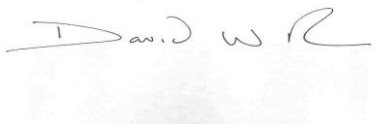
Public Document Pack

Health and Wellbeing Board

Wednesday, 18 January 2017 2.00 p.m.
Karalius Suite, Halton Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 29 March 2017

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 12 October 2016 at Bridge Suite, Halton Select Security Stadium

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and S. Banks, R. Brisley, S. Constable, G. Ferguson, T. Hill, M. Holt, S. Johnson-Griffiths, M. Larkin, A. Marr, A. McIntyre, D. Nolan, D. Parr, R. Patel, C. Samosa, S. Semoff, R. Strachan, T. Tierney, H. Teshome, S. Wallace Bonner and S. Yeoman

Apologies for Absence: Colin Scales, Chief Inspector Fairclough, Marie Sedgewick and Eileen O'Meara

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB11 MINUTES OF LAST MEETING

The Minutes of the meeting held on 6th July 2016 having been circulated were signed as a correct record.

HWB12 PRESENTATION BY JBA CONSULTING: VULNERABLE COMMUNITIES CLIMATE CHANGE AND HEALTH EFFECTS

The Board received a presentation from Rachel Brisley on behalf of JBA Consulting which outlined the company background and current and future climate risks in the UK and in Halton. The presentation also contained information on vulnerable communities and climate change and potential action to address those issues.

On behalf of the Board the Chair thanked Rachel Brisley for her presentation.

RESOLVED: That the presentation be noted.

HWB13 ADULT HEALTH AND SOCIAL CARE – ACCOUNTABLE COMMISSIONING SYSTEM

The Board considered a report of the Director of Adult Social Services, which presented a Project Initiation Document (PID), which outlined a proposal and associated mechanisms of how the further alignment of systems and services across Health and Social Care Services would improve the quality and efficiency of services provided to Adults in Halton.

In Halton, Adult Services had a long history of collaboration and integration. In April 2013 a Joint Working Agreement and associated pooled budget arrangements were introduced between the Council and NHS Halton Clinical Commissioning Group (CCG). Examples of successful Joint Working/Integration in respect of Adult Services were outlined in the report. As the management of the pooled budget had been extremely successful, improving outcomes for individuals, in addition to moving from a position of overspend for both Halton Clinical Commissioning Group and the Council to financial balance, the Council and NHS Halton CCG had entered into a new Joint Working Agreement which ran until 31st March 2019.

It was noted that both organisations believed it was an appropriate time to review current arrangements in place in respect of joint working and aligned organisational structures, leadership and governance arrangements across Adult Social Care and Health, in order to deliver more effectively on the desired outcomes for the residents of Halton. Consequently, a PID had been produced which outlined the aim of the project, rationale expected outcomes and process to be undertaken. A Project Board had also been established to take this forward and had met on a number of occasions. It was anticipated that the model, which would be developed as part of this project, would provide the necessary infrastructures for a sound basis to build upon when moving forward on the integration of front line services and the commissioning of services to support community hubs.

RESOLVED: That the report be noted.

HWB14 TRANSFORMING DOMICILIARY CARE

The Board considered a report of the Director of Adult Social Services, which presented proposed developments in relation to Domiciliary Care delivered through the Council. A review of the current Domiciliary Sector in the Borough had commenced which had led to understanding the key principles at the centre of an outcome based domiciliary

service which included:-

- Moving away from a one size fits all approach;
- Adopting a preventative model;
- Keep people independent;
- Improve quality of life;
- Increase community participation; and
- Improve Health and Wellbeing.

As part of the review there had been engagement with people who use the service and carers. Details on the views expressed were outlined in the report. In addition, an initial meeting with providers, the voluntary sector, social work teams, GPs and CCG colleagues had also been held.

It was clear from the feedback that there was a need for change, too many pressures on times, limited capacity, poor recruitment, financial pressures and waiting lists were concerns.

It was reported that one of the opportunities for new ways of working was a bid to the National Lottery for a Social Impact Bond. The National Lottery had opened up a new funding initiative aimed at Local Authorities developing changes within existing service provision to realise significant improvements in outcomes, both for an individual and financial for health and social care. The application was in three stages and, to date, the Council's bid had been successful at stages 1 and 2 and a full application would be submitted on the 22nd September 2016.

RESOLVED: That the report be noted.

HWB15 SYRIAN REFUGEE RESETTLEMENT HEALTH AND WELLBEING NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided information on the findings and recommendations of a prospective Health and Wellbeing Needs Assessment for the Syrian Refugee Resettlement Programme. The UK Government had committed to resettling 20,000 Syrian refugees over the next five years. The Syrian refugees would be part of the Vulnerable Persons Resettlement Programme and had five years humanitarian protection.

Across the North West, local authorities, including Halton Borough Council, had committed to supporting the Syrian Refugee Resettlement Programme. Liverpool City Council was co-ordinating the Resettlement Programme of

510 refugees on behalf of other local authorities in Merseyside. It was expected that Halton would host 100 of these refugees. The Local Authority would deliver housing provision, initial reception arrangements, casework and orientation support with English for Speakers of Other Language classes, in line with Central Government's Statement of Requirements.

A multi-agency forum had been established with stakeholders in Halton to assess, plan and implement local delivery for the Syrian Resettlement Programme.

The report outlined key issues from the prospective Health and Wellbeing Needs Assessment and also recommendations in respect of housing, health, education and training, employment and language, culture and social connections.

RESOLVED: That

(1) the report be noted; and

(2) the recommendations contained in Section 3.3. be supported.

HWB16 HALTON AFFORDABLE WARMTH STRATEGY 2016/20

The Board considered a report of the Director of Public Health, which provided a background to a new Affordable Warmth Strategy. The Strategy outlined Halton's approach to tackle fuel poverty and living in cold homes over the next five years. It would build upon a wide range of support that the Council and partners already provided for households to address fuel poverty and living in cold homes.

It was reported that in collaboration with other agencies, a vision, objectives, required actions and outcomes to further reduce the harms from living in cold homes in Halton had been agreed. A copy of the Halton Affordable Warmth Strategy 2016/20 had previously been circulated to Members of the Board.

RESOLVED: That

(1) the Affordable Warmth Strategy be approved; and

(2) the implementation of the Action Plan be supported.

HWB17 HEALTH AND WELLBEING BOARD STRATEGY

The Board received an update report on the development of the new One Halton Health and Wellbeing Strategy 2017/2022. The new strategy was being developed using a partnership approach and a multi-agency Health and Wellbeing Steering Group had been established to oversee its development. The Steering Group had used available evidence of health needs to identify issues of particular significance for the Borough. They included:-

- Continue to improve levels of early child development;
- The generally well, focussing on physical activity, healthy eating and alcohol reduction;
- Long term conditions, focussing on heart disease;
- Prevention and early detection of mental health problems and improved access to treatment;
- Ageing well, including falls prevention; and
- Prevention and early detection of cancers and improved access to treatments.

It was reported that success in delivering against the strategy could only be achieved by working in partnership with local people. Therefore, consultation with a wide range of Halton residents to ensure that the principles and priorities were reflective of the experience and needs of the local communities would take place. In addition, consultation would be undertaken by the voluntary sector, Health Watch and One Halton Portfolio Directors using pre-existing networks and forums for engagement. The final version of the One Halton Health and Wellbeing Strategy would be presented to the Board for approval in January 2017.

RESOLVED: That the Board supports the development of the new Strategy.

HWB18 HALTON STRATEGIC PARTNERSHIP RESTRUCTURING

The Board considered an update on the work that had taken place to restructure the Halton Strategic Partnership. On the 2nd March 2016 the Halton Strategic Partnership held a consultation event, attended by over 70 delegates from across the partnership, to discuss a proposed restructuring of the various strategic boards that sat under the partnership banner.

As there was a statutory requirement to have a Health and Wellbeing Board it was considered to merge the Halton Strategic Partnership with the Health and Wellbeing Board under the banner of the Health and Wellbeing Board.

However, it was recognised that it would be important to ensure that within the new expanded role of the Health and Wellbeing Board that it still remained focussed on the wider elements of health and its formal statutory role.

The new structure also saw several of the other Boards being dissolved or combined, with a new Economic Prosperity Board being created whose remit would include some of the areas of responsibility covered by the Liverpool City Region Combined Authority and thus providing a partnership forum for feeding into the wider LCR agendas. A copy of the proposed new partnership arrangements had previously been circulated to the Board

RESOLVED: The report be noted and the revised arrangements be supported.

Meeting ended at 2.50 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 18 January 2017

REPORTING OFFICER: Director of Public Health, Halton Borough Council and Director of Commissioning, Halton CCG

PORTFOLIO: Health and Wellbeing

SUBJECT: One Halton Health and Wellbeing Strategy

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with the draft **One Halton Health and Wellbeing Strategy (2017-2022).**

2.0 RECOMMENDED: That the Board comments on the draft Strategy and supports the development of Action Plans for each priority.

3.0 SUPPORTING INFORMATION

3.1 The One Halton Health and Wellbeing Strategy is an overarching strategy to improve health in Halton. The new Strategy will build upon the successes of the previous strategy and outlines the key priorities the Health and Wellbeing Board will focus on over the next five years (2017-2022). It provides a framework for local action. A set of action plans with timescales and leads are being developed.

3.2 The new Strategy provides:

- An overview of One Halton.
- Principles of how we will work together.
- A joint vision, new priorities and how and why these were chosen,
- An updated health and wellbeing profile for Halton.
- An outline of the progress made since 2013 and the challenges that remain.
- Examples of innovative work already being undertaken within Halton that take a place based approach, working with local people and using local assets e.g. Well North, Healthy New Towns.
- What we will do as a system at scale to make a difference.
- How we will measure success.

3.3 The Strategy has been developed using a partnership approach and was developed by a multi-agency steering group. The group was co-chaired by the Director of Public Health and Director of Commissioning for NHS Halton CCG it included membership from NHS Halton CCG, Health Watch, Halton & St Helens Council for Voluntary Services, HBC Children's Services, HBC Adult Social Care, HBC Public Health and a representative of the public.

3.4 The Strategy recognises that we will only be successful if all partners (including local people) play their part. The Strategy therefore outlines agreed principles of how we will work together. In order to deliver the One Halton Health and Wellbeing Strategy all partners will work in the following ways:

- Engage with and understand the needs of our local communities.
- Intervene early to prevent ill health.
- Early identification and support for clinical conditions.
- Skills developments to ensure people have the confidence to manage their own health and wellbeing.
- Ensure people are at the centre of planning and delivery of services.

3.5 Available evidence of health needs has been used to identify issues of particular significance for the borough. The priorities are backed by a strong evidence base considering the local JSNA, Right Care benchmarks and performance against the range of national and local targets. They include:

- Children and Young People: improved levels of early child development
- Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol
- Long-term Conditions: reduction in levels of heart disease and stroke
- Mental Health: improved prevention, early detection and treatment
- Cancer: reduced level of premature death
- Older People: improved quality of life

3.6 We believe that success in delivering against the Strategy can only be achieved by working in partnership with local people. Therefore, in developing the new Strategy we have consulted with a wide range of Halton residents to ensure that the principles and priorities are reflective of the experience and needs of our local communities. Engagement was undertaken by the voluntary sector, Health Watch and One Halton portfolio directors using pre-existing networks and forums for engagement e.g. Halton Peoples Health Forum. The feedback received has be used to inform the new One Halton Health and Wellbeing Strategy.

3.7 The final version of the Strategy will be shared with all key partners (including local people) and will be available online.

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing Strategy will inform collaborative action for the Council, NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The strategy and its associated action plans will inform future activity and spending across the health and care system. Any financial risk associated with the implementation of these will need to be shared across all relevant organisations. Agencies should work together to seek additional funding where available e.g. bids for external grants.

5.2 It should be noted that these prevention programmes will enable invest to gain in terms of GP time and expense and invest to save in terms of avoidable hospital admissions, time lost at work and social costs.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The Health and Wellbeing Strategy will include child development as a priority.

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Developing the Health and Wellbeing Board Strategy does not present any obvious risk however, there may be risks associated with the resultant

recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

Appendix A: One Halton Health and Wellbeing Strategy

Report Prepared by: Elspeth Anwar
Contact: Elspeth.anwar@halton.gov.uk

One Halton Health and Wellbeing Strategy

2017-2022

Contents

Foreword

Councillor Rob Polhill

Leader of the Council and Chair of the Health and Wellbeing Board

Welcome to our ***One Halton Health and Wellbeing Strategy.***

The new One Halton Health and Wellbeing Strategy 2017 – 2022 is an overarching strategy to improve health in Halton. It has been jointly developed after consultation with Halton Borough Council, NHS Halton Clinical Commissioning Group, the voluntary sector, Community Health Services, Health Watch, the blue light services, housing and local community groups.

Our first Health and Wellbeing Strategy 2013 - 2016 provided us with an excellent platform to take forward our good track record of partnership working. It enabled us to focus extra effort on a few key health challenges for local people. The new strategy seeks to build on this work so improving health is embedded in all our systems and within the local community.

Through the One Halton model, that engages local people and all partners, we propose that we start now to radically change the way we do things so that by 2022 fewer people will be suffering from poor health. Effective prevention and early action can deliver a 'triple dividend' by helping people to stay well and live healthy lives, thus reducing the demand for costly services and creating the conditions for a prosperous economy. We will take a whole systems approach and focus on people and places. We know that people who have jobs, good housing, meaningful activities and are connected to families and community feel, and stay, healthier. We will work at scale to implement evidence based interventions and

mobilise local communities to engage in their own health. We recognise the need to shift services into the community and make use of and build upon community assets.

We will work across the life course with identified and agreed priorities in each age group. As we go through the next five years and achieve our ambitions in those priorities we will then review our strategy and replace that priority with a new one.

With Halton's strong commitment to good health for all, integrated partnership, joint budgets, collaborative design, good quality and innovative services I am sure we can achieve our ambition.

Insert Signature

Cllr Rob Polhill

Executive Summary

Our vision: **One Halton working together to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives**

Our priorities for 2017-2022:

Children and Young People: improved levels of early child development

Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol

Long-term Conditions: reduction in levels of heart disease and stroke

Mental Health: improved prevention, early detection and treatment

Cancer: reduced level of premature death

Older People: improved quality of life

Our priorities contribute to our shared outcomes:

- More Halton children do well at school by reaching a good level of development educationally, socially and emotionally.
- Healthy fit workforce to drive economic prosperity with fewer people suffering long term conditions from the age of 50.
- More people will be supported to stay well and live independently for as long as possible.
- People lead full, active lives using a wide range of facilities within local communities including good quality housing, parks, arts and cultural facilities, leisure services and safe cycling routes.
- Reduced demand on services, improved quality and access.
- More efficient use of financial resources.

Delivering this Strategy

Ultimate responsibility for the implementation of the Strategy lies with the One Halton Health and Wellbeing Board. However, in order to deliver our vision and priorities we need everyone who lives and works in Halton to take an active role. We are passionate about improving the health and wellbeing of people living in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in achieving this goal.

The One Halton Health and Wellbeing Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. It does not replace existing strategies, commissioning plans and programmes, but influences them.

Integration is key to our strategic approach with all partners working together to deliver: joint commissioning, culture change through community development, training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work.

Ultimate responsibility for the monitoring of the implementation of the Strategy lies with the Health and Wellbeing Board who are accountable to the public.

A governance structure and One Halton priority groups will oversee the development and delivery of these priorities. Each group will be responsible for the development of an action plan setting out what all stakeholders will do to deliver the outcomes we want. They will use a life course approach and ensure each action plan includes action to maximise prevention and early intervention, provide high quality treatment based on need and supports people in both the short and long term.

Vision and Priorities

Our vision: Working as one to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives

Our priorities for 2017-2022:

- **Children and Young People: improved levels of early child development**
- **Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol**
- **Long-term Conditions: reduction in levels of heart disease and stroke**
- **Mental Health: improved prevention, early detection and treatment**
- **Cancer: reduced level of premature death**
- **Older People: improved quality of life**




One Halton

The One Halton Health and Wellbeing Strategy is our borough based plan to improve the health and wellbeing local people, their families and communities. This includes all people who live and work in Halton regardless of their age, gender, ethnicity, sexuality or occupation.

Our collective principles are that Halton people live healthy lives in vibrant communities; there is a fundamental change towards people managing their own health through the development of local care organisations that are mostly in the community with hospitals only used for specialist care. Hospitals will work together so everyone can benefit from high standards of specialist care and we will share clinical and non-clinical functions across lots of organisations.

Our purpose is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them. We want to support people to stay well in their homes, in particular to avoid crises of care that can result in hospital admission. General practices will support and empower individuals and communities by promoting prevention, self-care, independence and resilience. We will work with local people and with partner organisations including healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

Through signing up to deliver this One Halton Strategy we are jointly:

- Taking **ownership** of where we are now. We all recognise progress has been made but that there is more work to do.
- Being **responsible** for delivering on the agreed priorities and actions set out within this strategy.
- Making a **commitment** to make things better. For us to be successful all partners in Halton need to play their part including our local people.
- Being **accountable** for developing systems that deliver more joined up approaches to delivering services.

Principles of working together

As outlined we will only be successful in delivering this strategy if all partners (including local people) play their part. We have therefore agreed principles of working together. In order to deliver the One Halton Health and Wellbeing Strategy all partners will work in the following ways:

- Engage with and understand the needs of our local communities.
- Early intervention to prevent ill health.
- Early identification and support for clinical conditions.
- Skills developments to ensure people have the confidence to manage their own health and wellbeing.
- Ensure people are at the centre of planning and delivery of services.

In order to do this we need to:

- Engage with people to better understand their motivation and offer options.
- Work as integrated teams.
- Ensure consistent communications across health and care providers.
- Find or identify those people who do not access care.
- Provide the very best in care, now and in the future.
- Act as advocates for policies that reduce health inequalities.
- Consider the impact of poverty and how this can be tackled.
- Use innovative solutions, such as digital applications, to provide care and information.

These will help us to

- **Build a social movement**
- **Reduce variation in care across the borough and compared to England**
- **Develop a wide range of ongoing community conversations**
- **Reduce unnecessary demand and help focus services on those most in need**
- **Identify and further develop community advocates and champions**
- **Make the most of 'back office' services to increase efficiency**

Building on the success of our first Health and Wellbeing Strategy

In Halton we have a good track record of partnership working to improve health and wellbeing. The Halton Health and Wellbeing Board was established in 2013 and one of its first actions was to develop a Health and Wellbeing Strategy to improve the health of the local population. Halton's first Health and Wellbeing Strategy covered the period 2013 to 2016 and set out the vision for Health and Wellbeing in Halton. The Strategy was the overarching document for the Health and Wellbeing Board outlining the key priorities the Board has focussed on over the past three years.

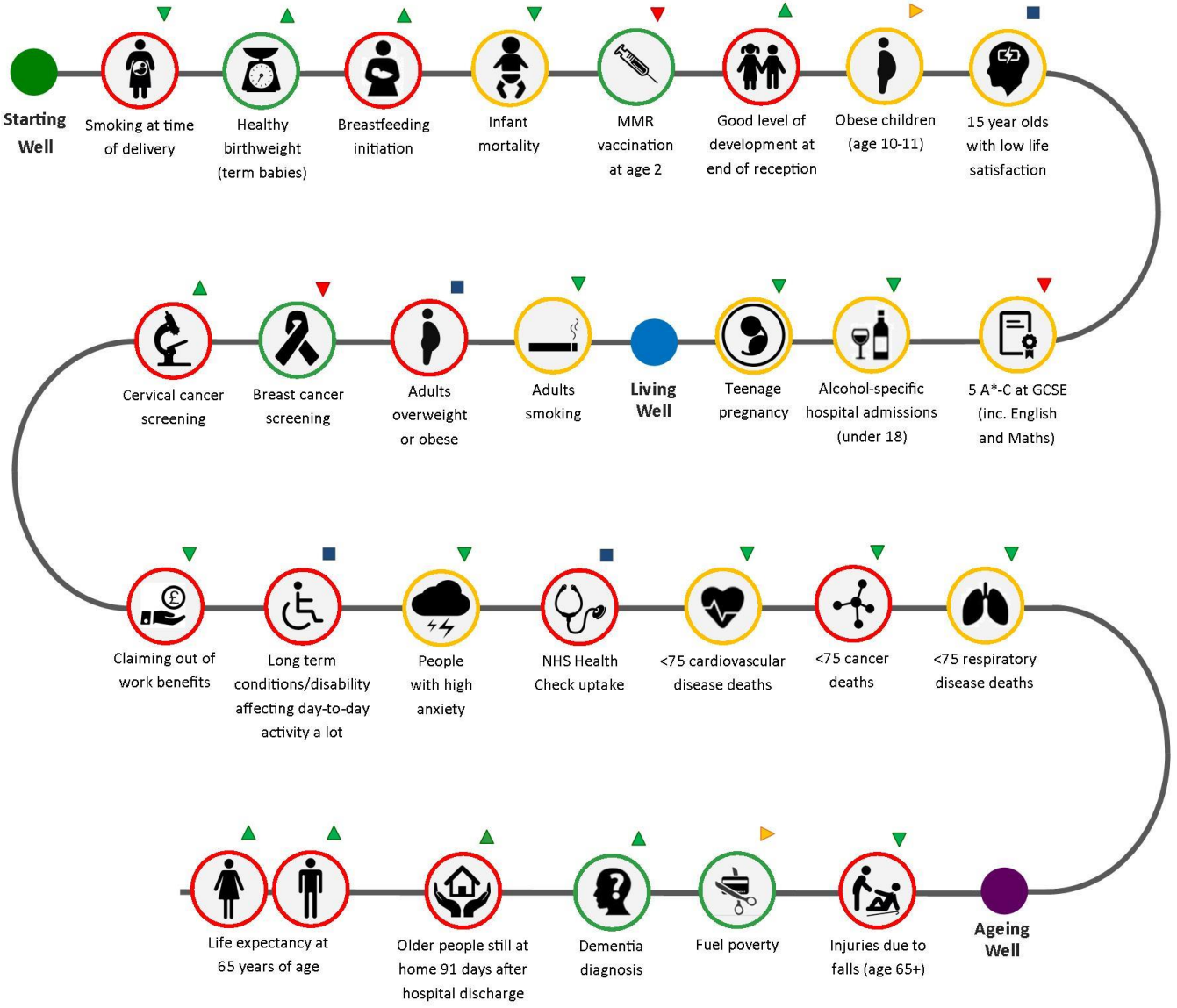
We are pleased to report that good progress has been made against the original priorities, including:

- An increase in the number of children achieving a good level of development by the end of reception
- A reduction in the number of young people admitted to hospital due to drinking alcohol
- An increase in early diagnosis of cancer and cancer deaths reducing
- Extra investment in falls prevention services
- A major review of child and adult mental health services in Halton

Full details of the progress made against the original priorities are outlined in **Appendix 1.**

Halton's Lifecourse Statistics 2015-16

A comparison to the North West



HALTON FACTS

Population

About **126,350** people live in Halton.

By 2030, this is projected to change:

age 0-18 ↓ 3.7%

age 19-64 ↓ 7.6%

age 65+ ↑ 46.4%

Deprivation

48% of Halton's population live in the top **20%** most deprived areas in England.

Child Poverty

24.5% of children aged 0-15 live in poverty in Halton

KEY

Direction of travel

- ▲ Improved since last period
- ▶ Similar to last period
- ▼ Worse than last period
- ■ No Comparator

Statistical significance to North West

- Better
- No different
- Worse

For more information & data sources please contact Halton Borough Council's Public Health Intelligence Team: health.intelligence@halton.gcsx.gov.uk

Icons made by Flaticon and available here: www.flaticon.com

Concept developed from Gateshead PHAR 2013/14 and Leicestershire PHAR 2015

How did we decide on our priorities?

The new One Halton Health and Wellbeing Strategy needs to reflect current priorities from elsewhere in the system whilst maintaining a local focus that is evidence based and reflects local people's views. Since 2013 when first strategy was published there have been significant developments within the policy landscape. The new strategy is aligned with developing system level plans across Local Authorities and the NHS.

The priorities are backed by a strong evidence base considering the local Joint Strategic Needs Assessment, NHS benchmarking and performance data against the range of national as well as local targets. They cover the two biggest killers locally as well as issues that reduce the quality of people's lives. We have listened to our local communities in deciding both the priorities themselves and some of the key actions needed. We have also chosen the priorities based on were we believe we need to enhance current activity.

One Halton priorities have been developed using the following approach:

- Engagement – with GPs, partners and providers as well as patients and public – this is the research phase to ascertain what needs to change and how it can change. This stage lays the foundations for the programme and determines effective buy-in
- Consultation – once firm plans are in place, the CCG will consult with all stakeholders on plans before they are approved and implemented
- Informing – targeted communication will run through the entire programme to ensure all stakeholders are kept informed at every stage of the programme.

For this strategy further consultation has been undertaken by One Halton portfolio directors using pre-existing networks and forums for engagement e.g. Halton Peoples Health Forum. For each priority a set of key actions were identified. There was wide spread community support for all the key actions we had identified as being needed to tackle each priority.

A fuller *'Story behind each of the priorities'* is covered over the next few pages.

The Story behind the priorities

Improved levels of early child development

What is the issue?

- By 3 years of age children in families living below the poverty line are 8 months behind in language and 9 months behind in school readiness compared to those with incomes above.
- Activities such as daily reading, regular bedtimes and library visits can improve cognitive development.
- Despite improvements, 2016 data shows Halton still has one of the lowest percentage of children achieving a good level of development at age 5 in England.
- Accidental injury levels are higher than nationally.

3 Key actions partners and the public feel are important

1. Enhancing school readiness programme.
2. Additional action to prevent child accidents.
3. Expanding parenting programmes and local Home Start schemes.

Outcomes: what would success look like?

- Improvement in the percentage of children achieving a good level of development at age 5.
- Reduction in Child poverty levels.
- Reduction in percentage of women smoking at time of delivery.
- Increased percentage of women breast feeding (initiation and at 6-8 weeks).
- Reduction in the rate of A&E attendances and hospital admissions amongst those age under 5 (generally and due to accidents).
- Reduction in under 18 conception rates.
- Increased reading skills in primary school aged children.
- Increased influenza vaccination uptake amongst pregnant women and young people aged under 5.
- Increased reading skills in primary school aged children

Generally Well: increased levels of physical activity & healthy eating and reduction in harm from alcohol

What is the issue?

- Obesity levels in both early childhood and in adults are above the national level.
- There are clear links with heart disease, stroke, cancers, respiratory and dementia.
- Only 44.7% adults eats at least 5 portions of fruit & vegetables per day and less than half (48%) take enough exercise. Levels of exercise are lower than England (57%) and are especially low amongst women.
- There are been significant improvements in the level of hospital admissions due to alcohol, especially for those aged under 18. However, levels remain higher than nationally for both under 18s and amongst the whole population.

3 Key actions partners and the public feel are important

1. Having a conversation with the public about their access to food.
2. Enhancing the infant feeding programme.
3. Introducing a women's exercise programme.

Outcomes: what would success look like?

- Increase the percentage of children and adults achieving recommended levels of physical activity.
- Increase the Percentage of children and adults meeting the recommended '5-a-day' on a 'usual day'.
- Reduce the levels of children and adults who are overweight and obese.
- Reduce the rate of hospital admissions due to alcohol for those aged under 18.
- Reduce the overall rate of alcohol-related hospital admissions.
- Reduce the death rate due to alcohol-related liver disease.

Long term conditions: heart disease and stroke

What is the issue?

- Although there have been improvements in the number of people with long term conditions being diagnosed, there is still a gap. This is especially so for hypertension (high blood pressure).
- Death rates from heart disease continue to fall but remain the second single biggest killer in Halton. The borough still ranks one of the lowest in England.
- Smoking prevalence has reduced (but may have increased most recently). Levels of adult obesity are some of the highest in the country – explain risk factors more clearly!

3 Key actions partners and the public feel are important

1. Screening in the community for atrial fibrillation (irregular heartbeat).
2. Enhancing early diagnosis of heart disease and self-care programmes.
3. Increasing screening for hypertension (high blood pressure) in the community.

Outcomes: what would success look like?

- Reduce smoking prevalence overall and amongst routine and manual groups and reduce the gap between these two groups.
- Increase the percentage of adults who undertake recommended levels of physical activity and eat at least five portions of fruit and vegetables per day.
- Improve early detection and increase the proportion of people treated in line with best practice and reduce the variation at a GP practice level.
- Reduce the level of hospital admissions due to heart disease, stroke and hypertension.
- Reduce the premature (under 75) death rate due to cardiovascular disease and stroke.

Improved Mental Health

What is the issue?

- 1 in 4 people attending their GP seek advice on mental health problems.
- Suicide rates in Halton are similar to England across all ages.
- Levels of hospital admissions due to self-harm are significantly higher than England.
- 8,365 (8.4% of patients aged 18+) are diagnosed with depression, a higher rate than England.
- 893 people in Halton have a diagnosis of dementia. This gives a diagnosis rate of 70%, based on the difference between the estimated number and number diagnosed and diagnosis rate. The number is increasing and the diagnosis rate improving.
- Many social factors make children more at risk of development mental health problems. Halton has poorer outcomes than England for many of these and an estimated 10.2% of 5-16 year olds with mental health problems.

3 Key actions partners and the public feel are important

1. Review the current Child and Adolescent Mental Health Services (CAMHS).
2. Enhancing services for adults with personality disorders.
3. Redesigning adult mental health services.

Outcomes: what would success look like?

- Improved diagnosis rate for common mental health problems and dementia.
- Reduced level of hospital admissions due to self-harm.
- Improved access to IAPT (talking therapy services), as well as increased percentage completing treatment and percentage recovery.
- Improved overall wellbeing scores and carers' wellbeing scores.
- Reduced excess under 75 mortality in adults with serious mental illness (compared to the overall population).
- Increased percentage of care leavers with good mental health.

Reduction in early deaths from cancer

What is the issue?

- Death rates remain some of the highest in the country and are the biggest single killer locally.
- Our highest rates for cancer are for lung, bowel and breast.
- Smoking rates have been falling.
- Alcohol-related hospital admissions for adults remain high.
- Obesity rates for adults remain high.
- The proportion of cancers caught early is similar to England and survival rates have been rising.
- Cancer screening rates have improved but are still lower than nationally. This is especially so for bowel screening uptake.

3 Key actions partners and the public feel are important

1. Enhancing the public awareness of early detection programmes.
2. Developing a new Tobacco Control Strategy and Action Plan.
3. Enhancing support for bowel screening to improve uptake.

Outcomes: what would success look like?

- Reduce smoking prevalence overall and amongst routine and manual groups and reduce the gap between these two groups.
- Increase uptake of cancer screening (breast, cervical and bowel).
- Improved percentage of cancers detected at an early stage.
- Improved cancer survival rates (1 year and 5 year).
- Reduction in premature mortality due to cancer.

Improved quality of life for older people

What is the issue?

- Halton has a higher than average aging population and this trend will continue.
- Compared to the national average Halton older people live shorter lives and a greater proportion of their lives in ill health .
- The numbers with dementia are rising.
- Older people are concerned about remaining healthy, independent and connected to others.
- The service older people most frequently cite as being of concern to them is transport.

3 Key actions partners and the public feel are important

1. Marketing campaign on preventing loneliness.
2. Develop an older people's transport group.
3. Develop a directory of services for older people.

Outcomes: what would success look like?

- Increased life expectancy at age 65.
- Increased disability free life expectancy at 65.
- Improved access to transport.
- Reduced levels of loneliness.
- Reduction in level of hospital admissions due to falls and hip fractures.
- Increased uptake rates for Influenza, pneumococcal and shingles vaccination.
- Reduction in permanent admissions to residential and nursing homes.

Example of how we are already working as "One Halton"

Case study 1: Well North: Well Halton

A Department of Health response to the Due North Report published in 2014 which highlighted the disparity in health outcomes between the north and the south of England. Well North's goals are to :-

- address inequality by improving the health of the poorest, fastest
- increase resilience at individual, household and community levels
- and reduce levels of worklessness, a cause and effect of poor health

The programme must be delivered the most deprived 10% of areas in the country. Well North seeks to make visible previously invisible at-risk people and attempt to solve, rather than manage, their illnesses and anxieties. Underpinning Well North is the recognition that for health inequalities to be addressed effectively, interventions must be built on developing community based programmes, which enable empowerment, control, self-determination and the freedom to lead lives that people have reason to value. Halton's approach is centred on three hubs:

1. Windmill Hill – building on community assets to support a bottom up approach for an Intergenerational Family Centre with Multidisciplinary teams, including a long term solution of access to medical services.

2. Halton Brook – building on a well-established community sector and multiple physical assets which lacks the expertise to capitalise on these in a way that will make them sustainable.

3. Well Widnes (Virtual Community Health Hub) – Building opportunities to create "start up and support" business models in the wards of Kingsway and Ditton between the public, private and voluntary, community and social enterprise (VCSE) sector to design, implement and govern a potential community Hub to stimulate entrepreneurship to improve the health and wellbeing of our local population.

Case Study 2: Healthy New Towns

Halton's Healthy New Town (Halton Lea) is all about people and community. People's needs and desires for a better environment, better housing and healthy community living. Our aim is to achieve this by designing-out elements which contribute to local poor health and designing-in better information, technology and services that promote health and wellbeing. To achieve all of this our immediate priorities and aims are:

1. *To develop a Masterplan for the Healthy New Town project:* This will involve a regeneration of the current hospital site and the derelict buildings adjacent to Runcorn Shopping Centre
2. *Focus on Runcorn Shopping Centre (RSC):* Halton Lea will not just be a place to shop, but a meeting place for health and social care knowledge exchange, local presentations, information about training and local employment as well as social interaction. We will link the RSC with the hospital site, multidisciplinary teams and the Halton Lea community via 'Community Navigators'
3. *Halton Hospital site:* We aim to reduce health inequalities and create a better community where people can access health and social care services more easily. This will improve their quality of life and wellbeing
4. *Digital Technology* as a cross-cutting theme: This will be a cross-cutting theme. Our aim is to link the Hospital site, Runcorn Shopping Centre and the Halton Lea community digitally. This will allow people to have access to services and information wherever they happen to be. We will continue to explore digital solutions to help support self-management, particularly among those with long-term conditions living at home.

Appendix 1: Progress since 2013 (linked to Page 4 building upon success)

Priority	Some key actions delivered during the 2013-16 strategy lifetime	What impact has this had	Why it remains a priority or not
Alcohol	• Alcohol Strategy developed. • Public Health Annual Report on Alcohol showcased local action. • Halton chosen by the Home Office to be a Local Alcohol Action Area.	• Hospital admission rates for under 18s have been falling. Halton levels are now similar to England and lower than the North West rate. • Alcohol related admissions amongst adults have also been falling, closing the gap. However, Halton rates remain higher than England.	The partnerships we have developed and the actions plans they have been implementing are now well established. These will continue. This means we no longer need to keep Alcohol as a local priority.
Cancers	• New cancer strategy developed. • Halton Action on Cancer partnership established.	• Cancer incidence increasing and now higher than England level. • Screening uptake remains lower than England. • increase in percentage of cancers diagnosed at an early stage with levels similar to England. • Cancer death rates under 75 years continue to fall. However, some increases recently, including cancer deaths considered preventable. • HPV vaccination rate higher than England and North West. • Smoking prevalence decreased amongst adults as a whole and for routine and manual workers. However, the gap remains. Figures for 2015 also show an increase from the downward trend.	We continue to strive towards improving preventative action, early detection and treatment. There have been some significant gains such as reduced smoking prevalence and increased survival rates. However, as Halton still ranks as amongst one of the poorest areas for cancer outcomes (primarily death rates under age 75) we need to keep a focus on cancers.
Child Development	• Early years strategy developed. • New partnership group established to oversee its implementation.	• Infant death rates as well as healthy weight at birth and obesity of Year 6 children have all been improving and are now similar or better than the England average. • Both smoking at time of delivery and breast feeding initiation rates are worse than the England average. However, there have been improvements in both indicators. • Obesity levels at Reception age remains higher than England	As the data shows we have made improvements in many outcomes for young children. The main indicator being used to judge the success locally, 'the proportion of children achieving a good level of development at the

Priority	Some key actions delivered during the 2013-16 strategy lifetime	What impact has this had	Why it remains a priority or not
		• Improved proportion of children achieving a good level of development at end of reception ('school readiness'): 37% in 2013 to 61.9% in 2016. However, there remains a substantial gap between Halton and England. • Child poverty was 25.9% in 2011 and fell to 23.6% in 2013.	end of reception' has improved. However, we recognise our progress has been slow compared to some similar boroughs. As such we need to maintain a focus on this work.
Falls amongst older people	• Falls Strategy developed. • Extra investment in falls prevention services. • Links with care homes. • Fire Service home safety checks include consideration of falls hazards and referrals where appropriate.	• Following a slight reduction between 2012/13, the rates have seen small year on year increases. • Admissions due to hip fractures decreased in 2012/13 but have since increased again.	We have seen significant reduction in the number of people admitted for hip fractures but not a reduction in falls. We will continue this work and continue to monitor outcomes through the Healthy Ageing priority work programme.
Mental Health	• Mental Health Strategy across all ages developed, with an action plan. • Major review and adult mental health services. • Improved access to 'talking therapies' known as IAPT.	• Self reported wellbeing scores have been falling. • It is estimated nearly 20% of adults 16-74 years have common mental health problems. 8.4% have a diagnosis of depression. These are higher levels than England. • Referrals, percentage entering and completing IAPT have all increased. Levels entering IAPT treatment higher than England with levels completing similar. • Admissions due to self harm statistically higher than England and North West. • Suicide rates similar to England.	Despite some improvements, mental health remains the single biggest cause of ill health and disability in Halton. Services have been reviewed but not all new models of care have been fully implemented yet. We therefore need to maintain a focus on this area.

Insert logos of all organisations

Members of the One Halton Health and Wellbeing Board

Warrington and Halton Hospitals NHS Foundation Trust

St. Helens and Knowsley Hospitals

Halton Children's Trust

Halton Safeguarding Children Board

NHS Halton Clinical Commissioning Group

NHS England

Halton Borough Council

Healthwatch

Bridgewater Community Healthcare NHS Trust

Halton and St. Helen's Voluntary and Community Action

5 Boroughs Partnership NHS Foundation Trust

Halton Housing Trust

Cheshire Police

Cheshire Fire Service

We'd love to hear from you

Do you have stories about a local group you are involved with? Do you have any comments about this strategy or any of the ideas in it?

Please contact us at:

Halton Borough Council

Runcorn Town Hall

Health Road

Runcorn

WA7 5TD

Telephone: 0303 333 4300

REPORT TO:	**Health and Wellbeing Board**
DATE:	**18th January 2017**
REPORTING OFFICER:	**Simon Banks, Chief Officer, NHS Halton CCG and Senior Responsible Officer, Alliance Local Delivery System**
PORTFOLIO:	**NHS Halton CCG**
SUBJECT:	**Cheshire and Merseyside Sustainability and Transformation Plan**
WARDS:	**Borough Wide**

1.0 PURPOSE OF THE REPORT

The purpose of this report is to share the Cheshire and Merseyside Sustainability and Transformation Plan (STP) with the Health and Wellbeing Board.

2.0 RECOMMENDATION: The Health and Wellbeing Board is asked to:

1. **Note the contents of the Cheshire & Merseyside Sustainability & Transformation Plan (STP); and**

2. **Note the commitment to continued local engagement and the requirement to comply with statutory requirements for public involvement, and to seek the views of the Health and Wellbeing Board about the next phase of local engagement.**

3.0 SUPPORTING INFORMATION

3.1 Background

The NHS Five Year Forward View, published in October 2014, set out strategic intentions to ensure the NHS remains clinically and financially sustainable. The Forward View highlighted three key areas:

- The health and wellbeing of the population;
- The quality of care that is provided; and
- NHS finance and efficiency of services.

Subsequently, the 2015/16 NHS planning Guidance set out the steps for local health systems to deliver the Five Year Forward View, backed up by a new Sustainability and Transformation Fund intended to support financial balance and to enable new investment in key priorities. As part of the planning process, health and care systems were asked to develop Sustainability and Transformation Plans, to cover the period from 2016/17 to 2020/21.

A total of 44 areas (or 'footprints') were identified across England to work together as health and care systems to develop Sustainability and Transformation Plans (STPs) that set out how these gaps can be addressed. STPs represent a change in the way that the NHS in England plans its services; with a stronger emphasis on collaboration to respond to the challenges facing local services and a focus on place-based planning for whole systems of health and care.

While STPs are primarily being led by the NHS, developing credible plans will require the NHS to work in close partnership with social care, public health and other local government services, as well as third sector organisations and local people.

The Cheshire and Merseyside Sustainability and Transformation Plan is the second largest STP in England. It covers a population of 2.5 million, has 12 CCGs, 20 providers and 9 local authorities.

The Cheshire and Merseyside STP was submitted to NHS England on 21st October 2016. This was drafted as a requirement of the NHS England Planning Framework and follows on from a first submission in June 2016. NHS England required time to review the October submission and set a publication date for the Cheshire and Merseyside STP for 16th November 2016.

The STP is drafted as a technical document responding to the requirements of NHS England. A public summary and frequently asked questions document have been produced to support public understanding of the rationale and the content of the plan. The STP document refers to a number of accompanying appendices which have also been published and can be accessed alongside the plan on all local NHS websites.

3.2 STP Priorities

The STP sets out four common priorities for Cheshire and Merseyside:

1. **Support for people to live better quality lives by actively promoting health and wellbeing.** The plan sets out priorities to address the factors that have a negative impact on population health and that are increasing pressure on services.
2. **The NHS working together with partners in local government and the voluntary sector to develop joined up care**, with more care accessible outside of hospitals to give people the support they really need when and where they need it.
3. **Designing hospital services to meet modern clinical standards and reducing variation in quality;** to establish consistency and improvement in clinical standards for hospital care across Cheshire and Merseyside.
4. **Becoming more efficient by reducing costs, maximising value and using the latest technology;** reducing unnecessary costs in managerial and administrative areas, maximising the value of clinical support services

and adopting innovative new ways of working, including sharing electronic information across all parts of the health and care system.

3.3 Local Delivery Systems

The Cheshire and Merseyside STP is designed to address the challenges of the region in terms of population health and wellbeing, quality of care and financial sustainability. The majority of delivery will be through the plans developed by the three local delivery systems (LDS): North Mersey; the (Mid Mersey) Alliance; and unified Cheshire & Wirral.

All three local delivery systems will deliver the same four key priorities set out in the Cheshire and Merseyside plan. However, each local plan will tailor the way these priorities are delivered to reflect the particular needs of their population and the local health and care system.

The three Local Delivery Systems are at different stages of development. For some areas, collaborative plans to improve health outcomes and to address the future sustainability of the health and care system have been in development for some time. For other areas, partners may have been collaborating for a shorter time and their local plans largely represent ideas still to be shaped into firm proposals.

3.4 The Alliance Local Delivery System (LDS)

The Alliance Local Delivery System (LDS) is made up of 4 Clinical Commissioning Groups (NHS Halton, Knowlsey, St Helens and Warrington CCGs) and 5 NHS providers (5 Boroughs Partnership NHS Foundation Trust, Bridgewater Community NHS Foundation Trust, St Helens & Knowsley Teaching Hospitals NHS Trust, Warrington and Halton Hospitals NHS Foundation Trust and Southport & Ormskirk Hospitals NHS Trust). The Alliance LDS is also engaging with the local authorities covering the boroughs of Halton, Knowsley, St Helens and Warrington.

The Alliance LDS builds upon the work already being done at a local level, the proposals submitted by the Alliance LDS include options and models of transformation for the local health system that aim to address a funding shortfall of £202 million, whilst at the same time improving health, wellbeing and outcomes by:

- Prevent the demand from materialising **(Prevention at scale)**
- Provide more (cost) effective ways of responding to the demand **(Out of Hospital Care)**
- Find more productive/efficient ways of delivering acute hospital care **(Reducing Variation & Improving Quality, Clinical Support Service Collaboration)**
- Making our overhead and running costs as efficient as possible **(Back Office Collaboration and Working Together more effectively)**

The proposals set out in the Alliance LDS were submitted to NHS England, and form part of the Cheshire and Merseyside STP. Following formal publication of the Cheshire and Merseyside STP, we are now further developing these proposals into outline plans and will commence wide scale programme of engagement and communication during 2017.

4.0 POLICY IMPLICATIONS

Since the Health and Social Care 2012 Parliament, through the Secretary of State for Health, sets a Mandate for the NHS to deliver. The delivery of this Mandate is overseen by NHS England and taken forward by Clinical Commissioning Groups. The production of the Sustainability and Transformation Plans across England has been mandated by NHS England, NHS Improvement and the other arms-length bodies and represents the response of providers and commissioners in the NHS to the financial settlement for the NHS agreed by Parliament within which they are required to deliver NHS Constitution and other standards.

5.0 OTHER IMPLICATIONS

It is recognised that there is significant public interest in STPs and the process by which proposals will be developed and agreed.

The view of NHS England is that there should be a public conversation to gain views on the proposals contained in the STP and its constituent parts in the form of the LDS plans.

It should be noted that the STP is a planning footprint and not a statutory entity. Consequently, with regard to accountability, individual NHS organisations will remain responsible for ensuring their legal duties to involve are met during the design, delivery and implementation process of specific proposals. This includes ensuring that any reconfiguration proposals which represent a potential significant variation in service are subject to public and local authority overview and scrutiny and formal public consultation.

A full engagement plan is being developed for the next phase of public and stakeholder engagement for the STP, with NHS and local authority representatives involved in shaping an overarching plan for Cheshire and Merseyside, which also reflects the different approaches that may be taken by each LDS. The Health and Wellbeing Board is asked to give a view on any additional engagement approaches on the contents of the STP in this context.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

NHS provided services for children and young people are included in the scope of the STP and the LDS delivery plans.

6.2 Employment, Learning and Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

The *One Halton* approach has been incorporated into the Alliance LDS submission as part of the STP and features prominently in the demand management and prevention at scale work stream.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

The STP Programme Team and the LDS teams are developing an assurance system to identify and mitigate the risks of this programme.

8.0 EQUALITY AND DIVERSITY ISSUES

In sharing the STP with the public and seeking further engagement the NHS is:

- Giving due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Giving regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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

Cheshire and Merseyside Sustainability and Transformation Plan (STP)

Cheshire and Merseyside STP Public Summary

Frequently Asked Questions

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NHS Foundation Trust

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16 November 2016

Dear Colleague

Cheshire and Merseyside Sustainability and Transformation Plan (STP)

We are writing to let you know that the Cheshire and Merseyside STP is being published today on all local NHS websites.

You will be aware that this is an ambitious draft plan to improve the health and well-being of the 2.5 million people living in the region.

The draft plan is one of 44 such plans being developed across the country in response to NHS England's Five Year Forward View (5YFV), a national plan that set out a vision for a better NHS.

The Cheshire and Merseyside Sustainability and Transformation Plan (STP) sets out our core purpose, which is to ensure that the people of Merseyside and Cheshire continue to have access to safe, good quality and sustainable services and ensuring that we make the best use of the funding we will receive over the next five years.

Ideas have come together in the Cheshire and Merseyside STP, which sets out four main priorities to address the challenges set out in the NHS Five Year Forward View; health and wellbeing, care and quality, and funding. The STP proposes to address those challenges by focusing on:

1. Support for people to live better quality lives;

2. The NHS working with partners to deliver joined up health and social care;

3. Designing hospital services to meet modern clinical standards and reducing variation in quality;

4. Becoming more efficient by reducing costs and maximising value.

Some of the proposals in the plan will be delivered in an integrated way across the whole region. However, due to the diversity of Cheshire & Merseyside, we are also working in three smaller partnerships called Local Delivery Systems (LDS) – North Mersey; the Alliance and Cheshire & Wirral. They will each deliver the same four key priorities but may tailor delivery to reflect the particular needs of each area and the local health and care system. Each of the Local Delivery Systems are at a different stage in their thinking. For example, plans to transform services have been in

development for some time through programmes such as *Healthy Liverpool* or *Caring Together* in Eastern Cheshire. For the other areas, where partners have been collaborating for a shorter time, ideas are at an earlier stage. This means that there will be opportunities at a very early stage for people to give their views and to get involved in shaping proposals.

The publication of the Cheshire and Merseyside STP on 16th November 2016 marks the start of further engagement on a way forward for local health and social care services. Over the next weeks and months we will be raising awareness and understanding about the need for change and will listen to ideas or concerns about any aspect of the plan.

We are committed to active involvement from patients, public, carers, staff and stakeholders in further shaping our ideas and proposals. Any emerging proposals to substantially change any service would be subject to thorough engagement and consultation with populations affected. We will only take forward proposals that are supported by strong clinical evidence and where we can demonstrate a positive impact in terms of quality, safety and sustainability.

We welcome your views on the content of the Cheshire and Merseyside STP.

Enclosed are additional documents in addition to the full STP document, including a public summary and frequently asked questions.

We expect you will also want to have conversations about the STP with your local clinical commissioning group, hospital trusts and other stakeholders. We look forward to receiving your feedback in order to help inform the next version of this plan.

The STP will be also discussed at all Health and Wellbeing Boards across Cheshire and Merseyside and we will engage with Overview and Scrutiny Committees on their requirements with regard to the plan.

We will continue to keep you informed and seek your views as proposals develop.

Can we take this opportunity to thank you for your interest and support for the NHS and social care system. We hope we can work with you to forge a constructive relationship to secure the best possible future for patients and the population of Cheshire and Merseyside.

Yours sincerely

Louise Shepherd
Cheshire and Merseyside STP Lead/
Chief Executive – Alder Hey Children's NHS Foundation Trust

Cheshire & Merseyside
Sustainability and Transformation Plan

People and Services Fit for the Future

2

The Challenge for the NHS

As a nation we are fortunate to have a National Health Service that is free at the point of care, delivering world class services.

However, we also know that the NHS is facing some big challenges and there are clear signs that it needs to adapt and change if it is to be fit for the future.

While on a day-to-day basis most areas are running well, we are seeing pressures in areas such as hospital care, A&E, mental health and GP services. Some of this is being experienced in longer waiting times and variable quality of care.

There are several reasons why the NHS is under pressure:

- People are living longer, but not always healthier, lives;
- Care is not always joined up for patients, especially for the frail elderly and those with complex needs. As a result, too many people do not get the right care in their homes or community, which creates an over-reliance on hospital services;
- We need to do more to support children, young people and adults effectively with their mental health challenges;
- At the same time, there is enormous pressure on health and social care budgets.

There is also a growing financial challenge. The NHS will continue to receive a small year on year increase over the next five years, but this is not keeping pace with increasing costs and increasing demand for services. If we do nothing, the NHS faces a £30 billion funding gap by 2021. For Cheshire & Merseyside our share of this funding gap is £908m.

We know that these issues require us to think more radically about how best to address the problems we face together otherwise we will fail to support the needs of our communities into the future.

In 2014, NHS England published a document entitled ***The Five Year Forward View (FYFV)***, which identified three priorities for the NHS to focus on in order to improve services and the health of our country:

1. **health and wellbeing** – supporting people to stay well
2. **quality of care** – providing good services consistently wherever you live
3. **NHS finances** – maximising efficiency and reducing duplication in services.

