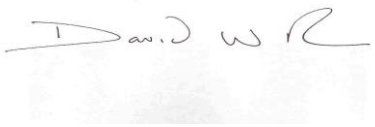
Public Document Pack

Health Policy and Performance Board

Tuesday, 27 February 2018 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

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

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.
The next meeting of the Board is to be confirmed.

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

Part I

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

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 28 November 2017 at Council Chamber, Runcorn Town Hall

Present: Councillors J. Lowe (Chair), Osborne (Vice-Chair), S. Baker, E. Cargill, Dennett, Horabin, M. Lloyd Jones and Parker

Apologies for Absence: Councillor Sinnott

Absence declared on Council business: None

Officers present: S. Wallace-Bonner, A. Jones, D. Nolan, L Wilson, H. Moir, L. Willis and E. O'Meara

Also in attendance: A. Williamson – Halton Safeguarding Adults Board; R. Ashworth and C. Lightfoot – OPEN

ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HEA23 MINUTES

The Minutes of the meeting held on 19 September 2017 having been circulated were signed as a correct record.

HEA24 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA25 HEALTH AND WELLBEING MINUTES

The draft minutes of the Health and Wellbeing Board from its meeting on 4 October 2017 were presented to the Board for information.

RESOLVED: That the minutes be noted.

HEA26 PRESENTATION: HALTON OLDER PEOPLE'S EMPOWERMENT NETWORK (OPEN)

The Board received a presentation from Richard Ashworth, Chair of Halton Older Peoples Empowerment Network (OPEN), and Clare Lightfoot, Forum Development

Officer, on the work undertaken by the Forum in the Borough.

Members were advised that Halton OPEN was established in 2001 and had become the collective voice of people aged 50 plus who lived and worked in Halton. Presently the membership was over 1,100 members. Their aim was to influence and encourage the development of services which could help to improve the quality of life and wellbeing of all older people in Halton. Halton OPEN worked with other agencies in the Borough including Halton Borough Council; Age UK Mid Mersey; Halton Clinical Commissioning Group (CCG) and Halton Partners in Prevention.

The presentation discussed the main issues affecting older people in Halton such as access to public transport; financial issues such as pensions, fuel bills and benefits; isolation/loneliness and health and wellbeing.

Members were advised that an annual telephone survey was carried out for the first time this year relating to isolation and loneliness and it was explained how this was conducted by the staff. Examples of responses of those people contacted were provided to the Board. It was reported that between 30% and 40% of respondents felt lonely and/or isolated.

Mr Ashworth advised the Board of the key successes for 2017 and how Halton OPEN was raising awareness of the forum in the Borough. He ended by outlining the future plans for Halton OPEN which included the improvement of the flow of information via the website, newsletters and information booklets.

Further to Members queries the following was noted:

- The leaflets referred to would be made available to Members for distribution to their constituents;
- Halton OPEN did not host social events as this was not its purpose and they did not have funding for this;
- Halton OPEN did attend other people's events when invited to do so, for example they recently attended an event at the Heath Business Park, to raise awareness of the organisation;
- The forum encouraged older people to do things for themselves and provided them with information to be able to do so, such as who to contact and directing them to an organisation that can help them and so on. However, if a member requested it they would

accompany an individual to an appointment.

RESOLVED: That the Board welcomes the presentation and notes the contents of the report.

Director of Adult Social Services

Mr Tom Baker, Co-Optee to the Health Policy and Performance Board, declared a Disclosable Other Interest in the following item as he was a Board Member of the Halton Safeguarding Adults Board.

HEA27 HALTON SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2016-2017

The Board received the Halton Safeguarding Adults Board (HSAB) Annual Report for 1 April 2016 to 31 March 2017, which was attached at Appendix A. The report was presented by Audrey Williamson, Chair of the HSAB.

It was noted that the Annual Report fulfilled one of the Safeguarding Adults Board's three core statutory duties which were to:

1. Develop and publish a strategic plan setting out how they would meet their objectives and how their member and partner agencies would contribute;
2. Publish an Annual Report detailing how effective their work had been; and
3. Commission safeguarding adults reviews (SARs) for any cases which met the criteria for these.

It was reported that all members of HSAB, HSAB sub-group chairs and the Safeguarding Adults Partnership Forum members were invited to submit an annual summary of their work activity. The focus of work activity addressed HSAB's priorities as identified from the 2015-16 Annual Report, Performance Framework and Strategic Plan (2016-2018), in addition to acknowledging local and national safeguarding adults emerging issues / trends / policies throughout the year.

The report provided a summary analysis of the data gathered from both NHS Halton Clinical Commissioning Group and Halton Borough Council's Safeguarding Adults Collection and highlighted what this information meant, for informing the work priorities for 2017-18. The work priorities for 2017-18 were agreed as follows:

1. Creating a safer place to live for all adults living in Halton (Safeguarding Prevention);
2. Providing the skills and knowledge to enable genuine

care and understanding for adults at risk of harm (Awareness Raising and Training); and

3. Gaining a greater understanding of how mental health can impact adults at risk being protected and cared for in the best way possible (Mental Health).

Members raised concerns over the growing numbers of homeless people who may have mental health issues and substance abuse issues and how they would be represented by the HSAB. In response it was agreed that this was a growing problem and would be highlighted to the Board. The Board was advised that multi agency risk assessments were being carried out with regards to mental health services and the importance of partnership working was stressed. It was noted that recognising problems at an early stage was important to prevent an illness from developing. Members noted that Halton's Citizen Advice Bureau had trained staff in suicide awareness.

RESOLVED: That the Board receives the Halton Safeguarding Adults Board Annual Report for 2016-17.

HEA28 GYPSY & TRAVELLER SERVICE : POLICY REVIEW

The Board received a report from the Strategic Director, People, which informed them of the annual review of Halton Gypsy Travellers Allocations Policy 2017-18. The *Gypsy and Traveller Sites – Pitch Allocation Policy (July 2017*) was appended to the report.

It was noted that the Policy was reviewed annually to ensure it was current and fully compliant with legislation and outlined the pitch allocation and illegal encampment procedure.

Information was provided in the report regarding the accommodation sites within Halton that were owned and managed by the Council and the private sites available. Unauthorised encampments since January 2017 had totalled 16, which were mainly in Runcorn, and the report discussed the protocol devised jointly between the Council and the Police, to deal with these.

The report further discussed issues at a local level with regards to managing the sites and the work of the Gypsy and Traveller Liaison Officer (GTLO).

Members discussed the procedure for applying for a vacant pitch, once it was advertised by the Council. One Member requested to know the total numbers of children on

the sites; this information would be provided to the Board following the meeting as it was not readily available. The Vice-Chair requested on behalf of the Board, that a visit of the traveller sites be made in the near future.

RESOLVED: That the Board noted the report and associated appendix and comments made with regards to this.

Director of Adult Social Services

HEA29 HALTON SUICIDE PREVENTION STRATEGY : UPDATE

The Board received a report from the Strategic Director People, which presented an update on progress in implementing the Halton Suicide Prevention Strategy (2015-2020). This was attached to the report at Appendix 1.

It was reported that suicide was a major public health issue and each suicide in Halton was an individual tragedy and a terrible loss to local families and communities. The numbers of people who took their own life in Halton each year were low, however those ending their own life should be viewed as the tip of the iceberg, and locally levels of distress and suicide attempts would be much higher. So although deaths by suicide in Halton were low, there was still a need for continuing vigilance and action around suicide prevention.

The report discussed the Strategy and its vision; areas for action; and outcomes and key achievements. It also provided information on the *Halton Suicide Prevention Partnership* multi agency group.

Members discussed the data relating to suicides in Halton and it was commented that some incidents may go unreported as the data could only include those deaths given a suicide verdict by the Coroner.

It was noted that the report and Strategy was based on data available in 2013; as the figures of suicide were low in Halton, it was necessary to do analysis's every 3 years.

RESOLVED: That the Board

1) notes the report and Strategy; and

2) supports the continued implementation of the Strategy, recommendations and actions.

HEA30 TELECARE CHARGING POLICY, PROCEDURE AND PRACTICE 2017

The Board received a report from the Strategic Director, People, which provided details of the Telecare Charging Policy, Procedure and Practice 2017, which was appended to the report at Appendix 1.

Members were advised that Halton Telecare Service (formally Lifeline) has been established for over 27 years. During this time, the services had grown from a static onsite warden service to a fully operational, assessment, installation and response service. Telecare has the potential to benefit people who may need care and support by increasing their confidence and helping them to remain in their own homes. The service was for anyone who felt at risk or vulnerable in their own homes and people chose to use the service for a variety of reasons as discussed in the report.

The report outlined the three service levels and the charges for these per week. It also provided information of the review of the charging methods for Telecare and the development of the Telecare Charging Policy, which was carried out by a task and finish group formed in January 2017. Appendix 2 contained information of the methods of payment and Appendix 3 gave the Telecare charges from April 2017.

Members welcomed the Policy, Procedure and Practice for Charging and agreed it presented a fairer system for the public.

RESOLVED: That the Board note the contents of the report and associated appendices.

HEA31 PERFORMANCE MANAGEMENT REPORT: QUARTER 2 2017/18

The Board received the Performance Management Reports for Quarter 2 of 2017/18. The Health Policy and Performance Board played a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities.

Members were advised that the report introduced, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to health in quarter 2, which included a description of factors which were

affecting the service.

The Board was requested to consider the progress and performance information and raise any questions or points for clarification and highlight any areas of interest or concern for reporting at future meetings of the Board. Members received and noted the Performance Management reports for Quarter 2 of 2017/18.

RESOLVED: That the Quarter 2 priority based reports be received.

Meeting ended at 8.08 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 27 February 2018

REPORTING OFFICER: Strategic Director, Community & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO:	Health Policy Performance Board
DATE:	27th February 2018
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Domiciliary Care in Halton
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To receive a presentation from Premier Care Limited, Halton Borough Council's lead contracted domiciliary care agency, regarding domiciliary care provision in Halton.

2.0 RECOMMENDED: that the Board

1. **Note the contents of the report and associated presentation.**

3.0 SUPPORTING INFORMATION

3.1 One of the main drives over the past decade both locally and nationally has been to offer support to people in their own home for as long a period as is possible. One of the most effective ways to do this has been through offering care and support to people in their own home through a domiciliary care agency.

Over the past 12 months, Halton have undertaken the re-procurement of domiciliary care provision within the Borough which has led to there being one main provider, Premier Care delivering provision, where there has previously being 9 providers.

Although there is one main provider, the existing contract with Premier Care, along with 3 other incumbent providers, has been extended until 31st March 2018, to allow those agencies to work together to establish a robust sub-contracting arrangement and support and strengthen local market providers.

3.2 The purpose of the presentation will be to provide Board Members with details of how the current system of Domiciliary Care provision works in Halton

The presentation will include an overview of implementation of the new contract arrangements, the challenges that have been encountered and how we (Premier Care and the Borough Council) are working together to maintain the delivery of high quality services to our local population.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified

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

6.1 **Children & Young People in Halton**
None identified.

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

6.3 **A Healthy Halton**
Domiciliary Care provision in Halton supports the Council's strategic priority of Improving Health.

6.4 **A Safer Halton**
None identified.

6.5 **Environment and Regeneration in Halton**
None identified.

7.0 **RISK ANALYSIS**

7.1 No risks associated with this report have been identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment is not required for this report.

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

9.1 None identified.

REPORT TO:	Health Policy Performance Board
DATE:	27 February 2018
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	One Halton Place Based Care
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To receive a presentation from David Parr, Chief Executive, Halton Borough Council on One Halton Place Based Care.

2.0 RECOMMENDED: that the Board note the contents of the report and associated presentation.

3.0 SUPPORTING INFORMATION

3.1 Following the departure of NHS Halton CCG's Interim Accountable Officer, the presentation will provide an overview to the Board on the arrangements that have been in place since 4th February 2018.

3.2 The arrangements in place will reinforce and continue to build upon the excellent relationship the Borough Council has with the CCG, in addressing the issues associated with the health and well-being of the residents of Halton.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified.

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

6.3 **A Healthy Halton**
The aims and objectives of NHS Halton CCG are directly linked to this priority.

6.4 **A Safer Halton**
None identified.

6.5 **Environment and Regeneration in Halton**
None identified.

7.0 **RISK ANALYSIS**

7.1 No risks associated with this report have been identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment is not required for this report.

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

9.1 None identified.

REPORT TO: Health Policy & Performance Board

DATE: 27 February 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Adults

SUBJECT: Scrutiny Review Report – Health Improvement Team

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with the draft Scrutiny Review report of the Health Improvement Team for approval to go forward to Executive Board.

2.0 **RECOMMENDATION: That the Board:**

i) **Comment on the findings of the Scrutiny Review;**
ii) **Endorse the Scrutiny Review and its recommendations to go forward to the Executive Board; and**
iii) **Consider scrutiny topics for 2018/19.**

3.0 **SUPPORTING INFORMATION**

3.1 Commissioning of the report

3.1.1 This report (attached as Appendix 1) was commissioned by the Health Policy and Performance Board. A scrutiny review working group was established and support was given by a Principal Policy Officer from the policy team and the Divisional Manager – Integrated Wellbeing Services.

3.1.2 The Board felt the scrutiny was timely given the HIT transfer to Council services in 2014 and the evolution and embedding of services since this period.

3.1.3 As a result a topic group was formed and the scrutiny process took place between June and November 2017.

3.1.4 Councillor Joan Lowe chaired the group and Members were asked to attend on an open invitation across the duration of the topic group.

3.2 Scrutiny review

3.2.1 The review involved the participation of seven Elected Members and the Health Policy and Performance Board's Healthwatch representative.

3.2.2 Activity undertaken included:

- Monthly meetings of the scrutiny topic group;
- Presentations and discussions with key stakeholders – included representation across the HIT, within the Council and with partner agencies;
- Attendance at difference classes delivered by the HIT;
- Attendance at a partnership meeting led by the HIT.

3.2.3 The Board identified six recommendations as a result of the topic group. Approval is now sought to take these recommendations forward to the Executive Board.

3.2.4 It should be noted that following the completion of the review the ring-fenced Health Improvement budget has been extended for a further twelve months.

3.3 Scrutiny Review 2018/19

3.3.1 As part of Member involvement in the current business planning process a range of topic areas have been identified for consideration for scrutiny during the municipal year 2018/19:

- Care Homes – Funding and Sustainability
- Supported Housing/Accommodation Review
- Acute Trusts/Acute Mental Health – National pressures and how these translate into local pressures.
- Accountable Care System

3.3.2 These are now open to discussion, and may be added to based the identification of additional topic areas.

3.3.3 It is intended that a final topic area will be chosen and a project brief ratified at the next Board meeting.

4.0 POLICY IMPLICATIONS

4.1 Existing policies are endorsed by the report. Further development of policy, procedure and practice may result from adoption of the recommendations. This will be undertaken by the service area.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The recommendations highlight a need to open up discussions around the future of HIT services in the light of the removal of ring-fenced budgets (now indicated for 31st March 2020 as per 3.2.4).

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
N/A

6.2 **Employment, Learning & Skills in Halton**
N/A

6.3 **A Healthy Halton**

The scrutiny review report and recommendations support the Council's strategic priority of Improving Health. Taking on board the recommendations from the report will support services which impact positively on the health and wellbeing of the borough's population.

6.4 **A Safer Halton**

N/A

6.5 **Halton's Urban Renewal**

N/A

7.0 **RISK ANALYSIS**

7.1 The report and recommendations support the Council's strategic priority of Improving Health. Taking on board the recommendations from the report will secure the future of services.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The scrutiny report considered the HIT in the context of opportunity and access. The range and scope of services considers the needs of the communities across Halton.

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

9.1 None under the meaning of the Act.

HALTON BOROUGH COUNCIL

Health Policy & Performance Board

Scrutiny Review of The Health Improvement Team (HIT)

Report December 2017

Contents:

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report, as outlined in the initial topic brief (Appendix One) is to:

- To understand the range and scope of interventions, activities and campaigns delivered through the Health Improvement Team service (HITs), including pathways into service.
- To appreciate how service priorities are identified and analyse any gaps in service against the health and wellbeing concern across the borough.
- To examine current performance data and explore the impact measures the service utilises to measure success.
- To consider how services are promoted and celebrated, including how public engagement is achieved.
- To reflect on the contribution the service makes to the Council's Public Health remit.
- To observe how well the HITs interacts and compliments with other health and social care services across the borough, including partnership work with other agencies and the third sector.
- To consider the impact of changes in legislation (including the Care Act 2014) in shaping the service offer.
- To compare and benchmark the service offer with other best practice delivery models.
- To offer constructive input into the future direction of the service.

2.0 POLICY AND PERFORMANCE BOARD (PPB)

2.1 This review was commissioned by the Health PPB and the topic formally adopted at the June 2017 meeting.

2.2 This report will be presented to Health PPB in February 2018. The report will also be presented to People Directorate Senior Management Team, Executive Board and boards or committees of stakeholders, as appropriate.

3.0 MEMBERSHIP OF THE TOPIC GROUP

3.1 An open invitation to participate in the scrutiny group was made to all members of the Health PPB. The table below details which PPB members and officers participated in the review:

3.2

Councillor Joan Lowe (Chair)	Councillor Margaret Horabin
Councillor Martha Lloyd-Jones	Councillor Mark Dennett
Councillor Pauline Sinnott	Mr Tom Baker (HealthWatch)
Councillor Stan Parker	Lisa Taylor, Divisional Manager, Integrated Wellbeing Service
Councillor Ellen Cargill	Nicola Hallmark, Principal Policy Officer, Adult Social Care, People Directorate

3.3 The Schedule of Activity (Appendix Two) shows the visiting presenters who contributed to the topic review.

3.4 **The Chair would like to extend thanks to all of those who took the time to participate in this review.**

4.0 METHODOLOGY

4.1 This scrutiny review was conducted through the following means:

- Information pack provided to Topic Group Members outlining the local delivery model of Health Improvement Services and examining progress against national performance indicators;
- Monthly meetings of the scrutiny review topic group;
- Reports and presentations made by key members of staff and project/campaign partners;
- Site visits to scheduled classes, at which there was opportunity to capture service-user contribution;
- Attendance at a partnership meeting;
- The final draft of this report was circulated to participating staff to check for accuracy.

5.0 BACKGROUND

5.1 The Health Improvement Team (HIT) together with the Sure Start to Later Life (SSLL) team provide an Integrated Wellness Service on a cradle to grave basis intended to deliver against health and social care agendas at a community level. Their range of activities span focused campaigns through to tailored services.

5.2 HIT has been in operation for almost 15 years and has advanced through turbulent times during a vast array of transformation and restructure across health and social care.

5.3 The original service began as a Big Lottery funded ‘Healthy Living Programme’ and a small Halton Primary Care Trust ‘health promotion’ function that was eventually merged to form a health improvement team within Halton and St Helen’s PCT. Following the removal of the PCT the service transferred to Bridgewater Community Healthcare NHS Foundation Trust with whom Halton Borough Council (HBC) contracted to deliver local health and wellbeing services.

5.4 The Health and Social Care Act 2012 gave each unitary and upper tier local authority the duty to improve the health of the people in its area as part of new Public Health functions. Ring-fenced grants support delivery of services and local authorities work within a defined structure to achieve a broad remit of aims and objectives. While most other authorities looked to continue commissioning services HBC wanted to further focus resource on a local level.

5.5 In 2014 an innovative and unique proposal, approved by HBC Executive Board, brought HITs in its entirety over to HBC, as a service jointly managed under Public Health and Adult Social Care. The staffing teams were TUPE

transferred over to the Council however some staff retained NHS terms and conditions due in part to the potential negative impact on long-standing pensions.

5.6 The introduction of the Care Act 2014 placed emphasis on the concept of 'Wellbeing' and on preventing and delaying the need for more complex care interventions. This cements the health promotion role that HITs undertakes as a key function of the Council's delivery of services to keep its community fit and well.

5.7 The work of HIT compliments other services, contracts and partnerships designed to impact on achievement against the Public Health Outcomes Framework (PHOF). The service remit is further governed by National Institute for Health and Care Excellence (NICE) guidance and standards, NHS National Service Frameworks (NSF), Adult Social Care Outcome Framework (ASCOF), and the measures set against a variety of funded project work taken on.

5.8 The HIT workforce comprises of a highly skilled staffing body of 54 people, working various patterns of full-time and part-time hours (the hours worked equate to 49.53 full-time equivalent posts). The range of disciplines covered by the activities undertaken is backed by training, and where appropriate registration with professional or accredited bodies.

5.9 The team structure allows for specialist and universal roles in order that the wide spectrum of delivery approaches are sustainable. Individual consultations, appointment-based sessions and classes run across the borough in community venues, schools and in people's homes. With Health Trainers based in each of Halton GP surgeries HIT are able to operate as an extension to primary care teams to achieve an effective interface with the public.

5.10 HITs operate a 'single point of access' approach to services. This means that whatever referral route is taken the individual's coming into services have access to the full remit of activities and interventions. This enables involvement to achieve number of outcomes, for example, someone starting out on a smoking cessation programme may also wish to access a 'Fresh Start' healthy eating programme. This would not require a second formal referral in order to gain admission to the offer.

6.0 EVIDENCE, ANALYSIS AND CONCLUSIONS

6.1 Opportunity and access

6.1.1 The Board were provided with a comprehensive overview of the scope and span of programmes offered through the HIT. They were informed that these sat within three main function areas which span the target age ranges of the services:

- **Start Well** – covers infant, early years and children's programmes.
- **Live Well** – under which the majority of work with adults is undertaken.
- **Age Well** – focusses more specifically at older people's needs.

6.1.2 Background information was given to provide context and understanding around the evolution of the service. Prior to its integration into the Council workforce the HIT only undertook a small remit of older people's provision. The assimilation completed the life cycle approach under which the service is now represented as an 'Integrated Wellbeing Service'.

6.1.3 The HIT is managed by Lisa Taylor, as Divisional Manager, who is in turn managed jointly by Eileen O'Meara, Director of Public Health and Sue Wallace-Bonner, Director of Adult Social Services. This ensures that joint working is embedded into the HIT structure. The Board learnt that HIT also has a strong and supportive relationship with NHS Halton Clinical Commissioning Group (HCCG) and has wide ranging collaborations and contact with statutory, private and voluntary groups across the community.

6.1.4 The majority of the work programmes and campaign activity delivered is governed by National Institute for Clinical Excellence (NICE) guidelines, the Adult Social Care Outcomes Framework (ASCOF), the Public Health Outcomes Framework, the five key priority areas set within the Council's 'Health and Wellbeing Strategy', and other Council-led priorities. It was heard that the services' work is intended to be robust, innovative and based on the delivery of evidence-based practice.

6.1.5 **Start Well** works under the sub-heading of 'Giving every child in Halton the best start in life'. Activity includes support of infant feeding and breastfeeding; work with families, including a Positive Parenting Programme; support in early years settings and with childminders; and a schedule of work within schools and with school-age children, including the 'Healthy Schools Programme' and a family-focussed 'Fit 4 Life' agenda.

6.1.6 **Live Well** centres on 'Helping adults' lead healthier, more active lives'. Here, awareness raising, health checks, screenings, lifestyle changes and direct interventions are delivered upon. Examples of work areas included the establishment of health trainers being based in GP practices; the 'Fresh Start' weight management service; smoking cessation activity; specialist exercise and lifestyle programmes for those with additional health needs such as cancer, respiratory problems or muscular skeletal difficulties; cancer awareness and screening campaigns; mental health awareness and promotion; and education work around the effects and recommended consumption levels of alcohol.

6.1.7 **Age Well** is aimed at 'Supporting healthy and active ageing for all Halton residents'. Concerns tackled across this area include loneliness and social isolation through befriending activity and community-based interventions, such as the Monday Lunch Club and the Community Garden; preventative, treatment and rehabilitation programmes for those at risk of falls, who have suffered from a stroke or other physically debilitating illness or condition; training and awareness campaigns, including dementia awareness and screening tools to look at memory loss, risk of falls and loneliness.

6.1.8 Key outcome measures for 2016 were presented to the Board from the 'Halton Integrated Wellbeing Service Performance Review – Jan-Dec 2016'. These

indicated an effective throughput of service users and showed that key target outcomes had been met (Some of the notable outcomes presented to the Board can be found in Appendix Three).

6.1.9 In addition to the ongoing activity, programmes of work, interventions and targeted campaigns the HIT deliver against a training remit. The Board heard that they operate as an accredited training centre for the Royal Society of Public Health and City and Guilds for provision of a Level 2 qualification in Understanding Health Improvement and a Level 3 Health Trainer Award, respectively. They undertake brief intervention training with local businesses (including health and social care providers), primary care teams and other front-line professionals.

6.1.10 The HIT operate a single front-door access point through their dedicated phone line and webpages. Interest and uptake also comes through from other referral points such as Community Nursing, the Midwifery Service, Social Services and GP surgeries. HIT has a team of Health Trainers who regularly based themselves in GP surgeries and who also undertake health checks and screenings within community venues.

6.1.11 From attendance at a 'Breathe Better' class it was learned that the HIT have specialist responsibility for dedicated services. The class, involving recovering heart failure patients and those with pulmonary disease forms part of the rehabilitation pathway from hospital care (for more information see site visit report - Appendix Four – Breathe Better).

6.1.12 Access to services is determined by individual requirements. Health and social care professionals identify need but also residents themselves. With the 'Fresh Start' programme, people can self-refer and this is often based on the experiences of family or friends (for more information see site visit report – Appendix Five – Fresh Start). Open access programme were seen to form a large part of the dissemination of Public Health messages.

