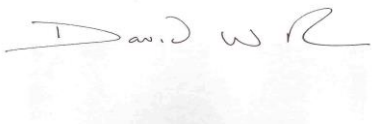
Public Document Pack

Health Policy and Performance Board

Tuesday, 15 November 2016 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Joan Lowe (Chair)	Labour
Councillor Sandra Baker	Labour
Councillor Marjorie Bradshaw	Conservative
Councillor Ellen Cargill	Labour
Councillor Mark Dennett	Labour
Councillor Charlotte Gerrard	Labour
Councillor Margaret Horabin	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Shaun Osborne	Labour
Councillor Stan Parker	Labour
Councillor Pauline Sinnott	Labour

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

The next meeting of the Board is on Tuesday, 7 February 2017

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

Part I

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

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 15 November 2016

REPORTING OFFICER: Strategic Director, Enterprise, Community & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

- Requires the disclosure of confidential or exempt information.

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Health Policy and Performance Board

DATE: 15 November 2016

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Wellbeing Board are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 6 July 2016 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill, (Chair) , Wright and Woolfall and N. Bunce, P. Cooke, T. Hill, M Larking, E. O'Meara, A. McIntyre, D. Parr, M. Reaney, C. Samosa, M. Sedgwick, S. Semoff, H. Sheldrick, R. Strachan, H. Teshome, L. Thompson, T. Tierney, S. Wallace-Bonner and S. Yeoman

Apologies for Absence: Councillor T. McInerney and S. Banks, D. Lyon, H. Patel and M. Pickup

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB1 MINUTES OF LAST MEETING

The Minutes of the meeting held on 9th March 2016 having been circulated were signed as a correct record.

HWB2 PRESENTATION BY MIKE LARKING, CHESHIRE FIRE AND RESCUE SERVICE

The Board received a presentation from Mike Larking, Cheshire Fire and Rescue Service, which provided information on expanding the current home safety assessments to support identified health issues. The presentation provided Members with details on the Fire Prevention in the Home Policy and the impact of a sustained programme of fire safety activity over the last five years in Cheshire.

The Board was advised that a Cheshire and Mersey Health and Fire Summit had been held on the 15th July 2015 and a number of issues had been identified to be considered and worked up which were designed to deliver a consistent and impactful intervention and support to NHS across the whole of Cheshire and Merseyside. Using Exeter health data, the service would continue to focus on those most at risk from fire but would work with Health partners to identify

those households which also faced additional health risks. In 2016/17, the Service would re-launch its Home Safety Assessment Programme as Safe and Well Visits, with fire fighters and advocates carrying out additional basic health checks. The Service planned to increase the current level of 25,000 home visits a year to around 40,000.

RESOLVED: That the report be noted.

HWB3 PRESENTATION - MEETING THE NEEDS OF CHILDREN AND YOUNG PEOPLE WITH SPECIAL EDUCATIONAL NEEDS AND/OR DISABILITIES - ANN MCINTYRE

The Board received a presentation from Ann McIntyre, Operational Director – Education, Inclusion and Provision, which provided information of how effectively Halton met the needs of and improved the outcomes of children and young people who had special educational needs and/or disabilities as defined in the Act and described in the Special Educational Needs Code of Practice: 0 to 25 years.

The Children and Families Act 2014 gave each Clinical Commissioning Group (CCG), a statutory duty to co-operate with the Local Authority in a co-ordinated assessment of the needs of individual children or young people assessed as having special educational needs. They also were required to agree a single outcome focused Education, Health and Care (EHC) Plan. The role of the Health and Wellbeing Board and the Halton profile in comparison to neighbouring local authorities, North West local authorities and the national average was detailed in the presentation.

In addition, Members were provided with an update on the current position and areas for development with regard to children and young people who had a special educational need or disability in Halton.

RESOLVED: That the presentation be received.

HWB4 HALTON HOUSING TRUST - DIRECTOR OF HOUSING AND WELLBEING

The Board considered a report which provided an update on the expansion of Halton Housing Trust (HHT) Director of Housing role to include Health and Wellbeing. This expanded role reflected on-going discussions between HHT, NHS Halton Clinical Commissioning Group (CCG) and Halton Borough Council's Director of Public Health, to

develop a role with joint housing and health responsibilities. This strategic role would enable further development of the positive joint working approach developed over the last few years. The report highlighted the Director of Housing and Wellbeing responsibilities, the initial agreed shared priorities for Halton, and a number of ways that HHT, Halton CCG and Public Health, could work more cohesively to achieve shared objectives.

It was noted that Halton CCG had agreed to make an initial contribution of £10,000 towards the cost of this role. This would be reviewed after an initial 12 month period.

RESOLVED: That the report be noted and that the Board supports the creation of a Director of Housing and Wellbeing.

HWB5 FINANCIAL RECOVERY AND SUSTAINABILITY PLAN

The Board considered a report of the Chief Officer of Halton CCG, which outlined the actions being undertaken by NHS Halton CCG to achieve financial recovery and sustainability. Over the three previous financial years NHS Halton CCG had managed to deliver a balanced year end budget and a 1% surplus.

It was reported that the next five years would be challenging and would involve some difficult and potentially contentious decisions about what services NHS Halton CCG chose to commission or decommission and what partnerships and activities could be invested or disinvested in. The initial figures over the next five years suggested NHS Halton CCG would need to find a cumulative total of £55.6m.

At its meeting of the Governing Body of NHS Halton CCG on the 7th April 2016, it was agreed that based on the forecasts, a financial recovery and sustainability plan was required by July 2016 to deliver recurrent savings over the next five years and to deliver more efficient and effective health and care services. The plan would explore four areas of action:-

- Improving health care;
- Improving value for money;
- Reducing costs by reviewing existing services; and
- Considering more difficult decisions.

On 2nd June 2016, the Governing Body agreed some core principles and a process for decision making on cost improvement identification to contribute to financial

sustainability. The process that was agreed would ensure that the impact of any commissioning decisions, whether about investment or disinvestment, took into account quality and equality issues and were taken forward following engagement with interested parties.

RESOLVED: That the report be noted.

HWB6 PUBLIC HEALTH ANNUAL REPORT ASSESSING NEEDS AND TAKING ACTION

The Board considered a report from the Director of Public Health, which provided Members with information on the 2015/16 Annual Report: Assessing Needs and Taking Action. The Annual Report would be available in July 2016 in hard copy and on line at www.halton.gov/PHAR.

The Board was advised that this year's Annual Report focussed on the work of the Public Health Evidence and Intelligence Scheme. The topic had been chosen to highlight some strategic pieces of work, their key findings and how they had been used or would be used by Halton Borough Council and its partner organisations. The pieces of work highlighted in the report where:-

- Children's Joint Strategic Needs Assessment (JSNA);
- GP JSNA;
- JSNA on Long Term Conditions; and
- Older People's JSNA.

RESOLVED: That the contents of the report be noted and the Board supports the recommendations.

HWB7 BETTER CARE FUND 2016/17

The Board considered a report of the Director of Adult Social Services, which provided information on the submission of the Better Care Fund 2016/17. It was reported that much of the 2016/17 submission remained a continuation of the successful approach in 2015/16 and initial feedback suggested that Halton would be approved unconditionally. This would be confirmed by 30th June 2016.

RESOLVED: That the report and associated documents be noted.

HWB8 WELL NORTH PROGRAMME

The Board considered a report which provided an update on the Well North Programme for Halton. Well North

was a Department of Health response to the Due North Report published in 2015, which highlighted the disparity in health outcomes between the north and the south of England. The development of the Well Halton Programme, under the auspices of Well North, had been conducted in partnership between NHS Halton CCG and Halton Borough Council. The Health and Wellbeing Board reviewed and approved the initial proposition and had received a progress report with a further report due in July. Regular updates and opportunities for engagement in the development of the Well Halton proposition had also been offered across the two organisations and community partners.

It was reported that three schemes had been agreed for Well Halton in the following areas; Windmill Hill, Halton Brook and Widnes.

An initial narrative had been developed for each area and the next steps were that each scheme would require a clearly identified governance structure, a project initiation document and clear leadership team to progress the schemes. Details of the membership for each scheme were outlined in the report.

RESOLVED: That

(1) the report be noted;

(2) the initial work programme for Well Halton be agreed; and

(3) the resources required to support Well Halton be agreed.

HWB9 HEALTH AND WELLBEING BOARD STRATEGY 2017-2022

The Board received a report from the Director of Public Health, which provided an update on the development of the new Halton Health and Wellbeing Strategy (2017/2022). One of the key responsibilities of the Health and Wellbeing Board was to develop a Health and Wellbeing Strategy to meet the needs of the local population. Halton's first Health and Wellbeing strategy covered the period 2013–2016 and set out the vision of Health and Wellbeing in Halton. As the current strategy finished in 2016, a new Health and Wellbeing Strategy would be developed to build on successes and to make further improvements.

Members were advised that it was important that the Strategy recognised:

- the agreement between the Government and the leaders of the Liverpool City Region (LCR) to devolve a range of powers and responsibilities to a Combined Authority;
- the NHS five year forward view; and
- the five-year Sustainability and Transformational Plan (STP).

Whilst the new Health and Wellbeing Strategy needed to reflect current priorities from elsewhere in the system, it would maintain a local focus that was evidence-based and reflected local people's views. Priorities identified within the new Strategy would be aligned with LCR Devolution and "One Halton" areas of focus. Those currently being discussed included:-

- Child development;
- Community immobilisation, health eating and exercise;
- Long term conditions CVD and cancer;
- Mental health; and
- Disabilities.

In addition, the new Strategy would include an updated Health and Wellbeing profile for Halton, outline the progress made since 2013 and the challenges that remained, provide an overview of priorities and how and why these were chosen, outline a system at scale to make a difference and outline how success would be measured.

Following consultation with public and key stakeholders, a draft of the new Strategy would be presented to the Health and Wellbeing Board for comment in October, with a final version submitted for approval in January 2017.

RESOLVED: That the Board provide leadership and oversight for the development of the new strategy and help inform its chosen priorities.

HWB10 DISCUSSION PAPER ON THE MANAGEMENT OF LETTINGS WITHIN THE BOROUGH AND THE IMPACT ON OLDER PEOPLE

The Board considered a report which highlighted the impact that some housing lettings could have on the health and wellbeing of older people within the Borough. In order to

ensure that the health and wellbeing of older people in housing lettings was improved and maintained, it was proposed that the Board consider the following:

i. to adopt a National Pensioners Convention (NPC) Dignity Code;

ii. to consider putting forward a recommendation to the Property Pool Plus to adopt the NPCs Dignity Code; and

iii. discuss how the health and wellbeing of older people within the housing lettings could be brought to the fore and draw attention to if so that other older people did not have their lives affected by inappropriate lettings.

RESOLVED: That

1) the report be noted;

2) the Board discuss the issues under Options for Change and develop a system-wide approach; and

3) the Board adopt the National Pensioners Convention Dignity Code.

Meeting ended at 3.50 pm

REPORT TO: Health Policy & Performance Board

DATE: 15 November 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Improving Access to Psychological Therapies (IAPT)

WARD(S) Boroughwide

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a presentation from Angela Ryan, Assistant Director for Halton, 5 Borough Partnership NHS Foundation Trust, which will provide the Board with an update in respect of Improvng Access to Pychological Therapies (IAPT) delivery and development of the service in Halton.

2.0 **RECOMMENDATION: That the Board notes the contents and provide comment on the report and presentation.**

3.0 **SUPPORTING INFORMATION**

3.1 5BP have held the contract for Halton IAPT services since August 2014. They are the principal provider for Step 2 and Step 3 intervention. They work closely with the third sector organisations to deliver psychological therapies for Halton residents.

3.2 **Service Data**

Date	Referrals	Entered Therapy	Completed Therapy	Recovery
Aug 14/15	3399	1584	964	40%
2015/16	3889	2402	1391	40.05%
2016/Sep 17	1687	1226	759	44.4%

3.3 **Access Recovery Standards**

IAPT services are monitored monthly by NHS England in relation to access and recovery standards. At present the Halton service prevalence rate i.e. clients entering therapy is on target at 7.47%, 89.9% of clients who completed treatment were seen within six weeks of referral and 93.7% were seen within 18 weeks of referral. The recovery rate for September is 44.4% against a target of 50% recovery rate.

3.4 **Internal waiting list**

The service has seen an increase in internal waiting times due to the issue of recruitment, this has been closely monitored on a weekly basis by the Trust and Clinical Commissioning Group (CCG).

3.5 **Staffing Establishment**

The current staffing establishment is 12.13 whole time equivalent for Step 2 and 14.75 whole time equivalent for Step 3, however, there has been issues recruiting Step 2 practitioners; this is a national problem. The Team Manager has worked closely with the local university in order to develop more training courses and at present has five trainees who have started to take active cases and will be fully trained by May 2017.

In terms of skill mix, all Step 3 staff are trained in cognitive behaviour therapy and three are trained in eye movement desensitisation reprocessing (EMDR) and one is trained in couples therapy.

The team offer one to one therapy, group therapy and they are in the process of piloting E-therapy.

The team at present offer appointments Monday to Friday between 8am and 8pm and Saturday mornings.

3.6 There have been changes in getting access to clinical space within locations that are not owned by Trust. The Team Manager has been working with agencies to try and find space which is suitable, accessible and within the locality. This has proven to be time consuming and can also cause delay in therapy due to lack of space.

3.7 Piloting E-therapy through ‘Silvercloud’.

3.8 The Team Manager, Lead Psychologist and Senior Management have enrolled on NHS England Capacity and Demand theory and action learning sets where they will complete the Bottom Up Capacity and Demand modelling tool. They will produce clear trajectories that monitor processes to deliver and maintain a sustainable waiting list.

4.0 **POLICY IMPLICATIONS**

4.1 The proposed model is in line with current local mental health strategy and national guidance.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified

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

6.1 **Children & Young People in Halton**

None identified.

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

None identified.

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified

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

9.1 None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 15 November 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Telehealthcare Strategy

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on the Telehealthcare Strategy at the Appendix.

2.0 **RECOMMENDATION: That the Board note the contents of the report and associated appendix.**

3.0 **SUPPORTING INFORMATION**

3.1 Introduction - The development of technology is affecting and extending the way care can be delivered in the health and social care arena. The population is ageing and there is a significant strain on healthcare resources with an increasing number of people affected by long-term chronic conditions.

3.2 Of the 18.5 million people in the UK who have a long-term medical condition, the vast majority of such individuals are aged 65+, living at home and because of their condition are more likely to:

- Request a home visit from their GP or require a visit from their District Nurse
- Oscillate to and from hospital (A & E and overnight stays) as their condition alternatively deteriorates and is stabilised
- Have their condition worsen to such an extent they require admission to residential care

3.3 This is an unsustainable position especially as the number of older people living longer is increasing and the pressure on primary and social care services becomes greater each year. Coupled with this is the fact that local authorities are in the financial position of having to do more with less.

3.4 One approach is the use of hi-tech home healthcare solutions. According to the DH as many as 35% of people currently living in residential care could be supported to live at home or in extra care housing schemes. This use of remote monitoring is increasingly enabling people to lead more independent lives. The term

Telehealthcare refers to both Telecare and Telehealth.

3.5 Many local authorities including Halton offer services in the form of an alarm system connected to the telephone. More than 1.5 million people in the UK have access to this type of service often called Telecare, Community Alarm, Careline, lifeline or Social Alarm. Detectors monitor and signal potentially dangerous situations and if an event is triggered a phone call results and if necessary a person is sent to investigate.

3.6 Telehealth allows health care to be delivered in radically different ways using innovative digital technologies. These can provide a virtual medical presence in a person's home, allowing real-time physiological measurements (blood pressure, oxygen saturation, heart rate, blood sugar…etc) and activity levels, to be communicated to health professionals by means of intelligent devices.

3.7 Hence, the person's home environment becomes a virtual ward and by means of a modern mobile phone, tablet or home computer and in the future TV vital signs monitoring and social care information can be exchanged between the person and professionals. Developments in this area have been considerable and digital health and social care will increasingly become an integral part of health and social care at home

3.8 This strategy points out the principal drivers behind the technology its advantages and possible future developments. It also stresses that it is difficult to gauge accurately overall costs and savings from current published literature, much of which is funded by providers of the software and equipment. Nonetheless, in the context of reduced funding from central government, Halton will need to be more innovative to ensure the needs of its community can not only be met now, but into the foreseeable future. Digital technology in the form of Telehealthcare seems the obvious way forward.

3.9 The Action Plan which is central to the strategy will operate on six different work-streams at minimal cost (Table 1 and Table 2) and in addition sets out significant challenges and their solution (Table 3). An important part of the solution is to determine a more accurate estimate of the cost of implementing Telehealthcare over a one-year period and at the same time estimate potential savings from fewer ambulance and GP call-outs and fewer admissions to A&E or hospital. This study will involve 14 individuals across 7 different conditions. By following these cases closely for a 12 month period, it will be possible to accurately assess cumulative costs and savings.

3.10 In addition to this Halton will continue to expand and improve its Telehealthcare monitoring service throughout the life of the strategy. We aim to have a 2% increase year on year at an estimated total cost of £36,000 for additional equipment and training, but relying upon the same staffing levels. This modest expansion will be funded through grants for further pilot studies which will provide comparative measures of actual cost and savings.

3.11 Future Developments – A number of strategic milestones have been set with a view to expanding the service, increasing public awareness in the service and working

with partner organisations to pilot and cost new technology as it develops over the next three years. This will require the expansion of the present Telehealthcare Steering group to monitor future developments particularly around priority areas and conditions prevalent in Halton.

3.12 Halton's currently Early Intervention/ Prevention Strategy highlights the importance of individual dignity, independence and equality while at the same time reducing loneliness and social isolation. It is the intention that Telehealthcare will continue this adoption of the Care Act 2014 'wellbeing' principle. This will enable those who are at home with a long-term condition to use the technology to maintain their quality of life through the exchange of information and social interactions.

4.0 POLICY IMPLICATIONS

4.1 In order to raise awareness among staff of the current and future importance of Telecare all relevant staff will need to be kept informed of new developments as part of their normal continuing Professional Development.

4.2 Telecare continues to be a significant part of HBC's Early Intervention/ Prevention strategy, which stresses the importance of individual dignity, independence and equality.

4.3 Telecare can have a crucial role in 'Vital Signs Monitoring' to assist individuals to manage their long-term conditions such as diabetes at home. This will be offered via the PCT with HBC in a supportive role and would be a useful precursor to developments such as the Virtual Ward. In this respect, Widnes-based GP surgeries will continue to pilot Telehealthcare within the Virtual Ward Concept. This will result in an increase in referrals for current sensors as well as a possible installation and technical support service for Telehealthcare applications.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 When Telecare is coupled with an appropriate individual support plan, the most significant outcome is that the person is able to remain safely and independently at home for longer. Greater independence, reduced risk and better quality of life are the prime movers for Telehealthcare. The average cost for residential care in Halton is £456.00 per week and the annual cost for hospital and home visits by GP and Community Matron for a person with COPD is £1,870. Hence there is the potential to save substantial amounts if through the preventive aspects of Telehealthcare, provided equipment, implementation, monitoring and training costs are not too high. The proposed pilot study aims to measure such costs and savings more precisely over a full year.

This pilot study and its analysis will be overseen by the Telehealthcare Steering Group. This group will be expanded to include further representation from the CCG, Care Management, Finance and ICT.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

Telehealthcare involves technology to enable professionals to remotely monitor data on certain aspects of a person's health benefitting people with disabilities with a range of conditions.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 Risk is balanced against individual need and rather than being seen as imposed surveillance. Telehealthcare operates as a carefully agreed set of responses that enable previously identified risks to be managed efficiently and safely within an agreed set of parameters specific to each individual and determined by their multidisciplinary team.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

9.1 None under the meaning of the Act.

Halton Clinical Commissioning Group

Draft

Telehealthcare Strategy

2016- 2018

Introduction - The Challenge, a Solution and many Questions

Around 18 million people in the UK have a long-term medical condition. Being able to manage effectively such a huge number of individuals is undoubtedly one of the most difficult challenges facing the NHS and social care. The vast majority of such individuals are aged 65+, living at home and because of their condition are more likely to:

- Request a home visit from their GP or require a visit from their District Nurse
- Oscillate to and from hospital (A & E and overnight stays) as their condition alternatively deteriorates and is stabilised

This is an unsustainable position especially as the number of older people who are living longer is increasing and so the pressure on primary care and social care services becomes greater each year. Coupled with this is the fact that local authorities are having to do more with less.