3

FIVE YEAR
ORWARD VIEW

Cheshire & Merseyside Sustainability and Transformation Plan

4

Cheshire & Merseyside in Partnership

2.5 million people

30 *NHS* organisations

9 local authorities

Although the NHS is a national public service it is made up of hundreds of organisations, including hospitals, community services, clinical commissioning groups and specialist services. In addition, public health and social care are the responsibility of local authorities who work in collaboration with the NHS. Community and voluntary organisations also provide a great deal of support to complete this picture. It's clear that the scale of the challenge is too big to be resolved by organisations making changes in isolation.

For this reason NHS England has established 44 Sustainability and Transformation (STP) 'footprints' across the country, bringing together NHS organisations, local authorities and other partners to work together to deliver the priorities from the NHS Five year Forward View, by developing new ideas and proposals to improve health, improve quality and to ensure that the NHS remains financially sound. This is being backed up by additional investment over the next five years, above existing NHS budgets, to address these challenges.

NHS organisations and local authorities across Cheshire & Merseyside are working together to develop ideas and proposals to share with the public about how we can address our challenges and come up with the right solutions. These ideas have come together in the Cheshire and Merseyside Sustainability and Transformation Plan (STP).

Cheshire and Merseyside is a diverse region; with urban areas that have higher levels of poor health and a greater concentration of hospital services, alongside towns and rural areas that have different challenges, including physical access to services.

"The role of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside is to co-ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole region now and into the future."

Louise Shepherd
Lead for the Cheshire and Merseyside STP and Chief Executive of Alder Hey Children's NHS Foundation Trust

6

Our Priorities

NHS organisations and local authorities have been working together for the last few months, looking at examples of good practice and improvements that have delivered good results elsewhere.

Our core purpose is to ensure that the people of Merseyside and Cheshire continue to have access to safe, good quality and sustainable services, which also means making the best use of the funding we will receive over the next five years.

Ideas and proposals have come together in the Cheshire and Merseyside Sustainability and Transformation Plan (STP), which has four main priorities:

1. **Support for people to live better quality lives by actively promoting what we know will have a positive effect on health and wellbeing.** The way we live now is having a negative impact on our health and putting pressure on services. Alcohol, smoking, poor diet and inactivity are increasing demands on the NHS. We have to change this.

2. **The NHS working together with partners in local government and the voluntary sector to develop joined up care,** with more of that care offered outside of hospitals to give people the support they really need when and where they need it.

3. **Designing hospital services to meet modern clinical standards and reducing variation in quality;** people should be confident that they will receive similarly high standards of hospital care regardless of where they live.

4. **Becoming more efficient by reducing costs, maximising value and using the latest technology**; reducing unnecessary costs in managerial and administrative areas, maximising the value of our clinical support services and adopting innovative new ways of working, including sharing electronic information across all parts of the health and care system.

Improving Health and Wellbeing

We want to see significant improvements in the health and wellbeing of people living in Cheshire and Merseyside. We want people to be better informed and empowered to make positive lifestyle choices and we want to do more to prevent illness. If we can support people to stay well for longer we will be able to improve quality of life and reduce reliance on the NHS.

The plan identifies three Cheshire and Merseyside-wide projects, that will support reductions in alcohol abuse, blood pressure and antimicrobial resistance.

There is a strong health and business case for investing in schemes to prevent people becoming ill. This is the most effective way to make the NHS sustainable in the longer term

Eileen O'Meara
Director of Public Health, Halton

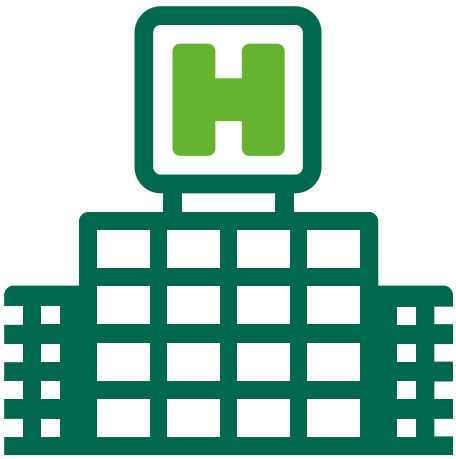
For example, tackling high blood pressure is about encouraging more people to have checks, not only in traditional ways such as through their GPs, but also in everyday places in communities, including pharmacies. If we increase awareness and checks we can intervene to support the thousands of people who have undiagnosed high blood pressure, which often has no symptoms, and avoid deaths and instances of stroke and heart disease.

Not only will these three schemes improve health, they will also reduce reliance on the NHS.

Better Care Outside of Hospital

One of the most far-reaching areas of change we could make is to establish integrated services for better care in our communities. In practice, this is about different parts of the NHS and social care services working together seamlessly with a better focus on people's needs.

For example, in our communities GPs will work in integrated teams with hospital specialists, district nurses, mental health workers and social workers to improve care for people with long-term conditions such as diabetes, elderly people who are frail or children and adults with very specific needs. If we do this effectively we will keep more people well, improve quality of life and have fewer people needing to be admitted to hospital.



"Offering good services closer to home will improve care for the most vulnerable in our communities and reduce admissions to hospital. This is good for patients and for the NHS."

Jerry Hawker
Accountable Officer, NHS Eastern Cheshire Clinical Commissioning Group

Improving Hospital Services

Across Cheshire and Merseyside we will undertake a review of clinical services across all our hospitals to identify where there are variations in quality and to look at how we can establish consistently high clinical standards. Our plans for hospital services will lead to greater collaboration and sharing of expertise and resources. The work to review variation and standards is at a very early stage and will take some further time to deliver impact.

In reviewing hospital services, we will be open about the issues we face that may lead to proposals to change how and where some hospital services are delivered.

For example, there is evidence that for some specialist areas, such as stroke services, it is better to concentrate care in fewer centres as we know that this will improve outcomes for patients.

We also have a shortage of doctors and nurses in some specialties, such as urgent and emergency care, which are making it difficult to provide good quality services in every hospital.

We will establish consistently high clinical standards in all Cheshire and Merseyside hospitals, so people can trust that services will be good regardless of their postcode.

Dr Simon Constable
Medical Director,
Warrington and Halton Hospitals NHS Foundation Trust

10

Better, More Efficient Care

We will also look for new opportunities to reduce costs and duplication, whilst at the same time improving care and access to services.

Reducing costs is a big driver for looking at our administrative and clinical support services, but there are also opportunities in clinical support services to improve standards and access in areas such as radiology, pharmacy and pathology. For example, hospitals each invest in expensive equipment such as scanners. As demand continues to increase there are opportunities to better share these resources across hospitals so that resources are being used optimally before we consider investing in new equipment.

When it comes to administrative support, our principle is to share resources across organisations, where this makes sense, in areas such as finance, human resources and IT, to achieve maximum efficiency.

The four main priorities set out in the Cheshire and Merseyside STP are supported by eight clinical programmes looking to improve the way we deliver:

- **Neuroscience**
- **Cardiovascular disease**
- **Learning disabilities**
- **Urgent Care**
- **Cancer**
- **Mental Health**
- **Women's and Children's**
- **Primary care (GP services)**

"We want every penny of NHS funding to be used effectively; there are opportunities to re-shape management and administrative support to reduce costs and maximise investment in patient-facing services."

Tracy Bullock
Chief Executive,
Mid-Cheshire Hospitals NHS Foundation Trust

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Local Delivery Systems across Cheshire and Merseyside

For some of our ideas it clearly makes sense to deliver them across the whole region. However, due to the diversity of Cheshire & Merseyside, we are also working in three smaller partnerships called Local Delivery Systems (LDS) – North Mersey; the Alliance and Cheshire & Wirral. All three local delivery systems will deliver the same four key priorities set out in the Cheshire and Merseyside plan. However, each local plan may tailor the way these priorities are delivered to reflect the particular needs of each area and the local health and care system.

All three local delivery systems will deliver the same four key priorities set out in the Cheshire and Merseyside plan. Each of the Local Delivery Systems are at a different stage in their thinking. For example, plans to transform services have been in development for some time through programmes such as Healthy Liverpool or Caring Together in Eastern Cheshire. For the other areas where partners have been collaborating for a shorter time, ideas are at an earlier stage. This means that there will be opportunities at a very early stage for people to give their views and to get involved in shaping proposals.

Number	Organisation
01	The Walton Centre NHS Foundation Trust
02	Southport and Ormskirk Hospitals Trust
03	Alder Hey Children's NHS Foundation Trust
04	Liverpool Heart and Chest Hospital NHS Foundation Trust
05	The Royal Liverpool & Broadgreen University Hospitals NHS Trust
06	Bridgewater Community Healthcare NHS Foundation Trust
07	Aintree University Hospitals NHS Foundation Trust
08	Liverpool Community Health NHS Trust
09	Clatterbridge Cancer Centre NHS Foundation Trust
10	Wirral Community NHS Foundation Trust
11	Wirral University Teaching Hospital NHS Foundation Trust

Number	Organisation
12	Liverpool Women's Hospital NHS Foundation Trust
13	Mersey Care NHS Foundation Trust
14	North West Ambulance Service NHS Trust
15	Warrington and Halton NHS Foundation Trust
16	East Cheshire NHS Trust
17	Cheshire and Wirral Partnership NHS Foundation Trust
18	Countess of Chester NHS Foundation Trust
19	5-Boroughs Partnership NHS Foundation Trust
20	Mid-Cheshire Hospital NHS Foundation Trust
21	St Helens and Knowsley Hospitals Trust

NHS Trusts


02
Southport
08
07
01
St Helens
05
03
13
15
06
11
10
12
04
21
Warrington
19
Runcorn
09
14
16
Macclesfield
CHESHIRE
17
Chester
18
20
Crewe
GREATER MANCHESTER
WEST MIDLANDS
Cheshire & Merseyside Sustainability and Transformation Plan

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Overview of Local Delivery System Plans

The Alliance: Warrington, Halton, St Helens and Knowsley

The work of the Alliance is at a very early stage of developing ideas to ensure local health services are sustainable and fit for the future.

The plans build upon ideas and developments already happening at local level, with local people. For example, in Warrington, GPs are already working together in 'clusters' to provide more services at GP practice level and in Halton, Wellbeing Practices have been in place for some time and are helping people to become healthier.

As ideas develop into plans we will be asking local people, staff and others for their feedback. Any proposals to change services will be consulted on at a local level, but this won't be until we have worked plans up further in 2017.

"The ideas and proposals detailed in the Alliance plan, are just that; 'ideas' that build upon developments already happening at local level. Whilst existing plans go some way to meet the challenges, we really do need to do more by working together to achieve better health and making sure that people receive the best possible care in the right place at the right time."

Simon Banks
Accountable Officer, NHS Halton CCG

Cheshire and Wirral LDS

Cheshire and Wirral LDS are also in the early stages of developing ideas to transform health services across this footprint. They have identified priorities for making their health care system sustainable now and in the future and have created collaborative, digital initiatives like the Cheshire and Wirral Care Records.

Cheshire and Wirral will continue to engage with local communities and consult on any major service changes, if they happen, later in 2017.

Cheshire and Wirral LDS are developing ideas to transform health services, building upon existing programmes including Caring Together, Healthy Wirral, The West Cheshire Way and Connecting Care. We have clear priorities for a health care system that is sustainable now and into the future and we will continue to engage with local communities about the best way forward.

Jonathan Develing
Senior Responsible Officer for the Cheshire and Wirral LDS

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North Mersey LDS

The North Mersey LDS serves the populations of Liverpool, Sefton, and Knowsley. North Mersey will build on programmes like Shaping Sefton and Healthy Liverpool, which was set up in 2013 in response to the city's Mayoral Health Commission, and recommended some significant changes to the way local health services should be delivered, to address poor health and relieve pressure on services.

North Mersey is one of the most complex health systems in the country, with nine NHS providers of services, including two adult acute hospitals and a range of other trusts.

The main intention, set out in the North Mersey plan, is to reduce unnecessary hospital care and shift the balance towards a pro-active wellness system rather than a system which just treats illness. This shift to better care outside of hospital will enable hospital services to be improved and redesigned to meet the future needs of patients.

North Mersey LDS has a three year head start and is already working collaboratively to embed changes in services, both in communities and in hospital. The area is also a national exemplar for digital innovation in health, with ambitious schemes to establish shared electronic health records and to use assistive technology to help people manage their health conditions.

We have developed a strong partnership across our system so we can truly act as one to address the challenges we face in tackling poor health and inequalities; maintaining good services both in and outside of hospital and protecting the excellent specialist services on our patch which serve the whole of Cheshire and Merseyside.

Katherine Sheerin
Chief Officer,
NHS Liverpool CCG

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What's Next?

To be successful STPs must be developed with, and based upon the needs of local patients, carers and communities, and health and social care professionals must be effectively engaged with those plans.

In preparing the Cheshire and Merseyside Plan local partner organisations have so far involved senior doctors and system leaders in drawing up ideas, and many more will be involved in developing the plans to take forward the four priorities for action.

The publication of the Cheshire and Merseyside STP on 16th November 2016 marks the start of further engagement on a way forward for local health and social care services.

Over the next weeks and months we will be talking to lots of people to ensure there is a good level of awareness and understanding about the need for change and to listen to ideas or concerns about any aspect of the plan as it currently stands.

Every partner organisation is committed to actively involving patients, carers, staff and local people in shaping future plans and ensuring they have their say on how services will look in the future. Any proposal to substantially change any service will be subject to thorough and detailed engagement and consultation with those people potentially affected by any suggested change.

We will only take forward proposals that are supported by strong clinical evidence and where we can demonstrate a positive impact in terms of quality, safety and sustainability.

The full STP document can be viewed on each of the following CCG websites:

www.liverpoolccg.nhs.uk
– North Mersey

www.wirralccg.nhs.uk
– Cheshire and Wirral

www.warringtonccg.nhs.uk
– The Alliance

Follow us on NHS social media channels and look out for information about opportunities to find out more and get involved on our websites.

For any queries or comments please get in touch by emailing **mlcsu.cmstp@nhs.net**

Cheshire & Merseyside Sustainability and Transformation Plan

REPORT TO: Health and Wellbeing Board

DATE: 18th January 2017

REPORTING OFFICER: Audrey Williamson – Independent Chair

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Safeguarding Adults Board Annual Report 2015-16

WARDS: Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the Halton Safeguarding Adults Annual Report is to inform the borough of the work that has been undertaken by the Board in the last 12 months to help safeguard adults in Halton from abuse or neglect.

2.0 RECOMMENDATION: That the report be noted

3.0 SUPPORTING INFORMATION

Under the Care Act 2014 the Safeguarding Adults Board must produce an annual report. Please see the attached Annual Report for a summary of the work which has been undertaken by the Board during 2015-16.

4.0 POLICY IMPLICATIONS

As section 3.0

5.0 FINANCIAL IMPLICATIONS

As section 3.0

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

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

6.3 **A Healthy Halton**

Halton Safeguarding Adults Board is now a statutory requirement under the Care Act 2014 and its primary aim is to help keep vulnerable adults in Halton safe from the risk of abuse or neglect.

6.4 **A Safer Halton**
Halton Safeguarding Adults Board is now a statutory requirement under the Care Act 2014 and its primary aim is to help keep vulnerable adults in Halton safe from the risk of abuse or neglect.

6.5 **Halton's Urban Renewal**

7.0 RISK ANALYSIS

No risks identified

8.0 EQUALITY AND DIVERSITY ISSUES

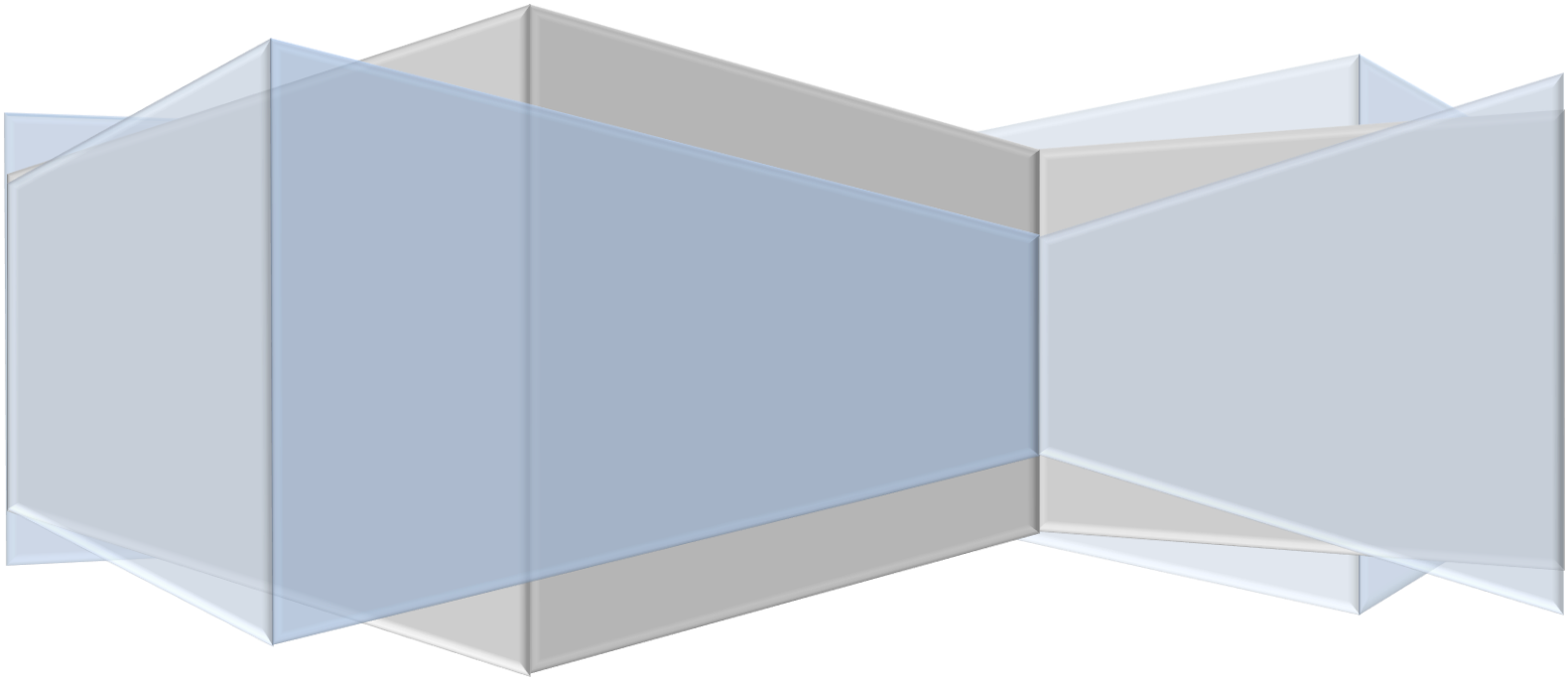
None identified

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

'**None under the meaning of the Act.**'

Halton Safeguarding Adults Board

Annual Report 2015-16



FOREWORD

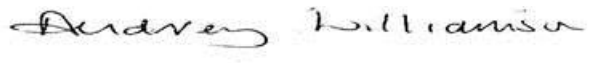
I am pleased to present the Safeguarding Adults Board's Annual Report 2015/16. We are required under the Care Act to produce an Annual Report which sets out the work of the partnership to safeguard vulnerable adults and to analyse the effectiveness of this work. I hope you find this report informative.

The Annual Report describes the developments during the last 12 months and provides case examples of how vulnerable adults are safeguarded. It highlights the challenges of implementing Making Safeguarding Personal, the Government initiative that enables vulnerable adults to play a central role when safeguarding concerns are investigated. Halton Safeguarding Adults Board will continue to monitor the outcomes for individuals who may need protection to ensure that their views are listened to.

Halton Safeguarding Adults Board will be improving the information it receives in the forthcoming year. We will review our performance framework to ensure that information provided is multi-agency rather than simply relying on one or two agencies to furnish the Board with information. This will also allow us to focus on outcomes or the quality of services as well as volume of safeguarding work.

On a personal level and having taken up the role of Independent Chair in November 2015, I have found working with Halton Safeguarding Adults Board both rewarding and challenging. Much has been achieved during this year and the partnership continues to prioritise safeguarding. We recognise there is more to do including raising awareness of safeguarding in our communities in order to prevent abuse and neglect taking place. There are clear plans to achieve this in our business plan next year.

Finally, I would like to thank all those who support Halton Safeguarding Adults Board, ensuring the smooth running of the Board's business. I would also like to thank all practitioners who work on a daily basis in this challenging area in Halton.



Audrey Williamson – Independent Chair

EXECUTIVE SUMMARY

A range of agencies and organisations have contributed to this report demonstrating both a commitment to this important area of work and to partnership working. It is only through agencies working together that vulnerable adults are truly safeguarded. Partnership work has always been a strength in Halton and this continues and is demonstrated in the Annual Report. All agencies are experiencing increasing demand for services but strong leadership continues to be provided by the three key agencies tasked with safeguarding vulnerable adults: Cheshire Police; Halton Borough Council and NHS Halton Clinical Commissioning Group, supported by a range of organisations including the Fire Service; Healthwatch; Probation Services and a range of health agencies.

Performance information is critical in assessing the effectiveness of safeguarding work. The implementation of the Halton Care Concerns Model by all providers this year, meant that the Board can be assured that the right referrals/concerns are being escalated to those agencies responsible for investigating them. This has led to a decrease in the numbers of safeguarding referrals to Adult Social Care Services, as practice issues are now being addressed by the Care Concerns Model in Halton.

The numbers of referrals concerning financial abuse have increased. This may be in part due to increased awareness of this form of abuse following the implementation of a Financial Abuse Toolkit, to enable agencies to assess potential risk in this area.

Performance data indicates that females aged 65 and over and receiving support in their own home due to a physical or sensory impairment, are most at risk of harm or abuse in Halton, therefore this is where the Board needs to focus its attention for future work.

Partner agencies have continued to support the work of Halton Safeguarding Adults Board and their contributions to helping to keep people safe in Halton have been summarised in this report, along with some of the key implementations the Board has put in place during this financial year.

INTRODUCTION

The purpose of Halton's Safeguarding Adults Board is to:

- Act as a multi-agency partnership board of lead officers and key representatives, which takes strategic decisions aimed at safeguarding adults at risk in Halton
- Determine and implement policy, co-ordinate activity between agencies, facilitate training and monitor, review and evaluate the safeguarding of adults
- Promote inter-agency cooperation activity between agencies
- Develop and sustain a high level of commitment to the protection of adults at risk
- Ensure the development of services to support people from hard to reach groups

The current membership of the Board includes representatives from each of the following:

- Halton Borough Council
- NHS Halton Clinical Commissioning Group
- Cheshire Constabulary
- Cheshire Fire and Rescue
- St Helens and Knowsley Hospitals NHS Trust
- Bridgewater Community Healthcare Trust
- Halton & Warrington Trading Standards
- Carer representative
- 5 Boroughs Partnership
- Age UK Mid Mersey
- Warrington & Halton Hospitals NHS Trust
- Care Quality Commission
- SHAP (advocacy)
- Riverside College
- Probation
- Housing Trust

The implementation of the Care Act 2014 from 1st April 2015, placed Safeguarding Adults Boards on a statutory footing for the first time. The Care Act states that Safeguarding Adults Boards have three core duties. They must:

- Develop and publish a Strategic Plan setting out how they will meet their objectives and how member and partner agencies will contribute
- Publish an Annual Report detailing how effective their work has been
- Commission Safeguarding Adults Reviews for any cases which meet the criteria

CURRENT PICTURE IN HALTON

From taking a closer look at the data collated for the statutory Safeguarding Adults Collection in 2015/16, we can start to build a profile of who are the most vulnerable to potential abuse in Halton and start to focus the work of the Board around addressing the needs of the community to help keep people safe in Halton.

In 2015/16, data indicated that the most potentially vulnerable in our community were females aged 65 and over, have an ethnicity of White British and who primarily require support for their physical needs from adult social care. The most prominent type of alleged abuse in Halton is physical abuse, followed by neglect. The alleged abuse is most likely to occur in the person's own home and perpetrated by someone who is known to the individual, for example, a relative or care worker.

By using this data the following information highlights the work that has been undertaken by Halton Safeguarding Adults Board in order to keep the people of Halton safe from potential abuse or neglect.

PERFORMANCE

Deprivation of Liberty Safeguards

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

In March 2014, the Supreme Court issued a judgement that clarified an 'acid test' for what constitutes a deprivation of liberty. The acid test states that an individual who lacks capacity to consent to the arrangement for their care and is subject to continuous supervision and control and is not free to leave their care setting, is deprived of their liberty and should be the subject of a DoLS application (whether they are in a care home or hospital

setting). The judgement marked a significant change to practice and has led to a tenfold increase in the number of applications received 2013-14 and 2014-15.

An action plan was developed to address and coordinate the Halton response to the Supreme Court judgement. The Integrated Adults Safeguarding Unit coordinates and manages the DoLS assessments and reviews and acts on behalf of the Supervisory Body (the Local Authority). The team members include a DoLS Coordinator and two dedicated DoLS Assessors. The team is supported by a small pool of Best Interest Assessors drawn from care managers and there is an ongoing training programme established to ensure that all appropriate staff are trained to undertake this role going forward.

The data identifies the significant increase in the amount of requests for assessments rising by 302% from 2014 to 2015. In the period April 2015 to March 2016, the local authority received over 400 referrals. Please see the table below for a comparison in the number of DoLS applications received 2014/15 to 2015/16.

Period	2014/15	2015/16
Q1	38	84
Q2	51	131
Q3	53	80
Q4	48	115
Total	190	410

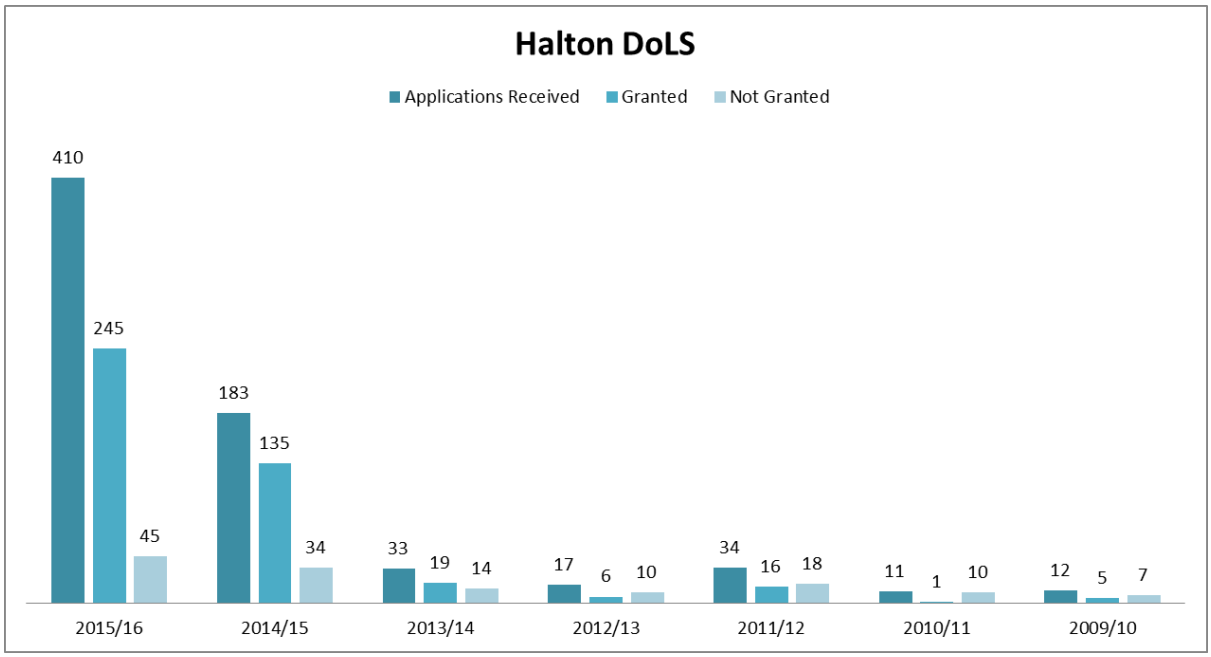


Figure 1: The figure above shows the increase in DoLS for Halton since it was introduced in 2009. DoLS applications have increased significantly since the 2014 Supreme Court Judgement, with an increase of 127 per cent from 2014/15 to 2015/16.

Despite the increase in DoLS applications received, Halton received the lowest number of applications of Councils in the North West.

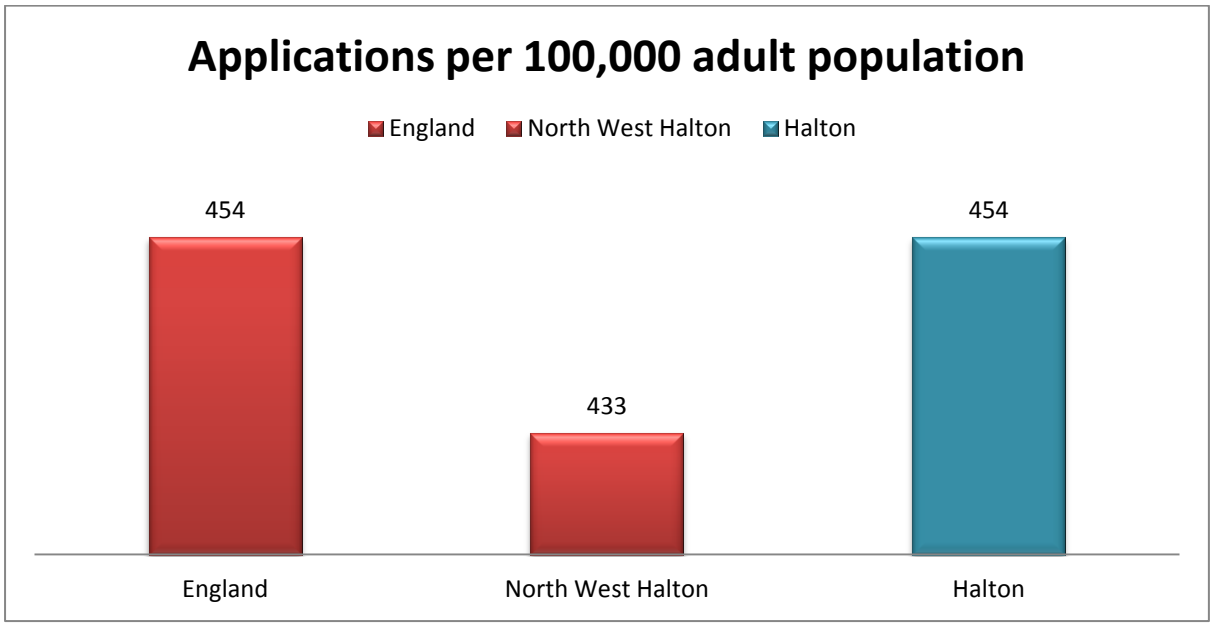


Figure 2: Applications received per 100,000 population, England, North West and Halton 2015-16 (Population data source Office for National Statistics – 2015 mid-year population estimates). Halton received 454 applications per 100,000 population, actual figures show that Halton received the lowest number of applications of all North West and Comparator Councils.

The results of the DoLS applications in Halton are as follows:

60% of DoLS applications were granted

11% of DoLS applications were not granted

10% of DoLS applications were withdrawn

19% of DoLS applications had not been signed off as at 31st March 2016 (the % of those not yet signed off were lower than the North West Average)

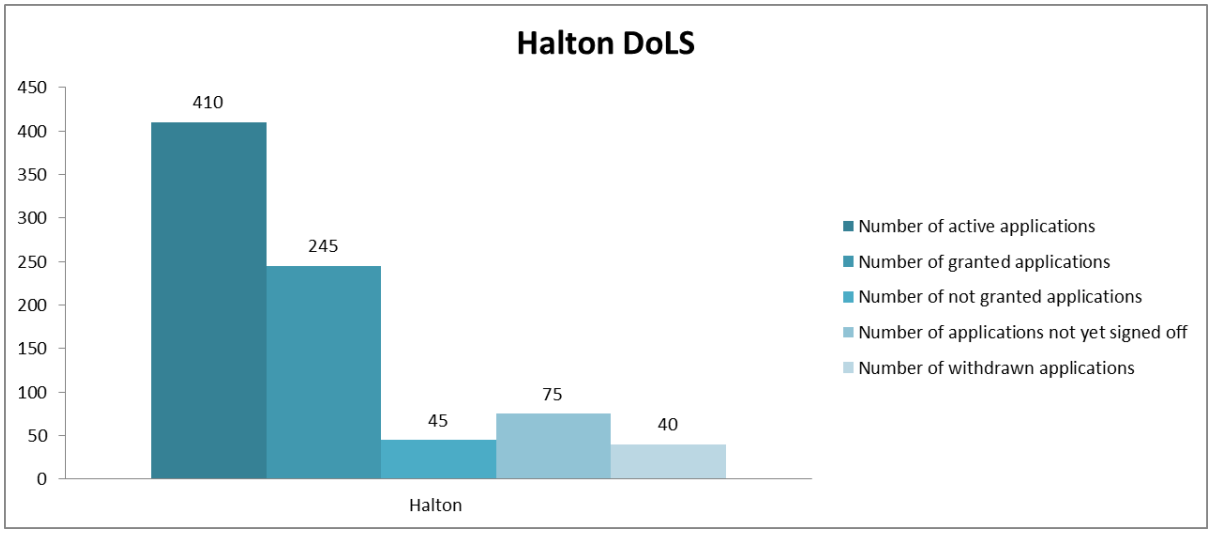


Figure 3: Halton figures for applications received, granted, not granted, not yet signed off and withdrawn for 2015-16

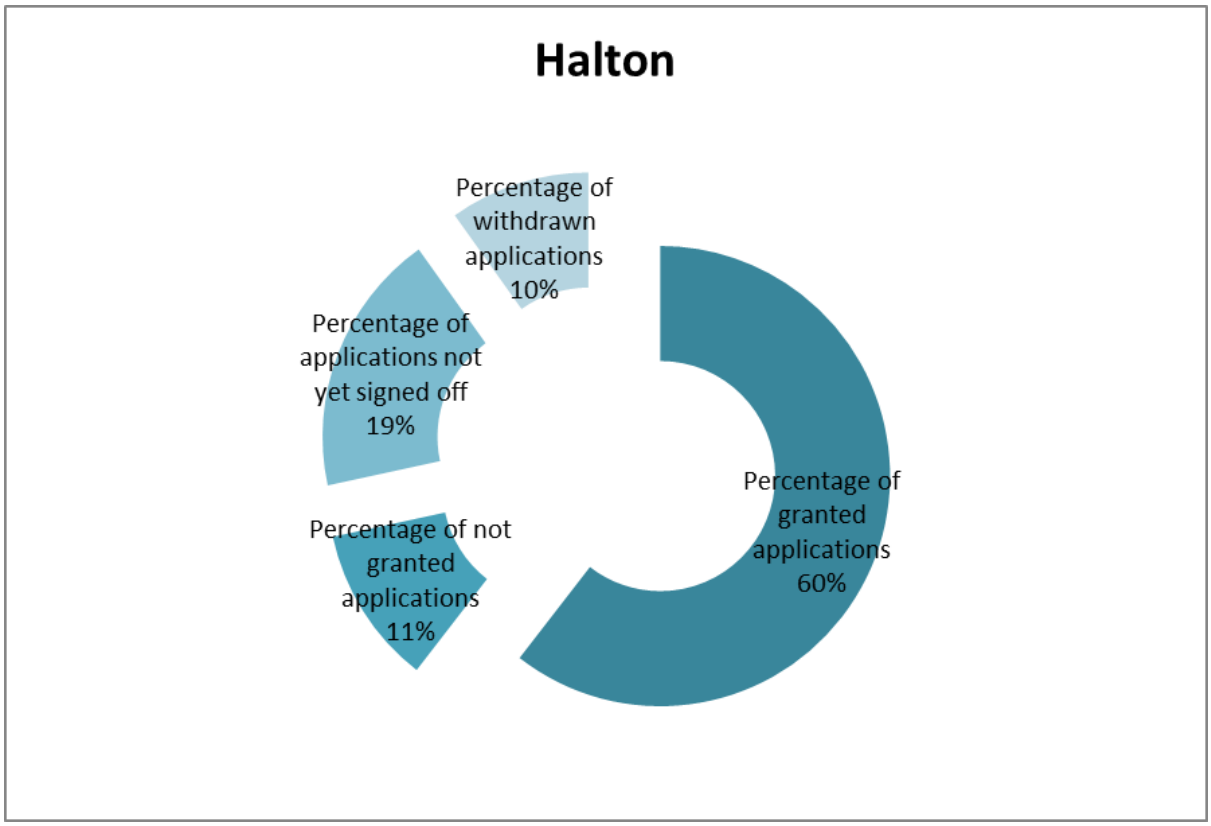


Figure 4: The percentages in relation to figure 3 for Halton

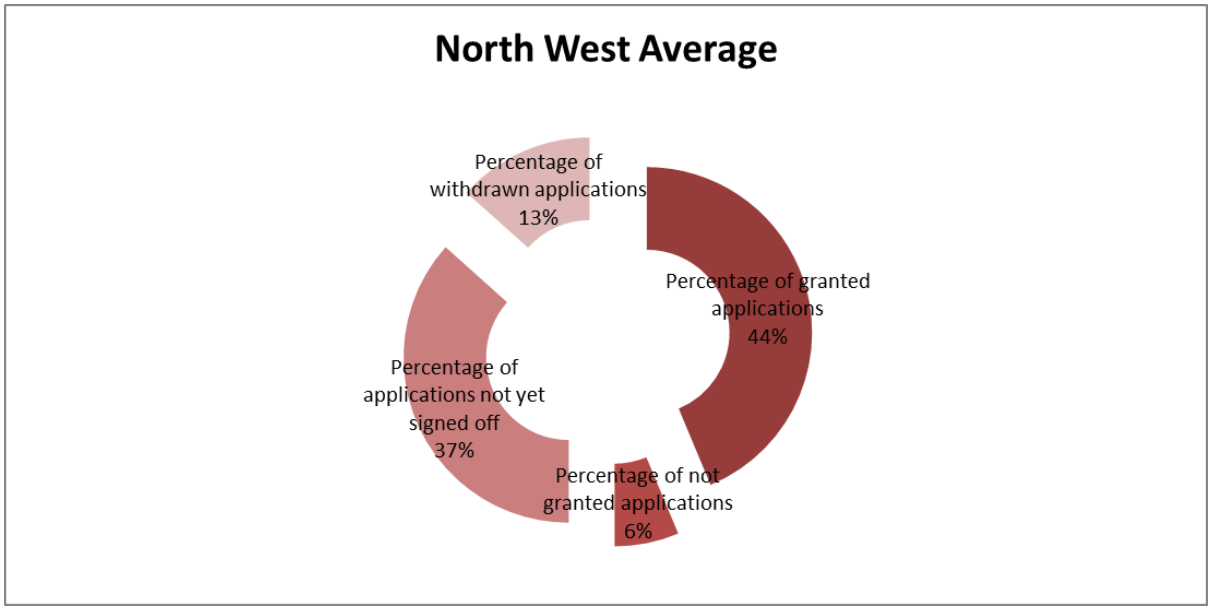


Figure 5 – The averages percentages in relation to figure 3 for the North West

When comparing Halton's figures against comparator local authorities, Halton again received the lowest number of applications. While Halton did not perform as well as comparator authorities who received a higher number of applications, this could be attributable to staffing issues within the Safeguarding Unit. On the whole Halton has performed well with 70% of applications received being completed and signed off as at 31st March 2016.

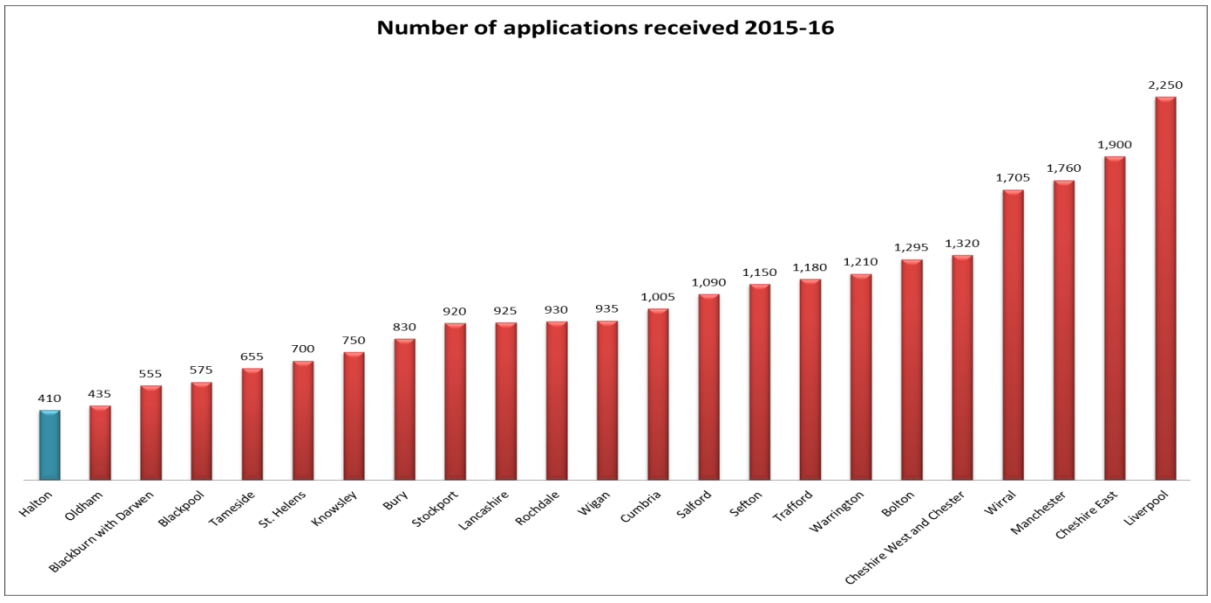


Figure 6: Applications received for North West Councils 2015-16

Safeguarding Adults Collection

The Safeguarding Adults Collection (SAC) is a mandatory performance return to be completed for the Health and Social Care Information Centre, to provide statistics from local authorities across the country regarding their safeguarding adult activity during the period 1st April 2015 to 31st March 2016.

The SAC data collection only includes cases of suspected abuse where the Council safeguarding service has been notified and recorded on their system. It does not include cases where partner agencies have dealt with the allegation and not shared the information with the Council. Therefore there may be cases of abuse that have not been reported to Councils.

The Care Act 2014 came into effect on 1st April 2015 and under Section 42 of the Act, for the first time it made safeguarding adults a statutory duty. This means where a local authority has reasonable cause to suspect that an adult in its area (whether or not they are ordinarily resident there):

(a) Has needs for care and support (whether or not the authority is meeting any of those needs) **and**
(b) Is experiencing, or is at risk of, abuse or neglect **and**
(c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

If this is the case, the local authority must make whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Definitions and terminology from previous years collections have changed to meet current practices. Therefore, care should be taken when making comparisons to previous years due to these changes.

Key Findings:

In 2015/16 it was found that adults most at risk from abuse were female, aged 65 and over and receiving care in their own homes. They are most likely to receive support due to a physical or sensory impairment. Overall Halton's performance remains stable from 2014/15 and in line with England and North West averages.

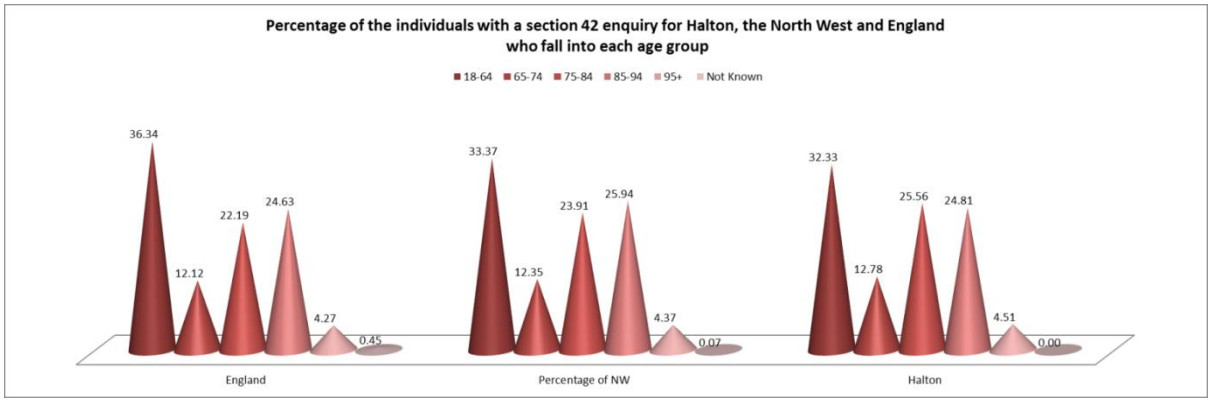


Figure 1 – Percentage of individuals with a Section 42 Enquiry by age

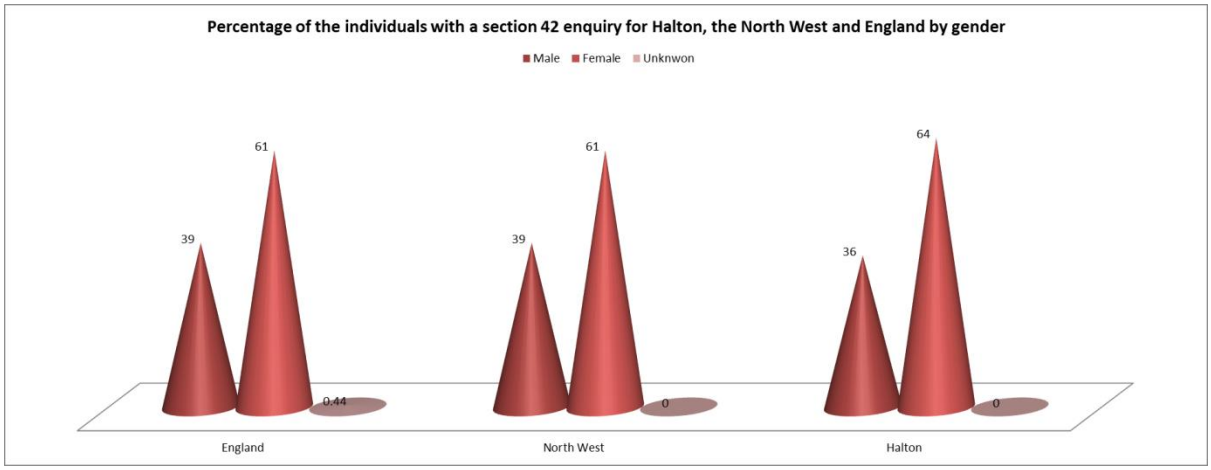


Figure 2 - Percentage of individuals with a Section 42 Enquiry by gender; Halton figures differed slightly from England and the North West with a higher percentage of females with a Section 42 Enquiry.

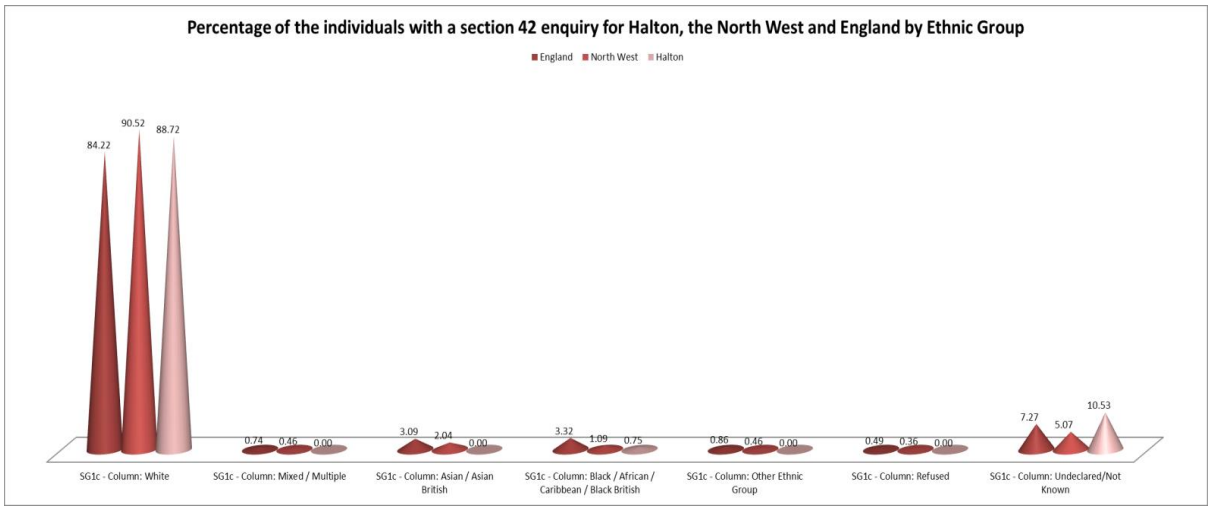


Figure 3 - Percentage of individuals with a Section 42 Enquiry by ethnicity

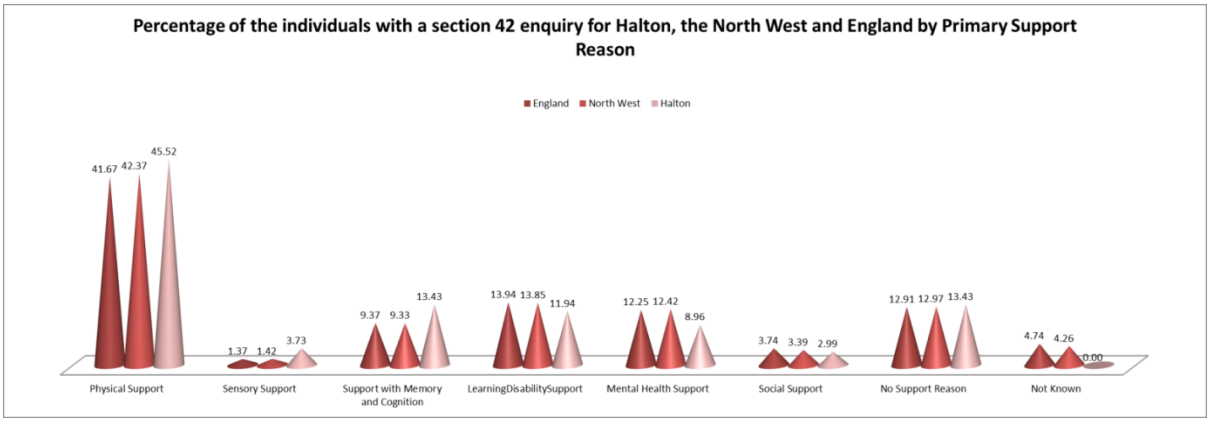


Figure 4 - Percentage of individuals with a Section 42 Enquiry by Primary Support Reason; as can be seen above Halton have a higher percentage of individuals with a PSR of physical support, sensory support and support with memory and cognition and a lower percentage of individuals with learning disability and mental health support.