6.1.13 Community-based venues are utilised for the majority of programmes and a split between Runcorn and Widnes was identified. The HIT acknowledged a reliance on people coming to them, with the exception of activities like home-based breastfeeding support and schools programmes. This suggests that those with mobility or transport needs could be in danger of finding services inaccessible. Planned work to overcome barriers to access is already underway, and includes:

- Collaborative work within residential care homes;
- A closer relationship with Care Management teams for signposting and early intervention;
- A recently appointed post – Health and Wellbeing Officer (Housing) - which is co- funded via Halton Housing, Adult Social Care, and Halton CCG, and aimed at permeating hard-to-reach and home-bound audiences.

6.1.14 Monitoring takes place to ensure that services are full utilised. Some activity was cited as seasonally fluctuating. Where downturns in attendance are identified the HIT will look to review the provision.

Conclusions

6.1.15 The range and depth of activity and scheduled work undertaken by the HIT was well received by the Board. The life span approach to health and wellbeing, combined with targets interventions, were applauded and felt to be an asset to the residents of Halton.

6.1.16 Service gaps and changes in priorities were recognised and accounted for and while some service access deficits were identified work is already planned to meet needs.

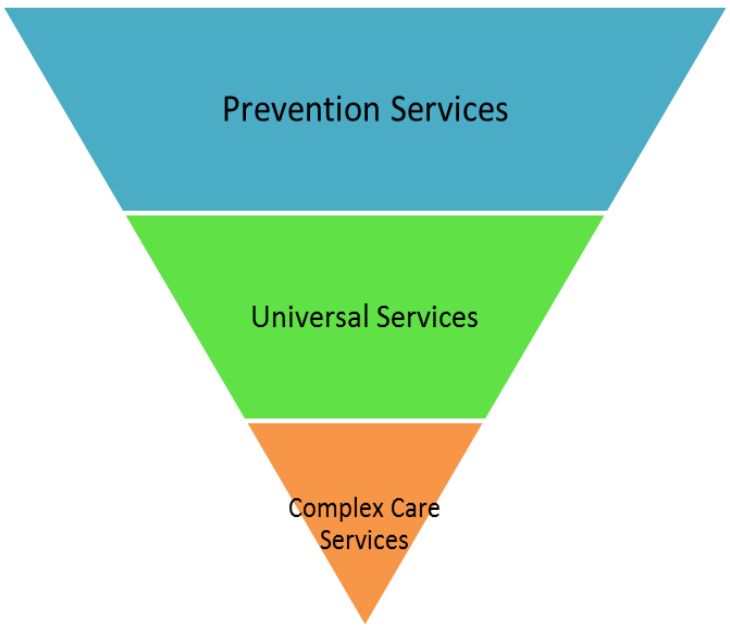
6.2 Working to a prevention model

6.2.1 The Care Act 2014 represented the most significant change to social care legislation in the past 60 years. A renewed and duty-driven focus on prevention and delay of needs was welcomed by the HIT as a large proportion of their work revolves around early intervention, health and wellbeing education and lifestyle changes.

6.2.3 The Board learnt how the services offered through HIT have the potential to impact positively on the 'prevention agenda'. It was stated that the service transferred to the Council to coincide with the legislative changes under the Care Act. In addition it coincided with the transition of Public Health services into local government.

6.2.4 Since transferring to the Council the HIT service offer has evolved and expanded. This was cited as a planned approach aimed at steering the flow of health and social care services towards a more proactive regime which emphasizes prevention and early intervention. A demand management model (see figure 1.1 below) was submitted to represent a repositioning of focus to ensure that not only are people living healthy lives but also that health and social care resource is effectively allocated:

Figure 1.1



6.2.5 While the main focus of the HIT sits within the concerns of Prevention Services it was conveyed that ongoing effort is being made to assure links with Universal (including Primary Care, signposting and low level social care support) and Complex Care Services (where more intense packages of care might be commissioned or hospital admission might be required). Partnership working was seen to be a key feature of the achievements of the HIT. This is aided by the community presence evident in their offer but also through active and ongoing relationship building.

6.2.6 A pilot programme was highlighted to evidence the service impact on prevention. This involved follow-up calls to routine issue of cancer screening kits. The pilot was based on the premise that early detection of cancer is pivotal to effective treatment. For this particular piece of work the HIT looked at bowel cancer screening kits, posted to people following their 60th birthday. Personal contact was made with those who failed to return their kit and a 10% increase in involvement was achieved.

6.2.7 Another programme – the Impaired Glucose Regulation Programme – was showcased. This involved work with GPs to identify and work with those who have raised glucose levels in blood tests and who may be considered 'pre-diabetic'. Intervention involved looking at healthier lifestyle choices.

6.2.8 In respect of older people's need a newly appointed Practice Manager to the HIT presented to the Board on a future vision for the Age Well service. This centres on prevention and delay of need with plans to work more closely with the Council's Reablement, Social Care in Practice and Hospital Discharge teams on issues of frailty, falls prevention, social isolation and dementia screening. The aim would be to make a cultural shift away from 'crisis management' to concentrate on enabling independence and rehabilitation.

Conclusions

6.2.9 It is acknowledged that preventing and delaying the need for more complex care and support is a priority that involves continued intervention. The Board were in agreement that long-term sustainability of the HIT is needed to ensure that the prevention agenda is effective.

6.2.10 It was widely recognised that Halton, as a borough, has some inherent health and wellbeing issues. The coverage of HIT services across a life-span approach is supported by the Board as an effective mechanism for embedding long-term cultural changes.

6.3 Service funding

6.3.1 A reoccurring theme throughout the topic groups involved recognition that funding for Health Improvement, from the Public Health budget, will see its ring-fence removed on 31st March 2019. This is a national concern with the potential that investment in health improvement services is diminished in the light of continued financial pressures across local government.

6.3.2 Within Halton the primary source of funding for the HIT comes from the ring-fenced Public Health budget. Other funding is received through adult social care, on an incremental and informal basis from NHS HCCG and grant-based project and activity is undertaken to fit with community priorities and available resource.

6.3.2 The HIT currently make nominal charges for some services, such as exercise classes within their lifestyle programmes. These are made directly to the service user and it has been found that charging can, in some instances, assure commitment to a programme of activity.

6.3.4 Charges made are used as revenue to sustain and develop HIT services. While the HIT try to use free-of-charge venues for the community-based activities they do on occasion have to use chargeable ones in order to ensure a spread of access points across the borough. Some of the fees are therefore used to boost the spread of location covered.

6.3.5 Income generation is actively sought through funding bids and contract work. A more recent award of £75,000 was referred to in respect of work to be undertaken to tackle the prevalence of smoking during pregnancy. It was stated that contract work and grant funding has generated over £125,000 for the HIT service during 2016/17.

6.3.6 The Healthy Schools Programme was highlighted as a particular success within Halton with 100% of schools being signed up. This revolves around a core programme of activity with a menu of additional support (covered Personal, Social and Health Education [PSHE], Weight Management programmes and school meals intervention) to meet localised needs. It was noted that schools programmes are currently not charged for, including work with Academies.

6.3.7 As part of their training arm of their activity the HIT charge local businesses, pharmacies (through the CCG) and the Fire Service for development sessions. It was not indicated that the charges made were based on a formally constituted pricing structure.

6.3.8 The role the HIT play in delivering against NHS HCCG objectives was widely recognised and celebrated within the topic group review. It was acknowledged by Public Health and the NHS HCCG that the HIT have a role to play in proposed 'Accountable Care Systems', set to see a greater alignment of "responsibility for resources and population health"[1] through delivery against Sustainability and Transformation Plans. Working arrangements between HIT and the NHS HCCG and are not currently formalised.

Conclusions

6.3.9 Concerns were raised over the future of funding for the HIT services. A number of routes and options were indicated for consideration in respect of partnership arrangements and service charges.

[1] http://healthcareleadernews.com/article/what's-difference-between-acs-and-aco

6.4 Promoting Services and engaging with appropriate networks

6.4.1 The Board heard that the HIT work with care management, trading standards, primary care, voluntary and third-sector groups, schools, private sector organisations and have representation on relevant committees, networks and boards (including the Transport Reference Group, Partners in Prevention, the NHS HCCG Service Development Committee, the Older People's Pathway Group, the Transforming Domiciliary Care Board and many others). Collaborative working was revealed to be paramount to achieving the reach of the service.

6.4.2 The integral need for the HIT to work in partnership with others was further expanded upon by Eileen O'Meara, Director of Public Health. She confirmed that Health Improvement forms one strand of the delivery requirements placed on Public Health. Within that strand the HIT are a focal point for achievement of designated Health Improvement outcomes but these are also impacted on through a range of other services and providers.

6.4.3 During the period of topic group attendance was made to the Active Halton Steering Group. This group is chaired by Lisa Taylor with the aim of raising levels of physical activity across the borough through the utilisation of existing resource, provision mapping and combined working. It brings together officers from across Council services and more widely from providers commissioned against a specific health and wellbeing remit. Representation on the group includes health improvement specialists, leisure services, sports development, early years and play co-ordinators, schools improvement, the youth parliament and Young Addaction. It was noted that the partners worked well together, sharing and re-directing resources towards needs.

6.4.5 Campaign activity forms a large part of the HIT remit, together with rolling programmes aimed at lifestyle changes and the management of long-term conditions as well as project work. Campaigns cover a wide range of health messages as defined by Public Health priorities including smoking cessation, alcohol awareness, cancer awareness and screening, general and targeted health checks, and mental health awareness. The HIT also undertake seasonal and focussed campaign activity such as the promotion winter flu jabs through to a full schedule of events for 'Older People's Week'. While many of these campaigns also require planning and delivery in conjunction with other services (for example Primary Care) the foremost need is to achieve public engagement. To this end the Board were familiarised with the marketing function of the HIT service. While the Council operate a consolidated marketing 'Centre of Excellence' the HIT has been afforded the opportunity to retain a dedicated marketing function to fulfil the demand to achieve a prominent public presence.

6.4.6 Targeted marketing and promotional materials were presented to the Board. These were represented by a range of posters, leaflets and other print materials and promotional items. The Board also heard about the use of the print media and the increasing value of social media. Interactive methods of conveying health messages, such as physical quantities of sugar to show the

content in certain drinks, are regularly employed and personal contact is made to reinforce messages and stimulate action.

6.4.7 The Board asked about Elected Member involvement in events and determined a gap in connections made.

6.4.8 Marketing within the HIT forms a strategic part of the success of the service. An example was presented in respect of planned campaigns to raise awareness around both flu and sepsis. Planned messages have been staggered over a time span to ensure that similar symptoms but different courses of action are not confused.

6.4.9 The reputation of the HIT service was cited as an essential factor in the success of their work, from people acting on awareness raising messages to referrals being made into services to their partnerships and collaboration. Halton OPEN, as Halton's older people's advocate group, referred to that fact that "information is one of the key concerns which older people worry about" and credited the HIT in facilitating their participation and 'voice' in relevant forums. Praise from other service areas presenting to the Board was directed at the HIT.

6.4.10 The audiences reached by campaigns, intervention and activities were applauded as extensive. The segmented approach of the three components of work area (Start Well, Live Well, Age Well) were challenged in respect of crossover. Intergenerational work was revealed as a potential area for further exploration. Confirmation was given that opportunities have been explored, particularly between early year's age children interacting with older people and would be taken forward as part of future plans. It was suggested that such activity had previously been held up by risk assessment requirements.

Conclusions

6.4.11 The HIT impact on a broad range of outcomes but they do not do this in isolation and effective relationships, public engagement, networking and strategic planning are vital to their success. This need continued effort and exploration of opportunities.

6.5 Service impact and influence

6.5.1 The majority of services the HIT undertake are based on a mandatory programme of delivery which is held to national measures. Primarily this involves monitoring against the PHOF with reports being submitted to the Department of Health, who in term audit the service performance. The service also impacts on the ASCOF and other Council-led priorities. Key outcomes for 2016 are further highlighted in Appendix Three.

6.5.2 The services delivered are benchmarked against various standards and performance criteria according to Public Health and local concerns. It was explained to The Board that this includes standards issued by the NICE as well as more specific requirements such as the Healthy Early Years Standards, work towards the Tobacco Control Agenda and the Suicide Safe Agenda, and the Gold Standards Model for the Age Well Exercise Programmes.

6.5.3 Figures captured towards monitoring services were explained to include referrals to different areas of service, advice and information given, uptake of activity and attendance at events. While performance measures are a requirement of the funding stream the Board learned that a more holistic philosophy underpins services delivered. This revolves around ‘making every contact count’, where any intervention, no matter how brief, is seen as invaluable to longer-term engagement.

6.5.4 An example of the effect of the ‘making every contact count’ approach was given around a HIT stall at the Vintage Rally in 2016. A lady who stopped to speak to the team was encouraged to have a mark on her hand looked at by the mobile cancer screening service, a Bridgewater Community Healthcare service also in attendance at the event. She declined and was signposted to her GP; her contact details were taken. The lady came back later in the day and asked if she could be accompanied to the screening. The mark on her hand turned out to be cancerous for which she required further treatment.

6.5.5 Feedback from the attendance at scheduled activity (Appendix Four and Five) illustrated the value and regard placed on services by individuals who use them. The encouragement and support given by team members was greeted with enthusiasm and commitment from participants. Comment was made by Cllr Horabin, of her attendance to the ‘Fresh Start’ sessions that the candidness of discussions was heart-warming. She felt that people were able to not only break down habit but overcome social barriers to achieve their goals. She cited the peer support element of the sessions as a key motivator.

6.5.6 The HIT explained their approach as a flexible one where activity is often widened to ensure uptake of core programmes. Details were given of a volunteer recruitment event held by the Sure Start to Later Life service. This resulted in a number of volunteers coming forward who are to be utilised to support transportation to older people’s medical appointments. This activity aims to impact on the wellbeing of frail and house-bound older people. The event also resulted in a number of referrals to other areas of service.

6.5.7 As explored in Section 6.4 the inter-service and cross organisational contact made by the HIT reflects good opportunity for influence. This supports the work of the HIT and additionally impacts on wider agendas. The associations and connections made furthermore provide opportunity for additional work and associated funding.

Conclusions

6.5.8 Being held to defined measures the HIT are inherently results driven. Their status and standing with both the public and partners is further testament to their impact and influence.

7.0 OVERALL CONCLUSION AND RECOMMENDATIONS TO HEALTH PPB

The Board found the review interesting and informative. They established that the HIT was a well-run, effectively structured and widely respected service. Recommendations made by the Board revolve around minimal service improvement opportunities but identify a clear need for wider strategic focus on maintaining services into the future.

Recommendations to the Health PPB:

1. There is a clear requirement to open up discussion around maintaining the funding of HIT to ensure services are sustainable following the removal of ring-fenced budgets.

2. An audit of certain health improvement services should be considered in relation to looking at charges made and the ability to sustain the broad range of activity.

3. Endorsement is given to current and planned collaborations, cross-agency and multi-disciplinary working (including HIT work with Care Management and the housing sector).

4. Reciprocal information sharing need to be further established between HIT and relevant Ward Councillors to enable communication and engagement across their wards.

5. The booking of venues for HIT activity should include consideration being made to costs (where possible free-of-charge venues should be utilised), disability access and transport links.

6. Continued effort should be made to explore opportunities for intergenerational activity which impacts on the health and wellbeing of residents of Halton.

Appendix 1: Scrutiny Topic Brief

Topic Title: Health Improvement Team

Officer Lead: Lisa Taylor – Divisional Manager – Health Improvement

Planned Start Date: June 2017

Target PPB Meeting: March 2018

Topic Description and Scope:

The Health Improvement Team service will be examined as the topic for this scrutiny. The study will look at the work of the division, its contribution to health and wellbeing outcomes, how priorities are determined, what performance measures are made and how success is celebrated. The Board will look to propose service improvements recommendations and evaluate the impact of the team's activities and interventions against the needs of the local population.

Why this topic was chosen:

The Health Policy and Performance Board wish to better understand the Health Improvement Team (HITs) and its role in improving health outcomes for the borough.

The division transferred (TUPE) from Bridgewater NHS Trust into Halton Borough Council in October 2014 as part of the Council's devolved Public Health remit. The work areas delivered upon by the division come under a ring-fenced budget as part of the Public Health grant.

The relocation of the division coincided with the implementation of the Care Act 2014 which put the concept of 'Wellbeing' into statute and entrusted local authorities with further responsibilities for the prevention and delay or care and support needs.

In 2015 Halton was 13th (out of 326 local authorities nationally) for Health Deprivation and Disability. The measure looks at risk of premature death and the impairment of quality of life through poor physical or mental health. (HBC Customer Intelligence Unit)

The Health Improvement Team deliver educational interventions, campaigns and tailored programmes designed to enable Halton residents to 'Start Well', 'Live Well' and 'Age Well'. The life-span approach adopted by the division sees workers deliver community-based provision aimed at improving outcomes related nutrition, exercise, lifestyle and wellbeing choices.

The division works in partnership with health and social care services across Halton to provide integrated health and wellbeing services. They have built collaborative relationships with key third sector partners enabling a cooperative approach to community engagement. Their work contributes to a multi-faceted approach to public health and is governed by national indicators.

The Board will examine areas of the adults' services provided by HITs focussing in on a number of areas of provision.

Key outputs and outcomes sought:

- To understand the range and scope of interventions, activities and campaigns delivered through the Health Improvement Team service (HITs), including pathways into service.
- To appreciate how service priorities are identified and analyse any gaps in service against the health and wellbeing concern across the borough.
- To examine current performance data and explore the impact measures the service utilises to measure success.
- To consider how services are promoted and celebrated, including how public engagement is achieved.
- To reflect on the contribution the service makes to the Council's Public Health remit.
- To observe how well the HITs interacts and compliments with other health and social care services across the borough, including partnership work with other agencies and the third sector.
- To consider the impact of changes in legislation (including the Care Act 2014) in shaping the service offer.
- To compare and benchmark the service offer with other best practice delivery models.
- To offer constructive input into the future direction of the service.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton – To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member-led scrutiny review of the Health Improvement Team service and the difference it makes to the health and wellbeing of local residents.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council and partner agencies to examine current services.
- Visit to community-based intervention sessions.
- Interviews with those who have accessed services.
- Desk top research in relation to outcome measures and best practice delivery methods.

Appendix 2: Schedule of Activity

Topic: Health Improvement Team Services

Meeting	Action	Objective/Outcome	Responsible Persons
Wednesday 14th June – 5.30-7.30pm – Committee Room 1	Overview of Services / Annual Report	• To understand the range and scope of interventions, activities and campaigns delivered through the Health Improvement Team service (HITs), including pathways into service. • To compare and benchmark with other best practice delivery models. • To appreciate how service priorities are identified and analyse any gaps in service against the health and wellbeing concern across the borough. • To consider the impact of changes in legislation (including the Care Act 2014) in shaping the service offer.	Lisa Taylor
Tuesday 20th June – Board Meeting	Board formally agree of Topic Brief		Chair
Tuesday 4th July – 5.30-7.30pm – Committee Room 1	Public Health	• To examine current performance data and explore the impact measures the service utilises to measure success. • To reflect on the contribution the service makes to the Council's Public Health remit.	Eileen O'Meara
18 July	Active Halton Steering Group Meeting	• To observe how well the HITs interacts and compliments with other health and social care services across the borough, including partnership work with other agencies and the third sector. • To compare and benchmark with other best practice delivery models.	Cllr Pauline Sinnott
Wednesday 2nd August –	HIT impact on the business of Adult Social Care Services	• To observe how well the HITs interacts and compliments with other health and social care services across the borough,	Marie Lynch – Divisional Manager –

5.30-7.30 – Committee Room 1		including partnership work with other agencies and the third sector. • To compare and benchmark with other best practice delivery models. • To consider how services are promoted and celebrated, including how public engagement is achieved.	Care Management
13 September – Brookvale Community Centre	Site visit – 'Breathe Better'	• To understand the range and scope of interventions, activities and campaigns delivered through the Health Improvement Team service (HITs), including pathways into service.	Cllr Martha Lloyd-Jones
Wednesday 13th September – 5.30-7.30pm – Committee Room 1	Community Engagement	• To consider how services are promoted and celebrated, including how public engagement is achieved.	Val Anderton, Health Improvement Team Marketing and Communications Officer
20th and 27th September - Runcorn Fire Station	Site visit – 'Fresh Start'	• To understand the range and scope of interventions, activities and campaigns delivered through the Health Improvement Team service (HITs), including pathways into service.	Cllr Margaret Horabin
Tuesday 3rd October – 5.30-7.30pm – Committee Room 1	1. HIT impact on the business of Halton CCG 2. Focus on Age Well	• To observe how well the HITs interacts and compliments with other health and social care services across the borough, including partnership work with other agencies and the third sector. • To compare and benchmark with other best practice delivery models. • To consider how services are promoted and celebrated, including how public engagement is achieved.	1. Dave Sweeney – Interim Chief Officer – Halton CCG 2. Zoe McEvoy, Practice Manager, Age Well
Wednesday 8th	1. Partnership Working	• To observe how well the HITs interacts and compliments with	1. Richard

November – 5.30-7.30pm – Committee Room 1		other health and social care services across the borough, including partnership work with other agencies and the third sector.	Ashworth, Halton Older People's Empowerment Network (OPEN)
	2. Review and recommendations	• To offer constructive input into the future direction of the service.	2. Chair

Appendix Three - Health Improvement Team - Key Outcomes 2016

START WELL

Pupils engaged in Healthitude programme

School children aged 7-16 engaged in Fit4Life schools programme

Schools engaged in Healthy Schools Initiative

Reduction in under 18 alcohol admissions since 2007 (to 2014)

1605 women supported to breastfeed their babies

Families engaged in Introducing Solid Foods
with 90% introducing solids to their baby after 5 months

144 vulnerable families supported

LIVE WELL

NHS Health Checks carried out in GP practices, workplaces and the community

New Weight Management clients with 75% losing weight at 6 months (combined service with 5BP)

People with long term conditions engaged in specialist exercise classes

IGR (Impaired Glucose Regulation) referrals received

Clients set a quit date with our Stop Smoking Service

Stop Smoking Quit Rate - up from 55%

Residents and Front Line Professionals received alcohol awareness training or IBA

People engaged with around early detection of cancer and screening

AGE WELL

750

Residents engaged in Halton Falls Service with 200 attending Age Well Exercise

sure start to later life

2515 People attended trips & day trips organised through Sure Start to Later Life service

192

IT Support sessions delivered to people in their own homes

575

Older, lonely & vulnerable adults attended 8 Grangeway Get Together events

84

2515 People attended trips & day trips organised through Sure Start to Later Life service

936 hours

Front Line Professionals received Age Well Awareness training

Appendix Four – site visit – 'Breathe Better'

Health Policy and Performance Board – Scrutiny Group

Topic: Health Improvement Team

Site Visit: 'Breathe Better'

Date/Times: Wednesday 13th September -2.30 to 3.30pm

Venue: Brookvale Community Centre

The service takes referrals from the hospitals for heart failure and pulmonary disease patients, following initial treatment. The class provides gentle exercise with a view of participants being signposted on to community provision at the end of their rehabilitation period.

Cllr Martha Lloyd-Jones attended the session on Wednesday 13th September 2017 to gain insight into the provision and speak with attendees.

The session was facilitator by HIT employee Paul Johnson. Paul gave an overview of the session, explaining that the ultimate aim is to refer people on to community provision: "We get community timetables from Paula Parle (Sports Development). These programmes are used as an exit route for our classes. This session is like a stop-gap between clinical and community support and forms part of their rehabilitation." Paul explained that the sessions form part of movement away from clinical intervention and give people the confidence to overcome the mental barriers to doing exercise following on from heart failure or other conditions.

Classes run weekly and are charged at £2.50 per session. Participants are reviewed at a 10-week and six-month period and routing will be made at these points dependant on suitable progression. Paul said that there used to be a questionnaire but now progress is measured more actively with 'shuttle run' tests and 'sit-to-stand' tests.

Paul clarified that the charge for the sessions supports attendance. "We used to charge after an initial 10-week period but people tended to drop-off. By charging from the start they tend to commit."

The class attended had six participants. Paul said that currently he has 23 people on the register and attendance is commonly 12-14 people. He explained that where people don't attend for a few sessions follow-up will be done to find out the reason for this and how they might be better supports. He indicated that referrals can be sporadic but the rolling nature of the programme ensures some attendance at any one time. Referrals all relate to Halton residents but may come from Halton, Warrington or Whiston Hospital. GP referrals are also made to the classes however Paul spoke of the majority of GP referrals going to Weight Management Programmes upon which HIT might re-refer internally to the class dependant on need.

He explained that the intensity of the session is individualised to the attendees who work with weights and resistance bands, amongst other equipment, as appropriate. Music is used to slow and fasten the pace of exercise and Paul established that session content varies to keep interest. The low-impact exercise being undertaken included walking, stretches and gentle endurance activity. Paul described that some of the exercises he was including in the session were also used in Falls Prevention classes to build stamina and balance.

The session was informal and relaxed and Paul indicated that when the HIT took on the service (from the hospitals) it was thought that heart monitors might be used. A decision was taken against this as it was felt too clinical and Paul suggested: "participants would be too fixated on numbers."

Participants were complimentary of the classes. K, who has been coming for a number of years, said that he has tried to access a 'walking football' group but is unable to get onto a group at present. Paul confirmed that the walking football comes under Sports Development rather than HIT and that K is accommodated within the class over the long-term as capacity is available for him to do that.

L said she was originally referred four years ago. She attended that class for a while and then stopped. Around six months ago she asked her GP to re-refer her into the sessions believing she would benefit at that time. She lives just two bus stops away from the Community Centre and she stressed that, as a person who lives on her own, the class provide her with social contact as well as the exercise. She has angina, arthritis and is waiting to hear if she is to be referred for a hip replacement. On being asked she stated that she did not practice any of the exercises at home, outside of the class. She confirmed however: "It definitely helps me. I do what I can but my hip is aggravated at the moment. Paul is fantastic; he always asks me about my health."

