right Care, Right Time, Right Place, Right Professionals<br>• Individual/Personalised Care Packages<br>• Care primarily provided in the community not hospital.<br>• Communities that welcome support.<br>• Care pathway relating to OATS<br>• Efficient funding<br>• History of wrap around care – third sector.<br>• Good third sector providers. |
| What could be improved? |
| • Information and support to families early on.<br>• Inclusive education systems.<br>• Avoiding the cliff of transition.<br>• Insufficient capacity in the autistic spectrum. |
| Gaps within the Process |
| • Post diagnostic support – Autism<br>• Autism (Big Gap)<br>• Crisis management capacity is not robust.<br>• Refresh Green Light Tool Kit<br>• No short term care in the home.<br>• Crisis House – Crash Pads<br>• Lack of agreed definition.<br>• Pool budgets, Joint funding – Something needs sorting out.<br>• Horizontal and vertical care integrated. |
| Quick wins. |
| • Develop a pathway – OATS repatriation.<br>• Utilise Merseyside Partners and the Joint Training Partnership – To be invested in.<br>• Review of the past five admissions.<br>• Audit Green Light Tool Kit<br>• Test PBS<br>• Agree Service Specifications – CLT<br>• Repatriate OATS<br>• Revisit SAF<br>• HWB Report<br>• TC-The Local vision for CCG's |

**REPORT TO:** Health and Wellbeing Board

**DATE:** 9 March 2016

**REPORTING OFFICER:** Director of Public Health

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Public Health Annual Report

**WARD(S)** Borough-wide

## 1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an update on the development of the Halton Public Health Annual Report (PHAR).

**2.0 RECOMMENDED: That the Board note the theme and development of the Public Health Annual Report.**

## 3.0 SUPPORTING INFORMATION

3.1 Since 1988 Directors of Public Health (DPH) have been tasked with preparing annual reports - an independent assessment of the health of local populations. The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively.

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

3.3 The Faculty of Public Health guidelines on DPH Annual Reports list the report aims as the following.

- Contribute to improving the health and well-being of local populations.
- Reduce health inequalities.
- Promote action for better health through measuring progress towards health targets.
- Assist with the planning and monitoring of local programmes and services that impact on health over time.

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

3.5 Each year a theme is chosen for the PHAR. Therefore it does not encompass every issue of relevance but rather focuses on a particular issue or set of linked issues. These may cover one of the three work streams of public health practice (health improvement, health protection or healthcare public health), an over-arching theme, such as health inequalities, or a particular topic such as mental health or cancer.

3.6 For 2015-16 the Public Health Annual Report will focus on the work of the Public Health Evidence and Intelligence Team. This topic has been chosen to highlight some key pieces of work and how they have been used or will be used by Halton Borough Council and its partner organisations.

3.7 The report will use a life-course approach around the following chapters:

- Starting Well
- Living Well
- Ageing Well

3.8 Each chapter will cover the following areas:

- Summary of piece of work
- Why approached that way
- How the work has been or will be used

3.9 Summary of Chapter Content

| **Chapter** | **Section and Example Content** |
|---|---|
| **1**. | **Starting Well**<br>• Children's JSNA |
| **2.** | **Living Well**<br>• GP JSNA<br>• Long Term Conditions |
| **3.** | **Ageing Well**<br>• Older People's JSNA |
| **4.** | **Recommendations** |
| **5.** | **Update on recommendations from PHAR 2013-14** |

3.10 The final version report will be presented to the Health and Wellbeing Board in July. Prior to this, an electronic copy will be circulated to members for feedback. Following any further amendments the final version will be made available in hard copy and online.

## 4.0 POLICY IMPLICATIONS

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

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The PHAR will highlight the Children's JSNA, which is a key piece of work for commissioners.

### 6.2 Employment, Learning & Skills in Halton

The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

### 6.3 A Healthy Halton

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

### 6.4 A Safer Halton

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health.