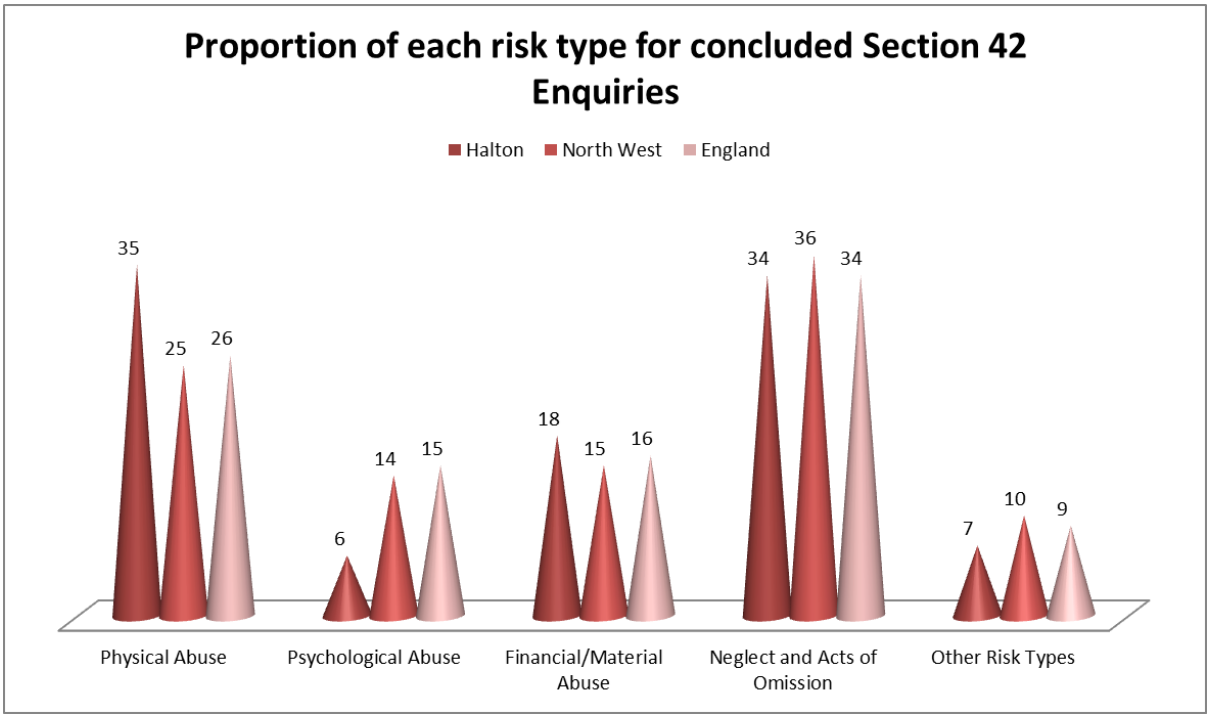


Figure 5 - Proportion of each risk type for concluded Section 42 Enquiries; while Halton have similar figures for most types of risk, however higher and lower for Physical abuse and psychological abuse.

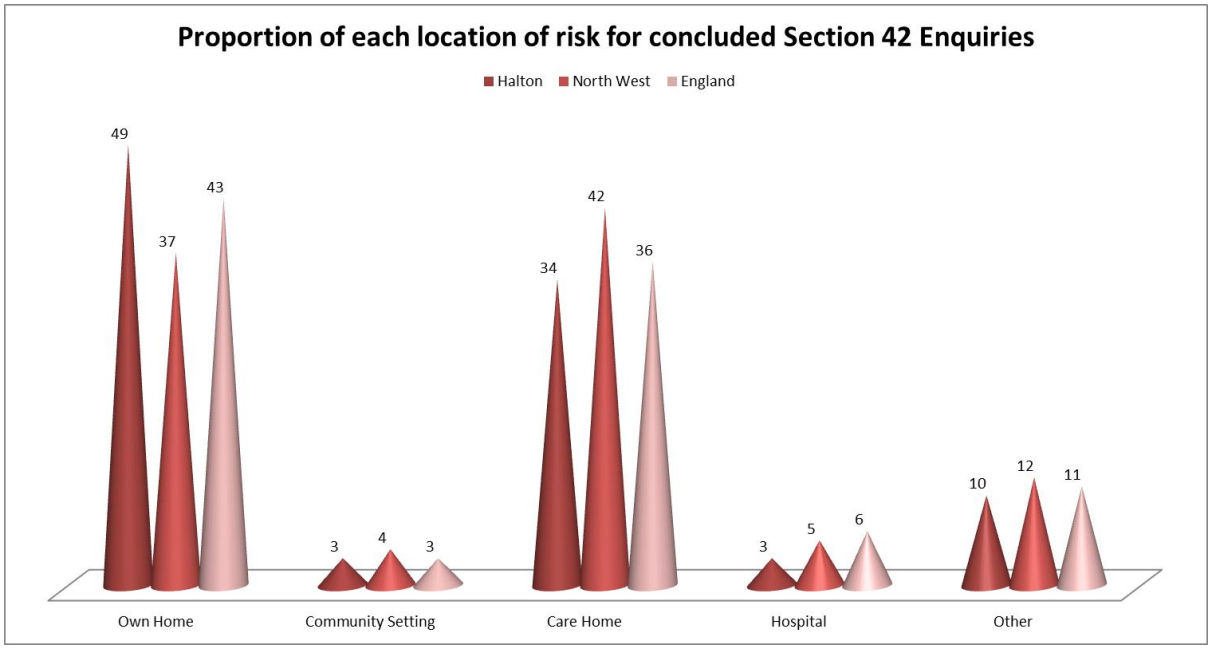


Figure 6 - Proportion of each location of risk for concluded Section 42 Enquiries; again figures are similar across Halton, England and the North West, with a shift for Halton who have higher a proportion of risk occurring in the individuals own home and fewer in care homes; for these areas, the figures are more in line with the rest of England.

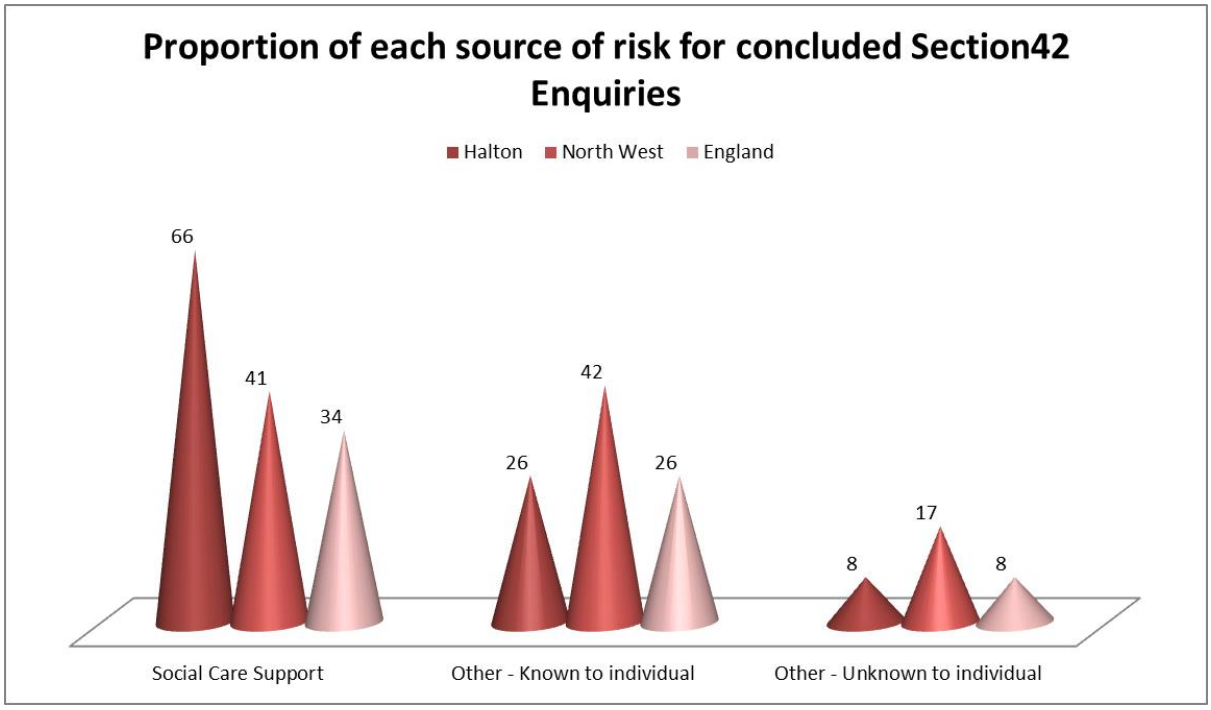


Figure 7 - Proportion of each source of risk for concluded Section42 Enquiries. Halton have considerably higher numbers of Social Care Support reported to have been the source of risk, with other figures being in line with those for England.

KEY IMPLEMENTATIONS DURING 2015/16

Advocacy Hub

Advocacy is delivered in two distinct ways in Halton. There are commissioned and non-commissioned services that deliver a varying array of advocacy across the borough. The current advocacy provision was reviewed in 2014. The review highlighted the following issues:

- There is no partnership working for commissioned advocacy services
- There are a whole range of organisations providing signposting and low-level advocacy who have been given no support or training
- Each service operates to a different set of targets
- There are clear gaps in some monitoring e.g. time taken on a case, nature of the care etc.
- Some areas are clearly under-utilised i.e. older people; carers
- There is a definite need for specialist advocacy within the borough, however, the specialist providers need to be linked via a more integrated pathway
- There is a wide disparity between unit costs for services

Recommendations from the Review:

1. Complete a review of existing befriending services in the borough and decide on future strategy in relation to this distinct area
2. Complete a skills audit of voluntary and community sector staff in relation to advocacy.

3. Establish a provider lead for the Advocacy Hub. This will be carried out by redesigning the existing service specification to include the Hub and Spoke Model as described below.

4. Devise and implement specific training to support low level Advocacy provision. This will be completed by the Advocacy Hub lead once this has been established.

Advocacy Hub and Spoke Model:

The proposed model of advocacy for Halton is a Hub and Spoke Model. It is proposed that the Hub is managed by a lead organisation, this provider would still be expected to deliver generic and Independent Mental Health Advocacy as well as managing the Advocacy Hub.

The Spoke element of the service will be in two parts, the commissioned elements where these services will contribute towards delivering the agreed targets of the Hub. Each of the providers will report directly to the Advocacy Hub in terms of both referrals and performance information and if required will be able to deliver generic advocacy.

The second part will be to support non-commissioned organisations to register with the HUB. This will give them access to training, peer support, information and signposting. This list below identifies some of the organisations who would be invited to register:

- Sure Start to Later Life
- Red Cross
- Alzheimers Society
- Vision Support
- Deafness Support
- Age UK Mid Mersey
- The Stroke Association
- Halton Healthwatch
- Carers Centre

Making Safeguarding Personal

Making Safeguarding Personal is a joint Local Government Association (LGA) and Association of Directors and Adult Social Services (ADASS) programme, that support Councils and their partners to develop outcome-focused, person-centred safeguarding practice. The approach aims to facilitate a shift in emphasis in safeguarding from undertaking a process to a commitment to improving outcomes alongside people experiencing abuse or neglect.

Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what is now known about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives so therefore empowering the adult at risk and working alongside them. The key message about this approach is a shift from a process supported by conversations to a series of conversations supported by a process.

Local Implementation:

Whilst it was acknowledged that practitioners are implementing person-centred safeguarding practice, this was not sufficiently evidenced on previous recording systems. A significant piece of work was undertaken to develop a system that evidences this practice. All safeguarding adults electronic records have been reviewed and redesigned to ensure that all care management teams can demonstrate that:

- Safeguarding assessments capture outcomes expressed by the adult at risk
- Safeguarding assessments evidence that person-centred interventions have been put in place for services who have defined the outcome they want
- Safeguarding assessments demonstrate the number and percentage of people whose expressed outcomes are fully or partially met

- Internal audits show the number and percentage of cases that close after case conference which has person centred protection plans that empower them to resolve the circumstances that put them at risk

- Internal audits show the number and percentage of people or their representatives who participated in the safeguarding process through regular consultation, attendance at meetings and that they received regular feedback evidencing that they have been kept at the centre of the process

- Internal audits show that the number and percentage of people who lack capacity have recorded Mental Capacity Assessments and Best Interest Decisions

- Internal Audits show that the number and percentage of people who were offered an independent advocate and the number of people who were supported by an independent advocate or both

- Service user feedback demonstrates the difference that the safeguarding process has made to their wellbeing

Halton has worked with MSP at bronze level and presented the work undertaken at the ADASS Spring Conference 2014, prior to the implementation of the Care Act and are advanced in our progress compared to other authorities.

We have undertaken a whole service redesign to incorporate person centred involvement and the capturing of outcomes. A full programme of workshops has been held to support both practitioners and managers and a MSP group established. The new IT system went live in July 2015 and the first report on outcomes was presented to the Board in November 2015.

HOW ARE WE KEEPING PEOPLE SAFE IN HALTON?

Financial Abuse Toolkit

In January 2015, a report regarding the local and national picture of financial abuse was presented to the Safeguarding Adults Board. As a result of this report, it was agreed that a Task and Finish Group would be established in order to develop a Financial Abuse Toolkit, for use by practitioners and the general public to raise awareness of what constitutes financial abuse and what actions can be taken to reduce the risk and hopefully prevent people experiencing this type of abuse.

The Task and Finish Group was established and met in March 2015. As a result of the meeting, a Financial Abuse Toolkit was drafted which was based on a similar model used successfully in East Sussex. The toolkit provides an overview of the wide ranging types of financial abuse which can affect people and also provides information and advice regarding potential victims and perpetrators; support services available and local case studies.

The toolkit can be used by both front line staff and the general public in order to raise awareness and help to make the local community more vigilant to this type of abuse.

The toolkit has been developed into an e-learning module which all Halton Safeguarding Adult Board partner agencies are able to access at:

http://enable.learningpool.com

Medication Errors

During 2014/15 there had been a number of large scale investigations into providers of social care and health care services, accounting for a large proportion of the referrals relating to neglect or omission with medication errors being a dominant feature.

Neglect is the deliberate withholding or unintentional failure to provide appropriate and adequate care and support, where this has resulted in, or is highly likely to result in the person experiencing severe ill health or adverse effects.

The National Patient Safety Agency (NPSA) defines a medication error as an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred.

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of, the health care professional, patient or consumer"

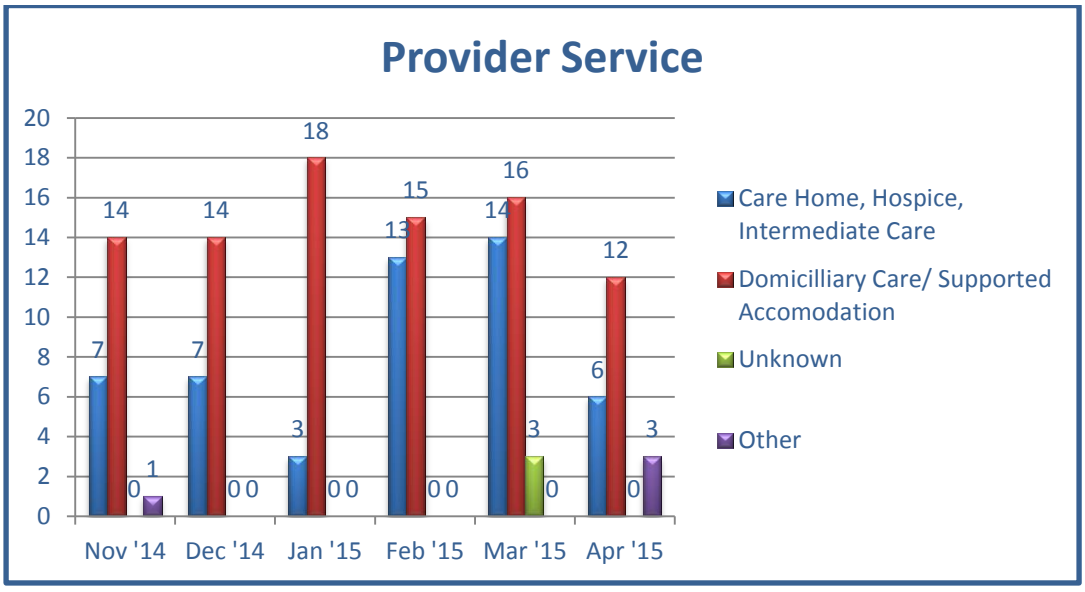
(National Coordinating Council for Medication Reporting & Prevention)

Care providers who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people using this service will have their medicines at the times they need them and in a safe way.

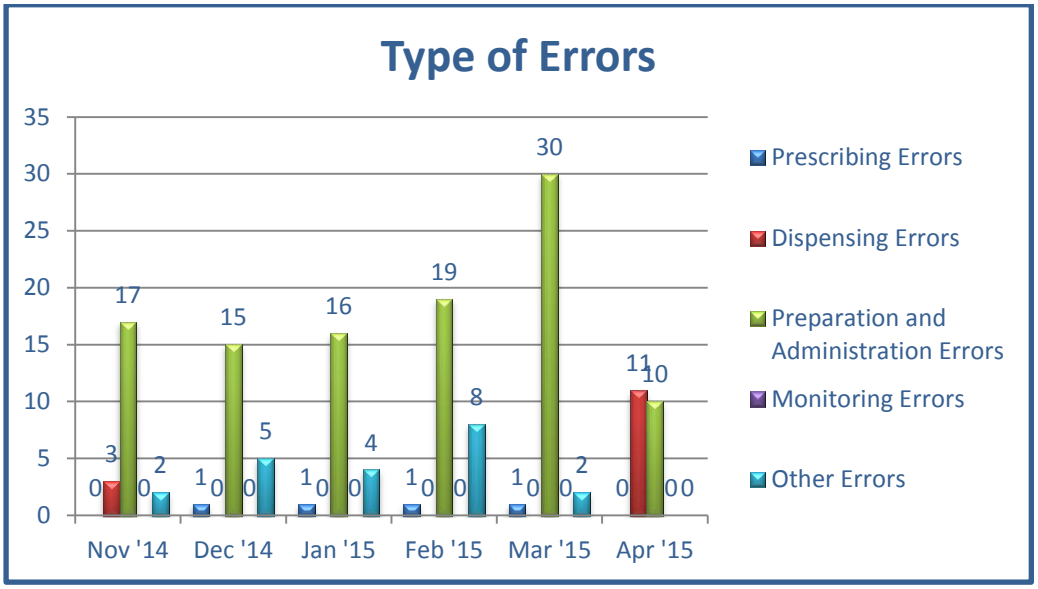
Medication incidents have a number of causes, such as lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction and poor communication.

The National Patient Safety Agency (NPSA) has divided definitions of medication errors into the following categories:

- Prescribing errors
- Dispensing errors
- Preparation and administration errors
- Monitoring errors
- Other errors including poor or inadequate communication and recording etc.



The graph above provides local data regarding the type of provider service who have made and then report the medication error. Initial analysis would cause concern regarding domiciliary care services and the higher incidence of reported errors, however, there is evidence to support that errors made within the care home setting are not being reported by themselves rather it appears to be other visiting professionals who identify the errors as part of a care review or wider scale investigation.



In line with the NPSA definitions the above table highlights that the majority of reported medication errors involve poor administration by care providers; this includes administation of the wrong medication or dose, administering medication too early or late and that the adminstration of medication has been recorded incorrectly or not recorded at all. The increased incidents of dispersing errors in April is in the main attributed to a decision made by one pharmacist in respect of 7 residents prescriptions, which were not available at the acute hospital setting.

Where 'other errors' are recorded, this includes scenarios where there have been insufficient stock, missing medication or missed calls by domiciliary care providers resulting in medication not being administered.

Where medication errors are reported action is required by the provider service to protect the adult at risk from harm and to ensure that no other adults are put at risk. In many cases the safeguarding investigation identifies that the worker needs more training and where this occurs the worker is supported to deliver safe care. The Care Home & Support Team is now well established in Halton with a dedicated Pharmacist who provides support and advice to the care homes. All data regarding medication errors are shared with the CCG Medicines Management Team so that trends, themes and ongoing support can be identified.

Halton NHS CCG Medicines Management Care Home Support Team (MMCHST) have been in post for over 6 months and have identified areas of good practice and areas which require improvement in regards to medicines management. When issues are identified the MMCHST offer advice on best practice to guide the home towards improvement. Issues surrounding controlled drugs have been reported to the Safeguarding Team and the Controlled Drugs Accountable Officer. Halton Safeguarding Team investigated the issues, informed the Police (where necessary) and offered support to the care home. Recently there was a very successful care provider forum where the MMCHST and Safeguarding Team co-presented on the subject "Mental Capacity Act and covert administration of medication". This was well received and demonstrated a united approach to local issues. The presentation is part of a project whereby the MMCHST will audit care homes documentation for the covert administration process and help to identify, and offer guidance, on where improvements are needed. The MMCHST will liaise with the Safeguarding Team if improvements are not sufficient after an agreed timeframe. Currently only a small number of medicines related safeguarding alerts come through to MMCHST, however, there are plans to work closer with the Safeguarding Team in the near future.

Care Concerns Model

Protecting vulnerable people from abuse, harm and exploitation in Halton is a key priority for the Council and its partners. It is important to ensure that resources are targeted to ensure they are used effectively and to ensure clear indicators exist regarding procedures that should be followed. The Care Act 20014 stipulates that safeguarding alerts received must be dealt with a proportionate response, whilst also adhering to the desired outcomes of the adult at risk.

Sometimes a concern arises which leaves managers uncertain as to whether it should be dealt with as a safeguarding matter or as one that constitutes poor practice but does not warrant initiating the Safeguarding Adults Procedures.

There will be occasions when it is appropriate for provider agencies to respond to incidents of poor practice without the need to instigate Safeguarding Adults Procedures.

Poor practice will always require a satisfactory response and this remains a provider service manager's responsibility. If it is not challenged it can result in a further deterioration in standards leading to longer-term difficulties or even catastrophic consequences for some individuals.

The Care Concern Model guidance outlines those circumstances in which the provider service should take responsibility for dealing with incidents as a matter of poor practice rather than referring them as safeguarding concerns and how those arrangements will be monitored.

Dealing with Incidents/Issues of concern:

On receiving information about an incident/concern, the provider service manager should determine whether it is appropriate for it to be dealt with under the Safeguarding Adults Procedures or as a Care Concern.

Identifying Care Concerns:

In making the decision, the Manager of the provider service should consider the nature, seriousness and other relevant circumstances of the incident/issue. Provider services will be expected to identify, investigate and rectify Care Concerns – poor practice in which the standard of care provided has fallen short of that expected and satisfactory, including failure to meet a service user's care/support needs – but which have not resulted in any harm to an adult at risk.

Care Concern Alert Process:

The main purpose of identifying a Care Concern is to rectify any deficiency immediately, understand why care was compromised and put in place measures to ensure that there is no repetition.

To support this process and to ensure that there is a full investigation and any lessons learnt are acted upon to improve service standards, the provider service must:

- Refer to the Thresholds Framework to determine if the criteria for a provider-led investigation is met
- Undertake the investigation
- Complete the Care Concern Alert Form and send it as soon as possible within 5 working days of the care concern being raised to the Quality Assurance Team – Halton Borough Council

Role of Halton Borough Council:

If Halton Borough Council considers that a matter notified to them as a Care Concern warrants further consideration for initiation of the Inter-Agency Safeguarding Adults Procedures, they will agree who will lead this process and will contact the manager of the provider service in accordance with agreement reached in a strategy discussion.

If not dealing with the referral through the Safeguarding Adults Procedures, it may be considered appropriate to take other action in addition to the Care Concern investigation by the provider service, for example:

- Assessment/Care Management/Review
- Complaints Procedure – Customer Care Team
- Disciplinary Procedure
- Contract Compliance – Quality Assurance Team
- Referral/Signposting to related services e.g. Drug/Alcohol Services; Trading Standards; Community Safety; Safeguarding Children/Child Protection; Domestic Abuse services etc.

Monitoring Arrangements:

Providers will be responsible for ensuring the ongoing quality of service standards and any actions that need to be taken as a result of the Care Concern.

All care concerns will be subject to quality assurance and where appropriate the Quality Assurance leads may contact the provider, where collective concerns arise or if best practice lessons can be learnt and shared at Provider Forums.

Safeguarding Champions

The Safeguarding Champions Forum was established in 2014 by the Integrated Adult Safeguarding Unit. The purpose of the forum is to provide a group where a provider service nominates a representative within their service (not necessarily a manager) to be the champion, who has a genuine interest in safeguarding and is able to disseminate any information discussed within the forum. The Safeguarding Champions do have the opportunity to decide upon agenda items and during the most recent meetings, the champions have been tasked with listing what information they would find most useful to be discussed at future meetings to determine how the agenda can be structured. Agenda items include Serious Case Reviews/Safeguarding Adult Reviews; any relevant case law; Making Safeguarding Personal; Mental Capacity Act and Deprivation of Liberty Safeguards etc.

The meetings are held on a quarterly basis and cover domiciliary care, care homes and other agencies (for example: Community Bridge Building Team; Adult Placement; Day Services; Supporting Living providers). Colleagues from the Police; Warrington and Halton Hospital Safeguarding Matrons; Care Home Support Team, Medicine Management Team and the Adult Safeguarding & Dignity Officer attend the forum to present an overview of the work they are involved in. Information that is current to social work practice is also discussed at meetings, types of information that have been presented/discussed include the financial abuse toolkit; self-neglect and domestic violence. Champions are asked to complete group exercises, which are aimed to increase their awareness and knowledge around a particular topic.

Following the establishment of the Safeguarding Champions Forum, members of the Integrated Adult Safeguarding Unit have attended a number of different services offering support, advice and awareness raising on safeguarding and care concerns. Awareness sessions are tailored to the needs of the provider, whom their representative has attended the Forum and raised issues/concerns. The forum is attended by 15-30 champions and feedback has been positive. The next step is to look at establishing a similar forum for Mental Capacity Act awareness, which would work in a similar fashion but aimed at more senior positions within each service, to ensure that the Mental Capacity Act is being followed and good practice guidance and examples are shared. This is being proposed due to the additional scrutiny now being given by the Care Quality Commission around the Mental Capacity Act and Deprivation of Liberty Safeguard within placement settings.

NHS
Halton Clinical Commissioning Group

NHS Halton Clinical Commissioning Group (CCG) requires all its commissioned providers to evidence how they enable and encourage service users to share their views to influence service delivery and change. This is monitored through contractual arrangements and performance monitoring of the quality schedule and in particular the safeguarding Key Performance Indicators. NHS Halton CCG facilitates a number of forums that enable service users to engage with health commissioners.

NHS Halton CCG requires that all CCG staff, Governing Body Members, Member Practice Staff and staff in all services it commissions, receive mandatory safeguarding training. During 2015/16 NHS Halton CCG has developed a Training Needs Analysis of all its staff members to identify the levels of safeguarding training required, to ensure that staff are appropriately trained and that they are aware of abuse and the right to a safe and dignified life. The NHS Halton CCG commissioned provider services are required to evidence that staff are aware of the risks of abuse and staff compliance with training

trajectories. This is monitored by NHS Halton CCG on a quarterly basis and reported to the Governing Body.

All NHS Halton CCG commissioned health providers are required to evidence that they have policies and procedures in place that safeguard their service users. The health providers must provide assurance to NHS Halton CCG that their policies and procedures are compliant with current legislation and clearly identify roles and responsibilities in relation to discharging safeguarding duties. NHS Halton CCG monitors compliance via the safeguarding key performance indicators.

NHS Halton CCG has supported the introduction of the role of a Mental Capacity/DoLS Coordinator within the CCG Designated Professionals Safeguarding Adults Team. This role will enable the Halton health community to respond appropriately to the requirements of the Mental Capacity Act, by providing advice and support for health commissioned services, ensuring that health service providers have access to and attend relevant training and monitor the quality of DoLS applications.

NHS Halton CCG employs Designated Safeguarding Professionals to support and enable the CCG to discharge their statutory duties. A key aspect of the Designated Safeguarding Professional's role is to facilitate the embedding of safeguarding within commissioning and performance management across the health economy and to work across the local health system to support other professionals in their agencies on all aspects of safeguarding.

The organisation has reviewed the contracts with its commissioned health providers. The CCG employs a range of performance monitoring measures to seek assurance from providers and demonstrate compliance with safeguarding duties. Assurance is monitored via contractual compliance, provider quarterly reporting against specific safeguarding key performance indicators, audit and through attendance at provider safeguarding committees and announced and unannounced provider visits.

5 Boroughs Partnership NHS
NHS Foundation Trust

The Trust has an approved Safeguarding Strategy which sets out the Safeguarding Assurance Framework for the implementation of safeguarding arrangements within the organisation, the accountability structures and the methods of monitoring to provide assurance of delivery of safe working practices in line with Trust Safeguarding Policies.

The Safeguarding Adults Team provide advice, guidance and support to all Trust staff, as well as training and quality checking safeguarding adults' activity in each of our 5 Boroughs covering all of our services (Mental Health; Learning Disabilities; Later Life and Memory Services; Child and Adolescent Mental Health Services; Forensic and Community Health Services). Under the Making Safeguarding Personal Agenda, practitioners reporting concerns to the team are guided to asking the individual concerned what they want to happen, are they aware of safeguarding and what this means to them and more importantly, what they don't want to happen.

The Safeguarding Adults Team have been involved with a Trust wide review of the consent agenda to ensure that service users and their carer's are fully involved in decisions regarding their care and treatment and that any decisions made, should the individual concerned lack the capacity to consent, are in their best interests.

The Trust is commissioned by 5 Clinical Commissioning Groups (CCGs) to provide safeguarding services across the organisation. The Trust Safeguarding Assurance Group is held on a quarterly basis which invites the Designated Nurses to support the Trust with assuring compliance and standards of safeguarding practice. The respective CCGs monitor the Trust's contractual performance, quality, safety and safeguarding arrangements through a joint Clinical Quality and Performance Group with 3 respective locality Quality, Safety and Safeguarding Monitoring Groups.

During the past year the Trust has significantly developed the Lessons Learned Forum, which enables systematic analysis of a range of patient quality and safety information including the outcomes of internal and external reviews following incidents in order to identify and improve the quality of services. A series of lessons learned events have taken place across the Trust during the past year involving practitioners aimed at the sharing of information and to improve clinical practice.

National Probation Service

The National Probation Service manages those who have been through the courts and receive a prison sentence for serious offences. Many such cases have perpetrated some form of domestic violence. Along with the Police, in appropriate cases, disclosure takes place with any new partner of that offender. In some cases, it is clear that the offender targets vulnerable partners and work undertaken with the couple involves ensuring that the new partner and potential victim understands what abuse is, which takes it beyond physical abuse to ensure that they have some knowledge with which to protect themselves and where to seek help, if required.

Dangerous offenders are managed under Multi Agency Public Protection Arrangements (MAPPA). Some of our most dangerous offenders also have mental health issues themselves, suffer from a Personality Disorder or have learning disabilities. They are not permitted to attend MAPPA, as in the past the information gained by offenders at a MAPPA meeting has placed them in a position to further abuse. However they are asked to provide a thought map to inform the meeting of their understanding of risks they present, the protective factors that are present and their needs and strengths and what they think the meeting could most effectively set up to meet their needs and protect those who may also be at risk from them.

The National Probation Service has recently published an Adult Safeguarding Policy and Practice Guidance. These have been made available to all Probation staff who have had a briefing on them and their contribution to adult safeguarding made explicit. Quite a lot of emphasis is on assessment so in the early stages of the order or license, the Probation Officer is asked to take an investigative approach to tease out any care and support needs the offender may have or present. They are made aware of the referral process to adult social care and also the escalation process as necessary. They are also asked to consider all the forms that abuse and neglect might take and be aware of the possible indicators to be aware and fully engaged in prevention.

The Probation Officers manage many cases where the victims are at risk and in need of care and support and where the offender will constantly harass or breach restraining orders. The victim liaison officers and the Probation Officers understand the many reasons the victim may have in not reporting further abuse and respect, but will also seek to empower victims to seek the support they need to keep them safe. On the other side, the Probation Officer needs to ensure that the controls and constraints that can be imposed on the perpetrator take some responsibility away from the victim that they should not have to “own”.

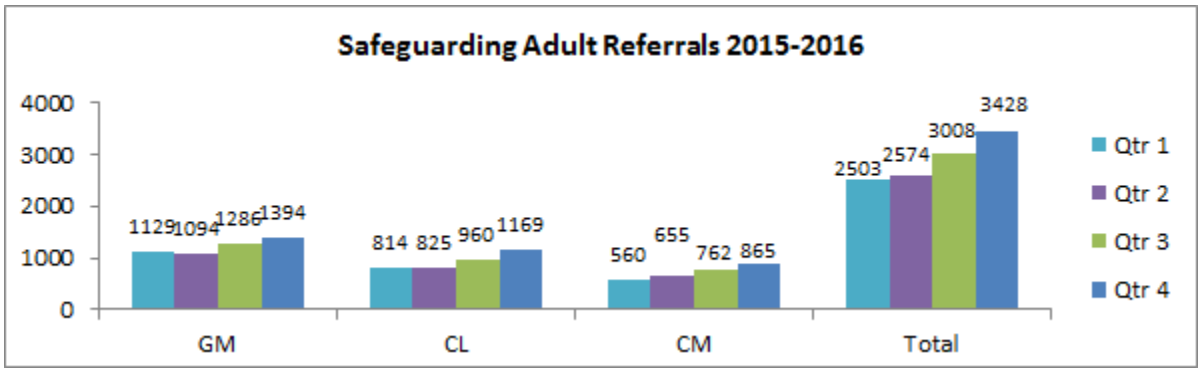
North West Ambulance Service

NHS

North West Ambulance Service NHS Trust (NWAS) is a regional service providing pre-hospital emergency care, urgent care and 111 services and Patient Transport Services.

Safeguarding activity has increased throughout the year, which is reflected in the increase in the numbers of safeguarding concerns raised about adults at risk. The numbers are broken

down into geographical area (GM = Greater Manchester CM = Cheshire and Mersey and CL = Cumbria and Lancashire)



The implementation of the Care Act 2014 with its focus on personal choice and empowerment for patients has resulted in an increase in requests to be involved in Adult Reviews and Strategy Meetings. Senior Clinicians and Managers support staff with engagement in safeguarding processes and regularly represent the Trust at associated meetings.

Each month the NWAS safeguarding concerns rejected by Adult and Children's Social Care are scrutinised to understand the themes and either re-allocated to the correct service or to the patients GP. Less than 6% of adult concerns are rejected. The rejections relate predominantly to mental ill health for adults and the Trust is working towards developing referral pathways with partners to address the risks.

Quality Audits

Audits have been introduced to monitor the quality of safeguarding calls made by staff to the Trust Support Centre. This provides additional data relating to safeguarding knowledge and how the process has facilitated information sharing. Early indicators show that referral information is of a high quality and is captured and documented by the Support Centre Advisors accurately. Areas for improvement are highlighted and raised with the staff concerned for their learning.

PREVENT Awareness and Training

92% of all NWAS staff have now received WRAP 3 training, which is the 'workshop to raise awareness of PREVENT' and part of the Government's anti-terrorism strategy. Prevent is any terror related activity that takes place in the pre-criminal space. WRAP is included within mandatory training for all staff and compliance with this national requirement has increased during 2015/16.

The Trust will be updating its mandatory training relating to Human Trafficking, Modern Slavery and Domestic Abuse in the next year. Training in these subjects is currently available within the Trust Learning Zone and is accessible to all staff.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

The Trust has a Safeguarding Adult Training Strategy and Needs Analysis, which is scrutinised by its commissioners and the Designated Safeguarding Adult Leads within the Clinical Commissioning Group.

The Trust has achieved 97% compliance with its Level 1 Training which is directed to ALL staff and equips staff to recognise and identify abuse and to alert a member of staff to make a referral. The Trust Safeguarding Team provides the training resource and advice and guidance to all areas of the Trust.

Overall Trust Safeguarding Activity which is captured in quarterly reports is broken down for each care group – Medical, Surgical, Clinical Support and St Helens, so that they can see the nature of their own safeguarding activity and its consequences. Records are kept of the areas from which safeguarding contacts are made which demonstrates that increasingly all areas are in contact with the safeguarding team seeking advice and, where necessary, being encouraged to make referrals. This provides overall assurance that all areas are engaged with the safeguarding agenda.

The Trust requests information from a range of agencies, to assist in enquiries and investigations relating to safeguarding incidents; care concerns; potential safeguarding adult reviews and fatalities which need to be managed in a consistent and robust manner, ensuring that the sharing of information is consistent with the Caldicott Principles and the Data Protection Act.

Whilst the Safeguarding Team acts as the single point of contact for such enquiries, the Team confer both with the Trust's Information Governance Team and the Legal Services Department to ensure compliance with the legislative framework around information sharing.

Mid Mersey ageUK

Age UK Mid Mersey has services that go into older people's homes, like our home visiting service for benefits checks and our practical support service. Our staff are very experienced

and will report back to line managers if they have concerns about the wellbeing of an older person.

Age UK work closely with the safeguarding team sharing what information is necessary and also speak to social workers to share any important factors. At all times this is done whilst being sensitive to the person's needs.

All Senior/Case Managers attend multi-agency training with the aim of ensuring they are aware of the signs of abuse and what to do/who to contact if they have concerns.

The Cheshire & Greater Manchester Community Rehabilitation Company (CRC) has policies in relation to staff responsibilities, in terms of safeguarding of adults and the potential impact on those who are involved with vulnerable adults; specifically policies in relation to safeguarding children, child sexual exploitation and working with domestic violence perpetrators and their responsibilities in relation to the protection of victims.

Cases are discussed in monthly Risk Management Review meetings between Senior/Case Managers and their Line Managers, to ensure that the identified risks are addressed, not only for the individual but for those who have contact with them and may be adversely affected by the individual's vulnerability.

Service User feedback is important to the CRC and regular reviews and self-assessment is built into our process to ensure that we are meeting the needs of individuals. Formal feedback is collated locally on a quarterly basis and CRC wide twice per year. Individual team performance and CRC-wide performance is disseminated and action plans devised, implemented and reviewed regularly.

Staff are required to attend domestic abuse training to ensure they are competent in working with those service users who have committed offences in the context of intimate/family relationships. Learning is supported by regular line management supervision, professional development days and peer support.

The organisation ensures all colleagues feel comfortable and confident to challenge as appropriate. Colleagues feel able to and do communicate/information share in a robust timely and effective manner, colleagues are open honest and transparent at all times without fear of reprisal.

The organisation ensures that all staff have regular training provided, this enables all colleagues to have a robust understanding of the many forms of abuse, how to recognise signs and how to seek help. Safeguarding is an agenda item at every staff meeting. Safeguarding concerns are reviewed at every clinical governance meeting.

The organisation ensures safeguarding concerns are reported in a robust and timely manner to all relevant parties. Relevant information is shared as applicable and proportionate assistance is received accepted and acted upon from safeguarding colleagues.

The organisation ensures all care and intervention is person-centred. Information is communicated in a robust and timely manner, permission is sought prior to any interaction or disclosure. Dignity, equality and diversity are heavily integrated into the care provision.

Trading Standards have dealt with victims of financial abuse perpetrated by strangers such as doorstep criminals and scammers.

All such victims are provided with advice and guidance on how to deal with cold callers on the doorstep, on the phone, through email and letter so that they are less vulnerable when they are targeted again. The option of registering with the Mail and Telephone Preference Services is also discussed with them.

All victims are given free materials that provide a prompt to assist them to deal with uninvited doorstep and telephone callers and mass marketing mail. A 'No Cold Calling' letterbox sticker tells uninvited callers to leave without knocking, a 'No Cold Calling' card for display in glass doors and windows carries the same message with reminders for the householder on the reverse so that they are prompted to deal with cold callers safely when answering the door.

All victims are invited to join iCAN, which is the Trading Standards email alert system used to warn members of doorstep crime incidents , scams and to provide general consumer information.

Trading Standards work to raise awareness with the general population about what scams are and how to avoid them through iCAN messages, press releases and talks to community groups.

We provide training to the staff of other council services and local organisations so that they are able to spot if one of their clients or service users has fallen victim to a scammer or door step criminal.

Some people told us that they began to be targeted by scammers when they lost a partner so we have provided the Registration Service with scams and doorstep crime awareness raising materials, which are given to every person who registers a death.

The Service has 11 call-block devices that they can loan to people who have been caught out by scams and who receive a lot of cold calls – 55% of all calls to those people have been blocked because they were either scams or marketing calls. We worked with people who had been caught out by scammers and saved them £46,445.

Trading Standards have developed links with other organisations and professionals so that we can work together to support, both emotionally and practically, those who have been victims of doorstep criminals or scammers. We will also put victims in touch with local groups and activities so that they can benefit from making connections with people outside of their homes.

healthwatch Halton

Healthwatch Halton has a duty to ensure that adults with care and support needs and their families rights are upheld through having their alleged incidents recognised and taken seriously and responded to in a timely manner. Healthwatch Halton therefore ensures that individuals making a complaint or disclosure is taken seriously and ask individuals what action or outcome they would like to achieve from their disclosure/information/complaint.

When discussing concerns/safeguarding issues with individuals the Healthwatch Halton support team explain that any concerns or safeguarding issues may need to be shared with the appropriate authorities, if they disclose that they or others are at significant risk of harm.

In line with best practice, Healthwatch Halton review documents regularly to ensure that they are up to date, suitable and reflect best practice and this includes the Safeguarding Adult Policy. Healthwatch Halton are committed to staff and volunteers having access to Halton Borough Council e-learning modules and adult safeguarding training. As raised with the SAB to ensure that directors, staff and volunteers working within Healthwatch Halton are able to recognise and respond appropriately when information is disclosed. Healthwatch Halton also ensures that all staff and volunteers during Enter & View training are aware of what constitutes abuse; those adults with care and support neds who are most at risk of abuse and the signs and indicators of abuse.

During an Enter & View visit, the manager is informed at the start of the visit that any safeguarding concerns identified during the visit will be explained to the manager before leaving the home. Any immediate action required to safeguard adults will be taken and that where appropriate the visit will be terminated and the safeguarding reporting process will be followed in accordance with the revised Healthwatch Halton Safeguarding Policy and Procedures.

Following the visit a further discussion is held via telephone with the relevant monitoring officer for the care home, to discuss the results of the visit including identified care concerns or safeguarding issues. To enable the monitoring officer to act quickly and prevent any care concerns escalating into safeguarding issues which includes the Healthwatch lead raising an alert with Halton Borough Council Safeguarding Unit following disclosures, when appropriate.

Healthwatch Halton has a responsibility of being responsive to what they identify as the consumer champion of health and social care and reporting identified trends and themes directly to the Safeguarding Adults Board.

Warrington and Halton Hospitals NHS Foundation Trust

The Trust policy has set out agreed key principles for work in relation to safeguarding vulnerable adults. The human and civil rights of vulnerable adults who are cared for in Warrington and Halton Hospitals NHS Foundation Trust will be promoted and protected. The independence, well-being and choices of vulnerable adults will be actively promoted. Vulnerable adults will be assumed to have capacity except where it is established that this is not the case. Where a vulnerable adult lacks the mental capacity to make decisions, assistance will be offered on a multi-disciplinary basis to achieve his/her best interests. A vulnerable adult who has mental capacity has the right to take risks. Services will recognise

and accept that an individual has the right to self-determination that may involve a degree of risk. Agencies will undertake and record risk assessments to monitor this.

All investigations and assessments of vulnerable adult abuse will take account of people's ethnic origins, gender, sexuality, age and disability, religious and cultural background and be carried out in an appropriate setting, manner and language. When intervention is necessary to reduce risk to a vulnerable adult, account will be taken of the disruption to the service user and every effort will be made to minimise this and to keep it in proportion to the identified risks.

Prevention from harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health services. The Trust supports this process through staff education.

Staff are made aware of their obligation for support and representation for those in greatest need. There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

All staff are train in adult safeguarding to level 1 or 2, they are supported and empowered to recognise abuse and report this with confidence. Staff are supported to be able to be involved to a level they feel competent to do so with the knowledge to understand who they can turn to when required for support with reporting.

The Trust promotes proportionality and least intrusive response appropriate to the risk presented. Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way. This process is supported by partnership working with local solutions, through services working with their communities. Safeguarding adults will be most effective where citizens, services and communities work collaboratively to prevent, identify and respond to harm and abuse.

The Trust has a facility that allows staff to 'speak out safely' if they have any concerns of any sort and this is monitored at all times by senior staff. Trust policies support our staff in their actions if they need to report abuse and they offer guidance on how to do this. During training staff are exposed to the relevant documents that they should use and are aware that the safeguarding team are here to support their practice. Staff are informed during training of how to raise a concern, they are reassured that reporting is the right and safe

thing to do, even if a situation arises where they doubt this. Staff are encouraged to report abuse of any category at all times regardless of who the suspected perpetrator may be.

The Safeguarding Team work closely and in partnership with relevant agencies and professional groups to allow for risks to be identified and plans put in place where ever possible allowing patients to continue to maintain their right to a family life.

CASE STUDIES

Case Example

In November 2014, the police made Trading Standards that they had been contacted by a Runcorn bank who was concerned about a large cash withdrawal Mrs M (a lady in her 80's) was trying to make. We made contact with the lady and her brother and discovered that she had been targeted by a trader who said they could flag her garden for £3,000. From her bank statements it was clear that she had probably paid the trader around £6,000. The money had been taken out a few hundred pounds at a time.

Mrs M had a poor memory and couldn't remember the transactions but she described different people asking for money at different times. It appeared that the lady had been repeatedly targeted by several doorstep criminals.

An officer worked with Mrs M and her brother to look at different ways Mrs M could use to protect herself and arrangements that could be put in place to reduce the risk of her withdrawing large amounts of cash to pay doorstep criminals or scammers.

Case Example continued:

Mrs M was given a 'No Cold Calling' window card and letterbox sticker. Mrs M decided to contact the bank and ask them to put a limit on the amount that could be withdrawn at a time and to give her brother access to her account online.

Some months later Mrs M's brother contacted the service again because Mrs M had tried to take a large amount of money out of her account. She had received a phone call from a man who said he had her money from the time she had lost the £4,000 but the cheque had been made out incorrectly and he needed £2,000 in cash first.

Mrs M agreed to a call-blocking device that we have loaned to her and we have passed her details to Cheshire Police who were considering putting a camera in her property that would only activate when the door was answered.

We told Mrs M about coffee mornings/meetings organised by Age UK and she agreed to her details being passed to the Age UK organiser. Mrs M went to the group and enjoyed it.

Case Example

A 90 year old lady was due to be discharged from hospital after having a fall and breaking her wrist. She was struggling due to poor mobility to do her garden and shopping. Age UK completed a benefit check for her and discovered she was not in receipt of Attendance Allowance. With her consent we ordered the Attendance Allowance forms and arranged for someone to go to her home and complete these. She was successful with her Attendance Allowance claim and now receives over £80 per week, meaning she can now afford to employ a gardener and get a taxi to do her shopping.

NEXT STEPS

Halton Safeguarding Adults Board is undergoing a period of reconfiguration with a review of the membership of the main board and the development of a Safeguarding Adults Partnership Forum to support the work of keeping people in Halton safe. This reconfiguration will ensure that the correct agencies are represented on the Board and members are able to make key decisions regarding work to be implemented by the Board or agreeing resources to support this work.

Through the Board's Business Plan we will monitor the work that has been undertaken by all partner agencies and we will continue to strive to make continued improvement in the safeguarding of adults in our borough.

The Sub Groups of the Board will report into the Board on a regular basis to provide updates regarding the work they have undertaken to assure the Board that adults at risk of harm or abuse are being supported effectively to keep safe and that we are Care Act compliant.

FUTURE PRIORITIES

Halton Safeguarding Adults Board held a Development Session on 11th March 2016, in order to agree future priorities for the Board. The session utilised an 'Appreciative Inquiry' model as a template for the session. Initially Board members were asked to look at the current reality for Halton Safeguarding Adults Board and to consider the following questions:

- What are you proud of?
- What is working well?
- What are your concerns, fears, issues?
- What are the challenges facing the Board?
- What opportunities exist for the SAB that could be utilised?
- What hopes do you have for the Board?

After discussing those areas, members were then asked to think about a common vision for the Board and to then identify actions that will enable the Board to achieve that vision.

The event allowed members to step out of the usual pace of everyday life or workplace and reflect on how we could all improve the effectiveness of the Board.

The following are options for a vision statement for the Board which were suggested at the Development Day:

No Neglect; No Abuse; No Discrimination; No Fear; No Decision about me without me

Yes to Empowerment; Yes to Quality; Yes to Involvement; Yes to Communication; Yes to Dignity

Ensuring ALL adults at risk: live, work and are supported to live in an environment free from abuse, exploitation, harassment, violence and aggression

To ensure that Halton has a culture that does not tolerate abuse, works together to prevent abuse and knows what to do when abuse happens

The following areas will form the main strategic aims of Halton Safeguarding Adults Board for 2016/17:

- **Strengthening the Board**
- **Early Intervention and Prevention**
- **Awareness Raising and Engagement with the Community**
- **Performance and Quality Assurance of Providers and Services**
- **Making Safeguarding Personal – listen to and do when adults tell us about their experiences of abuse and neglect, and the services and support they receive**

Key objectives have been identified for each of these priority areas following discussions at the Development Day and these have been collated into a Strategic Plan for Board. The Strategic Plan will be a fluid and flexible document whereby additional objectives may be added to the plan as various work streams progress through the course of the year. Progress reports will be presented to the Board at regular agreed intervals during the year for each of the key objectives to ensure all areas of the Strategic Plan are being monitored and any issues can be resolved at the earliest opportunity.

REPORT TO: Health and Wellbeing Board

DATE: 18th January 2017

REPORTING OFFICER: Director of Public Health, Halton Borough Council

PORTFOLIO: Health and Wellbeing

SUBJECT: Older People's JSNA

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with an update on the Joint Strategic Needs Assessment.

2.0 RECOMMENDED: That the Board notes the findings of the Older People's JSNA

3.0 SUPPORTING INFORMATION

3.1 Following the JSNA's focus on Children in 2013/14 and Lifestyles and Long Term Conditions in 2014/5, the 2015/16 JSNA focussed on the Health, Wellbeing and Social care needs of older people i.e. those people aged 65 and over.

3.2 A multi-agency steering group was established in July 2015 to oversee the development of the JSNA. Early discussions focussed on the structure and issues to be covered. As per the Children's JSNA a number of inter-related but stand-alone chapters were agreed. These would cover descriptions of the population, lifestyle behaviours, support needs to maintain independent living as well as chapters on the needs of older people living in care homes, safeguarding and end of life care. The final two chapters would not be exclusively older people, although they recognised that many people with such needs are aged 65 and over.

3.3 The steering group membership was drawn from:

- Halton Borough Council, both Adult Social Care and Public Health
- Halton Safeguarding Adults Board
- NHS Halton CCG
- Health Watch
- Age UK Mid-Mersey
- Halton OPEN (Older People's Empowerment Network)

- Halton & St Helens Council for Voluntary Services

In addition to those who were part of the steering group, staff from these organisations and from existing partnership groups enabled leads to utlise the expert knowledge of the relevant topic. Where there were existing partnership groups, draft chapters were shared and the group asked to sign off the chapter. This ensured ownership and increased the likelihood the issues covered were of relevance and used to inform decision-making.

3.4 Chapters covered are:

Chapter 1: Background, methods and key findings
Chapter 2: Population, social, economic and living circumstances
Chapter 3: Overall health and wellbeing of older people
Chapter 4: Lifestyles and prevention of ill health
Chapter 5: Ill health, frailty, unplanned care and support to live independently
Chapter 6: Mental health and emotional wellbeing
Chapter 7: Dementia
Chapter 8: Adult Safeguarding
Chapter 9: Health and wellbeing of older people living in care homes
Chapter 10: End of Life Care

Several of these have broken new ground for Halton and we are one of the few areas nationally to cover Adult Safeguarding and the health needs of people living in care homes.

All chapters were completed by September 2016 and are available on the JSNA webpage at:
http://www4.halton.gov.uk/Pages/health/JSNA.aspx

3.5 Each chapter encompassed a rich, detailed dataset as well as details of local service provision and lists of NICE and other national guidance on evidence-based practice. Each chapter includes a set of key issues which are also listed in Chapter 1 (see Appendix A). To aid use with and by a wider range of organisations and groups 'Infographics' are being developed. (see Appendix B) and a full suite will be made available on the JSNA webpage, covering all chapters.

