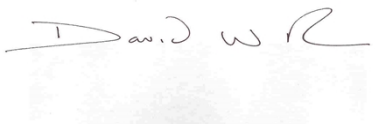
Public Document Pack

# Health Policy and Performance Board

**Tuesday, 25 February 2020 at 6.30 p.m.**
**Council Chamber, Runcorn Town Hall**



**Chief Executive**

## BOARD MEMBERSHIP

| | |
|---|---|
| Councillor Joan Lowe (Chair) | Labour |
| Councillor Sandra Baker (Vice-Chair) | Labour |
| Councillor Lauren Cassidy | Labour |
| Councillor Mark Dennett | Labour |
| Councillor Eddie Dourley | Labour |
| Councillor Pauline Hignett | Labour |
| Councillor Chris Loftus | Labour |
| Councillor Margaret Ratcliffe | Liberal Democrats |
| Councillor June Roberts | Labour |
| Councillor Pauline Sinnott | Labour |
| Councillor Geoff Zygadllo | 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 advised.*

**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, 26 November 2019 at Council Chamber - Town Hall, Runcorn*

Present: Councillors J. Lowe (Chair), Baker (Vice-Chair), Cassidy, Dennett, Dourley, P. Hignett, C. Loftus, Ratcliffe, Zygadllo and D. Wilson

Apologies for Absence: Councillors June Roberts and Sinnott

Absence declared on Council business: None

Officers present: S. Wallace-Bonner, A. Jones, D. Nolan, L Wilson and H. Moir

Also in attendance: K. Parker – Healthwatch Advisory Board, H. Heatherstone – British Red Cross and one member of the press

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

*Action*

HEA11 MINUTES

The Minutes of the meeting held on 17 September 2019 having been circulated were signed as a correct record.

HEA12 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA13 HEALTH AND WELLBEING MINUTES

The minutes relating to the Health and Wellbeing Board from its meeting of 10 July 2019 were presented to the Board for information.

One Member queried why the proposals in relation to the Urgent Care Centres' and the merging of Warrington and Halton CCGs' did not appear on the Health and Wellbeing Board's agenda; commenting that items of such importance should be.

The Chair advised that his comments would be fed back.

RESOLVED: That the minutes be noted.

Director of Adult Social Services

HEA14 BRITISH RED CROSS - HALTON SUPPORT AT HOME SERVICE

The Board welcomed Helen Featherstone, North of England Service Manager for Independent Living Services, British Red Cross (BRC) who provided a presentation to them on the Halton Support at Home Service, which is provided in the Borough by the BRC.

Members were advised that the BRC service supported people for a short period of time (up to 6 weeks) during the difficult transition from hospital to home. The service was an important part of the discharge management process, helping to alleviate the pressure on beds as well as offering practical support to people when they were at their most vulnerable. It was noted that the Service was also available to people in the community to help avoid hospital admission and operated Borough wide, between the hours of 9.00 am and 5.00 pm Monday to Friday.

The report and presentation provided details of the services, activities and interventions which may be provided to individuals whilst using the service. It was noted that under the current contract, BRC provided information on a number of indicators relating to numbers of referrals and numbers of service users, as well as outcome information.

Further to Members queries the following additional information was provided:

- The Health and Wellbeing Walk was praised and there was a similar walk in Runcorn, carried out by another organisation, the details would be sought and provided to the Board;
- People were able to access the BRC services more than once, in fact this had happened already;
- Referrals could come from family, friends and agencies; people were welcome to call the BRC in the first instance; and
- Some referrals did prove challenging due to some clients having complex needs so these would be signposted to an additional service for help.

RESOLVED: That the Board note the contents of the report and accompanying presentation.

Director of Adult Social Services

*The Chair, Councillor Joan Lowe, declared a disclosable other interest in the following item as her daughter in law worked for the domiciliary care provider. She did not take part in the discussion of the item and handed the Chair to the Vice Chair, Councillor Baker, for the duration of the item.*

HEA15 HEALTHWATCH HALTON – DOMICILIARY CARE SERVICES IN HALTON

The Board welcomed Kath Parker, the Chair of Healthwatch Advisory Board who presented the outcomes from Healthwatch Halton's recent survey on Domiciliary Care Services in Halton.

It was reported that in 2016, Healthwatch Halton undertook a project to gather the views of people using Home Care Services (Domiciliary Care) in Halton. Over 140 people took part in the survey, which concluded that the vast majority of service users were satisfied with their care but there were some issues that needed to be addressed and as such, the report made a number of recommendations.

It was noted that at the time the report was published, Halton Borough Council announced a review of provision of Domiciliary Care services across the Borough and following the review recommissioned home care services, with the contract being awarded to one main provider. Subsequently, HBC were interested in how the new provider was performing against issues the previous report had raised and as such, Healthwatch Halton undertook an evaluation of the new service provision as well. This report, published 24 October 2019, was appended to the report: *Domiciliary Care Services in Halton – what people told us about their experiences.*

Members were pleased to receive the report and the consensus was that an 80% satisfaction rate overall was a very good figure. They also recognised that there were consistent problems for the provider such as the continuity of carers; length of visit times; and high staff turnover for example.

The following points were discussed and noted following Members queries:

- Vera's Story and what would happen next in this scenario;
- Some clients were not clear about the care options available to them;

- The importance of independent advice for clients from other agencies and what could be done to improve this part of the service – it was agreed that this needed to be clarified;
- Continuity of care was recognised as a huge issue for the provider and was being monitored on a monthly basis; and
- A response to the survey had since been provided, a copy of which would be included in a future report to the Board.

RESOLVED: That the Board notes the Healthwatch Halton report relating to domiciliary Care Services in Halton. — Director of Adult Social Services

HEA16 PUBLIC HEALTH ANNUAL REPORT 2018-19

The Board received the Public Health Annual Report (PHAR) 2018-19, which was in the form of a short film which focussed on Workplace Health as its theme.