J, from Beechwood, was referred from Halton Hospital around three years ago. He suffered Atrial Fibrillation (AF) and was fitted with a pacemaker/defibrillator, upon which he is dependant. He explained that he completed six months of rehabilitation with the hospital before being transferred to this service. Outside of the group he walks his dogs but said that he did no additional exercise. He said that he has previously had a hip replacement and needs a knee replacement but a full anaesthetic creates risk with the pacemaker. He expressed that the class was accessible to him and suited his needs.

Cllr Lloyd-Jones asked Paul if there was similar provision in Widnes. Paul said there is but said that this group was less sociable at first. He said that a lot of encouraged was made for participants to engage with each other after the class. Some of the shared experiences have helped, for example, where certain medications have been tried by someone else and another person might then be able to take this information back to their GP.

She questioned Paul about exit routes, noting that some of the participants in today's session had been coming a long time. Difficulties with local provision were cited as one of the reasons people continued to attend. Paul said that the gym at Brookvale Leisure Centre is not staffed and this can create a real barrier to people with heart conditions as there's no on-hand advice or emergency first aid.

Paul said that there are plans to move this class to the Fire Station. He said that the facilities there are more like a gym and this allows attendees to get used to this equipment, with a view to moving on to a community gym. The Fire Station is also offer to HIT for free while the Community Centre is paid for. With classes at the Fire Station, Paul explained, there is a more natural exit route to the gym at the Heath which is staffed. Paul had floated the idea with participants of this session and they had responded well. "They were positive about the proposed change but a little fearful that there might be an expectation of them to use the equipment," he said, reinforcing that they would be support with the transition.

Appendix Five – site visit – 'Fresh Start'

Health Policy and Performance Board – Scrutiny Group

Topic: Health Improvement Team

Site Visit: 'Fresh Start'

Date/Times: Wednesdays -10.30am to 12pm

Venue: Runcorn Fire Station

This programme is one of a number run across the borough, held throughout the week, aimed at healthy lifestyles and weight management. The service area predominantly takes its participants through from GPs, Practice Nurses or self-generated referrals but will accommodate anyone who lives or works in Halton. The 'Fresh Start' programme is free and lasts for 10 weeks, after this time attendees can continue to take part for a further 6 months, in the form of 'Next Steps', at a cost of £2.50 per session.

The 'Fresh Start' sessions involve educational input followed by a period of exercise. Sessions last an hour and a half and participants have a 'weigh-in' at the start of each class so that their progress is logged. Those continuing onto the 'Next Steps' join the session after the learning takes place; to avoid duplication. Numbers in attendance are dependent on the venue capacity but the health trainers running this session stated that they have had up to 16 people involve at any one time. The HIT support sessions with online information and advice, including healthy option recipes.

Cllr Margaret Horabin attended two consecutive weekly sessions. The programme runs on a rolling basis and sees people step onto and out of the sessions to cover their allocated 10 week period.

The first session attended, on Wednesday 20th September, had just three participants and was facilitated by two HIT members, Kerry and Andy. The educational section of the sessions revolved around 'Eating Out'. Consideration and exploration was made around the behavioural influences of people's choices. The group were asked why they made certain decisions about what to eat and why. In reflection of take away meals the group suggested they opt for these because they are 'tasty', 'easy', 'convenient' and made use of 'when you get home and you don't want to be bothered.'

The group also reflected on 'ready meals'. Participant T said that he used them to control his portion size and always looks for the traffic light signals on the packaging. The two trainers warned of high salt content in ready meals which are used to prolong shelf life. Another attendee, D, corroborated this with her opinion that: "you wouldn't make a Sunday dinner and expect to keep in the fridge for two weeks." The trainers went on to further explain the traffic light systems can be misleading and that people should instead be looking for the content per 100g. "Sometimes it will be all green but that might be per quarter pack," Kerry reinforced.

The group shared the triumphs and tribulations of their week. T said, "I was walking past Greggs the other day and I fancied something sweet but I walked past. I used to be in Weight Watchers and I remember then saying 'nothing tastes as sweet as weight loss. It felt good to walk away." He was praised for his achievement. The trainers were encouraging and supportive advocating little steps and incremental

lifestyle changes to rather than deprivation approaches. They looked at a visual representation of different foods and how they fill you up as well as the cycles of peaks and slumps created by quick sugar fixes and how this leads to cravings and feelings of hunger more quickly.

D expressed her concern that she was to be on holiday next week, “I’m panicking because I know what I’m like.” She was advised to set small goals such as going for an extra walk or having dessert with her meal only every other night.

Group members D and A have only attended for a fortnight but have both seen a drop in their blood pressure already. They put this down to the increased activity rate as well as the changes to their diets. They, along with T, enthusiastically joined in the exercise element of the session, warming up with 10 minutes on either an exercise bike or treadmill before commencing circuit training, as set up by Kerry.

On Wednesday 27th September just two attendees were present at the session. Andy, one of the two facilitators explained that there are peaks and troughs in attendance, particularly seasonal, so they do tend to average out at a decent number. He said that were sessions really aren’t working or started to drop-off the HIT would look to relocate or change times.

Jason, the other facilitator, led the learning session. He gave out ‘Food Shopping Cards’ which explained the traffic light system seen on many convenience foods. This sets out the content per 100g which denotes which colour level the food is at for fats, saturated fats, sugar and salt. The group discussed ‘good’ fats and ‘bad’ fats, the effects of salt on blood pressure and the dangers of fast release energy sources. Attendee T told the group that one of his motivators for joining the session was a ‘borderline diabetic’ prognosis from his GP. T explained that he’s currently also under a nutritionist and has signed up for some cookery classes.

In order to test out the participants’ understanding of the system Jason gave out food labels highlighting alternative choices. These looked at Cheddar cheese versus cottage cheese, baked crisps versus ordinary fried crisps and a sugar-coated breakfast cereal versus a wheat-based one. This generated discussion and reiterated the need to look at the ‘per 100g’ content.

Following the educational input the group did their exercise session. Today this involved a variation on the gameshow ‘Play Your Cards Right’. Jason sent out a series of playing cards which group members had to guess whether the next was ‘higher’ or ‘lower’. Where they got it right the number on the card indicated the number of repetitions of a particular exercise; where they got it wrong they would do a minute of a particular exercise. The activity kept their interest and built a sense of teamwork.

REPORT TO: Health Policy & Performance Board

DATE: 27th February 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Introduction of the Referral Facilitation System (RFS): Update

WARD(S) Halton Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update on the introduction of the referral facilitation system in Halton in light of the national digital programme.

2.0 **RECOMMENDATION: That the Board:**

1) Notes the content of the report.

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

In October 2016, NHS Halton Clinical Commissioning Group's (CCG's) Governing Body approved an invest-to-save approach for the implementation of a Referral Facilitation System (RFS) as part of the CCG Quality Referral Programme. The process was to facilitate the transfer of primary care referrals to secondary care via a secure electronic Integrated Care Gateway (IGC).

The patient was then offered choice of secondary care Provider via use the of the national e-referral system (where available). The administration associated with e-referral i.e. contacting the patient and booking them into an appropriate clinic electronically, was then handled by the centralised Referral Management Centre (RMC) which is currently provided by Midlands and Lancashire Commissioning Support Unit (MLCSU).

National Programme Developments

Since the implementation of the referral system within Halton, the national NHS focus on managing system demand has grown significantly. NHS England (via NHS Digital) has now mandated all secondary care trusts to publish all of their first outpatient consultant led clinics onto the national e-Referral system (eRs). This is to ensure that e-Referral is the only mechanism for referral between primary and secondary care and as such ceasing paper or alternative (none eRs) electronic methods (e.g. centralised email addresses) of referral.

To support this mandate, a national 'Paper Switch-off' Programme has been implemented by NHS Digital to support Trusts and CCGs to move to full use of e-RS as the referral mechanism between primary and secondary care for all consultant-led first outpatient appointments by October 2018. The programme will also ensure Trusts are able to meet the conditions of the NHS Standard Contract

where, from 1 October 2018, providers: “need not accept (and will not be paid for any Activity resulting from) Referrals by GPs to Consultant-led acute outpatient Services made other than through the NHS e-Referral Service.”

Trusts have been asked to submit their plans for paper switch off to NHS Digital advising timescales of when they will be in a position to transition fully to eRs (for all specialties apart from an exclusion list to be agreed with the CCG)

Locally, the below dates have been submitted by secondary care providers:

Trust	Proposed ‘switch off’ Date
Warrington and Halton Hospitals NHS Foundation Trust (WHHFT)	February 2018
St Helens and Knowsley Hospitals NHS Trust	June 2018

Implications for Primary Care and the RFS
Locally, via the CCG Clinical Advisory Group a discussion took place as to the implications of this in relation to the current referral management process in light of the national programme and the current financial position within the CCG. It was agreed collectively by all practices that in light of a full transition to e-referral within secondary care first outpatient clinics that all practices would revert to using eRs direct.

As such, from July 2018 all practices will use the eRs via their clinical management system (EMIS Web) to refer their patients to secondary care, negating the need for a centralised referral management process.

This was agreed on the basis that the utilisation and publication of secondary care clinics would improve as part of the national programme thus eliminating significant issues that practices have experienced when using eRs in the past and also to ensure sustainability from a financial perspective in light of the significant costs associated with a central referral system.

4.0 **POLICY IMPLICATIONS**

4.1 The model is in line with the current national digital programme and local Quality, Innovation, Productive and Prevention (QIPP) programme.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None

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

6.1 **Children & Young People in Halton**

None identified

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

None identified

6.3 **A Healthy Halton**

The contents of this report are directly linked to this priority.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified

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

None identified under the meaning of the Act.

REPORT TO: Health Policy & Performance Board

DATE: 27th February 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Older People's Mental Health and Dementia Care

WARD(S) Halton Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To update on the impact of the reconfiguration of the older people's bed base within North West Boroughs Healthcare NHS Foundation Trust, following the closure of Grange Ward in the Brooker Centre.

2.0 RECOMMENDATION: That the Board:

a) Note the contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Background

The model of care (driven by Halton) was implemented in 2012 for Older People with Dementia and Memory loss which is a high quality community service pathway, designed to support people in their own home as long as possible. The objective was to re-design services for people in later life in order to ensure that effective, timely and personalised services are available, to support the growing number of people who will experience memory and cognitive loss and the onset of dementia.

The Building on Strengths model (2011) was developed by lead clinicians and managers within the Later Life and Memory Services within 5 Boroughs Partnership NHS Foundation Trust, and outlined a community based service supporting people to remain at home, whilst improving and maintaining the quality of life of service users and their carers. To support the community provision, the model proposed the redesign of inpatient care to provide specialist assessment and care where this could not be safely supported within a community setting.

This service provision, set out in 'Building on Strengths' (2011) continued the development of early and skilled intervention and the timely and appropriate support of people through their life experiences of living with the cognitive and emotional impact of the ageing process. The first phase of this work was implemented. The Trust is were then ready to proceed with re-design of inpatient care, as the 'Building on Strengths' model includes changes to the whole service pathway from early intervention, assessment and diagnosis through on-going support and care and, importantly, inpatient care.

3.2 Implementation and Impact of the Community Pathway

The new community model was implemented as a pilot in the Wigan Borough in March 2012 and across all other boroughs by May 2013. The model was designed to provide high quality early diagnosis and intervention for all who require it. The model includes:

- A Single point of access
- Same Day Screening by Senior Nurse
- Same day Face to Face Assessment for urgent referrals.
- Face to Face Assessment within 10 working days for non-urgent referrals
- Crisis Intervention and Rapid Response
- A Needs Led Care Framework/Supporting people to live independently
- Service users directed to appropriate path of service
- Offering a comprehensive and appropriate range of interventions including Psychological Interventions

3.3 Clinical Model for Later Life and Memory Services in-patient

The Royal College of Psychiatrists recommends a needs-based criteria for older people's mental health services which includes;

- People of any age with a primary dementia
- People with mental disorder and significant physical illness or frailty which contributes to, or complicates the management of their mental illness – exceptionally this may include people under 60
- People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people.

3.4 Key Principles of Change

- To provide inpatient care tailored to meet the specific needs of adults and offering greater choice and flexibility by providing an effective therapeutic environment.
- To develop a new admission option for older adults with a non-memory related mental illness who may be too frail or vulnerable to have their needs appropriately met within an adult acute mental health ward.
- To address the needs of those people whose condition is defined by physical and social factors leading to multiple conditions or diseases usually associated with later life.

3.5 Clinical Benefits

- Integrated Organic and Functional Care Models
- Management of severe Behavioural and Psychological Symptoms of Dementia
- Psycho-social approaches
- Enhanced Therapy support
- A Therapeutic Environment
- Enhanced Care
- Physical Health Factors
- Seamless Pathway Development
- Links to Social Care / 3rd Sector / Acute care
- Carer Support

3.6 Mental Health Service Review

An independent review of mental health services across North West Boroughs Healthcare NHS Foundation Trust (NWBFT) footprint (The Tony Ryan Review Dec 2015) was commissioned by CCG's and NWBFT

The methodology for the review included analysis of routinely collected data,

examination of policies and procedures and interviews with over 350 stakeholders including users, carers, staff working and managing services, commissioners and other interested parties.

Five key areas ("Big Ticket Items") for future development were identified following the review:

- The interface between primary and secondary care.
- How people with a personality disorder or highly distressed emotional disorders are supported by the whole system.
- The whole service model across the Borough (including 5BP services and all others).
- Step down from in-patient services and the use of out of areas placements in the private sector.
- The proposed future bed model.

The review referenced the pressure within the whole system of health and social care resulting in high demand for adult acute mental health admission beds. Although the exact usage and spend for out of area beds was not available for the review, NHS Halton CCG experiences a significant overspend in 2015/16 for both complex and acute patients who have been unable to access an adult acute mental health bed within the 5 Boroughs footprint. This is in addition to the contracted spend and remains a financial risk.

Update

This risk has been mitigated by the proposal of a 'risk share' between CCG's and the provider whereby for an agreed additional sum NWBFT have opened an additional 6 adult beds in the Brooker Centre to increase access to an acute bed for adults across the footprint. In addition in line with The 5 year Forward View for Mental Health requirements CCG's and providers are now being performance managed by NHS England against a trajectory to eliminate all out of area placements for acute beds by March 2021. The aim is to achieve this by increase offer of crisis support 24/7 outside of A&E Departments in conjunction with the extra local beds.

3.7 **Update**

The proposal regarding the closure of the beds at Grange Ward came to the PPB in September 2016. Details of the proposal are below

Halton (Brooker Centre)		
Male Adult	Female Adult	Organic
14	14	0 (access Warrington beds)
Knowsley		
Male Adult	Female Adult	Organic
18	15	12

Warrington		
Male Adult	Female Adult	Organic
18	15	18

St Helens		
Male Adult	Female Adult	Organic
17	16	0 (access Knowsley beds)

Wigan				
Male Adult	Female Adult	PICU	Functional	Organic
20	20	8	16	18

Grange Ward closed in December 2016 and the existing patients within Grange Ward (3 at the time) were moved to other wards within the NWBFT footprint. Mitigations were put in place to support the transport needs of families to ensure access for visiting and patient navigators where instigated to support families. At the same time an Admiral Nurse Service was commissioned by the CCG to support carers and families coping with caring for people with dementia to reduce the possibilities of carer breakdown which often contribute to the need for an in-patient bed. A Care Home Liaison Service is also commissioned by the CCG to support care homes in the management of residents with dementia to help upskill staff around supporting residents with dementia again to reduce the need for hospitalization.

Following the implementation of the community dementia pathway the numbers of Halton patients actually requiring an in-patient stay are relatively small.

The data for January 2017- March 2017 is below:-

- Jan 2017 – 5 admissions (3 in Kingsley, one in Rydal Ward and one in Sephton Ward)
- February 2017 - 3 admissions (2 in Kingsley and one in Sephton Ward)
- March - 4 admissions (3 in Kingsley and one in Rydal)

Since April 2017 – September 2017 the admission are detailed below

			April	May	June	July	Aug	Sept	YTD
58	Inpatient Admissions Per Ward	**Total**		**3**	**3**	**3**	**3**	**1**	**13**
58	Golborne Unit				1	1	1		**3**
	Kingsley Ward			3	1	1		1	**6**
	Parsonage Unit						1		**1**
	Rydal Unit				1	1	1		**3**

Systems are now in place to ensure that any Halton older person in patient who is resident on a ward in any other borough – including the functional unit in Leigh are seen by social care and are discussed in any discharge planning or bed management meetings. The latest Delayed Transfers of Care lists as at 18th January 2018 show that there are no Halton in patients currently delayed – the only borough in the five areas covered by North West Boroughs Healthcare NHS Foundation Trust.

4.0 POLICY IMPLICATIONS

4.1 The model is in line with the current local mental health strategy and national the mental drive for parity of esteem/improved quality for frail elderly.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Young carers who are identified as caring for older people with dementia or mental health problems will be consulted within the process.

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

6.3 **A Healthy Halton**
Dementia is a key priority within Healthy Halton and is in line with strategic drive. Mental Health remains a key priority of the Health and Well Being Board.

6.4 **A Safer Halton**
Ensuring the safety of vulnerable older people in mental health settings.

6.5 **Halton's Urban Renewal**
There are opportunities to align with Health New Towns Vision of Dementia friendly towns.

7.0 RISK ANALYSIS

7.1 The key issues were logged on the NHS Halton CCG risk register and have been monitored through the robust Mental Health Governance. The risks were reviewed during the implementation process. Risks were identified by Halton Borough Council in respect of their social work teams in terms of additional travel time, patient visits and associated costs; these risks will need mitigating through the redesign process. However due to the relatively small number of admissions in total hopefully the impact has not been as great as anticipated.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 North West Boroughs undertook the Equality Impact Assessment which fed into the public consultation as required. It included questions that were expected to be raised such as transport solutions for carers, robust consultation with affected groups. There were issues reported to the CCG following this process.

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

9.1

Document	Place of Inspection	Contact Officer
Independent review of mental health services (Tony Ryan Review)	Runcorn Town Hall	Leigh Thompson leigh.thompson@haltonccg.nhs.uk

REPORT TO: Health Policy and Performance Board

DATE: 27th February 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: All-Age Autism Strategy

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on the new Halton All-Age Autism Strategy at the Appendix.

2.0 **RECOMMENDATION: That the Board:**

i) Note the contents of the report and associated appendices; and

ii) Provide comment on the draft Strategy and its associated Delivery Plan.

3.0 **SUPPORTING INFORMATION**

3.1 The current Autism Strategy was developed in 2012. Since then there has been a number of national publications relating to Autism including: Think Autism: fulfilling and rewarding lives, the strategy for adults with autism in England, update 2014; Statutory guidance for local authorities and NHS organisations to support implementation of the adult autism strategy (2015); and progress report on Think Autism (2016).

Halton also took part in the Autism Self-Assessment Framework (SAF) which was completed at the end of 2016.

3.2 In order to move forward with planning a new All-Age Autism Strategy, a working group was established in July 2017 with the following membership:

Patrick Frost – Principal Manager - CCW (Chair)
Maria Saville – Principal Manager – PBSS, HBC
Ami McNamee - Specialist Teaching Lead (HBC Education)
Sam Murtagh - Commissioning Manager (HBC Children's Services)
Catrin Williams - Community LD Team (North West Boroughs NHS Trust)
Jane Morris - Principal Manager, LD Nursing Team (HBC Adult

Social Care)
Jane Birchall-Smith - Community LD Team (North West Boroughs NHS Trust)
Lisa Birtles-Smith, Clinical Lead LD (Halton CCG)
Alison Sutch, Children's Complex Needs Nurse (Halton CCG)
Emma Sutton-Thompson, Practice Manager (HBC)
Natalie Johnson, Policy Officer (HBC)

3.3 Autism Questionnaire

As part of the initial consultation, the group devised a short questionnaire which was posted out to 230 adults identified from CareFirst as having a diagnosis of Autism, and also the survey has been disseminated within children's as follows**:**

- Brookfields School, the Resource Bases, Cavendish School and Ashley School, Parent Partnership and Assessment Co-ordinator for those with EHC Plans;.
- Members of staff gave out to parents and to Mal Hampson at Halton Speak Out;
- In addition, the survey was added to the Local Offer in mid-September.

3.4 Draft Strategy

The group agreed that the main part of the strategy document would focus on the statutory guidance and Halton's position with specific areas (draft attached at Appendix 1). Contributions to the strategy were from a range of staff across HBC, HCCG and NW Boroughs NHS Trust.

The Delivery Plan has been developed jointly with service-users and stakeholders based on their experience of services and identifying areas for improvement. The Delivery Plan will be a "live" document that will drive priority areas for improvement forwards, ensure continuity and be led by a dedicated group, an Autism Action Alliance, which will be the first priority to establish, based on National guidance.

3.5 Consultation/Co-design of Delivery Plan

The consultation/co-design of the delivery plan has been undertaken by a combination of methods to suit different groups of people, including:

- Linking in with schools – parents coffee mornings;
- Experienced-based co-design event for Adults was held on 5th December 2017;
- Direct meetings with parent support groups – HAFS, ChAPS,

Face to Face SCOPE;

- Linking in with IMPART (parent partnership);

- Involving Halton Speak Out.

Children's representatives of the working group lead on the children's side of the consultation/co-design.

A provider consultation event for adults was held on 10th January 2018 with other groups that are linked to Autism to identify actions to be included within the Delivery Plan.

4.0 POLICY IMPLICATIONS

4.1 An Autism Action Alliance will be established to take responsibility for moving the Autism-agenda forward, implementing and monitoring the Delivery Plan. This will be the first action on the Delivery Plan.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 To ensure continuity of the Autism Strategy and Delivery Plan, the first priority is to establish Autism Action Alliance to lead on the implementation and monitoring of this. The Alliance would bring together different organisations, services and stakeholders and adults/children with autism and their families to set a clear direction for improved services.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Developing an All-Age Autism Strategy aims to take a more joined-up and holistic approach to developing opportunities and realising potential for people with Autism at every stage of their lives.

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

6.3 **A Healthy Halton**
National guidance states that an Adult Autism Strategy is a statutory requirement and there are certain criteria we should be implementing as a Local Authority and in partnership with other agencies. The development of an All-Age Autism Strategy goes above and beyond this requirement.

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 It is vital that the needs of people with Autism in Halton are met. This is strengthened by National legislation detailing clear areas to be included and addressed.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

9.1 None identified.

DRAFT ONE HALTON ALL-AGE AUTISM STRATEGY 2018 - 2021 And DELIVERY PLAN

Contents

Foreword

This new All-Age Autism Strategy in Halton aims to take a more joined-up and holistic approach to developing opportunities and realising potential for people with Autism at every stage in their lives. People with Autism are a valued part of the community of Halton and Halton Borough Council (HBC), NHS Halton Clinical Commissioning Group (CCG) and NW Boroughs Healthcare NHS Foundation Trust share a commitment to work together to improve the lives and opportunities for both children and adults with Autism in Halton.

We recognise that, although there are a lot of positives in the Autism services delivered in Halton, there are also areas that require more focus, especially around transition into adult services which we know can be a particularly difficult stage for young people. By joining together to develop an All-Age Autism Strategy, we are aiming for an ambitious approach, going above and beyond the national guidance.

The Strategy and the Delivery Plan set out our current position, the areas for improvement that we need to focus on over the next 3 years and the outcomes for individuals that we want to achieve. The Delivery Plan has been developed in conjunction with children and adults with Autism and their carers and families, along with the key providers of services within Halton. We would like to thank everyone who has been involved with the development of this Strategy and Delivery Plan, in particular people with Autism and their carers and families.

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

1.0 INTRODUCTION

1.1 National Context

In 2009 the Government implemented the first ever condition-specific legislation in England, the ***Autism Act 2009***[1], demonstrating the importance that Parliament has attached to ensuring that the needs of people with autism are fully met.

In 2010, the original Adult Autism Strategy, *Fulfilling and Rewarding Lives*, was published.

During 2014, an updated Adult Autism Strategy was developed, ***Think Autism*** building on from the 2010 version, with a progress report on the implementation of ***Think Autism*** which was published in January 2016. The main vision in ***Think Autism*** is:

"All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them, they can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents".

In March 2015, the Government produced updated statutory guidance for local authorities and NHS organisations to support the implementation of ***Think Autism***. The guidance was revised following responses to a consultation "No Voice Unheard, No Right Ignored" which was a consultation for people with learning disabilities, autism and mental health conditions. It examined how people's rights and choices can be strengthened. Halton's strategy is based on this guidance, the national consultation and local consultation with adults and children who have autism and local organisations who are involved with people with autism.

Recent legislation has also provided for new duties for services for people with autism, including the ***Care Act 2014*** and the ***Children and Families Act 2014***.

In 2014 the National Institute for Clinical Excellence (NICE) developed a quality standard on autism for adults and those under 18 which highlights how organisations can ensure they are delivering the best treatment and support for people with autism. The quality standard has 8 measurable statements to be used by organisations to improve the quality of care for those with autism. We have used these statements in our strategy and to contribute to shaping our Delivery Plan.

Implemented in September 2014, the Government published a new Special Educational Needs and Disability (SEND) code of practice for children and young people aged between 0 – 25 years and provides statutory guidance for organisations

[1] http://www.legislation.gov.uk/ukpga/2009/15/contents

that work with and support children and young people who have special educational needs or disabilities.