3.6 We know that Halton has traditionally had a population structure with a greater proportion in the younger and working age groups. This is changing and Halton's population is aging at a slightly faster rate than nationally. Halton's older population overall tend to be poorer and have worse health than their counterparts in the North West or England average. Life expectancy is lower as is healthy life expectancy. Yet, like elsewhere, older people in Halton make significant contributions to the local economy and to their communities.

3.7. Nevertheless, older people make up a greater proportion of GP consultations and hospital admissions than those under age 65. This is compounded by Halton over 65s having poorer overall health than nationally. Halton has been very successful in keeping people living in their own homes and has lower rates of admissions to care homes than nationally. However, as the number of older people is predicted to rise (and the number of working age people to fall) this will place an increasing strain on the health and social care system if current patterns and levels of use remain.

3.8 There are gaps in our knowledge base and these also have been highlighted in the relevant chapters and in the key findings. These especially relate to our understanding of the population-level needs of people living in care homes in the borough. This has elicited several new work streams.

4.0 POLICY IMPLICATIONS

4.1 The Older People's JSNA will inform collaborative action for the Council, NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 No additional funding required. However the JSNA will inform future activity and spending across the system.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Not relevant

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Developing the Older People's JSNA does not present any obvious risk however, there may be risks associated with action to address the findings. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

Appendix A: Older People's JSNA Summary Chapter
Appendix B: Older People's JSNA Summary Infographic

Report Prepared by: Sharon McAteer
Contact: sharon.mcateer@halton.gov.uk

Halton Joint Strategic Needs Assessment 2015/16

Older People:

Background, key findings and methodology

Reader information		
Author	Sharon McAteer	
JSNA Working group members	Emma Bragger Chris Carlin Karen Kenny Claire Lightfoot David Lyon Helen Moir Damian Nolan Kate Roberts Suzanne Sheppard Lisa Taylor Sue Wallace-Bonner Lynne Williams	Irene Bramwell Mark Holt Dawn Kenwright Marie Lynch Sharon McAteer Ann Nolan Lorna Plumpton Katy Rushworth Jan Snodden Peter Ventre James Watson
Number of pages	39	
Date release	July 2016	
Description	The document describes the policy context, estimated prevalence, risk factors and sub-groups of need, current service provision and national best practice in relation to (topic) amongst (if chapter only covers certain parts of the population add this here) in Halton.	
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Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

List of Abbreviations

BCF	Better Care Fund
CCG	Clinical Commissioning Group
DoLs	Deprivation of Liberty Safeguards
HBC	Halton Borough Council
HNA	Health Needs Assessment
HSCIC	Health and Social Care Information Centre
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
IPC	Integrated personal commisisoning
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
JWS	Joint Working Agreement
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
ONS	Office for National Statistics
OPEN	Older People's Empowerment Network
PHE	Public Health England
POPPI	Projecting Older People Population Information
STP	Sustainability and Transformation Plan
SUS	Secondary user system (used for accessing hospital admissions data)
UK	United Kingdom

Contents

1. Introduction

The population of the UK has fluctuated greatly in the past 100 years. The end of World War 2 saw a huge peak in the national birth rate which has then fluctuated and generally decreased in recent years. Improvements to the welfare state and increases in the standards of living have meant that those coming up to retirement today (the so-called "baby boomer generation") can expect to live much longer than their parents or grandparents lived.[1]

However, at the same time the number of babies being born in the UK has been steadily decreasing since 1964. This fluctuation in births over the years has meant that the median age of the UK is rising with 10 million people in the UK aged over 65 years old. This number is expected to rise significantly in the coming years with the retirement of the "baby boomer" generation. The latest projections are for 5½ million more elderly people in 20 years' time and the number will have nearly doubled to around 19 million by 2050.[2]

The population aged 65 and over will increase by 65% in the next 25 years with the older peopulation making up nearly a quarter of the total population by 2037, from 16% in 2012.

Within this, the 'oldest old' is the fastest growing age group in the population. In 2013 it was estimated that there were over 475,000 people aged 90 and over in the UK, of whom 13,780 people were aged over 100 and 710 were aged 105 or older. By 2035, it is expected that there will be nearly 1.5 million people aged 90+ in the UK, of whom nearly 100,000 will be centenarians.[3]

The scale of demographic change over the next 25 years is dramatic and has never been seen on this scale before. For the first time in history older people will outnumber the number of children under five years old.

Older people are as diverse a group of people as any other section of the population and within the overall numbers of older people quoted above lie significant differences in terms of characteristics, living arrangements, experiences and health outcomes. Socio-economic factors have a major impact on the experience of later life, resulting in very significant inequalities in life expectancy, and even greater inequalities in the length of time during which people can expect to live in good health. Prevalence of disability within older age groups also varies widely, depending on socio economic factors.

Less well known is that older people can be net contributors to the economy and there may even be the opportunity for councils to harness this demographic change for local economic benefit. However, not addressing ageing collectively and strategically now will store up problems for future years, placing further strain on social care funding and provision. Preparing for an ageing society is a place shaping opportunity and applying an 'ageing lens' to local functions will help to understand what needs to be done to improve the quality of life of this growing segment of the population. Older people make a huge contribution to society and need to be part of this conversation.

The impact of an ageing society extends well beyond social care and health, embracing all areas that affect older people's lives, including transport, housing, culture and leisure and the built environment.

This change in the structure of the UK population brings with it some significant challenges. Much of today's public spending on benefits is focussed on providing pensions, health and social care services to older people. The age profile of Halton's residents is slightly different to the national profile, with the new town development in the 1960s producing a population structure with a greater proportion of working age adults. However, the pattern of increasing proportions of the population being amongst those in the older age groups is now being replicated in the borough.

The chapters in this Joint Strategic Needs Assessment (JSNA) aim to set out the population trends within Halton and explore the various challenges these bring for local service providers. In addition to an overview of the health of older people in the borough, the needs assessment is structured around a number of key themes (see section 4.2.2. for a list of chapters):

These themes were selected in consultation with partner organisations across the borough, including Halton Clinical Commissioning Group (CCG) and Halton Borough Council (HBC) People and Economy Directorate, Age UK, Halton OPEN,[a] Healthwatch and Halton and St Helens Council for Voluntary Services. They take us through older age from being an active, healthy older person to one who is living with a long-term health condition, through living independently to needing support to live independently or the need to live in a care home. They also cover some key issues that relate to older age such as dementia, safeguarding and end of life care.

a) OPEN = Older People's Empowerment Network

2. Policy Context for JSNA

2.1. What is JSNA?

The Joint Strategic Needs Assessment (JSNA) is a systematic way of assessing the health and social needs of the local population. The JSNA should enable strategic partnerships and commissioning leads to make informed decisions about local action and services across a wide range of needs. It not only looks at the overall health and social needs of older people across the borough, but considers inequalities in outcomes and experience for specific groups. This relates to older people living in areas of deprivation, to age and gender, to disability, and to vulnerable groups.

Increasingly JSNAs are being seen as a process of continuous development and improvement, rather than single documents produced once every few years.

Whilst there are no direct policy implications in revising the JSNA in itself, the findings should inform commissioning decisions. As such the findings may impact on policy and commissioning decisions. The value of the JSNA lies in the degree to which it is understood and valued by strategic partnerships and commissioning leads - the extent to which it is a useful tool to inform their decision making. To fulfil this, it needs their active engagement to ensure it is 'fit for purpose'.

The definition from the Department of Health's JSNA Guidance[4] is:

> *"Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness".*

JSNA identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population. The basis of a high quality and robust JSNA is the analysis of current and predicted health and well-being outcomes. The JSNA process should be underpinned by partnership working, community engagement and evidence of effective interventions to address the issues identified.

Breaking the phrase down into its constituent parts is useful in defining what it means in practice:

Joint -The duty to undertake JSNA was introduced in 2007 in recognition that strategic planning for health and wellbeing was best done in partnership, and based on evidence. It is intended to provide a powerful model for joint working in every locality. The Health & Social Care Act sets out the role that JSNA, and its local evidence of need, should play in the work of the Health & Wellbeing Board (HWB) and the Joint Health & Wellbeing Strategy (JHWS).

Thus, a key element of the JSNA is that it should involve all the important stakeholders in identifying needs and acting upon them. Crucially the JSNA provides a new framework for health and social care to collectively work in partnership to identify the needs of the population they serve and to work together in commissioning services to meet those needs.

Strategic - the JSNA should identify those needs and service requirements that are most relevant and important to its population. The needs assessment process should provide health and social care organisations with evidence based identification of the key needs of its population and should therefore define the strategic direction in commissioning of services. This strategic direction should consider both todays and future health and social care needs.

Needs assessment - there are many definitions of needs assessment. In order to identify health and wellbeing needs the assessment process should make use of existing information, identify information gaps and should include the views of service users, patients and the population. Importantly the needs assessment must include outputs that can be translated into actions for the commissioning and delivery of health and social care services, health improvement and wellbeing programmes and other interventions. The process should consider social inclusion and should identify inequities and inequalities in health and well-being and in current service delivery.

2.2. How should a JSNA be done?

Whilst producing a JSNA is a mandatory requirement, keeping with the 'light touch' approach from national government, Department of Health guidance on the preparation of the JSNA allows for local initiative and discretion. The guidance does however make it clear that the JSNA should be seen as an evolving process of understanding local needs and establishing agreed priorities, rather than as a traditional planning document to be produced at a single point in time.

2.3. Local responsibility for developing the JSNA

The Health & Wellbeing Board has overall responsibility for the JSNA. Its development is led by the public health team.

Although the JSNA has been in existence since 2008 and has been used by commissioners to inform decision making, the impact of the Marmot review on health inequalities, has laid the foundations for local areas to relook at their approaches. The life course approach advocated by Marmot has been used in the development of the Health & Wellbeing Strategy and its action plans and is now used to summarise the JSNA on an annual basis.

A steering group, made up of a wide range of members from organisations, developed a framework for this older people's JSNA. Whilst the themes cover a number of strategic priorities for older people, we acknowledge this is not an exhaustive list and additional areas of work have been identified through this needs assessment.

3. Policy Context for Older People

3.1 National

3.1.1. Section 75

Section 75 of the NHS Act 2006 allows for budgets to be pooled between local health and social care organisations and authorities.[5] Resources and management structures can be integrated and functions reallocated between partners to provide more locally tailored services. The arrangements have allowed commissioning for new or existing services to be joined up.

In April 2013, HBC and NHS Halton CCG entered into a 3 year Joint Working Agreement (JWA) for the commissioning of services for people with Complex Care needs. With the introduction of the Better Care Fund (BCF) during 2015, a revised JWA, taking effect from 1st April 2015, was agreed to include the BCF allocation for 2015/16.

The focus on joint working and the pooling of resources between HBC Adult Social Care and NHS Halton CCG has continued to develop and strengthen since the introduction of the original JWA in 2013 and we currently have a pooled budget in the region of £42 million pounds.

Both NHS Halton CCG and the Council are committed to further developing our integrated approach to service delivery and transformation to improve the Health and Well-Being of Halton residents. The management of the current arrangements has been extremely successful, improving outcomes for individuals in addition to moving from a position of overspend for both organisations in relation to associated expenditure to that of financial balance.

As such both organisations are continuing with the current arrangements in place and have entered into a new JWA which will continue for another 3 years, until 31st March 2019.

The development of the JWA has been possible under Section 75 of the Health and Social Care Act 2006, which allows local authorities and health organisations to pool funds. The Agreement itself provides the legal framework in which HBC and NHS Halton CCG work together in order to achieve their strategic objectives of commissioning and providing cost effective, personalised, quality services to the people of Halton.

3.1.2. Better Care Fund

The £5.3bn Better Care Fund (BCF), formerly the Integration Transformation Fund, was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care.[6] It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being at the heart of health and care services. The aim of the BCF is to support a shift in health spend from hospital contracts to more community based services, self-care and prevention programmes. The BCF becomes a requirement from 2015/16 with the financial budget determined in line with CCG allocations.

Halton's Better Care Fund (BCF) in 2016/17 builds on the work undertaken by the fund in 2015 and develops further some key areas to enable people to access services they need more quickly and closer to their own home. The BCF focuses resources on a wide range of integrated, complex and

responsive services either fully funding services or contributing additional resources to increase capacity. This approach supported the achievement of key targets in the last BCF. In addition the BCF supports maintaining the eligibility criteria for social care and the Plan is integrated with the local Sustainability and Transformation Plan (STP).

NHS Halton Clinical Commissioning Group (CCG), Halton Borough Council (HBC) and Public Health are driven by a burning ambition to make Halton a healthier place to live and work, with a committment to ensuring that local people get the right care and support at the right time and in the right place. We will continue to uphold the rights of people under the NHS Constitution, appropriate legislation e.g. Care Act 2014 etc. and positively push the boundaries of quality standards and patient experience.

Our vision is **'to involve everyone in improving the health and wellbeing of the people of Halton'**.

Our purpose is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them.

We want to support people to stay well in their homes, in particular to avoid crises of care that can result in hospital admission. General practices will support and empower individuals and communities by promoting prevention, self-care, independence and resilience.

We will work with local people and with partner organisations including healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

3.1.3. Integrated Personal Commissioning Programme

In July 2014, NHS England offered local councils across England a new option in which individuals could control their combined health and social care support. Plans for a new Integrated Personal Commissioning (IPC) programme were set out, designed to blend comprehensive health and social care funding for individuals, and allow them to direct how it is used. Four groups of high-need individuals were to be included in the first wave from April 2015, and included "people with long term conditions, including frail elderly people at risk of care home admission." This new approach builds upon, but is in addition to, the Better Care Fund.[7]

Under the new IPC programme, a combined NHS and social care funding endowment will be created based on each individual's annual care needs. Individuals enrolled in the programme will be able to decide how much personal control to assume over how services are commissioned and arranged on their behalf.

The goals of the programme are:

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances.

- Prevention of crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management.
- Better integration and quality of care, including better user and family experience of care.

Halton was not one of the piot sites. However, moving forward, the learing from these sites will need to be considered.

3.1.4. Continuing Healthcare

NHS continuing healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital but have complex ongoing healthcare needs. It can be received in any setting including:[8]

- At home – the NHS will pay for healthcare, such as services from a community nurse or specialist therapist, and personal care, including help with bathing, dressing and laundry.
- In a care home – as well as healthcare and personal care, the NHS will pay for care home fees, including board and accommodation.

NHS continuing healthcare is free, unlike social and community care services provided by local authorities where charges are dependent on income and savings. Eligibility is based on having a complex medical condition and substantial and ongoing care needs. Applicants must have a "primary health need", which means that the main or primary need for care must be health related. Where an individual is eligible for NHS continuing healthcare, the CCG is responsible for care planning, commissioning services and for case management.

3.1.5. Safeguarding/ Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005.[9] They aim to make sure that people who do not have the mental capacity (ability) to make decisions about their care or treatment living in care homes, hospitals and supported living, are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home, hospital or supported living arrangement only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

The Mental Capacity Act says that someone who lacks mental capacity cannot do one or more of the following four things:

- understand information given to them
- retain that information long enough to be able to make a decision
- weigh up the information available and understand the consequences of the decision
- Communicate their decision – this could be by any possible means, such as talking, using sign language or even simple muscle movements like blinking an eye or squeezing a hand.

3.1.6. Care Act

Under the Care Act (2014), local authorities have new functions to create a single, consistent route to establishing entitlement to public care and support.[10] It also creates the first ever entitlement to

support for carers. The aim of the Care Act is to help improve people's independence and wellbeing and to ensure residents:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- can get the information and advice they need to make good decisions about care and support;
- Have a range of providers offering a choice of high quality, appropriate services.

Under the Act, there is more flexibility to focus on what the person needs and what they want to achieve, and to design a package of care and support that suits them. Depending on a person's finances, a local authority may ask an individual to contribute towards the costs of their care (up to and including the full amount). In cases where the costs of care would reduce a person's income below a set level, a local authority will pay some of the costs to make sure that the person is left with this minimum level of income.

The Act requires local authorities to provide information on:

- the types of care and support that are available – e.g. specialised dementia care, befriending services, reablement, personal assistance, residential care etc.;
- the range of care and support services available to local people, i.e. what local providers offer certain types of services;
- what process local people need to use to access the care and support that is available;
- where local people can find independent financial advice about care and support and help them to access it;
- how people can raise concerns about the safety or wellbeing of someone who has care and support needs.

From April 2016, the Care Act will introduce a cap on care costs and will provide new financial protection for those with modest wealth.

3.1.7. NHS Five Year Forward Plan

The NHS Five Year Forward View recognises that, with an ageing population, increased long term conditions, and funding for health that is not keeping pace with demand, promoting well-being and preventing ill-health will become even more important to the capacity and financial viability of the NHS. Providing better support for carers is therefore critical to the future of the NHS.

3.2. Local

3.2.1. Joint Health and Wellbeing Strategy

As a result of the Health and Social Care Act 2012, each local area was obliged to set up a new Health and Wellbeing Board. 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 for Health and Wellbeing in Halton. The Strategy was the overarching document for the Health and Wellbeing Board outlining the key priorities the Board has focussed on over the past three years. As the current strategy finishes at the end of 2016, the development of the next Health and Wellbeing Strategy is currently underway.

The new Strategy will not only have to ensure it remain evidence-based, using the JSNA to inform local priorities but is aligned with the developing system level plans across local authorities and the NHS. Since 2013 when first strategy was published there have been significant developments within the policy landscape. Of particular importance is the agreement between the government and the leaders of the Liverpool City Region to devolve a range of powers and responsibilities to the Liverpool City Region Combined Authority and the NHS Five Year Forward View requirement to produce a five year Sustainability and Transformational Plan (STP).

It is envisaged that many of the current priorities will remain, although perhaps with a different focus. They have yet to be agreed but in line with One Halton (see below) are likley to be:

- Child development
- Keeping people well
- Long term conditions
- Mental health
- Older people

Apart from child development all of these have relevance for older people, not just the older people specific priority.

3.2.2. Adult Social Care: People and Economy Directorate, Business Plan 2016 – 19

The Transformation Programme is a joint approach between Adult Social Care and the NHS to deliver personalisation and innovative approaches to support self-care, building on the work that has already been progressed in the borough. The 3 objectives of the programme are prevention, early intervention and managing complex care and care closer to home.

- Social care in practice
- Active ageing
- Telecare and telehealth
- Mental health service re-design
- Integrated hospital discharge teams
- Community Multi-disciplinary teams (MDTs)
- End of life services

3.2.3. One Halton

One Halton has emerged following the production of the Strategy for General Practice Services in which a new care model was set out focusing on integrated health and social care services working in the community. The goal of One Halton is to create a health care system that:

- works around each individual's needs
- supports people to stay well, and
- provides the very best in care, now and for the future

The objectives that have been developed for One Halton are:

- To work better together regardless of discipline
- To find or identify those 'hidden' people who don't access care
- To treat and care for people at the right time, in the right place by the right people

- To help people stay healthy and keep generally well
- To provide the very best in care, now and in the future

In moving One Halton forward, five areas of focus have been agreed. They are:

- Older people
- People with Long Term Conditions
- People with mental health conditions
- Families and children, and
- The generally healthy

3.2.4. Well North

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

The Well North principles are to:

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

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

Halton's successful bid includes the following approaches:

- An extension of the new One Halton concept with an all-system approach to improve outcomes.
- Development of community assets into Intergenerational Family Centres supporting local communities.
- Multidisciplinary teams too offer services to children, young people and families and older people in the centres and via outreach into the community.
- It will target the 10% poorest people in the Borough including
- It will look to support paediatricians and geriatrician outreach into the communities.
- It will support the Cultural manifesto and social/community movement in prevention, self-care and wellbeing.

3.2.5. Healthy New Towns

Healthy New Towns provides an opportunity for Health and social care organisations, alongside planning and development agencies to consider novel approaches to prevention and the delivery models of care. Creating an environment where health and care are at the heart of the physical environment and help to shape communities where good health and wellbeing opportunities are built in to urban design and the physical infrastructure and where community psyche reflects a sea change people's approach to living well, living long and living independently.

3.2.6. Other local plans of relevance

There are a wide range of local strategies not mentioned above that will imapct on, and give consideration to the needs of older people. The Core Strategy local plan is the strategic local plan for the borough. It sets out the spatial vision for the borough through to 2028, and a range of strategic objectives and policies. It was adopted in April 2013. It describes how land use will be developed to facilitate housing, economic development and regeneration and health. The Local Transport Plan considers the needs of those with disability and older people as does the Strategic Housing Market Assessment.

3.3. National Outcomes Frameworks

In recognition of the changes to the health and social care system, as a result of the Health & Social Care Act, three new outcomes frameworks have been developed:

- Public Health Outcomes framework
- NHS Outcomes Framework
- Social Care Outcomes Framework

There are many indicators which specifically look at the health and wellbeing of older population, with more being relevent. They are used throughout the JSNA.

4. Methodology

4.1. Local approach

As detailed in section 2 there is no set way of developing the JSNA. Locally, it was agreed that a standard approach to developing the individual elements of the JSNA may not be the most appropriate. Some issues may be best dealt with by short 'profiles' e.g. the section on detailing the population breakdown and socio-economic circumstances of older people in the borough. For other issues in-depth needs assessments would be more appropriate.

A number of strategies were written during 2014 and 2015. These include those written to support health & wellbeing strategy priorities as well as other public health, CCG and HBC priority issues. JSNA chapters on a range of long term conditons and on adults with physical and sensory disabilities were completed during 2014 and 2015, as were a number of lifestyle chapters. These have been used to inform the Older People's JSNA but the detail has not been duplicated in the relevent chapters.

4.2. Overseeing development of the JSNA

4.2.1. The steering group

Once it was agreed to undertake the older people's JSNA a small working group was established to take this forward. The group began by scoping and agreeing the approach to the JSNA, using a 'functional' lifecourse approach from describing ther population to healthy older age through to complex health and social care needs. The JSNA also includes two important issues that do not just relate to older people but where their needs predominate. These were adult safeguarding and end of life care. To write the chapters members of the working group were identified as leads and formed a number of smaller chapter specific groups, supported by information leads from Public Health Performance, as well as a wider range of stakeholders.

A standard template with writing guidance notes wwas issued to each chapter lead. However, it was more important to cover each issue as information emerged rather than follow a template strictly. Therefore the breadth and depth of each chapter was dictated by the issues it covered rather than being restricted to headings and page limits. Some of the chapters had not featured to any great extent in previous JSNAs, others had been covered within topic-based chapters and a few subject to in-depth needs assessments over the last year or two. The working group continued to meet at regular stages of JSNA development to ensure momentum was maintained as well as dealing with consistency and duplication issues.

4.2.2. Frameworks for the JSNA

A framework for the development of the new JSNA has been agreed with authors identified for each section:

Chapter 1: Background, methods and key findings
Chapter 2: Population, social, economic and living circumstances

Chapter 3: Overall health and wellbeing of older people
Chapter 4: Lifestyles and prevention of ill health
Chapter 5: Ill health, frailty, unplanned care and support to live independently
Chapter 6: Mental health and emotional wellbeing
Chapter 7: Dementia
Chapter 8: Adult Safeguarding
Chapter 9: Health and wellbing of older people living in care homes
Chapter 10: End of Life Care

Duplication with other chapters was discussed throughout the development of the chapter and an approach to dealing with it agreed.

4.3. Data analysis, including access to data and information

The JSNA uses a wide variety of data from both national and local sources, including:

- Office of National Statistics (census population data) (ONS)
- Index of Multiple Deprivation (IMD)
- Health & Social Care Information Centre (HSCIC)
- National organisations such as Public Health England (PHE) and the Projecting Older People Population Information (POPPI) website
- Halton Borough Council Care First 6: adult sociual care performance systems
- Secondary User System (SUS) data on hospital admissions was accessed via the Cheshire & Merseyside Commisisoning Support Unit and the data analysed by the Public Health Evidence & Intelligence Team
- Local providers
- Research papers
- National policy

The JSNA uses routinely collected data to profile the local population in terms of numbers who may potentially be at risk of a range of developing a range of conditions and problems. Where appropriate, it uses research to stratify the overall population, according to different levels of severity and types of condition.

The JSNA uses estimated data as well as numbers known to services. In this way, it attempts to describe any gaps between the total population who may have a need/condition and those known to services.

In this way the JSNA uses the same methodology as in-depth health needs assessments (HNAs). HNAs are a way of estimating the extent and nature of a population so that appropriate support is planned accordingly. The needs assessment can help:

- Estimate the current and future needs of a population
- Indicate the distribution of need: geographically and/or by sub-groups within the population of interest
- Identify the gap between met and unmet need.

HNA is a systematic method for reviewing the health needs and issues facing a given population, leading to agreed needs (priorities) for that population. The starting point in HNA is a defined population. This population can be defined in a number of ways. By:

- Geographic location – e.g. people living in a neighbourhood or catchment area
- Setting – e.g. school, workplace, prison or hospital
- Social experience – e.g. age, ethnicity, homelessness
- Experience of a health condition – e.g. disease, mental illness or physical disability.

Various models have been developed but the main components of the model used by public health are:

- *An epidemiological approach* – an examination of available information on incidence and prevalence, including hospital and primary care contacts, local audits, and estimates from local and national surveys
- *A comparative approach* – comparing local estimates of disease and/or activity with other similar areas or national data to assess if need is greater or lesser than expected
- *A corporate approach* – this approach gathers information on perceived needs from a wide range of health professionals, other sectors, patients and the community.The benefit of this approach is that it can be responsive to local concerns and encourages ownership of the issues that need to be addressed. The disadvantage is that if it is carried out in isolation it can focus on the stakeholders concerns, which may be influenced by political agendas, and can identify demands rather than need.

Thus, evidence of population need is collected in a systematic way from multiple sources from which the most important needs will emerge from more than one source.

Being able to describe the needs, using epidemiological, comparative and expressed data is only part of the process of conducting a health needs assessment. It is also important to know which interventions are best suited to addressing which needs. Each chapter includes a list of national best practice from sources such as NICE (National Institute of Health & Clinical Excellence), Department of Health, Social Care Institute of Excellence (SCIE) and King's Fund.

The breadth and depth of the JSNA is only as good as the information we have access to. There were delays in accessing some of the previously routinely collected data. This has been managed by the Public Health Evidence and Intelligence Team, supported by Adult Social Care Performance and Policy team and the Customer Intelligence Unit, CCG colleagues, and steering group members, to ensure as much data as possible was available to inform the work. Access to outcomes data from services has been patchy with changes in both commissioning and provider organisations as well as IT changes having contributed to this, with some new systems still not operational. This meant authors had to, at times, take a pragmatic approach on data/information availability. Any core data not available at time of writing or that could not be accessed has been reported on in the specific chapter section it relates to.

Data was collated by the Public Health Team and provided to each chapter group.

5. Key Findings and Priorities from each chapter

Chapter 2: Population, living, economic and social circumstances

Population

16% of Halton's population is aged 65 and over (21,013), with 3.8% over the age of 80 (4,841). This proportion is lower than the England level but Halton's 65+ population has increased by a greater percentage since 2002; 3% compared to 1.7% nationally. The largest percentage growth has been in the most elderly groups and this pattern is set to continue.

The registered population for the 17 GP practices within NHS Halton Clinical Commissioning Group (CCG) is slightly smaller than the resident population. The proportion of the population aged 65+ in each GP practice varies greatly from 7.3% to 19.8%.

It is predicted that the older population will continue to grow, with growth in Halton continuing to be greater than the North West and England rates. The 65+ population is predicted to increase by 42% between 2012 and 2037 with the 85+ age cohort tripling, from 2,100 to 6,400, over this time period.

Population characteristics

An estimated 8,960 of Halton residents aged 65+ have a disability, more women than men. The predominant religion is Christian with over 87% of 65+ population stating this as their religion compared to 75% for all ages. The proportion stating they have no religion is smaller, between 3.3% to 6.3% depending on age group, compared to 18.7% of the total population.

Most older people are married, 66.5% or six out of 10, but this falls across the older age groups, with just 21% of those aged 85 and over being married. This is due to increasing numbers being widowed, just 14.9% at age 65 up to 71.8% of those aged 85+. Over 94% are heterosexual/straight.

Economic activity and deprivation

92% of residents aged 65+ are economically inactive, with 6.3% being employees and 1.5% self-employed. Having a well paid job impacts on the likelihood and amount of private pension income. No actual data is available on total income but Halton people aged 65 and over have fewer qualifications, especially higher level ones, and were less likely to have been employed in managerial or professional occupations than their peers across the North West or England. This is likely to mean the amount of private pension income available is less.

This is substantianted by data on the proportion of Halton pensioners living in deprived areas. A quarter of Halton older people live in the 10% most deprived parts of England, with nearly half living in the most deprived 20%. Despite this a recent survey of people aged 55 and over showed that 82% of respondants were satisfied with their income, higher than Knowsley and Liverpool and the same as the average for Cheshire & Merseyside. This breaks down as 70% quite satisfied and 12% very satisfied. 90% were confident managing their income, similar to the Cheshire & Merseyside average.

Living and housing circumstances

Those aged 50-64 are the least likely to live alone of any age group. The proportion living alone increases with age after age 65, with those aged 85 and over most likely to live alone (83.9%). The majority of over 65s own their own home outright (58%) or live in social rented accomodation (33%). The number of older people receiving minor adaptions through the local authority rose from 2013/14 to 2014/15. Halton older people are less likley to live in homes with no central heating than their peers in England but the levels compared to the North West are similar; 3.1% of 65-74 year olds and 4.4% of 75+ year olds, with rates varying from 0% to 9.4% at electoral ward level. Fewer Halton residents (all ages) are living in fuel poverty than England and the North West. Halton has the 4th lowest level of fuel poverty within its 18 statistical neighbours grouping.

Transport

Free off-peak consessional bus travel throughout England gives the opportunity for greater freedom and independence to around 11 million older and disabled people in England. Community transport is available in Halton for those who find using regular public transport difficult. Yet, national and local research shows that many older people find it difficult to travel to local facilities such as health centres. 33.8% of Halton residents aged 65+ have no access to private cars, a level higher than the North West and England averages and higher than the population as a whole (20.8% of Halton's total population have no access).

Local community and connections

Only 44% of Halton residents aged 55 and over are very satisfied with their local community; across Cheshire & Merseyside only Liverpool had a lower percentage at 43% with the Cheshire & Merseysdie average being 55%. However, a greater proportion were generally satified, 49% compared to the average of 40%. Thus the overall level of satisfaction with their local community was only slightly lower, 93% in Halton compared to 95% on average. Only one in three had strong connections to the local community mostly through support from friends and neighbours. Despite this, a slightly higher proportion of Halton residents felt they had enough social support compared to the Cheshire & Merseyside average.

Older people are the mainstay of a large part of volunteering that takes place across the country. The slightly higher percentage of women do volunteering work compared to men apart from amongst the 75+ age group. Volunteering is highest in the 65-74 age group for both men and women.

Social isolation and loneliness

Despite some of the findings above, social isolation and loneliness increases with age, with the oldest old having the least everyday social contact. Strong social ties can have an impact on longevity as social isolation is associated with higher mortality in older people. There is a direct correlation between loneliness and poor physical and mental health outcomes. Using national research it is estimated that 4,203 Halton residents aged 65+ experience mild loneliness and a further 1,600-2,100 intense loneliness. As the population is predicted to rise, unless prevalence changes up to 7,000 will have mild loneliness and 2,800-3,500 intense loneliess by 2030. Local research shows many Halton people worry about becoming lonely in the future.

Being able to remain in their own homes, able to look after themselves and remain healthy are the most commonly cited concerns voiced by older residents in Halton. In terms of services they are most concerned about transport to key facilities and the amount of time their have to wait at medical appointments. The most common ways they find out about local services is through the local press and word of mouth. 15% use the Inside Halton newsletter and 10% use the internet to find out about local services.

Chapter 3: overall health and wellbeing

Older people are living longer and spending a greater proportion of their old age in relatively good health. Being healthy is one of the most important factors determining people's wellbeing. The Office for National Statistics (ONS) Annual Population Survey indicates that older people have some of the highest levels of wellbeing of any age with scores across the four indicators used being highest in the 65-74 group.

Despite the increase in life expectancy, levels are lower in Halton than the North West and England. Amongst women life expectancy at birth has shown a decrease for the first time during the latest reporting period. This is due to falls in life expectancy at 65, 75 and 85. However, it is too early to tell if this is simply a minor fluctuation or a change in the overall upward trend.

The greatest predictor of healthy life expectancy is employment at age 50-64 and levels in Halton are lower than the regional and national averages. Healthy life expectancy for both men and women in Halton is also lower than the North West and England averages. So not only do people in Halton not live as long on average but they spend less time in good health. This is reflected in data from the 2011 Census when only 42% of people living in Halton who wereover the age of 65 said their health was very good or good (36% said it was fair and 22% said it was very bad or bad). The percentage in good health amongst those aged 65+ is the lowest of all the age groups and with each age group post-65 it continues to fall.

At an electoral ward level, Halton's 65+ population in very good or good health varies from just 30% in Windmill Hill to 60% in Birchfield, with levels highest in the more affluent areas and lowest in the more deprived areas.

Death rates amongst those aged 65+ have been falling both locally and nationally. Halton's rates were higher than the regional and national rates in 2006-08 and this relative position has remained unchanged over time. Cancers and circulatory diseases are the top two causes of death. Respiratory disease is the third cause and is the second cause amongst those aged 90+. Mental and behavioural disorders become a more prevalent cause of death from aged 85+, mainly due to dementia.

Both nationally and locally most people over age 65 rate the overall experience of their GP surgery very good or fairly good (over 90%). Most have confidence in their GP and nurse and find making an appointment convenient. Slighty less, though still the majority, are satisfied with opening hours and time spent waiting at the surgery. However, this last point was one highlighted by the Halton OPEN surveys as something people were concerned about.

The majority of those who wanted to have an NHS dental appointment were able to do so. However, Halton was joint lowest with Liverpool for the percentage of over-55s who go to the dentist.

Despite the fact that 45% of those registered blind and 59% of those registered as partially sighted are aged over 75, Halton has lower rates (both all age and 65+) for NHS sight tests compared to the North West and England.

Apart from Halton Lea, where levels of both elective and non-elective hospital admissions are high, electoral wards with high elective admissions have low non-elective admissions and visa versa. This difference is particularly so for older people from Riverside ward and to a certain extent in Kingsway ward also.

Chapter 4: lifestyles and prevention of ill health

Health related behaviours

Overall, older people have healthier lifestyles than younger adults. Data from the 2012/13 Merseyside Lifestyle Survey (MLS) shows that older people, i.e. those aged 65 and over are:

- Less likely to smoke (17% compared to 30% of all adults aged 18+)
- Eat more portions of fruit and vegetables than the average with the 18-24 age group eating the least
- A lower percentage drink alcohol and of those that do only 4% drink to harmful levels, with older men are more likely to do so than older women
- 1 in 5 drink skimmed milk most regularly
- They are least likely to add salt to food at the table

However, there are some areas were older people's health related behaviour is not as good as younger adults:

- Older people do not undertake moderate or vigorous exercise to the same extent as younger adults
- They spend more time per day sitting and less walking
- Those aged 45-64 are most likely to be overweight and obese. Although the percentages are lower for those aged 65 and over the percentage of older people who are overweight or obese is higher than the borough average

Sexual relationships remain inportant for older people. Yet many find it difficult to talk to their partner or a health professional about sex. Levels of sexually transmitted infections (STIs) are lower in the 65+ age group than in any other age group and this has been consistently so over time. Halton rates are lower than the England average.

Screening and vaccinations

Cancer screening levels in Halton are lower than the national targets; uptake of bowel screening is 48.8% compared to the target of 60% with breast screening uptake being much closer to target at 69.8% compared to the target of 70%. No practice in Halton achieves the bowel screening target, with uptake ranging from 39% to 56%. For breast screening 5 practices reach the target, with uptake ranging from 57.6% to 78.5%. For both these screening programmes Beaconsfield practice has the highest uptake rate.

Influenza vaccinaton is offered annually to all those over the age of 65. Halton uptake is higher than England at 73.8% but falls just short of the 75% target. Practice uptake varies from 67.2% to 79.4%, with 7 practices achieving uptake above target. More Halton older people receive the pneumococcal vaccination than England, 70.8% compared to 68.9% but the local rate is lower than across Merseyside which overall sees a 70.8% uptake. The newest vaccination programme for older people was introduced from September 2013 and is for shingles. Uptake amongst the eligible population varies greatly from 18.2% to 76.9%, with the average uptake being 47.8%. Offered to people at age 70 there is also a catch up programme. Again less than half those eligible take this up, just 46.8% with practice level variation of 15.6% to 80.6%.

Falls

There is no local or national falls register. Using national research, the estimated prevalence of falls amongst those aged 65+ is 3,266 women and 2,154 men (2015 figures). Assuming the underlying prevalence remains static, given the projected increase in older people, this is likely to rise to approximately 4,915 women and 3,375 men by 2030. In a survey of people aged 55+ across Cheshire & Merseyside, 36% of Halton residents stated they have ever had a fall, the third highest across Cheshire & Merseyside, behing Liverpool and Knowsley. The pattern seen across Cheshire & Merseyside suggests deprivation may be a factor.

There were 8,243 attendances at A&E departments between April 2012 and March 2015. At least 23% of these were due to falls. This percentage may be higher as Warrington hospital does not code falls as a primary injury type. Whiston does and here 47% of the injuries seen in those aged 65 and over were due to falls. Applying this higher rate would suggest as many as 3,874 attendances during the 3-year peiod were due to falls, or nearly 1,300 per year.

The rate of hospital admissions due to falls in the over 65s is statistically significantly higher in Halton than the national average, although the rates have fallen between 2010/11 and 2013/14. Halton's rate for 2013/14 was the highest of its statistical neighbours group, statistically higher than every local authority in the group apart from Salford. Rates rise substantialy from aged 75+ and are highest in the 85+ age group for both men and women, with rates highest for women. Rates also vary by electoral ward and GP practice, lowest in Daresbury ward and Windmill Hill practice and highest in Broadheath ward and Hough Green practice. Only a small proportion of falls result in fractured neck of femur (hip fracture). Rates in Halton are statistically higher than comparators.

Unlike admissions, the mortality rate due to falls in the over 65s is relatively low in Halton compared to its statistical neighbours group. It is only the 5th highest (out of 18 local authorities in the group) for ages 65-74 and 6th highest for those aged 75+.

Chapter 5: ill health, frailty, unplanned admissions and support to live independently

One of the key concerns of local older people is their ability to remain healthy and independent. For those with long-term illness, disability and frailty being able to realise this can often depend on the availability and quality of domicillary support, both through formal routes provided by social care, working in partnership with primary and community healthcare, and the role of informal, unpaid carers. Many people live to an advanced age while maintaining physical and cognitive function, functional independence and a full and active life, with ill health and disability compressed into a relatively short period before death.[11] However, in a proportion of people, the normal gradual age-related decline in multiple body systems is accelerated, resulting in limited functional reserve, so that even a relatively minor illness or event has a substantial impact on health.[12] This increased vulnerability is termed frailty. Whilst previous chapters in this Joint Strategic Needs Assessment (JSNA) have looked at overall health and lifestyles issues, this chapter explores the issues facing people with long-term illness and disability living in the community (a separate chapter looks at the needs of people living in care homes).

There is no offical dataset on the number of people who are frail. This means we have to rell on national research and apply its prevalence rates to the local population. Doing this suggests there may be 2,000 Halton residents aged 65 and over who are frail with a further 8,741 pre-frail. Assuming the prevalence rates remain static, these numbers are predicted to nearly double over the next 21 years to 3,917 frail and 14,061 pre-frail by 2037.

The percentage of Halton residents with limiting long-term illness (LLTI) or disability increases with age, as it does nationally. Data from the 2011 Census shows that two out of ten (20.9%) of the total population has such a condition, whereas double that percentage 4 out of ten (42%) of those over the age of 65 do so; over half of 65-74 year olds do (52%), two in three 75-84 year olds (70%) and 85% of those aged 85+. This equates to 10,956 people aged 65 and over with a LLTI. Whilst not directly comparable, data from the annual GP survey supports this; it asks the respondants about how their health today affects their ability to carry out daily activities rather than long-term illness.

Data from the English Longitudinal Survey of Ageing (ELSA) shows that difficulties dressing and washing are the most prevalence difficulties people face with their daily activities. Nationally 6.7% of older people (aged 65+) living in their own residence have 3 or more activity of daily living (ADL) difficulties which equates to over half a million people. For Halton, applying these findings suggests 1,500 local residents aged 65+ with 3 or more ADL difficulties.

The Census shows that 10,956 older people indicated that difficulties with mobility limit ther lives, 6318 a lot (ranging from 28% of those aged 65-74 up to 59% of those aged 85+) and 4,638 a little. Not surprisingly then, nealry half of all those in receipt of adult social care have physical impairments which affect their mobility.

Older people are especially prone to falling with an estimated one in three people over the age of 65 falling at least once a year rising to one in two of those aged 80+. National resreach suggests only 5% of falls results in a fracture and/or admisison to hospital. This means most older people who have a fall do not come in to immediate contact with services and so it is not possible to put an actual number to the number of falls happening in the borough. Applying national research suggests

around 3,266 women and 2,154 men aged 65+ have a fall each year. As the number of older people increases so too will the number of falls. Unless successful interventions can be implemented these numbers will rise to 4,915 women and 3,375 men having a fall by 2030; a 51% increase for women and 57% increase for men. Halton has a much higher hospital admissions rate due to falls than the North West and England and the difference is statistically significant. This remains the case despite a reduction in the rate 2013/14 compared to 2010/11 agaist a static position for the comparators.

Looking at a range of specific conditions, there are substantial numbers suffering with incontinence, sensory impairments and long-term, incurable illnesses, including multiple illnesses. Incontinence is a significant, embarrasing and socially disabling condition, with an estimated 1,851 halton older residents suffering from bladder problems and nearly as many suffering from faecal incontinence (some will have both). Over 80% (8 out of 10) people aged 60 and over have visual impairments and 75% hearing impairments. One in five (22%) have both to varying degrees of severity. Prevalence and severity increases with age.

Whilst there are various condition-specific long term condition (LTC) GP disease registers as part of the Quality Outcomes Fraemwork (QOF) contract, these only count total numbers with the condition and are not available by gender and age breakdowns. However, national research shows LTCs tend to develop in middle age and prevalence increases with age, especially having multiple LTCs. The census data shows Halton has higher prevalence of LLTI and disabilities than nationally and regionally, 11.6% compared to 10.3% for the North West and 8.3% for England. Within this borough rate there is substantial variation at electoral ward level; 34.5% of 65-74 year olds in Birchfield compared to 95.7% of 85+ year olds in Norton South. In a telephone survey of 55+ year olds conducted by Liverpool John Moores University, more Halton older people said they had a LTC than any other borough in Cheshire & Merseyside, 65% against the survey average of 58%. Data from the latest available annual GP survey also shows an increase in LTCs by age; 58% of totla respondants compated to 95% amongst those over age 85. High blood pressure, arthritis and lower back pain being especially prevalent.

According to respondants to the annual GP survey, the majority of older people feel they definitely or at least to some extent have enough support from services to manage their LTCs. Most felt very or fairly confident in manageing their own health.

Co-morbidities (having more than one illness) commonly involve mental health problems. Peole with LTCs are 2-3 times more likely to experience mental health problems than the general population. AT least 4 million of the 15 million people in England with long-term physical health problems also have a mental health problem. National research also shows that outcomes for older people with co-extisting mental health problems admitted to hospital are generally poor with only one in three (31%) not being readmitted or moved to a care home and only 4 out of 10 recovering to their pre-acute illness level of functioning.

Levels of dementia are increasing with an estimated 1,347 Halton people aged 65+ with the condition. Whilst the level of diagnosis has been imrpoving this estimate remains higher than those with a diagnosis registered with their GP – 893 in 2014/15. This gives a diagnosis rate of 66.3%, leaving over 1 out of every 3 possible cases of dementia undiagnosed (although the gap has been closing and efforts continue to close it even further).

With high levels of long-term illness or disability it is unsurprising that the majority of the 65+ respondants in the 2014/15 GP survey said they had some level of daily pain or discomfort. This can have a negative influence on quality of life and on mental wellbeing. Yet national research also shows that older people are less likely to receive good pain management. Based on data from the Health Survey for England and local GP survey prevalence rates, it can be estimated that over 5,000 Halton older people aged 65-74, 4,000 aged 75-84 and 800-900 aged 85+ (estimated total 9,773-10,887 65+) are in some level of pain and discomfort.

There has been an increase in attendance rates at Accident & Emergency (A&E) departments amongst Halton 65+ residents. Despite some recent reduction in the rates, it still represents nealry twice as many attendances in 2014/15 compared to 2010/11. There are significant ward level variations with seven wardds statistically higher than the Halton average.

Data for England shows that 4 out of every 10 admissions to hospital amongst those aged 65+ are via the emergency route and this is higher than for those under age 65 (3 out of every 10). Amonst Halton older people, the most common reasons for emergency admisisons were respiratory conditons as well as urinary tract infections and heart problems. Whilst the length of stay fell between 2012/13 and 2013/14 it rose very slightly in 2014/15. With increasing numbers and costs per admission, the cost of hospital admissions for those aged 65+ is increasing. As with A&E attendances, there are significant ward level variations with a nearly ten-fold increase across the borough from 6,308.5 per 100,000 in Hale to 60,202.4 per 100,000 in Riverside wards. This is against a backdrop of increasing borough rate. The rate in 2014/15 was slightly higher for males than females.

For many older people their level of functioning deteriorates once they have been admitted to hospital. Reablement services aim to help people regain independence following events such as falls or hospital admissions. The number of older people still at home 91 days after discharge from hospital into a reablement/rehabilitation service is measured as part of the Adult Social Care Outcomes Framework. In 2014/15 65.6% of Halton people aged 65+ were still at home 91 days after discharge. This was slightly higher than the previous year but is below the borough statistical neighbours group average, regional and England averages. Conversely, Halton has a slightly higher percentage of people aged 65+ receiving reablement services following a stay in hospital than its comparators. Halton also has a lower delayed transfers of care rate and delayed transfers of care attributable to social care than comparators. These demonstrate good intergration between health and social care and responsiveness on oneward care package provision.

Older people may require an ongoing package of care post-reablement or they may become known to Adult Social Care due to reduced ability to cope on their own, even with the support of an unpaid carer. The number of clients and number of care packages has increased over the last five years. Halton has a lower rate of people entering care homes, although the numbers are increasing as the older population increases. Many older people will be in receipt of multiple services to meet complex needs. Short-term services aim to reable people and promote independence. Compared to its statistical neighbours group, North West and England rates, Halton has a higher percentage of new clients who receive such services, were the sequel is that they need no ongoing support or support of a lower level. This demonstrates that the borough has greater success in helping people to remain independent. Part of this success may also be that Halton has a high level of unpaid

carers, one of the highest percentages in England for the provision of 50 or more hours unpaid care per carer; 13.6% of the total population provides unpaid care compared to 11.4% England average with 19.1% of Halton residents aged 65+ providing unpaid care compared to 16% nationally. For 50+ hours of care provision 4.1% of Halton's population provides this level of unpaid care compared to 2.6% nationally, with the highest percentage providing this level of care being amongst those aged 65+, 9.9% in haton compared to 6.1% in England as a whole. In Halton 30.4% of unpaid carers provide 50+ hours care per week compared to 23.1% nationally and over half of all carers aged 65+ provide this level of care (England 38.4% of 65+ cares do so). It is therefore vital the the health of carers is looked after.

Adult social care services range from preventative to supporting those with complex needs to remain independent (and support to make to a care home when necessary). The use of telecare offers a cost-effective way of increasing older and disabled people's confidence in living independently knowing there is 'at the press of a button, at the end of a phone line 24/7 support' if difficulties arise such as having a fall. As people's health and social circumstances change they may find their home design no longer meets their needs. Rather, than having to move home or move into a care facility, equipment, minor and/or major home adaptations can help with mobility around the home and ability to maintain activities of daily living. Halton Borough Council has been providing an increasing number of minor adaptions over recent years. HBC Home Improvement Agency supports people aplying for the means-tested Disabled Facilities Grant (DFG). Once approved they assist with all aspects of the home improvement being carried out, liaising with Occupational Therapists/ Community Health Worker to ensure the work needs needs, applying for planning permisisons and overseeing contractors work.

It is not just the public sector that supports older people to maintain independence. The voluntary sector provides a wide range of services via faith organisations, charities such as Women's Institute and Royal Voluntary Services, support groups such as Halton Cancer Support Group and many others. Age UK Mid-Mersey also provides a wide range of advise and services to people aged 50+ in Halton, including Helping Hands, a DIY-type service offering volunteers who can do minor jobs around the house.

Recently Halton Borough Council has been leading a review to ensure collectively, the most is made of the wide range of servives operating in the borough. A number of improvement araes have been identified which are being worked on currently:

- Guidance on recognising frailty amongst both health and social care sectors, including the use of the Comprehensive Geriatric Assessment tool when older people present to services (including A&E)
- Rapid assessment 'close to home' and at hospital including management of frailty and improved discharge processes, including the use of voluntary sector
- Review of capacity, demand and models in Intermediate Care provision
- Outcome-based domiciliary care commissioning and contracting
- Strengthening of the existing primary and secondary falls prevention work

Chapter 6: Mental health and wellbeing

Local demographics

In Halton there are a higher proportion of females accessing secondary care mental health services to males and only a very small number of ethnic minority individuals, compared to white British. More work needs to be done to understand why this is and what can be done to change it. It may link to pride in males seeking help and for ethnic groups, religion and culture plays a strong part in not speaking out about mental health.

Increasing Older Population

Due to an increasing population nationally, there is forecast to be an increase in the number of older people with depression, within a few years. However, the resources available for health services given the current financial restraints, will at best remain the same, requiring the development of new service models to meet the need using a holistic approach.

Social Isolation and Loneliness

It is clear that loneliness and mental wellbeing are closely connected. In Halton there are approximately 21,013 older people. Of these: 2000 are likely to report feeling very or always lonely- likely to rise to 2800 by 2021 if unchecked,. In Halton 5000 of our over-75's live alone. We know loneliness is a danger to older people's mental health with an increased risk of depressive symptoms including depression, fatigue and poor levels of sleep. The Mental Health Foundation estimates that depression affects 20% of adults aged over 65 living in the community.

Information - There is no effective Directory of Services in Halton for older people. Many attempts have been made to create one but have usually been defeated due to cost or technical difficulties. Advocacy is a critical area.

Transport- There is a lack of evening transport around the borough, expensive taxi rates, and capacity issues with Dial-a-Ride. There is currently a CCG transport group trying to develop options around transport which I chair. Transport funding has been regularly cut over the past five years and there are likely to be further cuts going forward. Some investment in this area would result in better mental health outcomes.

Technology- there is a gap in providing simple Skype type devices for isolated older people. The Visbuzz system was piloted with 100 older people in the borough but was not adopted due to technical difficulties with the units. Again investment in this area would result in better mental health outcomes.

Befriending-There is evidence that befriending schemes can alleviate loneliness and other mental health issues. While there are some services which offer befriending through volunteers (Sure Start to Later Life/Age UK) they tend to have waiting lists of up to a year. A more local telephone befriending service would result in better MH outcomes for older people.