It was reported that since 1988 Directors of Public Health (DPH) had been tasked with preparing annual reports – an independent assessment of the health of local populations. The annual report was the DPH's professional statement about the health of local communities and was an important vehicle by which a DPH could identify key issues, flag up problems, report progress and thereby serve their local populations.

It was noted that each year a theme was chosen for the PHAR so therefore it did not encompass every issue of relevance, but rather focused on a particular issue or set of linked issues. Also, the PHAR was the DPH's independent, expert assessment of the health of the local population and whilst the views and contributions of local partners had been taken into account, the assessment and recommendations made in the report were those held by the DPH and did not necessarily reflect the position of the employing and partner organisations.

As the Director of Public Health was unable to attend the meeting, the Chair requested that any queries from Members be directed to her for a response.

RESOLVED: That the Public Health Report 2018-19 be received. — Director of Public Health

HEA17 NAMED SOCIAL WORKER / TRANSITION TEAM

The Strategic Director People, provided Members of the Board an update on the work of the Transition Team, based within the Care Management Division of Adult Services. It focussed on the continued use of the Named Social Worker (NSW) approach, following the provision of funding from One Halton for 2019-20.

As Members were already aware of the Transition Team and Named Social Worker pilot, they were provided with summary of this as a reminder. The report continued, with an update on funding for 2019-20 and gave details of current activity.

It was reported that since April 2019 when One Halton funding was identified, the Transition Team had continued to have an impact on the lives of young people. The intensive and pro-active work of the team, enhanced by the NSW approach, resulted in better outcomes for individuals at the same time as achieving cost savings. A case study demonstrating this was attached at appendix 1.

Members were pleased to receive the report and on behalf of the Board the Chair passed on their thanks to all staff involved in the pilot. Members discussed the sustainability of the project bearing in mind the caseloads were set to increase in the future. The importance of keeping family members and communities together was recognised.

RESOLVED: That the report be noted.

*The Chair, Councillor Joan Lowe, declared a disclosable other interest in the following item as her daughter in law worked for the domiciliary care provider. She did not take part in the discussion of the item and handed the Chair to the Vice Chair, Councillor Baker, for the duration of the item.*

HEA18 CARE HOME AND DOMICILIARY CARE UPDATE REPORT

The Board received a report from the Director of Adult Social Services which provided an update on the key issues with respect to quality in local Care Home and Domiciliary Care.

It was reported that in Halton there were 25 registered care homes which provided 760 beds operated by 14 different providers. The capacity within the care homes

ranged from homes with 66 beds to smaller independent homes with 6 beds; four of the homes were now owned by the Local Authority: Madeline McKenna, Millbrow, St Luke's and St Patrick's, which equated to 163 beds.

It was noted that the Care Quality Commission (CQC) was responsible for the registration, inspection and assessment of all registered providers however, the Care Act 2014 placed the duty of securing the quality of care in Halton on the Council itself.

Members were provided with details of the CQC's assessment process and details of the role of the Quality Assurance Team in the Local Authority. The report also provided the quarter 2 ratings given by each of them for care homes and domiciliary care services; it was noted that both ratings were almost the same. With regards to the amber ratings in paragraph 3.13, it was noted that this related to management issues and not the standard of care itself.

RESOLVED: That the report be noted.

HEA19 PERFORMANCE MANAGEMENT REPORTS QUARTER 2 OF 2019/20

The Board received the Performance Management Reports for quarter 2 of 2019-20. It was reported however that from page 102 onwards, under *Adult Social Care Department – Revenue Budget as at 30 September 201*9, this information was incorrect as it related to another department. Therefore the correct finance information would be sent to the Board following the meeting.

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 of 2019-20. This included a description of factors which were affecting the services.

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.

It was highlighted that under emerging issues a review of Intermediate Care Services was currently being undertaken for the reasons outlined in the report. A report providing further details would be submitted to the Board at a future meeting.

| | |
|---|---|
| RESOLVED: That the Performance Management Reports for quarter 2 be received. | Director of Adult Social Services |

*Meeting ended at 7.45 p.m.*

**REPORT TO:** Health Policy & Performance Board

**DATE:** 25 February 2020

**REPORTING OFFICER:** Strategic Director, Enterprise, Community & Resources

**SUBJECT:** Public Question Time

**WARD(s):** Borough-wide

## 1.0 PURPOSE OF REPORT

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

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

## 2.0 RECOMMENDED: That any questions received be dealt with.

## 3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

- Requires the disclosure of confidential or exempt information.

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

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

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

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

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

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

**4.0 POLICY IMPLICATIONS**

None.

**5.0 OTHER IMPLICATIONS**

None.

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

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

## 7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

**REPORT TO:** Health Policy and Performance Board

**DATE:** 25 February 2020

**REPORTING OFFICER:** Chief Executive

**SUBJECT:** Health and Wellbeing Minutes

**WARD(s):** Boroughwide

## 1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Wellbeing Board at its meeting held on 2 October 2019 are attached at Appendix 1 for information.

## 2.0 RECOMMENDATION: That the Minutes be noted.

## 3.0 POLICY IMPLICATIONS

3.1 None.

## 4.0 OTHER IMPLICATIONS

4.1 None.

## 5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

## 6.0 RISK ANALYSIS

6.1 None.

## 7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

# HEALTH AND WELLBEING BOARD

*At a meeting of the Health and Wellbeing Board on Wednesday, 2 October 2019 at The Halton Suite - Select Security Stadium, Widnes*

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and S. Bartsch, S. Constable, G. Ferguson, T. Hemming, T. Hill, S. Johnson Griffiths, J. Kemp, N. Kershaw, M. Larking, R. Macdonald, I. Onyia, K. Parker, P. Parle, D. Parr, J. Regan, S. Semoff, A. Shakeshaft, L. Thompson, S. Wallace Bonner, D. Wilson, K. Woodcock and S. Yeoman.