Telehealthcare offers a solution. It allows the individual to monitor their own condition at home with relevant information being automatically transmitted in real time down the phone line, via a digital unit to a monitoring centre. At that point operators can use triage software to view and manage the data received. Clinicians work with staff to set up a record for each patient. This record contains contact details and parameters within which each individual's readings should lie. If parameters are exceeded an alert is triggered and the person will be asked to resubmit a further set of readings. If these also exceed parameters the person's community matron or GP will be contacted and a visit arranged. This is one example of how a modern Telehealthcare system can be beneficial.

Over the next 3 years (the life of this strategy) Halton plans to obtain answers to some fundamental questions that the use of Telehealthcare raises. What are:

1. The benefits
2. The opinions of local people (users and professionals)
3. The principal drivers behind the popularity of Telehealthcare
4. The actual savings that it generates
5. Halton's priority areas over the life of the strategy
6. Halton's action plan to deliver in these priority areas
7. The challenges and how these will be met
8. What important milestones will be met on the way to 2018
9. Halton's approach to keeping abreast of future developments in the technology

1. The Benefits of Telehealthcare

This strategy uses as its source material the accompanying evidence paper. Informed by research, this highlights current best practice from other local authorities in England and elsewhere. Such practice clearly demonstrates that Telehealthcare can benefit the following groups of people who:

- Are frail/ elderly
- Have long-term conditions such as: obesity; diabetes; COPD; chronic heart failure
- Are at risk of falling
- Have dementia and other mental health conditions
- Have a learning, physical or sensory disability
- Have carers who need extra support

The social care and financial arguments supporting the use of Telehealthcare stem from the DoH 'Whole System Demonstrator' programme and other controlled studies since, such as Medvivo which was conducted in a large GP practice (Portsdown Group Practice). Medvivo (2014) found that the following gains are possible for individuals with COPD:

- 45% reduction in patient deaths (predominantly people over 65);
- 52% reduction in hospital admissions;
- 36% reduction in visits to Accident & Emergency (A&E);

- 35% reduction in GP visits;

In an attempt to estimate overall cost savings they found the following savings per person per year:

- £1,250 in reduced unplanned hospital admissions
- £110 in reduced visits to the GP
- £480 reduced visits by the community matron
- £30 in reduced attendance at A&E
- **£1,870 total annual savings per individual with COPD** (not including equipment and training)

However, it is important to note that few studies to date have included in their analysis the cost of equipment and training…etc. Initially this is likely to be substantial and in the case above, each person would require a laptop, specific monitoring devices, training and a programme of support. Any saving to be made by adopting Telehealthcare tends to be realised a number of years after implementation. Hence the general strategy for Telehealthcare adopted by local authorities, has been one of "invest to save." This results in pilot projects being used to test the benefits of the technology on small groups of individuals and if outcomes are met, further investment and expansion.

2. What local People Say:

A pilot study entitled '*Managing long-term conditions using telehealth in Halton and St Helens'* was carried out in 2013 and involved 60 Telehealth packages commissioned from Tunstall Healthcare. It was offered to individuals in three different chronic disease areas: heart failure, Chronic Obstructive Pulmonary Disease (COPD) and Stroke.

Community matrons reported that:

- Home visits were reduced
- They could prioritise their workloads more effectively
- Worsening of individual conditions was prevented
- Interaction with Sefton Careline enabled a more preventive approach
- Integrated working between health and social care was greatly improved
- People received a better quality service
- People experienced reduced levels of anxiety, better medication compliance and better self-management

The head of service delivery, Community Health Services said -

> "By deploying the Telehealth system for community-based care we are empowering patients, reducing anxiety, promoting independence and so improving overall quality of life. Telehealth also educates patients to be aware of their symptoms, to manage them, reducing part of the burden on healthcare providers"

A 59 year old type 2 diabetic who had suffered as stroke 2 years previously, was morbidly obese and hypertensive said -

> "Telehealth has given me and my family the greatest sense of security ever. I now feel like I'm in control of managing my own health."

From an individual perspective, Telehealthcare has the following important benefits:

- It greatly enhances prevention by enabling more efficient communication and response between the person and health and social care professionals. This enables potential problems to be identified and treated at a much earlier stage with obvious benefits
- It allows the person to remain at home in greater safety, giving them and their family (carer) more confidence that assistance can swiftly be summoned when required
- It increases self-confidence, enabling the individual to have more control over their life and the quality of their life. At the same time they feel safe in the knowledge that any issue which

previously was a major risk-factor can now be controlled. This allows the person the freedom to get on with their life, rather than being constrained by anxiety over their condition

- It facilitates daily interactions, which even on an automated basis help the person to feel more connected and less lonely – they know information about their well-being is being sent to others and that 'someone cares'
- Monitoring health data will help us to understand better how loneliness links to negative health symptoms, allowing us to inform future policy and strategy development (e.g. by providing an evidence-base that will enable us to invest in community-based activities which ultimately generate health savings).

3. Drivers:

- Compared to 2015, Halton's estimated population of individuals aged 65 years and over will increase by 8% by 2018 and by 40% by 2030
- For those aged 85 and over the increases are even larger – 13% by 2018 and 86% by 2030
- The prevalence of all conditions increases as a percentage of total population year on year (apart from disabilities within the 18-64 age group, due to the decreases in overall population within that group);
- Of particular significance are the following predicted increases when comparing specific conditions from 2015 to 2030:
    - 50% increase in the number of people aged 65+ living alone;
    - 68% increase in the number of people aged 65+ with dementia;
    - 49% increase in the number of people aged 65+ predicted to experience a fall.
- GP practices are major drivers in the development and use of Telehealthcare. Most of their patients are in the 60+ age group, living at home with long-term conditions. Telehealthcare makes it possible to reduce home visits in cases where the person's situation is not critical. This allows the practice to prioritise freeing up time for the GP to visit more serious cases
- In a sizeable community such as Halton, people have a wide variety of skills, talents and capabilities and are often looking for ways to contribute to their own or to a friend's or relative's support. Co-production recognises that people have assets such as knowledge, skills, experience, friends, family, colleagues and interests. These assets can be sampled to support a person's health and wellbeing. Halton is already making significant cultural and organisational shifts to embed asset-based approaches and co-production. However, it is clear that the future of person-centred healthcare whether driven by digital technological development such as Telehealthcare, or not, will require an important element of co-production.
- The Care Act 2014 which highlights the importance of wellbeing, independence and prevention.

It is clear that, in line with the national picture, Halton will inevitably experience an increase in its ageing population with expanding health and social care needs. In particular, there will be significant increases within the older age group of 85+, which is often characterised by having the highest and most complex needs. In the context of reduced funding from central Government, there will be a need to be efficient and innovative, to ensure that the needs of the population can be met now and further into the future.

Telehealthcare will have a major part to play in this, with benefits that are two-fold; it promises a more cost-effective response than traditional services which are heavily reliant on paid care staff visits or admission to residential care and it can actually improve outcomes for individuals and their family/carers. This is because services that allow people to remain in their own homes and lead an

independent life are in line with individual wishes for greater choice and control and also result in reduced feelings of pressure and anxiety for carers.

There is a commitment to increase the use of Telehealthcare in Halton to help address the financial challenges that are being faced by adult social care, as well as to ensure we continue to work towards truly personalised services and that we meet the requirements brought about by the Care Act 2014. It is acknowledged that this work will be most effective when the Council works jointly with health services and other partners.

4. Savings

This is the most problematic area of Telehealthcare. No single controlled comparative study has actually shown that a heavy investment in Telehealth digital technology will guarantee savings. Many have demonstrated that costs can be greatly reduced due to the fact that the person can remain at home longer and has far fewer episodes of ill health requiring a GP call-out or admission to A&E or an overnight stay or longer admission in hospital. However, against such obvious savings is the initial outlay in Telehealthcare equipment, maintenance, training and annual fees that are charged by Providers. Future developments will undoubtedly result in lower costs, as many systems are based on the use of 4G mobile phones which have very powerful data capture, presentation and analysis capabilities. Further as the development of the internet of things continues, home based Telecare and Telehealth devices will be able to communicate with each other to the extent that the base unit could be located within the person's television. This however will be beyond the life of this strategy.

Some gross estimates of costs per person per year are provided in the Evidence Document (section 4.8, 4.8, pages 20-23). For example, 'Falls' data (Table 8) suggests that Telehealthcare (Telecare) is saving the total annual cost of 1,000 falls costing £845,000. This however does not equate to a direct saving. The cost of equipment, training and telecare staffing…etc would also be substantial and is difficult to estimate. This is also the case for other often quoted areas of savings (facilitation of hospital discharges to a Telehealthcare service at home and GP call outs.

Table 8 (page 22) of the evidence document attempts to show by extrapolation from 2013-14 figures to 2017-18 gross comparative costs of social care with and without Telecare. The difference line implies an estimated annual saving by 2018 of £760,000. However, this doesn't take into account the increase in preventative services (non-Telehealthcare) over the same period which could substantially reduce the 'Without Telecare' costs. Such prevention would result from: enhanced Surestart, better information, an increase in carer activity and its impact due to the Care Act, improved signposting and greater involvement from voluntary services. This being the case the annual saving could be substantially less and closer to £400,000.

Accurately gauging savings as a result of investing in Telecare remains the principal difficulty facing all local authorities. The argument for the cost effectiveness of Telehealthcare has yet to be made. However, there is little doubt that the benefits of digital technology to both the individual and health and social care professionals are substantial. A major aim of this strategy will be to acquire a more accurate estimate of costs and savings and this will be a central theme of all future grant funded pilot studies.

5. Priority Areas

- Increase local awareness
- Keep pace with current development by piloting new technology via successful grant applications
- Deliver a quality service that is seamless and tailored to individual need
- Work in partnership with the NHS, housing and voluntary services
- Review the service regularly (at least annually) to ensure outcomes are met and there is clear continuous improvement
- Expand the service annually to keep pace with the increase in older people in Halton and their awareness of what Telehealthcare can do.

6. Halton's Action Plan for Developing Telehealthcare Services (Work-streams -Table 1)

The purpose of the Action Plan is to focus on Halton's priority health and social care needs. The plan will develop appropriate solutions to ensure outcomes are met. Table 4 (page 17) of the Evidence Document lists all of the priority conditions in Halton and their use of Telehealthcare and Table 5 provides further information on equipment that can monitor each condition.

The Action Plan lists each of the six work-streams and the overall approach taken is to:

- Improve and integrate health and social care
- Improve individual wellbeing as defined in the Care Act 2014
- Recognise the role of individuals making them aware of the benefits of Telehealthcare
- Focus on measurable agreed outcomes and measure more accurate savings which includes equipment costs and training …etc
- Maintain awareness of digital technology developments and make available information about its benefits
- Raise awareness locally and recognise the important roles played by partner organisations

Relevant teams are listed under each work-stream in Table 1 below. This also includes an approximate timescale, though most of the work will be extended across the entire life of the strategy.

Condition	Current Telehealthcare Solutions	Service Gaps	Future Ideas for Service Expansion

6 Action Plan – Telehealthcare (THC) Work-streams 2016-18 **Table 1**

Work-stream	Title
1 **Who**: Care Management, CCG, THC **Timescale**: Quarterly planning meetings 2016-18	*Improve and integrate health and social care:* • Helping people with long-term conditions to live independently at home by supporting them to manage their own health and care • Embedding Telehealthcare in such a way that people can move smoothly through transitions between services • Using Telehealthcare within preventative approaches
2 **Who**: Care Management THC, Surestart, **Timescale**: 2016-17	*Enhance Wellbeing:* • Supporting people to be active participants in the design and delivery of their technology-enabled services • Expanding service models for community based support and wellbeing
3 **Who**: Care Management, Carers Centre, Carers Commissioner, THC, Training **Timescale**: Throughout 2016	*Empowering people:* • Recognise the importance of the role provided by carers and develop solutions that will meet their needs and wellbeing • Raising awareness and evidencing the benefits for individuals and carers
4 **Who**: CF6, Performance, Care Management, THC **Timescale**: (pilot study) 2016-17	*Improve sustainability and enhance value:* • Develop consistent measures to track the impact Telehealthcare is having on individual outcomes and working practice • Establish a means of measuring actual savings due to the use of Telehealthcare
5 **Who**: Information and ICT leads, Marketing, LCR AT group, THC, Public Health **Timescale**: Throughout 2016-18	*Assisting development and economic growth:* • Spread awareness of the importance of digital technology developments among users, practitioners in enhancing independence and reducing risk • Keeping abreast of current developments in digital assistive technology particularly those using mobile phones with Apps
6 **Who**: CCG, Housing, HVS, Care Management, Marketing, Public Health **Timescale**: Throughout 2016-18	*Exchange development ideas, learning and best practice:* • Recognising and meeting the needs of health, housing, social care, independent and 3rd sector providers for new skills, education and training • Raising awareness, publishing and promoting innovative approaches, good practice and individual personal experiences

High Blood Pressure **Cost of training equipment …etc**: Monitor 2 people for 12 months to estimate annual cost of THC service. £250	BP monitor, GPS on phone Fall detector - waist, wrist, neck Door access – digital, wireless Mymedic unit		Use of Mobile phone Apps which combine BP and Fall detectors along with lifestyle monitoring.
Obesity **Cost of training equipment …etc**: Monitor 2 people for 12 months to estimate annual cost of THC service. £250	Glucose meter, BP monitor Weight scale Adapted home/ mobile phone Fall detector – waist wrist neck Mymedic unit	Automation can be blended with supervision and therapy. These could be tailored to the needs of the user with the view of improving lifestyles.	Preventive digital therapies are being developed to help people make changes to reduce the risk of developing long-term conditions (see Table below). Current approaches involving the Halton's preventative strategy such as information about healthier lifestyles, available local and national initiatives, health improvement strategies and individual monitoring and can be produced as an App for mobile phones.
Falls/ Stroke/ Epilepsy **Cost of training equipment …etc**: Monitor 2 people for 12 months to estimate annual cost of THC service. £250	Currently using a range of sensors in supported accommodation: BP monitor, GPS on phone Fall detector - waist, wrist, neck Door access – digital, wireless Mymedic unit		Looking at ways of embedding Telehealthcare into Reablement programmes.
COPD/ Asthma **Cost of training equipment …etc**: Monitor 2 people for 12 months to estimate annual cost of THC service. £250	A specific question tree is used with Telehealth.	No equipment is used to monitor either COPD or Asthma	Telehealthcare offers new ways to help manage rising costs and demand and economic work in Scotland suggests that using it to monitor people at home who have COPD has the potential to offer better value for money than conventional care. Halton's 'Respiratory Strategy' stresses the importance of: earlier detection of respiratory diseases; preventing respiratory ill-health; and promoting self-care and independence. Important service objectives stemming from the use of Telehealthcare at home are: patient-centred care which allows individuals with respiratory conditions to be more independent, taking more responsibility for their own care and quality of life; and improved long-term health outcomes for both the people with the condition and their carers.
Diabetes **Cost of training equipment …etc**: Monitor 2 people for 12 months to estimate annual cost of THC service. £250	Glucose meter Adapted home/ mobile phone GPS on phone Dashboard portal		Investigate the use of the smartphone as a 'Hub' for new diagnostic approaches. Glucose monitoring controlled by the phone and data sent to the Mymedic unit for GP response. Interventions to change lifestyles through regular coaching and group sessions can reduce the risk of developing diabetes.
Dementia/ Mental Health **Cost of training equipment …etc**: Monitor 2 people for 12 months to estimate annual cost of THC service. £250	Adapted home/ mobile phone Fall detector - waist, wrist, neck Heat, flood, CO Gas detectors Enuresis detector Open door detector GPS on phone Door access – digital, wireless Dashboard portal	Investigate digital therapy platforms. These enable people to connect with peers and share their experience. or connect with health professionals remotely.	Investigate the possible use of mobile phone Apps (Ginger.io. is one example). This is a depression programme enabling people to track their own mood. This can be combined with data from sensors in the smartphone which log the person's movements and their telephone use. This data can be shared with clinicians and offers an intervention when the data suggests they may benefit from support. Investigate the development of sensors around issues such as falls and wandering.
Adults with a Disability **Cost of training equipment …etc**: Monitor 2 people for 12 months to estimate annual cost of THC service. £250	Adapted home/ mobile phone GPS on phone Flood, CO, Gas detector		Incorporate elements of the current 'loneliness strategy' and the use of a mobile phone app to reduce social isolation within this group.

Table 2 Future Pilot Study to determine accurate costs/ savings in areas where there is a current a service gap.

7. Challenges and how these will be met

Table 3

	Barriers and Challenges	Solutions to the barriers and challenges
Public Awareness of the existence and potential benefits of the technology.	Telehealthcare improvements and new products are occurring at such a pace, it is difficult to keep abreast of developments. Often information is presented in specialist publications that the public (especially the older public) have difficulty accessing. There is a need for improved public marketing and education about the benefits to be had from using Telehealthcare.	A good way of informing Halton residents in general, older people especially, is to demonstrate by means of individual case studies. The University of Stirling Joint Improvement Team have cited a number of Case Studies which show how this approach can be very helpful (Telecare and sensory impairment – Using telecare effectively in the support of people with sensory impairments, University of Stirling, 2010, p. 23-27).
Telehealthcare Infrastructure, Training and workforce issues.	An area of major development in Telehealthcare is in 'Digital Therapeutics.' These are health and social care interventions that are delivered either wholly or significantly through a smartphone or laptop. They integrate clinical practice and therapy into a digital form. At a minimum, such interventions allow clinical information on a health condition to be combined with advice and techniques for dealing with that condition. They allow people to connect with peers and professionals remotely and the therapy offered can be tailored to their specific needs. Training is the principal barrier, particularly for users aged 65+ but also for those professionals who will be responsible for using the data to provide directed therapy.	Appropriate training must be in place and any advice or therapy offered targeted to the person, their needs and expected outcomes. Such Digital Therapeutics are often cited as a solution to help manage long-term conditions that call for behaviour (lifestyle) changes.
Accurate estimate of Savings minus Installation costs of Telehealthcare.	Few independent studies have provided accurate data on estimated savings.	This is an area that Halton will focus on over the life of this strategy. Future pilot studies of new equipment will incorporate this kind of analysis. The Telehealthcare Steering Group will need to be expanded to include further representation from: ICT, Care Management and the CCG.

8. Strategic Milestones on the way to 2018

We have set ourselves 3 strategic milestones to be achieved during the life of this strategy:

- Telehealthcare will enable choice and control in health, care and wellbeing services for an additional 300 people who have long-term conditions
- Increased awareness will enable those individuals who make use of health and social care services to be more proactive in seeking to use Telehealthcare systems
- We will promote and engage with an interactive community of innovators, service providers, health and social care professionals capable of piloting, delivering and assessing new Telehealthcare services

9. Keeping Abreast of Future Technology

Each year sees the development of technologies that could have a significant impact on a person's health and social care. Much of the technology is still on the horizon, but there is no doubt that the way local authorities approach health and social care, will of necessity have to change and adopt a digital approach. Such change will undoubtedly be driven by the use of digital technology. This will integrate both disciplines in such a way that individuals with specific needs will be able to communicate personal data monitoring their wellbeing to health professionals, who can then respond appropriately.

The Kings Fund (2016) has highlighted a number of such technologies that are predicted to change health and social care[1] An important part of Halton's strategy will be to monitor such digital developments and to seek funding to pilot test different approaches, particularly around key priority areas such as: COPD, Diabetes, Falls, Dementia, Disability, Mental Health and Heart disease.