Bereavement Councelling - Older people who have suffered bereavement from the loss of their partner do not have access to a local counselling service other than waiting 6 months for general

counselling via the GP. Older people would benefit from a bereavement counselling/support service, where they can be fast tracked to counselling if they have lost a partner, due to their age and higher risks of complications.

Group activities- Current research leans towards group interventions producing better mental health outcomes around loneliness and older people. While Age UK/SSLL/ Wellbeing Enterprises organise group interventions funding to develop a broader range of group activities/events aimed at lonely older people would pay dividends. NICE guidelines on older people: independence and mental wellbeing(NG32) go into more detail about good practice in this area, especially around the effectiveness of education and learning activities, volunteering and intergenerational activities. They are seen as cost effective mental health interventions and a good use of public money.

Commissioners should strive to deliver measures to address loneliness at a neighbourhood (or even ward) level as older people spend more time in, and often feel more committed to their neighbourhood. Breaking down areas at neighbourhood level can also be more manageable and allow effective targeting of initiatives and enables outreach efforts. The reduction in the HBC Community Development Team has meant a lessened focus on such community development work.

Risk factors of depression

Older people's mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers. Mental health needs interact in complex ways with long-term physical health problems. People with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems. In light of this and the recognition of the parity of esteem agenda, there will be an opportunity later in the year for commissioners to bid for recurrent funding to incorporate Long Term Conditions (LTC) Services into the Improving Access to Psychological Therapies (IAPT) Service for low to moderate mental health problems.

Acute Bed Base

Halton do not currently commission secondary and acute care mental health services specifically for older people, as they provide the same support for older people as they do adults. It has been identified as part of the 5 Boroughs Partnership (5BP) Footprint Review *(see 5 keys areas below)* that there is a significant cohort of older people whose specific clinical needs would be better met within a dedicated facility and by staff who are trained and experienced in managing their needs. Local MH providers and commissioners have been asked to ensure that the needs of each individual will be better met by adopting a more appropriate clinical bed model.

Five Borough Partnership (5BP) Independent Review

The mental health services provided across Halton are complex and varied. There are many areas of positive work being undertaken in each of the services which should be commended, particularly at a time when resources are stretched and also under threat of being reduced. There are also a number of areas for improvement both in relation to individual services and also the wider system they operate within, many have been identified within the independent review of the adult

and older adult acute care pathways within the 5 Boroughs Mental Health Trust undertaken in 2015.

The following **five key areas** for future development were identified within the 5BP footprint review:

1. The interface between primary and secondary care - The way in which people are supported in primary care and also move between primary and secondary care
2. How people with a personality disorder or highly distressed emotional disorders are supported by the whole system
3. The whole service model across the Borough (including 5 Boroughs Partnership NHS Foundation Trust services and all others
4. Step down from in-patient services and the use of out of areas placements in the private sector
5. The proposed future bed model

All of the five key areas mentioned above are inter-dependent and will all be implemented as part of a whole system approach to delivering the best quality, most efficient and value for money services that are possible within the resources available across the footprint.

Finally, the older people who use these services and families and carers require their voice to be heard within the on-going changes that will occur. How this is achieved needs to be agreed, but their voice is of great importance, whether through "user" / "carer" representatives or professional organisations acting on their behalf.

Chapter 7: dementia

The number of people with dementia has been rising in recent years and this is predicted to continue. Whilst some of this is due to greater awareness and diagnosis, the main driver is the increase in the older population (onset of dementia is rare before the age of 65).

Research has been emerging that shows whilst many of the causes of dementia are not amenable to change, there are several lifestyle risk factors, for both onset and progression of the condition. These include obesity, alcohol misuse and hypertension (high blood pressure). Levels of all these risk factors are higher in Halton than nationally, potentially putting the borough's population at greater risk.

It is estimated from national research that 1,287 people in Halton may have dementia. This is higher than the 895 people diagnosed in primary care. However, the difference has been reducing. In 2009/10 less than half the estimated numbers had been diagnosed (46%). By 2014/15 this was 69.9%. Due to the concerted efforts of all partners, including families of those with dementia, and especially amongst primary care staff, this 'diagnosis rate' should continue to increase, despite the increasing numbers.

The majority of people with dementia who are admitted to hospital are over the age of 80 but are not admitted due to their dementia. The most common reasons are injuries, respiratory illnesses and conditions of the urinary system. This underlines the need for all hospital staff to have an awareness of the needs of people with dementia during hospital stays and also as part of discharge planning.

- **Prevention:** Local Public Health Teams should have a role to play not only in increasing awareness of dementia signs and symptoms, but also in promoting where risks of developing particular types of dementia can be modified, and what protective behaviours can make a difference
- **Public and Professional Awareness:** Health, social care, 3rd sector stakeholders, Commissioners and service providers should be mindful of how the 'dementia demographic' is likely to change over future years, in particular young onset dementia and the potential for an increase in numbers of people with a learning disability developing a dementia. Awareness of signs, symptoms and needs of diverse cohorts of people
- **Pre diagnosis Support:** Commissioners should consider the demand for, potential value of and methods of pre diagnostic support, for people in the investigation stage and earlier
- **Diagnosis:** There should be a continued focus on early and timely diagnosis. Primary and secondary care should continue to be linked in to regional groups (such as the NHS Clinical Strategic Network for Dementia) that provide direction and learning to support GP in diagnosis and condition management
- **Increase awareness across hospital ward staff and take into account the approach to treatment where patients have suspected dementia or a dementia diagnosis:** Trusts should provide Tier 1 and Tier 2 Dementia Training to NHS staff. Admission to hospital offers an opportunity to identify undiagnosed dementia in older age patients. Where this is not already in practice, Trusts should consider undertaking a short cognitive assessment on admission that could identify signs of dementia, delirium or depression. Consideration should be given to the benefits of the physical ward environment for people living with dementia, in reducing risks of falls, for example, and aiding their recovery
- **Prescribing:** Commissioners and primary/secondary health colleagues to work together to better understand the prescribing of anti-psychotics to those with dementia. This should include both the individual context for use, adherence to guidance and care planning and review arrangements
- **Post diagnosis:** Consideration by commissions should be given to a Prime Provider model for a post diagnosis community pathway. Consideration should be given to the potential benefits of a single point of access , single assessment of initial need, promotion of, and access to, services on a prime provider pathway, information sharing etc, that could facilitate appropriate, flexible and timely support for the person and carer
- **Quality of Services:** All services that support people living with dementia, and their carers, should be reflective of the NICE Dementia Quality Standards (QS1 And QS30), and demonstrate that they have considered national best practice
- **Appropriateness of Services:** Commissioners should consider the diversity of provision to meet the needs of older people, younger people and people with a learning disability living with dementia. The needs of younger carers and carers who are in employment must also be considered
- **Respite:** Commissioners should consider the level and types of respite available, and barriers that inhibit people living with dementia and their carers using respite to enable a flexible respite model that meets the needs of a diverse cohort of people
- **Identifying and supporting carers**: Identifying carers should be a priority of every professional stakeholder involved form pre to post diagnosis. Carers provided with timely information, advice and guidance to help them make effective decisions about care and support can help them develop effective caring strategies, help them maintain their own wellbeing and build resilience

Chapter 8: care homes

Care homes now provide more beds than the NHS, for a predominantly older population with increasingly complex health needs

The care home population (aged 65+) has remained fairly stable increasing by just 0.3% between the 2001 and 2011 Census despite a growth in the 65+ population being 11% over this time period. This is likely due to the increased emphasis on care at home to aid independence for as long as possible. However, this means that the care home population is ageing with those over age 85 over-represented. It also means it is those with the most complex health and social care needs that are moving to live in care homes. The continued ageing of the population does mean there will be an increase in numbers in the future. Indeed this is starting to happen already with the downward trend in both temporary and permanent admisissions to care homes starting to reverse both nationally and locally.

In Halton 578 people live in care homes representing 2.8% of the 65+ population. This rises to 12.1% of those aged 85 and over. There are clusters of care homes in certain parts of the borough; Halton Lea, Appleton, Broadheath and Riverside wards have the highest number of people living in care homes reflecting care home locations.

The current model of primary care provision supports residents remaining with their existing GP following admissions to a care home. Whilst this provides continuity of care for the individual it does mean homes having to liaise with multiple practices. For the majority of care homes this is 5 or more up to a maximum of 10. Despite their more complex health needs, national research shows some primary care staff perceive care home residents to be lower risk and therefore of less priority. Changes in the GP contract and additional funding for services for patients aged 75+ offers opportunities for improving primary health care in care homes.

Personal care support is the dominant reason for Halton residents moving to live in a care home, with mental health support and memory & cognition support needs making up most of the remaining causes. This pattern is seen in both residental and nursing care. As people are remaining at home for longer, the length of stay in a care home before death has been decreasing in the borough from 2.1 years in 2010/11 to 1.2 years in 2014/15; for nursing homes this has been a reduction from 1.2 years in 2010/11 to 0.8 years in 2014/15.

National research shows nearly 2 out of 3 (68%) of care home residents do not have regular medical reviews or medication reviews (66%) and only 3% have access to occupational therapists. This appears to be a long standing issue. It leads to a lower percentage of patients being managed to quality targets.

Many care home residents have dementia and/or exhibit forgetfulness or confusion; mobility difficulties and incontinence affects over half of all residents, with the prevalence of long term conditions being higher than in the community-dwelling older population. Research also suggests as many as 1 in 5 are malnourished on admittance. The need to maintain moblity and levels of social activity, retain personal identity and intimate relationships are important considerations to maintain quality of life for residents moving to a care home.

As in the general population, hospital admisisons increase with age amongst care home residents. However, national datasets on health outcomes, primary care and hospital admissions do not differentiate the needs of care home residents. Local analysis using postcode of care homes as a proxy for care home residents shows that amongst the just under 600 care home residents for 2013/14 to 2014/15 there were 2,574 hospital admissions with 1,960 of these amongst residents aged 65+.

Research indicates residents in care home are less likely to have advanced end of life care planning in place. Yet research also shows that having this in place can reduce the number of days spent in hospital, improve the quality of life during this period and reduce the number of deaths taking place in hospital. Amongst the 65+ population as a whole, 75% of all deaths due to unspecified dementia and 80% of deaths due to other forms of dementia take place amongst care home residents as do 56% of all deaths due to cerebrovascular disease and over half of deaths due to diseases of the urinary system. Between 2010 and 2014 more Halton residents aged 65+ died in a care home than any other single location (2010 deaths out of a total of 4,611 during the 5-year period). A higher proportion of deaths in women aged 65+ occur in care homes than for men aged 65+, 48% compared to 37.5%. For both genders the percentage increases with age.

Key issues

- Develop integrated systems that support the personalisation agenda
- Develop an integrated Halton Borough Council and NHS Halton CCG Care Home Commissioning Strategy (informed by both national and local qualitative and quantitative research)
- Develop a GP care home model to reduce unwarranted variation in clinical practice and supports the delivery of high quality care
- Develop a care home nursing model which will promote and improve care
- Develop a workforce strategy with Providers which will support recruitment, retention and development of staff
- Develop a Care Home MDT Model which will include a re-alignment of community resources (including a 'named' care home social worker and complex care nurse) with an emphasis on person centred care, resulting in enhanced clinical decision making, better coordinated care and improved outcomes
- Develop Care Home 'Champions' to further improve care and quality of life for individuals
- Develop an integrated (primary care and care homes) patient management system to support and improve care
- Develop technology enabled care services that will support new models of care, co-ordinated around individual needs
- Develop clinical pathways which have a favourable impact on health outcomes
- Develop 'in and out of hospital' pathways to ensure appropriate admission and discharge processes
- Develop a fully integrated Halton Borough Council and NHS Halton CCG quality system, including an integrated dashboard composed of new metrics that provides assurance to both organisations of the quality of care delivered in care homes. Consideration should be given to the Safeguarding Adult Board to drive this development
- Develop a local Joint Intelligence Group, with members from adult health and social care to ensure the delivery of high quality care

- Develop a Care Home Partnership Network which includes representatives from care home providers (whose contribution will include views from residents), Halton Borough Council NHS Halton CCG, primary care and NHS providers to bring about improvements in care
- Develop a formal medicines management arrangement (including data sharing agreements) between Halton Borough Council and NHS Halton CCG, that will result in improved care
- Develop a Halton Borough Council and NHS Halton CCG joint policy ratification process for care home medicines management policies
- Introduce into the Halton Borough Council and NHS Halton CCG Falls Strategy a number of evidence based care home specific interventions
- Develop a multi-agency approach to improve the Vitamin D status of care home residents to lower their risks for falls and fractures
- On admission to a care home, unpaid carers systematically referred for a Carers Assessment
- Develop, support and monitor local arrangements to enable individuals in care homes are able to access opportunities both within the care home and in the wider community, to participate in meaningful activities that promotes their health and mental wellbeing

Chapter 9: Safeguarding

Key Findings

The rate of adult safeguarding referrals was higher in Halton than amongst its comparator groups for 2014/15. Changes in referrals processes during 2015/16 mean it is expected that the rate will have fallen during 2015/16 and there are indications that this has happened. However, at least for this initial year after the changes, it is likley the rate will remain higher than comparators. Despite the difference in rate of referrals, the age and gender profile in Halton is similar to comparators and has remained fairly constant over recent years. About 30+ per cent are amongst people aged 18-64, with 60+ per cent being aged 65 and over. These same percentage differences are seen for gender, with the smaller percentage being amongst males.

A greater percentage of Halton referrals in 2014/15 were previously unknown to the council compared to the national, regional and statistical neighbours averages. The location of alleged abuse remains predominantly the person's own home followed by in a care home. These 'usual residence' locations make up nearly 90% of all referrals.

There is a significant geographical variation across the borough, with the rate of referrals ranging from 140 per 100,000 population aged 18+ to nearly 1,700 per 100,000 population aged 18+, a nearly ten-fold difference. Deprivation is only weakly associated with this variation, determining about 36% of the relationship. The distribution of the older population (percentage of ward population aged 65+) appears more closely associated with the distribution of referrals. The location of care homes affects this age distribution pattern and so is also a factor in safeguarding referral patterns.

Physical abuse/risk and neglect & omission remain the two main types of alleged abuse. Although relatively small in comparison, financial abuse is of growing concern locally. This includes scams targeted at vulnerable people. A Trading Standards project has been successful in helping scam victims recouporate money from scammers and also in how to be more resistent to future scams.

Amongst male victims the most common relationship with the alleged perpetrator is community care staff followed by family. This is the reverse of the position for women but for both these are

the two most prevalent relationships. For both genders, service users/ other vulnerable people and residential care staff are the third and fouth most common relationships.

In Halton over 2 out of 3 cases investigated results in action taken and risk reduced. This is a much higher percentage than seen elsewhere, with borough comparators seeing less than half of cases with this outcome. In 65% of cases in Halton the allegation is fully substantiated. This is nearly twice as higher as the borough's comparators. Only 13% of cases in Halton are not substantiated compared to 30% elsewhere.

There has been an increased concern and local focus on medication errors. These occur predominantly in care homes due to preparation and administration errors. This is currently being investigated to reduce the number of errors and therefore risk to the individual.

There are clear links between adult safeguarding and domestic abuse. Halton has a higher rate of domestic abuse incidence reported to the police than other parts of Cheshire, with all borough's in Cheshire having lower rates than England. Halton has a lower rate of MARAC[b] cases discussed each quarter than other boroughs in Cheshire.

DOLS applications have increased ten-fold nationally between 2013/14 and 2014/15 since the Supreme Court landmark ruling lowered the threshold for what constitutes a deprivation of liberty.

Safegaurding is everyone's business and all major organisations operating in the borough have adult (and where appropriate child) safeguarding policies and procedures. The Integrated Adult Safeguarding Unit is a Halton Borough Council (HBC) and NHS Halton CCG funded team based in HBC. They deal with safeguarding referrals and investigations on behalf of all organisations in the borough. They also deal with Deprivation of Liberties (DoLS) cases and offer advice to care management teams in all organisations. This ensures consistency in referral criteria/approaches and best practice is maintained throughout the borough. This co-ordination role also ensures new guidance is cascaded swiftly and is consistently implemented.

Key priorities for Action

- Develop a Prevention Strategy and associated action plan to monitor progress
- Establishment of a Self-Neglect Panel
- Development of a Self-Neglect Strategy for Halton
- Continued identification and reporting of key themes and trends to Halton Safeguarding Adults Board
- Halton Safeguarding Adults Board to identify specific work streams required to respond effectively to identified key themes and trends in safeguarding
- Ensure any new policies and procedures developed are compliant with Care Act 2014 requirements
- Continue to monitor medication errors and investigate the reasons. Feed these in to the Halton Safeguarding Adults Board and CCG Governance.
- Continue to raise awareness amongst professionals and the public to ensure safeguarding concerns are appropriately referred to Halton Borough Council

b) MARAC = Multi-Agency Risk Assessment Conference

Chapter 10: End of Life Care (EOLC)

There has been a significant shift in the place where the majority of people die over the last century, from the majority of people dying at home to over half now dying in hospital. Yet, despite this, surveys show that home remains the preferred place of death for the majority of people.

People are generally regarded s approaching the end of life when they are likely to die within the coming 12 months. Palliative care supports people nearing the end of the lives to live as well as possible. This may be through specialist palliative care but for most generic services, well planned and provided will suffice. Whichever group of staff is involved, the complexity and personalised nature of need requires effective, multi-disciplinary working within and between health and social care services, which includes the active invovlement of family and friends.

National research shows that most people express a wish to die at home but only about one in five do so. In Halton just under four out of ten (40%) die in their usual residence, defined as either the own home or a care home. This is lower than England and Cheshire & Merseyside (approximately 45% and 43.5% respectively). This places NHS Halton CCG 36th lowest in England out of 211 CCGs and lowest in Cheshire & Merseyside for the last reporting period available.

The majority of deaths occur in those aged 65 and over, nealry 8 out of 10. The percentage of deaths occuring in hosital varies little with age. Whilst the percentage who die in their own home decreases with age, the percentage dying in a care home increases from 13.5% amongst those aged 65-84 to 32.2% amongst those aged 85 and over.

From age 65, a slightly lower percentage of men die in their own residence compared to women. However, the most significant gender difference is the higher percentage of women dying in a care home; 16.4% amongst those aged 65-84 and 35.7% at age 85+ compared to 10.7% and 25.6% for men of the same age.

Whilst hospitals continue to be the dominant place of death, there has been a reduction in the percentage in recent years, with a corresponding increase in the percentage of deaths occuring in care homes and a small increase in the percentage dying in their own residence. This means a key role for hosital remains the delivery of high quality EOLC including support to families. There have been imporvements in access to specialist palliative care but still, only 4 out of 10 hospitals provide 9am-5pm, 7 days a week access in the 2014 national audit (compared to 3 out of 10 during the 2013 audit). In the 2014 audit bot Halton's main acute hospital trusts reported they had this provision in place.

The 2014 hospital audits of palliative care showed that St Helens & Knowsley Hospital had a higher percentage of cases reviewed than Warrington Hospital Trust. Warrington did not have in-house training for staff but St Helens did. Overall, both trusts performed similar or better than the England average.

Halton has had a higher percentage of all age 'terminal admissions' admitted as an emergency than England but lower amongst those aged 85+. The most common cause of death is cancers at 30%, follwed by cardiovascular disease at 25% and respiratory disease at 15%. Overall people both nationally and locally are more likely to die in hospital if they live in more deprived areas.

National research shows that people with dementia, those who are Lesbian, Gay, Bisexual or Transgender (LGBT), are homeless or have a learning disability all face barriers/difficulties in accessing high-quality EOLC. Staff may be unaware of their particular needs and/or how to meet them. Families of children with terminal illnesses also have specialist needs.

Whilst in theory, the majority of deaths can be predicted and therefore EOLC planning established (NICE put this at about 75% predictable), in practice there is a wide margin for error, mostly due to over-optimism of prognosis. There are just over 1,000 deaths in Halton per year but only 382 people were on the palliative care register in 2014/15. Nevertheless this means the prevalence rate for pallitaive care for Halton CCG was similar to the North West and the same as the England average. All identified patients have regular reviews, a higher proportion than the North West and England.

Advanced Care Planning (ACP) is a key element of the end of life care pathway and policy which is reflected in the adoption of the Coordinate My Care tools to allow appropriate professionals invovledin the care of the patients to access their care plan. Locally, people who are believed to be in the last year of life are coded using the North West End of Life care Model. The tool is used in care homes and all people on the GP Gold Standards Framework (GSF) are thus coded. The Community Integrated Advanced Care Planning Service provides ACP for Halton and delivers training to staff from key providers of EOLC.

Whilst only a couple of Halton's care homes have achieved GSF for Care Homes, many more have received training and are at various stages of working towards it. Of the people with an ACP over 90% have achieved theor Proffered Place of Care (PCC) consistently over the last five years.

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6. Local Government Association (2015) Better Care Fund. London: Local Government Association. http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE

7. NHS England (2014) Integrated personal commissioning prospectus; making a reality of health and social care integration for individuals. London: NHS England

8. Department of Health (2012) National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

9. Health and Social Care Information Centre (2014) Mental capacity act deprivation of liberty safeguarding collection http://www.hscic.gov.uk/dols

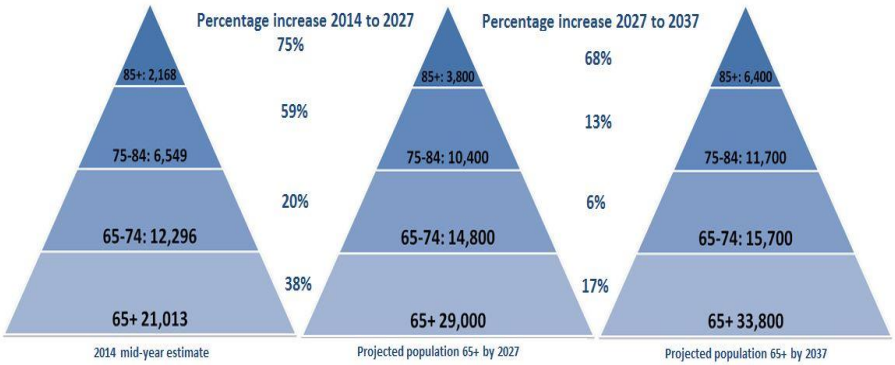
10. Legislation. Care Act 2014, chapter 23 http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

11. NICE Public Health Draft Guideline PHG64 (2014) Dementia, disability and frailty in later life – mid-life approaches to prevention

12. Clegg et al (2013) Frailty in elderly people Lancet; 381:pp752-62

Halton's older population

Data taken from the Halton Older People's JSNA
http://www4.halton.gov.uk/Pages/health/JSNA.aspx



Life expectancy increased by 2.3 years for females and 3.0 years for males in last decade (same as England average)

But recently been a slight drop in life expectancy at age 65 for females

8,960 have a disability, more women than men

Nearly 9 out of 10 say they are Christian

Economic status

8 out of 100 (8%) economically active

Halton older people are less likely to have higher level qualifications and to have been in professional/managerial posts than NW and England.

1 in 4

A quarter live in the 10% most deprived parts of England

1 in 2

Just over half live in the 20% most deprived parts of England

8 out of 10 satisfied with their income

9 out of 10 feel able to manage their finances

Living and social circumstances

Those aged 50-64 are least likely to live alone
Most people aged 65+ own their own home
8 out of 10 people aged 85+ live alone

The numbers receiving minor home adaptations from the council has increased. It is a key way of helping people to remain independent.

Public transport is a key concern. 3 out of 10 older people do not have a car compared to just 2 out of 10 amongst the general population

Many older people fear becoming lonely. Estimated 6,000 older people in Halton are lonely. Predicted to rise to 10,000 by 2030

Produced by Public Health Evidence & Intelligence Team.
Icons sourced from www.flaticon.com

Wellbeing and lifestyles amongst older people in Halton

Data taken from the Halton Older People's JSNA
http://www4.halton.gov.uk/Pages/health/JSNA.aspx

Life expectancy increased by 2.3 years for females and 3.0 years for males in last decade (same as England average)

But recently been a slight drop in life expectancy at age 65 for females

Only 42% of people aged 65+ said they were in good or very good health. Lower than England.

Disability-free life expectancy lower for men and women in Halton compared to England

Over **90%** rate overall experience of GP surgery as good.

Only **67%** go to the dentist

Cancers and heart disease the biggest killers.
Respiratory disease third highest cause of death.

Lifestyles

Fewer smoke: 17%, compared to 30% in general population (other surveys suggest adult smoking level is lower than this)

Eat more Fruit and Vegetables than younger people

Least likely to eat fast foods

Higher percentage are overweight and obese compared to the general population

Lower percentage undertake at least recommended levels of physical activity

More likely to be sedentary for a larger proportion of the day

Least likely to drink alcohol at harmful levels

Screening and Immunisations

Cancer screening uptake below targets:
- Bowel 48.8% uptake (target 60%)
- Breast 69.8% (target 70%)

Wide GP practice level variation

Vaccinations also below targets:
- Influenza uptake 73.8% (target 75%)
- Pneumococcal 70.8%
- Shingles 47.8%

Wide GP practice level variation

Falls Prevention

Estimated 3,266 women and 2,154 men have a fall each year. Figures predicted to rise.

36% have ever had a fall

Admissions due to falls (amongst those aged 65+) significantly higher than England. Admissions due to hip fracture have reduced and are now similar to England rate.

Exercise and eating a healthy diet can help prevent falls

Screening tools can be used to identify those most at risk

Produced by Public Health Evidence & Intelligence Team.
Icons sourced from www.flaticon.com and www.freepik.com

REPORT TO: Health and Wellbeing Board

DATE: 18th January 2017

REPORTING OFFICER: Director of Public Health and Public Protection

PORTFOLIO: Health and Wellbeing

SUBJECT: Public Health Prevention Programme at Scale

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to seek support from the Board to roll out prevention programmes at scale in Halton hospitals, primary care and community and to incorporate them in the Cheshire and Merseyside 5 Year Forward View Plan.

2.0 RECOMMENDED: That

1. **the Board supports the roll out of prevention programmes at scale commencing with blood pressure, reduced harm from alcohol and anti-microbial resistance; and**
2. **the Board recommends the above prevention programmes are incorporated in the Cheshire and Merseyside 5 Year Forward View Plan.**

3.0 SUPPORTING INFORMATION

3.1 The draft One Halton Health and Wellbeing Strategy prioritises alcohol harm reduction, heart disease, healthy eating and exercise, reduced mortality from cancer, improved mental health and improved quality of life for older people as key priorities. Focussing on blood pressure, alcohol misuse and anti-microbial resistance in Halton and out of Halton services, such as hospitals, directly underpins these priorities.

3.2 High blood pressure, also known as hypertension, is a preventable disease that is estimated to affect 1 in 4 people. There is national under diagnosis and while in Halton more people are diagnosed than the England average there is still approximately 12,500 people undiagnosed.

High blood pressure puts people at risk of costly and disabling conditions including stroke, heart failure, heart attack, chronic kidney disease and vascular dementia and is a key factor in premature death and disability.

3.3 Halton has joined with Cheshire and Merseyside partners in identifying high blood pressure as a priority for cross-sector collaborative action and has made great progress in forging a cultural shift towards integrated working and prevention. Cheshire and Merseyside is nationally recognised as 'leading the way' with its cross-sector strategy to tackle high blood pressure: 'Saving lives: Reducing the pressure', and the programme of work proposed here builds on this strategic system leadership approach.

3.4 Halton is part of the Cheshire and Merseyside Blood Pressure Board. Key partners include Cheshire and Merseyside Public Health Collaborative (Champs), Public Health England NW, NHS England, nine Local Authorities, 12 CCGs, the Cheshire & Merseyside CVD SCN, Voluntary Sector organisations, the National Institute of Clinical Excellence, Innovation Agency, Health Education England, Cheshire & Merseyside Fire and Rescue Services, industry partners, academic institutions, and more.

3.5 A shift in blood pressure outcomes and reduction in demand on the health and care system will be achieved by a continuation of the Cheshire & Merseyside cross-sector systems approach.

Priority interventions include:

Empowering patients and communities to live better:

- An **NHS settings approach to prevention at scale (e.g. 'Healthy Provider Declaration')**: Supporting all the 20 of the large NHS provider organisations in the sub-region to develop healthy local policy to support healthy eating as a key modifiable risk factor for staff, patients and visitors, and putting in place a package of support around implementation.

- Roll out **Making Every Contact Count** at scale and optimise impact through workforce development and use of supporting conversational tools/ technologies.

- **Changing behaviour through awareness raising campaigns**: Maximise the impact of existing national campaigns, particularly Blood pressure UK's 'Know Your Numbers' campaign.

- **Strengthening the role of community pharmacies** in the prevention, detection and management of high blood pressure through blood pressure testing, 24 hour blood pressure monitoring, and increased uptake and focus of medicines optimisation services.

- Increasing **availability of blood pressure machines and Ambulatory Blood pressure Monitors** to support detection and diagnosis in community settings

- **Primary care education and training programme** to accelerate and support quality improvement in primary care with dedicated education and training programme that utilises Sector Led Improvement principles.

4.0 Halton experiences a high level of alcohol related harm with 22,500 residents drinking at levels which could harm their health. Each year 792 people are admitted to hospital due to alcohol related conditions. Around 600 people a year are affected by alcohol-related violent crime and 50% of domestic abuse incidents involves alcohol as a contributing factor. The combination of crime, health, worklessness absenteeism, and social care costs to Halton arising from alcohol are estimated at £58 million per year – around £461 per resident.

4.1 Halton has a local comprehensive Alcohol Harm Reduction Strategy and Action Plans and now seeks to augment this by working with partners from Cheshire and Merseyside to focus upon areas within which the NHS, with support and in partnership, can play a key role to reduce alcohol-related harm.

This work has identified 3 key areas:

Enhanced support for high impact drinkers in hospital and community settings

- Develop ***multi-agency approaches to support change resistant drinkers***

- Ensure the ***provision of best practice multidisciplinary alcohol care teams in all acute hospitals.***

- Review alcohol treatment pathways and ***commission outreach teams in hospitals or the community*** that complement hospital based alcohol care teams by identifying and proactively engaging patients with repeated admissions as appropriate.

Large scale delivery of targeted brief advice

- Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff trained to offer and ***provide brief advice*** and refer to local specialist services as required.
- Ensure screening and advice by non-NHS partners as part of the delivery of ***Making Every Contact Count (MECC) interventions***. This will include evidence-based alcohol IBA as well brief interventions focusing on High Blood pressure (BP) (including BP checks), smoking cessation, diet and physical activity.

Effective population-level actions are in place to reduce alcohol-related harms

- Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards (As outlined by College of Emergency Medicine (CEM) Guidelines and the Standard on Information Sharing to Tackle Violence).
- Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners
- Ensure local partners collaborate to ensure that the data collected is being used effectively and work together to consider where improvements can be made. This will include:
    i. Targeting interventions to prevent violence and reduce alcohol-related harm
    ii. Targeting police enforcement in hotspot areas
    iii. Use of intelligence in the license review process and targeting alcohol licencing enforcement

5.0 Antimicrobial resistance (AMR) is the ability of a microbe to resist the effects of medication previously used to treat them. This term also covers antibiotic resistance, which applies to bacteria and antibiotics. Resistance commonly occurs because of misuse of antibiotics or antimicrobials. Resistant microbes are increasingly difficult to treat, requiring alternative medications or higher doses—which may be more costly or more toxic. Antimicrobial resistance is on the rise with millions of deaths every year.The World Health Organisation has stated that *Anti-microbial resistance is the greatest threat to global health in our lifetime.*

Although rates are declining Public Health England reports that Cheshire and Merseyside has one of the highest rates of MRSA bacteraemia in England (1.8 per 100,000 population). Cheshire and Merseyside also has one of the highest rates of reported Clostridium difficile in England (31.3 per 100,000 population) (PHE 2016)

Between 2010 and 2013, the highest combined general practice and hospital antibiotic consumption was in Merseyside, with similar levels reported as in Southern Europe.

Investing in action now to reduce unnecessary use of antibiotics will:

- Reduce the development of antibiotic resistance and health care acquired infection
- Save antibiotics for the treatment of serious infections, such as sepsis, thus saving lives
- Reduce morbidity and mortality for patients
- Reduce the number of community acquired infections which require hospitalisation

- Reduce the length of hospital stay
- Reduce the number of bed days lost due to outbreak management and increase the efficiency of the NHS
- Reduce the cost of treating infection as expensive last option antibiotics will not be necessary
- Reduce the overall prescribing costs due to reduce volume of antibiotics being used
- Drive action to prevent infections, such as catheter management and hydration to prevent urinary tract infections

key priority areas for local action have been identified to complement the national program of work. These are:

- Back Up prescribing,
- Education and training
- Antimicrobial stewardship

Cheshire and Merseyside has a 2016 AMR Strategy and Action Plan. It is proposed that the following elements should be further developed and incorporated into the Five Year Forward View:

- Implement the Primary Care element of the strategy and the action plan: recruiting GP champions.
- Provide a dedicated Community Microbiologist function to support AMR Stewardship.
- Provide dedicated medicine management input to support Primary Care and related AMR activities.
- Improve IT support across health economy to support implementation of AMR action Plan.

6.0 POLICY IMPLICATIONS

6.1 The Five Year Forward View Plan will inform collaborative action in Halton and across Cheshire and Merseyside.

7.0 OTHER/FINANCIAL IMPLICATIONS

7.1 However the Five Year Forward View Plan will inform future activity and spending across the Cheshire and Merseyside footprint.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The programmes outlined will benefit children and young people.

8.2 Employment, Learning & Skills in Halton

The programmes outlined will include additional education and training.

8.3 **A Healthy Halton**

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

8.4 **A Safer Halton**

Not applicable.

8.5 **Halton's Urban Renewal**

Not applicable.

9.0 RISK ANALYSIS

9.1 Developing the above mentioned projects does not present any obvious risk.

10.0 EQUALITY AND DIVERSITY ISSUES

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

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

Appendix A, B, C Five Year Forward View Project Initiation documents for alcohol harm reduction, blood pressure, antimicrobial resistance.

Five Year Forward View Plan

Cross-Cutting Theme/LDS Programme:

Demand Management and Prevention at scale

Service/Theme: Alcohol Harm Reduction

Date: October 2016

Version No: 10

Senior Responsible Owner (SRO): Fiona Johnstone (Director of Health and Wellbeing, Wirral Borough Council. Cheshire and Merseyside Director of Public Health Lead for Alcohol)

Clinical Lead:

Programme Support: Dr Elspeth Anwar, Public Health Consultant

Financial Support:

HR Support:

Clients:

1st Your Team

2nd C&M FYFV Working Group

3rd NHSE & ALBs, October 2016 FYFV Submission

Contents

Template – Rationale and Notes for Use

Rationale

The Five Year Forward View (5YFV) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health. It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

The FYFV Executive summary highlights the following:

- The NHS has dramatically improved over the past fifteen years.
- there is now quite broad consensus on what a better future should be
- radical upgrade in prevention and public health
- when people do need health services, patients will gain far greater control of their own care
- the NHS will take decisive steps to break down the barriers in how care is provided
- England is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'
- **Create integrated out-of-hospital care - the Multispecialty Community Provider**
- **Primary and Acute Care Systems**
- **Urgent and emergency care**
- **Smaller hospitals will have new options to help them remain viable**
- **Specialised Care**
- **Midwives will have new options to take charge of the maternity services they offer**
- **The NHS will provide more support for frail older people living in care homes**
- In order to support these changes, the national leadership of the NHS will need to act coherently together, and provide meaningful local flexibility
- We will improve the NHS' ability to undertake research and apply innovation
- it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local

The seven lines in **bold are 'New Models of Care' explained at pp. 20-26 of the 5YFV.** Sustainability & Transformation Plans (FYFVs) are a delivery mechanism for the 5YFV, they are the practical expression of the belief that one of the most powerful ways to achieve change is by working together – across entire communities and pathways of care – to find ways to close the gaps between where we are now and where we need to be in 2020/21.

In October 2016, FYFVs are required to submit more detailed plans to NHSE and the partner ALBs. Completion of these PIDs for our 3 LDSs and 7 Cross-Cutting Themes will allow us to present a consistent and coherent picture of these 10 suites of programmes at the heart of the C&M FYFV.

Use

All Cross-Cutting Theme Leads and LDS Programme Leads are requested to use this template both as a guide and the structure of the description of how the Vanguard/Programme/Initiative is configured, what it is aiming to achieve and the benefits that will accrue. **For all the sections within the template there are brief notes of guidance as to the suggested content for that section at the beginning. These are in italics and maybe left in the document, for the sake of clarity, or deleted when understood, according to the preference of the team compiling the report.**

The current owner of this template is the C&M FYFV Portfolio Management Office (PMO) and, therefore, all suggested amendments to the template should be passed to the PMO.

Executive Summary

The executive summary should contain *only text and include no new material; it should contain only words already found elsewhere in the document. The executive summary should aim to convey all the key messages of the report on a page. It should enable the reader to understand the important points upon which to focus, at a glance.*

The challenge

Alcohol is a cause of a wide range of health and social harms for individuals, their families and communities across Cheshire and Merseyside. In addition alcohol-related harm currently places a significant financial burden upon local public services.

None of this harm is inevitable and much could be prevented by taking a system wide approach to reducing alcohol-related harm.

This programme plan sets out actions which if delivered at scale will prevent alcohol-related harm, improve health and social outcomes for individuals and communities and reduce demand on local services across health, social services and criminal justice settings.

The 'do-nothing' scenario

If we 'do nothing' the implications for population health outcomes and the financial health of our local services across Cheshire and Merseyside will be stark. Put simply 'doing nothing' is not an option.

- **Health and Wellbeing:** Drinking at levels that can harm health is currently common. In Cheshire and Merseyside, 26.5% of the adult population consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health. Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. In addition to its impacts upon health alcohol is associated with significant social harms such as violence, domestic abuse and road traffic accidents. We also know that it is the poorer members of our communities who suffer the highest levels of alcohol-related harm. If we do not act now to reduce alcohol-related harm then increases in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend on wholly avoidable illness.

- **The financial impact:** If we do nothing alcohol misuse across Cheshire and Merseyside will continue to cost around **£994 million each year** (£412 per head of population):
  - **£218 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
  - **£81 million in social services cost** (Children's and adults social service provision)
  - **£276 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, licensing enforcement costs).
  - **£430 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)

Closing the Five Year Forward View 'Gaps' by reducing alcohol-related harm

Reducing alcohol-related harm will contribute towards the closing of all three 'gaps' highlighted in the Five Year Forward View.

1. **Closing the Health and Wellbeing Gap**

On an **operational level**, the programme of work aims to prevent, identify and manage alcohol-related harm. The impact of this will be a reduction in emergency admissions due to alcohol and alcohol-related conditions and reduced demand on health and social care.

On a **tactical level within the C&M FYFV**, upstream approaches to address alcohol-related harm will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, High Blood Pressure, mental health).

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to alcohol, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

2. **Closing the Care and Quality Gap**

Cheshire and Merseyside suffers from high levels of alcohol-related harm when compared to other regions. The proposed interventions to reduce alcohol-related harm will help close the care and quality gap. Closing this gap will lead to observed benefits in terms of fewer hospital admissions and saved bed days. Benefits will be realised over the five years, not only at the five year point.

By year 5, the following benefits will be obtained:

Cheshire and Merseyside:	4,081 fewer admissions due to alcohol Equating to 16,326 bed days saved
Wirral and Cheshire LDS:	1723 fewer admissions due to alcohol Equating to 6894 bed days saved
Mid Mersey Alliance LDS:	1088 fewer admissions due to alcohol Equating to 4,352 bed days saved
North Mersey LDS:	1270 fewer admissions due to alcohol Equating to 5080 bed days saved

3. **Closing the Finance and Efficiency Gap**

In order to deliver the programme of work, financial resource is needed over a five year period. This investment will lead to significant returns. At a Cheshire and Mersey level **an investment of £2,457,000 over 5 years** (*Yr 1: £278,000, Yr 2: £441,000, Yr 3:£560,000, year 4: £564,000, Yr 5: £614,000)* will **realise savings of £13,731,000** *(Yr 1: £615,000, Yr 2: £2,103,000 Yr 3: £2,745,000, Yr 4: £3,627,000 Yr5: £4,641,000).*

The ***net financial benefit*** at after 5 years of implementing the proposed interventions set out within this alcohol programme has been estimated at:

- **Cheshire and Merseyside:** £11,274,000
- **Cheshire and Wirral LDS:** £4,760,000
- **Mid Mersey Alliance LDS:** £3,005,000
- **North Mersey LDS:** £3,508,000

These are likely to be underestimations of the proposed financial benefits.

The Cheshire and Merseyside cross sector system approach to reducing alcohol-related harm

There is enormous scope within Cheshire and Merseyside to prevent alcohol-related harm in order to improve health and social outcomes and reduce demand on the health and wider economy.

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. This systems leadership approach will support and add value to the implementation of local strategies. This group would have oversight and be accountable for implementation of the FYFV action plan.

Proposed Service Model: Priority interventions to reduce demand

This programme plan sets out actions which if delivered at scale will prevent alcohol-related harm, improve health and social outcomes for individuals and communities and reduce demand on local services across health, social services and criminal justice settings.

In order to reduce alcohol-related harm within Cheshire and Merseyside we propose the following:

1) Enhanced support for high impact drinkers in hospital and community settings

    A. Develop ***multi-agency approaches to support change resistant drinkers***

    B. Ensure the ***provision of best practice multidisciplinary alcohol care teams in all acute hospitals.***

    C. Review alcohol treatment pathways and ***commission outreach teams in hospitals or the community*** that complement hospital based alcohol care teams by identifying and proactively engaging patients with repeated admissions as appropriate.

2) Large scale delivery of targeted brief advice

    A. Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff trained to offer and ***provide brief advice*** and refer to local specialist services as required.

    B. Ensure screening and advice by non-NHS partners as part of the delivery of ***Making Every Contact Count (MECC) interventions***. This will include evidence-

based alcohol IBA as well brief interventions focusing on High Blood pressure (BP) (including BP checks), smoking cessation, diet and physical activity.

3) Effective population-level actions are in place to reduce alcohol-related harms
   A. Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards (As outlined by College of Emergency Medicine (CEM) Guidelines and the Standard on Information Sharing to Tackle Violence).
   B. Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners
   C. Ensure local partners collaborate to ensure that the data collected is being used effectively and work together to consider where improvements can be made. This will include:
      i. Targeting interventions to prevent violence and reduce alcohol-related harm
      ii. Targeting police enforcement in hotspot areas
      iii. Use of intelligence in the license review process and targeting alcohol licencing enforcement

Reducing alcohol-related harm is everybody's business. The programme plan recognises that there is considerable amount of activity going on outside the NHS to reduce alcohol-related harm. This alcohol programme plan completes the jig saw by focusing upon areas within which the NHS (with support and in partnership) can play a key role to reduce alcohol-related harm.

Key performance indicators

It is proposed that progress be monitored by four key performance indicators:

- **KPI1: Emergency hospital admissions rates for alcohol specific admissions (National indicator: LAPE)**
- **KPI2: Mortality from alcohol specific conditions (National indicator: LAPE)**
- **KPI3: - Identification and Brief Advice (IBA) (Local indicators need to be developed)**
  - **A. Alcohol screening:** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems
  - **B. Alcohol brief advice:** Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice
  - **C. Alcohol referral:** Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team
- **KPI4: Alcohol-related violence (Local indicator needs to be developed)**

1. National, Regional, Local Context

This section should describe *relevant national standards, trends and challenges related to the team/service line activity that is the subject of the document. In particular, NHSE or other Arm's Length Body (ALB) policy guidance, national frameworks and demographic trends are likely to be some of the key points of reference to consider when constructing your vision. However, the section must be concise and limit this description to those aspects that bear directly upon the context in this geographic location.* ***This section should also exploit the NHSE 'FYFV footprint analyses pack for Cheshire and Merseyside' as well as the 'FYFV Aides Memoire'.***

Moreover, this section should go on to describe *relevant regional/local standards, trends and challenges related to the team/ service line activity that is the subject of the document; in particular, regional/local commissioning intention and contractual arrangements. The report should bring into focus any regional/local pilots or projects that have a bearing on the team/service. The key local stakeholders, who are influencing the current and future scope of team/service delivery, should be identified.*

Your Plan for the 'Cross-Cutting Theme' or 'LDS Programme' *should then describe which policies and guidance you will use the change programme as an opportunity to further develop.*

The Case for Change

Alcohol is a cause of a wide range of health and social harms for individuals, their families and communities across Cheshire and Merseyside. In addition alcohol currently places a significant financial burden upon local public services.

None of this harm is inevitable and much could be prevented by taking a system wide approach to reducing alcohol-related harm.

This programme plan sets out actions which if delivered at scale will prevent alcohol-related harm, improve health and social outcomes for individuals and communities and reduce demand on local services across health, social services and criminal justice settings.

a) The National Context

- Alcohol related harm costs England around £21bn per year, with £3.5bn to the NHS, £11bn tackling alcohol-related crime and £7.3bn from lost work days and productivity costs
- Alcohol is 10% of the UK burden of disease and death, making alcohol one of the three biggest lifestyle risk factors for disease and death in the UK, after smoking and obesity.
- Drinking at levels that can harm health is common. In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression.

- In England in 2014/15 there were 1.1 million estimated admissions where an alcohol-related disease, injury or condition was the primary reason for admission or a secondary diagnosis. This is 3% more than 2013/14.
- In England in 2014, there were 6,831 deaths which were related to the consumption of alcohol. This is an increase of 4% on 2013 and an increase of 13% on 2004.
- In England and Wales, 63% of all alcohol-related deaths were caused by alcoholic liver disease. Liver disease is one of the few major causes of premature mortality that is increasing. Deaths from liver disease have reached record levels, rising by 20% in a decade.
- There were 8,270 casualties of drink driving accidents in the UK in 2013, including 240 fatalities and 1,100 people who suffered serious injury.
- Alcohol places a significant burden upon NHS, local government and emergency services:
    - In 2009/10 there were 1.4 million alcohol-related ambulance journeys, which representing 35% of the overall total.
    - Estimates for the proportion of Emergency Department attendances attributable to alcohol vary, but figures of up to 40% have been reported, and it could be as much as 70% at peak times.
    - Up to 80% of weekend arrests are alcohol-related, and just over half of violent crime is committed under the influence.
    - Alcohol misuse is consistently found in a high proportion of those who perpetrate domestic abuse and sexual assault. Research has shown that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault.
    - Alcohol is typically found to be involved in 10-30% of all fires. Moreover, alcohol-caused fires are usually worse: 50% result in casualties, compared to 14% for other fires.
    - A survey of front line emergency survey staff found that dealing with alcohol-related harm takes up as much as half of their time.
    - 24% of children's social work is related to alcohol misuse, between 15-45% of adult social work cases are alcohol-related.
    - 89,107 individuals were treated at a specialist alcohol misuse service in England in 2014/15.

b) Standards and Policy Context

- Best practice for the prevention and clinical management of alcohol-related harm is set out within NICE guidelines and accompanying Quality Standards enable assessment of performance against the guidelines.
- International and National policy emphasises that alcohol harm is a major public health issue and outlines the need to take a truly cross sector approach in order to be successful in reducing alcohol-related harm:
    - WHO: Global strategy to reduce harmful use of alcohol
    - EU: The EU Alcohol strategy
    - HM Government: The Government Alcohol Strategy

- HM Government: The Modern Crime Prevention Strategy
- Health First: An evidence based alcohol Strategy for the UK

c) The Challenge in Cheshire and Merseyside

Cheshire and Merseyside suffers from high levels of alcohol-related harm when compared to other regions.

When compared to England:

- Alcohol has a significant impact upon the Cheshire and Merseyside economy. The costs from alcohol-related harm are extensive and fall across many areas including health and social care, crime, licensing and the workforce. Alcohol misuse across Cheshire and Merseyside costs around **£994 million each year** (£412 per head of population). Of these costs:
    - **£218 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
    - **£81 million in social services cost** (Children's and adults social service provision)
    - **£276 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, licensing enforcement costs).
    - **£430 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In Cheshire and Merseyside, 26.5% of the adult population (623,477 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
    - 9 out of the 12 CCGs have significantly higher rates of alcohol specific admissions
    - 7 out of 12 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and
    - 9 out of 12 CCGs have significantly higher rates of alcohol related admissions (broad definition).
    - 7 out of 12 CCGs have significantly higher rates of alcohol specific mortality
    - 7 out of 12 CCGs have significantly higher rates of Mortality from chronic liver disease
    - 9 out of 12 CCGs have significantly higher rates of hospital admission episodes for mental and behavioural disorders due to use of alcohol condition (Broad)
    - 6 out of 12 CCGs have significantly higher rates hospital admission episodes for alcoholic liver disease condition (Broad)

- In terms of numbers affected across Cheshire and Merseyside:
    - 1,212 people died from an alcohol-specific condition between 2012 and 2014.
    - 1,150 people died from chronic liver disease between 2012 and 2014.
    - 13,845 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
    - 37,865 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

d) The Challenges at Local Delivery System Level

The following LDS-level figures are based on main constituent CCG boundaries rather than exact LDS boundaries so may be subject to minor changes, i.e. they are based on the following footprints:

- **Cheshire and Wirral LDS:** South Cheshire, Eastern Cheshire, West Cheshire , Wirral, Vale Royal CCGs

- **The Mid Mersey Alliance LDS:** Knowsley, Warrington, Halton, St Helens CCGs

- **North Mersey LDS:** Liverpool, Southport & Formby, South Sefton CCGs

Please note: the real picture is more complex, with some CCGs, e.g. Knowsley CCG, facing into more than one LDS. More accurate LDS-level figures will be calculated as part of the next stage in the FYFV process.

i. Cheshire and Wirral LDS

- Alcohol misuse across the Cheshire and Wirral LDS costs around **£397 million** each year. Of these costs:
    - **£86 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
    - **£32 million in social services cost** (Children's and adults social service provision)
    - **£100 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, costs of licensing)
    - **£185 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In the Cheshire and Wirral LDS, 27% of the adult population (270,045 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
    - 2 out of the 5 CCGs have significantly higher rates of alcohol specific admissions
    - 1 out of 5 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and

  - 2 out of 5 CCGs have significantly higher rates of alcohol related admissions (broad definition).
  - 1 out of 5 CCGs have significantly higher rates of alcohol specific mortality
- In terms of numbers affected across the Cheshire and Wirral LDS:
  - 440 people died from an alcohol-specific condition between 2012 and 2014.
  - 407 people died from chronic liver disease between 2012 and 2014.
  - 4,900 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
  - 14,780 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

ii. The Mid Mersey Alliance LDS

- Alcohol misuse across the Mid Mersey Alliance LDS costs around **£271 million** each year. Of these costs:
  - **£61 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
  - **£24 million in social services cost** (Children's and adults social service provision)
  - **£74 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, costs of licensing)
  - **£116 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In the Mid Mersey Alliance LDS, 26% of the adult population (168,261 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
  - All 4 CCGs have significantly higher rates of alcohol specific admissions
  - All 4 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and
  - All 4 CCGs have significantly higher rates of alcohol related admissions (broad definition).
  - 3 out of 4 CCGs have significantly higher rates of alcohol specific mortality
- In terms of numbers affected across the Mid Mersey Alliance LDS:
  - 334 people died from an alcohol-specific condition between 2012 and 2014.
  - 340 people died from chronic liver disease between 2012 and 2014.
  - 3,890 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
  - 10,775 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

iii. North Mersey LDS

- Alcohol misuse across the North Mersey LDS costs around **£271 million** each year. Of these costs:
    - **£72 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
    - **£26 million in social services cost** (Children's and adults social service provision)
    - **£103 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, costs of licensing)
    - **£129 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In the North Mersey LDS, 25.9% of the adult population (185,169 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
    - All 3 CCGs have significantly higher rates of alcohol specific admissions
    - 2 out of 3 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and
    - All 3 CCGs have significantly higher rates of alcohol related admissions (broad definition).
    - All 3 CCGs have significantly higher rates of alcohol specific mortality
- In terms of numbers affected across the North Mersey LDS:
    - 438 people died from an alcohol-specific condition between 2012 and 2014.
    - 403 people died from chronic liver disease between 2012 and 2014.
    - 5,055 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
    - 12,309 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

e) Alcohol misuse is a major cause of heath inequalities

Alcohol misuse is a major cause of heath inequalities across the region with the most deprived members of our communities suffering from the higher levels of alcohol-related harm than more affluent areas. Across Cheshire and Merseyside lower socioeconomic status (SES) is associated with higher mortality for alcohol related causes.