Apologies for Absence: E. O'Meara, M. Pickup, A. Marr, Supt L. Marler, M. Vasic and A. Williamson

Absence declared on Council business: None

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

*Action*

HWB10 MINUTES OF LAST MEETING

The Minutes of the meeting held on 10th July 2019 having been circulated were signed as a correct record.

HWB11 LLOYDS BANKING FOUNDATION PRESENTATION

The Board received a presentation from Gill Baker, on behalf of Lloyds Bank Foundation, which outlined the background to the Foundation, underlying principles and their approach taken to work with small charities. It was noted that in 2019 the annual donation by the Bank to the Foundation based on profitability was £18.2m. The money was used to provide grants, capacity building support, work on policy and influencing and supporting bank staff with skills based volunteering.

The presentation outlined to the Board details of the 2018/19 Strategy, Reaching Further, which aimed for the Foundation to partner with small and local charities to help people overcome complex social issues and rebuild their lives.

RESOLVED: That the presentation be noted.

HWB12 INTEGRATED COMMISSIONING GROUP UPDATE REPORT

The Board considered an update report on the One Halton Integrated Commissioning Group. Since the last meeting the Group had:

- met on 19th August and a Workshop had been held on 15th August;
- a further Integrated Commissioning Group meeting had been scheduled for October;
- Commissioners had supported the development of the One Halton Plan;
- Cheshire and Merseyside Healthcare Partnership had shared a Place Based Matrix. This had now been completed and would be used as a reference tool by Commissioners when agreeing outcomes; and
- the Terms of Reference had been updated to include a section on conflicts of interest.

RESOLVED: That the report be noted.

HWB13 ONE HALTON - UPDATE REPORT

The Board considered a report which provided an update on the work of the One Halton Forum. Since the last meeting of the Board the One Halton Forum had met twice and discussed the One Halton Plan. The final draft of the Plan had now been shared with stakeholders on 13th September for any final amendments. A copy of the Plan had been circulated to Board Members.

Following comments received from stakeholders around the mental health element of the Plan, it was proposed that the Chief Executive, in consultation with the Leader, be given delegated authority to approve the final version of the One Halton Plan.

In addition, the Board had been previously advised that £25,000 had been allocated to be used for Communications and Engagement for One Halton. Since the last meeting of the Board it was noted that:

- a Communications and Engagement Manager was now in post; and
- a Communications and Engagement Strategy for One Halton had been produced;
- the process for funding requests had been developed and one request for funding had been received;
- a One Halton Budget Statement had been produced

and circulated to the Board.

RESOLVED: That

1. the contents of the report be noted;

2. in consultation with the Leader, the Chief Executive be given delegated authority to approve the final version of the One Halton Plan; — Chief Executive

3. Communications & Engagement Strategy is approved;

4. process for funding requests are noted;

5. funding requests made in this reporting period are noted; and

6. One Halton Budget Statement is noted.

HWB14 PROVIDER ALLIANCE UPDATE REPORT

The Board received a report which provided an update on the work of One Halton Provider Alliance. Board Members were advised on the key decisions made to date which were around:

- Urgent Treatment Centres;
- Workstreams;
- Place Based Integration;
- Place Based Matrix;
- Halton Integrated Frailty Service; and
- Place five year strategic plan – One Halton Plan.

The Board was also updated on the proposal to merge Halton and Warrington CCG's. Following consultation with its GP stakeholders around a proposal, a merger application would not be submitted to NHS England because of insufficient support from members in Halton. The Council would continue to work with the Halton CCG to help them reduce their running costs.

RESOLVED: That the report be noted.

HWB15 SEASONAL FLU PLAN 2019/20

The Board considered a copy of a report which presented an Annual Flu Plan with an overview of key changes to and requirements of the annual seasonal influenza vaccination campaign for the 2019/20 flu season

and implications of this for the Local Authority and health and social care partner agencies.

RESOLVED: That

1. the Board note the content of the Annual Flu Plan and note the changes to the national flu vaccination programme for 2019/20; and

2. each individual agency note their requirements in relation to the programme and promote flu prevention as widely as possible.

HWB16 HOW INEQUALITIES IMPACT ON HEALTH IN HALTON

The Board received a presentation from Ifeoma Onyia, on behalf of Public Health, which informed the Board of the national and local context on inequalities that were impacting on health outcomes for Halton's population. The Board considered examples of health inequalities within Wards in Halton, the benefits reducing health inequalities brought to health, social wellbeing and the economy and the work taking place within Halton to tackle health inequalities.

RESOLVED: That the report be noted and the key health inequalities identified within the presentation be incorporated into Halton's Place Based Plan.

Director of Public Health

HWB17 TACKLING CHEAP ALCOHOL AND ALCOHOL HARM IN OUR COMMUNITIES

The Board received a report of the Chief Executive and Director of Public Health, which provided an update on the work to tackle the harm caused by alcohol in communities; and sought Board support to participate with other similarly minded authorities across the North to build support amongst the public and politicians for the introduction of Minimum Unit Pricing (MUP).

It was noted that alcohol was one of the biggest public health challenges faced by Halton with rising levels of harm linked to increases in consumption over the past few decades. Halton suffered disproportionate harm when compared to the rest of the country, with estimated costs to the NHS alone of over £10million each year. 27% of the adult population in Halton were estimated to be drinking at increasing and higher risk levels. There were 2,152 hospital admissions caused by alcohol each year, with 32 adults dying as a result of alcohol consumption. Estimates suggested that in Halton 6,839 crimes, including thefts,

criminal damage and violence were caused by alcohol each year.