Telehealth and Telemedicine will facilitate the remote monitoring of patients within their own homes and support their condition in a community setting, to help to enable patients to retain greater independence. This digital technology will play an important role in the future care of patients with respiratory disease and other long-term conditions. For example, NHS Halton CCG expects Halton's Community Respiratory Service to make use of innovative, new and developing technologies to support patient care and achieve the outcomes outlined below:

- A reduction in A & E attendances
- A reduction in avoidable Emergency Admissions to hospital
- A reduction in delayed transfer of care for patients who have been admitted to hospital
- A reduction in permanent admissions to Nursing and Residential Care (including End of Life)
- A reduction in readmission to hospital

In this respect, Halton's overall approach to Telehealthcare is one of 'investing to save.' A recent successful partnership bid involving HBC, NHS Halton CCG and a Small Business Enterprise with the Royal Liverpool University Hospital, will acquire £25,000 of funding from the Local Government Association (LGA) to develop a digital application.

[1] Gretton, C. and Honeyman, M., The Kings Fund, The digital revolution: eight technologies that will change health and care, 1st January, 2016.

Halton intends to use this funding to invest in the unique development of what will ultimately become a universally available software application made available free to other LAs and which will result in substantial council savings (estimated as £50,000 annually). These projected savings will stem from reductions in: GP and other health and social care professional home visits, hospital stays, ambulance call-outs and trips to A & E as a consequence of using the software at home, in residential care homes and GP practices.

Halton will use the funding as follows:

- Initial software development (phase 1) and technical work that will enable the application to integrate with existing EMIS data logging resources that Halton and the majority of other LAs already have installed in their GP practices. This phase will involve the development of movement and temperature monitors customised to typical service user need (**£13,000**)
- User testing phase for proof of concept and scalability (**£1,500**)
- Development of phase 2 software to add oxygen saturation, plethysmography, cardiac monitoring and breathing rate in visual form for use with patients living at home with COPD or high cardiac risk (**£6,000**).
- Further testing phase for proof of concept and scalability (**£1,500**)
- All project management and training costs (**£3,000**)

The overall project will align with Halton's Strategic response and also as an action that is both based on and driven by the local CCG respiratory strategy. The potential benefits to the COPD and cardiac risk patient and their Carers at home are enormous, in terms of reduced risk through the use of state of the art telehealth care software. This will enable self-monitoring and provide early prevention of serious developments with data going straight to the GP surgery in easily understood visual form. This will allow health professionals to respond to a person's data before a crisis arises, or becomes worse, before being life threatening.

Summary

1. Further developments in Telehealthcare which integrate the use of digital Technology in health and social care, will play a major role over the lifespan of this strategy. Its importance lies in the fact that it:

- It greatly enhances prevention by enabling more efficient communication and response between the person and health and social care professionals. This enables potential problems to be identified and treated at a much earlier stage
- It allows the person to remain at home in greater safety giving them and their family (carer) more confidence that assistance is always at hand when required
- It increases self-confidence, enabling the individual to have more control over their life and the quality of their life. At the same time they feel safe in the knowledge that any issue which previously was a major risk-factor can now be controlled. This allows the person the freedom to get on with their life, rather than being constrained by anxiety over their condition.

2. Halton will continue to expand and improve its Telecare monitoring service throughout 2016 – 2018. At December 2015, we currently have 2,862 individuals using the telecare service. We aim to increase this by approximately 2%, year-on-year. Our target for the end of 2018 is **3,037** at an estimated cost of £36,000 for equipment, training, assuming no increase in current staffing. The intention is to fund this expansion through grants for pilot studies which will closely measure actual savings.

3. We will also continue to explore Telehealth as a means of tackling the formidable problem of loneliness which can have a serious negative impact on an individual's health and on their quality of life. Some estimates suggest this impact is equivalent to: smoking fifteen cigarettes each day; more severe than not exercising; and twice as harmful as obesity (Holt-Lundstad 2010). The lonelier a person is, the more likely they are to experience increased symptoms of depression. Loneliness has been linked to hypertension and in developing cardiovascular disease. Lonely individuals are twice as likely to develop Alzheimer's disease and conversely having dementia increases feelings of loneliness. Lonely people are also more likely to be admitted to care homes and hospitals. Our use of digital technology will help us to combat loneliness both now and in terms of informing future social care policy direction by:

- ❖ Facilitating daily interactions, which even on an automated basis help the person to feel more connected and less lonely – they know information about their well-being is being sent to others and that 'someone cares'

- ❖ Electronic monitoring of key health data will enable us to work to prevent situations which may exacerbate a person's loneliness e.g. preventing a fall (through monitoring blood pressure, weight, activity levels, and give dietary advice) which would limit mobility and social inclusion, preventing hospital admission which will disconnect the person from their familiar environment and relationships

- ❖ Monitoring health data will help us to understand better how loneliness links to negative health symptoms, allowing us to inform future policy and strategy development (e.g. by providing an evidence-base that will enable us to invest in community-based activities which ultimately generate health savings)

4. By improving communication in health and social care, the strategy will aim to support collaborative working and prevent health deterioration. This approach will involve the improved use of digital technologies such as the Electronic Monitoring Information Systems (EMIS), the Apple Health App and Patient Access apple. This will be the most ambitious use of Telehealthcare in Halton as it will involve information sharing between social care providers, GP's, hospitals and wider health services. This includes the ability to share and access real time data across multiple professionals/providers. Empowering people supported to be in control of their own health monitoring also works to increase the confidence, engagement and ability of older people to self-manage health needs. Planned applications include:

- An 'End of Life' electronic register linking hospice, primary care and care homes
- NWAS electronic alerts to reduce unplanned admissions
- Electronic prescriptions to reduce medication errors
- The adoption of a 'Nutrition and Hydration' application for care home staff to avoid poor nutritional status in care home patients
- A 'Weight Monitoring' application for care home staff for early identification of poor nutritional status and early disease pathology

The extended use of digital technology will enable us to build on some work already undertaken. This involves digitising GP contacts and a recent development where GP's work alongside care home managers, to alleviate the need for particular individuals being admitted into Hospital. Thus far (December 2015) this work is delivering some extremely positive results. The care home involved, has called on the Ambulance Service only half as much compared with other care providers in the borough and Hospital admissions have been reduced by 80%.

5. Through the application of Telehealthcare we aim to focus on efficiency by reducing the number of Safeguarding Alerts. This will provide a better quality service that is significantly more effective in its use of a Social Worker's time, as well as that of the GP. Also, by highlighting improved quality, we hope to achieve a reduction in additional separate health and social care quality assurance visits. We plan to focus on the use of integrated quality assurance.

6. The strategy will aim to demonstrate ways of using digital innovation which involve new ways of working. within both health and social care to further individual goals which collectively work to achieve the shared ambition of promoting the health, happiness and well-being of old**e**r people and correspondingly making the more effective use of scare resources. This is true integration. Evidence also shows where localities and health services are proactive in knowing their population and are able to understand individuals more fully, then related health problems can be managed much more effectively.

The use of EMIS terminals that have supporting software enabling communication with the GP Practice can significantly improve, the person's health which can be proactively managed with the results of tests being forwarded directly to a patient's record. Access to the technology is via software that can be installed on an IPad/tablet and then can be used to arrange virtual electronic GP consultations and real-time updating of patient records. This information creates an electronic version of Hospital Passports and health action plans which will also prove extremely useful when care providers need to communicate with hospitals. The automated element of this technology will enable better management of things such as Nutrition, Rehydration, Safeguarding, Hypertension and Respiratory problems. The empowerment of people supported by giving them control over the technology (underpinned by training) will further the choice and control agenda.

7. Expected outcomes the strategy aims to deliver:

- Reduced use of acute services and hospital admission by preventing key health issues leading to this for example, undetected UTI's, falls, malnutrition, dehydration etc
- Reduced loneliness by preventing health issues which restrict the person's ability to engage in social opportunities and activities e.g. maintaining mobility, preventing hospital admission
- Promote the confidence and self-esteem of older people by empowering them to engage in health self-management
- Reduced pressure on Social Worker, GP and other health and social care resources by information sharing which helps inform the most accurate response to the person's needs
- Development of an evidence-base which will help to target investment in community resources to reduce loneliness and its corresponding negative health symptoms
- Better integration of health and social care – avoiding duplication of resources and ensuring individual priorities are met.

Holt-Lundstad, J. (2010), Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Med 7(7)
http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&sqi=2&ved=0ahUKEwir0fTpoe3JAhXGWxQKHXOnAX4QFggtMAE&url=http%3A%2F%2Fwww.ncbi.nlm.nih.gov%2Fpubmed%2F20668659&usg=AFQjCNEi96Cf4Ii0Fh8K7dn9yJiw5jVrsQ&bvm=bv.110151844,d.d24

REPORT TO: Health Policy & Performance Board

DATE: 15 November 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Stroke Update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update Members of the Board on Stroke Reconfiguration in Mid–Mersey.

2.0 **RECOMMENDATION: That**

1) **Board Members understand the current clinical discussions and solutions to ensure Halton patients receive high quality stroke services;**

2) **Development of Telemedicine service across both sites for out of hours provision;**

3) **Quality Impact Assessment to be undertaken by Warrington Trust; and**

4) **Early Supported Discharge (ESD) and community provision across the patch be reviewed and uplifted as part of the discharge process and repatriation process from Whiston.**

3.0 **SUPPORTING INFORMATION**

3.1 **National Stroke Direction**

3.1.1 National Clinical Lead for stroke Professor Tony Rudd has challenged local teams to improve their SSNAP data performance by reviewing and where possible centralising their stroke services. Both London and Greater Manchester have centralised their stroke services but on a city wide basis.

3.1.2 Evidence demonstrates that patients who attend Stroke centres who take more than 6OO stroke patients per year have better outcomes, that the experience, expertise and 7 day specialist cover of higher volume centres reduce mortality and gives the patient an enhanced

journey.

3.1.3 Nationally stroke teams are aligning their stroke services with Sustainable Transformation Plan (STP) programmes and many due to sustainability issues – mainly around workforce, patient safety and inability to provide flexible 7 day working; are creating collaborative partnerships with neighbouring trusts. The aim of these partnerships is to reduce variation in service provision, so there is no post code lottery and that all patients receive the same care regardless of GP or locality.

3.2 **Workforce**

3.2.1 There is a national shortage of stroke consultants, around 40% of consultant stroke positions are vacant, many sites utilise locum cover, which means increase in stroke costs.

3.2.2 There is a national shortage of speech and language therapists, they are an integral part of the stroke rehabilitation multi-disciplinary team. Many stroke patients are left with speech or swallowing difficulties.

3.2.3 There is a national shortage of clinical psychologists, many patients following a stroke develop psychological and behavioural problems, there are many delays in accessing this service.

3.2.4 National Stroke Royal College Physicians guidance out Oct 2016. Have made some significant changes.

3.2.5 The new recommendations throw up more challenges for acute trusts:

- Every stroke patient should have a CT scan within an hour of admission (previously only patients requiring thrombolysis would have one within the hour so 15 – 20% of stroke numbers and all stroke patients should have a CT scan within 12hours).
- All TIA patients will be seen within 24 hours regardless of risk (previously only high risk patients would be seen within 24hrs and low risk patients within 7 days)
- All patients requiring Carotid surgery will have the procedure within 7 days (previously it was within 14days)

3.3 **Mid Mersey Stroke Update**

3.3.1 Warrington & Halton Hospital (WHH) take approx. 400 stroke per annum and approx. 800 stroke mimics per annum. Sentinel Stroke National Audit Programme (SSNAP) has the hospital rated at a C.

3.3.2 St Helens and Knowsley Trust (SHKT) take approx. 700 strokes per

annum and approx. 1400 stroke mimics. SSNAP has the hospital rated at an A.

3.3.3 Mid Mersey created a Stroke Board. This board has representation from CCG's, primary care, local authorities and acute providers. The Board has agreed the vision that SHKT will be a single stroke provider of acute services and that in a phased approach that all WHH acute stroke patients will be transferred to SHKT for the 1st 72 hrs of care and then repatriated either through Early Supported Discharge (ESD) teams or back to acute trust for longer more complex patients. This board is also now aligned with the Mid Mersey Alliance. Formal Governance to follow.

3.4 **Background**

3.4.1 WHH have struggled over the past 3 years with reduced consultant workforce, a decision was made in 2014 to transfer stroke patients from WHH to SHKT from 8pm – 8am, Mon – Fri for those stroke patients who require stroke thrombolysis (clot busting drug). This solution worked well and was further expanded in October 2015 to 5pm to 8am and expanded again in April to include weekend 5pm - 8am.

3.4.2 At the Mid Mersey Stroke Board, it was highlighted from November 2016, WHH would no longer be able to run an acute stroke service. They would be left with one substantive stroke consultant and 1 locum. Situation that all acute strokes would need to be transferred to SHKT needs to be done quickly. This has been an issue for last year, but has reached crisis point in July, service not sustainable.

3.5 SHKT need to find an extra 16 beds for these patients and currently also have a reduced consultant workforce, this is outstanding since February. Repatriation policy needs to be developed and agreed, existing repatriation policy not effective with hospital capacity issues. Warrington have offered a potential solution to reducing some of the workload for Whiston patients, this has yet to be formally presented and accepted. Clinical risk for WHH has been reduced by the recruitment of 2 x part time locum consultant stroke physicians which will leave 0:8 substantive consultant, 1 full time locum and 2 part time locums. Whiston staff will have 5 wte substantive consultants and 1 locum.

3.6 Telemedicine Service would benefit both sites in relation to providing a sustainable consultant presence out of hours, Telemedicine audit across Cheshire & Merseyside showed that all sites want to be involved but more local service than regional, help neighbouring trusts.

3.7 SHKT inpatient therapy team will not have sufficient workforce to deliver recommended 45 mins of each therapy time to increased

number of patients, a proposal of what is required is being completed for local trust boards.

3.8 ESD and Community teams are effective in Warrington and Halton, although do miss components from their team such as Speech and Language Therapists, Psychology, their service could be enhanced to reduce capacity in Whiston, Knowsley ESD are effective and also have a social worker sitting in their team, St Helens ESD are struggling due to being over- subscribed and under resourced, which has impacted on having a 2/3 week wait for ESD, this has impacted on Length of Stay (LoS) for those patients within the Trust. One of the main issues is lack of dedicated social worker and delays in packages of care and residential beds. Further discussion and evaluation of top 3 priorities are being agreed and a proposal is to be taken to the STP board for funding consideration.

4.0 POLICY IMPLICATIONS

4.1 No formal governance process agreed.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Finance and contracting discussions underway to work out any change to tariff or transfer of service.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

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

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 No finance presence from the CCG's on the Board or acting on behalf of all CCG's, no formal Senior reporting officer (SRO) of the project.

No formal transformation involvement within Acute Trusts

Formal governance process to be agreed through alliance

Formal proposal is required and agreed so that public consultation and locality awareness raising takes place.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None.

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

None.

REPORT TO:	Health Policy & Performance Board
DATE:	15 November 2016
REPORTING OFFICER:	Director of Adult Social Services
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Windmill Hill: General Medical Services
WARD(S)	Windmill Hill

1.0 **PURPOSE OF THE REPORT**

1.1 This report provides an update on the commissioning of a general practice service at Windmill Hill from April 2017 to ensure that the Board are assured that we achieve the best from primary care services for the people of Windmill Hill.

2.0 **RECOMMENDATION: That the Board notes the update on the contracting of general medical services at Windmill Hill.**

3.0 **SUPPORTING INFORMATION**

3.1 Before a final decision could be made on the options for Windmill Hill Medical Centre presented to the Board in June, the CCG's Primary Care Commissioning Committee (PCCC) requested that the following actions be undertaken a) Equality Impact Assessment (EIA); b) patient engagement; and c) market testing.

3.2 The EIA concluded that none of the options being considered were discriminatory, as long as a number of recommendations in relation to the dispersal of patients registered at the Widnes branch were followed.

3.3 The patient engagement exercise highlighted that over half of respondents, the majority of whom were patients at the Windmill Hill Medical Centre, had no concerns regarding the practice being run as a branch surgery. The main themes which emerged from those who expressed a concern were continuity of care, accessibility and losing the small, personal nature of the practice.

3.4 Market testing to identify whether Windmill Hill as a stand-alone contract was sustainable and viable, was undertaken in July and August. Although three organisations registered an interest on the Contracts Finder portal, none subsequently provided a formal response. All three were approached to query why they had not submitted a completed response. Only one company responded stating other opportunities in the pipeline, list size and location were the prohibitive factors. It was felt that the lack of information received could indicate that potential bidders were not interested in this service.

3.5 The PCCC's Chair subsequently approved the recommendation to procure a

branch surgery at the Windmill Hill site, carry out a mini procurement amongst existing providers in Halton and disperse the smaller element of the contract at the Widnes site. This still has the potential to be challenged but the risk was deemed low

3.6 **Procurement of Windmill Hill Branch Surgery:** The CCG's primary care team is working with a procurement specialist to run the procurement process. The procurement plan and timescales have been agreed, and an evaluation panel convened. A service specification and financial modelling have also been developed. A bidder session was held on 22 September 2016 attended by a number of interested practices. It is planned to commence the formal process on 17 October 2016, with a contract being awarded in early January 2017.

3.7 **Widnes Branch List Dispersal:** All patients registered at the Widnes branch have received a letter informing them of the decision to close the branch surgery and giving them the opportunity to raise any particular concerns or issues. Extra support or information will be provided for any patients that have a particular concern. It is planned to write to the patients again in November with information on how to register with an alternative practice. All practices in Widnes with an open list are prepared for the influx of patients from the list dispersal, and three have expressed a particular interest in registering these patients. Deductions and new patient registrations will be monitored weekly.

3.8 Regular meetings continue with the incumbent provider of primary care services at Windmill Hill and the practice's PPG.

4.0 POLICY IMPLICATIONS

4.1 The commissioning of a quality, safe and effective general medical service at Windmill Hill is critical to ensuring the continued improvement in the health and wellbeing of residents.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None.

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 a Windmill Hill GP practice.

6.2 Employment, Learning & Skills in Halton

The report will help to support maintaining a healthy workforce by focussing on the care provided by a Windmill Hill GP practice.

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 The risks/opportunities associated with the proposed options were considered by the PCCC. The final options selected were the ones which the Committee felt offered optimum risk mitigation.

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**

9.1 None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 15 November 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Domiciliary and Care Homes Quality Report

WARD(S): Boroughwide

1.0 **PURPOSE OF REPORT**

1.1 To update the Board on the Quality of provision within the care home and domiciliary care market in Halton.

2.0 **RECOMMENDATION: That the Board note the contents of the report and the challenges identified in Appendix 1**

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

It is a key priority for Halton Borough Council to ensure the provision of a range of good quality services to support Adults requiring support in the Borough. The Care Act has put this on a statutory footing through new duties regarding the promotion of effective and efficient operation of the care market in which there must be a choice of diverse high quality services that promote wellbeing.

3.2 The care home market in Halton consists of 27 registered care homes which provide 788 beds operated by 16 different providers. The capacity within the care homes ranges from homes with 66 beds to smaller independent providers with 6 beds. The total spend in 2015/16 across all funding streams was £24,200,758

3.3 There are 9 domiciliary care providers supporting 610 service users across the Borough. The total spend on domiciliary care for 2015/16 was £11,223,470 across all funding streams.

3.4 **Quality Monitoring and Assurance**

The Care Quality Commission (CQC) is responsible for the registration, inspection and assessment of all registered providers. However, the Care Act 2014 places the duty of securing the quality of care in Halton on the Council itself.

3.5 The CQC assessment process enables all registered care providers to be classified into one of four categories following an appraisal which asks 5 key questions:

- Is the service safe?
- Is the service effective?

- Is the service caring?
- Is the service responsive?
- Is the service well led?

The four award categories are:

- Inadequate
- Requires Improvement
- Good
- Outstanding

3.6 The results of all CQC inspections are published, including the rating awarded.

3.7 The HBC Quality Assurance team gather intelligence and information on Providers via quality and contract performance monitoring; this includes, “soft intelligence” from key stakeholders, review of the latest CQC report, business plans and financial accounts. This information is then used during regular monitoring visits.