Research has suggested that alcohol can be seen as a contributing factor for almost 50% of the indicators within the Public Health Outcomes Framework for England. Addressing alcohol-related harm would therefore be a key route to improving public health and reducing general health inequalities.

f) ***An opportunity to act at a system level and at scale to reduce alcohol-related harm***

There is enormous scope to prevent alcohol-related harm in order to improve health and social outcomes and reduce demand on the health and wider economy.

Reducing alcohol-related harm is everybody's business. The programme plan recognises that there is considerable amount of activity going on outside the NHS to reduce alcohol-related harm delivered through alcohol strategies within local government. In addition there is the Reducing Alcohol Harm through Licensing group which will review evidence and lead action at scale around issues such as licensing and availability, campaigns, and price across Cheshire and Merseyside.

This alcohol programme plan completes the jig saw by focusing upon areas within which the NHS (with support and in partnership) can play a key role to reduce alcohol-related harm.

2. Assumptions & Constraints

Assumptions and constraints will describe *the context, given the continuing work to redefine and optimise pathways and services that each programme will need to support and underpin. This will include a series of assumptions and constraints about how the pathways or services will operate in the future.*

Your Plan *should then describe which how your programme relates to, and contributes towards, the changes required in these pathways or services and how you will use them as parameters for your design work.*

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1. **Assumptions** relate to:

a. **The cross-sector systems approach**
b. the **relationship** between **outputs** and short, medium and longer term **outcomes** and **impacts**
c. **Economic modelling and the return on investment** of interventions

a. Cross – sector systems approach

- Underpinning the alcohol harm reduction programme is a key assumption that the best way to improve outcomes for available resources is to take a cross-sector system approach to tackling alcohol-related harm with networks of partners delivering pathways of care that cover prevention, early identification and treatment.
- It is assumed that a Cheshire and Merseyside Alcohol Programme Board will be established to provide cross-sector system leadership across the sub-region, facilitating true integrated working and realisation of how interdependencies can yield improved outcomes despite challenging constraints on resources
- Successfully addressing alcohol misuse (outcomes, patient experience, and efficiency/productivity) will require an explicit system-wide commitment and change is required at scale.
- Service provision, particularly relating to public health and prevention will be significantly impacted by funding allocations and commissioning decisions taken by local authorities and NHS England.

b. The **relationship** between **outputs** and short, medium and longer term **outcomes** and **impacts.**

- Initial modelling has been undertaken to identify the relationship between outputs and short, medium and longer term outcomes and impacts. A key next step following the establishment of a system steering group will be the collaborative development of a logic model to identify short, medium and long-term outcomes linked to the key interventions outlined within this work programme.
- Evidence of impact on reducing alcohol-related harm comes from outside of Cheshire and Merseyside there is an assumption being made that impacts of these programmes will be replicable within Cheshire and Merseyside.
- There is an assumption that the proposed interventions will meet a real gap and need that isn't being met. For example related to the proposed Alcohol identification and brief advice (IBA). An IBA programme where there is genuinely no IBA currently

would have a given effect, however healthcare workers may currently provide alcohol advice but this is not identified as IBA.
- There is considerable synergy and overlap between the proposed interventions therefore there may be an overestimation of impact across the programmes.

c. Economic modelling and the Return on Investment of interventions

- The evidence base for the financial impact of the proposed interventions is mainly based upon evaluations conducted elsewhere. An assumption has been made that impacts of these programmes will be replicable within Cheshire and Merseyside.
- The costs-benefit and return on investment of the proposed interventions has been modelled using best assumptions of costs and impacts available. Full details of assumptions made related to costs are included under costs within ***Section 7 Facilities and Estates.***
- These modelled costs and benefits are only indicative based on best evidence. A more thorough exercise is required to understand what level of alcohol activity happens already across Cheshire and Merseyside as there is a lot of good practice already and a real awareness of the need to tackle alcohol as a driver of healthcare costs and costs to the whole economy.
- The CCG and LDS boundaries may not be completely coterminous. For the purposes of this analysis we have assumed that the Knowsley CCG population is in the Mid Mersey Alliance.
- In general we have taken a healthcare perspective to cost savings, but the cost savings could be much greater when criminal justice, private costs, and work productivity are factored in. Most evidence suggests that criminal justice cost savings may be greater than healthcare cost savings for interventions to reduce harmful drinking or support dependent drinkers. For instance, the Cardiff information sharing model produced estimated criminal justice savings of £5.4million over 5 years.
- Many of the healthcare cost savings are PbR reference cost type savings which would fall to the commissioner if they have a PbR contract. The reality is more complex as hospitals have fixed and variable costs and if one person is not in a hospital bed, very often another patient will take their place. But in the long run, cost savings from a reduction in alcohol related admissions should be realised.
- Bed days saved have been calculated based upon an average length of stay of 4 days.
- We are assuming that additional investment in alcohol care teams will produce the same kind of cost savings as seen in Bolton hospital, which saw a benefit cost ratio of £3.85 for every £1 spent. However we know that there has already been an investment in many areas of Cheshire and Merseyside; for instance the Royal Liverpool has been given as an example nationally of an alcohol care team. However there has also been audits that suggest many alcohol care teams do not include all of the crucial elements like a dedicated consultant lead and multidisciplinary team.
- We are assuming that a multi-agency approach to alcohol will produce similar results to those seen in the Nottinghamshire alcohol related long term conditions team pilot, which produced cost savings of £371,000 from an estimated programme cost of £200,000. However there is some uncertainty around whether these costs are accurate.
- We are assuming that alcohol Identification and Brief Advice (IBA) will produce an average £24 a year healthcare cost saving in individuals having an IBA over the next five years. This came from a presentation from Public Health England and is most likely a

conservative estimate. It is in line with other estimates from the NSMC social marketing tool and the National Institute for Health and Care Excellence (NICE) Return on Investment tool. For hospital admissions we are assuming that for every 171 individuals having an IBA, one hospital admission will be averted, which is from the NSMC Alcohol Behaviour Change Value for Money tool.

- In general, estimates of the cost savings from IBA vary hugely so a piece of work could be done locally to try to estimate more accurately the impact of IBA, for example by looking at the costs of alcohol admissions in different alcohol risk groups.
- We are assuming that investment in collection and sharing of intelligence in order to reduce alcohol-related violence will produce the type of healthcare cost benefits seen in the Cardiff model of information sharing; this produced an average healthcare cost benefit ratio of £14.80 for every £1 spent in the first five years.
- Several of the programmes we are proposing may have overlapping or similar objectives, for instance in identifying high risk drinkers, reducing unnecessary hospital admissions, and promoting intensive management of dependent drinkers. So some of the benefits from these discrete programmes may be double counted. Programmes may have a competitive effect (where they are competing for the same outcomes) or a synergistic effect (where the outcomes are actually greater than if the programmes were delivered alone).

2. **Constraints** relate to:

a. Current lack of a **System Leadership Approach**
b. **Finance**
c. the **evidence base**

a. **System Leadership Approach:** A system leadership approach needs to be established for the alcohol work stream. This may impact upon when interventions can be delivered creating a longer lag until benefits will be realised. Creating the governance to work collaboratively will be challenging, particularly with fragmented commissioning arrangements at local and regional levels.
b. **Finance:** Austerity and financial pressure across all sectors limits resources and opportunities. The proposed interventions will deliver financial savings over the course of the 5 years. However some investment may be required to "invest to save". Without additional financial resource to pump-prime the alcohol programme, the ability of the interventions set out in the action plan to close the three 'gaps' will be greatly lessened.
c. **Evidence base:** The evidence base for the proposed alcohol interventions is generally strong however gaps and uncertainties remain in the evidence base which could benefit from further research.

3. Risks

Risk management (RM) will form an integral part of the programme planning and the review cycle and is firmly embedded within the governance arrangements. The simple, but proven approach to RM involves the identification of key risks in each of the workstreams through the application of our RM policy. A risk management policy is in place that will provide a standardised approach to the identification, assessment, recording and reporting of risks. An integrated risk log will be developed as part of robust programme management

approach and will analyse the causes of a risk and identify current controls to manage the outcome to mitigate the likelihood and impact. The key controllable risks are outlined below:-

- Drinking at levels that can harm health is currently common. In Cheshire and Merseyside, 26.5% of the adult population (623,477 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health. Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. In addition to its impacts upon health alcohol is associated with significant social harms such as violence, domestic abuse and road traffic accidents. We also know that it is the poorer members of our communities who suffer the highest levels of alcohol-related harm. If we do not act now to reduce alcohol-related harm then increases in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.
- **Public Engagement.** The costs for implementing a programme at scale are low but there is the risk that the public may not engage with the programme. This will be mitigated by ensuring good communications, engaging charities, public/patient groups/ community initiatives as part of a systems approach to implementation.
- There is a risk that there is insufficient **system capacity** to deliver the programme at scale (staff, IT etc).
- **Professional Engagement:** There is a risk that the system (NHS Secondary Care, CCGs and primary care clinicians) may fail to engage and implement the programme. Mitigated by Substantial engagement with clinicians including PHE/Strategic Clinical Network, and clinical champions.

3. Model of Care and/or Service Model

The profile for the pathway/service line being described *should contain information regarding, but not limited to, the following;*

- *The model of care, including how the three dimensions of quality will be delivered:*
  - *Patient Safety*
  - *Patient Experience*
  - *Clinical Effectiveness*

- *The Service Model, including:*
  - *Sub specialities*
  - *Location(s) of pathway/service delivery*
  - *Attributes of pathway/service delivery (those that merit highlighting)*

Your Plan *should then describe which aspects of the model of care and service model you will use the change programme as an opportunity to further enhance.*

Taking a system leadership approach to reducing alcohol-related harm across Cheshire and Merseyside

As outlined there is enormous scope within Cheshire and Merseyside to prevent alcohol-related harm in order to improve health and social outcomes and reduce demand on the health and wider economy.

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. This systems leadership approach will support and add value to the implementation of local strategies. This group would have oversight and be accountable for implementation of the FYFV action plan.

This plan outlines how the NHS will work closely with local government and other local partners to build on existing local efforts and strengthen and implement interventions to reduce alcohol-related harm and close the local health and wellbeing gap.

In order to reduce alcohol-related harm within Cheshire and Merseyside we propose the following:

1) Enhanced support for high impact drinkers in hospital and community settings
2) Large scale delivery of targeted brief advice
3) Effective population-level actions are in place to reduce alcohol-related harms

Reducing alcohol-related harm is everybody's business. The programme plan recognises that there is considerable amount of activity going on outside the NHS to reduce alcohol-related harm. This alcohol programme plan completes the jig saw by focusing upon areas within which the NHS (with support and in partnership) can play a key role to reduce alcohol-related harm.

PRIORITY 1) ENHANCED SUPPORT FOR HIGH IMPACT DRINKERS

- Alcohol currently places a high burden of harm on emergency services and hospitals across Cheshire and Merseyside however a significant proportion of this harm is avoidable.
- A small number of alcohol dependent clients are resistant to change placing a significant burden on public services through frequent hospital attendances, admissions and repeat offending. It has been estimated that 75% or more of dependent drinkers are not in treatment at any one time.
- In other areas alternative approaches and care pathways have been established for change resistant drinkers which have been proven to improve outcomes and save money and resources **(See Case study 1).**
- Effective hospital based alcohol care teams have been shown to reduce hospital admissions and readmissions. We know that there has already been an investment in many areas of Cheshire and Merseyside; for instance the Royal Liverpool has been given as an example nationally of an alcohol care team. In addition a recent PHE survey found that the majority of hospitals across Cheshire and Merseyside have an alcohol care team, however that the majority of those services are alcohol liaison nurse services. These services may benefit from further enhancement to meet national standards for best practice alcohol care teams. Evidence suggests that to be most effective such services should be multi-disciplinary, led by a consultant and supported by an alcohol assertive outreach service to manage the most frequent attendees **(See case Study 2).**
- There is beneficial overlap with priority 2 and 3 as a key role of hospital based alcohol care teams is the delivery of alcohol identification and brief advice (IBA) within the hospital setting (through direct delivery and education and training of wider hospital staff) to those identified as drinking at increasing or higher risk levels.

Aim of this priority:

To reduce the harm to individuals whose alcohol use impacts most heavily on services.

Actions:

In order to achieve this aim we will:

D. Develop ***multi-agency approaches to support change resistant drinkers***
E. Ensure the ***provision of best practice multidisciplinary alcohol care teams in all acute hospitals.***
F. Review alcohol treatment pathways and ***commission outreach teams in hospitals or the community*** that complement hospital based alcohol care teams by identifying and proactively engaging patients with repeated admissions as appropriate.

Case Study 1: Supporting high impact service users - The Blue Light project

The *Blue Light Project* is Alcohol Concern's national initiative to develop alternative approaches and care pathways for change resistant drinkers who place a huge burden on public services. The project has shown that there are positive strategies that can be used with this group. Moreover, the approach has demonstrated a **reduction in demand on emergency and acute services** leading to significant **returns on investment**.

The Blue light project has been developed in partnership with Public Health England and approximately 50 local authorities across the country.

The two key elements of the local transformation work are:

- **Training of specialist and non-alcohol specialist staff in the *Blue Light* approach**. This will ensure that staff across the health, social care, housing and criminal justice services, are identifying these clients and impacting on their behaviour.
- **Development of multi-agency operational group** to ensure a joint identification and ownership of the highest impact clients and ensuring a consistent and persistent focus on these individuals.

Impacts observed in other areas include:

- ✓ Increased engagement and successful treatment with community alcohol treatment services
- ✓ Reduced demand on emergency and acute services through:
  - Reductions in ambulance call outs
  - Fewer emergency department attendances
  - Fewer unplanned admissions

Wider positive impacts:

- ✓ Improved multi-agency working
- ✓ Reduction in police incidents and criminal activity
- ✓ Identification and management of safeguarding issues
- ✓ Improved housing and employment status.

References

Alcohol Concern. Working with Change Resistant drinkers: The project manual.

Case Study 2: Alcohol Care Teams: Reducing acute hospital admissions and improving quality of care

Detailed evidence-based recommendations for models of multidisciplinary alcohol care in acute hospitals have been drafted by the British Society of Gastroenterology, the Alcohol Health Alliance UK, and the British Association for Study of the Liver, along with those of the Quality, Innovation, Productivity, and Prevention (QIPP) case study, and the Health First: an evidence based alcohol strategy for the UK.

Acute hospital model for an alcohol care team

- A consultant-led, multidisciplinary, patient-centred alcohol care team to be integrated across primary and secondary care
- 7 day alcohol specialist nurse service
- Coordinated policies for the emergency department and acute medical units
- Rapid assessment, interface, and discharge liaison psychiatry service
- An alcohol assertive outreach team for frequent attenders to hospital
- Formal links with local authority, clinical commissioning groups, public health, and other stakeholders

Impact:

The Royal Bolton Hospital

The Royal Bolton Hospital collaborative care for alcohol-related liver disease and harm is a multidisciplinary team consisting consultant gastroenterologists, a liaison psychiatrist, a psychiatric alcohol liaison nurse, a liver nurse practitioner and a dedicated social worker.

The introduction of the 7 day alcohol liaison service cost £165,000 annually, saving 2000 bed days (current tariff is £318 per day) and £636,000(£471,000 net) annually, and liberating 4-6 hospital beds.

Alcohol assertive outreach service in Salford

The alcohol assertive outreach service team works with a cohort of the top 30 patients (frequent attenders) with the highest levels of alcohol-related admissions over a 6-month period. Each 6 months, this cohort is refreshed. The team also works proactively with any patient, who has had 2 alcohol-related admissions within a short period of time, the so-called ‘fast risers’.

Work with the first top 30 cohort resulted in a 59% reduction in Emergency Department attendances in the 3-month period post-intervention, when compared with the 3-month period before intervention (average monthly attendances were reduced from 120 to 49). There was also a 66% reduction in average monthly hospital admissions (50 to 17).

References

NICE. Quality and Productivity: Proven Case Study. Alcohol care teams: reducing acute hospital admissions and improving quality of care.
Public Health England. Alcohol care in England’s hospitals: An opportunity not to be wasted.

PRIORITY 2) LARGE SCALED DELIVERY OF TARGETED BRIEF ADVICE

- We recognise that much of the harm from alcohol use can be attributed to the drinking habits of non-dependent drinkers.
- Through reducing alcohol consumption among increasing and higher risk drinkers we can have a significant impact upon reducing future alcohol-related harm and hospital admissions due to alcohol-related conditions.
- Alcohol IBA is simple, structured and brief advice given to a person after completing a validated alcohol screening tool. The evidence base for the effectiveness of IBA is strong.
- Screening undertaken as part of alcohol IBA may identify dependant drinkers who can then be referred onto specialist community alcohol treatment services.
- There is beneficial overlap with priority 1 as a key role of hospital based alcohol care teams is the delivery of alcohol identification and brief advice (IBA) within the hospital setting (through direct delivery and education and training of wider hospital staff).
- There is also beneficial overlap with priority 3 as once identified individuals can be offered alcohol identification and brief advice (IBA) by appropriately trained staff within hospital and ambulance services and referred onto alcohol care teams in the acute hospital setting or community alcohol treatment services.
- Although this priority is focussed upon upskilling staff to deliver IBA. There is also the potential to use digital technology to deliver self-directed IBA across Cheshire and Merseyside linked to delivery of a proposed Cheshire and Merseyside social norms campaign aimed at reducing alcohol consumption (*Drink less, Enjoy More campaign*).

Aim:

To reduce population level alcohol consumption and associated alcohol-related harm through implementation of system-wide targeted advice and care.

Actions:

In order to achieve this aim we will:

C. Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff trained to offer and provide brief advice and refer to local specialist services as required.

D. Ensure screening and advice by non-NHS partners as part of the delivery of ***Making Every Contact Count (MECC) interventions***. This will include evidence-based alcohol IBA as well brief interventions focusing on High Blood pressure (BP) (including BP checks), smoking cessation, diet and physical activity.

N.B. The **Making Every Contact Count (MECC) intervention** is also included within the High Blood Pressure Programme Plan.

Example of overlap between alcohol and high blood pressure work streams:

A patient attends the GP practice for a blood pressure (BP) check. The healthcare assistant takes the BP and it is found to be very high so the patient is asked about any lifestyle factors that may be affecting it and an alcohol risk assessment is undertaken using the AUDIT-C screening tool. The Alcohol IBA pathway is commenced when the patient is found to be AUDIT C positive. The healthcare assistant feels confident to provide appropriate advice and liaise directly with other services in the pathway because she knows who they are, where they are located and whether they are relevant for this particular patient.

Case Study 3: Alcohol Identification and brief advice (IBA)

Alcohol IBA is simple, structured and brief advice given to a person after completing a validated alcohol screening tool. It is a preventative approach aimed at identifying and providing brief advice to increasing and higher-risk drinkers. IBA is both effective and cost effective in reducing the risks associated with drinking.

The evidence for IBA is strong

The World Health Organisation and the Department of Health have both acknowledged over 50 peer reviewed, academic studies that demonstrate IBA is both effective and cost effective in reducing the risks associated with drinking.

Impact:

- 1 in 8 recipients of IBA reduce their drinking to lower-risk levels after brief advice. The effects persist for periods up to two to four years after intervention and perhaps as long as nine to ten years. This compares with 1 in 20 smokers who benefit from stop smoking advice.
- Identification and Brief Advice (IBA) can reduce weekly drinking by between 13% and 34%, resulting in 2.9 – 8.7 fewer drinks per week. This will reduce relative risk of alcohol-related conditions by 14%, and absolute risk of lifetime alcohol-related death by 20%.

References

The Health Innovation Network. Alcohol Identification and Brief Advice (IBA) toolkit. http://www.hin-southlondon.org/system/resources/resources/000/000/223/original/HIN_AIBA_Toolkit_v15_FINAL.pdf

PRIORITY 3) EFFECTIVE POPULATION-LEVEL ACTIONS ARE IN PLACE TO REDUCE ALCOHOL-RELATED HARM.

Highlight effectiveness of population based approaches

- Alcohol-related violence places a significant burden upon emergency departments, emergency services and the criminal justice system.
- It is estimated that just over half of total violent incidents involving adults were alcohol related.
- Emergency Departments (EDs) can contribute distinctively and effectively to alcohol-harm reduction and violence prevention by working with Crime and Disorder Partnerships and sharing simple anonymised data.
- Ambulance services can also identify alcohol-related harm and violence.
- This information can then be used to targeting interventions to prevent violence and reduce alcohol-related harm through targeted interventions and the use of intelligence in the license review process.
- There is beneficial overlap with priority 1 and 2 as once identified individuals can be offered alcohol identification and brief advice (IBA) by appropriately trained staff within hospital and ambulance services and referred onto alcohol care teams in the acute hospital setting or community alcohol treatment services.
- This priority is strongly linked to activity going on outside the NHS to reduce alcohol-related harm delivered through local government licensing work.

Aim:

To prevent alcohol-related violence and to reduce alcohol-related harm.

Actions:

In order to achieve this aim we will:

D. Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards (As outlined by College of Emergency Medicine (CEM) Guidelines and the Standard on Information Sharing to Tackle Violence).

E. Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners

F. Ensure local partners collaborate to ensure that the data collected is being used effectively and work together to consider where improvements can be made. This will include:

i. Targeting interventions to prevent violence and reduce alcohol-related harm

ii. Targeting police enforcement in hotspot areas

iii. Use of intelligence in the license review process and targeting alcohol licencing enforcement

Case Study 4: Sharing of data to reduce alcohol-related violence

Addenbrooke's Hospital has been collecting and sharing data since 2007. Their work in this area was prompted by A&E consultant Adrian Boyle seeing the evidence that had emerged from the work done in Cardiff and realising the potential to prevent violent assaults in Cambridge. All data collection takes place at the point of patient registration. Receptionists collect three core data items: a free text description of the location of the assault, the date and time of assault and what weapon was used.

Impact:

Addenbrooke's has seen a 20% reduction in the number of assaults requiring emergency department care and a 35% reduction in the violent crimes with injury reported to the police. The data collected by the Emergency Department was instrumental in supporting Cambridge City Council uphold a case against a licensing appeal that had been made.

"This activity has been one of the most effective things we have done and we feel really good about having prevented over 200 assault victims a year needing hospital treatment."

Adrian Boyle, Consultant in Emergency Medicine

Further case studies available at: http://www.alcohollearningcentre.org.uk/Topics/Latest/ED-Datasharing-Case-Studies/

4. Performance

Performance should describe *the current, as well as trend, levels of demand for the pathway/service being defined; this information should be contrasted with the current, as well as trend, capacity in the pathway/service. This should lead to an explanation of the current, as well as trend, level of activity.*

Your Plan *should then describe which dimensions of the performance you will use the change programme to further transform and any opportunities for business development that you use the programme to exploit.*

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. This systems leadership approach will support and add value to the implementation of local strategies. This group would have oversight and be accountable for implementation of the FYFV action plan. A key initial action following the establishment of the system steering group will be the collaborative development of a logic model to identify short, medium and long-term outcomes linked to the key interventions outlined within this work programme and the development of a performance dashboard.

We propose the following high level Key Performance Indicators (KPIs) to monitor the impact of the proposed interventions:

KPI1: Emergency hospital admissions rates for alcohol specific admissions (National indicator: LAPE)

KPI2: Mortality from alcohol specific conditions (National indicator: LAPE)

KPI3: - Identification and Brief Advice (IBA) (Local indicator needs to be developed)

D. **Alcohol screening:** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems
E. **Alcohol brief advice:** Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice
F. **Alcohol referral:** Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team

Proposed indicators based upon NHS providers meet Preventing ill health by risky behaviours CQUIN (https://www.england.nhs.uk/wp-content/uploads/2015/12/ann-a-cquin.pdf)

KPI4: Alcohol-related violence (Local indicator needs to be developed)

Current performance against KPIs is as follows:

KPI	Description	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	Cheshire and Merseyside
KPI1: Emergency hospital admissions rates for alcohol specific admissions	Number of CCGs with higher than national hospital admissions rates for alcohol specific admissions	2 out of 5 *(2012-2014)*	4 out of 4 *(2012-2014)*	3 out of 3 *(2012-2014)*	9 out of 12 *(2012-2014)*
	Number of hospital admissions rates for alcohol specific admissions	4,900 *(2014/15)*	3,890 *(2014/15)*	5,055 *(2014/15)*	13,845 *(2014/15)*
KPI2: Mortality from alcohol specific conditions	Number of CCGs with higher than national mortality from alcohol specific conditions	1 out of 5 *(2012-2014)*	3 out of 4 *(2012-2014)*	3 out of 3 *(2012-2014)*	7 out of 12 *(2012-2014)*
	Number of deaths from alcohol specific conditions	440 *(2014/15)*	334 *(2014/15)*	438 *(2014/15)*	1,212 *(2014/15)*
KPI3: - IBA	A. Alcohol screening	*Currently unknown: Local indicator needs to be developed*			
	B. Alcohol brief advice	*Currently unknown: Local indicator needs to be developed*			
	C. Alcohol referral	*Currently unknown: Local indicator needs to be developed*			
KPI4: Alcohol-related violence	*To be developed*	*Currently unknown: Local indicator needs to be developed*			

Targets for progress and timescales for each KPI will be developed by the system steering group.

5. Staffing

This section should describe *all those staff groups that make a substantive contribution to the delivery of the pathway/service being described. The current numbers, as well as the trends, should be graphically demonstrated for the following groups:*

- *Social Care*
- *Medical*
- *Nursing*
- *Allied Health Professionals (AHP)*
- *Managerial*
- *Administrative and Clerical*

This section should also address the current position and trends relating to:

- *Sickness and absence*
- *Annual appraisals*
- *Recruitments and retention*
- *Availability*
- *Productivity*
- *Any on-going actions in response to staff surveys*

Your Plan *should then describe which aspects of the pathway/service staffing you will use the change programme as an opportunity to further develop.*

Key local stakeholders:

- 12 CCGs
- 9 Local Authorities
- Acute Trusts
- Community services
- Primary Care
- Public Health England NW
- NHS E C&M
- Cheshire and Merseyside Public Health Collaborative (Champs)
- Voluntary Sector organisations
- C&M Fire and Rescue Services
- Merseyside & Cheshire Police Forces

The proposal includes a specific programme manager post within the System Leadership team to facilitate and manage engagement and co-operation between different stakeholders.

Due to the nature of the cross-sector approach, the staffing groups that contribute to the delivery of the alcohol priorities are many. Key staff groups by priority include:

Priority 1: Enhanced support for high impact drinkers in hospital and community settings

- Specifically commissioned teams in secondary & acute care and community outreach
- Staff in local authority commissioned specialist alcohol treatment services
- Adult Social Care
- Adult mental health services

- Housing trusts
- Police
- Ambulance services
- Community and voluntary sector

Priority 2: Large scale delivery of targeted brief advice

- Community pharmacy staff, including Healthy Living Pharmacy leads and champions
- Primary care teams including GPs, Practice nurses, Health care workers, receptionists
- Secondary care, all staff with an opportunity/ training to do a brief intervention as part of the Making every contact count (MECC) programme
- Staff in any other applicable MECC provider

Priority 3: Effective population-level actions are in place to reduce alcohol-related harms

- Community safety partnerships, Police, Ambulance Services
- Acute care department reception staff, managers, doctors and consultants
- Acute care trust IT staff and analysts

6. Information Management & Technology

This section should describe *the current, as well as planned use of IM&T as an enabler to the aims of the programme. The analysis should include current experience with IM&T including issues that cause problems. The levels of capability to use the IT systems should feature along with levels of support and training required.*

Your Plan *should then describe what new systems and other IM&T solutions form part of the wider improvement aspirations for the pathway/service and how they will be realised.*

IM&T is a key enabler to the aims of the programme and the measurement of impact. Population health management systems, which join up datasets across primary, secondary and community care, that are currently being delivered within Cheshire and Merseyside e.g. The Wirral Care Record and Population Health Registries will support the identification and management of individuals suffering from alcohol-related harm. Such systems can also be used to evaluate the impact of the proposed interventions.

Both priorities 1 and 2 require basic levels of IT use and both can be achieved within existing IT provision with minor changes to data collection.

In order to monitor IBA delivery across Cheshire and Merseyside and the three Local Delivery Systems (LDS) data will need to be collected and analysed related to:

A. Alcohol screening: Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems

B. Alcohol brief advice: Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice

C. Alcohol referral: Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team

These proposed indicators are based upon NHS providers meet Preventing ill health by risky behaviours CQUIN (Further details available here: https://www.england.nhs.uk/wp-content/uploads/2015/12/ann-a-cquin.pdf).

It may be that areas with developed population care records can pilot the method of capturing of IBA offered across the health and social care system and share learning with other areas.

There is also potential to use digital technology to deliver IBA across Cheshire and Merseyside linked to delivery of a Cheshire and Merseyside social norms campaign aimed at reducing alcohol consumption (*Drink less, Enjoy More campaign*).

Priority 3 relies on collection of specific data (e.g. violence location, time, date, weapon and assailants, alcohol consumption). Following previous work on the C&M wide Trauma and Injury Intelligence Group (TIIG) most, if not all, EDs within the area collect some of this data already or can quickly reinstate it. This work would be an opportunity to standardise the data collected and ensure it complies with best practice models e.g. The Cardiff Model.

Relevant data collection, IT support and links with crime reduction partnerships can be achieved at no extra cost to local EDs and Crime & Disorder Reduction Partnerships (CDRPs) are funded to facilitate data sharing.

The model requires Hospital Trust IT capacity to anonymise and share ED data. Based upon learning from implementation in other areas the process flows as follows:

Step One: 24 hour electronic data collection by ED clerical staff when patients first attend.

Step Two: Monthly anonymisation and sharing of data by Hospital Trust IT staff with Crime & Disorder Reduction Partnerships (CDRP) analyst.

Step Three: Monthly combination of police and ED data by CDRP analyst.

Step Four: Summary of violence times, locations and weapons by CDRP analyst.

Step Five: Continuous implementation and updating of prevention action plan by CDRP violence task group.

Step Six: Continuous tracking of violence trends – overall trends and trends in violence hotspots.

7. Facilities & Estates

This section should describe *the future plans for pathway/service within a given environment(s). There will be a description of the facilities that will be required by, and made available to, the pathway/service as well as a comprehensive understanding of the space to be occupied. The section will also include details of equipment requirements that may be new or significant enhancements.*

Your Plan *should then describe how the pathway/service will deliver its vision for the future within the new environment.*

All plans are designed to be realised within existing facilities and estates belonging to key partners in community pharmacies, primary and secondary care.

- System Enablers:
    - Systems Leadership
    - Communications and Engagement
    - Evaluation
    - Non labour and Overheads
- Provision of MDT Alcohol Care Teams in Acute Providers and outreach teams
- Multi-agency approach to support change resistant drinkers
- Identification and Brief Advice (IBA)
- Collection and sharing of intelligence in order to reduce alcohol-related violence

8. Interdependencies

This section should describe *the current interdependencies that the pathway/service has with other teams and services. This includes both those products and services you require from others to operate successfully as well as those products and services that you provide which are essential to the operations of others. Any current issues should be highlighted along with the plans for the plans to resolve them.*

Your Plan *should then describe how those interdependencies will be assured through the programme of change. This could be by reference to programme participation as stakeholders; joining/monitoring a programme upon which you may have a key interdependency. Alternatively, you may simply choose to reference the specific programme plan that will be addressing that interdependency.*

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a Cheshire and Merseyside cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. A robust management approach that will be taken and through this governance structure, interdependencies between each programme and cross cutting themes and across the local delivery systems will be identified and the impact understood.

This will be achieved by the development of a performance dashboard that captures key outputs and outcomes from across the system enabling the importance of interdependencies to be demonstrated and embedded.

Operational Level Interdependencies

Within this system, a wide range of interdependencies and partnership working will evolve between key stakeholders as the system leadership approach will be developed and implemented. This includes but is not limited to:

- Acute Trusts/ Secondary Care (which providers)
- Community services
- Primary Care
- NHS England (C&M)
- PHE (NW)
- Champs Public Health collaborative (PH teams from 9 local authorities and lead Commissioners/Alcohol Leads)
- Voluntary sector partners
- Cheshire and Merseyside Fire and Rescue
- 12 Clinical Commissioning Groups
- Academia
- Community Pharmacy
- Cheshire and Merseyside Police Force

Tactical and Strategic Interdependencies

Taking action to reduce alcohol-related harm will have significant cross-sector benefits.

- **Benefits to other FYFV work streams:** Including but not limited to the Blood pressure priority, cancer, cardiovascular disease and mental health.
- **Benefits beyond the NHS**: across the criminal justice, social care and wider economy.

9. Benefits

This section should describe *the impact the programme will have on the following three 'gaps' which are at the heart of the 5YFV:*

- ***The health and wellbeing gap:*** *if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.*
- ***The care and quality gap:*** *unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.*
- ***The funding and efficiency gap:*** *if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.*

Your Plan *should then describe which benefits will accrue against which 'gap' in terms of* ***baseline, target, and planned trend of improvement to meet the benefit target in time****. The objectives to support benefits realisation should be SMART objectives, that is: Specific, Measurable, Achievable, Realistic, Time bound.*

The impact of this programme on the three 'gaps' are set out below.

1. **Closing the Health and Wellbeing gap**

Through this cross-sector system approach to reducing alcohol-related harm, LDSs across C&M will be ensuring patients receive the most appropriate interventions in the right places and at the right time, driving a cultural shift towards prevention and self-care.

On an **operational level**, the programme of work aims to prevent, identify and manage alcohol-related harm. The impact of this will be a reduction in emergency admissions due to alcohol and alcohol-related conditions and reduced demand on health and social care.

On a **tactical level within the C&M FYFV**, upstream approaches to address alcohol-related harm will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, High Blood Pressure, mental health).

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to alcohol, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

2. **Closing the care and quality gap**

Cheshire and Merseyside suffers from high levels of alcohol-related harm when compared to other regions. The proposed interventions to reduce alcohol-related harm will help close the care and quality gap. Closing this gap will lead to observed benefits in terms of fewer hospital admissions and saved bed days.

The proposed interventions to reduce alcohol-related harm will lead to clear benefits in terms of closing the care and quality gap across Cheshire and Merseyside by year 5. Benefits will be realised over the five years, not only at the five year point.

These benefits will be observed in terms of reductions in hospital admissions and reduced bed days saved.

Bed days saved have been calculated based upon an average length of stay of 4 days.

Cheshire and Merseyside: 4,081 fewer admissions due to alcohol
Equating to 16,326 bed days saved.

Wirral and Cheshire LDS: 1723 fewer admissions due to alcohol
Equating to 6894 bed days saved

Mid Mersey Alliance LDS: 1088 fewer admissions due to alcohol
Equating to 4,352 bed days saved

North Mersey LDS: 1270 fewer admissions due to alcohol
Equating to 5080 bed days saved

Further details of the benefits of the link between the proposed interventions and reduced admissions and bed days saved over the 5 year period is outlined within the Annex.

3. Closing the funding and efficiency gap

Reducing alcohol-related harm will help close the funding and efficiency gap across Cheshire and Merseyside.

The costs and benefits of the proposed alcohol interventions have been modelled at a Cheshire and Merseyside and LDS level.

The net financial benefit at after 5 years of implementing this programme has been estimated at:

- **Cheshire and Merseyside:** £11,274,000
- **Cheshire and Wirral LDS:** £4,760,000
- **Mid Mersey Alliance LDS:** £3,005,000
- **North Mersey LDS:** £3,508,000

These are likely to be underestimations of the proposed financial benefits:

- We have taken a healthcare perspective to cost savings, but the cost savings could be much greater when criminal justice, private costs, and work productivity are factored in. Most evidence suggests that criminal justice cost savings may be greater than healthcare cost savings for interventions to reduce harmful drinking or support dependent drinkers. For instance, the Cardiff information sharing model produced estimated criminal justice savings of £5.4million over 5 years.

- No costs or benefits of the proposed MECC has been included within the cost-benefit analysis.

Assumptions related to the economic modelling undertaken is included within ***Section 2: Assumptions and Constraints.***

A full breakdown of economic calculations and their release over the 5 year period is included within the Annex.

10.Proposed Action Plan

The art of the Action Plan is to *ensure that it is comprehensive, compelling and timely. The Action Plan should address all of the salient points highlighted in the other sections of the report; namely, all those points where* ***Your Plan*** *will act as a change programme to help close the three gaps. As such, and like the executive summary, it should therefore contain no information that does not already appear in the contents of the PID.*

Otherwise, the content of the Action Plan should deliver milestones which address, but are not limited to, the following three 'gaps' (as described in the 'Benefits' Section above):

- ***The health and wellbeing gap:*** *if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.*
- ***The care and quality gap:*** *unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.*
- ***The funding and efficiency gap:*** *if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.*

The 5YFV states that none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there. Changes to capacity and or activity in response to trends in demand

The Action Plan should also promote accountability by having a named individual for each task. Finally, the action planning must provide assurance as to how the change will be made to happen and that there is the capacity and capability in place to underpin delivery. All action plans should be governed by a Programme Board or similar entity.

An action plan is included on the next page.

						5YFV gap addressed					
Intervention	**Aim**				**Objective**	**Financial**	**Health and Wellbeing**	**Care and Quality**	**Lead/support**	**KPI**	**Target KPI change**
1. FYFV demand reduction (Alcohol) steering group	**Overarching**				A. Establish a system wide leadership approach through the establishment of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol related harm**.** This systems leadership approach will support and add value to the implementation of local strategies. **This group would have oversight and be accountable for implementation of the FYFV action plan.** B. **Business case**- work up a more detailed business case based on more accurate programme costings and including £ value for QALYs gained. C. Develop and continue to **risk register** (building on those set out in the PID document) and plans to mitigate risks, using a standardised approach to identification, assessment, recording and reporting of risks. D. Develop and implement a **Stakeholder engagement and communications** plan to mitigate the risk of failure of partners to engage E. Establish a data/outcomes working group responsible for evaluation framework/logic model that underpins the FYFV objectives.	Y	Y	Y	Fiona Johnstone (Lead DPH for Alcohol). Champs Support Team programme lead (TBC) and wider system partners	Oversight of all 4 high level KPIs.	Collaborative development of a logic model to identify short, medium and long-term outcomes and target changes linked to the key interventions outlined within this work programme.
PRIORITY 1. Enhanced Support for High Impact Drinkers		**Treatment**			A. Develop multi-agency approaches to support change resistant drinkers' B. Ensure the provision of best practice multidisciplinary alcohol care teams in all acute hospitals. A current scoping will be required in order to inform the future provision to optimal levels C. Review pathways and commission outreach teams in hospitals or the community that complement hospital based alcohol care teams by identifying and proactively engaging patients with repeated admissions as appropriate.	Y	Y	Y	To be established via working group	KPI1: Emergency hospital admissions rates for alcohol specific admissions (National indicator: LAPE) KPI2: Mortality from alcohol specific conditions (National indicator: LAPE)	Year on year reductions over 5 years. N.B. cost-benefits (across whole programme) is based upon a 6% reduction in alcohol-specific admissions by year 5.
PRIORITY 2. Large Scale delivery of targeted Brief Advice			**Detection**		A. **Identification and Brief Advice.** Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff trained to offer and provide brief advice and refer to local specialist services as required. B. Ensure screening and advice by non-NHS partners as part of the delivery of **Making Every Contact Count (MECC)** interventions to include evidence-based alcohol IBA as well brief interventions focusing on High BP (including BP checks), smoking cessation, diet and physical activity. ***INTERDEPENDENT WITH BLOOD PRESSURE ACTION PLAN***	Y	Y	Y	To be established via working group	KPI3: - Identification and Brief Advice (IBA) *(Local indicators need to be developed)* A. Alcohol screening: Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems B. Alcohol brief advice: Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice C. Alcohol referral: Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team	Year on year increase over 5 years. NB cost-benefits (across IBA programme) is based upon undertaking IBA in primary care with 7.5% of adult population by year 5.
PRIORITY 3. Effective population level actions				**Prevention**	i. Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards i. Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners i. Ensure local partners collaborate to ensure that the data collected is being used effectively and work together to consider where improvements can be made. This will include: i. Targeting interventions to prevent violence and reduce alcohol-related harm ii. Targeting police enforcement in hotspot areas iii. Use of intelligence in the license review process and targeting alcohol licencing enforcement	Y	Y	Y	To be established via working group	KPI4: Alcohol-related violence *(Local indicator needs to be developed)*	Year on year reductions over 5 years

a) Annex

The aim of an annex is to *add greater details, visuals and examples for better understanding of the main document (e.g. Performance – you may wish to display a visual as an annex to refer to from the text within this section)*

2. Appendices

An appendix is different from an annex in that it *can be considered without the main text; it is a document in its own right that still makes sense if it stands alone. It cannot be added to the main text but still has importance as regards the original document.*

Your content starts here…..

Cheshire and Merseyside FYFV Working Group

Cross-Cutting Theme/LDS Programme:

Demand Management and Prevention at scale

Service/Theme: **High Blood Pressure**

Date: 11th Oct 2016

Version No: 1

Senior Responsible Owner (SRO): Dr Muna Abdel Aziz, Lead DPH for High BP

Clinical Lead:

Programme Support: Dr Melanie Roche, Acting Public Health Consultant

Financial Support:

HR Support:

Clients:

1st C&M BP system

2nd C&M FYFV Working Group

3rd NHSE & ALBs, October 2016 FYFV Submission

Contents

Executive Summary

The challenge
With 625,000 people in Cheshire & Merseyside (C&M) affected by high blood pressure (BP) and almost half of this number thought to be unaware that they have the condition, it is critical that urgent action is taken to prevent, identify and manage people at risk of developing serious diseases such as heart attack, stroke, heart failure and chronic kidney disease.

The 'no change' scenario
The implications for population health outcomes and health and care finances of continuing with the current way of working would be stark.

- **Health and Wellbeing:** We know that around a quarter of people are suffering from hypertension but we are only treating around 16%. We have an ageing population who are increasingly at risk of hypertension due to age, obesity and drinking to excess. If we do not start to address this disease right across the system at scale we will have increasing cases of stroke, heart attacks and vascular dementia that will require long term care and give people poor quality of life.

- **Financial:** The financial costs of this scenario are huge. Even taking a relatively narrow perspective of the costs of managing heart attacks, strokes and heart failure costs are estimated at £71m over 5 years for C&M (or £31m, £18m, and £22m respectively for Cheshire and Wirral, Mid Mersey, and North Mersey LDSs, respectively). This is likely to be a significant underestimate of true costs however. If vascular dementia, CKD and other costs are considered the true cost is likely to be towards £500m for Cheshire and Merseyside. The relatively narrow 'no change' costs perspective has been presented here for consistency with net financial benefits presented below.

Closing the Five Year Forward View 'Gaps' by tackling high BP
Addressing high BP will contribute to the closing of the three 'gaps' highlighted in the Five Year Forward View, i.e. Health and Wellbeing, Care and Quality, and Finance and Efficiency.

1. **Closing the Finance and Efficiency Gap**

Closure of the Finance and Efficiency Gap will be evidenced by a **net financial benefit** of proposed interventions.

In order to deliver the BP programme of work, financial resource is needed over a five year period, 'pump-priming' in the early stages to increase capacity and capability through staff training, capital costs, communications, marketing and evaluation.

Investment of around £500k per annum across C&M will deliver a net financial benefit of between £7m and £8.2m in five years (discounted) based on 5% to 15% increase in diagnosis, and all GP practices performing as well as the 75th best percentile for managing blood pressure in people with hypertension.

Based upon the estimated total number of people with high BP in each CCG, at LDS-level this equates to net financial benefits of £2.8-£3.3m (Cheshire and Wirral LDS), £2-£2.3m (Mid Mersey LDS), and £2.2 to £2.6m (North Mersey LDS).

While this does not factor in any additional costs for the extra cases diagnosed, net benefits are likely to be an underestimate as they do not include savings related to dementia or CKD, and do not take into account the value of Quality Adjusted Life Years (QALYs) gained.

While total financial benefits are calculated for a five year period, benefits will be realised gradually over the five years, not only at the five year point.

2. Closing the Health and Wellbeing Gap

Health and wellbeing benefits will be realised on 3 levels; operational, tactical and strategic.

On an **operational level**, preventing identifying and controlling high BP will benefit patient outcomes by reducing medical complications such as stroke and heart attack, and reduce demand on health and social care, with net financial benefit.

On a **tactical level within the C&M FYFV**, upstream approaches to address high BP through modifiable lifestyle factors will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, neurology, alcohol) by reducing the prevalence of risk factors for a wide range of conditions in addition to high BP.

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to high BP, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

Closure of the Health and Wellbeing gap will be evidenced by progress against KPIs 1&2:

- **KPI1 (Impact):** fewer CCGs with higher than the national average hospital admissions for heart attacks and strokes
- **KPI2 (Prevention)**: more NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)

3. Closing the Care and Quality Gap

In C&M if all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths.

At LDS level this would mean prevention of

- **Cheshire and Wirral LDS**: 262 events could be prevented over 5 years: 74 strokes, 47 heart attacks, 103 heart failures, 38 deaths
- **Mid Mersey Alliance LDS:** 188 events could be prevented over 5 years: 52 strokes, 34 heart attacks, 74 heart failures, 28 deaths
- **North Mersey LDS:** 203 events could be prevented over 5 years: 57 strokes, 37 heart attacks, 79 heart failures, 30 deaths

Closure of the Care and Quality Gap will be evidenced by progress against KPIs 3&4:

- **KPI3 (Detection)**: Gap between observed and expected prevalence of BP
- **KPI4 (Management)**: Increase in the % patients treated to target levels, and a reduction in practice-level variation

The Vision
The collective vision of partners across C&M is that our communities will have the best possible blood pressure.

The Cheshire and Merseyside cross-sector system strategy to tackle high BP
C&M partners identified high BP as a priority for cross-sector collaborative action over two years ago and have made great progress in forging a cultural shift towards integrated working and prevention. Cheshire and Merseyside is nationally recognised as 'leading the way' with its cross-sector strategy to tackle high BP 'Saving lives: Reducing the pressure', and the programme of work proposed here build on this strategic system leadership approach.

Stakeholders
Key partners include Cheshire and Merseyside Public Health Collaborative (Champs), Public Health England NW, NHS England, nine Local Authorities, 12 CCGs (covering the 3 C&M LDS), the C&M CVD SCN, Voluntary Sector organisations, the National Institute of Clinical Excellence, Innovation Agency, Health Education England, C&M Fire and Rescue Services, industry partners, academic institutions, and more.

Proposed Service Model: priority interventions to reduce demand
A shift in BP outcomes and reduction in demand on the health and care system will be achieved by a continuation of the C&M cross-sector systems approach, including the C&M BP Board, networks and collaborations that contribute to delivery of the C&M Strategy to tackle high BP 'Saving lives: Reducing the pressure. Priority interventions include:

<u>Reducing demand on primary care:</u>

PRIORITY 1) Empowering patients and communities to live better:

- An **NHS settings approach to prevention at scale (e.g. 'Healthy Provider Declaration')**: Supporting all the 20 of the large NHS provider organisations in the sub-region to develop healthy local policy to support healthy eating as a key modifiable risk factor for staff, patients and visitors, and putting in place a package of support around implementation

- Roll out **Making Every Contact Count** at scale and optimise impact through workforce development and use of supporting conversational tools/ technologies

- **Changing behaviour through awareness raising campaigns**: Maximise the impact of existing national campaigns, particularly Blood Pressure UK's 'Know Your Numbers' campaign

PRIORITY 2) Strengthening the role of community pharmacies in the prevention, detection and management of high BP through BP testing, 24 hour BP monitoring, and increased uptake and focus of medicines optimisation services

- Increasing **availability** of **BP machines and Ambulatory Blood Pressure Monitors** to support detection and diagnosis in community settings

Reducing demand on secondary care:

PRIORITY 3) Primary care education and training programme to accelerate and support quality improvement in primary care with dedicated education and training programme that utilises Sector Led Improvement principles

Monitoring Progress

Progress against the programme will be demonstrated by four key performance indicators (KPIs):

- **KPI1 (Impact):** CCGs with higher than the national average hospital admissions for heart attacks and strokes
- **KPI2 (Prevention)**: NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)
- **KPI3 (Detection)**: Gap between observed and expected prevalence of BP
- **KPI4 (Management)**: Increase in the % patients treated to target levels, and a reduction in practice-level variation

1. National, Regional, Local Context

The Case for Change

a. National context

High BP is the **second highest cause of premature death and disability** (second to smoking) in England. It is the most common long term condition in the UK, affecting more than 1 in 4 adults and accounts for 12% of all visits to general practice in England

High BP is caused by mostly **modifiable risk factors**, such as being overweight or obese, smoking, physical inactivity, poor diet, and too much alcohol.

Almost half of those affected by high BP are **unaware**, in part due to a **lack of symptoms** until complications develop, e.g. heart disease, stroke, dementia, chronic kidney disease.

People from the most **deprived areas are 30% more likely** to high have BP, and to have poor health outcomes as a result, and due to the **ageing population** high BP and its consequences are likely to become more common over time.

If no action is taken, high BP is likely to contribute to reduced health and wellbeing, (more heart attacks, strokes, heart failure, chronic kidney disease and vascular dementia), an increase in health inequalities, and **greater demand** on primary, secondary, and social care services. PHE's 'Tackling High Blood Pressure' estimates 'no change' scenario costs related to BP to be £2.1billion a year across England. Taking no action is not an option.

b. Standards and Policy context

Best practice for clinical management of high BP is set out in **NICE guidelines** for hypertension and accompanying NICE Quality Standards enable assessment of performance against the guidelines.

The **Quality and Outcomes Framework (QoF)** for hypertension measures performance in primary care in relation to BP care. QoF standards do not however always align with accepted best clinical practice standards.

There is increasing recognition that high BP cannot and should not be the concern of primary care alone, and that a **cross-sector system approach** with greater emphasis on **integration and prevention** is key to improving outcomes and a sustainable approach. Key documents in this regard include:

- PHE and the National Blood Pressure System Leadership Board, published 'Tackling High Blood Pressure' in 2014
- NHSE Five Year Forward View, in particular in relation to prevention, public health and integrated working
- PHE's 'Action on cardiovascular disease: Getting serious about prevention', 2016

c. The Challenge in Cheshire and Merseyside (C&M)

Modifiable risk factors for high BP are common across C&M (two thirds of adults are overweight, one third are physically inactive, and up to a third of adults in some areas smoke), fuelled by high levels of deprivation (32% live in the most deprived areas) (Source: Saving lives: Reducing the pressure).

Approximately **625,000 people** are thought to be affected by high BP in C&M but around **275,000 are estimated to be unaware** they are affected.