Members were advised that research from Sheffield University indicated that Halton would see significant benefits from the introduction of a 50p MUP in England:

- The NHS locally would save £256,200 per year;
- Alcohol related hospital admissions would fall by 130 per year;
- 65 deaths would be avoided over the ensuing 20-year period; and
- 196 fewer associated crimes would be committed per year.

Given the disproportionate levels of harm experienced across the North of England, the view expressed at Stakeholder meetings showcasing the research, held in Warrington and Durham late in 2018, was that the North West and North East should work together to influence national MUP discussions. As a working group, the aim was to facilitate and encourage willing participant local authorities to work together to influence the national debate on MUP.

In light of the harms caused in Halton by the widespread availability of cheap alcohol and the improvements in alcohol related health and crime promised by the above research, work was now underway to start the process of building public and political support for MUP and to seek to engage with politicians and Parliament. The Board was asked to support the call to urge the Government in Westminster to introduce MUP in England without delay.

In addition, the Board was asked to support, should the Government be unwilling to introduce MUP, joining a group of North West and North East Councils to take local action on this issue. Such an approach would enable consultation with local people on making a bid to introduce MUP at a regional/sub-regional/local level by making a bid using the Sustainable Communities Act.

Arising from the discussion, Cheshire Fire would provide information on the number of fire alcohol related deaths.

RESOLVED: That

1. the report be noted; and

2. the Board supports the decision for Halton to participate with other similarly minded authorities across the North to build support amongst the public and politicians for the introduction of Minimum Unit Pricing (MUP).

HWB18 PUBLIC HEALTH ANNUAL REPORT

The Board considered a copy of the Public Health Annual Report (PHAR) 2018/19. Each year a theme was chosen for the PHAR and for 2018-2019 the Report would be a short film that focussed on Workplace Health. This topic had been chosen to highlight key areas pertinent to the Health and Wellbeing of the working population within the borough. The report would emphasise the measures being taken to both prevent poor health and improve the health of workers and their families.

The film would cover the following areas:

- what has been happening with workplace health in Halton;
- what impact the work undertaken has had on local businesses and their employees;
- outcomes associated with this work; and
- recommendations for the future.

The final version of the film would be presented to the Health and Wellbeing Board in January.

RESOLVED: That the Board note the contents of the report.

HWB19 HEALTHY WEIGHT IN HALTON - A WHOLE SYSTEMS APPROACH 2019- 2025

The Board received an update on the development of Halton's Healthy Weight Strategy. Over the past ten years there had been a huge amount of work to help the people of Halton maintain a healthy weight. A summary of these services were provided within the strategy and included; the Healthy Child Programme, the Healthy Schools programme, workplace health initiatives, Sure Start to Late Life and Health Checks.

The strategy aimed to build on the success of these programmes but would also look at new ways of working to reflect the many influences on obesity and the need to continue to work in partnership across agencies to improve outcomes.

In order to address the challenge locally, Halton entered into a partnership with Leeds Beckett University with a view to designing local whole systems approaches to assist in preventing and tackling obesity. Halton was one of only 6 local authority areas across England chosen as a pioneer site. Working with researchers from Leeds Beckett university two initial workshops were held to utilise the whole-systems approach to identify priorities and form the basis for the strategy and action plan.

Following the workshops, a Whole Systems Obesity network was set up to refine the priorities and develop a range of actions for each one. The strategy itself sets out some key actions, however, a more comprehensive action plan had been developed, to be overseen by the network and would be regularly updated and monitored to ensure it delivered against the priorities for the lifetime of the strategy. The overarching priorities were set out in the report.

Whilst a comprehensive action plan sat behind the strategy with timescales and responsibilities, in order to understand how our actions were impacting on health and wellbeing locally, progress against indicators in the Public Health Outcomes Framework would also be monitored.

Arising from the discussion it was agreed that the comments regarding people with disabilities would be taken back to the Strategic Lead.

RESOLVED: That the contents of the report be noted.

HWB20 TRANSFORMING DOMICILIARY CARE (TDC) PROGRAMME

The Board received a report from the Strategic Director – People, which gave an update on the progress of the Transforming Domiciliary Care (TDC) Programme and information on Premier Care – Lead Provider for commissioned domiciliary care in the Borough.

It was reported that the Council had been working with a range of partners to develop how domiciliary care was delivered in the Borough, known as the Transforming Domiciliary Care Programme. The term *Domiciliary Care* was used to describe the help some adults need to live as well as possible when coping with an illness or disability they may have.

Members were presented with information about the TDC Programme and the aims of the project. The report

also discussed the Programme's capacity and demand, service user assessment and management and workforce development.

Arising from the discussion the representative from Heathwatch advised that they had prepared a report on Domiciliary Care within Halton and they would be willing to meet with Officers to discuss the report outcomes.

RESOLVED: That the report be noted.

HWB21 PHYSICAL ACTIVITY - KEY PRIORITY FOR HEALTH

The Board considered a report of the Director of Public Health, which updated members on the work of Halton's Active Me (adult) project. The project was operated by a Sport and Physical Activity Officer and utilised short-term funding to set up new physical activity sessions in the community where need had been identified.

The report outlined the current health picture in Halton, adult physical activity levels in Halton and the challenges for increasing physical activity in Halton.

RESOLVED: That Members note and support physical activity as a priority for health.

*Meeting ended at 3.40 p.m.*

**REPORT TO:** Health Policy & Performance Board

**DATE:** 25th February 2020

**REPORTING OFFICER:** Strategic Director, People

**PORTFOLIO:** Children, Education and Social Care

**SUBJECT:** Age UK – Mid Mersey: Supporting Later Life

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a presentation from Mark Lunney, Chief Executive, Age UK – Mid Mersey (Age UKMM), regarding the work the organisation undertakes in the Borough.