3.8 The team also operate an early warning system, which includes;
Provider self-assessment, Quality Dashboard and Electronic Care Monitoring (Domiciliary care).

3.9 The Quality Assurance Team, utilise a RAG rating system to assess the quality of the care provision; Green (Good / Excellent), Amber (Adequate / Satisfactory), Red (Poor-with actions)

3.10 **Quarter 1 Position**

There are currently 3 homes within Halton that CQC have assessed as requiring improvement. The remaining 24 homes have been assessed as good. There are no homes in ‘special measures’. CQC have undertaken 5 visits to care homes within the Borough during quarter 1.

3.11 The Quality Assurance Team has rated: 13 Care homes as Green, 10 as amber and 5 as red.

3.12 Of the 5 care homes rated as red, we only have a contract with one of the homes; however we are working with all 5 to improve the quality of care provided.

3.13 The Quality Assurance Team have rated the 15, contracted providers as 3 green,3 amber and 4 red, 5 providers have not been rated as yet.

3.14 In addition, both domiciliary care and care home providers are measured on the number of safeguarding or care concerns reported to the safeguarding unit.

The majority of the care concerns identified within care homes are due to missed medications and the safeguarding referrals in respect of unwitnessed falls within the care homes. During Quarter 1 we have received 79 safeguarding referrals and 127 care concerns, from the care home providers.

Similarly within the domiciliary care market we received 33 safeguarding referrals and 17 care concerns mainly concerned with missed medication errors.

3.15 In addition all providers are required to notify CQC in respect of all notifiable incidents within the care home. Harm includes significant falls within the home.

Number of CQC Notifications received	44	26	40	25
	Apr-16	May	Jun	Jul
Harm	9	9	16	9
Death	18	10	13	12
Pressure Sores	0	0	0	0
Infection Outbreak	0	1	0	0
DoLS	16	4	8	3
Other	1	2	3	1

4.0 POLICY IMPLICATIONS

4.1 The Care Act 2014 placed a new duty on the Local Authority in respect of provider failure.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

The safeguarding of adults whose circumstances make them vulnerable to abuse is fundamental to their health and well-being.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 The key challenges identified within Appendix 1 impact on the stability of both the domiciliary care and care home markets.

The current domiciliary care market in the borough is unable to provide sufficient capacity to meet the needs of the local population posing significant risk to vulnerable people, the delivery of the council's statutory duties. Further work with the domiciliary care providers is ongoing to address other aspects of these issues.

The Local Authority remain responsible for supporting failing services and work with CQC who are required to inform Local Authorities of financially failing services.

8.0 EQUALITY & DIVERSITY ISSUES

8.1 It is essential that the Council addresses issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its Quality Assurance and Safeguarding processes.

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

9.1 None under the meaning of the Act.

Appendix 1

Key Challenges within Care Homes in Halton

It is important to note that many people staff, residents and families consulted as part of the Quality Assurance Team consultation processes are very positive about many aspects of the care they receive. Key challenges to delivering high quality care have been identified with many of them being interdependent.

- People are being admitted to care homes with more severe and complex care needs resulting in residents being placed in homes with much greater dependency needs.
- Recruitment and retention concerns are reported to be one of the top issues for care homes. A shortage of highly trained care assistants and registered nurses places additional stress on staff. It also compounds the pressure homes have with meeting the needs of residents with higher dependency and more complex needs.
- Agency staff are often used to support care homes and there is a high agency usage of staff across all areas. Whilst recognised for their valuable staffing input this can have an impact on continuity of care and they do not always have sufficient individual knowledge of the people they support.
- There are difficulties providing training to staff because if staff attend training it potentially leaves the home understaffed. The high turnover of staff leaves care staff continually supporting and training new recruits.
- Lack of a career pathway and training and development opportunities for both care staff and nurses
- The lack of leadership within care homes
- The risk of financial failure of care homes due to reliance on agency staff and increased costs over all areas.
- Internal QA processes not being applied to the learning and development of internal systems

All care homes reported the benefits from some of the innovative preventative measures developed locally. The use of the Pharmacy Team, Care Home Support Team and, to provide additional support and training into the care homes, Rapid Clinical Assessment Team

REPORT TO: Health Policy & Performance Board

DATE: 15 November 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 2 2016/17

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 2 of 2016/17. This includes a description of factors which are affecting the service.

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

i) Receive the Quarter 2 Priority Based report

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

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

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 2, 2016/17.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None under the meaning of the Act.

Directorate Performance Overview Report

Directorate: People Directorate

Reporting Period: Quarter 2 – Period 1st April – 30th September 2016

1.0 Introduction

1.1 This report provides an overview of issues and progress within the Directorate that have occurred during the second quarter 2016/17.

2.0 Key Developments

2.1 There have been a number of developments within the Directorate during the second quarter which include:

Homelessness

Asylum & Refugee Programme.
The Syrian Refugee Programme is underway and the Merseyside Sub Region has agreed to accommodate 510 refugees, with Halton taking up to 100. All the necessary arrangements are due to be finalised and each authority will agree what services will be commissioned. Liverpool has devised a service specification, which is on the chest, with closing date of 31/10/16. Halton will buy into a number of the services within the spec and form part of the procurement and evaluation process.

Gypsy Traveller Site
The new permanent traveller site is complete and the allocation process is underway. The site is due to officially open 14th November 2016 and a number of pitches have been allocated to priority travellers.
An appeal was lodged however, it was unsuccessful and the original court judgement was upheld. A further verbal appeal has been granted which is due to be heard early November 2016, whereby, a number of pitches will be retained on the new site, pending the appeal decision.

Adult Social Care

Transforming Domiciliary Care
We have carried out a review of domiciliary care in Halton which will support our overall plan to submit a funding application to the National Lottery Commissioning Better Outcomes fund. The application is due for submission by September 22nd and if successful we will be in a position to start implementation within three months. The review so far has allowed us to consider what the current service offers and how it may change in the future, as a result we are in the process of developing a new service specification that will significantly change the way in which we provide care at home. This will include:

- Removing time calls
- Increasing flexibility
- Reducing the number of providers (currently we have 9)
- Assess people for outcomes not just set tasks
- Increase the number of reviews that take place
- Work with the providers to deliver quality of life outcomes, reduce social isolation and improve people's wellbeing

Day Services
'The Route', which opened in November 2015, offers work placement opportunities in a busy food retail and customer service-based setting. It is the newest addition to an interlinked portfolio of some 15 small businesses developed by the service which includes a microbrewery, an ice-cream manufacturing business, high street hairdressers, a pie and confectioners production line amongst fruit and veg producers and small poultry farm. Service users often experience work across a range of our businesses developing transferable skill and broadening experience (see Roberta's Journey).
Used as part of a progression programme for service users the outlet acts as a stepping stone to enhance skills already gained across other services. The synergy between the ventures is well reasoned with The Route sells soups and cake slabs made at the kitchens in Oakmeadow Community Support Centre, cupcakes produced by the Independent Living Centre, and the ice cream manufactured through Community Services at Norton Priory.

The Community Multi-Disciplinary Team Model
A number of legislative and policy developments have contributed to the development of the community multi-disciplinary approach in Halton, further integrating health and social care in the borough. One of the schemes outlined within Halton's Better Care Fund is in relation to the continued developed of Integrated Health and Social Care Teams which 'aims to deliver high quality, effective and efficient assessment, care and support planning for people with a wide range of health and social care needs'. In Halton, we have held a dedicated Steering group with membership across health and social care developing a new model for Multi-Disciplinary Team working, which is now ready to be implemented.

The model for Community MDTs in Halton consists of staff from several different professional backgrounds, including GPs, Social Workers, Community Care Workers District Nurses, Social Care in Practice (SCiP) workers, Community Matrons, Continuing Health Care Nurses, and Wellbeing Officers, who are able to respond to people who require the help of more than one kind of professional. The MDT will work in an integrated way, aligned to GP practices.

The model works with four GP Hubs: Widnes North, Widnes South, Runcorn West and Runcorn East. Each Hub has clusters of GP surgeries. Each GP surgery has its own MDT, are working with an identified GP patient population. The model promotes the MDT have dedicated meetings to look at unplanned admissions to hospital and at complex cases. Referrals can be taken daily and directed to the relevant professionals in the MDT.

Mental Health Services
<u>Review of the 5Boroughs Acute Care Pathway and Later Life and Memory Services:</u> following the in-depth review of the way in which the Acute Care Pathway is delivered in relation to adults with severe mental illnesses, and of the delivery of services for people with memory deficiencies, work has been continuing both locally and across the footprint of the 5Boroughs to put in place the recommendations of the review. In Halton, two

groups are in place which are looking at the ways to improve the discharge to primary care services of people whose mental health is such that they no longer need secondary care services, but also to ensure that processes for referral and acceptance into secondary care are smooth and effective.

As a part of the delivery of the review recommendations, the 5Boroughs have redesigned their management structure, so that each local area is supported by senior managers within the Trust, and local services relate much more to the local population. This is allowing for much greater involvement of the 5Boroughs in local strategic planning and operational groups.

Across the wider footprint of the 5Boroughs, work has taken place to improve the way that services are delivered for people with personality disorders and/ or chaotic and high risk lives. The Trust's bed base has been reviewed, and proposals for change have now been submitted to the Health Policy and Performance Board in Halton.

Direct Payments in Mental Health: work has been taking place in Halton to improve the uptake of direct payments for people with mental health problems. Direct payments give people much greater control over their daily lives and help to build self-esteem, coping skills and self-confidence. However, in common with much of the rest of the country, it has been hard to achieve a high uptake of direct payments for this group of people. A new service is now in place, delivered by Halton Disability Partnership, which works directly with people with complex mental health problems to support and encourage them to take up the offer of direct payments. From a baseline of 23 people, there are now 35 people with mental health needs who now receive a direct payment for their care and support. Further redesign of the care pathway (see above) is expected to lead to an increase in these figures.

PUBLIC HEALTH

Mindfulness Programme

A mindfulness programme has been put to tender and has been sucessfully awarded. The programme will deliver mindfullness training and awareness programme across a schools setting with the aim to improve mental health and wellbing and contribute towards improved personal resilience in school aged children.

World Mental Health Day

Halton Borough Council celebrated World Mental Health Day on Monday 10 October with a conference and social event for residents and local professionals to inform and entertain. There were owls, dancers, bands and discussion groups.

The conference at Riverside College (Centre Stage, Kingsway) was attended by over 100 people and tied in with the theme of 'Building a Mentally Healthier Halton' - an ongoing theme for the Health Improvement Team.

150 local residents also attended the 'feel good' social event in the evening at The Studio in Lacey Street, Widnes. Performers included SJ Pure Dance, Hearts and Voices Choir and poet Clive Little.
The events were a partnership with Riverside College and The Studio, with support across local services and teams including health, education, housing and police, with the aim of finding ways to make people healthier and happier.

National Recovery Walk
Halton was proud to host the National Recovery Walk, organised by Public Health and the commisioned substance misuse service provider CGL. More that 7,000 people took part in the walk across Halton on Saturday 9th September to raise awareness of the seriousness of addiction and celebrate recovery.

Vintage Rally Health Engagement
Health Improvement Team (HIT) supported the Vintage Rally on 24th & 25th September held in Victoria Park in Widnes. The team undertook various health engagement opportunities including make your own smoothie, involving people in healthy eating and importance of '5 a day' messages, alongside a physical activity message – making smoothies in a blender by powering it with pedal power on a bike. The HIT engaged 531 in the health marquee with a further 160 people involved in cancer awareness through the information iVan which was specially commissioned for the event.

3.0 Emerging Issues

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

Adult Social Care

Domiciliary Care
The current domiciliary care market is under a certain level of pressure. There have been a number of issues that have contributed to an increase in the current waiting times for packages of care to be picked up. These include:

- Low levels of staff recruitment
- Low numbers of car drivers making certain parts of the borough more difficult to cover
- Increased overheads with the implementation of the National Living Wage.
- Pressures faced from neighbouring authorities.

We are working proactively with all of the senior management teams of each of the nine providers to find solutions to the outstanding packages. Meetings are taking place on a fortnightly basis and a number of solutions are already being explored.

Mental Health Services
Social Work for Better Mental Health: this national programme is designed to bring clarity to the work of social workers within mental health services. In partnership with Sefton Council, Halton is an early implementer of the programme, which is intended to focus the work of social workers within mental health Trusts, to ensure that their professional skills are best used. A detailed local self-assessment is taking place, which will be used to reshape the delivery of mental health social work in this area.

People with complex mental health conditions who are placed out of borough: there are a number of people with complex mental health needs and high levels of disruptive and risky behaviour who have been placed in specialist facilities out of borough (often some distance away) because local services have been unable to meet their needs. Work is going on between the Council, the Clinical Commissioning Group and the 5Boroughs to look at the needs of these people and decide whether some of them can now be more appropriately supported locally, as their condition has improved. Although there are some

people who will need this level of specialist support for an indefinite period, it is clear that some are now ready to return to their own neighbourhoods and be near their families and networks again. Work is therefore taking place to ensure that this happens, by providing them with the appropriate levels of care and support locally.

Serious Incidents in mental health: since the end of July 2016, there has been an increase in the number of serious incidents relating to people with mental health needs in the borough. A multiagency group, led by the Clinical Commissioning Group and the Halton Safeguarding Adults Board, is co-ordinating a detailed programme of review and analysis of each of these cases, to find out whether there are any lessons to be learned and changes to local systems which might be required.

PUBLIC HEALTH

Continued requirement to meet efficiency targets is likely to impact upon the delivery of some key programmes in the foreseeable future.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. During the development of the 2015/16 Business Plan, the service was required to undertake a risk assessment of all key service objectives with high risks included in the Directorate Risk Register.

As a result, monitoring of all relevant 'high' risks will be undertaken and progress reported against the application of the risk treatment measures in Quarters 2 and 4.

Progress against high priority equality actions

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

6.0 Performance Overview

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

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q2 Progress
CCC1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **March 2017** (AOF 4) **(KEY)**	✓

CCC1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **March 2017** (AOF 4) **(KEY)**	✓
CCC1	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **March 2017** (AOF 4) **(KEY)**	✓
CCC1	The Homelessness Strategy be kept under annual review to determine if any changes or updates are required. **March 2017. (AOF 4, AOF 18) (KEY)**	✓
CCC2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **March 2017 (AOF 21)**	✓
CCC3	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Groups, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **March 2017 (AOF 21 & 25)**	✓

Supporting Commentary

CCC1 Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder

We have recently completed the Department of Health Autism Self-Assessment Framework and this will lead to a revised and improved strategy.
There is now an agreed way forward across children and adult services to improve transition processes and hence outcomes for young people and their families.

CCC1 - Continue to implement the Local Dementia Strategy, to ensure effective services are in place

Quarter 2 saw the publication of the Dementia Chapter of the Older People's JSNA , the contents of which will help shape the refresh of the Dementia Delivery Plan (Scheduled Q3/4). During Q2 the roll out of the Age Well Community Memory Screening training for front line staff from across a arrange of partner organisations has taken place. With 40+ professionals and vol/community sector participants having undertaken the training.
Progress is being made with the implementation of the START intervention for dementia carers, with Halton Carers centre agreeing to undergo the necessary training to be able to deliver the intervention as part of their 'offer' to dementia carers. Support from Halton Positive Behaviour Support Service (who undertook the pilot) and training is scheduled to take place during Q4, with the intervention being available from January 2017.
The Halton Dementia Action Alliance held an end of life and advanced care planning event to raise awareness amongst people living with dementia, families, carers, voluntary sector and professionals of the dementia specialist support available locally.
Work is ongoing with GP practices and care homes in relation to the dementia diagnosis rate, which currently stands at 69.1%. Halton CCG aspiration is to achieve 75%, but changes in the way that the diagnosis rate is calculated (only counting those aged over 65) has meant that the overall diagnosis rate for Halton has appeared to drop. The Later Life and Memory Service Care Home Liaison Team have been undertaking screening in Care Homes to identify those who are living with a dementia, but without a diagnosis, and practices are supported to undergo data cleansing exercises to identify those who have been uncoded on the dementia register.

CCC1 - Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems

Early in 2016, a detailed review across the whole 5Boroughs footprint was published; this review considered the various care pathways for adults with mental health problems and older people with memory loss, and made a number of proposals for change. Various work streams are taking place both locally and across the 5Boroughs, and the Council is working with the Clinical Commissioning Group and the 5Boroughs to ensure that the recommendations are delivered.

CCC1 - The Homelessness Strategy be kept under annual review to determine if any changes or updates are required

The homeless strategy action plan is reviewed annually, to ensure it reflects economical and legislative changes / trends. The homeless forum will take place December 2016 and the action plan will be updated.

The homeless strategy will be fully reviewed June 2017 to determine LA priorities for next five years.

CCC2 – Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this

During Q2 Healthwatch engaged with over 390 people. There were **2334 visits** to the website in quarter 2; an **8% increase** on the same period in 2015. Three 'Enter & View' visits have taken place to local care homes. From these visits themes are emerging around Hospital Discharge and medication issues. Widnes Academy (Halebank) became the first school to gain Healthwatch School accreditation. Healthwatch has also met with local CQC inspectors to find the best way of sharing the intelligence HW Halton gathers on NHS and social care services; gathered intelligence with other local Healthwatch and Healthwatch England to feed in to an upcoming review on delays in Social Care Assessments; worked with Umbrella Halton (BME) on arranging an annual 'Hello Halton' event at Riverside College for ESOL Students, and held discussions around support of Asylum Seekers, based in Widnes on arrival.

CCC3 - Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.

Work continues on the further alignment of system and services across Health and Adult Social Care in line with the associated project brief previously approved by Halton Borough Council, NHS and Halton Clinical Commissioning Group.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q2 Actual	Q2 Progress	Direction of travel
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	3.21	3.00	3.10	✓	↑
CCC 4	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6).	0	0	0	✓	↑
CCC 5	Number of households living in Temporary Accommodation (Previously NI 156, CCC 7).	15	17	2	✓	↑
CCC 6	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	5.1	5.5	0.76	✓	↑

Supporting Commentary

CCC3 - Adults with mental health problems helped to live at home per 1,000 population

This continues to be a challenging target, because a reconfiguration within the 5Boroughs reduced the numbers of people who could be counted in this cohort. The work to develop new care pathways into and out of long term care should increase the numbers however.

CCC4 - The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years

The Authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients.
The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC5 - Number of households living in Temporary Accommodation
Trends indicate a National and Local Increase in homelessness. This will have an impact upon future service provision, including temporary accommodation placements. The changes in the TA process and amended accommodation provider contracts, including the mainstay assessment , has had a positive impact upon the level of placements. The Housing Solutions Team takes a proactive approach to preventing homelessness. There are established prevention measures in place and that the Housing Solutions team fully utilise, and continue to promote all service options available to clients. The emphasis is focused on early intervention and empowerment to promote independent living and lifestyle change.

CCC6 - Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)
The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention.
The officers now have a range of resources and options to offer clients threatened with homelessness and strive to improve service provision across the district. Due to the early intervention and proactive approach, the officers have continued to successfully reduce homelessness within the district

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q2 Progress
PA 1	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21 & 25**) **March 2017** **(KEY)**	✓
PA 1	*Integrate frontline services with community nursing (AOF 2, 4, & 21)* ***March 2017***	✓
PA 1	Monitor the Care Act implementation (AOF 2,4, 10, 21) ***NEW*** **(KEY)**	✓
PA 1	Develop an integrated approach to the delivery of Health and Wellbeing across Halton (AOF 2, 4, 21) **March 2017**	✓
PA 2	Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets. **March 2017.** (AOF 2, AOF 3 & AOF 4)	✓

Supporting Commentary

PA 1 - Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target
Budget position at quarter 2 reflects increased pressure on the Better Care Fund in respect of supporting people with complex needs and the national mandated, but as yet unfunded, increase in the NHS funded component of nursing home admissions.