1.2 Local Context

Halton has a number of key local strategies and policy documents that are key drivers in areas of priority for health and social care. The documents include the following, which are all accessible on the HBC website at www.halton.gov.uk :

- One Halton Health and Wellbeing Strategy 2017 – 2022
- Halton Joint Strategic Needs Assessment (JSNA) 2017
- Pan Cheshire Local Safeguarding Children's Board Procedures 2017
- Adult Social Care Local Account 2015/16
- Safeguarding Adults in Halton: Interagency Policy, Procedures and Good Practice Guidance 2015 – 2018
- SEND Joint Commissioning Strategy 2017
- Children and Young People's Commissioning Strategy 2017-2020

The One Halton Health and Wellbeing Strategy sets out the vision of the Halton Health and Wellbeing Board (HWBB) and states six different priorities for the borough for the time period the document is active. These priorities can be life-course and condition specific:

- Children and Young People (CYP): improved levels of early child development;
- Generally Well: increased levels of physical activity & 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; and
- Older People: improved quality of life.

Overview of Halton's population

The population of Halton, as of 2016, is older than that of England.[2] There is a greater proportion of the over-all Halton population aged 50-69 than England and, a much lower proportion of the population aged between 15 and 44. This emphasises the potential for an ageing population to impact upon the borough's working age population. Although there are currently a lot of people of working age in Halton, a lot are within 10-20 years of retirement age and so this may present issues with workforce population in the future.

The age breakdown of Halton's population is expected to change over the next two decades. The proportion of people over the age of 74 is expected to swell and the proportion of children and people of working age is expected to contract. This is the case nationally also, but is predicted to be emphasised more so locally. As of 2016

[2] Halton's Joint Strategic Needs Assessment 2017

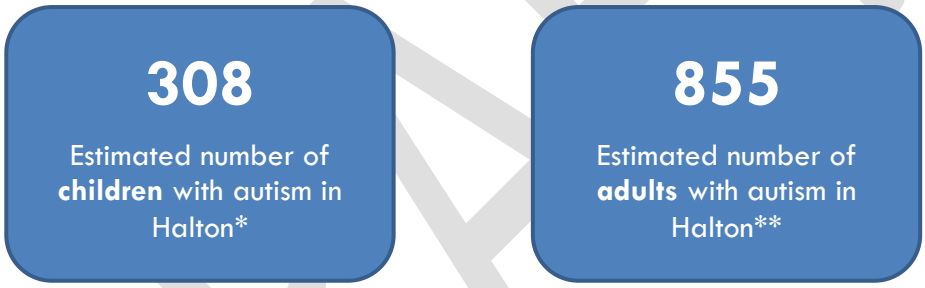
12.0% of Halton's population are aged 70 and above, whereas, in 2039 Halton's projected population aged over 70 will represent almost a fifth (19.6%) of the entire population of the area

Estimated Prevalence of Autism in Halton

The Centre for Public Health, Liverpool John Moores University[3] was commissioned by NHS England in 2016 to deliver this health needs assessment for learning disabilities and autism amongst adults and children for the nine Cheshire and Merseyside local authority areas. The report focuses on the health and wellbeing needs of adults and children with learning disabilities/autism.

The report provides some information on the estimated prevalence of autism amongst adults and children in each local area. Unfortunately, it is only possible to estimate because there are no definitive records held.

Estimated numbers are generated by applying national prevalence rates to local population data:



**Estimated numbers of children with ASD have been calculated by applying the prevalence rate of 1% reported by the National Autistic Society (2013) to local population projections (308 is the estimated number @ 2018 based on the 2012 population projections).*

***Estimated numbers of adults with ASD have been calculated using the national morbidity survey on autism in adults. This survey found the prevalence of ASD to be 1% of the adult population (Health and Social Care Information Centre, 2009) at a 1.8% rate amongst men and 0.2% amongst women. These prevalence rates have been applied to population estimates (2015) to give a predicted number of 855 adults with autism in Halton (760 males, 95 females).*

[3] Learning disabilities and autism: A health needs assessment for children and adults in Cheshire and Merseyside (Centre for Public Health, Liverpool John Moores University, January 2016)

Establishing an accurate number of people with autism in Halton is extremely difficult because there is no register or exact count kept and this is the case across all areas. Records are held by local authorities in terms of the people they provide services to, schools will know how many of their pupils have autism and GPs and diagnostic services will hold their own records, but none of these datasets take account of those who are 'hidden' because they are not in contact with services or are not diagnosed.

A key action as part of the Delivery Plan will be to establish more accurate records of those with autism in Halton; this will depend on partnership working and data sharing, taking a systematic and co-ordinated approach across education, health and social care.

1.3 What is Autism?

Within Think Autism, the term autism is described as "an umbrella term for all autistic spectrum conditions, including Asperger Syndrome. Many people with autism also have related hidden impairments such as attention deficit hyperactivity disorder, dyspraxia, dyslexia, dyscalculia and language impairments as well as associated mental health conditions and linked impairments that may not be obvious to other people".[4]

Autism is a lifelong condition that affects how a person communicates with and relates to other people. It also affects how a person makes sense of the world around them. The three main areas of difficulty, which all people with autism share, are known as the "triad of impairments", which are:

- Social Communication - using and understanding verbal and non-verbal language, such as gestures, facial expressions and tone of voice;
- Social Interaction – recognising and understanding other people's feelings and managing their own; and
- Social imagination – understanding and predicting other people's intentions and behaviours and imagining situations outside their own routine.

1.4 The aim of this strategy

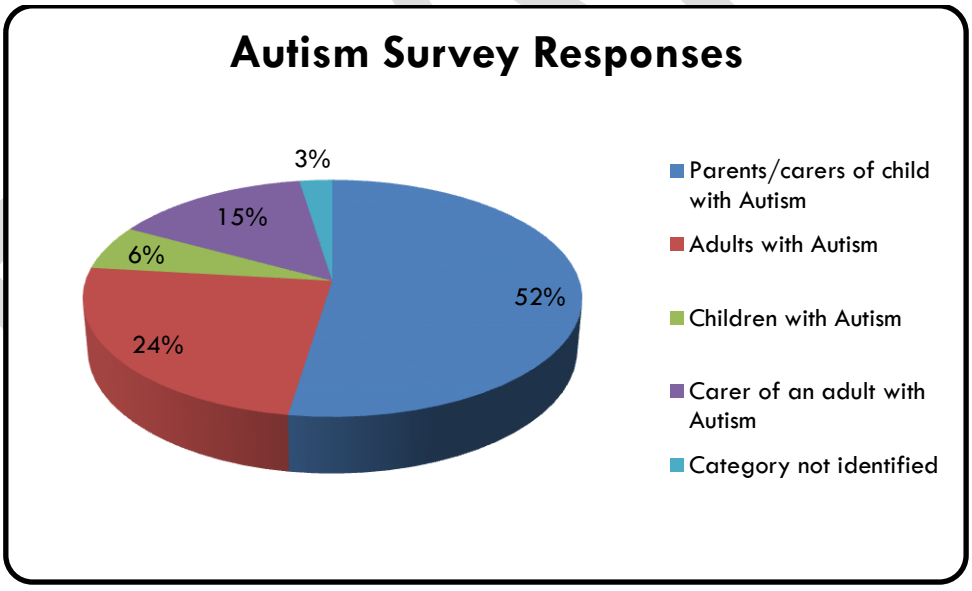
This is a high level strategy, designed to support people with autism in Halton, ensuring that services across Halton work in collaboration with key partners to move forward the priorities set out in ***Think Autism***. The strategy aims to identify areas that require improvement, based on the views of adults and children with autism in Halton, and their carers and families, which link in to the national statutory guidance and national consultation.

[4] New definitions of Autism are due out in early 2018 - http://www.autism.org.uk/about/diagnosis/criteria-changes.aspx

1.5 How the Delivery Plan was developed

At the end of this strategy there is a Delivery Plan which focusses on the areas for improvement. Halton are committed to working with people with autism and partner organisations in making improvements in this area. This has been a partnership approach between HBC, NHS Halton CCG, NW Boroughs Partnership, the independent and voluntary sector and people with autism and their carers/families. This has included:

- An initial easy-read survey sent by post to:
  - Adults with Autism/Asperger's
  - Headteachers at Brookfields Cavendish, Simms Cross, The Grange, St Peter and Paul schools to circulate to children with a diagnosis;
  - Local Offer;
  - Halton SEND Partnership information, advice and support service (SENDIASS);
  - Assessment Co-ordinators within SEN team;
  - SCOPE About Disability;
  - Halton Speak Out; and
  - Parents from children in Disabled Children's Services.
- The survey was also advertised on the Councils' Facebook and Twitter accounts



From the initial survey responses, the main two areas for improvement highlighted were:

- More places to socialise/more activities for people with Autism; and
- More support for young adults through transition.

Following the initial survey, we then held various consultation events across Halton to identify priorities and highlight areas for improvement including:

- Experienced-based consultation event with adults with autism at Runcorn Town Hall;
- Coffee mornings at schools;
- The Voice of Autism – Ashley High School; (see Appendix 1);
- Consultations with schools (see Appendix 2);
- Simms Cross Resource Base Questionnaire to Parents (see Appendix 3);
- A provider consultation event with key stakeholders.

EXPERIENCED-BASED CONSULTATION EVENT WITH ADULTS WITH AUTISM, RUNCORN TOWN HALL ON 5TH DECEMBER 2017

The event was facilitated by staff from Halton Borough Council and North Wet Boroughs Healthcare NHS Foundation Trust and was attended by adults with autism and their carers. Individuals had the opportunity to give their view of services based on their own experiences. The afternoon was filmed to be used to further improvements in autism services in Halton.

The discussions at the event were grouped into three key areas, which are displayed below along with the main points raised:

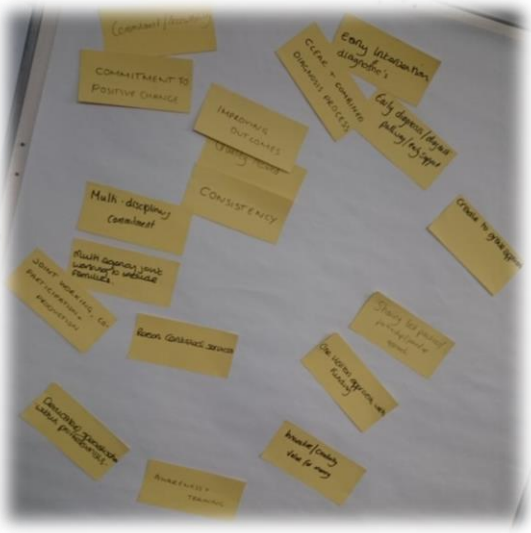
Discussion area	Key points
Autism services in Halton	• Good support is available. • Attendees reported getting the support they need when they need it. • There are no problems with the services that are in place although people feel there could be more support/services on offer. • Some services don't have specialist knowledge or experience of autism. • There is no dedicated autism group in Halton – the nearest is Liverpool or Manchester.

Discussion area	Key points
Relationships with people providing treatment and support	• Good relationships are established with individual members of staff who provide extra help and support which is appreciated (e.g. ring people for you). • Getting out and about helps – builds confidence and stops people being introverted about their condition. • Changes in Social Worker can sometimes cause stress and strain.
Experiences as a person diagnosed with autism	• Local services, e.g. shops/pubs, don't need to know about your condition. • The general public don't realise some of the issues associated with autism, e.g. clumsiness, and therefore may not understand behaviour to be related to the condition. • One attendee reported a bad experience with door staff in a local pub being unfriendly to everyone – once he told them about his condition they were okay with him. • There is the need to see things through the eyes of a person with autism to understand what they are going through. When people realise there is something different about you they can either be friendly or ostracise you.

PROVIDER CONSULTATION EVENT HELD AT THE STADIUM ON 10TH JANUARY 2018

The afternoon was facilitated by Helen Sanderson Associates and involved local providers of Autism services, including: Community Integrated Care (CiC), Cheshire Autism Practical Support (CHaPs), Halton Autistic Family Support (HAFS), Making Space and PossAbilities. There was also representation from HBC's Positive Behaviour Support Service (PBSS), Day Services, Disabled Children's Service and NHS Halton CCG's Children's Complex Needs Nurse.

The group identified ***principles*** that they felt should underpin this work.



Principles

- Commitment and Accountability for positive change;
- Multi-disciplinary working/joined-up working and sharing best practice;
- Person-centred services that focus on improving outcomes;
- Early Diagnosis pathway/early support;
- Awareness and training in Autism for all staff; and
- Quality – setting standards, innovative/creative value for money.

Discussions focussed on what is currently working well and what areas could be improved upon.

What is working?

Committed and professional services	Person-centred services – direct payments / personal budgets
Support for families, support groups	Person-centred planning
Accessible and flexible services	Variety of short break services and activities
Joint working / working together	Education – two schools are working
PBSS does work	Some commitment from services/providers

What needs to be improved?

Review pay for Personal Assistants	Process of diagnosis
Training	Funding services – pooling/multi-agency
Mental health	Child and Adolescent Mental Health Services (CAMHS)
Education still needs some improvement	If people or groups are good quality within an agency they can get broken up/moved on and the quality gets diluted but not replaced or passed on

Lack of specialist services – disparity in quality between and within agencies	Strategic/joint commissioning
PBSS needs more resources	Need more commitment to joint working
Attitudes and approaches – people not being listened to	Increased resources needed
Strive to become/develop more person-centred services	

It was stressed at the consultation event the importance of commitment and accountability for moving the Autism-agenda forward. The areas identified above have been translated into the Delivery Plan as actions that need to be improved. The Delivery Plan will be driven forward, monitored and implemented by an Autism "Board" which will be established as the first action on the Plan.

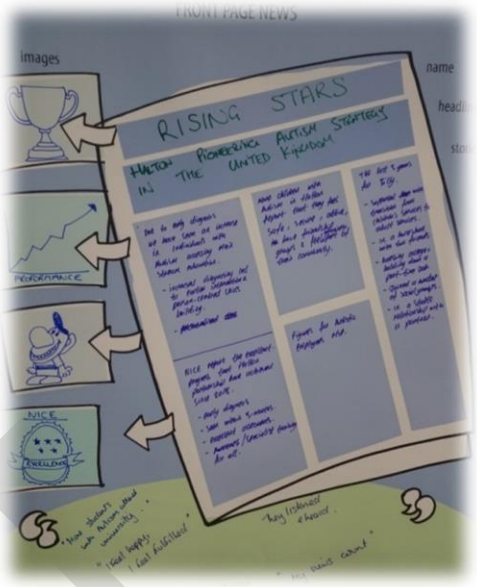
As a final exercise, providers identified what the newspapers could be reporting on in three years' time, if everyone works together to make the improvements and stays fully committed to changing things for the better. Everyone in the room said they wanted to continue to support the Autism-agenda and work together on improving outcomes for people with Autism in Halton.

What Good Looks Like – below you can see the groups with their newspaper front pages



Name: Rising Stars

Headline: Halton pioneering Autism Strategy in the United Kingdom



Stories:

Due to early diagnosis we have seen an increase in individuals with autism accessing mainstream education.	More children with autism in Halton report that they feel safe, secure and active and have friendship groups and feel genuinely part of their community.	The last three years for Billy: • Supported with transition from children's services to adult services. • In a house with two friends. • Accessing college and holding down a part-time job. • Joined a number of social groups. • In a stable relationship with partner.
Increased diagnosis led to earlier intervention and person centred skills building.	Figures for autistic employees rise.	
NICE report the excellent progress that Halton partnership has achieved since 2018.		

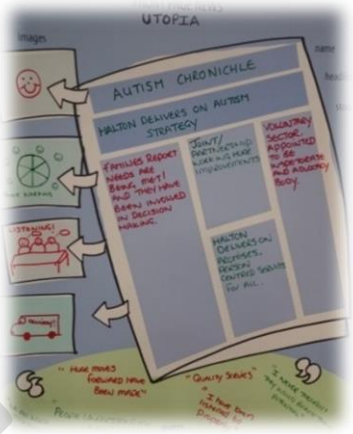
Quotes:

"More students with autism attend university" "I feel happy"

"I feel fulfilled" "They listened and heard" "My views count"

Name: Autism Chronicle

Headline: Halton delivers on Autism Strategy



Stories:

Families report needs are being met and they have been involved in decision making.	Joint partnership working huge improvements. Halton delivers on promises – person-centred services for all.	Voluntary sector appointed to be inspectorate and advocacy body.

Quotes:

"Huge moves forward have been made" "People understand me now" "Quality services" "We all work together" "I have been listened to properly" "I never thought they would reach their potential"

Name: Halton News & Views

Headline: Halton Strategy hits success!

Stories:

Clear and consistent diagnosis pathways in place.	Joint funding available to provide appropriate services. Co-participating and co-production.	Improvements in person-centred planning.
Early support identified to improve outcomes and life opportunities.	People living the life they choose.	More training programmes in place for staff and professionals.

Quotes:

"Finally! We are listened to!" "I know what services I can access" "Diagnosis clear and guided"

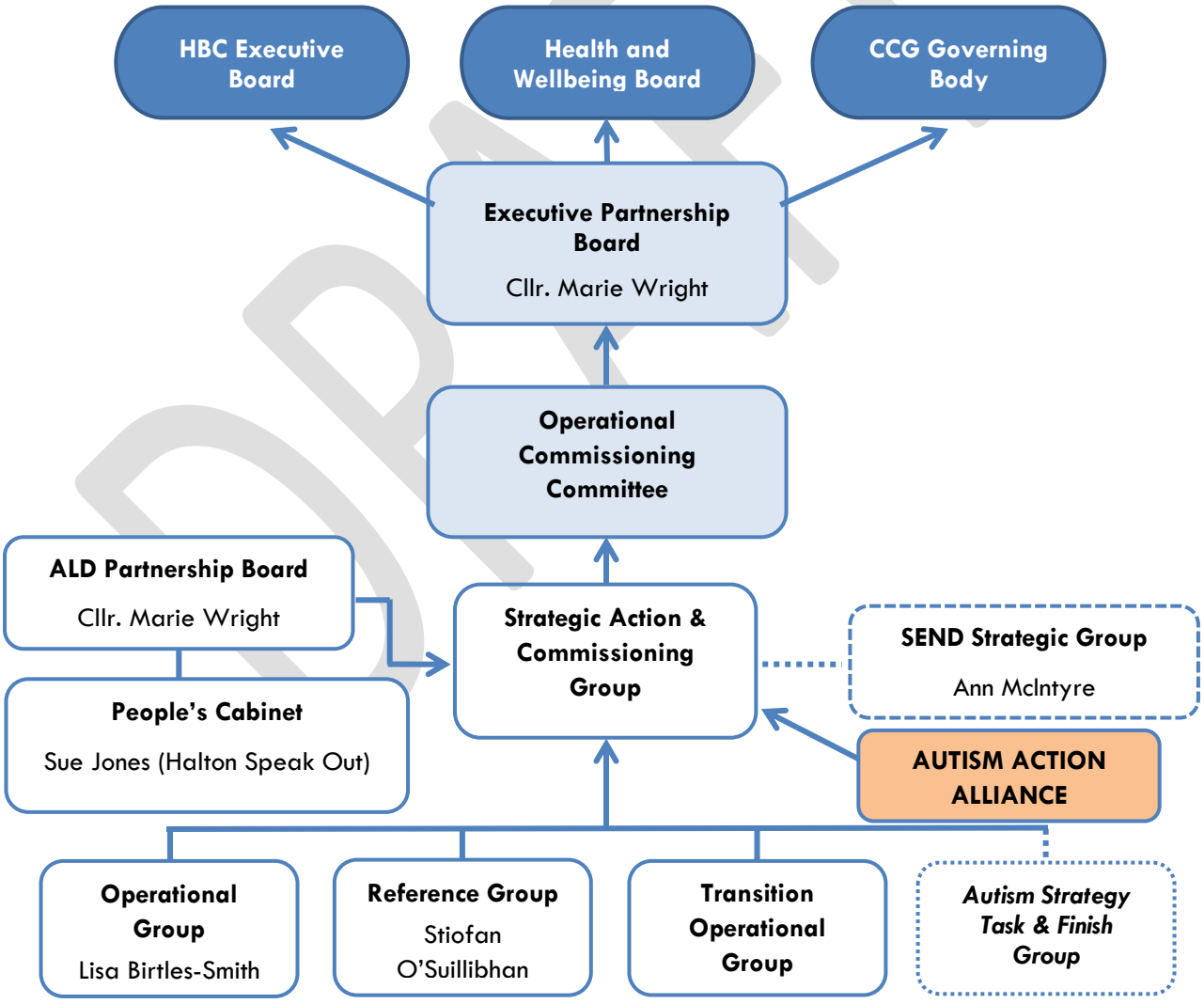
2.0 Strategic Objectives

Halton's All-Age Autism Strategy provides a real opportunity for the needs of people with autism and their carers to be recognised and to ensure that they have the same opportunities as everyone else.

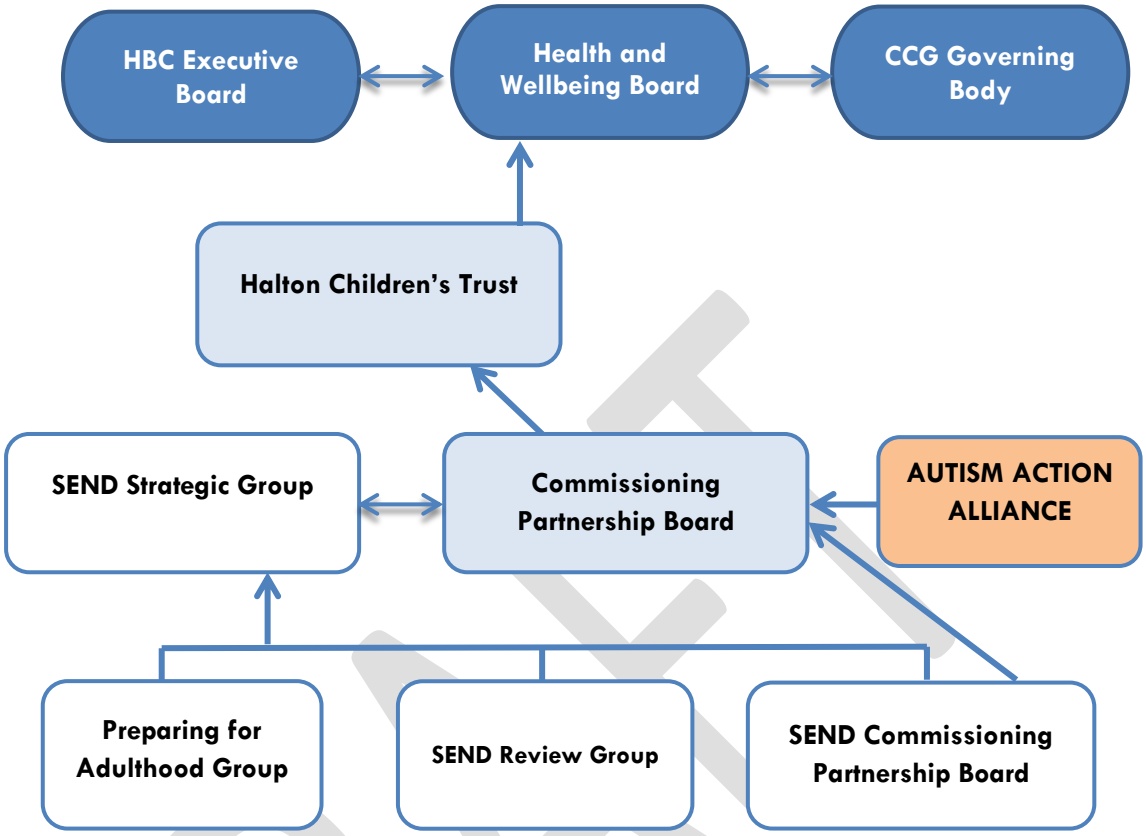
This strategy has been split into the strategic objectives based on the Department of Health's (DH) statutory guidance ***Think Autism***.

2.1 Local Planning and Leadership

Governance Structure – Learning Disability Services for Adults



Governance Structure – Children's Services



2.1.1 Identification and diagnosis of autism

Guidance from the DH states that while Local Authorities will lead commissioning for care and support services for people with autism, CCGs are expected to take the lead responsibility for the commissioning of diagnostic services to identify people with autism, and work with Local Authorities to provide post-diagnostic support for people with autism (regardless of whether they have an accompanying learning disability, other hidden impairments or a co-occurring mental health problem).

Adults

For adults with an identified Learning Disability (LD), a diagnostic assessment for autism can be accessed within LD services. However, should people with an LD be able to access generic Autism Diagnostic Services, then, under the principles of the Green Light Toolkit for Mental Health (National Development Team for Inclusion, 2012, 2013) reasonable adjustments should be made to enable this access. Halton Community LD Team follow the NW Boroughs Healthcare NHS Foundation Trust diagnostic pathway for LD and autism.

Referrals are accepted via the HBC hub or directly into the team and can be made by GP's, social workers, other professionals, carers or by self-referral. As part of the

referral process, a completed screening tool is required to ensure that the need for an assessment is clinically indicated and core areas of diagnostic presentation exist. The referral will then be discussed at the team meeting and, if appropriate, placed on the waiting list for an assessment. Within the team, assessments are completed using a range of tools including Autism Diagnostic Interview-Revised (ADI-R) and Autism Diagnostic Observation Schedule (ADOS) as recommended in the NICE guidance. As per NICE guidance on diagnosis, where possible a family member or carer is engaged to inform both current presentation and developmental history.

Following diagnosis, people with LD and autism receive multi-disciplinary support as required from the team. Clients accessing the LD service receive support based on clinical and presenting need, for those persons who receive a diagnosis the availability and access to the service will not change however, the diagnosis may provide additional information about need and provision of interventions.