2.0 **RECOMMENDATION: That the Board:**

i) Note the contents of the report, appendices and associated presentation.

3.0 **SUPPORTING INFORMATION**

3.1 Age UKMM has operated across Halton for over 30 years and is highly respected and recognised as the leading voice for older people.

We deliver a range of services under contract agreements with the Local Authority and Clinical Commissioning Group alongside delivery of a range of ageing well services via external grant funding work, advice, campaigning, and lobbying for the interests of older people across our areas of benefit.

Our Core service is led by our dedicated and highly experienced information/advice staff and volunteers. We use this route of contact and engagement to widen our holistic support across a range of wellbeing support.

3.2 Our contracted services include:-

- Information, signposting and advice – Benefits, Health & Social Care, Housing, Ageing, legal and end of life planning.
- Engagement and Influencing
- Social Inclusion, (loneliness & Isolation, befriending, volunteering)
- Installation Services – alongside the Local Authority

- Strategic Stakeholder representation (Range of board level influencing, Safeguarding, Domiciliary Care, Older People Delivery Board, Loneliness, frailty and transport groups)
- Carers strategic input and development

3.3 In addition and with appropriate funding sources, we can and, indeed have delivered a range of community based work around.

- Care homes
- Social Prescribing
- Independence at home
- Hospital support services

Recently the organisation has seen significant reduction in funding, whilst offering extensive flexibly on service levels and quality being retained as best we can. However, with more investment and collaboration, Age UKMM could offer significant added value and outcomes to both health and social care unmet needs for Halton. Without which we are intrinsically suppressed in both our capacity and reach at a time when demand is at peak. We actively support live casework to over 2000 people per annum and handle over 3000+ contacts.

A recent and powerful case study and respect campaign profile is included separately alongside our report on and contributions to wider One Halton partnerships; see appendices

3.4 We offer exceptional value for money return on investment for every Halton pound spent on Age UKMM Services. With some recent innovations that include:

- Older Peoples Engagement Panels (this year has included financial workshop, provision of information in borough) and an extensive engagement report to the Older People's Delivery Board.
- Promotion of Halton's older peoples' voice at city region level/ with presentations delivered
- Safeguarding case study learning resource
- Integration with AUKMM Information & Advice and calling out to service users escalating areas of concern up to council e.g. trip/falls prevention

Included with this report is our Halton Engagement Annual Report, our Respect photobook and healthy ageing brochure. Our quarterly report to the Council includes a range of financial and statistical monitoring data that demonstrates year on year we reach and exceed targets that were set.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Our funding has declined by 10% year on year for the last 3 years with further cuts faced next year.

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**
This report is associated with this priority.

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

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.

# Age UK Mid Mersey

- Part of a National framework but Independent.
- Areas of benefit include;

  Halton, St Helens, Knowsley, Warrington
- Runcorn Church street & Widnes market sites
- 38 staff, 152 Volunteers, £1m T/O
- "***To promote improved quality of life and empowerment for older people and their carers***". (**One Halton priorities 2017-2022)*

# Love later life!

Our range of services include:

- **Information, signposting and advice – Benefits, H&SC, Housing, Ageing,  legal and end of life planning.**
- **Engagement and Influencing**
- **Social Inclusion, (loneliness & Isolation, befriending, volunteering)**
- **Installation Services – alongside council**
- **Strategic Stakeholder representation (Range of board level influencing, Safeguarding, Dom care, Older People Partnership Board, Loneliness, frailty and transport groups,**
- **Older Carers strategic input and development**

# Added Value

**"We reach, engage and support over 275,000 local people across Merseyside".**

- **IN** addition and with appropriate funding resources, we can and, indeed have, delivered a range of community based pilot work around.
- **Care homes**
- **Social Prescribings**
- **Independence at homes**
- **Hospital and at home support services**

# Innovation

Real value for money return on investment for every Halton pound spent on Age UKMM Services. Recent innovations that include:

- **Older Peoples Engagement Panels (this year has included financial workshop, provision of information in borough) and an extensive Engagment Report to OPPB.**
- **Promotion of Halton's older peoples' voice at city region level/ with presentations delivered**
- **Safeguarding case study learning resource**
- **Integration with AUKMM I&A and calling out to service users escalating areas of concern up to council e.g. trip/falls prevention**

# Partnership

- Age UK MM have strong input, influence and leadership on many strategic boards.
- Chair the SAB Partnership Forum
- Lead on #Beagoodneighbour 2019 (& 2020)
- Advise on Transforming Domicillary Care
- Involved with a range of collaborations in our sector.
- About to join healthwatch board (April 20).

# Return on investment

- Over **£40k** external funding into Halton
- Secured **£450+** of extra benefits entitlements locally
- Received over **2,000** direct referrals from local partner agencies.
- **450** case loads pa
- Typically handle: **6,000** telephone I & A enquires pa.
  **2,000** F2F /Drop in enquiries pa.
  **10,000+** Age UK I&A Leaflets and Info.
  over **2,000** calls via national helpline.
- Support a wide range of stakeholder intelligence

# Respect Campaign

## #DoYouSeeMe?

- Age UK Mid Mersey wants to challenge cultural attitudes towards ageing and older people; to encourage society to change their perspective about this group of people so that they are seen as more than their just their age.

- Respecting older people and celebrating their life time of experience and their wisdom; the value of age, a life well lived, lessons learnt and all that being older has to offer society.