PA 1 - Integrate frontline services with community nursing
Key development this quarter is the development of system wide information sharing agreements and promising indications that Halton will receive regional NHS information technology grants that will make the joining together of information technology systems easier

PA 1 - Monitor the Care Act implementation
Quarterly review continues to monitor activity in respect of the Care Act duties and responsibilities.

PA 1 - Develop an integrated approach to the delivery of Health and Wellbeing across Halton
Integrated approach is now in place.

PA2 - Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets.
The 'Making it Real' action plan continues to be delivered. The use of personal budgets continues to increase. There is an ongoing pilot in mental health to increase

direct payments.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q2 Actual	Q2 Progress	Direction of travel
PA 2	Percentage of VAA Assessments completed within 28 days	85% (estimated - further data quality work ongoing to confirm this)	85%	80%	✓	↑
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	97%	95%	96%	✓	⇔

Supporting Commentary

PA 2 - Percentage of VAA Assessments completed within 28 days
We are on track to meet the target for this measure.

PA 6a - Percentage of items of equipment and adaptations delivered within 7 working days
We are on track to meet this target.

Public Health

Key Objectives / milestones

Ref	Milestones	Q2 Progress
PH 01a	Work with PHE to ensure targets for HPV vaccination are maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2017**	✓
PH 01b	Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2017**	✓
PH 01c	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2017**	✗
PH 02a	Facilitate the Healthy Child Programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½	✓

	years and 5 years. **March 2017**	
PH 02b	Maintain the Family Nurse Partnership programme **March 2017**	✓
PH 02c	Facilitate the implementation of the infant feeding strategy action plan. **March 2017**	✓
PH 03a	Expansion of the Postural Stability Exercise Programme. **March 2017**	✓
PH 03b	Review and evaluate the performance of the integrated falls pathway. **March 2017**	✓
PH 04a	Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol. **March 2017**	✓
PH 04b	Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA). **March 2017**	✓
PH 04c	Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support. **March 2017**	✓
PH 05a	Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions).	✓
PH 05b	Implementation of the Suicide Action Plan. **March 2017**	✓

PH 01a **Work with PHE to ensure targets for HPV vaccination are maintained in light of national immunisation Schedule Changes and Service reorganisations**.

No new data since last report.

Initial preliminary results show that first dose HPV vaccination are above 90% target for the year, and dose 2 is almost at target already, despite not being formerly reported until 2017. We will continue to engage with current school nurse providers to support high level delivery.

PH 01b **Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%**.

No new data since last report.

We continue to engage with all partners, to increase local uptake of cancer screening. The Memoradum of Understanding with the Cancer Task Group at Public Health England and Cheshire and Merseyside authorities is making progress and continues to undertake campaigns to raise awareness and attendance, including bowel screening campaigns (in addition to local work), and breast screening collaborations. Other local activities have involved working with local pharmacies around breast screening call and recall, and making contact with people who had missed their appointment, re-engaging with them to book another screening appointment.

PH 01c **Ensure Referral to treatment targets are achieved and minimise all avoidable breaches.**

Individual breaches by hospitals continue to be investigated and analysed so that the root causes for the delays can be assessed and mitigated. 62 day referral is currently below target and it is unlikely that Halton will achieve the 85% target (January 2016 data 79%). Public Health and Halton CCG are currently working with Trusts to improve reporting and system wide assurance. A new Health and Wellbeing Cancer Action Plan is being developed to address system wide issues, which should help develop a system approach to reducing breaches . This will also be a key focus within the development of a regional Cancer Alliance, and part of the STP approach going forward.

PH 02a **Facilitate the Healthy Child Programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years.**

Child development is a priority area for One Halton, and a working group is developing and refreshing an action plan. The commissioned independent report into child development and the outcomes from the themed Ofsted visit have been used to form the framework for the action plan. There are indications of recent improvements in child development (from non published data), and an event is being planned for November, to update stakeholders and engage them in the development of the action plan.

The Health Visiting Service is delivering all the new components of the national Healthy Child Programme, including assessing mothers' emotional health at 6-8 weeks and completing an integrated developmental check at 2-2$^{1/2}$. The early years setting and health visitors share the findings from the development checks to identify any areas of concern, so that services can collaboratively put in place a support package as required. A group is working to further develop the integrated check, improve data sharing and consistency of plans following the check.

The CCG has invested in perinatal mental health, including training of health visitors and community staff to support mothers to bond with their baby and support parents experiencing perinatal mental illness (during pregnancy and immediately after birth). Perinatal pathways are in the process of being agreed, to improve consistency of care.

The new Parent Craft programme (Your Baby and You) is being delivered, and has been well attended, the acceptability and effectiveness of the model is being evaluated.

PH 02b **Maintain the Family Nurse Partnership programme**

Family Nurse Partnership is fully operational with a full caseload.

PH 02c **Facilitate the implementation of the infant feeding strategy action plan**.

The implementation of the infant feeding action plan is underway, with oversight from the Halton Health in the Early Years group.

Breastfeeding support continues to be available across the borough in community and health settings. The infant feeding coordinator and children's centres are working towards achieving BFI (Unicef Baby Friendly Initiative) in the children's centres and are due to be inspected in the summer of 2017, alongside a Bridgewater inspection. This involves training children's centre staff, and auditing their practice.

The team continue to maintain baby welcome premises and are refreshing the Halton Early Years award, which encourages healthy living practices in early years settings, and includes breastfeeding.

PH 03a Expansion of the Postural Stability Exercise Programme.

Key activity this quarter:

- Currently delivering six classes per week, three in both towns, level 1, 2 and 3 (level 1 being for most complex clients). Level 3 classes have become a maintenance class – 'Keep it Moving'. Classes work on a rolling programme with a review every 15 weeks up to 45 weeks in total. This means there has been an increase in classes from the previous level of 2.
- A total of 25 people have been supported through the service in quarter 2.

PH 03b Review and evaluate the performance of the integrated falls pathway.

The review of the falls pathway has been scoped and will be implemented over the next quarter. This will include considering how the pathway works, what restrictions there are, resource issues and overall performance of falls within the borough. An initial benchmarking report is being presented through existing governance structures in quarter 3.

PH 04a Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol

Good progress continues to be made in reducing the number of young people being admitted to hospital due to alcohol. Key activity includes:

- Delivery of alcohol education within local school settings (Healthitude, R U Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Delivery of community based alcohol activity.
- Reviewing and updating the early identification and brief advice (alcohol IBA) training and resources for staff who work with children and young people).
- The launch of the Halton Community Alcohol Partnership which brings together partners to reduce underage drinking and associated antisocial behaviour.
- Working closely with colleagues from Licensing, the Community Safety team, Trading Standards and Cheshire Police to ensure that the local licensing policy helps prevent underage sales and proxy purchasing.

PH 04b Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA)

Work continues to raise awareness among the local community of safe drinking recommendations and to train staff in alcohol identification and brief advice (alcohol IBA). The Chief Medical Officer has recently updated the low risk weekly guidelines (men and women are advised not to regularly drink more than 14 units a week). Work has been undertaken to update resources and communicate this message to the public at events across the borough e.g. the Vintage Rally.

PH 04c Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support

On the first of April 2016, in line with the start of the new 5 year contract for the provision of specialist adult community substance misuse services (including alcohol) in Halton, CRI formally changed their business name to "Change, Grow, Live" (CGL). CGL continue to support individuals with alcohol misuse problems in Halton and support their recovery. During 2015-16 a total of 297 individuals underwent alcohol tratement (58% male, 42% female). A further 176 individuals underwent treatment for alcohol and drug misuse. Performance continues to be good, with outcomes remaining high when compared to national figures:

- Successful alcohol treatment completion rate was 53% locally, compared to 39% nationally (2015/16).
- Individuals leaving alcohol treatment successfully and not returning within 6 months was 52% locally, compared to 38% nationally (2015).

PH 05a **Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions).**

The action plan and activity reports from sub groups are reviewed at the Mental Health Oversight Board.

A review of the Mental Health Strategy and refresh of high level indicators based on new national policy drivers has been completed and approved by the Mental Health Oversight Group. This will be cascaded across subgroups rolled out from October 2016.

PH 05b **Implementation of the Suicide Action Plan.**

The action plan continues to be overseen by the Halton Suicide Partnership group. Activity towards becoming a Suicide Safer Community is underway and a series of training programmes have been rolled out to multiple partners and agencies acorss a multi disciplinary footprint.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q2	Current Progress	Direction of travel
PH LI 01	Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population *Published data based on calendar year, please note year for targets.*	167.0 *(2015)*	176.0 *(2016)*	159.6 *(Q3 2015 – Q2 2016*	✓	↑
PH LI 02	A good level of child development	54.7% *(2014/15)*	54.6% *(2015/16)*	Annual data only	?	↑
PH LI 03	Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition).	3360.0 *(2014/15)*	3294.1 *(2015/16)*	Annual data only	?	↑
PH LI 04	Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population	767.2 *(2014/15)*	808.4	Annual data only	?	?

PH LI 05	Under 18 alcohol-specific admissions Crude Rate, per 100,000 population	51.0 *(12/13 to 14/15)*	55.0	Annual data only	?	N / A
PH LI 06	Self-reported wellbeing: % of people with a low happiness score	11.8% *(2014/15)*	12.4%	Annual data only	?	

Supporting Commentary

PH LI 01 Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population
Data used is rolling annual, based on calendar year of date of death registered.
The rate has seen an improvement up to June 2016 and is on track to hit the 2016 target.

PH LI 02 A good level of child development
2014/15 data saw an improvement. Data used is annual published data; 2015/16 is not yet available.

PH LI 03 Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition)
Data used is annual, published data. 2015/16 data is not yet available.
This will remain the case until a solid source of local data can be attained.

PH LI 04 Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population
No update from previous quarter available.
Provisional alcohol related admission data have shown an increase since last quarter. This trend is reflected across the region and work is being undertaken via the Halton alcohol strategy to reverse this trend (as outlined in section above).

PH LI 05 Under 18 alcohol-specific admissions Crude Rate, per 100,000 population
No update from previous quarter available

PH LI 06 Self-reported wellbeing: % of people with a low happiness score
2014/15 data was similar to 2013/14 data (11.8%). This is based on annual published survey data for Halton residents calculated from the question "Overall, how happy did you feel yesterday?" Respondents answer on a scale of 0 (not at all happy) to 10 (completely happy) and this indicator is a percentage that scored 0-4.

APPENDIX: Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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

Departmental Quarterly Monitoring Report

Directorate: People

Departments: Adult Social Care

Period: Quarter 2 – 1st July 2016 to 30th September 2016

1.0 Introduction

This quarterly monitoring report covers Adult Social Care Services first quarter period up to 30th September 2016. It describes key developments and progress against all objectives and performance indicators for the service.

The way in which symbols have been used to reflect progress is explained within Appendix 4.

2.0 Key Developments

Homelessness

Asylum & Refugee Programme.
The Syrian Refugee Programme is underway and the Merseyside Sub Region has agreed to accommodate 510 refugees, with Halton taking up to 100. All the necessary arrangements are due to be finalised and each authority will agree what services will be commissioned. Liverpool has devised a service specification, which is on the chest, with closing date of 31/10/16. Halton will buy into a number of the services within the spec and form part of the procurement and evaluation process.

Gypsy Traveller Site
The new permanent traveller site is complete and the allocation process is underway. The site is due to officially open 14th November 2016 and a number of pitches have been allocated to priority travellers.
An appeal was lodged however, it was unsuccessful and the original court judgement was upheld. A further verbal appeal has been granted which is due to be heard early November 2016, whereby, a number of pitches will be retained on the new site, pending the appeal decision.

Adult Social Care

Transforming Domiciliary Care

We have carried out a review of domiciliary care in Halton which will support our overall plan to submit a funding application to the National Lottery Commissioning Better Outcomes fund. The application is due for submission by September 22nd and if successful we will be in a position to start implementation within three months. The review so far has allowed us to consider what the current service offers and how it may change in the future, as a result we are in the process of developing a new service specification that will significantly change the way in which we provide care at home. This will include:

- Removing time calls
- Increasing flexibility
- Reducing the number of providers (currently we have 9)
- Assess people for outcomes not just set tasks
- Increase the number of reviews that take place
- Work with the providers to deliver quality of life outcomes, reduce social isolation and improve people's wellbeing

Day Services

'The Route', which opened in November 2015, offers work placement opportunities in a busy food retail and customer service-based setting. It is the newest addition to an interlinked portfolio of some 15 small businesses developed by the service which includes a microbrewery, an ice-cream manufacturing business, high street hairdressers, a pie and confectioners production line amongst fruit and veg producers and small poultry farm. Service users often experience work across a range of our businesses developing transferable skill and broadening experience. Used as part of a progression programme for service users the outlet acts as a stepping stone to enhance skills already gained across other services. The synergy between the ventures is well reasoned with The Route sells soups and cake slabs made at the kitchens in Oakmeadow Community Support Centre, cupcakes produced by the Independent Living Centre, and the ice cream manufactured through Community Services at Norton Priory.

The Community Multi-Disciplinary Team Model

A number of legislative and policy developments have contributed to the development of the community multi-disciplinary approach in Halton, further integrating health and social care in the borough. One of the schemes outlined within Halton's Better Care Fund is in relation to the continued developed of Integrated Health and Social Care Teams which 'aims to deliver high quality, effective and efficient assessment, care and support planning for people with a wide range of health and social care needs'. In Halton, we have held a dedicated Steering group with membership across health and social care developing a new model for Multi-Disciplinary Team working, which is now ready to be implemented.

The model for Community MDTs in Halton consists of staff from several different professional backgrounds, including GPs, Social Workers, Community Care Workers District Nurses, Social Care in Practice (SCiP) workers, Community Matrons, Continuing Health Care Nurses, and Wellbeing Officers, who are able to respond to people who require the help of more than one kind of professional. The MDT will work in an integrated way, aligned to GP practices.

The model works with four GP Hubs: Widnes North, Widnes South, Runcorn West and Runcorn East. Each Hub has clusters of GP surgeries. Each GP surgery has its own MDT, are working with an identified GP patient population. The model promotes the MDT have dedicated meetings to look at unplanned admissions to hospital and at complex cases. Referrals can be taken daily and directed to the relevant professionals in the MDT.

Mental Health Services

Review of the 5Boroughs Acute Care Pathway and Later Life and Memory Services: following the in-depth review of the way in which the Acute Care Pathway is delivered in relation to adults with severe mental illnesses, and of the delivery of services for people with memory deficiencies, work has been continuing both locally and across the footprint of the 5Boroughs to put in place the recommendations of the review. In Halton, two groups are in place which are looking at the ways to improve the discharge to primary care services of people whose mental health is such that they no longer need secondary care services, but also to ensure that processes for referral and acceptance into secondary care are smooth and effective.

As a part of the delivery of the review recommendations, the 5Boroughs have redesigned their management structure, so that each local area is supported by senior managers within the Trust, and local services relate much more to the local population. This is allowing for much greater involvement of the 5Boroughs in local strategic planning and operational groups.

Across the wider footprint of the 5Boroughs, work has taken place to improve the way that services are delivered for people with personality disorders and/ or chaotic and high risk lives. The Trust's bed base has been reviewed, and proposals for change have now been submitted to the Health Policy and Performance Board in Halton.

Direct Payments in Mental Health: work has been taking place in Halton to improve the uptake of direct payments for people with mental health problems. Direct payments give people much greater control over their daily lives and help to build self-esteem, coping skills and self-confidence. However, in common with much of the rest of the country, it has been hard to achieve a high uptake of direct

payments for this group of people. A new service is now in place, delivered by Halton Disability Partnership, which works directly with people with complex mental health problems to support and encourage them to take up the offer of direct payments. From a baseline of 23 people, there are now 35 people with mental health needs who now receive a direct payment for their care and support. Further redesign of the care pathway (see above) is expected to lead to an increase in these figures.

3.0 Emerging Issues

Adult Social Care

Domiciliary Care
The current domiciliary care market is under pressure. There have been a number of issues that have contributed to an increase in the current waiting times for packages of care to be picked up. These include:

- Low levels of staff recruitment
- Low numbers of car drivers making certain parts of the borough more difficult to cover
- Increased overheads with the implementation of the National Living Wage.
- Pressures faced from neighbouring authorities.

We are working proactively with all of the senior management teams of each of the nine providers to find solutions to the outstanding packages. Meetings are taking place on a fortnightly basis and a number of solutions are already being explored.

Mental Health Services
Social Work for Better Mental Health: this national programme is designed to bring clarity to the work of social workers within mental health services. In partnership with Sefton Council, Halton is an early implementer of the programme, which is intended to focus the work of social workers within mental health Trusts, to ensure that their professional skills are best used. A detailed local self-assessment is taking place, which will be used to reshape the delivery of mental health social work in this area.

People with complex mental health conditions who are placed out of borough: there are a number of people with complex mental health needs and high levels of disruptive and risky behaviour who have been placed in specialist facilities out of borough (often some distance away) because local services have been unable to meet their needs. Work is going on between the Council, the Clinical Commissioning Group and the 5Boroughs to look at the needs of these people and decide whether some of them can now be more appropriately supported locally, as their condition has improved. Although there are some people who will need this level of specialist support for an indefinite period, it is clear that some are now ready to return to their own neighbourhoods and be near their families and networks again. Work is therefore taking place to ensure that this happens, by providing them with the appropriate levels of care and support locally.

Serious Incidents in mental health: since the end of July 2016, there has been an increase in the number of serious incidents relating to people with mental health needs in the borough. A multiagency group, led by the Clinical Commissioning Group and the Halton Safeguarding Adults Board, is co-ordinating a detailed programme of review and analysis of each of these cases, to find out whether there

are any lessons to be learned and changes to local systems which might be required.

4.0 Service Objectives/Milestones

4.1 Progress Against Objectives/Milestones

Total	✓	?	✗

Appendix 1

5.0 Performance Indicators

5.1 Progress Against Performance Indicators

Total	✓	?	✗

Appendix 2

6.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. During the development of the 2015/16 Business Plan, the service was required to undertake a risk assessment of all key service objectives with high risks included in the Directorate Risk Register.

7.0 Progress Against High Priority Equality Actions

The Council must have evidence that it reviews its services and policies to show that they comply with the Public Sector Equality Duty (PSED) which came into force in April 2011. The PSED also requires us to publish this information as it is available.

As a result of undertaking a departmental Equality Impact Assessment no high priority actions were identified for the service for the period 2014 – 2015.

8.0 Data Quality Statement

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

9.0 Appendices

Appendix 1 Progress Against Objectives/Milestones

Appendix 2 Progress Against Performance Indicators

Appendix 3 Financial Statement

Appendix 4 Explanation of Use of Symbols

Appendix 1: Progress against objectives/milestones

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

Milestones	Progress Q2	Supporting Commentary
Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21 & 25**) **March 2017** **(KEY)**	✓	Budget position at quarter 2 reflects increased pressure on the Better Care Fund in respect of supporting people with complex needs and the national mandated, but as yet unfunded, increase in the NHS funded component of nursing home admissions.
Integrate frontline services with community nursing (AOF 2, 4, & 21) ***March 2017***	✓	Key development this quarter is the development of system wide information sharing agreements and promising indications that Halton will receive regional NHS information technology grants that will make the joining together of information technology systems easier.
Monitor the Care Act implementation (AOF 2,4, 10, 21) ***NEW*** **(KEY)**	✓	Quarterly review continues to monitor activity in respect of the Care Act duties and responsibilities.
Develop an integrated approach to the delivery of Health and Wellbeing across Halton (AOF 2, 4, 21) ***March 2017***	✓	Integrated approach is now in place.
Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **March 2017** (AOF 21)	✓	During Q2 Healthwatch engaged with over 390 people. There were **2334 visits** to the website in quarter 2; an **8% increase** on the same period in 2015. Three 'Enter & View' visits have taken place to local care homes. From these visits themes are emerging around Hospital Discharge and medication issues. Widnes Academy (Halebank)

Appendix 1: Progress against objectives/milestones

		became the first school to gain Healthwatch School accreditation. Healthwatch has also met with local CQC inspectors to find the best way of sharing the intelligence HW Halton gathers on NHS and social care services; gathered intelligence with other local Healthwatch and Healthwatch England to feed in to an upcoming review on delays in Social Care Assessments; worked with Umbrella Halton (BME) on arranging an annual 'Hello Halton' event at Riverside College for ESOL Students, and held discussions around support of Asylum Seekers, based in Widnes on arrival.