There are also close links between partnerships on areas such as alcohol and domestic violence.

### 6.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

## 7.0 RISK ANALYSIS

7.1 Developing the PHAR does not present any obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

## 8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None

**Report Prepared by:** Katherine Woodcock, Public Health
**Contact:** 0151 511 6851 katherine.woodcock@halton.gov.uk

**REPORT TO:** Health and Wellbeing Board

**DATE:** 9 March 2016

**REPORTING OFFICER:** Strategic Director, People & Economy

**PORTFOLIO:** Health & Wellbeing

**SUBJECT:** Positive Behaviour Support Service

**WARDS:** Borough wide. Commissioned also by Knowsley (children and adult services), Cheshire East (children services) and Sefton (adult services)

## 1.0 PURPOSE OF THE REPORT

1.1 To update the Board on the activity of the Positive Behaviour Support Service (PBSS).

## 2.0 RECOMMENDATION: That the Board

1) **Take note of the report; and**

2) **Support the on-going work of the PBSS.**

## 3.0 SUPPORTING INFORMATION

3.1 PBSS has been fully operational since November, 2011. Jointly funded by NHS Halton Clinical Commissioning Group (CCG), it is a specialist service for children and adults with the primary purpose of improving life quality for those individuals who present with behaviours that challenge services. Eligibility criteria for the service are moderate to severe Learning Disability, including those with a diagnosis of Autistic Spectrum Condition. The service is currently supporting 15 adults and 18 children in the Halton area. PBSS will also be supporting the return of 6 adults to Halton from 'out of borough' placements (planning to commence 12/1/16). The service meets several of the recommendations for service users who engage in behaviour that challenges set out in the post Winterbourne transforming care agenda (Bubb, 2014), Ensuring Quality Services (LGA, NHS England, 2013) and NICE guidelines (May, 2015).

3.2 **Staffing**

PBSS now have a staff team of 17. Staff are organised by locality e.g. there is a Halton team compromising two Practice Managers (Behaviour Analysts) one leading services for adults the other for children, a care manager (Assistant Behaviour Analyst), who is shared across adults and children and two support workers (shared across adults and children). PBSS also has two additional posts in Halton - a care manager specific to Halton Educational Services and a Practice Manager who has the lead for developing behaviour analytic services

for older people with Dementia. These posts and relative on costs and managerial and clinical support are funded by cumulative contributions from Communities, Children and Enterprise and the CCG totalling £332,000 (Communities- £142,000, CCG- £112,000 and Children and Enterprise- £77,800). Posts funded by other commissioners equate to nearly £400, 000.

3.3 PBSS works across four domains of activity:

a) Early intervention,
b) Crisis prevention,
c) Technical support and
d) Placement development.

3.4 Referral Characteristics (whole service):
Table 1:

| | | % of referrals | | |
|---|---|---|---|---|
| | | **Adult (n=89)** | **Child (n=94)** | **Total (n=183)** |
| Age when referred (n=183) | Preschool (0-3) | - | 3.5% | 1.9% |
| | School-age (4-13) | - | 72.4% | 39.9% |
| | Transition (14-17) | - | 24.1% | 13.3% |
| | Adult (18+) | - | - | 44.9% |
| People referred with diagnosis of autism (n=171) | | 46.8% | 69.6% | 59.1% |
| Diagnosis of Intellectual Disability (ID) (n=164) | Mild ID | 2.5% | 2.4% | 2.4% |
| | Moderate ID | 11.3% | 4.8% | 7.9% |
| | Severe ID | 30.0% | 28.6% | 29.3% |
| | Severity unspecified | 46.3% | 16.7% | 31.1% |
| | No known ID | 10.0% | 47.6% | 29.3% |
| Living arrangements at time of referral (n=165) | Family home | 39.1% | 83.7% | 64.7% |
| | Supported tenancy | 42.2% | - | 18.0% |
| | Residential home | 12.5% | 5.8% | 8.7% |
| | Residential school | - | 3.5% | 2.0% |
| | Assessment and treatment unit | 6.3% | - | 2.7% |
| | Foster placement | - | 7.0% | 4.0% |
| Primary referral issue (n=167) | Physical aggression | 72.4% | 67.0% | 69.5% |
| | Self-injurious behaviour | 14.5% | 15.4% | 15.0% |
| | Verbal aggression | 5.3% | 4.4% | 4.8% |
| | Low engagement in activity | 5.3% | 4.4% | 4.8% |
| | Other | 2.6% | 8.8% | 6.0% |
| Referring professional (n=169) | Social work professional | 46.8% | 44.6% | 45.6% |
| | LD nurse | 35.1% | - | 16.0% |
| | CAMHS worker | - | 9.8% | 5.3% |
| | Education professional | - | 27.2% | 14.8% |
| | Other health professionals | 16.9% | 15.2% | 16.0% |
| | Other | 1.3% | 3.3% | 2.4% |