Mid Mersey age UK






# #DoYouSeeMe?

Mid Mersey age UK

**#DoYouSeeMe?**

# Respect Campaign

- 2020 Community Conference
- Widen reach Across Merseyside
- NW and National
- Campaign lobby to MPs & Ministers
- Integrate with partners
- Corporate strategy

**#DoYouSeeMe?**

**Questions ?**

**Mark Lunney CMgr.**
**CEO**
**marklunney@aukmm.org.uk**

**#DoYouSeeMe?**

**Appendix: Respect Campaign – Do you See me?**

Mid Mersey ageUK

**Respect campaign #DOYOUSEEME: Campaign Summary 2019/20**

**Respecting older people and celebrating their life time of experience and their wisdom; the value of age, a life well lived, lessons learnt and all that being older has to offer society.**

*PLEASE SHARE THIS DOCUMENT WITH ALL STAFF/VOLUNTEERS/CONTACTS*

HALTON BOROUGH COUNCIL

CRONTON SIXTHFORM COLLEGE

# Information Provision for Older People in Halton

## Age UK Mid Mersey Engagement

## June 2019

Supported by:

**Contents:**

## 1. Background and introduction

Information provision and low-level support are vital elements to ensuring that older people can quickly and effectively access and navigate the services and support they require to maintain their independence and well-being.

Information and advice is fundamental to enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support.

***"Information is not a luxury, but a commodity we need in some abundance if we are to manage our lives well.***

***And there are heavy penalties to pay for not having information- wrong decisions, missed opportunities, wasted time and money, even pain.***

***The irony is that information often exists, somewhere, but does not get to the people who need it in a form that enables them to act on it."***

***Lord Young of Dartington.***

## 2. Engagement on Information Provision

In May 2019, Age UK Mid Mersey held a focus group with its Older Peoples' Expert Panel to explore the needs and problems faced by older people in relation to information provision. This was requested by the panel as a topic for discussion during a workshop in March 2019. Whilst the panel is aware that there are several agencies working in Halton providing a range of information to older people, they wanted to take a step back and look at how older people access information. Eleven expert Panel members were involved in a deeper discussion and since February 2019, 63 clients have been engaged with regards to gaining a deeper understanding of the issues around information provision (this is an ongoing programme of engagement around issues affecting older people). This report also reflects the views of our Information and Advice Service who speak to several clients per day.

The panel members examined:

- *The barriers older people face in getting information - particularly becoming aware of services which could help them;*
- *Older people's views on what information services they want and their key priorities in terms of vehicle/format*

The Care Act specifies that Local Authorities must ensure that people have sufficient information to make an informed decision about how their needs are met. In Halton there are several providers of information who work jointly, networking and sharing good practice through meetings such as Partners in Prevention to ensure that the most vulnerable people in the community are provided with an accessible and quality service. Specialist organisations such as the Stroke Association, Alzheimers Society, Runcorn and Widnes Cancer Support, Macmillan, Halton Haven, Mind, Vision Support, Carers Centre, Age UK Mid Mersey, Deafness Resource Centre, Red Cross, Sure Start to Later Life, Halton Disability Partnership, Citizen's Advice, Health Improvement Team and many others come together to support older people to maintain the best quality of life that they can in whichever life situation they find themselves; from providing support to a carer, applying for benefits through to help when discharged from hospital.
For the purpose of this study we have consulted with Age UK Mid Mersey Information and Advice Service as well as speaking to individual clients as part of the ongoing engagement work we carry out.

Age UK Mid Mersey's Information and Advice Service in Halton works across the Borough to give a wide range of signposting, information and advice to people over the age of 50, their families and carers.

**Type 1 Signposting/information (typically lasting less than 30 minutes)**
The client knows what Information they need. Information is provided to the client and they go away and act on this information.

**Type 2 Information/advice (typically lasting one hour)**
The client may not be clear about what it is they need. For example; they have been told by a friend that they should be eligible for additional income due to poor health.
In this case, Officers would ask further questions to establish if they could be eligible for disability benefits. If it was felt that they fitted the eligibility criteria, the client would be advised to put a claim in for the benefit and they would be provided with the relevant contact details to do so. In many cases support would be provided to complete complicated forms or make relevant phone calls.

**Type 3 Casework (typically lasting at least one and half hours per session with clients being seen on more than one occasion)**
The client presents with multiple issues, often with long term conditions or sensory impairment. Clients will have access to impartial information for their individual circumstance enabling them to make informed choices about their future. The service takes a holistic approach, looking not just at the initial problem but also at how the client's lifestyle, income and health may be impacting upon the situation. Generally speaking, it is the experience of Information and Advice that this type of client will not move forward without this type of support.

Through talking to clients, we have found generally that self-sufficiency arises through necessity or choice. Some older people are self-sufficient seekers for information; lots more are reliant on other people. As the service moves from type 1 to 3, the volume of clients decreases but the amount of time increases per client as type 3 clients have multiple issues requiring a more holistic approach from the Information and Advice Service.

As explained previously, this consultation was initiated as a result of talking to our Expert Panel. They felt that this subject needed to be explored and discussed with reference to older people. It is important to note that although our focus group sessions are structured, we allow for more of a discussion and this is very much led by the participants. Eleven panel members booked onto the session. We also asked several individual clients where they looked for sources of information and had similar discussions with them if they were willing to expand.

The questions asked at the session in May are outlined below:

1. What sort of information is important to you to live a good quality of life?

Health: type of info

Finance: type of info

Social: type of info

2. How do you find out where to get information on activities/health/finances from?

Main sources: discussion.

3. What format do you prefer information in? (Online, face to face, leaflets etc.)

4. Do you feel confident navigating information online?

5. How do you think much older isolated people manage to find information if they aren't online?

6. If all information was online how would you feel about that?

## 3. Findings

Our main findings are outlined below.