Appendix 1: Progress against objectives/milestones

Ref	Objective
Service Objective: PA 2	Continue to effectively monitor the quality of services that are commissioned and provided in the borough for adult social care service users and their carers

Milestones	Progress Q2	Supporting Commentary
Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets. ***March 2017*** *(AOF 2, AOF 3 & AOF 4)*	✓	The 'Making it Real' action plan continues to be delivered. The use of personal budgets continues to increase. New social work assessment documentation has been developed to bring this process fully in line with the Care Act while supporting the ongoing emphasis on use of personalised services. This will be introduced with an expanded suite of training around the care act and "asset" based assessment and support planning for all social work staff.

Appendix 1: Progress against objectives/milestones

Ref	Objective
CCC 1	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care needs

Milestones	Progress Q2	Supporting Commentary
Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **March 2017.** (AOF 4) **(KEY)**		We have recently completed the Department of Health Autism Self-Assessment Framework and this will lead to a revised and improved strategy. There is now an agreed way forward across children and adult services to improve transition processes and hence outcomes for young people and their families.
Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **March 2017.** (AOF 4) **(KEY)**		Quarter 2 saw the publication of the Dementia Chapter of the Older People's JSNA , the contents of which will help shape the refresh of the Dementia Delivery Plan (Scheduled Q3/4). During Q2 the roll out of the Age Well Community Memory Screening training for front line staff from across a arrange of partner organisations has taken place. With 40+ professionals and vol/community sector participants having undertaken the training. Progress is being made with the implementation of the START intervention for dementia carers, with Halton Carers centre agreeing to undergo the necessary training to be able to deliver the intervention as part of their 'offer' to dementia carers. Support from Halton Positive Behaviour Support Service (who undertook the pilot) and training is scheduled to take place during Q4, with the intervention being available from January 2017. The Halton Dementia Action Alliance held an end of life and

Appendix 1: Progress against objectives/milestones

		advanced care planning event to raise awareness amongst people living with dementia, families, carers, voluntary sector and professionals of the dementia specialist support available locally. Work is ongoing with GP practices and care homes in relation to the dementia diagnosis rate, which currently stands at 69.1%. Halton CCG aspiration is to achieve 75%, but changes in the way that the diagnosis rate is calculated (only counting those aged over 65) has meant that the overall diagnosis rate for Halton has appeared to drop. The Later Life and Memory Service Care Home Liaison Team have been undertaking screening in Care Homes to identify those who are living with a dementia, but without a diagnosis, and practices are supported to undergo data cleansing exercises to identify those who have been uncoded on the dementia register.
Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **March 2017** (AOF 4) **(KEY)**	✓	Early in 2016, a detailed review across the whole 5Boroughs footprint was published; this review considered the various care pathways for adults with mental health problems and older people with memory loss, and made a number of proposals for change. Various work streams are taking place both locally and across the 5Boroughs, and the Council is working with the Clinical Commissioning Group and the 5Boroughs to ensure that the recommendations are delivered.
The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **March 2017** (AOF 4, AOF 18) **(KEY)**	✓	The homeless strategy action plan is reviewed annually, to ensure it reflects economical and legislative changes / trends. The homeless forum will take place December 2016 and the action plan will be updated. The homeless strategy will be fully reviewed June 2017 to determine LA priorities for next five years.

Appendix 1: Progress against objectives/milestones

Ref	Objective
CCC 2	Effectively consult and engage with people who have Complex Care needs to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required

Milestones	Progress Q2	Supporting Commentary
Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **March 2017** (AOF 21)	✓	During Q2 Healthwatch engaged with over 390 people. There were **2334 visits** to the website in quarter 2; an **8% increase** on the same period in 2015. Three 'Enter & View' visits have taken place to local care homes. From these visits themes are emerging around Hospital Discharge and medication issues. Widnes Academy (Halebank) became the first school to gain Healthwatch School accreditation. Healthwatch has also met with local CQC inspectors to find the best way of sharing the intelligence HW Halton gathers on NHS and social care services; gathered intelligence with other local Healthwatch and Healthwatch England to feed in to an upcoming review on delays in Social Care Assessments; worked with Umbrella Halton (BME) on arranging an annual 'Hello Halton' event at Riverside College for ESOL Students, and held discussions around support of Asylum Seekers, based in Widnes on arrival.

Appendix 1: Progress against objectives/milestones

Ref	Objective
CCC 3	Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs

Milestones	Progress Q2	Supporting Commentary
Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **March 2017** (AOF 21 & 25)	✓	Work continues on the further alignment of system and services across Health and Adult Social Care in line with the associated project brief previously approved by Halton Borough Council, NHS and Halton Clinical Commissioning Group.

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
PA 2	Percentage of VAA Assessments completed within 28 days	85% (estimated – further data quality work ongoing to confirm this)	85%	80%	✓	↑	We are on track to meet the target for this measure.
PA 3	**PLACEHOLDER: Outcome focussed measure on Safeguarding** *(New Indicator)*						
PA 4	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	87.4%	80%	92.31%	✓	↑	We have exceeded the target set for this year. Performance has improved considerably compared to the same period last year which reported 85%
PA 5	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-learning, in the last 3 years	43%	52%	45%	✓	↑	We are currently exceeding the position achieved last year and we are continuing to work to exceed the target by the end of the year

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	97%	95%	96%	✓	⇔	We are on track to meet this target.
PA11	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ (ASCOF 2Aii, Previously PA 12 [13/14]) *Better Care Fund performance metric*	541.7%	637.3	208.9	?	↓	As at the end of quarter 2 we have placed 45 clients into permanent residential / nursing care. For the same period in 2015/16 we had placed 53 clients.
PA 12	Delayed transfers of care (delayed days) from hospital (average per month) *Better Care Fund performance metric*	2475	236 per month	406	?	N/A	The Q2 figure is for July only and is well above target. The Q2 will be subject to change in both October and November when the August and September data is released, so the Q2 figure will not be final until the new year.

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	15231 v plan 16668 (Feb 16)		1524 V target 1509 (July)	?		The CCG has queried a large increase in the number of non-elective admissions witnessed at Warrington Hospital this year (+30%) this has not been seen in the number of A&E attendances and it believed that the new ambulatory care unit at Warrington hospital may be having an adverse impact on the number of non-elective admissions.
PA 15	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric*	685.1	TBC	N/A	N/A	N/A	The performance data is only being collected on an annual basis, the next date that data will be available is May 2017

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	3.21	3.00	3.10	✓	↑	This continues to be a challenging target, because a reconfiguration within the 5Boroughs reduced the numbers of people who could be counted in this cohort. The work to develop new care pathways into and out of long term care should increase the numbers however.
CCC 4	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years	0	0	0	✓	↑	The Authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients. The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 5	Number of households living in Temporary Accommodation (Previously NI 156)	15	17	2			Trends indicate a National and Local Increase in homelessness. This will have an impact upon future service provision, including temporary accommodation placements. The changes in the TA process and amended accommodation provider contracts, including the mainstay assessment , has had a positive impact upon the level of placements The Housing Solutions Team takes a proactive approach to preventing homelessness. There are established prevention measures in place and that the Housing Solutions team fully utilise, and continue to promote all service options available to clients. The emphasis is focused on early intervention and empowerment to promote independent living and lifestyle change.

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 6	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	5.1	5.5	**0.76**			The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention. The officers now have a range of resources and options to offer clients threatened with homelessness and strive to improve service provision across the district. Due to the early intervention and proactive approach, the officers have continued to successfully reduce homelessness within the district

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Adult Social Care Outcomes Framework Indicators The following indicators are reported annually and derived from the Adult Social Care Survey and Adult Social Care Combined Activity return. Finalised statutory return information for the past year is normally available by Quarter 1 of the next financial year.							
Quality							
PA 16	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B(1)	63.3%	65%	N/A	N/A	N/A	
PA 19	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)	70%	68%	N/A	N/A	N/A	

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Quality							
CCC 13	Social Care-related Quality of life (ASCOF 1A) (Previously CCC 16)	19.0%	20%	N/A	N/A		Data generated from annual adult social care survey. The next survey will be run in early 2017
CCC 14	The proportion of people who use services who have control over their daily life (ASCOF 1B) (Previously CCC 17)	77.7%	80%	N/A	N/A		Data generated from annual adult social care survey. The next survey will be run in early 2017
CCC 15	Carer reported Quality of Life (ASCOF 1D)	8.1% (14/15)	9.0%	N/A	N/A		Data is generated from biennial carers survey. The next survey will be run in 2017.
CCC 16	Overall satisfaction of carers with social services (ASCOF 3B)	48.9% (14/15)	50%	N/A	N/A		Measure is generated from biennial carers survey. The next survey will be run in 2017.

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 17	The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C)	78.8%	80%	N/A	N/A		Measure is generated from biennial carers survey. The next survey will be run in 2017.
CCC 18	Overall satisfaction of people who use services with their care and support (ASCOF 3A)	69%	70%	N/A	N/A		Measure is generated from annual adult social care survey. The next survey will be run in early 2017.

Appendix 2: Progress against performance indicators

Ref	Description	Actual 2015/16	Target 2016/17	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Sustainable Community Strategy Area Partner Indicators							
CCC 19 SCS SH7a	Increase the percentage of successful completions (drugs) as a proportion of all treatment (over 18)	29.7%	Above NW Average	**24.0%** **(Jul 15 – Jun 16)**	✓	↓	Successful completions (according to the NDTMS website) show good progress against the national (15.2%) and North West (17.8%) averages. The Halton percentage has decreased from the same period the previous year (31%).
CCC 20 SCS SH8a	Reduce the number of individuals re-presenting within 6 months of discharge	14.3%	Above NW Average	**6.7%** **(Jun 16)**	✓	↑	Re-presentations within 6 months (according to the NDTMS website) are lower compared to the national (10.9%) and North West (9.9%) averages. The Halton percentage has decreased since the previous period last year (11.4%).

Appendix 3 Financial Statements

ADULT SOCIAL SERVICES & PREVENTION AND ASSESSMENT DEPARTMENT

Revenue Budget as at 30th September 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,921	3,753	3,699	54
Other Premises	80	34	45	(11)
Supplies & Services	400	182	187	(5)
Aids & Adaptations	113	14	14	0
Transport	18	14	14	0
Food Provision	28	13	13	0
Other Agency	23	3	0	3
Contribution to Complex Care Pool	18,692	6,678	6,826	(148)
Total Expenditure	**27,275**	**10,691**	**10,798**	**(107)**
Income				
Fees & Charges	-306	-151	-149	(2)
Reimbursements & Grant Income	-212	-145	-141	(4)
Transfer from Reserves	-1,168	-34	-34	0
Capital Salaries	-111	-55	-55	0
Government Grant Income	-137	-137	-137	0
Total Income	**-1,934**	**-522**	**-516**	**(6)**
Net Operational Expenditure	**25,341**	**10,169**	**10,282**	**(113)**
Recharges				
Premises Support	389	186	186	0
Central Support Services	1,874	889	889	0
Internal Recharge Income	-1,284	-637	-637	0
Transport Recharges	29	13	11	2
Net Total Recharges	**1,008**	**451**	**449**	**2**
Net Department Expenditure	**26,349**	**10,620**	**10,731**	**(111)**

Comments on the above figures:

In overall terms, the Net Department Expenditure for the second quarter of the financial year is £37,000 under budget profile excluding the Complex Care Pool.

Appendix 3 Financial Statements

Employee costs are currently showing £54,000 under budget profile. This is due to savings being made on vacancies within the department. Some of these vacancies have been advertised and have been or are expected to be filled in the coming months. However, if not appointed to, the current underspend will continue to increase beyond this level.

Other Premises expenditure is £11,000 over budget profile. This is a result of expenditure on maintenance and repairs for Independent Living equipment which includes approximately 403 stair lifts, 18 thru floor/wheelchair lifts and 84 ceiling track hoists requiring an annual service and potentially repairs. For quarter two, the cost included 174 visits to properties, an increase of 52 visits on the first quarter. This increase has placed additional pressure on the budget. However, alternative funding is currently under investigation.

Capital Projects as at 30th September 2016

	2016-17 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Upgrade PNC (Telehealthcare Lifeline System)	100	50	45	55
Community Meals Oven	10	0	0	10
Total	**110**	**50**	**45**	**65**

Comments on the above figures:

Work is ongoing with the PNC upgrade. Hardware has been purchased and the contractor is liaising with the council to start the build. Completion is expected within the next six months.

The purchase of the Community Meals oven is expected to take place within the financial year, with spend to match the capital allocation.

Appendix 3 Financial Statements

COMPLEX CARE POOL

Revenue Budget as at 30th September 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	4,196	1,366	1,314	52
End of Life	192	74	97	(23)
Sub Acute	1,727	800	792	8
Urgent Care Centres	815	48	48	0
Joint Equipment Store	847	157	115	42
Contracts & SLA's	987	354	382	(28)
Intermediate Care Beds	596	298	339	(41)
BCF Schemes	1754	651	651	0
Adult Care:				
Residential & Nursing Care	21,695	9,402	9,149	253
Domiciliary & Supported Living	9,403	4,712	5,153	(441)
Direct Payments	5,284	2,849	3,297	(448)
Day Care	437	140	161	(21)
Carers Breaks	431	230	230	0
Meals on Wheels	227	106	98	8
Frailty Pathway	155	0	0	0
Contingency	518	0	0	0
Total Expenditure	49,264	21,187	21,826	(639)
Income				
Residential & Nursing Income	-5,059	-2,200	-2,533	333
Community Care Income	-1,840	-701	-659	(42)
Meals on Wheels Income	-245	-102	-76	(26)
Direct Payments Income	-254	-98	-180	82
BCF	-9,491	-4,745	-4,745	0
CCG Contribution to Pool	-12,846	-6,423	-6,423	0
Other CCG income	-114	-59	-56	(3)
ILF Grant	-723	-181	-181	0
Liability as per Joint Working Agreement	0	0	-147	147
Total Income	-30,572	-14,509	-15,000	491
Net Department Expenditure	**18,692**	**6,678**	**6,826**	**(148)**

Appendix 3 Financial Statements

Comments on the above figures:

The overall net department budget is £148,000 over budget profile at the end of the second financial quarter.

Intermediate Care Services includes spend for the Therapy & Nursing Teams, Rapid Access Rehabilitation and Reablement.

End of Life is over budget profile by £23,000 at the mid-point of the year, the year-end position is expected to be approximately £40,000 over budget. This is due to more hours of care being provided than originally agreed in the contract.

Intermediate Care Beds includes payments for 6 extra beds. Use of these beds was stepped down during the first quarter and ended in June therefore there will be no further spend on these, hence the reduction in the overspend from quarter one.

The Adult Health and Social Care budget is currently £284,000 over budget profile, which is a substantial increase from quarter one. This is due to an increase in short term residential respite, short term direct payments and adult placements where domiciliary providers were not able to provide a service.

In addition to these changes the Free Nursing Care rate has increased from April 2016 by 40%, from £112 to £156.25. This amounts to £350,000 additional costs for the current financial year, however to date no additional funding has yet been received from the Department of Health.

The total number of clients receiving a permanent residential care package decreased by 1.7% during the first half of the financial year, from 592 clients in April to 582 clients in September. However, the average cost of a permanent residential package of care increased from £557 to £581 for the same period.

The total number of clients receiving a domiciliary package of care reduced by 2.5% during the first half of the financial year, from 807 clients in April to 787 clients in September. However, the average cost of a domiciliary care package increased from £235 to £236 in the same period.

The total number of clients receiving a Direct Payment (DP) increased by 10.1% during the first half of the year, from 444 clients in April to 489 clients in September. The average cost of a DP package reduced from £271 to £254 for the same period.

Carers Breaks and Meals on Wheels have now been incorporated into the Pooled Budget. Work is ongoing to realign the Adult Heath and Social Care budget in line with projected spend patterns and this will be completed during the next financial year.

Due to the volatile nature of the Adult Health and Social Care budget and the current pressures being experienced, steps are being taken to identify underspends in other areas to bring down spending so that it is back in line with budget and a balanced budget can be achieved.

Appendix 3 Financial Statements

Capital Projects as at 30th September 2016

	2016-17 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	635	315	190	445
Stair lifts (Adaptations Initiative)	250	125	164	86
RSL Adaptations (Joint Funding)	200	100	96	104
Madeline McKenna Residential Home	450	0	0	450
Total	**1,535**	**540**	**450**	**1,085**

Comments on the above figures:

Total capital funding consists of £1,378,000 Disabled Facilities Grant (DFG) for 2016/17, and £157,000 DFG funding carried forward from 2015/16, to fund ongoing expenditure. The allocation of the funding between DFGs, Stair Lifts and RSL adaptations will be reviewed during the year, and may be reallocated between these projects depending on demand. It is anticipated, however, that total spend on these three projects can be contained within the overall capital allocation.

The £450,000 earmarked for the purchase of the Madeline McKenna residential home includes an allowance for the refurbishment of the premises.

Appendix 3 Financial Statements

COMMISSIONING & COMPLEX DEPARTMENT

Revenue Budget as at 30th September 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance to Date** (Overspend) £'000
Expenditure				
Employees	6,282	3,120	3,047	73
Other Premises	243	129	139	(10)
Supplies & Services	342	176	190	(14)
Other Agency Costs	620	297	295	2
Transport	190	95	77	18
Contracts & SLAs	151	87	89	(2)
Emergency Duty Team	94	47	48	(1)
Payments To Providers	3,031	1,024	1,024	0
Total Expenditure	**10,953**	**4,975**	**4,909**	**66**
Income				
Sales & Rents Income	-198	-130	-147	17
Fees & Charges Income	-232	-116	-77	(39)
Reimbursements & Other Grant Income	-492	-181	-190	9
CCG Contribution To Service	-360	-133	-86	(47)
Transfer From Reserves	-1,351	0	0	0
Total Income	**-2,633**	**-560**	**-500**	**-60**
Net Operational Expenditure	**8,320**	**4,415**	**4,409**	**6**
Recharges				
Premises Support	236	118	118	0
Transport	390	195	214	(19)
Central Support Services	1,088	521	521	0
Internal Recharge Income	-649	-269	-269	0
Net Total Recharges	**1,065**	**565**	**584**	**(19)**
Net Department Expenditure	**9,385**	**4,980**	**4,993**	**(13)**

Appendix 3 Financial Statements

Comments on the above figures

Net departmental expenditure is currently £13,000 above budget profile at the end of the second quarter of the financial year.

Employee costs are currently £73,000 below budget profile. This results from savings made on vacant posts above the targeted staff savings level of £300,000. The majority of these savings have been made within Day Services and Mental Health Services. Most of these posts were recruited to in the first two quarters of the financial year, and it is not anticipated that the level of savings above target will continue for the remainder of the year.
Premises expenditure is currently running above budget profile by £10,000. This budget will be monitored carefully during the year, given that the winter months will bring additional pressures on utility costs, and remedial action will be taken if necessary to ensure a balanced budget at year-end.

Income for the year to date is less than the budgeted income target. The income above target in relation to sales and rents relates to trading services provided by Day Services, which continue to perform well. However, income from charging service users for transport costs is significantly below target, resulting in a projected under-achievement of Fees and Charges income in the region of £60,000 for the year. Income received from the Clinical Commissioning Group also remains a concern. This income relates to Continuing Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user's care packages. The shortfall is currently projected to be £90,000 for the year.

At this stage in the financial year, it is anticipated that net spend for the year will be in excess of the annual budget by approximately £25,000.

Capital Projects as at 30th September 2016

Capital Expenditure	2016/17 Capital Allocation £'000	Allocation to Date £'000	Actual Spend £'000	Total Allocation Remaining £'000
ALD Bungalows	299	0	0	299
Bredon Reconfiguration	356	7	7	349
Grangeway Court Refurbishment	343	200	193	150
Community Capacity Grant	57	0	0	57
Total Capital Expenditure	**1,055**	**207**	**200**	**855**

Comments on the above figures.