Table abstract from: Toogood, S, O'Regan, D, Saville, M, McLennan, K, Welch, C, Morgan, G and McWade, P 'Providing Positive Behavioural Support Services: referral Charactheristics, resource allocation, case management and overview of outcomes' *International Journal of Positive Behavioural Support* 5,(2), 25–32

3.5 The service offers a variety of training opportunities for parents/carers and staff in Positive Behaviour Support, Active Support and Interactive Training. PBSS also provides other training functions e.g. the behaviour management

aspect of Foster Parent training. PBSS are currently providing focused Active Support training in Adult Placement settings, nursing homes and day services for older people.

3.6 Service outcomes for individual service users include increased opportunity for activity engagement, higher presence in the community and reductions in behaviour that challenges. Outcomes for parent/informal carers of service users and staff includes: an increased confidence to a) reduce likelihood of challenging behaviour occurring and b) support appropriately when behaviours do happen; a greater understanding of why behaviours may occur and an increased confidence to support individuals to engage in more activity and access their local communities. A further benefit of the service is overall cost reduction to packages or care by either moving from residential settings out of borough to local community reducing levels of support within community settings or avoiding placement breakdown in the first place.

3.7 The PBSS won a BILD leadership award for innovative practice with Adults and Children in 2014. It is also cited in the NICE guidelines for 'Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (May, 2015). Three papers have recently been published in the International Journal of Positive Behavioural Support (IJPBS). The first paper is a description of the PBSS and the work is does, the second is an economic evaluation of the service and the third is an overview of service referral characteristics, resource allocation, case management and outcome overviews. PBSS is also regularly referenced as an example of good practice by other professionals on social networking groups e.g. Positive Behaviour Support Chat. In conjunction with the Experimental Analysis of Behaviour Group (EABG) and Bangor University PBSS is developing a North West Applied Behaviour Analysis Forum. This is a replication of an event that takes place in London and offers Continuing Education Units for Behaviour Analysts. The development of a North West forum will keep Halton's work at the forefront of Positive Behaviour Support on a national level and also provide a more cost effective way for the behaviour analysts in the service to maintain their professional credentials.

3.8 **PBSS Case Studies**

**See Appendix 1**

## 4.0 POLICY IMPLICATIONS

The 'registration with professional bodies' policy has been amended to include requirements for senior managers in PBSS to be Board Certified Behaviour Analysts (BCBAs) or in pursuit of BCBA status.

Available services from PBSS are referenced in the Restrictive Physical Interventions policy, HBC and the prevention of exclusion from building based services and withdrawal of services form individuals homes policy.