For adults without a learning disability, autism diagnostic assessments can be accessed via the Adult Social Care (ASC) diagnostic service within NW Boroughs Healthcare NHS Foundation Trust. This service covers St Helens, Knowsley, Warrington and Halton boroughs and the assessments are funded by the CCGs. This service is currently based at Willis House, Whiston, L35 2YZ. Referrals can be made directly to the team and can be made by GP's, social workers, other professionals, carers or by self-referral. It is requested that an Autism-Spectrum Quotient – 10 items (AQ-10) screening self-assessment is completed with the referral and the team will then further explore suitability of an assessment. Within the team assessments are completed using a range of tools including Diagnostic Interview for Social and Communication Disorders (DISCO), ADI-R and ADOS. A report is then provided outlining the diagnostic decision and makes person centred recommendations. With the person's consent, this is shared with GP and relevant agencies. For those receiving a diagnosis of autism, the report outlines the statutory guidelines about assessment or reassessment of need and carers assessments that should follow a diagnosis of autism.

This is a diagnostic service only. Adults with autism who do not have a learning disability should access mainstream health services as and when they are needed. Mainstream services should make reasonable adjustments to support those accessing the service with autism. The Greenlight Toolkit outlines the reasonable adjustments that mainstream mental health services should implement to support people with autism.

Children

For Children in Halton, the Diagnostic Pathway is set out in a chart, which can be seen at Appendix 4. Feedback from the consultation events stressed that this is an area that requires evaluation. This will be an action on the Delivery Plan.

2.2 Transition from childhood to adulthood

Transition to adulthood is a crucial stage in the lives of all young people, and a time when those with autism may face particular challenges. Good transition support for children and young people with autism can have a profound impact on their ability to reach their potential, through access to further learning or training, employment and independent living opportunities. Co-operation between the relevant authorities is crucial if the person is to fulfil their potential. Local Authorities children's and adult services, children's health services and social care all need to play a part. Under the Children and Families Act 2014 Local Authorities have duties towards children and young people with autism and their families. There are also requirements that Local Authorities must meet under the Care Act 2014 as young people make their transition from children's services into adult services.

Recognising the importance of effective transition for people with disabilities and/or complex needs (including those with autism), Halton established a dedicated Transition Team early in 2017 alongside the development of a new multi-agency Transition Protocol for the period 2017-2020.

This approach ensures that legislative obligations are met and the transition process is joined up across education, health and social care with increased and targeted co-ordination and communication from all agencies starting from Year 9 (age 13/14) up to the age of 25 years or until an individual's appropriate transfer into generic adult services.

Throughout the transition process, there is a person-centred and outcome-focussed approach with young people and their families/carers being fully involved in decision-making. They are supported, through a strengths-based approach, to be aspirational and reach their full potential in relation to education/employment, living independently, participating in society and being as healthy as possible in adult life.

2.2.1 Planning

The planning process for Transition will start in Year 9 (age 13/14) and at this point the Transition Team will become involved in planning for the transition to adult services, for young people with an Education, Health and Care Plan (EHCP) and a diagnosis of Autism.

The process will ensure that a young person has a named social worker, when required up until year 14 (age 18/19), who will attend all review meetings that are called by the school and the young person, their parents and carers or chosen representative, the school teacher, SEND representative, relevant health professionals, careers advisors and a person-centred facilitator.

In advance of the year 9 review, school will support the young person to complete the **'My Transition Plan'** document, which will be discussed during the review meeting and added to and updated as appropriate afterwards. The Transition Social Worker will support school staff with this process. The purpose of My Transition Plan is to capture the young person's aims and aspirations for the future, the options that may be available to them as they move towards adulthood and the care and support they may require.

To assist with transition planning, young people and their families should be referred to the Preparing for Adulthood section of Halton's Local Offer, which provides information, support and advice across education, health and social care covering ages 0-25 years. In addition, the Care and Support for You Portal provides information, advice and signposting with regards to adult social care services (age 18+).

My Transition Plan sits alongside the EHC Plan and the Health Action Plan, which is initiated by the school nurse at year 9, as necessary. Some young people may also have an 'All About Me' book, which is produced by schools from year 7 onwards (schools are responsible for maintaining this). Each of these documents will be considered within the review and updated by the relevant professional as appropriate following the meeting. The Transition Social Worker, supported by the relevant school, takes responsibility for the My Transition Plan. The SEND Service has responsibility for the EHC Plan. Health staff in attendance at the review will give consideration to whether the young person needs any therapeutic involvement or if any further referrals need to be made.

In years 10 to 14 it is focussed on firming up the options when leaving statutory education. There should be taster sessions offered from the educational setting that the young person is looking to attend post-16 and these will be explored and confirmed by the current setting.

If leaving school or college (year 11/14), the young person's final School Health Review (to incorporate the Health Action Plan) should be completed by the school nurse or paediatrician and a copy given to the young person/their family and shared with their GP (if consent given). It should also be made available to adult services to inform future health needs.

The Social Worker will work with the young person in a variety of settings, whichever one is the most comfortable for the young person and their family. Future planning outside of education will also be discussed, future accommodation, employment, friendship and social opportunities and how much support they will require to ensure this is an achievable goal.

2.2.2 Transition protocol

The Protocol applies to children and young people between the ages of 14 and 25 who have disabilities and/or complex needs, including the following distinct groups:

- Those who have an EHC Plan (or a Statement of Special Educational Needs (SEN));
- Those who are likely to meet the eligibility criteria for adult social care services (in line with the Care Act 2014);
- Those with Continuing Healthcare needs;
- Those with complex needs (e.g. behaviours that challenge services, learning disabilities, severe autism, acute or chronic medical conditions);
- Those who would benefit from support in planning for adult life but do not have an EHC Plan/SEN (e.g. those with high-functioning autism or social/emotional/mental health difficulties/ill health);
- Carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood.

The Protocol provides professionals from across education, health and social care services who are involved in supporting young people through transition with information about what should happen and when, who has responsibility and how agencies should work together.

The transition timetable is outlined within the Protocol, which explains that Year 9 marks the start of the formal transition to adulthood process and it is at this point that the Transition Team will become involved in planning for the move to adult services. This is in line with the requirement under the Children & Families Act 2014 that every EHC Plan review from Year 9 onwards must have a focus on preparing for adulthood.

The Protocol also describes how, in line with the Care Act 2014, a transition assessment will be conducted for young people with care and support needs if they are likely to have needs when they reach age 18. Adult carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood are also entitled to a transition assessment.

2.3 Training of staff who provide services to children and adults with autism

NICE guidance states that all health and social care practitioners involved in working with, assessing, caring for and treating people with autism should have sufficient and appropriate training and competencies to deliver the actions and interventions that are required. NICE also state the importance of people with autism being involved in the delivery of training to health, social care and education practitioners.

2.3.1 Autism Awareness

Through a contract we have with the LD Training Alliance a two-day autism awareness training course is offered. This is to increase basic awareness of how people with autism present and effective support strategies that can be utilised. This is suitable for carers, support staff or professionals who require a basic understanding of autism or professionals who have limited prior knowledge of autism. All staff within Adult Social Care have access to this course.

The British Psychological Society (BPS) have autism modules via e-learning. Levels 1 and 2 are free, level 3 has a cost. The link to the modules can be accessed here: https://beta.bps.org.uk/psychologists/professional-development/find-cpd

SEN Service provides whole school staff awareness to schools and settings as required. Elklan for Verbal ASC is offered on a yearly basis for up to 20 staff delivered over three full days. The offer also includes nurseries with Early Years training and visits by autism specialist teachers and portage to settings who have received training. Ashley school, through the teaching school alliance also offers regular training.

The SEN Service also provides on at least an annual basis the York Intervention for parents and carers of young people on the autism spectrum training. This is a nine week training course which aims to support parents develop an understanding of autism and provide them with strategies to help manage behaviours that challenge. Sibling training and support is also provided by the SEN Service through Halton Young Carers on a regular basis. We are also intending to set up training for children and young people with autism based on what parents have asked for from the York Intervention.

Commissioned services such as Chatter Bug Speech and Language Therapy Service provides training for parents in areas such as; use of visual supports and use of PECs (Picture Exchange Communication System).

Brookfields Special School provides NAS Early Bird training for parents and carers of young children. The aim provides guidance and strategies to support children and encourages confidence building in supporting interaction and communication skills. Brookfields Special School also provides parents and carers of children at the school with training around visual supports and use of PECs.

The Graduated Approach

According to the SEND Code of Practice, schools and settings should support pupils with SEND including autism using an Assess, Plan, Do, Review process/approach.

The first step in supporting a child or young person with a diagnosis of autism is to ensure that high quality differentiated teaching taregted at the area of need is the first response to supporting a child with SEND including autism (SEND Code of

Practice, 2014 6.37). Within Halton, schools and settings should not delay in providing intervention and support for children with SEND, including autism and should deploy their own resources and provision targeted at the area of need in the first instance.

The Graduated Approach can be considered as a process where increasing levels of support are implemented, and referrals are made to advisory services as appropriate. Where schools and settings can evidence that they have followed the Graduated Approach and implemented the advice of external agencies, but the child has needs that are unmet, the next step in the Graduated Approach is to apply for support for Enhanced Provision.

Enhanced Provision allows schools and settings to supply evidence that a child or young person has needs that cannot be met within the school or setting's own resources. It also enables schools and settings to use funding flexibly for the benefit of the child or young person. Enhanced Provision is top up funding provided by the Local Authority to help meet the needs of the child or young person. This provision can take the form of training, equipment, specialist resources or additional adult support and it is the school or setting's responsibility to demonstrate this need and the rationale for this intervention and support. Enhanced Provision is time limited and will remain in place for one year.

2.4 Education, health and care plans

The DH Guidance states that the Children and Families Act 2014[5] provides for a new SEND support system, covering education, health and social care. A key change within the Act is that it replaces SEND statements and Learning Difficulty Assessments (LDAs) with more co-ordinated EHC plans for children and young people aged 0 – 25 with the most complex needs. This brings parity of rights for those at school and at college. There is also continuity of support beyond 18 + up to 25 for a young person if they need it to achieve their desired education and training outcomes and to help prepare them for adulthood. EHC plans provide a much greater focus on long-term outcomes.

Not every child or young person with a diagnosis of autism will require an EHC Plan. All schools and settings are expected to follow the graduated approach as outlined above. Schools and settings are required to follow a process of assess, plan, do, review in response to any emerging SEND need including autism. Many children and young people with a diagnosis have their needs met at SEN support level within schools and do not require support beyond this. A minority of children and young people within Halton may require the support of an EHC Plan.

[5] http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

2.4.1 New school provision for children with autism

In Halton, we have a range of provision for children with a diagnosis of autism. Our aim is that many children and young people can have their needs met within their local mainstream schools so that they can access education within their own communities. In order to support schools to meet the needs of children and young people with autism, we offer a range of support and services including:

- Education Psychology Consultation;
- Specialist Teacher and advisor involvement;
- Outreach support from specialist settings;
- Speech and Language Therapy Service; and
- Training and support for schools and settings who support children and young people with autism.

Some children and young people with autism have needs that are exceptional and cannot be met within mainstream school. In order to support children who have needs that are beyond what a mainstream school can provide, there is a range of provision available including resource based and specialist provision.

In order to access this provision, children and young people's needs are assessed on an individual basis following an application for an EHC assessment.

Resource bases

Simms Cross School and The Grange School have resource base provision to meet the needs of children in Key Stage 1 and 2. Each base is staffed by a teacher and two teaching assistants. There is provision for 14 children with a diagnosis of autism to attend the bases. The resource bases have highly skilled and specialist staff who are able to support the needs of children with autism. The concept of the resource base enables children to continue to access some mainstream school experience and to learn alongside typically developing children whilst providing individualised, specialist support to meet the needs of the child. Historically, children were placed in the base following a request for Enhanced Provision. From September 2017, children admitted to the base will typically be allocated a place following an EHC assessment.

St Peter and Paul School and The Grange School have resource base provision for children with a diagnosis of autism in Key Stage 3 and 4. Each base has provision for seven children and are staffed with at least three members of staff. Staff within the resource base have received additional training in autism such as the three day Canterbury and Christchurch University course in 'Understanding autism in school – Certificate in Autism'.

Special School Provision

Halton has a range of special school provision designed to meet the needs of pupils with SEN including autism. Places to special schools are allocated through an EHC Plan assessment. Each one of Halton's special schools provides a carefully tailored curriculum designed to meet the needs of children with SEN.

Brookfields Special School is a National Autistic Society (NAS) accredited community school which provides education for primary aged children with severe and complex learning difficulties and autism. Outreach support for mainstream primary schools is also provided through Brookfields.

Chesnut Lodge Special School is a community special school providing education that caters for children with complex physical and medical needs between the ages of 2 and 16.

Ashley High School is an NAS accredited secondary provision for pupils with a diagnosis of autism or social communication difficulty. Pupils placed in Ashley High School are high functioning pupils who receive a similar curriculum to mainstream peers but due to their vulnerability require a smaller setting with specialist staff.

Cavendish High Academy is for secondary aged pupils between the ages of 11-19 with severe and complex learning difficulties, profound and multiple learning difficulties including those with autism.

For more information on any of Halton's schools, please see the Local Offer which provides more information on each of the schools and the support they offer: https://localoffer.haltonchildrenstrust.co.uk/schools/

2.5 Transition to adult health services

Under the Children and Families Act 2014, CCGs must co-operate with local authorities to jointly commission services that will help meet the outcomes in EHC plans. This should include supporting the transition between children and adult services.

The Halton Community LD Team sits within North West Boroughs Healthcare NHS Foundation Trust. The Halton Community LD Team is a multidisciplinary service that supports adults with a primary diagnosis of a learning disability who have difficulties accessing mainstream services *because of their learning disability.* If a person is not previously known to the team, first and foremost, information will be required as to the presence of a learning disability. This may be gathered via: a clinical interview with the person and/or their carers, a review of previous educational statements of SEN or professional health reports. Some people may require more in depth assessment to identify if they have a learning disability.

The Halton Community LD Team comprises: speech and language therapists, occupational therapists, physiotherapists, clinical psychologists, therapy assistants and a consultant psychiatrist. There is also a community matron for learning disabilities who sits within Bridgewater Community Healthcare NHS Foundation Trust and a team of LD nurses who sit within HBC.

Users of services receiving clinical support from learning disability services will have a learning disability and an unmet health need. People with a LD may also have a diagnosis of autism or require an assessment for autism. Users accessing these services receive support based on clinical and presenting need.

The team has good links with HBC's Social Services Transition Team and have provided guidance on indicators a person may meet criteria for having a LD, and therefore may require support from the specialist LD team. The team also meets regularly with health services in Woodview Child Development Centre to improve the identification of individuals requiring intensive support around transitioning from children's to adults services within specialist learning disabilities service input. Professionals from the team may attend ECH Plan meetings, where invited, for clients who are currently accessing the service.

For adults with autism who do not have a learning disability, health services would be accessed from mainstream teams. Mainstream services should make reasonable adjustments to support those people with autism accessing their service.

2.6 Preventative support and safeguarding

The Care Act 2014[6] places a duty on local authorities to provide or arrange preventative services for people within their communities. LAs should ensure they are considering the needs of their local child, young person and adult population who have autism, including those who do not meet the eligibility threshold for care and support.

[6] https://www.legislation.gov.uk/ukpga/2014/23/contents

2.6.1 Access to information and signposting

DH guidance states that it is important that all people with autism, whatever their level of need, can easily access information in their local area about what support from peers, charities and other community groups is available.

In Halton we have our Local Offer website, which is an online resource available to everyone, in particular:

- Children and young people with SEN and/or Disabilities (SEND) from birth to 25 years;
- Parents/carers and families; and
- Practitioners and professionals.

By working closely with children, young people, parents, carers and professionals we have used their ideas and feedback to change the layout, content and information available on the Local Offer to ensure it is user-friendly, in an accessible format and easy to understand. The main 'home' page is set out in themed topic sections and from there information can be easily found in itemised drop-down boxes.

Halton SEND Partnership information advice and support service (SENDIASS) is Halton's statutory information advice and support service. The service delivers FREE and confidential independent, impartial advice, guidance and support to children, young people (0-25 years) and their families around SEN and/or disabilities, SEND. Access to support from Halton SEND Partnership is not dependant on a formal diagnosis of needs; the service covers initial concerns or identification of potential SEN or disabilities, through to ongoing support and provision.

Chapter 2 of the SEND Code sets out in detail the duties that rest on local authorities to ensure that information, advice and support is available to children and young people with SEN and disabilities, and their parents. The Code describes how such services should be provided (2.4), the principles that should be taken into account (2.8), who information, advice and support should be available to (2.9 – 2.16), and what services should be provided (2.17 – 2.23).

Effective information, advice and support will result in service users being able to navigate SEND processes (including education, health and social care), participate in decision making, and, where necessary, challenge service providers to ensure that the needs of children and young people with SEN and disabilities are identified, assessed, provided for and reviewed in accordance with the Children and Families Act 2014 and the SEND Code.

2.7 Reasonable Adjustments and Equality

DH guidance for Adults states that for many people with autism, mainstream public services can be hard to access. People with autism can have a number of sensory differences affecting all five senses that can impact on their lives in a number of ways including communication, socialising and living independently. All public sector organisations, including employers and providers of services are required to make reasonable adjustments to services with the aim of ensuring they are accessible to disabled people, including people with autism. People with autism have a right to access mainstream services just like anyone else.

For adults with autism who do not have a learning disability, health services would be accessed from mainstream teams. Mainstream services should make reasonable adjustments to support those people with autism accessing their service.

Adults with autism accessing health services should also have a hospital passport so that their personal information and preferences are clear to all staff.

2.8 Supporting people with complex needs

DH guidance for Adults states that people with autism who also have mental health conditions or behaviours viewed as challenging are entitled to get good quality safe care, whether at home, living in the community or in hospital. People should be assessed, treated and cared for in the community wherever possible. People should live in their own homes with support to live independently if that is the right model of care for them.

Local Government Association (LGA) and NHS England make some key recommendations for services for children, young people, adults and older people with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges. The guidance was produced in response to Action 19 of Transforming Care: A national response to Winterbourne View Hospital; and reaffirms a model of care which is known to represent best practice. NHS England has also produced further guidance on models of care for intensive support services for people with learning disabilities and/or Autism.

Core principles that should be in place across all education, health and social care services accessed by all children and adults with a learning disability and/or Autism who may engage in behaviour that challenges include:

- Improved life quality;
- Reduction in prevalence and incidence of behaviours;
- Reduction in the number of people placed in restrictive placements e.g. Assessment and Treatment Unit (ATU), residential school etc.; and
- Reduction in the inappropriate use of medication, restraint and seclusion as behavioural intervention.

With reference to challenging behaviour several best practice recommendation are made:

1) Behaviour Support is based on an holistic assessment (incorporating Functional Assessment) of the context in which the behaviours occurs;
2) There is a written individual support plan;
3) The behaviour support plan includes: a description of behaviour that challenges; a summary of the reasons for this behaviour; proactive strategies and reactive strategies;
4) Monitoring and review arrangements; and
5) Implementation arrangements.

The PBSS provides such services. Individuals referred to the service are given a full Functional Assessment of behaviour, carried out by a Board Certified Behaviour Analyst (BCBA). From this a person centred intervention and Positive Behaviour Support plan is developed. Support is then provided by the service to implement the plan and monitor its effectiveness and progress. Once an individual has reached their behavioural objectives, which will include both challenging behaviour reduction targets and also improved quality of life indicators e.g. increase community access, then discharge processes will commence. Individuals are provided with a detailed exit and maintenance plan with a view to preventing procedural drift and a re-emergence of behaviours that challenge.

PBSS pick up referrals for those individuals with the most complex behavioural needs. A high number of individuals referred to PBSS have a diagnosis of Autism. Referrals are triaged in adult service by the Adult LD Nurse Team. Part of their role is to screen out any underlying health issues impacting upon the individuals' behaviour before progressing additional assessments/sign posting to specialist services e.g. PBSS. Individuals with Autism and a LD who engage in lower level behaviours are supported in adult services by the LD Nurse Team who also utilise a functional assessment approach. Service users may also access support by Speech and Language Therapist (SALT), Psychology or Occupational Therapist (OT) as part of a Multi-Disciplinary Team (MDT) approach to challenging behaviour. In children's services behavioural support for lower intensity behaviours is offered by Woodview children's services or CAMHS where there is a mental health issue also.

PBSS also provide training to other mainstream services in Positive Behaviour Support. Training is offered with a view to skilling up services e.g. adult short break, to be better equipped to support people who can engage in behaviour that challenges services.

LGA and NHS England also recommend that an Active Support model of care is provided. Active Support is an evidence based approach to supporting increased

meaningful activity. Halton has taken a strategic effort to utilise Active Support as a model of care across adult services e.g. all day service staff and supported housing staff have been given training in Active Support and adopt this model of care. PBSS also support Active Support training with independent service providers supporting individual's referred to the service.

For individuals sectioned under the Mental Health Act the Care and Treatment Review (CTR) protocol is followed. CTRs were developed as part of NHS England's commitment to improving the care of people with learning disabilities, autism or both in England with the aim of reducing admissions and unnecessarily lengthy stays in hospital and reducing health inequalities. CTRs are focussed on children, young people and adults who have learning disabilities, autism or both **and** who either have been or may be about to be admitted to a specialist mental health / learning disability hospital either in the NHS or in the independent sector. The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the care and treatment and differing support needs of the person and their families are met, and that barriers to progress are challenged and overcome.

Behaviour others may find challenging lessens with the right support and individuals benefit from personalised care and living in the community. It is important that those who support people with complex needs, whose behaviour may challenge or who may lack capacity should have a good understanding of supported decision-making, understand the principle that people would not be treated as lacking capacity simply because they make an unwise decision; should consider their wishes and feelings, and all health and social care organisations need to understand the principle of least restrictive care, identifying a range of interventions and seeking the least restrictive ones for people with autism.

For adults with autism and a LD who require admission to a mental health hospital setting, Byron Ward is based at Hollins Park Hospital in Warrington. This is within North West Boroughs Healthcare NHS Foundation trust.

Dynamic Support Database

The development of a Risk Register was referenced in the National Care & Treatment Review (CTR) protocol document to ensure there was support available to those individuals who may be at risk of admission to a Mental Health Inpatient unit. Across Cheshire & Merseyside the term 'Dynamic Support Database' is used rather than Risk Register. There is an agreed Standard Operating Framework, outlining agreed standards to be adhered to across the Cheshire & Merseyside Transforming Care Partnership[7] footprint for the development and maintenance of Dynamic Support Database for adults (i.e. who are aged 18 years or over) with a diagnosed LD, who may also have an Autistic Spectrum Condition, who are registered with a GP within

[7] http://www.cwp.nhs.uk/about-us/our-campaigns/transforming-care/

respective CCG areas, and who are currently clinically managed through the direct involvement of a local Specialist Community LD Team.

This is the web link for the accessible standard: https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf

2.9 Working with the Criminal Justice System

Under the Care Act 2014 (from April 2015) LAs must assess the care and support needs of adults (including those with Autism) who may have such needs in prisons or other forms of detention in their local areas, and meet those needs which are eligible; and work with prisons and other LAs to ensure that individuals in custody with care and support needs have continuity of care when moving to another custodial setting or where they are being released from prison and back into the community.

A needs assessment document produced by the Centre for Public Health at Liverpool John Moores University in Jan 2016[8] suggest that the prevalence of ASD in CJS is higher than the prevalence of ASD in the general population however this conclusion is modified by the poor methodologies and biased samples used in the studies which formed part of Murphy and King's review (2014). Similarly the prevalence of offending in ASD populations are also difficult to interpret but suggest that adults with ASD commit the same or fewer offences than those in non-ASD populations.

The Youth Justice system differs from the adult system in that there is a statutory requirement to consider the welfare and wellbeing of the child, aged 10-17, as well as the need for public protection in any actions taken by the Police and Courts.

The 1998 Crime and Disorder Act requires the Chief Executive of the LA to ensure there is a multi-agency partnership in place including the Police, Probation, Health, Education and LA as well as other relevant partners. In Halton this is delivered in a wider partnership with Warrington, Cheshire West and Chester and Cheshire East councils who have formed Youth Justice Services to deal with children in contact with the Youth Justice system.

All children referred to the Youth Justice Service (YJS) in Halton have come to the attention of the Police and when circumstances of the child and or incident allows, the presumption is not to prosecute or utilise the formal Criminal courts system but to effect an appropriate out of Court disposal which generally means no impact in terms of a criminal record.

The primary model for Out-of-Court disposals is via the award winning (Howard league for Penal reform 2017) Divert programme which seeks to identify relevant

[8] "Learning Disabilities and Autism: a health needs assessment for children and adults in Cheshire and Merseyside"

issues within the child's experiences and address them without recourse to the formal court system wherever possible.

All children referred to the YJS whether via formal Court outcomes or by way of Out-of-Court disposal are assessed utilising a nationally credited assessment tool-AsetPlus - which includes issues of general and mental health. The Youth Justice Service refers those children with identified or suspected needs related to autism to the general service provision within Halton. YJS staff receive regular training to ensure they are up to date with a wide range of issues affecting children in the contact with the Police.

Children detained by the Police prior to charge or Court appearance will be the responsibility of the Police during this period, but where detention is not required will be transferred to the LA for appropriate placement.

Children who receive a custodial outcome, whether sentenced or awaiting Court decisions, will receive a full health assessment and access to relevant services via the Institution in which they are placed, which can be anywhere in England or Wales as commissioned by the Youth Justice Board. The majority of children from Halton placed in a custodial setting will find themselves in Wetherby Young Offender Institution in Yorkshire. The YJS will retain case responsibility and will liaise with the child, family and home based services for the duration of the sentence in custody and upon release.