Building work on the ALD Bungalows is expected to be completed within the financial year, with spend to match allocation.

The Bredon Reconfiguration project is funded from previous year's Adult Social Care capital grant. Spend for the year is anticipated to be within the capital allocation.

Work to refurbish Grangeway Court is currently underway, and it is expected that the works will be completed within the calendar year. At this stage in is anticipated that total expenditure will remain within the capital allocation.

The Community Capacity Grant allocation represents unspent grant funding from previous financial years, which is available to fund new capital projects, or augment existing capital allocations.

Appendix 4 Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 2: 1st April to 30th September 2016

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the second quarter of 2016/17 for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Adult Social Care (including housing operational areas)
- Public Health

2.0 Key Developments

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

Homelessness

Asylum & Refugee Programme.
The Syrian Refugee Programme is underway and the Merseyside Sub Region has agreed to accommodate 510 refugees, with Halton taking up to 100. All the necessary arrangements are due to be finalised and each authority will agree what services will be commissioned. Liverpool has devised a service specification, which is on the chest, with closing date of 31/10/16. Halton will buy into a number of the services within the spec and form part of the procurement and evaluation process.

Gypsy Traveller Site
The new permanent traveller site is complete and the allocation process is underway. The site is due to officially open 14th November 2016 and a number of pitches have been allocated to priority travellers.
An appeal was lodged however, it was unsuccessful and the original court judgement was upheld. A further verbal appeal has been granted which is due to be heard early November 2016, whereby, a number of pitches will be retained on the new site, pending the appeal decision.

Adult Social Care

Transforming Domiciliary Care
We have carried out a review of domiciliary care in Halton which will support our overall plan to submit a funding application to the National Lottery Commissioning Better Outcomes fund. The application is due for submission by September 22nd and if successful we will be in a position to start implementation within three months. The review so far has allowed us to consider what the current service offers and how it may change in the future, as a result we are in the process of developing a new service specification that will significantly change the way in which we provide care at home. This will include:

- Removing time calls
- Increasing flexibility

- Reducing the number of providers (currently we have 9)
- Assess people for outcomes not just set tasks
- Increase the number of reviews that take place
- Work with the providers to deliver quality of life outcomes, reduce social isolation and improve people's wellbeing

Day Services
'The Route', which opened in November 2015, offers work placement opportunities in a busy food retail and customer service-based setting. It is the newest addition to an interlinked portfolio of some 15 small businesses developed by the service which includes a microbrewery, an ice-cream manufacturing business, high street hairdressers, a pie and confectioners production line amongst fruit and veg producers and small poultry farm. Service users often experience work across a range of our businesses developing transferable skill and broadening experience (see Roberta's Journey).
Used as part of a progression programme for service users the outlet acts as a stepping stone to enhance skills already gained across other services. The synergy between the ventures is well reasoned with The Route sells soups and cake slabs made at the kitchens in Oakmeadow Community Support Centre, cupcakes produced by the Independent Living Centre, and the ice cream manufactured through Community Services at Norton Priory.

The Community Multi-Disciplinary Team Model
A number of legislative and policy developments have contributed to the development of the community multi-disciplinary approach in Halton, further integrating health and social care in the borough. One of the schemes outlined within Halton's Better Care Fund is in relation to the continued developed of Integrated Health and Social Care Teams which 'aims to deliver high quality, effective and efficient assessment, care and support planning for people with a wide range of health and social care needs'. In Halton, we have held a dedicated Steering group with membership across health and social care developing a new model for Multi-Disciplinary Team working, which is now ready to be implemented.

The model for Community MDTs in Halton consists of staff from several different professional backgrounds, including GPs, Social Workers, Community Care Workers District Nurses, Social Care in Practice (SCiP) workers, Community Matrons, Continuing Health Care Nurses, and Wellbeing Officers, who are able to respond to people who require the help of more than one kind of professional. The MDT will work in an integrated way, aligned to GP practices.

The model works with four GP Hubs: Widnes North, Widnes South, Runcorn West and Runcorn East. Each Hub has clusters of GP surgeries. Each GP surgery has its own MDT, are working with an identified GP patient population. The model promotes the MDT have dedicated meetings to look at unplanned admissions to hospital and at complex cases. Referrals can be taken daily and directed to the relevant professionals in the MDT.

Mental Health Services
<u>Review of the 5Boroughs Acute Care Pathway and Later Life and Memory Services:</u> following the in-depth review of the way in which the Acute Care Pathway is delivered in relation to adults with severe mental illnesses, and of the delivery of services for people with memory deficiencies, work has been continuing both locally and across the footprint of the 5Boroughs to put in place the recommendations of the review. In Halton, two groups are in place which are looking at the ways to improve the discharge to primary

care services of people whose mental health is such that they no longer need secondary care services, but also to ensure that processes for referral and acceptance into secondary care are smooth and effective.

As a part of the delivery of the review recommendations, the 5Boroughs have redesigned their management structure, so that each local area is supported by senior managers within the Trust, and local services relate much more to the local population. This is allowing for much greater involvement of the 5Boroughs in local strategic planning and operational groups.
Across the wider footprint of the 5Boroughs, work has taken place to improve the way that services are delivered for people with personality disorders and/ or chaotic and high risk lives. The Trust's bed base has been reviewed, and proposals for change have now been submitted to the Health Policy and Performance Board in Halton.

Direct Payments in Mental Health: work has been taking place in Halton to improve the uptake of direct payments for people with mental health problems. Direct payments give people much greater control over their daily lives and help to build self-esteem, coping skills and self-confidence. However, in common with much of the rest of the country, it has been hard to achieve a high uptake of direct payments for this group of people. A new service is now in place, delivered by Halton Disability Partnership, which works directly with people with complex mental health problems to support and encourage them to take up the offer of direct payments. From a baseline of 23 people, there are now 35 people with mental health needs who now receive a direct payment for their care and support. Further redesign of the care pathway (see above) is expected to lead to an increase in these figures.

PUBLIC HEALTH

Mindfulness Programme
A mindfulness programme has been put to tender and has been sucessfully awarded. The programme will deliver mindfullness training and awareness programme across a schools setting with the aim to improve mental health and wellbing and contribute towards improved personal resilience in school aged children.

World Mental Health Day
Halton Borough Council celebrated World Mental Health Day on Monday 10 October with a conference and social event for residents and local professionals to inform and entertain. There were owls, dancers, bands and discussion groups.
The conference at Riverside College (Centre Stage, Kingsway) was attended by over 100 people and tied in with the theme of 'Building a Mentally Healthier Halton' - an ongoing theme for the Health Improvement Team.

150 local residents also attended the 'feel good' social event in the evening at The Studio in Lacey Street, Widnes. Performers included SJ Pure Dance, Hearts and Voices Choir and poet Clive Little.
The events were a partnership with Riverside College and The Studio, with support across local services and teams including health, education, housing and police, with the aim of finding ways to make people healthier and happier.

National Recovery Walk
Halton was proud to host the National Recovery Walk, organised by Public Health and the commisioned substance misuse service provider CGL. More that 7,000 people took part in the walk across Halton on Saturday 9th September to raise awareness of the seriousness of addiction and celebrate recovery.

Vintage Rally Health Engagement
Health Improvement Team (HIT) supported the Vintage Rally on 24th & 25th September held in Victoria Park in Widnes. The team undertook various health engagement opportunities including make your own smoothie, involving people in healthy eating and importance of '5 a day' messages, alongside a physical activity message – making smoothies in a blender by powering it with pedal power on a bike. The HIT engaged 531 in the health marquee with a further 160 people involved in cancer awareness through the information iVan which was specially commissioned for the event.

3.0 Emerging Issues

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

Adult Social Care

Domiciliary Care
The current domiciliary care market is under a certain level of pressure. There have been a number of issues that have contributed to an increase in the current waiting times for packages of care to be picked up. These include:

- Low levels of staff recruitment
- Low numbers of car drivers making certain parts of the borough more difficult to cover
- Increased overheads with the implementation of the National Living Wage.
- Pressures faced from neighbouring authorities.

We are working proactively with all of the senior management teams of each of the nine providers to find solutions to the outstanding packages. Meetings are taking place on a fortnightly basis and a number of solutions are already being explored.

Mental Health Services
Social Work for Better Mental Health: this national programme is designed to bring clarity to the work of social workers within mental health services. In partnership with Sefton Council, Halton is an early implementer of the programme, which is intended to focus the work of social workers within mental health Trusts, to ensure that their professional skills are best used. A detailed local self-assessment is taking place, which will be used to reshape the delivery of mental health social work in this area.

People with complex mental health conditions who are placed out of borough: there are a number of people with complex mental health needs and high levels of disruptive and risky behaviour who have been placed in specialist facilities out of borough (often some distance away) because local services have been unable to meet their needs. Work is going on between the Council, the Clinical Commissioning Group and the 5Boroughs to look at the needs of these people and decide whether some of them can now be more appropriately supported locally, as their condition has improved. Although there are some people who will need this level of specialist support for an indefinite period, it is clear that

some are now ready to return to their own neighbourhoods and be near their families and networks again. Work is therefore taking place to ensure that this happens, by providing them with the appropriate levels of care and support locally.

Serious Incidents in mental health: since the end of July 2016, there has been an increase in the number of serious incidents relating to people with mental health needs in the borough. A multiagency group, led by the Clinical Commissioning Group and the Halton Safeguarding Adults Board, is co-ordinating a detailed programme of review and analysis of each of these cases, to find out whether there are any lessons to be learned and changes to local systems which might be required.

PUBLIC HEALTH

Continued requirement to meet efficiency targets is likely to impact upon the delivery of some key programmes in the foreseeable future.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2016/17 Directorate Business Plans.

5.0 Progress against high priority equality actions

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

6.0 Performance Overview

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

"Rate per population" vs "Percentage" to express data

Four BCF KPIs are expressed as rates per population. "Rates per population" and "percentages" are both used to compare data but each expresses the same amount in a different way. A common guide used is that if a percent is less than 0.1 then a rate (e.g. per 100,000) is used. For example, permanent admissions to residential care expressed as a rate (50 admissions per or for every 100,000 people) makes more sense when comparing performance with other authorities rather than as a percentage (0.05%) which is quite a small number and could be somewhat confusing. More examples below:

Location	Rate per 100,000 population	Percent
Region A	338.0	0.34%
Region B	170.5	0.17%
Region C	225.6	0.23%

Prevention and Assessment Services **Key Objectives / milestones**

Ref	Milestones	Q2 Progress
PA 1	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21, 25) March 2017**	✓
PA 1	Integrate frontline services with community nursing (AOF 2, 4, & 21) **March 2017**	✓

Supporting Commentary

PA 1 - Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target
Budget position at quarter 2 reflects increased pressure on the Better Care Fund in respect of supporting people with complex needs and the national mandated, but as yet unfunded, increase in the NHS funded component of nursing home admissions.

PA 1 - Integrate frontline services with community nursing
Key development this quarter is the development of system wide information sharing agreements and promising indications that Halton will receive regional NHS information technology grants that will make the joining together of information technology systems easier

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q2 Actual	Q2 Progress	Direction of travel
PA 2	Percentage of VAA Assessments completed within 28 days	85% (estimated - further data quality work ongoing to confirm this)	85%	80%	✓	↑
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	97%	95%	96%	✓	⇔
PA 11	Permanent Admissions to residential and nursing care homes per 100,000 population,65+ (ASCOF 2A1) *Better Care Fund performance metric*	541.7%	637.3	208.9	?	↓
PA 12	Delayed transfers of care (delayed days) from hospital (average	2475	236 per month	406	?	N/A

Ref	Measure	15/16 Actual	16/17 Target	Q2 Actual	Q2 Progress	Direction of travel
	per month) *Better Care Fund performance metric*					
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	15231 V plan 16668 (Feb 16)		1524 V target 1509 (July)	?	
PA 15	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric*	685.1	TBC	N/A	N/A	N/A
PA 16	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B1) *Better Care Fund performance metric*	63.3	Data published for 15/16, figures have remained stable from 14/15. This is an annual collection figures for 16/17 will be available late 2017			
PA 20	Do care and support services help to have a better quality of life? (ASC survey Q 2b) *Better Care Fund performance metric*	93.3	Data published for 15/16, figures have remained stable from previous years. This is an annual collection figures for 16/17 will be available late 2017			

Supporting Commentary

PA 2 - Percentage of VAA Assessments completed within 28 days
We are on track to meet the target for this measure.

PA 6a - Percentage of items of equipment and adaptations delivered within 7 working days
We are on track to meet this target.

PA 11 - Permanent Admissions to residential and nursing care homes per 100,000 population,65+
As at the end of quarter 2 we have placed 45 clients into permanent residential / nursing

care. For the same period in 2015/16 we had placed 53 clients.

PA 12 - Delayed transfers of care (delayed days) from hospital per 100,000 population
The Q2 figure is for July only and is well above target. The Q2 will be subject to change in both October and November when the August and September data is released, so the Q2 figure will not be final until the new year.

PA 14 - Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population
The CCG has queried a large increase in the number of non-elective admissions witnessed at Warrington Hospital this year (+30%) this has not been seen in the number of A&E attendances and it believed that the new ambulatory care unit at Warrington hospital may be having an adverse impact on the number of non-elective admissions.

PA 15 - Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+)

The performance data is only being collected on an annual basis, the next date that data will be available is May 2017

PA 16 - Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
Annual Collection

PA 20 - Do care and support services help to have a better quality of life?
Annual Collection

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q2 Progress
CCC 1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **March 2017** (AOF 4)	✓
CCC 1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **March 2017** (AOF 4)	✓
CCC 1	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **March 2017** (AOF 4)	✓
CCC 1	The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **March 2017** (AOF 4, AOF 18)	✓
CCC2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **March 2017** (AOF 21)	✓
CCC3	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **March 2017** (AOF 21 & 25)	✓

Supporting Commentary

CC1 - **Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder**

We have recently completed the Department of Health Autism Self-Assessment Framework and this will lead to a revised and improved strategy. There is now an agreed way forward across children and adult services to improve transition processes and hence outcomes for young people and their families.

CC1 - Continue to implement the Local Dementia Strategy, to ensure effective services are in place

Quarter 2 saw the publication of the Dementia Chapter of the Older People's JSNA , the contents of which will help shape the refresh of the Dementia Delivery Plan (Scheduled Q3/4).

During Q2 the roll out of the Age Well Community Memory Screening training for front line staff from across a arrange of partner organisations has taken place. With 40+ professionals and vol/community sector participants having undertaken the training.

Progress is being made with the implementation of the START intervention for dementia carers, with Halton Carers centre agreeing to undergo the necessary training to be able to deliver the intervention as part of their 'offer' to dementia carers. Support from Halton Positive Behaviour Support Service (who undertook the pilot) and training is scheduled to take place during Q4, with the intervention being available from January 2017.

The Halton Dementia Action Alliance held an end of life and advanced care planning event to

raise awareness amongst people living with dementia, families, carers, voluntary sector and professionals of the dementia specialist support available locally.
Work is ongoing with GP practices and care homes in relation to the dementia diagnosis rate, which currently stands at 69.1%. Halton CCG aspiration is to achieve 75%, but changes in the way that the diagnosis rate is calculated (only counting those aged over 65) has meant that the overall diagnosis rate for Halton has appeared to drop. The Later Life and Memory Service Care Home Liaison Team have been undertaking screening in Care Homes to identify those who are living with a dementia, but without a diagnosis, and practices are supported to undergo data cleansing exercises to identify those who have been uncoded on the dementia register.

CC1 - Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems
Early in 2016, a detailed review across the whole 5Boroughs footprint was published; this review considered the various care pathways for adults with mental health problems and older people with memory loss, and made a number of proposals for change. Various work streams are taking place both locally and across the 5Boroughs, and the Council is working with the Clinical Commissioning Group and the 5Boroughs to ensure that the recommendations are delivered.

CC1 - The Homelessness strategy be kept under annual review to determine if any changes or updates are required
The homeless strategy action plan is reviewed annually, to ensure it reflects economical and legislative changes / trends. The homeless forum will take place December 2016 and the action plan will be updated.
The homeless strategy will be fully reviewed June 2017 to determine LA priorities for next five years.

CC2 – Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this
During Q2 Healthwatch engaged with over 390 people. There were **2334 visits** to the website in quarter 2; an **8% increase** on the same period in 2015. Three 'Enter & View' visits have taken place to local care homes. From these visits themes are emerging around Hospital Discharge and medication issues. Widnes Academy (Halebank) became the first school to gain Healthwatch School accreditation. Healthwatch has also met with local CQC inspectors to find the best way of sharing the intelligence HW Halton gathers on NHS and social care services; gathered intelligence with other local Healthwatch and Healthwatch England to feed in to an upcoming review on delays in Social Care Assessments; worked with Umbrella Halton (BME) on arranging an annual 'Hello Halton' event at Riverside College for ESOL Students, and held discussions around support of Asylum Seekers, based in Widnes on arrival.

CC3 - Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.
Work continues on the further alignment of system and services across Health and Adult Social Care in line with the associated project brief previously approved by Halton Borough Council, NHS and Halton Clinical Commissioning Group.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q2 Actual	Q2 Progress	Direction of travel
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	3.21	3.00	3.10	✓	↑
CCC 4	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6).	0	0	0	✓	↑
CCC 5	Number of households living in Temporary Accommodation (Previously NI 156, CCC 7).	15	17	2	✓	↑
CCC 6	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	5.1	5.5	0.76	✓	↑

Supporting Commentary

CCC3 - Adults with mental health problems helped to live at home per 1,000 population

This continues to be a challenging target, because a reconfiguration within the 5Boroughs reduced the numbers of people who could be counted in this cohort. The work to develop new care pathways into and out of long term care should increase the numbers however.

CCC4 - The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years

The Authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients.

The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring

authorities.

CCC5 - Number of households living in Temporary Accommodation
Trends indicate a National and Local Increase in homelessness. This will have an impact upon future service provision, including temporary accommodation placements. The changes in the TA process and amended accommodation provider contracts, including the mainstay assessment , has had a positive impact upon the level of placements. The Housing Solutions Team takes a proactive approach to preventing homelessness. There are established prevention measures in place and that the Housing Solutions team fully utilise, and continue to promote all service options available to clients. The emphasis is focused on early intervention and empowerment to promote independent living and lifestyle change.

CCC6 - Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)
The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention.
The officers now have a range of resources and options to offer clients threatened with homelessness and strive to improve service provision across the district. Due to the early intervention and proactive approach, the officers have continued to successfully reduce homelessness within the district

Public Health

Key Objectives / milestones

Ref	Milestones	Q2 Progress
PH 01a	Work with PHE to ensure targets for HPV vaccinations are maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2017**	✓
PH 01b	Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2017**	✓
PH 01c	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2017**	✗
PH 02a	Facilitate the Healthy Child Programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2017**	✓
PH 02b	Maintain the Family Nurse Partnership programme **March 2017**	✓
PH 02c	Facilitate the implementation of the infant feeding strategy action plan. **March 2017**	✓
PH 03a	Expansion of the Postural Stability Exercise Programme. **March 2017**	✓

PH 03b	Review and evaluate the performance of the integrated falls pathway. **March 2017**	✓
PH 04a	Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol. **March 2017**	✓
PH 04b	Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA). **March 2017**	✓
PH 04c	Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support. **March 2017**	✓
PH 05a	Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions).**March 2017**	✓
PH 05b	Implementation of the Suicide Action Plan. **March 2017**	✓

PH 01a **Work with PHE to ensure targets for HPV vaccinations are maintained in light of national immunisation Schedule Changes and Service reorganisations**.

No new data since last report.

Initial preliminary results show that first dose HPV vaccination are above 90% target for the year, and dose 2 is almost at target already, despite not being formerly reported until 2017. We will continue to engage with current school nurse providers to support high level delivery.

PH 01b **Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%**.

No new data since last report.