## 5.0 FINANCIAL IMPLICATIONS

The cost of the PBSS to Halton is less than the savings achieved. The table below shows **examples** of actual annual savings (totalling £142, 269) and estimated avoided annual costs (totalling £440, 000). The service has also generated £200, 000 in efficiencies (spread over 2014/15 and 2016/17).

| Gender | Diagnosis | Age (at referral time) | Actual savings | Estimated avoided cost |
|---|---|---|---|---|
| F | LD | 18 | £13, 278 supported to maintain in borough provision through crisis period and supported change to in house service provider | £30,000 avoided out of borough placement, which would cost in the region of £30, 000 more than current package of care |
| F | LD | 52 | £57, 637- return to local supported tenancy | N/A |
| M | LD, ASC, VI, Epilepsy | 18 | | £135, 000<br><br>Avoided out of borough placement (originally being requested by parents), which would cost in region of £135,000. Maintained living with parents |
| M | LD, ODD | 17 | £71, 354<br><br>Supported reduction in staffing levels from 2:1 to 1:1 | |
| M | LD, ASC | 14 | | £150,000<br><br>Avoided specialist residential school (originally being requested by parents), which would cost in region of £200,000 (minus cost of day placement). Maintained living with parents |
| M | LD, ASC, Chromosome disorder | 17 | | £125, 000<br><br>Avoided specialist residential school (originally being requested by |

| | | | | |
|---|---|---|---|---|
| | | | | parents), which would cost in region of £200,000 (minus cost of day placement). Maintained living with parents |

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

The PBBS contributes to the health and happiness of children and young people within Halton by providing a response to challenging behaviour attempts to avoid exclusion from mainstream services/education, as evidenced by the example case study provided within this report. The service also provides support to parents/carers to manage challenging behaviour so that overall quality of life is improved for the child/young person and their family.

6.2 Employment, Learning and Skills in Halton

PBSS supports Halton day services (which are an employment based model) to ensure some of the more complex service users can access the service and experience work based activities.

6.3 A Healthy Halton

The support provided by the PBSS to address behaviours that challenge contributes to the health, wellbeing and overall quality of life of the most vulnerable members of the community by enabling them to avoid being placed out of the borough away from their support networks and allowing them to continue receiving high quality and cost-effective services within the borough. There is also a positive impact on the wellbeing of carers, as they are supported to deal with challenging behaviour more effectively, which in turn improves their own quality of life.

6.4 A Safer Halton

None

6.5 Halton's Urban Renewal

None

## 7.0 RISK ANALYSIS

PBSS provides direct specialist support to local individuals whose behaviour challenges. Not having this support for those individuals would increase a) the risk of placement breakdown within the community (living with parents/supported tenancy/school) b) the risk of placement in out of borough high cost provision.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 PBSS supports some of the most complex and vulnerable members of society.

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

9.1 None under the meaning of the Act.

**Appendix 1**

Case study 1

## Background

Lucy was a 20 year old woman who was referred to PBSS in crisis, after a two-year planned transition to a supported tenancy was unsuccessful. She had little verbal communication and mostly used idiosyncratic Makaton signs. The behaviours of concern included:

- Physical aggression (pushing, slapping, hair pulling, kicking, spitting, biting, etc.)
- Self-injury
- Inappropriate touching of others (including approaching strangers, kissing, hugging)
- Loud vocalisations

After the supported tenancy arrangements had broken down, Lucy returned to live in her family home. The intensity of the behaviours of concern increased. Due to parental health issues, it was not possible for parents to manage the behaviours that Lucy was displaying at home. Lucy was accommodated in temporary accommodation, while a permanent suitable property was identified.

## Assessment

A full functional behaviour assessment was completed. As an immediate measure to stabilise the situation, a PBSS support worker was released to work alongside Lucy's direct support worker, who had previously supported Lucy at home.

During Lucy's time in her temporary accommodation, she slept for only 3 to 5 hours per night. As a result, her support staff ratio was increased to 2:1, 24 hours per day. Community access was ceased on a temporary basis, due to potential risks to the public from challenging behaviour. In-house activities were provided on a scheduled basis to ensure Lucy was engaged.