Older people experience barriers in accessing information in three ways:

- **becoming aware** that there is information, advice or advocacy that can help in their situation;

**"You don't know what you don't know"**

There appears to be concerns around what people think they need and what they really need to know – are people missing out on what they are entitled to? There appears to be definite differences in quality of life for those who access information and those who don't, as illustrated by those who access appropriate benefits, care services and information on travel and social activities.

- **gaining access** to appropriate and comprehensive information and advice; and
- **further assistance and follow up** to act on the information in order to achieve a solution (particularly those with low confidence/sensory impairments)

***Health information***

The older people we spoke to want information across a range of health and social care services, particularly following the onset of illness (their own or that of family members). Needs for a variety of health information as well as advice about welfare benefits were frequently mentioned in the discussion, as was assistance in filling in complex benefit claim forms.

People look for **"Professional health information backed by the NHS"**. Participants are particularly interested in weight management, exercise and how to live well and what to expect at what age. Other participants mentioned that they would like to know when you ***don't*** need a GP referral and can self-refer as they felt that this information is still not widely available and that GPs have little time to sit and discuss.

Discharge from hospital packs were another issue mentioned – some felt that certain hospitals had got it right (such as Whiston), but that it could be hit and miss at other hospitals and they felt that made older people without an advocate incredibly vulnerable and unable to speak up when they were leaving to go home from hospital. When asked if participants understood how to access additional support in the community following discharge from hospital, panel members said that they would go through their GP – again, the GP appeared to be a main source of information but there are concerns around time and resource.

One major source of complaint with regards to ongoing support from hospital was follow-up. Participants felt that the onus is very much on the patient to report any issues.

**"Sometimes there is no follow up check that the person is okay at home"** and **"Care packages can be "bitty" and difficult to pull together to make one package that works".**

A final comment was made that people still not aware of the "Telecare" system and the costs and benefits.

***Social Activities/general***

There was a great deal of discussion around single travel. More and more people are travelling on their own and participants generally felt that there was not enough information around "how to" travel alone in terms of insurance, keeping costs down , availability of single rooms and information needed on those companies that treat single people fairly.

A lengthy discussion was had around the impact of retirement – there is not enough support available to prepare – with budget reductions– participants felt that they are left to adjust and yet, there seems to be more support on preparing people for work.

Comments were made about older people being provided with almost too much information (information overload) by organisations and the person feeling overwhelmed with it – it needs to be provided at a pace suitable to the individual. One organisation held group sessions for older people being referred to them via a GP - if that organisation explained that there was an opportunity for a one to one after the group, **"You would be more likely to stick with it"**.

Participants felt that GPs do not have time to socially prescribe. But felt that GPs are a "primary" source of information for the most vulnerable or carers with regards to loneliness and isolation.

Information about how social media can benefit older people would be useful – whilst there is a lot of warning about the risks, it might be a good thing to combine the warnings with some positivity.

It was agreed that one point of information (with a telephone number) for social activities would be of benefit – but that this would need to be updated constantly with a staffed contact number as "**There is nothing worse than making the effort to get somewhere to find it closed, especially as you might have had to get two buses!"**

**"It's one thing providing the information – it's a whole other thing actually going on your own"**

***Finance***

All participants agreed that this topic is a minefield and felt that this was the most intimidating aspect of information. Benefit forms can be off putting and complex. All of this creates a barrier to claiming the right benefits – much of the information is online, you can save money if you apply online for certain services – it literally costs more in many cases to do things offline. Much of the information around benefits is word-of-mouth and you do need a trusted agency/expert to help you.

Older people lacked information about reliable tradespeople who could do household repairs, cleaning or gardening. They felt that they were open to scams and that information on avoiding this is useful although they conceded that, even with this, many older people are vulnerable due to lack of confidence.

The thought of claiming benefits can be off putting – previously in life, one wouldn't have needed benefits and there is also the uncertainty of older life which can complicate matters. The marketing information should encourage people to claim without judgement or making them feel that they are "needy".

**"Not so bad, if you are doing it for someone else!"**

***How do you find out where to get information on activities/health/finances from?***

Participants discussed how best to get information out to people so that you can help them. They agreed that for some people, it can take time to build up those relationships and break down the barriers.

**"It's not a case of just talking once"**

This type of engagement provides individual person-centred support to older people facing difficulties in particular those struggling to cope with life changing events, e.g. bereavement, illness, divorce, retirement, going into care etc.

There is a lot of pride within this group – some Age UK Mid Mersey clients won't even have a blue badge because they don't want to be seen as older/needing support.

All agreed that community groups are important for disseminating info and one participant mentioned that he carries out a "role call". **"Is anyone not here? Do we need to call on them? Are they okay?"**

Within the group of Information and Advice clients engaged it would appear that local knowledge, GP surgeries, friends and less frequently community groups were cited as main ways that people found out where to get information, with several citing hospital staff such as ambulance staff when being transported to hospital as important. Age UK Mid Mersey clients value the active approach taken by health and social care staff who advised them of additional services they could receive.

One participant mentioned the importance of having a "paper record" so that you can remember where you got the information and a copy of what was discussed – **"You do forget"**.

What doesn't help is that many agencies work in the area and **"Nobody is joining the dots….services are still disjointed".**

There were several good examples of where information about available support can reach people mentioned – GPs, shops, hairdressers, chemists and prescription delivery services, carers and care organisations, free local newsletter (e.g. Inside Halton), Age UK Mid Mersey, Direct Link, SureStart, neighbourhood schemes, community groups, churches, libraries.
Participants want to see all agencies working together to promote each other.

**"Many older people develop trust with an information provider and they have that local knowledge where to go – almost like a routine or a habit"**

***What format do you prefer information in?***

Most of the focus group participants are comfortable with searching and finding information online. All participants felt that the best way to inform, in an ideal world, is face to face or over the phone with a well-designed leaflet coming close second. All information must be either regular and/or timely depending on the issue. As previously stated, most participants and Age UK Mid Mersey clients would feel a lot happier if somebody provided them with a sheet of paper with all the contacts and what was discussed during the appointment.