Health checks uptake across C&M, an intervention that includes BP testing, ranges from 5%-12% across C&M CCGs (falling short of the national target of 20%)

There is considerable **practice-level variation**, including rates of diagnosis, exception reporting, and treating to target.

Despite a trend (from 2012/12 to 2014/15) towards a greater proportion of patients with high BP achieving a minimum QoF target of <150/90mmHg (Source: NCVIN CVD Profiles), **around 1/5 are still not controlled to a minimum standard**. As the QoF BP threshold differs from that set out in NICE guidelines, many more than this are likely to benefit from having their BP controlled to a more aspirational (lower) level.

It is estimated that around 800 heart attacks and strokes could be prevented annually through optimising BP treatment alone.

Most C&M Clinical Commissioning Groups (CCGs) have **higher than average Cardiovascular Disease (CVD) prevalence** (11/12).

Hospital admissions rates are higher than the England average for **heart attacks and for strokes** in 7 and 4 out of the 12 CCGs, respectively, and there has been little overall change in the rate of all age stroke admissions across C&M in more than a decade (2003/04 to 2014/15) (Source: NCVIN CVD Profiles).

Death rates are higher than the England average for **heart attacks and for strokes** in 10 and 8 out of the 12 CCGs, respectively.

Taking in to account demand on the health and care system from heart attacks, strokes, Heart Failure, CKD and dementia the **financial cost of the 'no change' scenario** is estimated to be in the region of £500m over 5 years for Cheshire and Merseyside (or around £71m over 5 years if complication costs are limited to heart attacks, strokes and heart failure).

d. Challenges at Local Delivery System Level

The following LDS-level figures are based on main constituent CCG boundaries rather than exact LDS boundaries so may be subject to minor changes, i.e. they are based on the following footprints:

- **Cheshire and Wirral LDS:** South Cheshire, Eastern Cheshire, West Cheshire , Wirral, Vale Royal CCGs

- **The Mid Mersey Alliance LDS:** Knowsley, Warrington, Halton, St Helens CCGs

- **North Mersey LDS:** Liverpool, Southport & Formby, South Sefton CCGs

Please note: the real picture is more complex, with some CCGs, e.g. Knowsley CCG, facing into more than one LDS. More accurate LDS-level figures will be calculated as part of the next stage in the FYFV process.

i. Cheshire and Wirral LDS

- Over 284,000 people are thought to be affected by high BP
- 162,000 people are on QoF hypertension registers
- A further 122,000 are estimated to be undiagnosed
- The value of an extra 15% diagnosis per annum is estimated at £550,000
- Nearly 1/5th of patients known to have high BP are still not controlled to minimum QoF standards (<150/90)
- Over 6,200 additional people would have their BP controlled if all practices achieved as well as the average of the best achieving practices in their CCG
- If all GP practices performed as well as the 75th best percentile
    - 262 events could be prevented over 5 years: 74 strokes, 47 heart attacks, 103 heart failures, 38 deaths
    - Saving >£6.8m NHS costs and ~£1.5m social care costs
- Emergency hospital admissions for heart attack and stroke are similar to the national average
- 'No change' scenario costs, including BP complication costs for heart attacks, strokes and heart failure, are estimated at £31m

ii. Mid-Mersey Alliance LDS

- Over 175,000 people are thought to be affected by high blood pressure
- Nearly 105,000 are on QoF hypertension registers
- A further 71,000 are estimated to be undiagnosed
- The value of an extra 15% diagnosis per annum is estimated at £319, 000
- Nearly 1/5th of those known to have high BP are not controlled to minimum QoF standards (<150/90mmHg). In one CCG, a trend towards fewer BP patients achieving this minimum target BP can be seen (2012/13 to 2014/15).
- Over 4,600 additional people would have their BP controlled if all practices achieved as well as the average of the best achieving practices in their CCG
- If all GP practices performed as well as the 75th best percentile
    - 188 events could be prevented over 5 years: 52 strokes, 34 heart attacks, 74 heart failures, 28 deaths
    - Saving over £4.8m NHS costs and £1m social care costs
- Emergency hospital admissions for heart attack and stroke are 30% and 4% higher than the national average, respectively

- 'No change' scenario costs, including BP complication costs for heart attacks, strokes and heart failure, are estimated at £18.5m

iii. North Mersey LDS

- Over 199,000 people are thought to be affected by high blood pressure
- Over 112,000 people are on QoF hypertension registers
- A further 87,000 are estimated to be undiagnosed
- The value of an extra 15% diagnosis per annum is estimated at £392,000
- Nearly 1/5th of those known to have high BP are not controlled to minimum QoF standards (<150/90)
- Nearly 4,400 additional people would have their BP controlled if all practices achieved as well as the average of the best achieving practices in their CCG
- If all GP practices performed as well as the 75th best percentile
    - 203 events could be prevented over 5 years: 57 strokes, 37 heart attacks, 79 heart failures, 30 deaths
    - Saving nearly £5.3m NHS costs and over £1.1m social care costs
- Emergency hospital admissions for heart attack and stroke are slightly higher and lower than the national averages, respectively
- 'No change' scenario costs, including BP complication costs for heart attacks, strokes and heart failure, are estimated at £22m

Cheshire and Merseyside: Taking a cross-sector systems approach

In response to the challenges that high BP poses to both health and wellbeing and the sustainability of the health and care systems in C&M, great progress has been made locally in forging the **cultural shift** necessary to address the issue.

The collective **vision o**f partners across C&M is that **our communities will have the best possible BP.**

C&M has been described by the national PHE team as **'leading the way'** in its innovative cross-sector approach to tackle high BP, and the C&M high BP strategy (Saving lives: Reducing the pressure) has been described as **'state of the art'** by Professor Norm Campbell, leader of a team in Canada responsible for world-leading transformations in BP detection, treatment and control. A link to the C&M strategy can be found as an example of good practice on the World Hypertension League website.

Cheshire and Merseyside cross-sector Blood Pressure Board was established in November 2015, and the Board launched its strategy, **'Saving lives: Reducing the pressure'** in May 2016

Stakeholders of the C&M BP strategy are from a wide range of sectors and organisations including

- Public Health England NW
- NHS E C&M

- Cheshire and Merseyside Public Health Collaborative (Champs)
- 9 Local Authorities
- 12 CCGs (covering the 3 C&M LDS)
- Voluntary Sector organisations including Stroke Association, British Heart Foundation, Blood Pressure UK, Health Equalities Group
- NICE
- Innovation Agency
- Health Education England
- C&M Fire and Rescue Services

It is within the context of this local cross-sector BP strategy and system that this FYFV BP programme of work is proposed.

2. Assumptions & Constraints

Assumptions and constraints can be considered in two groups relating to the:

1. **Programme of BP work** (including the cross-sector systems approach)
2. **Economic modelling**

1. The programme of BP work (including a cross-sector systems approach)

Assumptions

Underpinning the high BP plan is a key assumption that the best way to improve outcomes for available resources is to take a **cross-sector system approach** to tackle high BP with networks of partners delivering pathways of care that cover prevention, detection and management (PHE 'Tackling high blood pressure, NHS Five Year Forward View, Pan-Canadian BP work)

- The relationship between prevention, detection and management is **not linear**, for example, secondary care can play and important role in prevention, and detection and management roles can be shared with non-clinical community partners in a range of settings

- Assumptions about the relationships between outputs (interventions) and short, medium and long term outcomes/ impacts are set out in the 'Saving lives: Reducing the pressure' **logic model-style indicator dashboard** (see link to strategy in annex).

- It is assumed that the **C&M Blood Pressure Board** will continue to provide cross-sector system leadership across the sub-region, facilitating true integrated working and realisation of how interdependencies can yield improved outcomes despite challenging constraints on resources

- Due to reduced prevalence of high BP and it's complications, and the expansion of partner roles, it is assumed that overall primary care will benefit from a **net reduction in demand** despite 'asks' of the primary care team set out in this programme of work.

Constraints

- **Resources-** At present the majority of the work within the C&M BP strategy is being achieved through 'gift in kind' (partners giving their time and expertise), and financial resources are limited. Without additional financial resource to pump-prime the BP programme, the ability of the interventions set out in the action plan to close the three 'gaps' will be greatly lessened.

- **Evidence base-** C&M is recognised as being 'ahead of the curve' nationally in its cross-sector system approach to tackle high BP. As such the proposed programme of work is based on a combination of evidence of interventions that demonstrate impact where this is available, but for some areas, evidence of impact is not yet available as no-one as taken the next step. When this is the case, proposed actions

are based on available evidence blended with theory, pragmatism and peer consensus (in part achieved through the National Blood Pressure Board, on which the lead DPH for BP in C&M sits, as well as through the C&M BP Board and the C&M Health Care Public Health Leads Group). In doing so, C&M is adding to the available evidence base.

- **Risks**
  A risk management policy is in place that will provide a standardised approach to the identification, assessment, recording and reporting of risks. An integrated risk log will be developed and will analyse the causes of a risk and identify current controls to manage the outcome to mitigate the likelihood and impact. The key controllable risks are outlined below

  i. We know 25% of people are suffering from hypertension but we are only treating circa 16%. We have an **ageing population** who **are increasingly at risk of hypertension** due to **age, obesity and drinking too excess**. If we do not start to address this disease right across the system at scale we will have increasing cases of stroke, heart attacks and vascular dementia that will inflate treatment costs, require long term care and give people poor quality of life.

  ii. **Public Engagement.** The costs for implementing a programme at scale are low but there is the risk that the public may not engage with the programme. Mitigated by good communications, engaging charities, public/patient groups/ community initiatives as part of a systems approach to implementation

  iii. There is a risk we lack the **capacity** to deliver the programme at scale. We can mitigate this by training local people in the community as well as staff and use community pharmacists.

  iv. **Managerial – Professional Engagement.** There is a risk that the system (CCGs and primary care clinicians) may fail to engage and implement the programme. Mitigated by Substantial engagement with clinicians including PHE/SCN, clinical champions, CVD-leads via SCN and a Sector Led Improvement approach.

  v. **Changes to National funding arrangements,** e.g. to Medicines Use Reviews (which are currently under review) would reduce opportunities for community pharmacies to work with primary care around medicines optimisation. Mitigate with alternative funding source (e.g. Enhanced Supply) to continue with and optimise impact of existing service.

2. Economic modelling

<u>Assumptions</u>

- Itemised estimated C&M BP **programme costs** are set out in section 7 ‘Facilities and Estates’

- Programme costs are **pro rata** based on estimated total number of people with hypertension in each CCG.

- Maximum net financial benefit is based on **15% increase in diagnosis**, and all GP practices performing as well as the **75th best percentile** for managing blood pressure in people with hypertension
- **Sensitivity analysis** was carried out varying the increase in diagnosis to **5% and 10%** in the event of assumptions around increased detection being difficult to achieve
- The estimated cost savings from increasing hypertension diagnosis are based on economic modelling commissioned by PHE for **'Tackling High Blood Pressure: From evidence into action';** while the estimated cost savings from better blood pressure control in people diagnosed with hypertension are from a series of **CVD prevention opportunity tools** produced by PHE which are based on best current epidemiological and economic evidence.
- While total financial benefits are calculated for a **five year period**, benefits will be **realised gradually** over the five years, not only at the five year point. Within the modelling, benefits (outcomes) have been staged as follows: 0% in year 1, then 25%, 50%, 75% and 100% in years 2-5, in keeping with timeframes on the 'Saving lives: Reducing the pressure' indicator dashboard
- **Discounting at 3.5% per annum** has been undertaken for the main scenario (15% increase in diagnosis)
- The biggest and most sustainable way to impact on high BP is **prevention**, e.g. population level approaches, especially those that reduce salt intake.
- **MECC** is estimated to give a benefit to cost ratio of around £35 gained for each £1 spent
- Prevention benefits from population approaches and MECC will also be felt across the majority of **cross-cutting FYFV themes** and the other prevention priority, alcohol.

<u>Constraints</u>

- All LDS-level figures are based on **main constituent CCG boundaries** rather than exact LDS boundaries so may be subject to changes. LDS boundaries in this document are taken as:
    - **Cheshire and Wirral LDS:** South Cheshire, Eastern Cheshire, West Cheshire , Wirral, Vale Royal CCGs
    - **The Mid Mersey Alliance LDS:** Knowsley, Warrington, Halton, St Helens CCGs
    - **North Mersey LDS:** Liverpool, Southport & Formby, South Sefton CCGs

  The real picture is more complex, with some CCGs, e.g. Knowsley CCG, facing into more than one LDS. More accurate LDS-level figures will be calculated as part of the next stage in the FYFV process.

- Economic modelling does not factor in any **additional costs** for the extra cases diagnosed, but net benefits are likely to be an underestimate as they do not include savings related to dementia or CKD, and do not take into account the value of Quality Adjusted Life Years (QALYs) gained.

- Project costs and different scenarios relating to primary care performance **have not been varied** within the sensitivity analysis

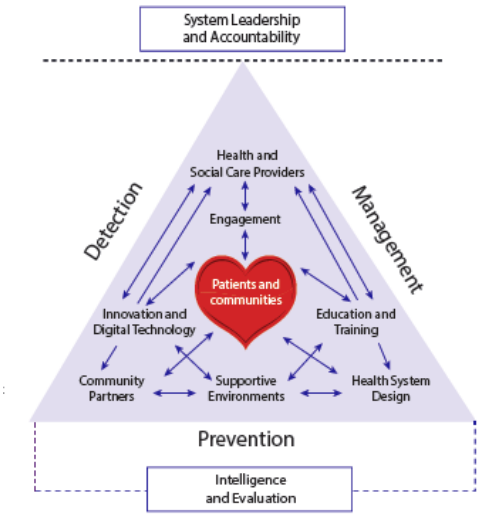
- While project costs for a 'healthy provider declaration' and MECC have been included in the net benefit calculations, benefits gained from resulting prevention of BP and related complications have not been included. As such, net benefits for BP are likely to be **underestimated.**

3. Service Model

Background context: The C&M BP strategy

The proposed programme of work is embedded within the C&M Cross-sector approach to tackle high BP, as set out in the Cheshire and Merseyside cross-sector strategy to tackle high BP 'Saving lives: Reducing the pressure', launched May 2016. The strategy has been described by PHE as nationally 'pace-setting', and as 'State of the art' by the leader of the world-leading team for tackling high BP, Professor Norm Campbell.

The main objectives of the strategy are represented schematically below:



The full strategy is available to download via the following link:
www.champspublichealth.com/high-blood-pressure

A 'coalition of the willing' has been building in Cheshire and Merseyside for two years, culminating in 'Saving lives: Reducing the Pressure', and service model builds on this, including a wide range of stakeholders across the BP 'system;

- Patients and communities
- Community partners, e.g. voluntary sector, Fire and Rescue Service
- Community pharmacies
- The primary care team (GPs, PNs, HCAs)
- Secondary care

Through enhanced prevention, detection and management of high BP, the programme of BP work proposed here builds on the C&M BP strategy and will reduce demand on primary, secondary and social care services by focusing on:

1. **Empowering patients and communities to live better**
2. **Enhancing the role of community pharmacies in detecting and managing high BP**
3. **Consistent delivery of best BP management in primary care.**

Reducing demand on primary care

PRIORITY 1) Empower Patients and Communities to Live Better

Prevention of high BP and its consequences by helping populations to lead healthy lives and to self-care is the most sustainable way to improve outcomes and reduce demand on primary care. This can only be achieved by working hand in hand with partners from a range of organisations and sectors as part of a cross sector strategy that includes population-based approaches, and ties in with local authority Early Intervention & Prevention Agendas, Integrated Transformation Programmes and the Pioneer and Vanguard initiatives across the FYFV footprint.

Aim: Reduce the impact of high BP on primary care by preventing it developing in the first place, and by empowering patients and communities to self-manage through lifestyle change if high BP does develop.

CCGs can contribute to the C&M BP system achieving this through:

- **Healthy local policy** (including in relation to reducing salt intake) within local health and care provider settings, and advocacy for healthy national policy as part of the C&M BP System.

- **Making Every Contact Count/ brief interventions** focusing on High BP (including BP checks), smoking cessation, alcohol, diet, physical activity. MECC can be rolled out widely in partnership with health care organisations and non-clinical community partners including voluntary sector organisations.

- **Social Marketing** campaigns to raise awareness around BP and support the MECC work

Case Studies 1 a and b

1a. Health and wellbeing study for NHS staff, Clatterbridge Cancer Centre (CCC)
Dr Robbie McDermott, Dr Peninah Thumbi, Yang Liu, Nick Bain, June 2015.

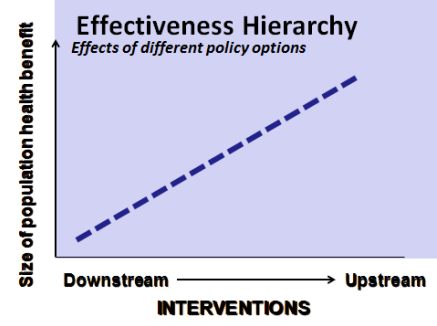
Why should NHS provider organisations support healthy eating, and how can they do it?
With increasing evidence that NHS staff behaviours influence the behaviour of patients and the public, Clatterbridge Cancer Centre (CCC) was keen to reduce unhealthy risk behaviours amongst their staff. The CCC is one of the largest networked cancer centres in the UK, but engagement around prevention and promotion of healthy lifestyles amongst staff and patients was limited. NHS provider organisations can be ideal settings for population approaches to improve health and wellbeing (including healthy eating and BP), but the supply of cheap, high energy food may contribute to them achieving the opposite.

***Intervention**; CCC and the Health Equalities Group, HEG (a Liverpool-based charitable health and wellbeing alliance) commissioned research into the barriers and drivers for staff adopting healthier lifestyles.*
***Results;** Weight (a key risk factor for high BP) was identified as the risk factor affecting most staff (45%), and the majority were keen for change and support to do so. Workplace-based support was considered essential, including 24 hour access to healthy food, and reduced access to unhealthy food (e.g. in vending machines).*

***"If I forget to bring in my own lunch, it's a nightmare. I'm like, 'I either queue up my whole break or I eat rubbish instead'"** Radiographer.*

***Relevance;** This report underlines the importance of NHS providers increasing availability of healthy food, and that this will be beneficial to staff, patients and visitors.*

***1b. Local Authority Declaration on Healthy Weight,** Food Active, spring 2016.*
Upstream population-level policies have a larger impact on public health outcomes than interventions that target individuals.



The Local Authority Declaration on Healthy Weight (Food Active, HEG) was designed to support local government to exercise their responsibility in developing and implementing policies which promote healthy weight. In January 2016 Blackpool became the first local authority to adopt the Declaration, and has since made significant progress with vending machines, procurement, healthy packed lunches, awareness raising campaigns, healthy catering awards and other areas.
The evidence base behind the Declaration is equally relevant and important to NHS provider organisations, hence the proposal for the development of a 'Healthy Provider Declaration' on healthy food to support development and implementation of provider-level policy.

For more information on the Local Authority Declaration on Healthy Weight go to
http://www.hegroup.org.uk/images/resources/Healthy_Weight_Briefing_paper.pdf

Link to a blog about the Blackpool Declaration:
http://www.foodactive.org.uk/blackpool-council-the-first-adopters/

Implementation of this evidence base can directly support provider organisations to meet requirements for part 1b of the recently introduced health and wellbeing CQUIN, 'Healthy food for staff, patients and visitors'.

PRIORITY 2) Enhanced role of Community Pharmacy in BP detection and management

For those who do develop high BP, some of the roles traditionally carried out in general practice can be undertaken in, or in partnership with community pharmacies, improving outcomes whilst reducing demand on primary care.

Aim: Reduce the impact of high BP on primary care by supporting primary care to and community pharmacy to work more closely in relation to high BP detection and management.

This can be achieved through Enhanced Services that support:

- **Diagnosis**: BP testing and 24 hour ambulatory BP monitoring in community pharmacies, with appropriate advice and signposting

- **Medicines optimisation**: Increase uptake of existing services such as Medicine Use Reviews and New Medicines Service, and greater focus of these reviews on antihypertensive medications in line with C&M prevention priorities

Case Study 2

The impact of interventions by pharmacists in community pharmacies on control of hypertension: a systemic review and meta-analysis of randomised controlled trials.

Ejaz Cheema, Paul Sutcliffe & Donald R. J. Singer, June 2014. British Journal of Clinical Pharmacology. DOI:10.1111/bcp.12452

A recent systematic review and meta-analysis of randomised controlled trials (RCTs) confirmed that community pharmacists can make a clinically important contribution to the management of hypertension in patients with or without associated cardiovascular co-morbidities.

16 RCTs (3,032 patients) were included, and the pharmacist-led interventions were patient education on hypertension, management of prescribing and safety problems associated with medication, and advice on lifestyle. These interventions were associated with significant reductions in systolic (-6.1mmHg, 95% confidence interval -0.8 to -8.4mmHg, p<0.00004) and diastolic blood pressure (-2.5mmHg, 95% confidence interval -1.5 to -3.4mmHg, p<0.00001). As addition to improvements in blood pressure, the analysis demonstrated that in comparison to patients receiving usual care medication adherence improved, as did control of other cardiovascular risk factors, including both diabetes and cholesterol.

This case study supports the community pharmacy interventions set out here in relation to BP detection and medicines optimisation.

Reducing demand on secondary care

PRIORITY 3) Support consistent delivery of best practice across Primary Care

While there is much scope to strengthen prevention, a proportion of patients will still develop high BP and require clinical care. As a risk factor for heart disease, stroke, dementia and chronic kidney disease, controlling high blood pressure to target in primary care plays a key role in reducing demand on primary and secondary care in dealing with the health and social consequences of high BP. However, there is variation in the standard of BP care delivered across primary care.

Aim: Reduce the burden of the medical consequences of high BP on secondary care by supporting best practice and reduced variation in primary care in relation to BP management.

CCGs can accelerate and support primary care quality by supporting education and training in primary care aimed at improving:

a. Insight into practice-level benchmarking data
b. Improved use of hypertension registers and case-finding, coding
c. Clinical skills, e.g. BP measurement, prescribing guidelines etc.
d. Use and interpretation of 24 hour ambulatory and home BP monitoring
e. Implementation of NICE Guidance
f. Audit of performance against NICE Quality Standards
g. Closer working with community pharmacies around medicines optimisation
h. Knowledge of the sub-regional BP pathway and strategy

Case study 3

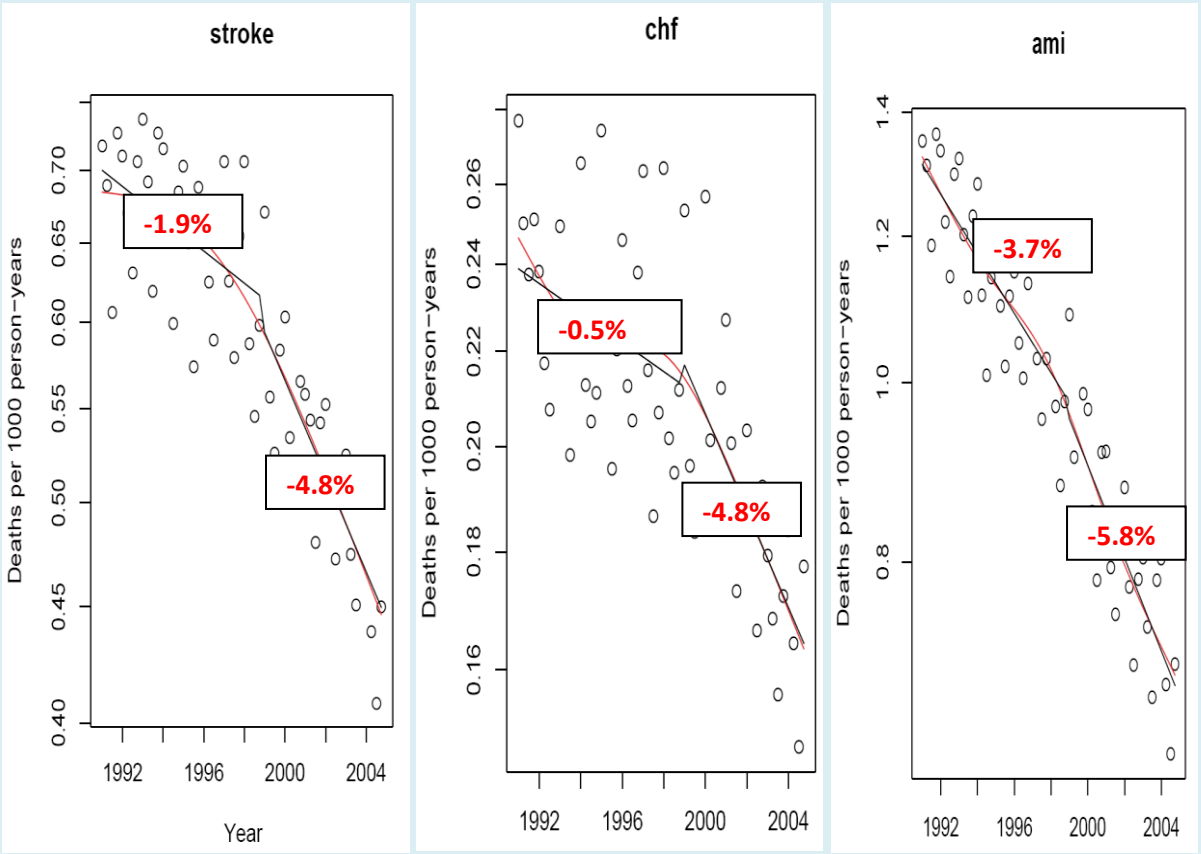
The Canadian Hypertension Education Program (CHEP), part of the Pan-Canadian Framework on the Prevention and Control of Hypertension, *led by Professor Norm Campbell and the Healthy Blood Pressure Steering and Drafting Committee*

In the early 1990s Canada had a high prevalence of hypertension and poor rates of treatment and control (13%). In 2000 the hypertension community in Canada developed a National Strategy for High Blood Pressure Prevention and Control which included the Canadian Hypertension Education Program (CHEP), a knowledge translation programme targeted originally at primary care practitioners to detect, treat, and control hypertension. Ten years later Canada has highest reported rates of treating and controlling hypertension in the world (66% 2007-2009).

Key messages *of the CHEP knowledge translation programme included: know the current BP of all your patients, encourage the use of approved devices and proper technique to measure BP at home, assess and manage CV risk in hypertensive patients including modifiable risk factors, and treat high BP to target (more than one drug is usually required).*

Impact: *The introduction of CHEP in 1999 was associated with improvements in BP awareness, treatment, control and outcomes, including a marked reduction in deaths from stroke, heart failure and heart attacks (acute myocardial infarction), see figures below.*

Changes in Stroke, Heart failure (chf) and Acute Myocardial Infarction (ami) deaths after CHEP starts in 1999:



Evidence from world-leaders in this field supports the introduction and roll out of a primary care BP education and training programme across Cheshire and Merseyside, building on local initiatives such as the Beacon Practice Pilots, developing originally in Wirral.

Prof Campbell who led the Canadian team in this work has endorsed the C&M BP strategy on which this BP plan is based, describing it as ‘state of the art’.

For further information see ‘Pan Canadian Framework on the Prevention and Control of Hypertension: a discussion paper on the way forward. Prof Norm Campbell et al, March 2012.

Delivering the 3 dimensions of quality
The programme of work will deliver the 3 dimensions of quality (patient safety, patient experience and clinical effectiveness:

- **Patient safety**
  In order to ensure public and patient safety is paramount, it is proposed that the C&M BP Board Embed systematic triangulation and review of cross-sector patient safety measures into strategy dashboard (e.g. complaints, litigation, incidents etc.).

- **Patient experience**
  The cross-sector approach will enhance patient experience by ensuring interventions are available at the right place and time, enabling de-medicalisation where appropriate, self-empowerment, and quality care closer to home.
  The health benefits from reducing the risk of blood pressure will also benefit a wide range of conditions, improving overall health and wellbeing.
  Patient/ lay representation on C&M BP Board and ongoing patient/lay consultation to ensure patient experience is improved

- **Clinical effectiveness**
  Clinical practice will be more closely and consistently aligned with best practice (NICE guidelines on hypertension). This will be captured in KPI4, an increase in the percentage of patients treated to target levels (150/90mmHg) and a reduction in practice-level variation.

4. Performance

Key Performance Indicators (KPIs)
The KPIs for the programme of work reflect impact, prevention, detection and management of high BP, aligning to the three Five Year Forward View 'Gaps' around Health and Wellbeing, Care and Quality, and Finance.

C&M BP Programme KPIs

KPI1 (Impact): CCGs with higher than the national average hospital admissions for heart attacks and strokes

KPI2 (Prevention): NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)

KPI3 (Detection): Gap between observed and expected prevalence of BP

KPI4 (Management): Increase in the % patients treated to target levels, and a reduction in practice-level variation

Current performance against the KPIs is as follows:

Performance against KPIs at LDS level

KPI	Description	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS
KPI1	Number of CCGs with higher than national average hospital admissions for heart attacks	1	4	2
	Number of CCGs with higher than national average hospital admissions for stroke	1	2	1
KPI2	NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)	0/20		
KPI3	Reduction in gap between observed and expected prevalence of BP	0.569 (n=161,921)	0.597 (n=104,838)	0.564 (n=112,414)
KPI4	% patients treated to target levels (<150/90mmHg) is increased	80.80% n=130,944	80.60% n=84,453	81.60% n=92,087
	Practice-level variation in % patients treated to target is reduced	26%	36.50%	43.60%

Progress targets (including timeframes) for the KPIs are set out below:

KPI targets

KPI	Target KPI change
KPI1. CCGs with higher than national average hospital admissions for heart attacks and strokes, respectively	Annual decrease from baseline evident from Y3, down to 0 by Y5
KPI2. NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)	Annual 25% increase from baseline evident from Y2, to give 100% by Y5.
KPI3. Reduction in gap between observed and expected prevalence of BP	Measurable increase in O/E hypertension prevalence ratio (equivalent to a 2.83% annual increase in prevalence from baseline, or a 15% increase from baseline by end Y5)
KPI4. a. % patients treated to target levels (<150/90mmHg) is increased b. practice-level variation is reduced	a. ~1% increase per annum in patients achieving target BP levels (<150/90mmHg). (Equivalent to increases in the no. of additional people who would have BP controlled if all practices achieved as well as the average of the best achieving practices at baseline by year 5) b. 50% reduction in practice level variation by Y5, or approximately 10% reduction per annum

For expected **LDS-level progress against KPIs**, see section 9, ‘Benefits’.

5. Staffing

In terms of staffing, this programme of work has direct and indirect implications for staffing.

Direct implications
Investment in posts needed:

- to support the system leadership approach
- to lead on the development and implementation of education and training programme

Due to the nature of the cross-sector approach, the staffing groups that contribute to the delivery of the BP pathway reach into many thousands. The number of HCWs with direct patient across C&M is over 55,000 (figures from NHSE Seasonal Flu Report 2016). This will enable actions at pace and scale. A targeted rolling programme of training for staff around Making Every Contact Count (MECC) is needed, including for

- Non-clinical community partners, e.g. voluntary sector staff, Fire and Rescue Service staff
- Community pharmacy staff, including Healthy Living Pharmacy leads and champions (estimated to be around 1,200 community pharmacists working regularly in C&M with patient access)
- Primary care teams including GPs, Practice nurses, Health care workers, receptionists
- Secondary care staff

Indirect implications

Indirect implications include the need for clear and consistent communications and engagement across the system, and engagement of key partners to mobilise the system.

An indirect benefit of the healthy provider policy intervention will be a contribution to a healthier and more productive workforce, thus supporting sustainability of the wider FYFV.

6. Information Management & Technology

The C&M BP System partners have a strong background in exploring the art of the possible in terms of how digital technology and innovation can facilitate delivery of key strategic objectives. In 2015 C&M got to the final stages of an NHSE Innovate UK Test Bed Bid Process, a process which itself galvanised the C&M BP partners and gave clarity as to which elements of the system would benefit from digital innovation and investment.

The three areas developed were broadly:

1. **Applications, devices and sensors** for the detection and management of high BP in community settings (e.g. kiosks, Phone apps etc.)
2. **Decision support** to facilitate standardised best clinical care in primary care
3. **Shared digital platform** to enable cross-sector interoperability and analytics

While the bid was not successful, C&M have been acting on the constructive feedback from NHSE by better defining the BP pathway, and how patients and the public will move through the system and addressing information governance issues. This is being done by:

- **Warrington shared digital platform pilot,** focusing on BP detection and management providing proof of concept for health kiosks in the community and a shared platform approach to enable data to be shared with primary care

- **Defining of 'front end' of BP pathway** through FRS Safe and Well checks pilot, and forging the way to strengthen the role of community pharmacies, including through the Beacon Practice pilots and Healthy Living Pharmacies programme

As such, C&M is now in a much stronger position to realise the potential that digital solutions have to offer the BP strategy.

Within the 3 priority interventions in this programme of work, use of digital technologies could include;

1. **Empowering patients and communities**
    - Developing a conversational tool to support delivery of MECC
    - Standards compliant BP testing devices/ apps

2. **Community pharmacies**
    - Standards compliant BP testing devices
    - 24 hour BP monitors
    - Home BP monitoring equipment
    - electronic referrals from primary care for Medicine Use Reviews and New Medicine Services

3. **High Quality BP Management in primary care**
    - Shared digital platform for patient records with key partners, e.g. community pharmacy
    - Decision support software

7. Facilities & Estates

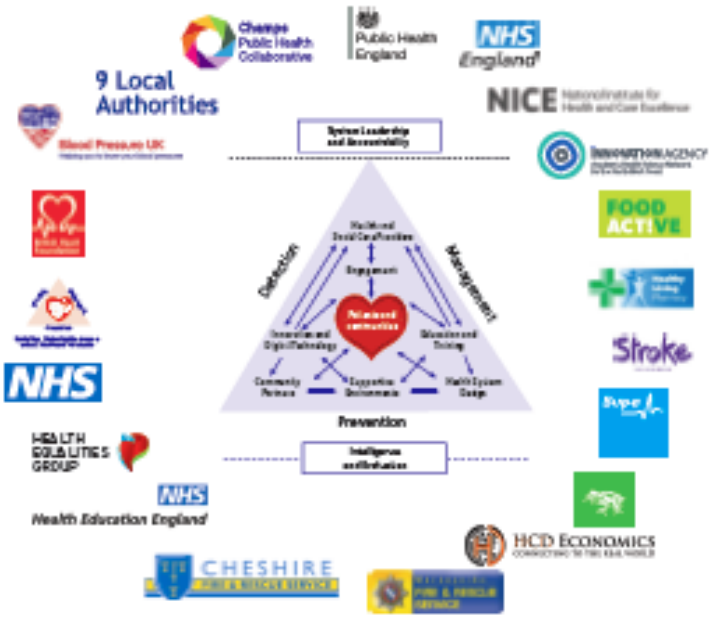
For the most part the actions can be put into place within existing facilities and estates belonging to key stakeholder partners, largely in community pharmacies, primary and secondary care.

- System leadership Staffing costs
- ‘Healthy Provider Declaration’
- MECC: workforce development
- Behaviour change campaigns and communications
- BP technologies
- Primary care education and training programme
- Evaluation
- Non labour and Overheads (rent, equipment etc.)

8. Interdependencies

Interdependencies can be identified at 3 levels; operational, tactical and strategic.

Operational level interdependencies
The priorities outlined here are embedded within the C&M Cross-sector strategy to tackle high BP.



Within this system, a wide range of interdependencies and partnership working is evolving between key stakeholders including, but not limited to:

- Public Health England (NW and national)
- NHS England C&M
- Cheshire and Merseyside Public Health Collaborative (Champs)
- 9 Local Authorities
- 12 CCGs (covering the 3 C&M LDS)
- Voluntary Sector organisations including Stroke Association, British Heart Foundation, Blood Pressure UK, Health Equalities Group
- NICE
- Innovation Agency
- Health Education England
- C&M Fire and Rescue Services

By capturing key outputs and outcomes from across the system into a single indicator dashboard, the importance of interdependencies is demonstrated and embedded within the C&M BP strategy, ‘Saving lives: Reducing the pressure’.

Tactical level interdependencies

Upstream approaches to address high BP through modifiable lifestyle factors (e.g. as 'Healthy Provider Declaration' and MECC at scale will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, neurology, alcohol) by reducing the prevalence of risk factors for a wide range of conditions in addition to high BP.

Strategic level interdependencies

The longer term benefits of the prevention of future illness, both in terms of those related to high BP, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

Also, the Boorman Report (2009) demonstrated that better staff health and wellbeing is associated with better organisational performance and improved patient outcomes. Interventions that increase staff health and wellbeing will therefore improve organisational productivity, outcomes and sustainability.

9. Benefits

Impact of the programme on addressing the 3 'Gaps' at the heart of the Five Year Forward View:

1. **The Health and Wellbeing Gap**
2. **The Care and Quality Gap**
3. **The Finance and Efficiency Gap**

Addressing the Five Year Forward View Gaps

All interventions that make up the C&M BP programme of work will address the Financial and Health and Wellbeing Gaps through enhanced prevention (primary, secondary or tertiary) and the cross-sector system approach, which will maximise value (benefits in health outcomes for available resources) across the system. The majority of interventions also contribute to the Care and Quality Gap. This is represented schematically below.

Schematic representation of how the C&M BP Interventions will address the 5YFV 'Gaps'.

		5YFV gap addressed		
Intervention	**Aim**	**Finance and Efficiency**	**Health and Wellbeing**	**Care and Quality**
1. FYFV demand reduction (BP) steering group	**Overarching**	Y	Y	Y
2. System Leadership approach		Y	Y	Y
3. Population approach to prevention	**Prevention**	Y	Y	
4. BP awareness raising campaigns		Y	Y	
5. Making Every Contact Count at scale		Y	Y	
6. Blood pressure equipment	**Detection**	Y	Y	Y
7. Primary care education and training programme		Y	Y	Y
8. Medicines Optimisation	**Management**	Y	Y	Y

1. Closing the Health and Wellbeing gap

The Five Year Forward View states that 'if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness'.

Through a cross-sector system approach, LDSs across C&M will be ensuring patients receive the most appropriate interventions in the right places and at the right time, driving a cultural shift towards prevention and self-care.

On an **operational level**, the programme of work aims to prevent identify and control high BP. The impact of this will be a reduction in medical complications such as stroke and heart attacks, and reduced demand on health and social care. Progress against KPIS 1 to 4 will indicate progress towards this aim (see tables below).

On a **tactical level within the C&M FYFV**, upstream approaches to address high BP through modifiable lifestyle factors will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, neurology, alcohol) by reducing the prevalence of risk factors for a wide range of conditions in addition to high BP.

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to high BP, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

2. Closing the Care and Quality Gap

The Five Year Forward View states that 'unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist'.

The C&M BP programme of work aims to support delivery of best clinical practice across the sub-region. In particular, progress against KPIs 3 (Increase in observed and expected (O/E) BP prevalence ratio) and 4 (the percentage of patients who are treated to target levels (<150/90mmHg) and reduced practice-level variation) will reflect this (see tables below).

In C&M if all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths.

At LDS level this would mean prevention of

- **Cheshire and Wirral LDS**: 262 events could be prevented over 5 years: 74 strokes, 47 heart attacks, 103 heart failures, 38 deaths
- **Mid Mersey Alliance LDS:** 188 events could be prevented over 5 years: 52 strokes, 34 heart attacks, 74 heart failures, 28 deaths

- **North Mersey LDS:** 203 events could be prevented over 5 years: 57 strokes, 37 heart attacks, 79 heart failures, 30 deaths

3. Closing the Funding and Efficiency Gap - net financial benefit.

The Five Year Forward View states that 'if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments'.

Assuming that all areas move towards a 15% increase in hypertension diagnosis and all GP practices move towards performing as well as the current 75th percentile in terms of managing blood pressure in people with hypertension, the following net financial benefits (balancing total programme costs against 5 year savings) have been modelled at LDS level. Benefits are staged over five years with 0% in year 1, and 25%, 50%, 75% and 100% in years 2-5. See section 7 for estimated programme costs.

Scenario 1. Net financial benefit (assuming 15% increase in diagnosis) - base case scenario without and with future costs and benefits discounted at 3.5% per annum.

i. **Cheshire and Wirral LDS;** £3,716,502 (no discounting), £3,318,788 (discounted)
ii. **Mid Mersey Alliance;** £2,558,913 (no discounting), £2,287,597 (discounted)
iii. **North Mersey LDS;** £2,867,558 (no discounting), £2,563,136 (discounted)
iv. **Cheshire and Merseyside;** £9,142,973 (no discounting), £8,169,521 (discounted)

Sensitivity analysis: In order to account for the possibility of LDSs being unable to achieve the 15% increase in BP diagnosis, a sensitivity analysis was carried out assuming 5% and 10% increases in diagnosis, respectively. Results (scenarios 2 and 3, respectively) demonstrate that while net benefit is reduced, net financial benefit is still very favourable.

Scenarios 2&3. Net financial benefit if LDS areas achieve 5% or 10% increase in high blood pressure diagnosis.

i. **Cheshire and Wirral LDS;** £2,797,871 (5%), £3,257,187 (10%)
ii. **Mid Mersey Alliance;** £2,027,577 (5%), £2,293,245 (10%)
iii. **North Mersey LDS;** £2,214,876 (5%), £2,541,217 (10%)
iv. **Cheshire and Merseyside;** £7,040,324 (5%), £8, 091,648 (10%)

Economic modelling does not factor in any additional costs for the extra cases diagnosed, but net benefits are likely to be an underestimate as they do not include savings related to dementia or CKD, and do not take into account the value of Quality Adjusted Life Years (QALYs) gained.

While total financial benefits are calculated for a five year period, benefits will be realised gradually over the five years, not only at the five year point.

For breakdown of economic calculations see appendices.

Local Delivery System performance and KPI targets

Progress towards closing the three 'gaps' will be monitored by a small number of KPIs. The tables below set out current performance and annual targets for each KPI at LDS and Cheshire and Merseyside levels.

Tables: Current performance and quantified targets at LDS and C&M levels for the BP programme KPIs (1-4).

a. KPI1: Number of CCGs with higher than national average hospital admissions for heart attacks and strokes, respectively.

KPI	Description	Target	Baseline and targets	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	Cheshire and Merseyside
KPI1	1a. Number of CCGs with higher than national average hospital admissions for heart attacks	Year on year decrease from baseline (from Y3 to Y5)	**Baseline 2016/17**	**1**	**4**	**2**	**7**
			2017/18	**1**	**4**	**2**	7
			2018/19	**1**	**4**	**2**	7
			2019/20	**0**	**3**	**1**	4
			2020/21	**0**	**2**	**0**	2
			2021/22	0	0	0	0
	1b. Number of CCGs with higher than national average hospital admissions for stroke	Year on year decrease from baseline (from Y3 to Y5)	**Baseline 2016/17**	1	2	1	4
			2017/18	1	2	1	4
			2018/19	1	2	1	4
			2019/20	0	1	0	1
			2020/21	0	0	0	0
			2021/22	0	0	0	0

b. KPI2: Large NHS providers (n=20) meet HWB CQUIN 1b, 'Healthy food for staff, patients and visitors'

KPI	Description	Target	Baseline and targets	Cheshire and Merseyside
KPI2	Large NHS providers (n=20) meet HWB CQUIN 1b, 'Healthy food for staff, patients and visitors'	Year on year increase from baseline	**Baseline 2016/17**	0
			2017/18	0
			2018/19	5 (25%)
			2019/20	10 (50%)
			2020/21	15 (75%)
			2021/22	20 (100%)

c. KPI3: Increase in observed and expected (O/E) BP prevalence ratio

KPI	Description	Target	Baseline and targets	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	Cheshire and Merseyside
KPI3	Increase in observed and expected (O/E) BP prevalence ratio	Measurable increase in O/E hypertension prevalence ratio (equivalent to a 15% increase in diagnosis at 5 years, or 2.83% per annum)	**Baseline O/E ratio 2016/17 (and no. on QoF register)**	0.569 (n=161,921)	0.597 (n=104,838)	0.564 (n=112,414)	0.575 (n=379,173)
			2017/18	n=166,510	n=107,809	n=115,600	n=389,921
			2018/19	n=171,230	n=110,865	n=118,877	n=400,974
			2019/20	n=176,084	n=114,008	n=122,247	n=412,340
			2020/21	n=181,076	n=117,240	n=125,712	n=424,029
			2021/22	0.655 (n=186,209)	0.686 (n= 120,564)	0.648 (n=129,276)	0.661 (n=436,049)

d. KPI4: Increase in % patients treated to target levels (<150/90mmHg) and reduced practice-level variation

KPI	Description	Target	Baseline and targets	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	C&M
KPI4	4a. Increase in % patients treated to target levels (<150/90mmHg)	~1% per annum increase in % patients achieving target BP levels of <150/90mmHg *(Equivalent to increases in the no. of additional people who would have BP controlled if all practices achieved as well as the average of the best achieving practices at baseline by year 5)*	**Baseline 2016/17 no. patients treated to target (and as % on QoF register)**	80.8% (n=130,944)	80.6% (n=84,453)	81.6% (n=92,087)	(n=30,7484)
			2017/18	81.80%	81.60%	82.60%	
			2018/19	82.80%	82.60%	83.60%	
			2019/20	83.80%	83.60%	84.60%	
			2020/21	84.80%	84.60%	85.60%	
			2021/22	85.8% (n=137, 176)	85.6% (n=89,067)	86.6% (n=96, 483)	(n=322,736)
	4b. Practice-level variation in % patients treated to target is reduced	10% reduction in practice level variation per annum, to target of 50% reduction by Y5	**Baseline variation 2016/17**	26%	36.50%	43.60%	
			2017/18	23.40%	22.85%	39.24%	
			2018/19	20.80%	29.20%	34.88%	
			2019/20	18.20%	25.55%	30.52%	
			2020/21	15.60%	21.90%	26.16%	
			2021/22	13%	18.25%	21.80%	

10. Proposed Action Plan

C&M BP Programme Action Plan (2017/18 to 2021/22)

The C&M BP Board will work with the evolving Accountable Care Organisations across C&M to ensure delivery of the action plan. The Senior Accountable Officer is Muna Abdel Aziz, Lead DPH for high BP.

Intervention	Aim	Objective	5YFV gap addressed: Financial	5YFV gap addressed: Health and Wellbeing	5YFV gap addressed: Care and Quality	Lead	KPI	Target KPI change
1. FYFV demand reduction (BP) steering group	Overarching	**Business case**- work up a more detailed business case based on more accurate programme costings, including £ value for QALYs gained, and based on more accurate LDS boundaries. Develop the **risk register** (building on those set out in the PID document) and plans to mitigate risks, using a standardised approach to identification, assessment, recording and reporting of risks. **Stakeholder engagement and communications** plan to mitigate the risk of failure of partners to engage	Y	Y	Y	Eileen O Meara (Lead DPH for PH contribution to FYFV) and Muna Adbel Aziz (Lead DPH for BP)	**KPI1 (Impact):** No. of CCGs with higher than national average hospital admissions for heart attacks and strokes respectively	Year on year reduction from Y3 to target of 0 by Y5
2. System Leadership approach	Overarching	Ensure a **system leadership approach continues** through the cross-sector Board, networks and collaborations that contribute to delivery of the C&M Strategy to tackle high BP 'Saving lives: Reducing the pressure Embed systematic triangulation and review of cross-sector **patient safety measures** into strategy dashboard (e.g. complaints, litigation, incidents etc.).	Y	Y	Y	Muna Abdel Aziz, Lead DPH BP Supported by Mel Roche, Acting PH consultant, Champs Support Team and Gunjit Bandesha (PHE NW)		
3. Population approach to prevention	Prevention	Support the 20 large NHS provider organisations to develop **healthy local policy** to reduce modifiable risk factors for staff, patients and visitors, e.g. in the form of a 'Healthy Provider Declaration' and put in place a package of support around implementation	Y	Y		Robin Ireland, Health Equalities Group	**KPI2 (Prevention):** NHS providers meet HWB CQUIN 1b, 'Healthy food for staff, patients and visitors'	Year on year increase from baseline from Y2 to target of 20/20 by Y5
4. BP awareness raising campaigns	Prevention	**Empower patients and communities to understand key messages:** Maximise the impact of existing national campaigns, particularly Blood Pressure UK's 'Know Your Numbers' campaign (including but not limited to KYN week) linking with community pharmacies, community partners and voluntary sector partners to maximise impact	Y	Y		Tracey Lambert, Champs Support Team		
5. Making Every Contact Count at scale	Detection	**Engage with patients and communities:** Workforce development to enable roll out MECC at scale across primary and secondary healthcare settings, community pharmacies and with non-clinical community partners (e.g. Fire and Rescue Service and voluntary sector organisations). Include basic BP measurement skills and signposting in line with C&M BP pathway. Optimise impact of MECC through use of supporting conversational tool/ technologies.	Y	Y		Collaboration (TBC) between: HEE (TBC) Gunjit Bandesha (PHE NW)- Re conversational tool	**KPI3.** Reduction in gap between observed and expected (O/E) prevalence of high BP	Measurable increase in O/E hypertension prevalence ratio (equivalent to a 15% increase in diagnosis at 5 years)
6. Blood pressure equipment	Detection	Increase the availability of standards compliant **BP machines** and **Ambulatory Blood Pressure Monitoring (ABPM)** to meet local need in relation to MECC and diagnosis, e.g. community pharmacies, community partners (e.g. FRS), general practices, other NHS provider settings.	Y	Y	Y	Depending on funding source: Julie Kelly (NHSE C&M) Helen Cartwright (Champs Support Team)		
7. Primary care education and training programme	Management	Accelerate and support **quality improvement in primary care** with dedicated **education and training programme** that utilises Sector Led Improvement principles (e.g. through a 'Beacon Practice' pilot approach) to support: a. Insight into practice-level benchmarking data b. Improved use of hypertension registers and case finding c. Clinical skills, e.g. BP measurement, prescribing guidelines etc. d. Use and interpretation of 24 hour ambulatory BP monitoring e. Implementation of NICE Guidance f. Audit of performance against NICE Quality Standards g. Closer working with community pharmacies around medicines optimisation (see 7.) h. Knowledge of the sub-regional BP pathway and strategy Initial focus on practices with poorest performance against KPIs 3&4 wound support achievement of rapid return on investment.	Y	Y	Y	Ifeoma Onyia, PH Consultant (in partnership with Dr Bruce Taylor GP, CVD Lead)	**KPI4** **a.** % patients treated to target levels (<150/90mmHg) is increased **b.** practice-level variation in % patients treated to target is reduced	a. ~1% increase per annum in patients achieving target BP levels (<150/90mmHg). (Equivalent to increases in the no. of additional people who would have BP controlled if all practices achieved as well as the average of the best achieving practices at baseline by year 5) b. 50% reduction in practice level variation by Y5, or approximately 10% reduction per annum
8. Medicines Optimisation	Management	Closer working with community pharmacies to improve medicines optimisation through **increased uptake and focus of Medicines Use Reviews (MUR) and New Medicines Service (NMS) on antihypertensive medicines**.	Y	Y	Y	Julie Kelly, NHSE		

a) Annex

b. Appendices

Link to the Cheshire and Merseyside cross-sector blood pressure strategy, ‘Saving lives: Reducing the pressure’

http://www.champspublichealth.com/high-blood-pressure

Cheshire and Merseyside FYFV Working Group

Cross-Cutting Theme/LDS Programme:

Demand Management and Prevention at scale

Service/Theme: Antimicrobial resistance

Date: 27th September 2016

Version No: 1

Senior Responsible Owner (SRO):

Clinical Lead:

Programme Support: Dr Joanna Cartwright, CCDC PHE

Financial Support:

HR Support:

Clients:

1st Your Team

2nd C&M FYFV Working Group

3rd NHSE & ALBs, October 2016 FYFV Submission

Contents

Template – Rationale and Notes for Use

Rationale

The Five Year Forward View (5YFV) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health. It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

The FYFV Executive summary highlights the following:

- The NHS has dramatically improved over the past fifteen years.
- there is now quite broad consensus on what a better future should be
- radical upgrade in prevention and public health
- when people do need health services, patients will gain far greater control of their own care
- the NHS will take decisive steps to break down the barriers in how care is provided
- England is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'
- **Create integrated out-of-hospital care - the Multispecialty Community Provider**
- **Primary and Acute Care Systems**
- **Urgent and emergency care**
- **Smaller hospitals will have new options to help them remain viable**
- **Specialised Care**
- **Midwives will have new options to take charge of the maternity services they offer**
- **The NHS will provide more support for frail older people living in care homes**
- In order to support these changes, the national leadership of the NHS will need to act coherently together, and provide meaningful local flexibility
- We will improve the NHS' ability to undertake research and apply innovation
- it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local

The seven lines in **bold are 'New Models of Care' explained at pp. 20-26 of the 5YFV.** Sustainability & Transformation Plans (FYFVs) are a delivery mechanism for the 5YFV, they are the practical expression of the belief that one of the most powerful ways to achieve change is by working together – across entire communities and pathways of care – to find ways to close the gaps between where we are now and where we need to be in 2020/21.