## Intervention Plan

The intervention plan included:

- Sleep routine program
- Communication resources:
    - Food/snack communication book
    - Visual staff support board
    - Social Stories for: going to the hospital/receiving treatment; appropriate/inappropriate touch
    - Visual activity schedule & protocol for each activity
- A reward system, for reinforcement of appropriate behaviour

All of Lucy's support staff received training in Active Support, alongside training in the individual intervention plan.

**Outcomes**

Suitable accommodation was identified for Lucy, who is now supported on a 1:1 basis within her own tenancy. She no longer requires the support of waking night staff and the majority of her community access is supported on a 1:1 basis.

Lucy now makes her own meals with support from staff and independently engages in all household chores. She enjoys activities such as swimming, going to the cinema, accessing a local walking group, and going shopping. She has been honoured by a local self-advocacy group with an award for making such a positive change in her life.

Case study 2

**Background**

Ben was a 6 year old boy referred to PBSS due to concerns about challenging behaviours at school. Ben attended a year 1 classroom in a mainstream school in Halton, with no additional support. Challenging behaviours consisted of:

- aggression towards peers (hitting)
- frequent disruptive behaviours (touching peers, touching peers' hair, playing with objects, shouting out, writing on peers' work).

At the time of the referral, Ben spent lunch-times standing with an adult to prevent aggression, and other children actively avoided Ben whenever possible. Ben frequently disrupted the classroom, and his behaviour was reported to significantly impact the learning of all students in the class. Ben was at risk of exclusion.

Ben had speech and communication difficulties. At home no behavioural concerns were reported. However, further conversations with caregivers revealed that Ben received constant attention at home and all of his needs were met instantly to prevent him engaging in property destruction. Ben's caregivers reported to find interactions with school stressful, specifically being called to discuss behaviour incidents at the end of the day in front of other parents.

**Assessment**

Assessment consisted of three direct observations spread across different times of the school day, with a focus on break and lunch-times. A Behaviour of Concern Assessment (BOCA) interview and Questions about Behavioural Function (QABF) rating scales were completed with the class teacher. The assessment concluded that the primary function of the behaviours was to obtain attention, including reprimands. A secondary function of the behaviours was for sensory stimulation, i.e. the behaviours appeared to be automatically reinforced as a result of the stimulation gained from engaging in them.

## Intervention

An intervention plan was prepared by the Assistant Behaviour Analyst, and a school meeting was held with the Special Educational Needs Co-ordinator (SENCO) and class teacher in February 2014 to discuss implementation. The intervention plan included:

- A reinforcement system, to provide Ben with adult attention on a frequent basis.
- Structured time at lunch to teach Ben appropriate ways to interact with peers.
- A teaching programme to tolerate waiting for things (a 'wait' programme).
- Visual support, including social stories, behaviour rules, visual schedules, and timers.
- A home/school communication book, to ensure consistency between environments and enable Ben to receive praise at home following a good day at school.

The Assistant Behaviour Analyst introduced the 'wait' programme, and modelled this to a teaching assistant who continued to implement and generalise this. The 'wait' programme was then generalised to home. The other recommendations were discussed with staff and adapted to the specific classroom environment. Feedback was provided on the implementation of recommendations during follow-up visits, and modifications were made accordingly. Extensive discussions were held on the importance of being proactive to prevent challenging behaviour, to ensure the structured lunch-times were not considered a reward and withheld if there were challenging behaviours. The time between follow-up visits gradually increased as staff became confident in implementing recommendations and trouble-shooting difficulties as they arose.

## Outcomes

Over the course of 4 months, it was reported that occurrences of challenging behaviour reduced. Although data on challenging behaviour were not collected, Ben frequently earned rewards at school and was no longer required to remain with an adult during breaks. PBSS monitored the transition to Year 2, to ensure recommendations transferred to the new class. Thereafter, PBSS closed the referral, and maintenance visits were scheduled to coincide with significant times in the school calendar. Ben has maintained his place in a mainstream school which was at risk.