The wider YJS which covers the Cheshire Policing footprint and the four LA areas has access to specific speech and language services but these are currently unavailable in Halton.

At the age of 18, children transition to the adult criminal justice system and are expected to be transferred to the national Probation service for the reminder of any formal Court order.

The short ***case study*** below illustrates how the YJS Diversionary approach works in practice.

- 12 year old child arrested for six offences of criminal damage and one offence of assaulting a police officer.
- From the Police interview, it was clear that the child's level of difficulties were such that he struggled to comprehend the consequences of his

actions i.e. recognise them as criminal acts.

- The case was referred to the Youth Justice award winning Divert scheme by police.

- The YJS triaged the referral and noted the child was known to children's services. YJS completed an assessment and liaison which included screening for SEN and disabilities through co-located CAMHS and Education specialists in YJS.

- YJS worked closely with the LA to advocate and help broker specialist education provision in Southport to support the child's identified needs.

- YJS contacted victims of offences who were happy for the matters to be dealt with by way of an out of court disposal.

- YJS and Police followed Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act[9] guidance around joint decision-making for out of court disposals and made recommendation for the offences to be dealt with by way of an informal sanction called 'community resolution'.

- Outcome – the child was successfully diverted away from the formal criminal justice system and into appropriate support and intervention that would meet his needs, reduce risk of repeat offending and avoid harming his future life prospects with a formally recorded police caution or conviction.

[9] http://www.legislation.gov.uk/ukpga/2012/10/contents/enacted

The Voice of Autism – Ashley High School **APPENDIX 1**

QUESTION	PUPIL RESPONSES
As an Autistic young person, what do you think is working for you in terms of your Autism?	• The school is autistic friendly and they are not like other schools • Small classes • Support • Having free time as a reward • No changes • My cards (visuals) • Stress relievers like sports, video games and music • Rewards for full credits in lessons • People understanding that I think differently to other people • Playing sports • Good/kind teachers • The help I am getting • Having fun in school, fun lessons • Science • Drawing • Being more mature • A mum that understands me • Money from government • My own room
What would make life easier for you at school?	• No loud noises, it hurts some people's ears • Not too much pressure on me to do my work • People accepting I am hyper sometimes • Having opportunities to calm down • Easy homework • Having special colours and drawing time • Time to think • Listening to my problems • To have a good morning at home so I take my good mood to school
What would make life easier for you at home? **QUESTION**	• If I had more friends my age • When I bounce on my trampoline • Being allowed to go on my Xbox in the week • Not too much work • Building stuff on Minecraft • Letting me watch 'I'm a Celebrity' at the start and the end • No arguing, not talking at the wrong time • More mum and dad time • If we talked it out • Hit cushions • Personal space, relax time, a prize if I'm good on a Friday • To have a good day at school so I have a positive attitude at home

	PUPIL RESPONSES
What does a good day look like for you?	• When I try to make the school better by being a Fire Marshall • Stress free and freedom of choice to do what I want, privacy • Reading, enjoyable lessons • When I don't get wound up by others • Getting full credits in lessons • Nice relaxed lessons with free time and Xbox at home • If my brain doesn't feel hard • More school drawing, looking at online images to draw • Getting no warnings • When I'm happy • Having fun, being with my parents, no one picking on me • Every day at school • Relaxing all day • Having a good morning at home so I enjoy myself at school
What does a bad day look like for you?	• When I get stressed out for certain reasons, when people annoy me I get angry • Friendships being broken • Two or more home-works a day • Being spoken to when I don't want to talk • When someone calls me a bad name (I would tell the teacher) • Change of timetable • Double lessons • When I get tired and mithered to death • Hard work, hard homework • Wednesday because of Science • Getting told off at school and at home • If I could not go to school • Getting told off because of my actions • When I'm unhappy • Being picked on, called names etc • People not letting me play football with them • Running out of sweets • When I get in trouble at home so I don't enjoy my day at school
Any other comments (continue over the page if necessary)	• I would like to go to other schools and make them aware of what Autism is and what the difficulties are • I would like a Halton Autistic football team • More DT as I think it is good to learn more about making stuff • Less pupils who are being annoying • Primary was 'hell' but I'm out of it

Consultation with Schools Appendix 2

Thursday 9th November, 3.30pm-4.30pm at Ashley High School

Attended: RB Teacher Simms Cross, RB lead and SENCO, Simms Cross, RB Lead, St Peter and Paul's, Head teacher, Chesnut Lodge, DHT, Ashley, Assistant Head teacher, Ashley, Head of 6th Form and Autism Lead, Ashley, Infant base, The Grange, KS3 Base, The Grange, Practice Manager, Disabled Children's Service, Specialist Teacher.

- Welcome and introductions
- Overview/ aim of the strategy
  We discussed briefly the aims and overview of the strategy and purpose behind it. Ami stressed the need to include and get the schools involved as key partners in the process.
  Ami thanked schools for sharing the questionnaire. We had a large response particularly from Brookfields.

- Parental and child/ young person feedback
  We discussed the highlights from the feedback as shown on the next page. We also discussed the following training needs and support for parents:
    - York training is well established and attended but it is a lengthy course and not all parents can engage with this
    - Short courses that we could offer to all parents as a network of schools
    - Specific courses for parents e.g. sex and relationships, social media and internet use
    - Mental health and emotional wellbeing to support

- Further opportunities to gather pupil voice and consultation
    - Helping and supporting children to understand autism
    - Perhaps a video of children exploring what autism is and what it means which could be included on the local offer
    - Whether each school could appoint their own 'autism ambassadors' within the school to participate and work with schools and the community around understanding autism
    - Schools have agreed to have a discussion with pupils and share any further feedback.

- Inclusion of schools as stakeholders in the strategy

Schools welcomed the opportunity to network and wanted to continue to be involved in the strategy and any further opportunity to contribute.

- Any other business

Schools found the meeting helpful and have requested to meet again. The next meeting will take place on **Thursday 11th January at 3.45pm at Simms Cross, Widnes.**

The agenda will cover:

Emotional health and wellbeing for children with autism.
Schools will bring along and share resources and ideas they have developed to address emerging difficulties.
Ami to contact CAMHS and EP Service to see if there is any representation possible at this meeting.

Key themes from the feedback

Number of completed surveys received – 76

30 received via Ami McNamee, the rest through the post

Adult with autism	19
Carer of an adult with autism	12
Child with autism	5
Parent/carer of a child with autism	38
Blank	2
Total	76

Autism	50
Asperger's	11
Blank	15
Total	76

Type of school

Mainstream	5
Special	39
Resource base	1
Blank	1
Total	46

Key themes emerging:

- Lack of post-diagnostic support
- Praise for some services

What schools and colleges can do better:

- Make mainstream schools more autism friendly
- Holiday periods particularly over 6 weeks can be difficult for parents
- Better links between health/ services and schools including services going into school
- Communication- parents can sometimes feel as though they are not fully included in school life
- Transport can be problematic for some children
- Some comments regarding change being too frequent

What else needs to change:

- More opportunity for social groups and activities
- Parents and CYP not always aware of service that are available to them
- Some concerns over transition to other services
- Consistency of staffing

SUMMARY OF SIMMS CROSS RESOURCE BASE QUESTIONNAIRE TO PARENTS **APPENDIX 3**

13 questionnaires sent out, 10 returned.

	How does your child feel about school?
Enjoys/ happy	/////////
Bad/a little bit good	/

Questions Asked	**What are the challenges your child faces?**		**Any concerns regarding the support?**		**What is working well?**		**Any further support RB could offer?**	
Responses	Handwriting	///	None	////////	Everything	//	None	///////
	Completing work	///	Changes in Base	//	1:1 Reading activities in RB	//	Continue Coffee Mornings	///
	Reading	//			1:1 writing activities In RB	/	Continue to inform parents	/
	Keeping his own behaviour under control	/			Staff's approach and knowledge of child	// // //	Explain things in more details to parents with EAL.	/
	Homework	//			Daily Routine	/		
	Waking up	/			Incentives	// /		
	Hard work	/			Able to return to Base	//		
	Socialising/ Boundaries	//			Peer Massage	/		
	Anxiety	/			Golden Time	/		
	Independence	//						
	None	/						

Additional comments from parents

"Just to say thank you for all the help and understanding to date", "The Resource Base staff are amazing", "Brilliant education setting, I'm forever grateful".
"Thank you to all staff", "I don't think there is anything else the staff can do, you all do an amazing job".
"Thank you".

Referrals requiring multiple health services to a single point, one referral form.

Referral not indicating that universal support has been offered/taken-up.

Signposting to other sources of support
Some referrals may need to be signposted to universal early support such as Children's Centres /Health Visitor/School behaviour support/School Nurse support. Family to employ behaviour support strategies in school/at home.
If universal provision implemented does not resolve the issue then Child can be referred back to specialist service. Some may need to be referred to Tier 2/3 CAMHS support if outside expertise of this group.

Assessment commences (18 weeks RTT with appropriate combination of:
AHP assessments
ANP / Community Paediatrics assessment
History, Observation in Nursery / School
Parental/School questionnaires
Early years / Portage information (if involved)
CAMHS information (if known to service)
Ed Psychology, Specialist Teacher (if known to service)
Some assessments may be jointly conducted e.g. SLT + ANP, OT/PT, Additional Needs Nurse / Community Paediatrics.
Initial advice will be given to parents by assessors about managing presenting situation.

Weekly Triage by small group 2-3 of below:
Advanced Nurse Practitioner (ANP), Child Paediatrician, Speech & Language Therapist, Occupational Therapist, Physio, Portage, Educational Psychologist, CAMHS, Orthoptist.

Multi professional panel meets to discuss assessment findings, by week 20 at latest.
Group reviews all assessment findings and information provided by others and develop support plan (regardless of diagnosis)
Decision made:
1. If any further assessments are needed by ANP / Medical Staff
2. If ADOS needed
3. If other medical tests needed
Next actions:
a. Support plan prepared for feedback
b. Complete any further assessments identified
c. Joint written report developed
d. Agree which professionals to feedback to family
e. Agree source of emotional support for family e.g. HV, SN, family member, Portage, Specialist Teacher, School.

CYP & Family Feedback Meeting
Meet with CYP & / or Family. Emphasis on 'support' not diagnosis
Feedback
a. Assessment findings
b. Support plan
c. Diagnosis if appropriate
d. Next steps - ongoing with some services, discharge from other services.

Referral accepted for Specialist Health Assessments. Group agree which professionals are to commence assessments and which may be later.
For medical assessment a child may be assessed by ANP/C Paediatrician (clinical decision by panel).
Where required, Admin/Assistant send leaflet/questionnaires to parents and schools, to obtain views of child in a range of settings.
Recommendation from Panel may be for some families to commence behaviour support via W Stratton/other courses as well as or instead of assessment.

Support does not require medication / medical oversight
Continue the support with AHPs, Specialist Nurses/School /CAMHS/Education Psychology if involved. Discharge from Community Paediatrics back to GP.

Support requires medication / medical oversight
Continue the support with AHPs, Specialist Nurses / School / CAMHS/Education Psychology if involved.
Community Paediatrics manages medication (or shared care arranged with GP) and overview of medical needs with support from ANP.

ONE HALTON ALL-AGE AUTISM STRATEGY

DELIVERY PLAN 2018 – 2019

1	LOCAL PLANNING AND LEADERSHIP				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
1.1	User-led delivery plan monitoring	Establish Local Autism Action Alliance as a sub group of the Learning Disability Partnership Board	May 2018	Patrick Frost, HBC	
1.2	Develop a local register of people diagnosed with Autism.	GPs to continue to record when a person receives a diagnosis on the patient's record. Develop co-ordinated approach to gathering details of current and new diagnosis and updating register.	September 2018	Lisa Birtles-Smith, NHS Halton CCG	

1	LOCAL PLANNING AND LEADERSHIP				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
1.3	Strategic/joint commissioning	Consider joint commissioning across the board (CCG/HBC Adults/HBC Children's) for any new or reviewed Autism services and undertake in a co-production manner. Report on current delivery of support linked to Autism from more generic commissioned services (link to 1.4). Links to local autism user group (as outlined at 6.3)	March 2019 May 2018	Sam Murtagh/Sheila McHale (Lisa Birtles-Smith)/HBC Commissioner Sam Murtagh/ Sheila McHale (Lisa Birtles-Smith)/HBC Commissioner	
1.4	More commitment to joint working and utilising good practice from others areas to improve services.	Review local area to ascertain areas of good practice. Look at the viability of Autism-accredited services.	March 2019 March 2019	Members of the Autism Action Alliance. Patrick Frost, HBC	

1	LOCAL PLANNING AND LEADERSHIP				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
1.5	Identify external funding opportunities for Autism Services.	Review any external funding opportunities specific to Autism and work together as a multi-agency group on developing these funding opportunities.	March 2019	Emma Sutton-Thompson, HBC	
1.6	Promote new Strategy and raise awareness locally	Link in to World Autism Awareness Week from 26th Mar to 2nd April 2018	April 2018	Policy Team, HBC/Ami McNamee,	

2	TRAINING FOR STAFF				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
2.1	All staff across all agencies to be Autism-aware. Selected staff to be supported to be specialists ("autism champions").	Develop and implement e-learning on Autism Awareness for all staff and increase access to LDTA autism training. Identified staff to access further specialist training in Autism.	March 2019 March 2019	Nicola Hallmark, HBC/Jane Birchall-Smith, /Lisa Birtles-Smith, CCG Nicola Hallmark, HBC/Jane Birchall-Smith, /Lisa Birtles-Smith, CCG	

3	EDUCATION				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
3.1	Improved links between health services, social care and education.	Improved integration of Education, Health and Social Care within the EHC process.		Alison Sutch, CCG/Anita Parkinson, HBC/Tracey Coffey, HBC	
3.2	Support mainstream schools to develop 'Autism' and communication friendly settings	Schools and settings encouraged to develop their provision to meet the needs of CYP with Autism. Brookfields provide mainstream schools with Autism-friendly training as part of outreach support. Schools and settings to demonstrate on their Local Offer SEN Information Report dates of their most recent Autism Awareness Training and how they have adapted their provision to meet the needs of CYP with Autism.	March 2019 Sept 2018 Sept 2018	Ami McNamee, HBC Tracy Ryan, Local Offer	

3	EDUCATION				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
3.3	To improve the scope and range of post-diagnostic training opportunities for parents and carers.	York: Intervention and Support for Parents and Carers of children with Autism training offered on at least an annual basis to parents. Ensure that parents and carers receive information about the training through the post-diagnostic family feedback meeting. Ensure details of any ChAPS training is cascaded through specialist Autism settings and through family feedback meetings at Woodview.	March 2019 March 2019 March 2019	Ami McNamee, HBC March 2019 Katrina Mardsen, Additional Needs Nursing, Woodview	
3.4	Increase knowledge of parents in Autism-related areas.	Commission specific training courses for parents, e.g. sex and relationships, social media and internet use.	March 2019	Ami McNamee, HBC to co-ordinate with individual schools.	

3	EDUCATION				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
3.5	Support schools to develop their provision to meet the emotional health and wellbeing of children and young people with Autism Increase support to parents and carers to meet the needs of CYP with Autism	Training and sharing of best practise for schools through half termly meetings. Ensure schools are to be aware of appropriate signposting, e.g. to GPs. Implementation of Nurture For Learning Vision across Halton to help schools, settings and services to meet the emotional health and wellbeing needs of all CYP and their families	January 2018 March 2018	Ami McNamee, HBC to coordinate along with Education Psychology Service " "	
3.6	More opportunity for social groups and activities for children.	Liaise with other departments to promote social groups and activities for children.	March 2019	Anita Blakey, HBC	
3.7	Develop existing parent resource base meetings to ensure training needs are met.	Regular coffee mornings to support parents of children with Autism and opportunities for speakers.	May 2018	Ami McNamee, HBC	

4	SUPPORTING PEOPLE WITH MENTAL HEALTH NEEDS

REFERENCE	INTENDED OUTCOME	KEY ACTION	TARGET DATE	RESPONSIBLE OFFICER/ ORGANISATION	PROGRESS
4.1	Improved services for people with Autism and Mental Health needs	Review the services provided by CAMHS to ensure they are fit-for-purpose	March 2019	Sheila McHale, CCG/Alison Sutch, CCG	
4.2	Improved services for adults with autism and MH needs	Ensure all MH staff in ASC are Autism-aware (link to training above).	March 2019	Lindsay Smith, HBC	

5	SUPPORTING PEOPLE WITH COMPLEX NEEDS				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
5.1	The PBSS Service to be accessible to more of the population.	The following interim targets to establish if the PBSS Service should be extended or not and if it is what are the resource/financial implications. Identify existing behavioural services that currently meet the needs of individuals with Autism and no LD. Identify how many people would benefit from an expansion of PBSS eligibility. Identify the level of resource PBSS would need to meet this capacity.		Maria Saville, HBC/Sheila McHale, CCG Maria Saville, HBC/Sheila McHale, CCG Maria Saville, HBC/Sheila McHale, CCG Maria Saville, HBC/Sheila McHale, CCG	

6	AUTISM SERVICES				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
6.1	Improved process of diagnosis and information once diagnosed.	Review process of diagnosis for both Children and Adults. Produce information pack/online information to give to people once diagnosed.	March 2019 March 2019	Lisa Birtles-Smith/Alison Sutch, CCG Lisa Birtles-Smith/Alison Sutch, CCG	
6.2	Review specialist services and knowledge of staff in the Borough to ensure that the needs of people with autism are met adequately within Halton.	Mapping the gap in specialist and generic services/identifying good practice and look to jointly commission any that are required using person-centred approaches. Research the region to find good examples of day service provision for autistic adults that could be replicated in Halton.	March 2019 March 2019	Sam Murtagh/Sheila McHale (Lisa Birtles-Smith)/Adult Social Care Commissioner Sam Murtagh/Sheila McHale (Lisa Birtles-Smith)/Adult Social Care Commissioner	

6	AUTISM SERVICES				
REFERENCE	**INTENDED OUTCOME**	**KEY ACTION**	**TARGET DATE**	**RESPONSIBLE OFFICER/ ORGANISATION**	**PROGRESS**
6.3	Establish local user group for people with Autism.	Research how groups in Manchester and Liverpool function and try to replicate locally. Establish terms of reference/membership following the research.	March 2019 March 2019	CHAPS/Patrick Frost, HBC CHAPS/Patrick Frost, HBC	
6.4	Ensure adequate short breaks provision in the borough to meet the needs of children with autism.	Review current short break provision for children with autism in the borough.	March 2019	Sam Murtagh, HBC	
6.5	Ensure children are at the centre of planning and children/parents/carers are fully able to contribute to the development of their transition plans.	Transition team to facilitate person-centred, strengths based approaches to the development of transition plans.	March 2019	Debbie O'Connor, HBC	

REPORT TO: Health Policy & Performance Board

DATE: 27th February 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Top-Up Fees

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To introduce the Board to the new policy for 'Additional Payments for Accommodation In Residential Care' (Top-Up Fees)

2.0 **RECOMMENDATION: That the Board:**

i) Note the contents of the report and associated appendix.

3.0 **SUPPORTING INFORMATION**

3.1 The Care Act required local authorities to develop a framework for the implementation of Care Home top up fees.

A "top up" is the difference between what the local authority would usually expect to pay (depending on that particular person's care needs) and the extra cost of a specific care home. The additional cost is reflected in an additional service or added value. Top up fees can apply If the person chooses a care home that is more expensive than the Council agreed rate. This includes circumstances where the person has been paying for their own care under a private arrangement.

3.2 Affordability is considered at the point of assessment and review. An individual service agreement and information leaflet has been developed to ensure that people understand the importance of reporting a change in circumstances and where they can get independent financial advice. Care Home can only implement a review of top up fee once a year.

3.3 Where Halton is responsible for meeting a person's care and support needs the person will have the right to choose between different providers of that type of accommodation provided that:

- the accommodation is suitable in relation to the person's assessed needs
- the cost is no more than the amount specified in the adult's

personal budget
- the accommodation is available
- the provider of the accommodation is willing to enter into a contract on the Council's rates, terms and conditions

This choice will not be limited to existing settings, providers or within that local authority's geographical boundary. There will be genuine choice across the appropriate provision.

3.4 When the more expensive accommodation was a matter of choice rather than necessity (less expensive accommodation was available, but not chosen), the council will fund the personal budget amount only. Paying the Top-Up becomes the responsibility of the person or their representative.

3.5 Where someone is placed in a more expensive setting solely because the council has been unable to make arrangements at the anticipated cost, the additional cost will be reflected in the person's personal budget

3.6 Supporting the individual's right to independence and choice the Social Worker will discuss with all parties the most effective method of payment and this will be based on an individual case basis and the most effective solution agreed. This will either be to make their own separate arrangement with the provider for payment of the Top-Up component or in some circumstances request the Council to pay on their behalf. This will normally be because the person has

- deferred payment status
- s117 status
- Special circumstances

3.7 There are currently 9 homes across the Borough who have implemented Top up Fees:

Beechcroft (HC1)	£50.00
Croftwood (Minster Care)	£30.00 for en suite rooms
Ferndale Court (HC1)	£50.00 Residential & Nursing Unit Residential Dementia Unit £80 - £100 dependent upon room
Ferndale Mews (HC1)	£50.00
Ryan Care	£50.00
Simonsfield (Hill Care)	£25.00 for certain rooms

St Patricks (CIC)	£60.00
St Lukes (CIC)	£60.00
Widnes Hall (Anchor)	£30.00 - £80.00

4.0 **POLICY IMPLICATIONS**

4.1 This policy will be reviewed in the summer of 2018 in the light of the expected government green paper on care and support for older people.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified

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

6.1 **Children & Young People in Halton**

None identified.

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

None identified

6.3 **A Healthy Halton**

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

6.4 **A Safer Halton**

None identified

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 None Identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified

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

9.1 None identified under the meaning of the Act.

People Directorate

Halton Clinical Commissioning Group

Additional Payments for Accommodation In Care Homes

(Top-Up Fees)

Policy

2018

CONTENTS

INFORMATION SHEET

Service area	Complex Care, Financial Assessment and Social Care Commissioning
Date effective from	January 2018
Responsible officer(s)	Divisional Manager Complex Care Area Manager Revenues & Benefits Quality Assurance Manager Complex Care and Commissioning Policy Officer (Communities)
Date of review(s)	September 2018
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)** •	Mandatory
Target audience	Complex Care Financial assessment and commissioning teams
Date of SMT decision	30/01/18
Related document(s)	Charging Policy 2018 Mental Health Act, Section 117 Policy, HBC 2015 Choice of Accommodation Under the Care Act – Top Up Payments – Information for Providers and Clients (2017) Choice of Accommodation Under the Care Act, First Party, Third Party and S117 Top-Ups – Information for HBC Social Care Workers (2017) Competition & Markets Authority (2017) – Care homes market study, 30th Nov., 2017).
Superseded document(s)	None
File reference	GGCTUPJAN18

	POLICY	
1	**Scope**	
1.1	This is a joint policy between Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group. The policy is intended to assist officers of Halton Borough Council involved in carrying out social care needs' assessments and financial assessments. It also includes officers carrying out reassessments, reviews and support planning, or who are otherwise involved in the arrangement and administration of services for people with assessed eligible care needs. It provides a clear framework to the Council's position on Care Home Top-Up payments. The Care Act 2014, The Care and Support and After-care (Choice of Accommodation) Regulations 2014 and the revised Care and Support Statutory Guidance (Annex A) published by the Department of Health in February 2017 provide the legal framework in relation to top-up charges or 'additional payments' for residential care placements.	The government is to publish a green paper on care and support for older people by the summer of 2018.
2	**Choice of accommodation and additional payments**	
2.1	The Adult Social Care assessment determines the level of funding to be provided by Social Care, which reflects an individual's care and support needs. The financial assessment completed by the Income Assessment and Debtor's Team determines the contribution towards care costs to be met by the service user. Together, the agreed Adult Social Care budget and the calculated service user contribution are referred to as a 'personal budget.' This is the total amount the Council has agreed can be spent on the person's social care and support needs.	
2.2	Many care homes in Halton offer accommodation that can be paid for by a personal budget for residential care which is allocated to people who are assessed by Adult Social Care as firstly being eligible for services and secondly having savings and assets below the upper capital limit of £23.250. However, this policy focuses on more expensive accommodation, which is subject to additional payments, often referred to as 'Top-Up' payments.	
2.3	Choosing a care home is an important decision which requires careful consideration and planning in terms of practicalities, the wellbeing of the individual and financially. The Council is committed to ensuring that at least one choice of accommodation is affordable within an individual's agreed personal budget. However, there may be circumstances in which a person chooses to move into a care home that costs more than their personal budget. This could be for reasons of comfort, location or personal preference.	
2.4	Where a person chooses a setting that is more expensive than the amount identified in their personal budget arrangements can be made in certain circumstances as to how the difference will be met. This is known as a 'top-up' payment and is the difference between the amount specified in the personal budget and the actual cost. In such cases, arrangements can be made for the person to be placed in their preferred placement provided a third party is willing and able to meet the additional cost. In certain circumstances the person in need of care and support meets the criteria to pay their own top up (referred to as first party). Where someone is placed in a more expensive setting solely because the Council has been unable to make arrangements at the anticipated cost, the additional cost will be reflected in the person's personal budget.	
3	**Third party top-ups**	
3.1	A Third party is someone who is willing to pay the difference between what the care home charges and the council agrees to pay. This could be a friend, relative, or charitable organisation (such as the armed forces). If this is the case, they can pay the shortfall through what is known as a 'third party top-up'.	The Composition and Marketing Authority - *Final Report, Care Homes Market Study (30th Nov., 2017)* has
3.2	The third party must be aware that they are committing to the payment of the top-up for the full duration of the person's stay in a care home. At no point can the third party use	

	the cared for persons assets or income to cover the top up payments.	recommended stronger protection and clearer policy and guidance on the payment of 3rd Party Top-Ups. The CMA report suggests: Care Act Statutory Guidance needs to provide better information for Care Home residents, their families and those arranging care. It also stresses providers should not approach them or their representatives such as relatives in order to ask for a Top-Up.
3.3	Where a top up is being levied a care home placement cannot be confirmed until the third party has agreed to the terms and conditions of the tri-partite agreement; the contract between the Council, the care provider and the third party, in writing.	
3.4	Only one person can be named as the third party contributor on the tri-partite agreement, which confirms the details of the placement. However, this does not mean that the named person cannot collect funding from other friends, relative, or charitable organisation, who may also wish to contribute to the top-up payment. It does however mean that the named person is responsible for making payments directly to the home, or via the Council, and may be liable for any default on the payment. The most effective method of payment will be based on an individual case basis and the most effective solution agreed. This will either be to make their own separate arrangement with the home for payment of the Top-Up component or in some circumstances the Council to pay on their behalf.	
3.5	Where someone is placed in a more expensive setting solely because the council has been unable to make arrangements at the anticipated cost, the additional cost will be reflected in the person's personal budget	
3.6	If the third party is no longer able to continue with the agreement, the Council must be informed of this as soon as possible. The Council will then consider the options available and complete a needs assessment of the cared for person to determine the most appropriate course of action, which may include moving the person to an alternative care home. The Council will pay the top-up charge until alternative arrangements to meet the cared for person's needs have been confirmed.	
3.7	Third party top-up agreements will be reviewed annually by the social worker completing the review of the cared for person's needs and placement arrangements.	
4	**First-party top-ups**	
4.1	The person whose needs are to be met by the care home placement may themselves eligible to make top-up payments in some circumstances.	
4.2	A person can pay their own top-up fee (known as a first-party Top-Up) if: • they have entered into either a 12 week Property Disregard; • They have a Deferred Payment Agreement in place; • They are receiving accommodation that is provided under Section 117 for mental health aftercare.	
4.3	First party top-ups may be an option where the person owns their own property and is subject to a 12-week property disregard. The top-up may be paid from the cared for person's disregarded income or savings (savings below the lower capital limit) during this period. If after the 12 week property disregard period the resident does not want to join the Deferred Payment Scheme, they can no longer pay their own top-up charge and a third party would have to assume responsibility for the payment of the top-up.	Deferred Payment Policy 2018
4.4	Once accepted onto the Deferred Payment Scheme, the Council will pay the top-up payments directly to the provider, along with any other accommodation costs that are to be added to the property debt, until such a point that the property is sold. The Council will then recover the total amount loaned to the person to cover their accommodation and top-up charges, plus an amount for interest and administrative costs.	
5	**Price increases**	
5.1	Halton does not guarantee that any increases to accommodation fees will be covered by the Council. As a consequence, there may be a greater difference between the personal budget of the cared for person and the increased accommodation charge. This means that any additional amount that the Council is not able to pay, will need to be funded through an increase in the top-up paid by the third party, or be added to the loan available through the Deferred Payment Agreement.	