We continue to engage with all partners, to increase local uptake of cancer screening. The Memoradum of Understanding with the Cancer Task Group at Public Health England and Cheshire and Merseyside authorities is making progress and continues to undertake campaigns to raise awareness and attendance, including bowel screening campaigns (in addition to local work), and breast screening collaborations. Other local activities have involved working with local pharmacies around breast screening call and recall, and making contact with people who had missed their appointment, re-engaging with them to book another screening appointment.

PH 01c **Ensure Referral to treatment targets are achieved and minimise all avoidable breaches.**

Individual breaches by hospitals continue to be investigated and analysed so that the root causes for the delays can be assessed and mitigated. 62 day referral is currently below target and it is unlikely that Halton will achieve the 85% target (January 2016 data 79%). Public Health and Halton CCG are currently working with Trusts to improve reporting and system wide assurance. A new Health and Wellbeing Cancer Action Plan is being developed to address system wide issues, which should help develop a system approach to reducing breaches . This will also be a key focus within the

development of a regional Cancer Alliance, and part of the STP approach going forward.

PH 02a Facilitate the Healthy Child Programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years.

Child development is a priority area for One Halton, and a working group is developing and refreshing an action plan. The commissioned independent report into child development and the outcomes from the themed Ofsted visit have been used to form the framework for the action plan. There are indications of recent improvements in child development (from non published data), and an event is being planned for November, to update stakeholders and engage them in the development of the action plan.

The Health Visiting Service is delivering all the new components of the national Healthy Child Programme, including assessing mothers' emotional health at 6-8 weeks and completing an integrated developmental check at 2-$2^{1/2}$. The early years setting and health visitors share the findings from the development checks to identify any areas of concern, so that services can collaboratively put in place a support package as required. A group is working to further develop the integrated check, improve data sharing and consistency of plans following the check.

The CCG has invested in perinatal mental health, including training of health visitors and community staff to support mothers to bond with their baby and support parents experiencing perinatal mental illness (during pregnancy and immediately after birth). Perinatal pathways are in the process of being agreed, to improve consistency of care. The new Parent Craft programme (Your Baby and You) is being delivered, and has been well attended, the acceptability and effectiveness of the model is being evaluated.

PH 02b Maintain the Family Nurse Partnership programme

Family Nurse Partnership is fully operational with a full caseload.

PH 02c Facilitate the implementation of the infant feeding strategy action plan.

The implementation of the infant feeding action plan is underway, with oversight from the Halton Health in the Early Years group.

Breastfeeding support continues to be available across the borough in community and health settings. The infant feeding coordinator and children's centres are working towards achieving BFI (Unicef Baby Friendly Initiative) in the children's centres and are due to be inspected in the summer of 2017, alongside a Bridgewater inspection. This involves training children's centre staff, and auditing their practice.

The team continue to maintain baby welcome premises and are refreshing the Halton Early Years award, which encourages healthy living practices in early years settings, and includes breastfeeding.

PH 03a Expansion of the Postural Stability Exercise Programme.

Key activity this quarter:

- Currently delivering six classes per week, three in both towns, level 1, 2 and 3 (level 1 being for most complex clients). Level 3 classes have become a maintenance class – 'Keep it Moving'. Classes work on a rolling programme with a review every 15 weeks up to 45 weeks in total. This means there has been an increase in classes from the previous level of 2.
- A total of 25 people have been supported through the service in quarter 2.

PH 03b Review and evaluate the performance of the integrated falls pathway.

The review of the falls pathway has been scoped and will be implemented over the

next quarter. This will include considering how the pathway works, what restrictions there are, resource issues and overall performance of falls within the borough. An initial benchmarking report is being presented through existing governance structures in quarter 3.

PH 04a Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol

.

Good progress continues to be made in reducing the number of young people being admitted to hospital due to alcohol. Key activity includes:

- Delivery of alcohol education within local school settings (Healthitude, R U Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Delivery of community based alcohol activity.
- Reviewing and updating the early identification and brief advice (alcohol IBA) training and resources for staff who work with children and young people).
- The launch of the Halton Community Alcohol Partnership which brings together partners to reduce underage drinking and associated antisocial behaviour.
- Working closely with colleagues from Licensing, the Community Safety team, Trading Standards and Cheshire Police to ensure that the local licensing policy helps prevent underage sales and proxy purchasing.

PH 04b Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA)

Work continues to raise awareness among the local community of safe drinking recommendations and to train staff in alcohol identification and brief advice (alcohol IBA). The Chief Medical Officer has recently updated the low risk weekly guidelines (men and women are advised not to regularly drink more than 14 units a week). Work has been undertaken to update resources and communicate this message to the public at events across the borough e.g. the Vintage Rally.

PH 04c Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support

On the first of April 2016, in line with the start of the new 5 year contract for the provision of specialist adult community substance misuse services (including alcohol) in Halton, CRI formally changed their business name to “Change, Grow, Live” (CGL). CGL continue to support individuals with alcohol misuse problems in Halton and support their recovery. During 2015-16 a total of 297 individuals underwent alcohol tratement (58% male, 42% female). A further 176 individuals underwent treatment for alcohol and drug misuse. Performance continues to be good, with outcomes remaining high when compared to national figures:

- Successful alcohol treatment completion rate was 53% locally, compared to 39% nationally (2015/16).
- Individuals leaving alcohol treatment successfully and not returning within 6 months was 52% locally, compared to 38% nationally (2015).

PH 05a Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions).

The action plan and activity reports from sub groups are reviewed at the Mental Health Oversight Board.

A review of the Mental Health Strategy and refresh of high level indicators based on

new national policy drivers has been completed and approved by the Mental Health Oversight Group. This will be cascaded across subgroups rolled out from October 2016.

PH 05b Implementation of the Suicide Action Plan.

The action plan continues to be overseen by the Halton Suicide Partnership group. Activity towards becoming a Suicide Safer Community is underway and a series of training programmes have been rolled out to multiple partners and agencies acorss a multi disciplinary footprint.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q2	Current Progress	Direction of travel
PH LI 01	Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population *Published data based on calendar year, please note year for targets.*	167.0 *(2015)*	176.0 *(2016)*	159.6 *(Q3 2015 – Q2 2016*	✓	↑
PH LI 02	A good level of child development	54.7% *(2014/15)*	54.6% *(2015/16)*	Annual data only	?	↑
PH LI 03	Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition).	3360.0 *(2014/15)*	3294.1 *(2015/16)*	Annual data only	?	↑
PH LI 04	Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population	767.2 *(2014/15)*	808.4	Annual data only	?	↓
PH LI 05	Under 18 alcohol-specific admissions Crude Rate, per 100,000 population	51.0 *(12/13 to 14/15)*	55.0	Annual data only	?	N / A
PH LI 06	Self-reported wellbeing: % of people with a low happiness score	11.8% *(2014/15)*	12.4%	Annual data only	?	↑

Supporting Commentary

PH LI 01 Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population
Data used is rolling annual, based on calendar year of date of death registered.
The rate has seen an improvement up to June 2016 and is on track to hit the 2016 target.

PH LI 02 A good level of child development
2014/15 data saw an improvement. Data used is annual published data; 2015/16 is not yet available.

PH LI 03 Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition)
Data used is annual, published data. 2015/16 data is not yet available.
This will remain the case until a solid source of local data can be attained.

PH LI 04 Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population
No update from previous quarter available.
Provisional alcohol related admission data have shown an increase since last quarter. This trend is reflected across the region and work is being undertaken via the Halton alcohol strategy to reverse this trend (as outlined in section above).

PH LI 05 Under 18 alcohol-specific admissions Crude Rate, per 100,000 population
No update from previous quarter available

PH LI 06 Self-reported wellbeing: % of people with a low happiness score
2014/15 data was similar to 2013/14 data (11.8%). This is based on annual published survey data for Halton residents calculated from the question "Overall, how happy did you feel yesterday?" Respondents answer on a scale of 0 (not at all happy) to 10 (completely happy) and this indicator is a percentage that scored 0-4.

APPENDIX 1 – Financial Statements

ADULT SOCIAL SERVICES & PREVENTION AND ASSESSMENT DEPARTMENT

Revenue Budget as at 30th September 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,921	3,753	3,699	54
Other Premises	80	34	45	(11)
Supplies & Services	400	182	187	(5)
Aids & Adaptations	113	14	14	0
Transport	18	14	14	0
Food Provision	28	13	13	0
Other Agency	23	3	0	3
Contribution to Complex Care Pool	18,692	6,678	6,826	(148)
Total Expenditure	**27,275**	**10,691**	**10,798**	**(107)**
Income				
Fees & Charges	-306	-151	-149	(2)
Reimbursements & Grant Income	-212	-145	-141	(4)
Transfer from Reserves	-1,168	-34	-34	0
Capital Salaries	-111	-55	-55	0
Government Grant Income	-137	-137	-137	0
Total Income	**-1,934**	**-522**	**-516**	**(6)**
Net Operational Expenditure	**25,341**	**10,169**	**10,282**	**(113)**
Recharges				
Premises Support	389	186	186	0
Central Support Services	1,874	889	889	0
Internal Recharge Income	-1,284	-637	-637	0
Transport Recharges	29	13	11	2
Net Total Recharges	**1,008**	**451**	**449**	**2**
Net Department Expenditure	**26,349**	**10,620**	**10,731**	**(111)**

Comments on the above figures:

In overall terms, the Net Department Expenditure for the second quarter of the financial year is £37,000 under budget profile excluding the Complex Care Pool.

Employee costs are currently showing £54,000 under budget profile. This is due to savings being made on vacancies within the department. Some of these vacancies have been advertised and have been or are expected to be filled in the coming months. However, if not appointed to, the current underspend will continue to increase beyond this level.

Other Premises expenditure is £11,000 over budget profile. This is a result of expenditure on maintenance and repairs for Independent Living equipment which includes approximately 403 stair lifts, 18 thru floor/wheelchair lifts and 84 ceiling track hoists requiring an annual service and potentially repairs. For quarter two, the cost included 174 visits to properties, an increase of 52 visits on the first quarter. This increase has placed additional pressure on the budget. However, alternative funding is currently under investigation.

Capital Projects as at 30th September 2016

	2016-17 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Upgrade PNC (Telehealthcare Lifeline System)	100	50	45	55
Community Meals Oven	10	0	0	10
Total	**110**	**50**	**45**	**65**

Comments on the above figures:

Work is ongoing with the PNC upgrade. Hardware has been purchased and the contractor is liaising with the council to start the build. Completion is expected within the next six months.

The purchase of the Community Meals oven is expected to take place within the financial year, with spend to match the capital allocation.

COMPLEX CARE POOL

Revenue Budget as at 30th September 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	4,196	1,366	1,314	52
End of Life	192	74	97	(23)
Sub Acute	1,727	800	792	8
Urgent Care Centres	815	48	48	0
Joint Equipment Store	847	157	115	42
Contracts & SLA's	987	354	382	(28)
Intermediate Care Beds	596	298	339	(41)
BCF Schemes	1754	651	651	0
Adult Care:				
Residential & Nursing Care	21,695	9,402	9,149	253
Domiciliary & Supported Living	9,403	4,712	5,153	(441)
Direct Payments	5,284	2,849	3,297	(448)
Day Care	437	140	161	(21)
Carers Breaks	431	230	230	0
Meals on Wheels	227	106	98	8
Frailty Pathway	155	0	0	0
Contingency	518	0	0	0
Total Expenditure	49,264	21,187	21,826	(639)
Income				
Residential & Nursing Income	-5,059	-2,200	-2,533	333
Community Care Income	-1,840	-701	-659	(42)
Meals on Wheels Income	-245	-102	-76	(26)
Direct Payments Income	-254	-98	-180	82
BCF	-9,491	-4,745	-4,745	0
CCG Contribution to Pool	-12,846	-6,423	-6,423	0
Other CCG income	-114	-59	-56	(3)
ILF Grant	-723	-181	-181	0
Liability as per Joint Working Agreement	0	0	-147	147
Total Income	-30,572	-14,509	-15,000	491
Net Department Expenditure	**18,692**	**6,678**	**6,826**	**(148)**

Comments on the above figures:

The overall net department budget is £148,000 over budget profile at the end of the second financial quarter.

Intermediate Care Services includes spend for the Therapy & Nursing Teams, Rapid Access Rehabilitation and Reablement.

End of Life is over budget profile by £23,000 at the mid-point of the year, the year-end position is expected to be approximately £40,000 over budget. This is due to more hours of care being provided than originally agreed in the contract.

Intermediate Care Beds includes payments for 6 extra beds. Use of these beds was stepped down during the first quarter and ended in June therefore there will be no further spend on these, hence the reduction in the overspend from quarter one.

The Adult Health and Social Care budget is currently £284,000 over budget profile, which is a substantial increase from quarter one. This is due to an increase in short term residential respite, short term direct payments and adult placements where domiciliary providers were not able to provide a service.

In addition to these changes the Free Nursing Care rate has increased from April 2016 by 40%, from £112 to £156.25. This amounts to £350,000 additional costs for the current financial year, however to date no additional funding has yet been received from the Department of Health.

The total number of clients receiving a permanent residential care package decreased by 1.7% during the first half of the financial year, from 592 clients in April to 582 clients in September. However, the average cost of a permanent residential package of care increased from £557 to £581 for the same period.

The total number of clients receiving a domiciliary package of care reduced by 2.5% during the first half of the financial year, from 807 clients in April to 787 clients in September. However, the average cost of a domiciliary care package increased from £235 to £236 in the same period.

The total number of clients receiving a Direct Payment (DP) increased by 10.1% during the first half of the year, from 444 clients in April to 489 clients in September. The average cost of a DP package reduced from £271 to £254 for the same period.

Carers Breaks and Meals on Wheels have now been incorporated into the Pooled Budget. Work is ongoing to realign the Adult Heath and Social Care budget in line with projected spend patterns and this will be completed during the next financial year.

Due to the volatile nature of the Adult Health and Social Care budget and the current pressures being experienced, steps are being taken to identify underspends in other areas to bring down spending so that it is back in line with budget and a balanced budget can be achieved.

Capital Projects as at 30th September 2016

	2016-17 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	635	315	190	445
Stair lifts (Adaptations Initiative)	250	125	164	86
RSL Adaptations (Joint Funding)	200	100	96	104
Madeline McKenna Residential Home	450	0	0	450
Total	**1,535**	**540**	**450**	**1,085**

Comments on the above figures:

Total capital funding consists of £1,378,000 Disabled Facilities Grant (DFG) for 2016/17, and £157,000 DFG funding carried forward from 2015/16, to fund ongoing expenditure. The allocation of the funding between DFGs, Stair Lifts and RSL adaptations will be reviewed during the year, and may be reallocated between these projects depending on demand. It is anticipated, however, that total spend on these three projects can be contained within the overall capital allocation.

The £450,000 earmarked for the purchase of the Madeline McKenna residential home includes an allowance for the refurbishment of the premises.

COMMISSIONING & COMPLEX DEPARTMENT

Revenue Budget as at 30th September 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance to Date** (Overspend) £'000
Expenditure				
Employees	6,282	3,120	3,047	73
Other Premises	243	129	139	(10)
Supplies & Services	342	176	190	(14)
Other Agency Costs	620	297	295	2
Transport	190	95	77	18
Contracts & SLAs	151	87	89	(2)
Emergency Duty Team	94	47	48	(1)
Payments To Providers	3,031	1,024	1,024	0
Total Expenditure	**10,953**	**4,975**	**4,909**	**66**
Income				
Sales & Rents Income	-198	-130	-147	17
Fees & Charges Income	-232	-116	-77	(39)
Reimbursements & Other Grant Income	-492	-181	-190	9
CCG Contribution To Service	-360	-133	-86	(47)
Transfer From Reserves	-1,351	0	0	0
Total Income	**-2,633**	**-560**	**-500**	**-60**
Net Operational Expenditure	**8,320**	**4,415**	**4,409**	**6**
Recharges				
Premises Support	236	118	118	0
Transport	390	195	214	(19)
Central Support Services	1,088	521	521	0
Internal Recharge Income	-649	-269	-269	0
Net Total Recharges	**1,065**	**565**	**584**	**(19)**
Net Department Expenditure	**9,385**	**4,980**	**4,993**	**(13)**

Comments on the above figures

Net departmental expenditure is currently £13,000 above budget profile at the end of the second quarter of the financial year.

Employee costs are currently £73,000 below budget profile. This results from savings made on vacant posts above the targeted staff savings level of £300,000. The majority of these savings have been made within Day Services and Mental Health Services. Most of these posts were recruited to in the first two quarters of the financial year, and it is not anticipated that the level of savings above target will continue for the remainder of the year.

Premises expenditure is currently running above budget profile by £10,000. This budget will be monitored carefully during the year, given that the winter months will bring additional pressures on utility costs, and remedial action will be taken if necessary to ensure a balanced budget at year-end.

Income for the year to date is less than the budgeted income target. The income above target in relation to sales and rents relates to trading services provided by Day Services, which continue to perform well. However, income from charging service users for transport costs is significantly below target, resulting in a projected under-achievement of Fees and Charges income in the region of £60,000 for the year. Income received from the Clinical Commissioning Group also remains a concern. This income relates to Continuing Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user's care packages. The shortfall is currently projected to be £90,000 for the year.

At this stage in the financial year, it is anticipated that net spend for the year will be in excess of the annual budget by approximately £25,000.

Capital Projects as at 30th September 2016

Capital Expenditure	2016/17 Capital Allocation £'000	Allocation to Date £'000	Actual Spend £'000	Total Allocation Remaining £'000
ALD Bungalows	299	0	0	299
Bredon Reconfiguration	356	7	7	349
Grangeway Court Refurbishment	343	200	193	150
Community Capacity Grant	57	0	0	57
Total Capital Expenditure	**1,055**	**207**	**200**	**855**

Comments on the above figures.
Building work on the ALD Bungalows is expected to be completed within the financial year, with spend to match allocation.

The Bredon Reconfiguration project is funded from previous year's Adult Social Care capital grant. Spend for the year is anticipated to be within the capital allocation.

Work to refurbish Grangeway Court is currently underway, and it is expected that the works will be completed within the calendar year. At this stage in is anticipated that total expenditure will remain within the capital allocation.

The Community Capacity Grant allocation represents unspent grant funding from previous financial years, which is available to fund new capital projects, or augment existing capital allocations.

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 30th September 2016

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	3,385	1,621	1,564	57
Supplies & Services	265	96	92	4
Other Agency	21	21	16	5
Contracts & SLA's	7,561	3,552	3,550	2
Total Expenditure	**11,232**	**5,290**	**5,222**	**68**
Income				
Other Fees & Charges	-59	-37	-36	(1)
Sales Income	-44	-44	-46	2
Reimbursements & Grant Income	-161	-131	-136	5
Government Grant	-10,718	-2,691	-2,691	0
Transfer from Reserves	-500	0	0	0
Total Income	**-11,482**	**-2,903**	**-2,909**	**6**
Net Operational Expenditure	**-250**	**2,387**	**2,313**	**74**
Recharges				
Premises Support	162	81	82	(1)
Central Support Services	592	226	226	0
Transport Recharges	18	9	8	1
Support Income	-64	0	0	0
Net Total Recharges	**708**	**316**	**316**	**0**
Net Department Expenditure	**458**	**2,703**	**2,629**	**74**

Comments on the above figures:

In overall terms, the Net Department Expenditure for the second quarter of the financial year is £74,000 under budget profile.

Employee costs are currently £57,000 under budget profile. This is due to savings being made on vacancies within both of the Environmental, Public Health & Health Protection and Public Health Divisions. Some of these vacancies have been advertised and are expected to be filled in the coming months. However, if not appointed to, the current underspend will continue to increase beyond this level.

At this point in the financial year, it is expected spend will be within budget at year-end.

Capital Project as at 30th September 2016

Capital Expenditure	2016/17 Capital Allocation £'000	Allocation to Date £'000	Actual Spend £'000	Total Allocation Remaining £'000
Halton Recovery & Wellbeing Project	45	45	45	0
Total Capital Expenditure	**45**	**45**	**45**	**0**

Comments on the above figures.

The Halton Recovery & Wellbeing Project work has been carried out on the physical refurbishment of the Halton Recovery Hub in line with the grant application. The work was completed during July 2016.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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