In October 2016, FYFVs are required to submit more detailed plans to NHSE and the partner ALBs. Completion of these PIDs for our 3 LDSs and 7 Cross-Cutting Themes will allow us to present a consistent and coherent picture of these 10 suites of programmes at the heart of the C&M FYFV.

Use

All Cross-Cutting Theme Leads and LDS Programme Leads are requested to use this template both as a guide and the structure of the description of how the Vanguard/Programme/Initiative is configured, what it is aiming to achieve and the benefits that will accrue. **For all the sections within the template there are brief notes of guidance as to the suggested content for that section at the beginning. These are in italics and maybe left in the document, for the sake of clarity, or deleted when understood, according to the preference of the team compiling the report.**

The current owner of this template is the C&M FYFV Portfolio Management Office (PMO) and, therefore, all suggested amendments to the template should be passed to the PMO.

Executive Summary

The executive summary should contain *only text and include no new material; it should contain only words already found elsewhere in the document. The executive summary should aim to convey all the key messages of the report on a page. It should enable the reader to understand the important points upon which to focus, at a glance.*

AMR is the greatest threat to global health in our lifetime and failure to act now will mean that by 2050, 10 million lives per year will be lost to drug resistant infections and elective surgery, such as hip replacement and caesarean sections, will be high risk.

Cheshire and Merseyside has one of the highest rates of healthcare acquired infection and combined general practice and hospital antibiotic consumption in England.

Investing in action now to reduce unnecessary use of antibiotics will:

- Reduce the development of antibiotic resistance and health care acquired infection
- Save antibiotics for the treatment of serious infections, such as sepsis, thus saving lives
- Reduce morbidity and mortality for patients
- Reduce the number of community acquired infections which require hospitalisation
- Reduce the length of hospital stay
- Reduce the number of bed days lost due to outbreak management and increase the efficiency of the NHS
- Reduce the cost of treating infection as expensive last option antibiotics will not be necessary
- Reduce the overall prescribing costs due to reduce volume of antibiotics being used
- Drive action to prevent infections, such as catheter management and hydration to prevent urinary tract infections

There key priority areas for local action have been identified to complement the national program of work. These are:

- Back Up prescribing,
- Education and training
- Antimicrobial stewardship

Delaying addressing antimicrobial stewardship and resistance will mean it will be much harder to achieve control and we can be certain of is that, in the absence of interventions to slow the emergence of resistance, and improve infection prevention and control that the impacts will be felt not just in isolated areas but at a far more fundamental level, across our societies and healthcare systems. To make the health and social care system sustainable investment is needed now.

1. National, Regional, Local Context

This section should describe *relevant national standards, trends and challenges related to the team/service line activity that is the subject of the document. In particular, NHSE or other Arm's Length Body (ALB) policy guidance, national frameworks and demographic trends are likely to be some of the key points of reference to consider when constructing your vision. However, the section must be concise and limit this description to those aspects that bear directly upon the context in this geographic location.* ***This section should also exploit the NHSE 'FYFV footprint analyses pack for Cheshire and Merseyside' as well as the 'FYFV Aides Memoire'.***

Moreover, this section should go on to describe *relevant regional/local standards, trends and challenges related to the team/ service line activity that is the subject of the document; in particular, regional/local commissioning intention and contractual arrangements. The report should bring into focus any regional/local pilots or projects that have a bearing on the team/service. The key local stakeholders, who are influencing the current and future scope of team/service delivery, should be identified.*

Your Plan for the 'Cross-Cutting Theme' or 'LDS Programme' *should then describe which policies and guidance you will use the change programme as an opportunity to further develop.*

Your content starts here…..

Nationally

'AMR is the greatest threat to global health in our lifetime'

Trends/ challenges

- In total about 700,000 people die every year from drug resistant strains of common bacterial infections, HIV, TB and malaria. This number is likely to be an underestimate due to poor reporting and surveillance.
- It is accepted that that by 2050, 10 million lives a year and a cumulative 100 trillion USD of economic output are at risk due to the rise of drug resistant infections if we do not find proactive solutions now to slow down the rise of drug resistance.
- The greatest burden of morbidity for most infectious diseases, except for those transmitted primarily through sexual contact or injecting drug use, falls on the very young or old.
- The economic burden from infectious diseases in England, including costs to the health service, to the labour market and to individuals themselves, is estimated at £30 billion each year, with a large proportion of these costs incurred because of respiratory or gastrointestinal infections.
- In England, the total consumption of antibiotics in primary and secondary care increased significantly by 6.5% over the last four years; from 21.6 DDD per 1000 inhabitants in 2011 to 23.0 DDD per 1000 inhabitants in 2014. Between 2013 and 2014, total consumption increased by 2.4%.
- Upper respiratory tract infections (URTIs) account for 60% of primary care antibiotic prescribing.
- In 2014, the majority of antibiotics in England were prescribed in general practice (74%), followed by prescribing for hospital inpatients (11%), hospital outpatients (7%), patients seen in dental practices (5%) and patients in other community settings (3%).

- There is limited evidence of benefit re antibiotics: acute otitis media, pharyngitis, acute bronchitis and the common cold.
- Between 2010 and 2014 the rate of bloodstream infections caused by E. coli and K. pneumoniae has increased by 15.6% and 20.8% respectively.
- The number of antibiotic resistant E. coli bloodstream infections has increased overall between 2010 and 2014.
- There has been a 23% reduction in S. pneumoniae bloodstream infections between 2010 and 2014; this may be related to increased pneumococcal vaccination rates.

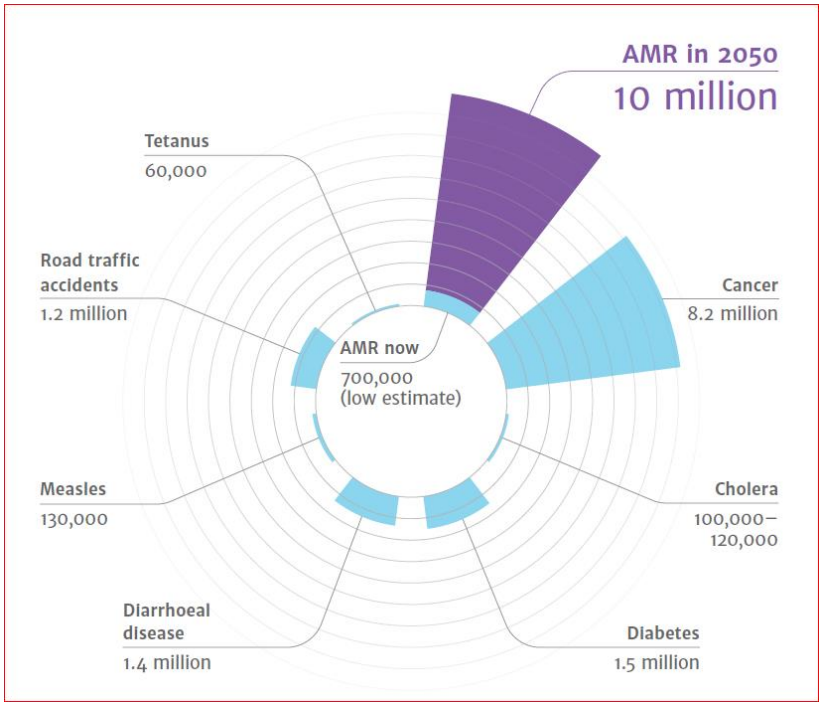
Regional and local

'Cheshire and Merseyside has one of the highest rates of healthcare acquired infection and combined general practice and hospital antibiotic consumption in England.'

Trends/ challenges

- The North West has the highest number of Carbapenemase producing Enterobacteriaceae (CPE) in the UK, these are extremely drug resistant gram negative bacteria
- Cheshire and Merseyside has one of the highest rates of MRSA bacteraemia in England (1.8 per 100,000 population). Cheshire and Merseyside also has one of the highest rates of reported Clostridium difficile in England (31.3 per 100,000 population) (PHE 2016)
- Between 2010 and 2013, the highest combined general practice and hospital antibiotic consumption was in Merseyside, with similar levels reported as Southern Europe with 30.4 DDD per 1,000 inhabitants per day, over 30% higher than Thames Valley with the lowest consumption, (22.8 DDD per 1,000 inhabitants per day).

Global deaths attributable to AMR every year



Review on Antimicrobial Resistance

Standards and Policy context

WHO AMR Global report on surveillance 2014 produced in collaboration with Member States and other partners, provides a picture of the magnitude of AMR and the current state of surveillance globally. The European Centre for Disease Control produced a similar report which provides a picture of the AMR situation in Europe.

In the UK the National Institute for Clinical Excellence Guidance (NG15): Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use provides good practice recommendations on systems and processes for the effective use of antimicrobials.

In addition the UK has the Five Year Antimicrobial Resistance Strategy (2013 to 2018) sets out actions to address the key challenges to AMR with an overarching goal being to slow the development and spread of AMR. It focusses activities around 3 strategic aims:

(1) Improve the knowledge and understanding of AMR
(2) Conserve and steward the effectiveness of existing treatments
(3) Stimulate the development of new antibiotics, diagnostics and novel therapies.

Finally since 2016 in the UK the CQUIN scheme has a target for antimicrobial stewardship which is intended to deliver clinical quality improvements and drive transformational change and the quality premium rewards clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. There is also a focus on reducing antimicrobial resistance and includes incentives for achieving this.

Cheshire & Merseyside Strategy

- Cheshire and Merseyside Antimicrobial Resistance Strategy and Action Plan, launched 2014, in the context of the UK Five Year Antimicrobial Resistance Strategy 2013 to 2018. This was developed by a multiagency cross health and social care group who contributed there time for free, however now investment is need to implement the plan and drive change.
- This document has been created following a three year review by PHE North West's Cheshire and Merseyside Health Protection Team and draws from the findings of five different Antimicrobial Resistance (AMR) steering groups which were set up to explore the following identified local priorities:

1. Back Up prescriptions in primary care
2. Near patient testing/point of care testing
3. Education, awareness-raising and training
4. Developing a comprehensive antibiotic stewardship programme for primary and community care
5. Data and Intelligence

- Within the context of the sub-regional strategy implementation of the action plan is at Clinical Commissioning Group and Local Authority footprint. Each locality has established a multidisciplinary AMR working group to progress implementation.
- AMR is a standing item on the Health Protection Fora through which the Directors of Public Health gain assurance with regard to Health Protection.
- National risk register contains AMR as well as the Cheshire and Merseyside LHRP risk register.

Key local stakeholders

Implementation of the strategy action plan requires cross sectoral involvement, but absolutely key are commissioners and providers including:

- 9 Local Authorities
- 12 CCGs
- Acute and Community Trusts
- Primary Care providers
- Care and nursing homes
- Community pharmacies

At a national and regional level there are many organisations with involvement and a vested interest in addressing antimicrobial resistance including:

- NICE
- Health Education England
- The Royal Colleges
- Public Health England NW
- NHS E C&M
- Cheshire and Merseyside Public Health Collaborative (ChaMPs)
- Primary and secondary education
- Undergraduate and postgraduate Medical, Dental, Nursing and Veterinarian education

Not addressing this issue will mean that within the next 5 years hospital beds will be closed due to outbreaks; deaths will occur from untreatable infections; and length of hospital stay will increase due to resistant health care acquired infections. To make the health and social care system sustainable investment is needed now.

2. Assumptions & Constraints

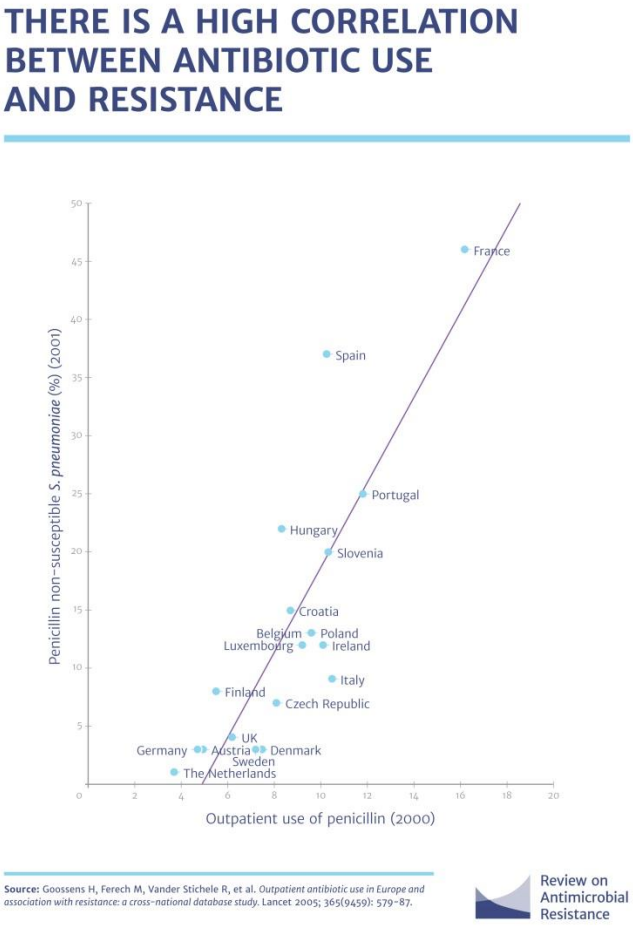
Assumptions and constraints will describe *the context, given the continuing work to redefine and optimise pathways and services that each programme will need to support and underpin. This will include a series of assumptions and constraints about how the pathways or services will operate in the future.*

Your Plan *should then describe which how your programme relates to, and contributes towards, the changes required in these pathways or services and how you will use them as parameters for your design work.*

Your content starts here…..

Assumptions and constraints

- A key assumption is that a reduction in inappropriate antibiotic prescribing will reduce the number of resistant infections associated with high mortality and cost.
- What is known is that countries with high antibiotic use have high levels of resistant infections and that antibiotic consumption drives the development of resistance in both pathogens and normal bacteria carried by individuals without any harm.



- Without good antimicrobial stewardship and infection prevention and control practices in health, social care and community settings the existing multidrug resistant infections will continue to spread.
- New resistance patterns are developing at a faster rate than the development of new antimicrobial agents.
- Investment in the development and then judicious use of antibiotics and new antimicrobial agents is required so that treatment options for resistant infections remain.
- Reduction in antimicrobial use needs to be global and across all sectors including agriculture and veterinary practice.
- Alternative sources of antibiotics, such as the internet and cross counter sales, need to be restricted.
- The development of rapid diagnostics could transform the way we use antimicrobials in humans and animals: reducing unnecessary use, slowing AMR and so making existing drugs last longer, however, this will require investment
- Austerity and financial pressure across all sectors limits resources and opportunities
- The reduction in demand and use of antibiotics requires a universal program of public and professional education and fundamental change in behaviour.

- There is a potential conflict of the reduction in inappropriate antibiotic usage and the early recognition and treatment of sepsis to save lives.

There is work at a national and international level to address many of the above constraints.

3. Model of Care and/or Service Model

The profile for the pathway/service line being described *should contain information regarding, but not limited to, the following;*

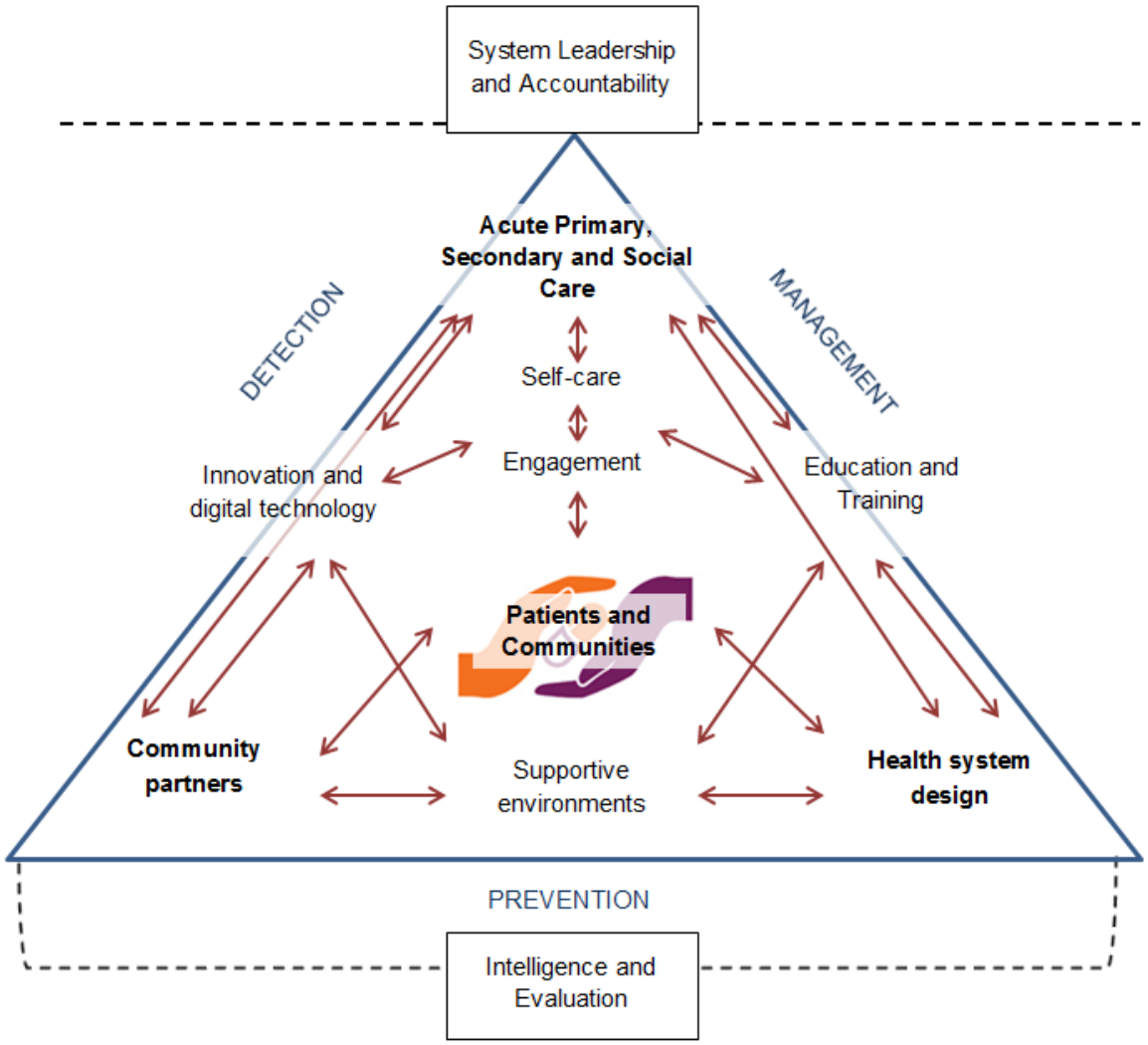
- *The model of care, including how the three dimensions of quality will be delivered:*
  - *Patient Safety*
  - *Patient Experience*
  - *Clinical Effectiveness*

- *The Service Model, including:*
  - *Sub specialities*
  - *Location(s) of pathway/service delivery*
  - *Attributes of pathway/service delivery (those that merit highlighting)*

Your Plan *should then describe which aspects of the model of care and service model you will use the change programme as an opportunity to further enhance.*

Your content starts here….

The model proposed is embedded within the Cheshire and Merseyside Cross-sector approach to tackle AMR.



It focuses on the role of health and care providers but with clear and strong links with a wide range of partners across the system. Our model of care focuses on empowering patients and communities, enhancing the role of community pharmacies in managing infections which do not require antibiotics and being gate keepers for dispensing antibiotics.

How the model will deliver the 3 dimensions of quality:

- **Patient safety**
  In order to ensure public and patient safety is not compromised, oversight by the NHSE with CCGs of complaints, litigation, incidents (and near misses), Patient Advice and Liaison Service, and patient experience reports from key stakeholders in relation to antibiotic prescribing is important.
  Addressing the over use of antimicrobials will reduce the risk of patients acquiring multidrug resistant healthcare acquired infections and the preservation of the ability to perform safe elective and emergency surgery. This will also reduce the length of hospital stay, patient morbidity and mortality.

- **Patient experience**
  The North West has secured the pilot for the National Public Engagement campaign for AMR. As part of this focus groups will be held to ascertain people's views regarding AMR and the reduction in inappropriate prescribing.
  Patient experience will be improved due to reduced hospital stay and ease of discharge. There will be improved quality of care with timely treatment and reduced anxiety for patients.

  In the evaluation of the pilot patient experience will be examined.

- **Clinical effectiveness**
  The overall reduction in antibiotic prescribing in primary and secondary care result will result in specific antimicrobial use for specific infections and giving a better outcome for the patient
  The reduction in prescribing of broad spectrum antibiotics in primary and secondary care will result in a reduction in prescribing costs making it coct-effective.
  The implementation of delayed prescribing will maintain treatment options for severe infections, ultimately preserving life.
  Delayed prescribing has also been shown over time to reduce the demand for primary care consultations.
  There has been agreed a Pan-Mersey formulary which takes into account local resistance patterns. In addition this has been adopted by Cheshire, Warrington and Wirral leading to consistency and standardisation of prescribing.
  In addition there has been a change in laboratory reporting across Cheshire and Merseyside so that there are consistent messages given to prescribers when bacteria found are normal and not representative of infection leading to reduced prescribing.

The service model focuses on:

- Patients and communities and the role of self-care
- Community partners
- Community pharmacies
- The primary care team
- Dental practices
- Secondary care
- Social care settings

Attributes

The implementation of the AMR action plan across Cheshire and Merseyside seek to gain consistency of action through multiple interventions which together will change public and professional expectations and practice. It is only by all aspects of the health and social care system along with a public awareness campaign that public and professional behaviour change will be achieved.

4. Performance

Performance should describe *the current, as well as trend, levels of demand for the pathway/service being defined; this information should be contrasted with the current, as well as trend, capacity in*

the pathway/service. This should lead to an explanation of the current, as well as trend, level of activity.

***Your Plan** should then describe which dimensions of the performance you will use the change programme to further transform and any opportunities for business development that you use the programme to exploit.*

Your content starts here…..
Nationally, PHE produces a quarterly AMR surveillance data work book and template. The workbook contains antibiotic susceptibility testing data voluntarily submitted to the AmSurv system that is presented by PHE Centre geographies and England. The organism/antibiotic combinations presented in the work book are based on recommendations in the UK 5 Year Antimicrobial Resistance Strategy 2013 to 2018.

A panel of metrics will be used to monitor progress. This will also allow comparison between areas at local authority and LDS level to the average for England and the North West.

The panel of metrics includes:

Antimicrobial Resistance

- CCG-assigned MRSA rates by CCG and financial year
- % of E. coli blood specimens with susceptibility tests to a carbapenem; by quarter
- % of E. coli blood specimens with susceptibility tests to a 3rd Generation Cephalosporin; by quarter
- % of E. coli blood specimens with susceptibility tests to ciprofloxacin; by quarter
- % of E. coli blood specimens with susceptibility tests to gentamicin; by quarter
- % of E. coli blood specimens with susceptibility tests to piperacillin/tazobactam; by quarter
- % of community E. coli urine specimens with susceptibility tests to trimethoprim; by quarter
- % of community E. coli positive urine specimens non-susceptible to trimethoprim; by quarter
- % of community E. coli urine specimens with susceptibility tests to nitrofurantoin; by quarter
- % of community E. coli positive urine specimens non-susceptible to nitrofurantoin; by quarter

Antibiotic Prescribing

- Total number of prescribed antibiotic items per 1000 resident individuals by quarter
- Total number of prescribed antibiotic items per STAR-PU by quarter
- % of prescribed antibiotic items from cephalosporin, quinolone and co-amoxiclav class by quarter
- Twelve month rolling total number of prescribed antibiotic items per 1000 individuals per day
- Twelve month rolling total number of prescribed antibiotic items per STAR-PU
- Twelve month rolling % of prescribed antibiotic items from cephalosporin, quinolone and co-amoxiclav class

- Proportion of trimethoprim class prescribed antibiotic items as a ratio of trimethoprim to nitrofurantoin by quarter

Health Care Associated Infection

- All C. difficile rates by CCG and financial year
- All MRSA bacteraemia rates by CCG and financial Year
- CCG-assigned MRSA rates by CCG and financial year
- All MSSA rates by CCG and financial year
- All E. coli bacteraemia rates by CCG and Financial Year
- All E. coli bacteraemia counts by CCG and month
- All C. difficile counts by CCG and month
- Trust-assigned MRSA counts by CCG and financial year
- Third party-assigned MRSA counts by CCG and financial year
- All MRSA bacteraemia counts by CCG and month
- Trust-assigned MRSA bacteraemia counts by CCG and month
- CCG-assigned MRSA bacteraemia counts by CCG and month
- Third party-assigned MRSA bacteraemia counts by CCG and month
- All MSSA bacteraemia counts by CCG and month

Antimicrobial Stewardship engagement indicator

- Antibiotic Guardians per 100,000 population per calendar year by CCGs

Current activity/ demand (and trends)

- Medicines management within CCGs have data at an individual practice level, this shows that when delayed prescribing is implemented then antimicrobial prescribing starts to reduce. Investment is needed to support practices in implementing delayed prescribing.
- Data on prescribing is publically available at Local Authority level via 'Fingertips'. This shows that antimicrobial prescribing in Cheshire and Merseyside remains in the highest quintile for England.
- The 'AMR workbooks' provide drug /bug combination resistance data at LA level. This allows microbiological prescribing advice to be given to primary care regarding the best first choice antimicrobial. Investment in community microbiologists is needed to make this available across Cheshire and Merseyside.
- Secondary care review prescribing data on a monthly basis, but investment in antimicrobial pharmacists is needed to ensure that this happens reliably and in sufficient depth.
- Dental prescribing will be available at practice level by the end of the year, allowing high prescribing practices to be identified and supported to change practice.
- In 2017/ 18 targets have been set for Acute Trusts to publish:
    - total and broad-spectrum antibiotic prescribing by Defined Daily Dose (DDD) per 1000 admissions (2016/17 AMR CQUIN data)
    - The proportion of antibiotic prescriptions that are reviewed within 72 hours (2016/17 AMR CQUIN data)
    - Hospital-onset *E. coli* bloodstream infection (BSI) rates per occupied bed-days

- For Clinical Commissioning Groups to publish:
    - Rates of resistance to nitrofurantoin and trimethoprim among *E. coli* and other coliforms isolated from urine specimens submitted from the community
    - Ratio of trimethoprim to nitrofurantoin prescribing in community settings
- Over the last year a reduction in primary care prescribing has been demonstrated, however due to the high prescribing baseline Cheshire and Merseyside remains in the top quintile for antibiotic prescribing.

5. Staffing

This section should describe *all those staff groups that make a substantive contribution to the delivery of the pathway/service being described. The current numbers, as well as the trends, should be graphically demonstrated for the following groups:*

- *Social Care*
- *Medical*
- *Nursing*
- *Allied Health Professionals (AHP)*
- *Managerial*
- *Administrative and Clerical*

This section should also address the current position and trends relating to:

- *Sickness and absence*
- *Annual appraisals*
- *Recruitments and retention*
- *Availability*
- *Productivity*
- *Any on-going actions in response to staff surveys*

Your Plan *should then describe which aspects of the pathway/service staffing you will use the change programme as an opportunity to further develop.*

Your content starts here…..

Due to the nature of the cross-sector approach, the staffing groups that contribute to the delivery of the AMR reaches into many thousands, enabling actions at pace and scale. Key staff groups include:

- Community pharmacy staff
- Community dental staff
- Primary care teams including GPs, Practice nurses, Health care workers, receptionists
- Secondary care- Microbiologists, pharmacists, junior doctors, consultants, nursing staff.
- Directors of Public Health
- Quality leads in CCGs
- Medicines management leads

Key issues

- There is very limited availability of GP champions to help practices implement delayed prescribing and antibiotic audit. These champions need protected/ paid sessions in order to do this.
- Community microbiology advice is very limited. Again designated paid sessions are needed though this resource could be shared between areas with smaller populations.
- In secondary care there are pharmacists with AMR in their portfolio however this time is often not protected and vulnerable to not being prioritised during times of staffing pressures.
- Data on non- medical prescribers is not reported separately from the medical principle they prescribe for.
- Prescribing data is not available for private dental practices.
- For any prescription issued there is a six month window for it to be dispensed and this means that community pharmacists are key to ensuring that any antibiotics prescribed are for the current episode of illness and not for a subsequent episode. This will require additional time and may require an increase in the number of community pharmacies

Information Management & Technology

This section should describe *the current, as well as planned use of IM&T as an enabler to the aims of the programme. The analysis should include current experience with IM&T including issues that cause problems. The levels of capability to use the IT systems should feature along with levels of support and training required.*

Your Plan *should then describe what new systems and other IM&T solutions form part of the wider improvement aspirations for the pathway/service and how they will be realised.*

Your content starts here…..

Across Cheshire and Merseyside there is a need to implement electronic prescribing as some practices continue to use paper prescriptions. Prescribing at out of hours services and accident and emergency units is not reflected in the prescribing data.

In addition a patient information system which allows different organisations to see when a patient has a resistant infection alert on their notes from another Trust is needed. This will allow the receiving service to isolate the patient effectively, treat any infection appropriately and prevent spread of the resistant organism to others.

6. Facilities & Estates

This section should describe *the future plans for pathway/service within a given environment(s). There will be a description of the facilities that will be required by, and made available to, the pathway/service as well as a comprehensive understanding of the space to be occupied. The section will also include details of equipment requirements that may be new or significant enhancements.*

Your Plan *should then describe how the pathway/service will deliver its vision for the future within the new environment.*

Your content starts here…..

The AMR action plan can be put into place within existing facilities and estates belonging to key stakeholder partners, largely in community pharmacies, primary and secondary care.

Community pharmacies already have space for private consultations regarding the issue of antibiotic including a review of symptoms, although the capacity may need to be increased.

Improvement in available of molecular diagnostic techniques.

7. Interdependencies

This section should describe *the current interdependencies that the pathway/service has with other teams and services. This includes both those products and services you require from others to operate successfully as well as those products and services that you provide which are essential to the operations of others. Any current issues should be highlighted along with the plans for the plans to resolve them.*

Your Plan *should then describe how those interdependencies will be assured through the programme of change. This could be by reference to programme participation as stakeholders; joining/monitoring a programme upon which you may have a key interdependency. Alternatively, you may simply choose to reference the specific programme plan that will be addressing that interdependency.*

Your content starts here…..
Within this system, a wide range of interdependencies and partnership working is evolving between key stakeholders.

There are key interdependencies with:

- Healthcare-associated infection and infection prevention and control programmes, including:
    - reduction of infections in the first instance, and therefore need for antibiotics for example, reduction of urinary tract infections in care homes,
    - ensuring infections are diagnosed and treated quickly and effectively in line with treatment regimens
- Primary care quality improvement and medicines management programmes to tackle variation in quality of prescribing in primary care, including:
    - implementation of antimicrobial stewardship
    - comprehensive implementation of delayed/back-up prescribing
    - improving access to expert advice
    - robust education and training for prescribers on AMR
- Care home quality improvement programmes e.g. the care home award scheme recently piloted in Cheshire & Merseyside
- Public awareness, self-care and demand management programmes
- IT development programmes
- Laboratory
- Emergency planning, response and resilience programme

- Undergraduate and postgraduate education programmes

Key stakeholders include:

- 12 CCGs
- NHSE (C&M)
- NHS Providers
- Dentistry
- Community pharmacies
- PHE (NW and national)
- Cheshire and Merseyside Public Health Collaborative (Champs)
- Local Authorities
- Patient groups and representatives
- Health Education England
- Care home sector

The importance of interdependency is embedded within the Cheshire and Merseyside AMR strategy and action-plan. There has been multiagency multidisciplinary participation in developing the overarching strategy and action-plan for Cheshire and Merseyside. The programme steering group will be reviewed to assure the interdependencies.
Key outputs and outcomes from across the system will be captured into a single indicator panel metrics to support assurance.

At Local Authority/CCG level, local groups are at different stages of development to oversee implementation at a local level, and will include relevant local stakeholders across linked programmes. AMR is reported to Health and Wellbeing Boards through local Health Protection Fora, with different arrangements at local level to report through NHS Quality Fora. AMR has been added to the risk register of the Local Health Resilience Partnerships (LHRPs) in Cheshire and in Merseyside, and progress against plans will be monitored by the partnerships.

8. Benefits

This section should describe *the impact the programme will have on the following three 'gaps' which are at the heart of the 5YFV:*

- ***The health and wellbeing gap:*** *if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.*
- ***The care and quality gap:*** *unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.*
- ***The funding and efficiency gap:*** *if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.*

Your Plan *should then describe which benefits will accrue against which 'gap' in terms of* ***baseline, target, and planned trend of improvement to meet the benefit target in time****. The objectives to support benefits realisation should be SMART objectives, that is: Specific, Measurable, Achievable, Realistic, Time bound.*

Your content starts here…..

Benefits to the health and wellbeing gap
If AMR is not addressed then within our lifetime surgery such as hip replacement will become too risky to perform due to the risk of infection and emergency surgery will have a high mortality risk as infections will not be able to be prevented or treated.

In addition, death due to community acquired infections, which were previously easily treated, will increase. The burden of this will fall disproportionately on the very young and very old, as well as on the least affluent part of society as this is where the greatest burden of disease lies. This will widen health inequalities.

Addressing the issue of AMR has the potential to reduce the length of hospital stay; reduce delays in time to surgery; reduce the cost of pharmaceuticals and facilitate patient discharge. These efficiencies could then be reinvested to introduce rapid diagnostics to further improve prescribing and infection prevention and control.

The care and quality gap
Without action and investment antibiotic resistance will continue to spread and new resistances develop for infections that can currently be treated. Over the last two years the rate of development of new resistance patterns has been far more rapid than expected.

As a result serious infections such as septicaemia will not be treatable and mortality will increase. Already antibiotics which were abandoned because of their severe side effects have to be used to treat such infections.

The number of urine infections which are resistant to antibiotics has increased year on year, requiring hospital admission and prolonging length of stay. The level of resistance will continue to rise unless preventative strategies are implemented.

In hospitals where outbreaks of multidrug resistant infection have occurred, the number of bed closures necessary to control the outbreak has led to severe pressures and has had a high financial and reputational cost to the organisation.

The funding and efficiency gap
At present it is not known what the return on investment for antimicrobial resistance is, however, PHE (Statistics and Modelling team) are estimating key parameters that can be used to estimate the cost of resistant infections in healthcare settings and (in the longer term) AMR in the community.

It is clear doing nothing is not an option, as this will mean that in the long term more will have to be spent to address antimicrobial resistance. Where the evidence of effectiveness is lacking, evaluation is a key part of the intervention.

To fully implement the action plan investment will be needed as there is not capacity in the system to accommodate the additional actions. The action plan is a suite of interventions which are synergistic and need to happen consistently across the Cheshire and Merseyside footprint. The effect of the whole will be greater than the sum of the parts.

9. Proposed Action Plan

The art of the Action Plan is to *ensure that it is comprehensive, compelling and timely. The Action Plan should address all of the salient points highlighted in the other sections of the report; namely, all those points where* ***Your Plan*** *will act as a change programme to help close the three gaps. As such, and like the executive summary, it should therefore contain no information that does not already appear in the contents of the PID.*

Otherwise, the content of the Action Plan should deliver milestones which address, but are not limited to, the following three 'gaps' (as described in the 'Benefits' Section above):

- ***The health and wellbeing gap:*** *if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.*
- ***The care and quality gap:*** *unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.*
- ***The funding and efficiency gap:*** *if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.*

The 5YFV states that none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there. Changes to capacity and or activity in response to trends in demand

The Action Plan should also promote accountability by having a named individual for each task. Finally, the action planning must provide assurance as to how the change will be made to happen and that there is the capacity and capability in place to underpin delivery. All action plans should be governed by a Programme Board or similar entity.

Your content starts here…..

Cheshire and Merseyside Antimicrobial Resistance Strategy Action Plan – Overarching Areas for Development

	Area for Development	Suggested Action Plan	RAGB	Responsible persons / body	Evidence
1.	Ensure every Trust, Community Trust, [including non-medical prescribers] and CCG has an AMR action plan	➢ Obtain assurances that every trust has an AMR action plan ➢ Obtain assurances that every trust has an Antimicrobial Stewardship Committee			
2.	Implement Back Up Prescribing for the treatment of upper respiratory tract infections Audit post implementation (read code 8BPO)	➢ Implement Back Up Prescribing via Practitioner-Centred Approach or Patient-Centred Approach (see appendix 2) ➢ Consider implementation in Accident and Emergency Departments, Walk-In Centres, Out Of Hours and with Non-Medical Practitioners. Consistency can be achieved by harmonising access to GP records. ➢ Consider involving Healthwatch prior to implementation			
3.	Engagement – Pharmacy	➢ Ensure consistent messages are given by all prescribers and all			

	Care Homes	pharmacists. ➢ Pharmacies should support the AMR strategy as appropriate ➢ Consider scaling up of the Care Home Hygiene Award Scheme			
4.	Ensure AMR awareness, stewardship and training is delivered to all prescribers, non-medical prescribers and health care workers	➢ Target all prescribers (medical, non-medical, pharmacists) and consider including AMR in yearly mandatory training ➢ There are many training national resources available to support training (see appendix 2) ➢ Training should aim to address and meet the PHE Antimicrobial prescribing and stewardship competencies (see appendix 3)			
5.	Support public facing media campaigns to aid and inform about Antimicrobial Resistance	➢ Local Authorities and CCGs should consider local engagement with any national or international AMR campaigns and plan local activities to promote the initiative ➢ Dates where AMR can be promoted locally are: 1. European Antibiotic Awareness Day in mid-November[1] 2. The World Health Organisation's			

[1] http://ecdc.europa.eu/en/EAAD/Pages/Home.aspx

		World Antibiotic Awareness Week in mid-November[2]			
6.	Implementation of AMR and Stewardship education at the primary and secondary school level	➢ It is recommended that the free 'e-Bug' resource produced by PHE is utilised in all schools to encourage a generational change in the attitude to the use of antibiotics http://www.e-bug.eu/			
7.	Identify a dedicated Community Microbiologist function to support AMR Stewardship	➢ Ensure protected sessions are available and consider whether these can be enhanced to a more proactive and accessible clinical advisor service for GPs and other antibiotic prescribers in the community			
8.	Identify an Antimicrobial Stewardship Lead GP	➢ Establish whether this role exists already ➢ If not, consideration should be given to how this resource can be identified and secured			
9.	Ensure that every secondary care trust is implementing PHE Start Smart - Then Focus toolkit (best practice recommendations)	➢ Obtain assurances that every trust has implemented the tool kit, including a ward-focused antimicrobial team			
10.	Ensure that every GP Practice is implementing	➢ Obtain assurances that every GP			

[2] http://www.who.int/mediacentre/events/2015/world-antibiotic-awareness-week/event/en/

	TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) (best practice recommendations)	Practice has implemented the tool kit			
11.	Ensure every Trust and CCG has an Antimicrobial Pharmacist and ensure that they are provided with sufficient protected time to fulfil this role	➢ Obtain assurances that every trust has a dedicated Antimicrobial Pharmacist			
12.	Ascertain assurances that community antimicrobial formularies are confluent with secondary care antimicrobial formularies and obtain assurances that community antimicrobial formularies are used by primary care prescribers	➢ Primary and secondary care formularies should dovetail ➢ Obtain assurances that Community Antimicrobial Formularies exist and include information regarding Antimicrobial Resistance			

Cheshire and Merseyside Antimicrobial Resistance Strategy Action Plan by Responsible Body

Members of the Public Health England North West's Cheshire and Merseyside's Health Protection Team attended the Cheshire and Merseyside Directors of Public Health System Leadership Meeting on 15th July 2016. The AMR strategy and action plan was presented to the Directors of Public Health. This was a constructive meeting where several outcomes were agreed.

This included agreement to progress the action plan and assign actions for each responsible body:

	Responsible Body	Area for Development	Suggested Action Plan	RAGB	Evidence
1.	Clinical Commissioning Groups	Every CCG should have an AMR Action Plan	➢ Obtain assurance ➢ A comprehensive AMR action plan that covers primary and secondary care is crucial for assurance and ongoing monitoring of local AMR activities		
		Every CCG should have an AMR Steering Group	➢ Obtain assurance		
		Every CCG should have an Antimicrobial Stewardship Lead GP	➢ Establish whether this role exists already ➢ If not, consideration should be given to how this resource can be identified and secured		
		Every CCG should ensure AMR awareness, stewardship and	➢ Target all prescribers (medical, non-medical, pharmacists) and consider		

		training is delivered to all prescribers, non-medical prescribers and healthcare workers (including in community settings such as district nurses and nursing home staff) across the CCG footprint and to consider including this in mandatory training	including AMR in yearly mandatory training ➢ There are many training national resources available to support training (see appendix 2) ➢ Training should aim to address and meet the PHE Antimicrobial prescribing and stewardship competencies (see appendix 3)		
		Every CCG should identify a dedicated Community Microbiologist function to support AMR Stewardship	➢ Ensure protected sessions are available and consider whether these can be enhanced to a more proactive and accessible clinical advisor service for GPs and other antibiotic prescribers in the community		
		Every CCG should ensure that there are resources to fund an Antimicrobial Pharmacist and that there is sufficient protected time to fulfil this role	➢ Obtain assurances that every trust has a dedicated Antimicrobial Pharmacist		
		Every CCG should seek assurances from primary, secondary and tertiary care Trusts that they are progressing the AMR Action Plan and the areas for development that are specific to primary, secondary and tertiary care	➢ Obtain assurances		
		Every CCG should provide	➢ Obtain assurances		

		assurances that the AMR Action Plan is progressing in primary, secondary and tertiary care to the Directors of Public Health via the Health Protection Forum			
		Every CCG should consider the required reduction in prescribing antibiotics necessary for CCGs to move from the current level of antibiotic prescribing (and associated quintile) to the lowest quintile (associated with the lowest level of antibiotic prescribing) when linking this to the relevant CQUIN and Quality Premium	➢ Further information can be found here: ➢ https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/amr-cquin/ ➢ https://www.england.nhs.uk/wp-content/uploads/2016/03/qualty-prem-guid-2016-17.pdf		
		Every CCG should ascertain assurances that community antimicrobial formularies are confluent with secondary and tertiary care antimicrobial formularies and obtain assurances that appropriate community antimicrobial formularies are used by primary care prescribers	➢ Primary, secondary and tertiary care formularies should dovetail ➢ Obtain assurances that Community Antimicrobial Formularies exist and include information about Antimicrobial Resistance		
		Every CCG should support public facing media campaigns to aid and inform about Antimicrobial Resistance	➢ Local Authorities and CCGs should consider local engagement with any national or international AMR campaigns and plan local activities to promote the initiative ➢ Dates where AMR can be promoted locally are:		

			➢ European Antibiotic Awareness Day in mid-November[3] ➢ The World Health Organisation's World Antibiotic Awareness Week in mid-November[4]		
		Every CCG should share the Antimicrobial Resistance Strategy Action Plan and Checklist for Cheshire and Merseyside 2016 with appropriate stakeholders and partners	➢ Namely: -Primary Care Organisations -Secondary and Tertiary Care Organisations -Pharmacies -NHS England		
2.	Primary Care Organisations	Every GP Surgery should have an AMR Action Plan	➢ Obtain assurances		
		Every GP Surgery should have implemented and be utilising Back Up Prescribing	➢ Implement Back Up Prescribing via Practitioner-Centred Approach or Patient-Centred Approach (see appendix 2) ➢ Consider implementation in Accident and Emergency Departments, Walk-In Centres, Out Of Hours and with Non-Medical Practitioners. Consistency can be achieved by harmonising access to GP records. ➢ Consider involving Healthwatch prior to implementation		
		AMR awareness, stewardship and	➢ Target all prescribers (medical, non-		

[3] http://ecdc.europa.eu/en/EAAD/Pages/Home.aspx
[4] http://www.who.int/mediacentre/events/2015/world-antibiotic-awareness-week/event/en/

		training should be delivered to all prescribers / non-medical prescribers and healthcare workers. Consideration should be given to including this in mandatory training	medical, pharmacists) and consider including AMR in yearly mandatory training ➢ There are many training national resources available to support training (see appendix 2) ➢ Training should aim to address and meet the PHE Antimicrobial prescribing and stewardship competencies (see appendix 3)		
		GP Surgeries should support public facing media campaigns to aid and inform about Antimicrobial Resistance	➢ Local Authorities and CCGs should consider local engagement with any national or international AMR campaigns and plan local activities to promote the initiative ➢ Dates where AMR can be promoted locally are: 3. European Antibiotic Awareness Day in mid-November[5] 4. The World Health Organisation's World Antibiotic Awareness Week in mid-November[6]		
		There should be an Antimicrobial Stewardship Lead GP for each GP Practice	➢ Establish whether this role exists already ➢ If not, consideration should be given to how this resource can be identified		

[5] http://ecdc.europa.eu/en/EAAD/Pages/Home.aspx
[6] http://www.who.int/mediacentre/events/2015/world-antibiotic-awareness-week/event/en/

			and secured		
		Ensure every GP Practice has implemented the RCGP / PHE TARGET Toolkit	➢ Obtain assurances that every GP Practice Is using the RCGP / TARGET Toolkit ➢ http://www.rcgp.org.uk/clinical-and-research/toolkits/target-antibiotics-toolkit.aspx		
		Ascertain assurances that community antimicrobial formularies are confluent with secondary care antimicrobial formularies and obtain assurances that community antimicrobial formularies are used by primary care prescribers	➢ Primary and secondary care formularies should dovetail ➢ Obtain assurances that Community Antimicrobial Formularies exist and include information regarding Antimicrobial Resistance		
3.	Secondary and Tertiary Care Organisations	Ensure the Trust has an AMR Action Plan	➢ Obtain assurances		
		Ensure Trusts support and implement Back Up Prescribing where appropriate (e.g. A&E)	➢ Ensure Accident and Emergency Departments are aware of and engage with the local and national AMR Strategy, particularly supporting Back Up Prescribing ➢ Consideration should be given to linking primary care medical and medication records with secondary and tertiary care hospital IT systems to ensure continuity of care. This will help ensure that secondary care clinicians are aware of any recent or pending Back Up Prescriptions when		

			patients attend Accident and Emergency Departments		
		Ensure AMR awareness, stewardship and training is delivered to all prescribers / non-medical prescribers and healthcare workers – consider including this in mandatory training	➢ Target all prescribers (medical, non-medical, pharmacists) and consider including AMR in yearly mandatory training ➢ There are many training national resources available to support training (see appendix 2) ➢ Training should aim to address and meet the PHE Antimicrobial prescribing and stewardship competencies (see appendix 3)		
		Support public facing media campaigns to aid and inform about Antimicrobial Resistance	➢ Local Authorities and CCGs should consider local engagement with any national or international AMR campaigns and plan local activities to promote the initiative ➢ Dates where AMR can be promoted locally are: European Antibiotic Awareness Day in mid-November[7] ➢ The World Health Organisation's World Antibiotic Awareness Week in mid-November[8]		
		Ensure implementation of PHE Start Smart – Then Focus Toolkit	➢ Obtain assurances that every trust has implemented the tool kit, including a		

[7] http://ecdc.europa.eu/en/EAAD/Pages/Home.aspx
[8] http://www.who.int/mediacentre/events/2015/world-antibiotic-awareness-week/event/en/

			ward-focused antimicrobial team ➢ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF		
		Ensure every Trust has an Antimicrobial Pharmacist that is provided with sufficient protected time to fulfil the role	➢ Obtain assurances that every trust has a dedicated Antimicrobial Pharmacist		
		Ascertain assurances that community antimicrobial formularies are confluent with secondary care antimicrobial formularies and obtain assurances that community antimicrobial formularies are used by primary care prescribers	➢ Primary and secondary care formularies should dovetail ➢ Obtain assurances that Community Antimicrobial Formularies exist and include information regarding Antimicrobial Resistance		
4.	Pharmacies	Ensure Pharmacy engagement with the local and national AMR Strategy	➢ Pharmacies should support the AMR strategy as appropriate		
		Ensure consistent messages are given by all pharmacists in line with the local and national AMR strategy, particularly around supporting Back Up Prescribing	➢ Pharmacies should support the AMR strategy as appropriate		
5.	Directors of Public Health	Directors of Public Health should receive assurances from CCGs via Health Protection Fora that the AMR Strategy and Action Plan are progressing	➢ Obtain assurances		
		Implement AMR and Stewardship education at the primary and secondary school level (e.g. utilise	➢ It is recommended that the free 'e-Bug' resource produced by PHE is		

		e-Bugs resource)	utilised in all schools to encourage a generational change in the attitude to the use of antibiotics ➢ http://www.e-bug.eu/		
6.	NHS England	NHSE should support the implementation of the AMR Strategy and Action Plan where appropriate	➢ Provision of support where needed or requested		
		NHSE will obtain assurances that the AMR Strategy and Action Plan is progressing via Quality Surveillance Groups (QSGs)	➢ Obtain assurances		
7.	Public Health England North West Centre	Public Health England North West's Cheshire and Merseyside Centre will brief the Clinical Commissioning Groups (CCGs) on the AMR strategy and action plan at the CCG Committee(s)-in-common	➢ Briefing and support will be provided to CCGs as required		
		PHENW will provide expert advice and support where there are issues progressing the action plan	➢ Provision of support when requested		
		PHENW will provide oversight by attending Quality Surveillance Groups	➢ Attendance at Quality and Surveillance Groups		
		PHENW will provide oversight by attending Health Protection Fora	➢ Attendance at Health Protection Fora		
		PHENW to consider ways of scaling up Care Home Hygiene Award Scheme	➢ Local engagement, develop and provision of resources		

a) Annex

The aim of an annex is to *add greater details, visuals and examples for better understanding of the main document (e.g. Performance – you may wish to display a visual as an annex to refer to from the text within this section)*

Your content starts here…..

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2. Appendices

An appendix is different from an annex in that it *can be considered without the main text; it is a document in its own right that still makes sense if it stands alone. It cannot be added to the main text but still has importance as regards the original document.*

Your content starts here…..