5.2	The person agreeing to pay the top up needs to be made aware at the point of agreeing the top up that the top up may not be static and could be subject to increase, not more than annually. If the cared for person has a change in circumstances, a new financial assessment will need to be completed which may change the level of contribution the person has to pay. However, this may not reduce the need for a top-up payment.	

REPORT TO: Health Policy & Performance Board

DATE: 27th February 2018

REPORTING OFFICER: Strategic Director

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 3 2017/18

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 3 of 2017/18. This includes a description of factors which are affecting the service.

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

i) Receive the Quarter 3 Priority Based report

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

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

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 3, 2017/18.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 3: 1st October to 31st December 2017

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the third quarter of 2017/18 for service areas within the remit of the Health Policy and Performance Board. These areas include:

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

2.0 Key Developments

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

Adult Social Care:

We are proud to announce the commencement of two Local Area Coordinators in the New Year.

What is Local Area Coordination?

Local Area Coordination is a long-term, evidence-based approach to supporting children and adults who may be isolated, excluded or who face challenges due to age, disability or mental health condition, and their families and carers to:

- Stay strong, safe and connected as contributing citizens
- Build more welcoming, inclusive and supportive communities
- Build partnerships with local people, communities, organisations and services - nurturing and sharing the resources within our communities and ensuring that disabled people, people with mental health problems, older people families and carers are active, valued members.

How is Local Area Coordination different?

Local Area Coordination creates a single accessible point of contact in a local community, and is designed to support people to avoid a crisis.

They take a preventative approach; they take time to get to know individuals and families, their local communities and service partners. LAC displays several clear differences from other services, especially those delivered by statutory agencies.

What does Local Area Coordination focus on?

- the talents, skills and resources within our local communities
- strengthening community capacity, (and less on funding)
- the importance of planning for and having confidence in the future, personal networks and community connections
- supporting people to develop practical ways of reaching life aspirations - choice & control
- creating more welcoming, inclusive and accessible communities.

Useful reading
http://lacnetwork.org/wp-content/uploads/2016/02/LAC-catalyst-report.pdf

Learning Disability Nurses

- There continues to be an increase in referrals to the team, in particular referrals for eligibility screening. The complexity and support required for the individuals is also increasing.
- 2 Nurses are currently completing a mortality review for a neighbouring borough as part of the National Learning Disability Mortality Review programme (LeDeR). The capacity to conduct reviews is significantly reduced due to referrals to the team.
- The team have completed 4 out of the 5 days Family Planning Association training on delivering sexual health programmes to people with a Learning Disability.
- The team continue to work with NWBH to update the Dynamic Risk Database.
- The team have representatives attending the ALD partnership Board, transition group and health groups.
- The Nurses are working closely with the psychiatrist to support her with the STOMPLD agenda enabling safe reductions in antipsychotic/anxiolytics, where clinically indicated, over a longer period. Any medication reductions will be part of an MDT discussion to reduce the medication related behavioural and placement issues.
- Joint work is ongoing with children's' services supporting parents with learning disabilities.
- A member of the team has supported a number of individuals undergoing cancer treatment. Sadly one of the individuals has passed away.
- The team are changing the way they work with individuals with Health Action Plans to align these more closely to the annual health checks and outcomes from the CIPOLD inquiry in addition to National and International Mortality Review findings

Commissioning

An open tender is underway to commission a service that combines Healthwatch and the advocacy services into one single contract. The benefits of this approach will include;

- improving access for local people through a single gateway to advocacy services
- providing a seamless service to people who may have need of different aspects of advocacy at different times
- enabling a more efficient and flexible use of resources for the successful provider
- improving the financial sustainability of these services through the combining of contract values and an economy of scale
- providing a more efficient contract

The outcome of the tender will be published in mid-January 2018, with the new service commencing in April 2018

Care Management

We have completed the first two phases of our work with Meridian to conduct a study of our Social Work provision across Assessment teams IAT, Complex Care, Widnes and Runcorn, as part of our ongoing improvement process. Meridian is an international organisation specialising in process and efficiency improvement. They have extensive experience in the health and care sector and have worked throughout Ireland and the UK in the last 20 years assisting Boards, Trusts, Hospitals, Health and Care providers in service redesign, capacity planning and improving our client service.

We have held an open workshop with staff to discuss the outcomes and progress of all the work involved to date. We outlined the aims to ensure that we establish fairness and consistency in the allocation of workload to all staff. Team managers have worked closely with Meridian to review the thresholds and procedures within the three Care Management teams; Complex Care Runcorn, Complex Care Widnes and the Initial Assessment Team. We have been particularly interested in reviewing the allocation process, and our internal Panel processes. We seek to share good practice across the teams to implement a more consistent approach to these key activities. We believe that this will provide the best outcomes for our service users through increased consistency.

We are now launching phase three of the project to work with Children's and Adults on the service redesign of "cradle to grave" Learning Disability (LD) services.

Building on the programme of training on strengths based social work practice to promote excellent social work practice, this has promoted staff, to help support and empower people to live the lives they want.' Now emphasising the use of professional engagement and judgement, as opposed to procedural approaches, with a focus on the individual, taking a holistic and co-productive approach to keeping the person at the centre of all decisions, identifying what matters to them and how best outcomes can be achieved. The training has emphasised, enabling people to find the best solutions for themselves, to support them in making independent decisions about how they live. We continue to look at developing models of good practice and an ongoing part of this work. In addition we have joined Ripfa which offers a research engine to promote evidence based practice and several training opportunities, a presentation was made to staff explaining the benefits. The Principal Social Worker continues to meet with all social workers in a "Social Work Matters" Forum on a quarterly basis, to promote good practice.

A revised Blue Badge Policy, Procedure & Practice (PPP) following comprehensive review was presented to SMT in June 2017.highlighted two key issues that have arisen during the review process with regards to:

- Enforcing correct use and tackling potential abuse of the scheme; and
- The eligibility requirements for organisational badges.

The draft Policy has been submitted to the September HPPB and agreed, it has been to Pre-Agenda and endorsement was finalised at Exec Board on October 19th 2017. Work is underway with organisations who may have previously received badges to inform them of the changes.
A Transition Team in Halton, was set up in February 2017 as a pilot. The team has 3 social workers, which originate from Children and Adult services. The role of the team is to ensure the smooth transition of young people with disabilities, from 14 years old to 25 who are leaving children's service into Adult services.

Named Social Worker Pilot

The Team has been working as part of a government scheme to pilot "Named Social Workers", since September 2017, on an approach championed by Lyn Romeo Chief Social Worker. It is One-to-one intense Social Work intervention for 15 17/18 year olds with learning disabilities, autism and mental health conditions. Halton is one of 6 Local Authorities; chosen to be part of a £400,000 Government investment, with Halton Borough Council receiving £92,827 from the scheme, The extra investment, has been received positively by those who used the service and their families.
The first stage of the pilot has given a clear sense of the difference that a named social worker can make in transforming learning disability services .

The Ambition of the Halton Borough Council, Named Social Worker pilot, is to identify all young people in Halton, who have an Educational and Health Care Plan and will require a Transitional assessment. The overall aim is to ensure that all 17/18 year olds with Complex Physical and / Learning disabilities will have an identified named social worker, who will remain open to them, throughout their Transition journey.

We will be working with young people and their families, as well as health, Education, housing and providers to ensure that all future planning is seamless to support young people leaving children's services.

After the 6 months of the pilot, Halton Borough Council, will aim to continue with this model, with people with these Severe Learning Disabilities, will be given one primary point of contact to provide advice, work with family and carers and encourage patients to live more independently in the community. The aim is to cut down unnecessary long spells in hospitals and other NHS inpatient facilities, reducing the unnecessary hands-off between different professionals, with a positive attitude towards a person-centred culture and asset based approach, which is underpinning our practice across the system, rather than being a paperwork process.

We are developing, an understanding of the resources that are required for our community, encouraging a long term commitment from all agencies, with a potential to 'invest to save'.

Health Minister Jackie Doyle-Price said: "This is a fantastic scheme in Halton that will give people personalised community care and more support to live independently. It is an important step forward as we aim to transform learning disability services for people both in Bradford and across the country."

The pilot is part of the Department's response to the 2015 'No voice unheard, no right ignored' consultation, which sought views on strengthening the rights of people with learning disabilities, autism and mental health conditions to enable them to live more independently.

The Department has also funded the Innovation Unit – a social enterprise – and the Social Care Institute of Excellence to support the local areas, co-ordinate the pilot and to evaluate the scheme. The second phase of the pilot will now be rolled out across Bradford, Halton and Shropshire.

Review of the North West Boroughs Acute Care Pathway and Later Life and Memory Services

This review took place twelve months ago, and implementation of the review recommendations is now nearly complete. Locally:

- A new management structure within the North West Boroughs has been developed which relates more directly to the strategic and operational mental health processes in the area. North West Boroughs managers are involved directly in planning and development groups, and social services managers are linked closely to the new arrangements
- The delivery of community services by North West Boroughs is being redesigned to focus more specifically on Halton, and within that to meet the needs of both Widnes and Runcorn (and the related smaller communities). As examples, the Assessment Service was previously shared with Warrington but now solely focuses on Halton, and the Recovery Team, which used to cover the whole Borough, is being split across Widnes and Runcorn
- New care pathways have been developed across primary and secondary care, which intervene with people at a much earlier stage in their mental health condition (which is known through research to have more positive outcomes), thereby reducing the likelihood of referral on to more specialist services provided by the North West Boroughs. For those already known to the secondary care services, the pathways make it easier for people to be discharged back into the care of local community support services

Developing the use of the Mental Health Resource Centre in Vine Street, Widnes

This resource was originally developed to provide an integrated hub for a range of mental health services in Halton, but for some years it was underused and not fulfilling this aim. Following the provision of capital allocations from the Borough Council, NHS Halton Clinical Commissioning Group and the North West Boroughs, work has been taking place to achieve the original objectives when the building was first

developed. Downstairs, the building has been redesigned to allow the North West Boroughs Assessment and Home Treatment team to be based there, with a small but important crisis resource which will help to divert people from needing admission to hospital when in mental health crisis. Upstairs remains occupied by the council's successful Mental Health Outreach Team and the Community Bridge Building Team, but again the area has been redesigned to develop a flexible working area. As a result, social workers from the Recovery Team are now based within this resource. This interplay of NHS mental health services, council community mental health support services and council social work services will allow for much greater communication between the services, and for quick and simple referral pathways and support services to be put in place for individuals with mental health problems.

Redesign of Mental Health Social Work Service and Mental Health Outreach Team

As previously reported, an internal review of the mental health social work service led to a decision to change the way social workers in the mental health system deliver their service. As from 1st October 2017, they are no longer acting as formal care coordinators of people with mental health needs, and are only using the council's electronic system to record their activities, rather than entering some activity on the council's system and others on the NHS records. Social workers still work fully alongside their NHS colleagues, and clear and detailed pathways for assessment, referral, risk management and care management (including assessment of the needs of carers) have been developed. A clear statement of social work roles and tasks has been developed. The transition into this approach took place with the full involvement of NHS colleagues and has been delivered effectively, with no disruption to the people who use services. This is allowing social workers to concentrate on their core social work tasks within the context of a complex mental health structure.

A similar internal review of the work of the Mental Health Outreach Team has taken place. This has resulted in a change in focus of the team's work, with a new emphasis on time-limited, outcome-focused work with people with the full range of mental health needs, from high risk and complex needs to people who only have the support of primary care services. The expectation is that the interventions will be developed with the person themselves, to meet their needs and aspirations, to reduce reliance on higher level services and promote much greater engagement with their communities. The transition has again been smooth, with no negative impact on people who use services, and referral rates remain high.

Millbrow

Last year Four Seasons Healthcare approached the Council to advise of the imminent closure and de registration of Millbrow Care Home. Various plans were explored as to how the home could be supported not only to improve the care quality within the home but to stop the closure. Millbrow Care Home transferred to the ownership of the Council in December. The home is being supported by professionals drawn from both the CCG and the Council to ensure that residents are safe and cared for and standards raised.

Domiciliary Care

The contract for the provision of domiciliary care was awarded to Premier Care Ltd with full implementation completed in November. 3 other existing domiciliary care provided indicated their desire to continue working in the borough and have commenced negotiations facilitated by the council to explore sub-contracting arrangements. The existing contracts of these providers were extended to allow these negotiations to progress and are due to be completed in Quarter 4.

Public Health:

We have developed a whole system comprehensive plan for flu vaccinations in 2017/18. This includes the vaccination of all elderly patients being discharged from Halton Hospital. Results are encouraging so far

but the flu season has not yet ended and we have a very virulent strain this year. We are therefore continuing to promote flu vaccinations for all eligible patients.

The new 0-19 Healthy Child Programme will commence in March 2018. This programme has been awarded to Bridgewater Commuity Trust and will play a key role as part of the children's Early Help Strategy.

3.0 Emerging Issues

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

Adult Social Care:

Autism Strategy

This work stream involves focused work to develop an all age autism strategy. There has been a working group meeting to develop and coordinate this work and this has resulted in a range of consultation events. An initial survey was sent to adults with autism, schools, parents and a range of groups with contact with children and parents. Following this children's services have undertaken a range of consultation events including coffee mornings and face to face meetings with providers. Similarly Adult services have undertaken an experience based co-design consultation events with adults with a diagnosis of autism as well as consultation event with providers facilitated by Helen Sanderson associates. The Strategy and development plan are currently being written and are on track to be ready for a submission to SMT by the end of January, a further submission to HPPB mid-February and final sign off at exec board by the end of March.

Halton Women's Centre

This has been a highly-regarded local service for some years, and has been seen as the only one of its kind in the North West of England, providing low-level mental health support to vulnerable women, and opportunities for personal development, education and training. Following the closure of the charity that had been commissioned to run the service, its management was drawn into the borough council, with direct support provided by the Mental Health Outreach Team. A detailed review of its role and function is currently being undertaken.

Public Health:

There continues to be breaches concerning treatment of patients by Consultants within 62 days. The CCG is working with the hospitals to understand why this is happening. Patients are offered appointments but some do not attend.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2017/18 Directorate Business Plans.

5.0 Progress against high priority equality actions

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

6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Directorate. It should be noted that given the significant and unrelenting downward financial pressures faced by the Council there is a requirement for Departments to make continuous in-year adjustments to the allocation of resources in order to ensure that the Council maintains a balanced budget. Whilst every effort continues to be made to minimise any negative impact of such arrangements upon service delivery they may inevitably result in a delay in the delivery of some of the objectives and targets contained within this report. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

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

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

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

Adult Social Care

Key Objectives / milestones

Ref	Milestones	Q3 Progress
1A	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target	✓
1B	Integrate social services with community health services	✓
1C	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder.	✓
1D	Continue to implement the Local Dementia Strategy, to ensure effective services are in place.	✓
1E	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems.	✓
1F	The Homelessness strategy be kept under annual review to determine if any changes or updates are required.	✓
3A	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.	✓

Supporting Commentary

1a - A financial recovery plan is in place to ensure the budget comes out on target

1b - Multi-disciplinary Team work is ongoing across primary care, community health care and social care

1c - A new All-Age Autism strategy is being developed with key stakeholders and people with autism and their carers. An Experienced-Based Co-Design event took place on 5th December, along with a number of different events with Children, young people and their parents/carers which will all be used to develop the delivery plan.

1d - The local dementia delivery plan has been agreed and places focus for the next 12 months GP care plan reviews, support for carers, raising standards in care homes through education and advanced care plans for people with dementia in the community. Work is underway during quarter 3 to extend The Dementia Post Diagnosis Community Pathway Prime Provider contract from April 2018, for the +1 year option.

1e - Following the review of the North West Boroughs services in 2016/ 17, the Trust has put in place a new local management structure which is engaging more fully with Halton's strategic and

operational processes. Council managers are linked closely with these new arrangements and meet regularly to consider operational and strategic issues. The Trust's community services are now focusing more specifically on the needs of the local communities, and council services have been redesigned to fit with this new structure. New care pathways are in place to support people at an earlier stage of their mental health condition, and to help those who are involved with North West Boroughs services to re-engage with their local communities more easily.

1f - The annual homelessness strategy review is underway and a further consultation event is scheduled for February 2018. The action plan is presently being reviewed and will be updated to reflect key priorities.
The homelessness strategy is due to be fully reviewed 2017/2018 and consultation events with partners are ongoing. A five year strategy document report will be completed and passed to senior management for approval early 2018. The strategy will include a five year action plan, which will determine the LA priorities and key objectives, to ensure it reflects economical and legislative changes.

3a - The work on developing the One Halton placed based commissioning and service delivery is ongoing.

Key Performance Indicators

Older People:						
Ref	**Measure**	**16/17 Actual**	**17/18 Target**	**Q3**	**Current Progress**	**Direction of travel**
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric***	515.3	635	461.9	✓	↓
ASC 02	Delayed transfers of care (delayed days) from hospital per 100,000 population. ***Better Care Fund performance metric***	519	TBC	629	✗	↓
ASC 03	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	3381	13,289	3404	✗	↓
ASC 04	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) ***Better Care Fund performance metric***	N/A	N/A	23.1% (Oct 17)	✗	↓
ASC 05	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B)	62.12%	65%			

	Better Care Fund performance metric					
Adults with Learning and/or Physical Disabilities:						
ASC 06	Percentage of items of equipment and adaptations delivered within 7 working days	93%	96%	93%	✓	
ASC 07	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 1)	74%	78%	75%	✓	N/A
Ref	**Measure**	**16/17 Actual**	**17/18 Target**	**Q3**	**Current Progress**	**Direction of travel**
ASC 08	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 2) DP	44%	44%	29%	U	N/A
ASC 09	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	86.90%	87%	88.15%	✓	
ASC 10	Proportion of adults with learning disabilities who are in Employment (ASCOF 1E)	6.9%	7%	4.98%	U	
ASC 11	Out of Borough Placements – number of out of borough residential placements	32	30	NYA	NYA	NYA
People with a Mental Health Condition:						
ASC 12	Percentage of adults accessing Mental Health Services, who are in employment.	N/A	N/A	0.49%	N/A	N/A
ASC 13 (A)	Percentage of adults with a reported health condition of Dementia who are receipt of services.	52.86%	TBC	11.23%	N/A	N/A
ASC 13 (B)	Percentage of Carers who receive services, whose cared for person has a reported health condition of Dementia.	11.57%	TBC	14.50%	N/A	N/A
Homelessness:						
ASC 14	Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2002.	NA	500	88	✓	
ASC 15	Homeless Households dealt with under homelessness provisions of	NA	100	4	✓	

	Housing Act 1996 and LA accepted statutory duty					
ASC 16	Number of households living in Temporary Accommodation	1	17	2	✓	↑
ASC 17	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	6.62	6.00%	0.94%	✓	↑
Safeguarding:						
ASC 18	Percentage of VAA Assessments completed within 28 days	83.5%	88%	76.41%	U	↓
ASC 19	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-learning, in the last 3-years (denominator front line staff only).	48%	56%	43%	U	↓
ASC 20 (A)	DoLS – Urgent applications received, completed within 7 days.	73%	80%	N/A	N/A	N/A
ASC 20 (B)	DoLS – Standard applications received completed within 21 days.	77%	80%	N/A	N/A	N/A
ASC 21	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)	81.30%	82%	N/A	N/A	N/A
Carers:						
ASC 22	Proportion of Carers in receipt of Self Directed Support.	99.4	TBC	99.33%	N/A	N/A
ASC 23	*Carer reported Quality of Life (ASCOF 1D, (this figure is based on combined responses of several questions to give an average value. A higher value shows good performance)*	8.10%	9	N/A	N/A	N/A
ASC 24	*Overall satisfaction of carers with social services (ASCOF 3B)*	48.90%	50	N/A	N/A	N/A
ASC 25	The proportion of carers who report that they have been included or	78.80%	80	N/A	N/A	N/A

	consulted in discussions about the person they care for (ASCOF 3C)					
ASC 26	Do care and support services help to have a better quality of life? (ASC survey Q 2b) ***Better Care Fund performance metric***	93.30%	93%	N/A	N/A	N/A

Supporting Commentary

Older People:

ASC 01 As at the end of quarter 3 we have placed 103 clients into permanent residential / nursing care. For the same period in 2016/17 we had placed 54 clients.

ASC 02 There has been a significant deterioration in performance since August. Although full Q3 data is not yet available the position to November is a 3 month average of 622 delayed days (rate of 629 per 100,000) problems exist around capacity for care at home, patient/family choice in not accepting transitional beds and Trusts enforcing the home of choice policy. Local information shows that the elevated rates of DTOC continued into December although the numbers of patients delayed in early January appears to be much lower.

ASC 03 The target for the full year is 13,289 per 100,000. The CCG has individual monthly targets. Non-Elective activity is 3% over plan and 0.5% above last year's position, the CCG has seen a large reduction at Warrington (-4%) however this has been more than offset by the increase seen at St Helens, where the number of non-elective admissions has increased by 6%. The CCG has also seen an increase in the A&E conversion to admission rate from 40% to 50% in the last 12 months at Whiston and the percentage of those patients with the lowest recorded acuity who are admitted to a bed is recorded as 26% in Whiston compared to 1% at Warrington. These anomalies are being raised with the trust to provide satisfactory explanations.

ASC 04 Although this metric is no longer collected, a similar metric records the percentage of admissions which were a readmission within 30 days. For Halton this figure was 23%, this is exceptionally high, the usual figure is around 14% which is in line with other neighbouring CCG's. It is likely this may be a data quality error, however there was an increase in non-elective activity in October but it is unknown why this would only impact Halton residents.

ASC 05 Annual collection only to be reported in Q4.

Adults with Learning and/or Physical Disabilities:

ASC 06 Performance very slightly less compared to the same period last year (94%). Target should still be achieved.

ASC 07 There is no comparable data for the same period in 2016/17.

ASC 08 There is no comparable data for the same period in 2016/17.

ASC 09 Target achieved.

ASC 10 Performance very slightly less compared to same quarter last year (5%).

ASC 11 Data is not yet available for Q3

People with a Mental Health Condition:

ASC 12 This is a new indicator for 2017/18, therefore no comparable data

ASC 13 (A) This is a new indicator for 2017/18, therefore no comparable data

ASC 13 (B) This is a new indicator for 2017/18, therefore no comparable data

Homelessness:

ASC 14 In accordance with the Homelessness legislation, all Local Housing Authorities have a statutory duty to administer and address homelessness within the Borough. It must offer advice and assistance and give due consideration to all applications for housing assistance.

The Local Authority must have a reason to believe that an applicant may be homeless or threatened with homelessness, and make the necessary enquiries in accordance with the Homelessness Act 2002, to determine whether a duty is owed under Part 7 of the Housing Act 1996

The statutory homelessness figures identified for quarter three are low, however, this is consistent with the increased level of prevention activity administered by the Housing Solutions Team. The team fully utilise all prevention initiatives and financial resources available to reduce homelessness.

ASC 15 Part 7 of the Housing Act 1996 sets out the powers and statutory duties that all housing authorities are fully compliant. The LA must ensure that vulnerable clients who present as homelessness are offered advice and assistance.

The Local Authority has a statutory duty to provide both temporary and secure accommodation to clients accepted as statutory homeless. The figures are generally low, which is due to the high level of officer activity and initiatives to prevent homelessness.

ASC 16 National and Local trends indicate a gradual Increase in homelessness, which will impact upon future service provision, including temporary accommodation placements.

The introduction of the Homelessness Reduction Act 2016 will have a big impact upon homelessness services, which will result in a vast increase in the use of the temporary accommodation.

ASC 17 The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention.

The officers now have a range of resources and options that are offered to vulnerable clients threatened with homelessness. The team strive to improve service provision across the district. Due to the early intervention and proactive approach, the officers have continued to successfully resolve and reduce homelessness.

Safeguarding:

ASC 18 Performance down compared to the same period last year. However, an exception report detailing assessments open longer than 28 days is sent to the teams monthly for them to action.

ASC 19	This figure is down on last year's figures. However, the increase in employee numbers as a result of the transfer of additional staff from Millbrow and Madeline McKenna will affect and decrease the percentage.
ASC 20 (A)	Data not available due to reporting issues which are being investigated.
ASC 20 (B)	Data not available due to reporting issues which are being investigated.
ASC 21	Annual collection only to be reported in Q4.
Carers:	
ASC 22	New indicator for 2017/18 therefore no comparable data.
ASC 23	Annual collection only to be reported in Q4.
ASC 24	Annual collection only to be reported in Q4.
ASC 25	Annual collection only to be reported in Q4.
ASC 26	Annual collection only to be reported in Q4.

Public Health

Key Objectives / milestones

Ref	Milestones	Q3 Progress
PH 01a	Increase the uptake of smoking cessation services and successful quits among routine and manual workers and pregnant women	✓
PH 01b	Work with partners to increase uptake of the NHS cancer screening programmes (cervical, breast and bowel)	✓
PH 01c	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. AND/ OR Increase awareness among the local population on the early signs and symptoms of cancer.	U
PH 02a	Facilitate the Healthy child programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years.	✓
PH 02b	Maintain the Family Nurse Partnership programme.	✓
PH 02c	Facilitate the implementation of the infant feeding strategy action plan	✓
PH 03a	Expansion of the Postural Stability Exercise Programme.	✓
PH 03b	Review and evaluate the performance of the integrated falls pathway.	✓
PH 04a	Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol	✓

PH 04b	Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA	✓
PH 04c	Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support	✓
PH 05a	Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions.	✓
PH 05b	Implementation of the Suicide Action Plan.	✓

Supporting Commentary

PH 01a Throughput of clients accessing smoking cessation services in Halton has remained the same during Q3 2017 (July-September) as compared to the same period in 2016. This goes against the national trend where most Stop Smoking Services are experiencing reductions in throughput.

Halton CCG has received £75,000 of funding from NHS England for use in this financial year (2017/18) to reduce maternal smoking rates. An action plan with focussed outcomes has been developed outlining joint proposals for the use of this funding for evidence based effective interventions to reduce maternal smoking. Home visits are offered to allow pregnant women referred into the service.

PH 01b Halton are continuing to identify areas and opportunities to maximise uptake fo screening. We are working in collaboration with the Cheshire and Merseyside Cancer Prevention Group to look at opportunities at scale for improving screening uptake and will be developing local actions to reflect this.

PH 01c Halton is working with the Chershire and Merseyside Prevention Group to explore opportunities for identifying and developing a early detection awareness campaign to try and maximise impact on local more resistent populations.
The Halton 62 day performance has been poor in the last quarter nad CCG are working across pathways to understand the reason for patient breeches. The 2 week wait performance has improved with targets being achieved through the quarter.

PH 02a The 0-19 (25 with special educational needs) programme has be recommissioned and been awarded to Bridgewater community health care trust. The specification includes health visiting, Family Nurse partnership, School Nursing, NCMP, Vision and hearing screening, and immunisations. The new contract for the integrated service will start in April 2018.

The Health Visiting Service is delivering all the components of the national Healthy Child Programme, including assessing mothers' emotional health at 6-8 weeks and completing an integrated developmental check at 2-21/2. The early years setting and health visitors share the findings from the development checks to identify any areas of concern, so that services can collaboratively put in place a support package as required.

PH 02b Family Nurse Partnership was recommissioned as part of the integrated service. It continues to be fully operational with a full caseloa and works intensively with first time, teenage

mothers and their families. The service works with some very complex cases and is building their multidisciplinary links across a wide range of agencies, to improve outcomes for these families. The service will be an integral part of the new 0-19 Service.

PH 02c The implementation of the infant feeding action plan is underway, with oversight from the Halton Health in the Early Years group.

Breastfeeding support continues to be available across the borough in community and health settings, and all families have access to introduction to solid food sessions.

A breastfeeding campaign is currently underway, largely through social media. The campaign is using local women's stories to help mums to understand the reality of breastfeeding, and show how they can overcome some of the challenges. This was developed following feedback that campaigns give women unrealistic expectations of the ease of breastfeeding.

PH 03a Health Improvement continues to provide the "Age Well programme" across the borough. Work continues to integrate the Age well service in with intermediate care to facilitate safer discharges back to the community for those accessing intermediate services, both residential and in the community. HIT Continue to deliver staff training to frontline professionals to raise awareness of falls prevention and the appropriate falls pathways.

PH 03b Work to progress the new falls strategy 2018-2022 continues. A multi-agency clinical working group has taken a comprehensive review of the current service against NICE guidelines and has made recommendations for service changes/development that are to be put in place as part of the strategy action plan. Work is underway to develop a comprehensive training programme which is to be rolled out to raise confidence in the use of screening tools and to increase capacity in service via staff having the skills to work more effectively with patients to improve strength, balance and gait without referring for specialist services.

PH 04a Good progress has been made in recent years in reducing the number of young people being admitted to hospital due to alcohol. Key activity includes:

- Delivery of alcohol education within local school settings (Healthitude, Amy Winehouse Foundation, Cheshire Police).
- Delivery of community based alcohol activity.
- Delivering early identification and brief advice (alcohol IBA) training and resources for staff who work with children and young people).
- Running the Halton Community Alcohol Partnership which brings together partners to reduce underage drinking and associated antisocial behaviour.

More recent data has seen this downward trend level off. Therefore local partnership work needs to continue.

PH 04b Work continues to raise awareness among the local community of safe drinking recommendations and to train staff across the health, social care, criminal justice, community and voluntary sector in alcohol identification and brief advice (alcohol IBA).

PH 04c During Q2, the service received 87 new referrals for alcohol only (62) or alcohol and non-opiate problems (25). Local data suggests that by the end of Q2 162 individuals were engaged in structured treatment where alcohol was the primary concern, and 43 were involved in post treatment recovery support. A further 67 clients were in receipt of support for non-opiate and alcohol problems.

PH 05a Halton Healthy Improvement and Public heatlh continue to roll out a series of programmes and training activities around Mental health, with good partnership working on the delivery of action plans, raising awareness and provision of community based programmes and activities. The Mental Health oversight group have not met for 6 months and there is a potential for the oversight and scrutiny arrangements across thebreadth of the mental health remit to affect

performance and coordination.

PH 05b The Suicide prevention action plan has been updated and continues to be implemented. The plan links closely with the Cheshire and Merseyside No More Suicides strategy. Champs are leading on a area collaborative approach to gain Suicide Safer Community Status.
A real time surveillance intelligence flow has been set up which will anable faster identification of potential trends and clusters.

Key Performance Indicators

Ref	Measure	16/17 Actual	17/18 Target	Q3	Current Progress	Direction of travel
PH LI 01	A good level of child development (% of eligible children achieving a good level of development at the end of reception)	61.9% (2015/16)	65.0% (2016/17)	60.9% (2016/17)	✗	↓
PH LI 02a	Adults achieving recommended levels of physical activity (% adults achieving 150+ minutes of physical activity)	48.5% (2015)	49.0% (2016)	58.1%	N/A	N/A
PH LI 02b	Alcohol-related admission episodes – narrow definition (Directly Standardised Rate per 100,000 population)	841.7 (2015/16)	841.7 (2016/17)	866.5 (Q1 2017/18) Provisional	U	↓
PH LI 02c	Under-18 alcohol-specific admissions (crude rate per 100,000 population)	55.5 (2013/14-2015/16)	54.1 (2014/15-2016/17)	61.3 (2015/16-2017/18)Provisional	✗	↓
PH LI 03a	Smoking prevalence (% of adults who currently smoke)	16.6% (2016)	16.2% (2017)	Annual data only	U	**N/A**
PH LI 03b	Mortality from cardiovascular disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar*	92.0 (2016)	89.8 (2017)	98.8 (Oct '16 – Sep '17) Provisional	✗	↓

	year, please note year for targets					
PH LI 04a	Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)	341.5 (2015/16)	332.3 (2016/17)	336.7 (2016/17) Provisional		
PH LI 04b	Self-reported wellbeing: % of people with a low happiness score	12.7% (2015/16)	11.1% (2016/17)	Annual data only		**N/A**
PH LI 05	Mortality from all cancers at ages under 75 (Directly Standardised Rate, per 100,000 population) *Published data based on calendar year, please note year for targets*	177.2 (2016)	169.2 (2017)	192.1 (Oct '16 – Sep '17) Provisional		
PH LI 06ai	**Male** Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*	17.3 (2013-15)	17.6 (2014-16)	17.3 (2014-16)		
PH LI 06aii	**Female** Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*	18.8 (2013-15)	19.1 (2014-16)	19.1 (2014-16)		
PH LI 06b	Falls and injuries in the over 65s	3016. (2015/16)	3000.5 (2016/17)	3301.2 (2016/17)		

	(Directly Standardised Rate, per 100,000 population; PHOF definition)			Provisional		
PH LI 06c	Flu vaccination at age 65+ (% of eligible adults aged 65+ who received the flu vaccine, GP registered population)	72.2% (2015/16)	75.0% (2016/17)	72.6% (to end 2017) Provisional	U	

Supporting Commentary

PH LI 01 - Small reduction in the proportion of children achieving a good level of development at the end of reception means we have failed to meet the target for 2016/17.

PH LI 02a - Method previously used is now archived – therefore targets and previous data have been removed. Quarter 3 position included is the newly created 'current method', which will be used in published data from now on.
Target has been removed; this will be revaluated for the Q1 2018/19 PPB.

PH LI 02b - The provisional 2017/18 rate suggests that the threshold hasn't been met. The Q1 17/18 data is currently higher than the threshold. The threshold for 2016/17 was not met.

PH LI 02c - The provisional 2017/18 rate suggests that the threshold hasn't been met. The Q2 17/18 data is currently higher than the threshold. The threshold for 2014/15-2016/17 was not met.

PH LI 03a - No new data currently available.

PH LI 03b - 35 deaths from cardiovascular disease in Q2 2017 meant a substantial increase in the rate of premature deaths for the year to June 2017 (rate of 102.2 per 100,000 population). There were fewer deaths in Q3 2017 which resulted in a reduction in the rate from the year to Q2 to Q3.

PH LI 04a - No update available; IT issues mean we are temporarily unable to access the service to extract the data for this indicator.

PH LI 04b - No new data currently available.

PH LI 05 - Currently missing target. The 58 premature cancer deaths between July and September 2017 meant an increase in the rate of under 75 cancer mortality to the year ending September 2017.

PH LI 06ai - Male life expectancy at 65 remained at 17.3 years for 2014-16; failing to meet target.

PH LI 06aii - Female life expectancy increased to 19.1 years for 2014-16; meeting the target set.

PH LI 06b - No update available; IT issues mean we are temporarily unable to access the service to extract the data for this indicator.

PH LI 06c - As of the end of December 2017, the 75% target for flu vaccination uptake among those aged 65+ is not being met. The flu vaccination period finishes at the end of January.

ADULT SOCIAL CARE DEPARTMENT

Revenue Budget as at 31st December 2017

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000
Expenditure				
Employees	13,862	10,300	10,059	241
Other Premises	354	250	253	(3)
Supplies & Services	1,249	896	895	1
Aids & Adaptations	113	67	64	3
Transport	201	132	128	4
Food Provision	195	126	106	20
Contracts & SLAs	495	383	388	(5)
Emergency Duty Team	95	71	74	(3)
Other Agency	624	450	449	1
Payments To Providers	1,443	1,164	1,177	(13)
Contribution to Complex Care Pool	20,646	11,459	12,420	(961)
Total Expenditure	**39,277**	**25,298**	**26,013**	**(715)**
Income				
Sales & Rents Income	-307	-260	-284	24
Fees & Charges	-741	-555	-483	(72)
Reimbursements & Grant Income	-1,102	-558	-553	(5)
Transfer From Reserves	-631	0	0	0
Capitalised Salaries	-111	-83	-83	0
Government Grant Income	-854	-801	-811	10
Total Income	**-3,746**	**-2,257**	**-2,214**	**(43)**
Net Operational Expenditure	**35,531**	**23,041**	**23,799**	**(758)**
Recharges				
Premises Support	517	388	388	0
Asset Charges	83	0	0	0
Central Support Services	3,352	2,424	2,424	0
Internal Recharge Income	-1,795	-1,255	-1,255	0
Transport Recharges	497	282	282	0
Net Total Recharges	**2,654**	**1,839**	**1,839**	**0**
Net Department Expenditure	**38,185**	**24,880**	**25,638**	**(758)**

Comments on the above figures:

In overall terms, the Net Department Expenditure for the third quarter of the financial year is £203,000 under budget profile, excluding the Complex Care Pool.

Employee costs are currently £241,000 below budget profile. This is due to savings being made on vacancies within the department. The bulk of the staff savings are currently being made in the Care Management and Initial Assessment teams. These services have undergone a review, and a permanent savings target of £100,000 resulting from the deletion of a number of currently vacant posts has been agreed for the 2018/19 budget.

Fees & Charges income will struggle to achieve agreed budgets for the year. This is due to the Community Meals income target applied in 2016/17, and built into the 2017-18 base budget, which is not projected to be achieved. Estimates based on the third quarter's income indicate a net shortfall in the region of £90,000 for the full year. The impact of the shortfall in budgeted income has been reviewed as part of the process in setting the 2018/19 base budget position.

The above figures exclude the revenue budgets and costs for the recently purchased residential care homes, Madeline McKenna (purchased November 2017) and Millbrow (purchased December 2017). Funding has been identified to cover costs for the remainder of this financial year, and work is ongoing to ensure that the revenue costs are correctly budgeted for from the 2018/19 financial year onwards.

Capital Projects as at 31 December 2017

	2017-18 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Upgrade PNC	6	6	6	0
ALD Bungalows	199	0	0	199
Bredon Reconfiguration	56	56	56	0
Vine Street Development	100	10	9	91
Purchase of 2 Adapted Properties	520	0	0	520
Total	881	72	71	810

Comments on the above figures:

The £6,000 funding relating to the upgrading of the PNC represents the unspent capital allocation carried forward from the previous financial year to enable the scheme's completion. The scheme has now completed, with residual payments to match this allocation.

Building work on the ALD Bungalows is expected to be completed within the 2017/18 budget year with spend to match allocation.

The Bredon Reconfiguration project is funded from previous year's Adult Social Care capital grant. The scheme, which commenced in 2016/17 with a total project budget of £343,000 has now been completed. The final cost was £34,000 below the budget allocation. This saving has been used as a contribution towards the capital costs of the purchase of Millbrow residential home

The Vine Street Development project relates to the adaptation of the Mental Health Resource Centre in Widnes in order to better meet service user's needs. Construction is currently underway, with completion expected within the current financial year.

The £520,000 capital allocation for the purchase of 2 adapted properties relates to funding received from the Department Of Health under the Housing & Technology for People with

Learning Disabilities Capital Fund The funding is to be used for the purchase and adaptation of two properties to meet the particularly complex and unique needs of two service users. The scheme is anticipated to be completed in the final quarter of this financial year.

COMPLEX CARE POOL

Revenue Budget as at 31 December 2017

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000
Expenditure				
Intermediate Care Services	4,677	2,874	2,543	331
End of Life	194	138	153	(15)
Sub-Acute	1,734	1,239	1230	9
Urgent Care Centres	815	428	401	27
Joint Equipment Store	616	334	482	(148)
CCG Contracts & SLA's	1,215	959	917	42
Intermediate Care Beds	596	447	447	0
BCF Schemes	2,836	1,312	1,284	28
Carers Breaks	434	247	208	39
Adult Health & Social Care Services:				
Residential & Nursing Care	21,631	13,914	14,112	(198)
Domiciliary & Supported Living	13,511	8,713	9,766	(1,053)
Direct Payments	6,937	5,759	6,442	(683)
Day Care	410	236	314	(78)
Total Expenditure	55,606	36,600	38,299	(1,699)
Income				
Residential & Nursing Income	-5,963	-3,828	-4,004	176
Domiciliary Income	-1,867	-1,163	-1,126	(37)
Direct Payments Income	-458	-286	-319	33
BCF	-9,661	-7,246	-7,246	0
Improved Better Care Fund	-2,974	-2,231	-2,231	0
CCG Contribution to Pool	-13,225	-9,982	-9,982	0
ILF	-699	-349	-349	0
All other income	-113	-56	-57	1
Total Income	-34,960	-25,141	-25,314	173
Net Operational Expenditure	**20,646**	**11,459**	**12,985**	**(1,526)**
Liability as per Joint Working Agreement (HCCG share - 37%)	**0**	**0**	**-565**	**565**
Adjusted Net Operational Expenditure	**20,646**	**11,459**	**12,420**	**(961)**

Comments on the above figures:

The overall net budget for the Complex Care Pool budget is £961,000 (including the HCCG liability share) over budget profile at the end of the third financial quarter. This is due, in the main, to the continued expenditure pressures on adult health and social care packages of care as reported in quarter two. The Pool Manager has put in place a financial recovery action plan, with performance against the plan being closely monitored on a fortnightly basis.

The recovery plan focuses attention on specific areas within health and social care budgets that may offer up opportunities to influence and deliver cost and efficiency savings, whether this is by undertaking targeted reviews and re-assessment of existing client care packages and funding arrangements, or by reviewing current policies and practice in relation to eligibility criteria etc. Some savings have already been made from this and as the process continues, it is envisaged more efficiencies can be found.

Intermediate Care Services are under budget profile by £331,000 due largely to a combination of a small number of staffing vacancies and reduced agency costs across the services.

Expenditure on End of Life services continues to exceed budget profile and is currently £15,000 over the expected budget to date. The year-end position is now expected to be approximately £20,000 over budget. This is a further reduction from that reported at quarter two as the service continues to deliver less hours.

The Urgent Care Centres net spend includes payments for the Rapid Clinical Assessment Team (RCAT) scheme which has now ended. This has resulted in a forecast £35,000 underspend for the financial year.

The Joint Equipment forecast out-turn position of £269,000 reported in Quarter two remains in place for Quarter three. However this is currently being investigated further as part of the pooled budget recovery plan and therefore the forecast may be revised down.

The Adult Health and Social Care net spend budget is currently £1,839,000 over budget profile and is expected to be circa £2,600,000 by end of the financial year. The pressure areas are analysed below:

Residential & Nursing Care

Continuing Health Care (CHC) and Joint Funded Care (JFC) packages are exerting pressure on the budget as an increasing number of people are deemed eligible for CHC. These service users are also receiving care for longer periods of time than previously. A number of these care packages are transitionally funded placements which are not being assessed within the 28 day timescale. As part of the recovery plan, the CHC team have been targeting these and there has been a marked improvement in the number of reviews being completed on time. Some of these packages have also been deemed not eligible for CHC and should therefore generate some additional income from client contributions.

Count and Spend:

The total number of clients receiving a permanent residential care package has increased from 599 clients in April to 611 clients in December. The average weekly cost of a permanent residential package of care decreased from £586 to £584 for the same period.

In addition to the above there are currently 35 out of Borough CHC placements and 18 joint funded CHC placements which command a higher weekly price. The in borough average placement costs are £647 per week whereas average out of borough placement costs are currently £978 per week.

In 2016/17 the rate for NHS-Funded Nursing Care (FNC) was increased from £112 per week to £156.25. This has subsequently been reviewed by Department of Health and the rate from April 2017 has been set at £155.05. This remains another pressure on the pool budget. There are currently 96 service users receiving FNC (increase of 4 since quarter two) and the financial impact of the extra costs for these clients is approximately £214,000 for 2017/18.

Domiciliary & Supported Living
The year-end forecast for domiciliary care joint funded packages has increased by £47,000 since quarter 2. The transitional domiciliary care package forecast has reduced by £115,000 mainly due to the reviews of existing client care packages and funding arrangements that have taken place.

The forecast CHC domiciliary care package has increased by £340,000 from quarter two. £258,000 of this is due to just 2 service users, one of which is receiving 1 to 1 care in an out of borough residential home and the other has gone from domiciliary care to supported living. This in itself demonstrates volatility in community care spend and how just a few high cost packages can make such a huge difference to outturn projections.

Long term (out of area) mental health service users previously living in hospitals have been brought back into the local community exerting extra cost pressure on the pooled budget. As part of the recovery plan Halton Clinical Commissioning Group Management Team have agreed to contribute £256,000 towards these packages.

Count and Spend:
The total number of clients receiving a domiciliary care package decreased by 1.02% from 788 clients in April to 780 clients in December. However, the average cost of domiciliary care package has increased by 8.2% from £299 in April to £323 in December.

Direct Payments
There is a net decrease of £45,000 since quarter two. This is mainly due to reimbursements from clients as a result of unspent Direct Payments found during the audit review process.

Count and Spend:
The total number of clients receiving a Direct Payment (DP) has increased by 2.8% from 470 clients in April to 483 clients in December. The average cost of a DP package has increased from £323 to £329 (an increase of 1.98%).

Contingency budget from the CCG minimum contribution to the Better Care Fund has been utilised to offset some of the pressures mentioned above. However the anticipated forecast overspend for the Complex Care Pool budget (before allowing for the HCCG's share of any liability) is expected to be circa £2,200,000 at year end. As stated above, a financial recovery action plan has already been implemented by the Pool Manager to look at reducing adult health and social care costs to bring the expenditure back in line with budget in order to ensure a balanced budget is achieved at year end.

Pooled Budget Capital Projects as at 31 December 2017

	2017-18 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	749	485	478	271
Stair lifts (Adaptations Initiative)	300	225	219	81
RSL Adaptations (Joint Funding)	250	180	155	95
Millbrow Residential Home	925	725	725	200
Madeline McKenna Residential Home	450	305	305	145

Total	**2,674**	**1,920**	**1,882**	**792**

Comments on the above figures:

Total DFG capital funding consists of £1,504,000 Disabled Facilities Grant (DFG) allocation for 2017/18 and £345,000 DFG funding carried forward from 2016/17, to fund ongoing expenditure
The allocation of the funding between DFGs, Stair Lifts and RSL adaptations will be reviewed during the year, and may be reallocated between these projects depending on demand. It is anticipated, however, that total spend on these three projects can be contained within the revised overall capital allocation.

The £450,000 allocated for the purchase of the Madeline McKenna residential home includes an allowance for the refurbishment of the premises. The purchase was completed in November 2017, and the establishment is now managed by Halton Borough Council's Adult Social Care department.

Capital allocations have been revised to incorporate the purchase and refurbishment of Millbrow residential home. The purchase was completed in December 2017, and is also now managed by Halton Borough Council's Adult Social Care department.

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 31 December 2017

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	3,497	2,435	2,383	52
Other Premises	5	0	0	0
Supplies & Services	273	149	175	(26)
Contracts & SLA's	7,180	4,733	4,733	0
Transport	5	4	4	0
Other Agency	18	18	17	1
Total Expenditure	**10,978**	**7,339**	**7,312**	**27**
Income				
Other Fees & Charges	-76	-74	-60	(14)
Government Grant	-10,454	-7,237	-7,237	0
Reimbursements & Grant Income	-263	-218	-218	0
Transfer from Reserves	-652	-130	-130	0
Total Income	**-11,445**	**-7,659**	**-7,645**	**(14)**
Net Operational Expenditure	**-467**	**-320**	**-333**	**13**
Recharges				
Premises Support	127	95	95	0
Central Support Services	802	617	617	0
Transport Recharges	20	14	15	(1)
Support Income	-94	-23	-23	0

Net Total Recharges	**855**	**703**	**704**	**(1)**
Net Department Expenditure	**388**	**383**	**371**	**12**

Comments on the above figures

In overall terms, the Net Department Expenditure for the third quarter of the financial year is £12,000 under budget profile.

Employee costs are currently £52,000 under budget profile. This is due to savings being made on vacancies within both of the Environmental, Public Health & Health Protection and Health & Wellbeing Divisions. Most of these vacancies have been advertised and have been or are expected to be filled in the coming months. However if not appointed to, the current underspend will continue to increase beyond this level in the final quarter of the year.

Expenditure on Supplies & Services is currently £26,000 over budget profile. This is due to legal costs relating to a Trading Standards case. This case went to trial during the third quarter & therefore shouldn't continue to be a budget pressure for the remainder of 2017/18.

Other fees and charges income is currently showing £14,000 below budget profile, of which 50% relates to domestic pest control fees income underachieving. This will remain a budget pressure throughout the remainder of 2017/18 despite an in year budget realignment.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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