Unlike the Expert Panel, most Age UK Mid Mersey clients that were engaged do not use digital technologies and search engines to look up information.

Many of these people have a genuine fear of technology and do not have access to a PC or tablet. Many Age UK Mid Mersey clients value the personal assistance provided, especially those whose ability to seek out information for themselves is restricted. Continuity helps to instil trust and confidence that the problem will be resolved.

When asked if they would prefer information to be subject or agency based – participants responded with *BOTH*. Subject based is easier to understand in the first place but this must be delivered by a trusted Agency to instil trust. The perceived trustworthiness of the information provider was also important. In some topic areas, the independence of the advice giver was valued; in others, it was their expertise. Although, most participants repeated that working together and ensuring that there was no duplication was important.

Language used is important – it needs to be positive where possible. For example – many older people would not wish to be described as "elderly frail people".

If information must be online, Expert Panel participants were okay with this but they pointed out that due to the group of older people that do not access information online, websites are not always easy to navigate, **"You can get lost – closing tabs down – only to find you've got to start again!"**

People worry about scams. Does education about scams work or is it about vulnerability and confidence? It was agreed that it's probably a combination of the two. It is about **"…being savvy – can you teach savviness?"** and **"Assertive friend needed!"**

**"People have different capacities and those who are vulnerable have to trust others which can make them all too open to being scammed".**

***Do you feel confident navigating information online?*** *And* ***If all information was online how do you feel about that?***

Again, most of the Expert Panel would be comfortable with this, however WIFI, tablets, PCs are not affordable to everyone and they all agreed that many older people are literally, **"…terrified of technology - it feels like you have less control"** and **"This would be rather limiting and, dare I say, rather boring!"**

**"If website designers spoke to older people – they might learn a thing or two about how to make things more accessible!"**
Participants also pointed out that printed information is not always perfect – there can be issues with text, format, colour and so forth; with costs and distribution being expensive.

***How do you think much older isolated people manage to find information if they aren't online?***

General comments were made about how the community has changed – people seem less friendly and welcoming, **"No one smiles or says hello"**, **"People are not as polite and there is less eye contact".** They felt that this attitude could be more prevalent in urban areas. People are less likely to offer help – **"It's more a case of "Well, you know where I am!""**.
For those that are truly isolated, they are faced with a double edged sword – too trusting but yet the need to trust. They don't always have the option to speak to neighbours. A trusted agency or joint approach helps – participants preferred this approach as the local authority can seem **"authoritarian"**
**"Goodness only knows where someone who has no one and who is ill or has sensory issues gets the help they need and the right information!"**
All participants agreed that this is where working together with other agencies and organisations helps, **"The local postman may well know where the truly isolated people are".**
An example of good practice is where GP surgeries invite agencies into the surgery to support their work.

***An additional Question – What would be the worst case scenario for information provision?***

"Phone number with loads of number options!"

"Online - this isn't ideal for many older people"

"Quiet, barely audible automated messages"

"Foreign accent"

"Trying to prove that you're not a robot!"

"Cold callers – especially to those people that are just delighted that someone has called them"

## 4. Key messages and Recommendations from this consultation

No single solution could meet all the needs expressed by older people in Halton. The partnerships providing information in Halton are doing well. However, there appears to be a gap for some older people in terms of being aware of where to go for sources information and what information they actually need.

- Many older people are very unsure of what information they need. They simply need help and it is up to the professionals to help them to get the right help in the right format and at the right time – all with the appropriate consent.
- Older people value information that is topic based, however, they prefer this information to be delivered by a trusted agency with a specialism. They do, however, want to see agencies working together to support each other and to avoid duplication or conflicting information.
- It is not enough to provide information – many older people need support in using that information effectively.
- Older people want support that helps to relate information to particular circumstances and assistance to obtain the services they needed. The information provided needs to continue to be available at a point of change or crisis in their lives.
- Older people do not appear to differentiate between information, advice and advocacy - they see it simply as help.
- Online information may well be the future and many older people are comfortable and recognise this, but there is still a group of older people who do not have access to IT and do not trust it. Will this replace a friendly face when that person is particularly vulnerable?
- Older people have diverse approaches to obtaining information. Different modes and styles of information suit people at different times and in relation to different topics. Again, organisations need to be mindful of this.
- A follow-up service is appreciated, ensuring a solution is achieved, rather than simply being referred on to yet another potential source of information. Older people generally desire continuity of contact and to avoid having to retell their story to new people. The personal touch is important - it is resource intense but makes such a difference with face to face being the ultimate in service provision.
- Knowledge about a service is pointless if it cannot be accessed because appropriate means of transport are not available or staff shortages/resources mean that the service is not currently available, or that it costs too much to access.

- Some directories of services tend to be agency-based rather than issue or topic-based, making it difficult to obtain information about diverse needs and always out of date. So whilst many older people like a paper version of information, directories might not be the best solution.
- Feedback is incredibly important to groups like the panel – if they feel listened to and effective, people are more likely to engage.
- Provision needs to be made available to those with sensory impairments as highlighted in the introduction. All local organisations need to work together to share assets in preventing barriers to this extensive group of older people.
- The volume of information available can be as problematic as an absence of information. Examples of information overload were cited – organisations need to be aware of this.
- If information must be provided online then it must be designed with older people in mind – many issues around trust and scams and getting "lost" once they click off a tab and not being able to get back to where they are. Online might work better once a person has become confident and has passed through the crisis phase in their life.

**End of Report**

# E.ON SY8 Client satisfaction survey results – benefits

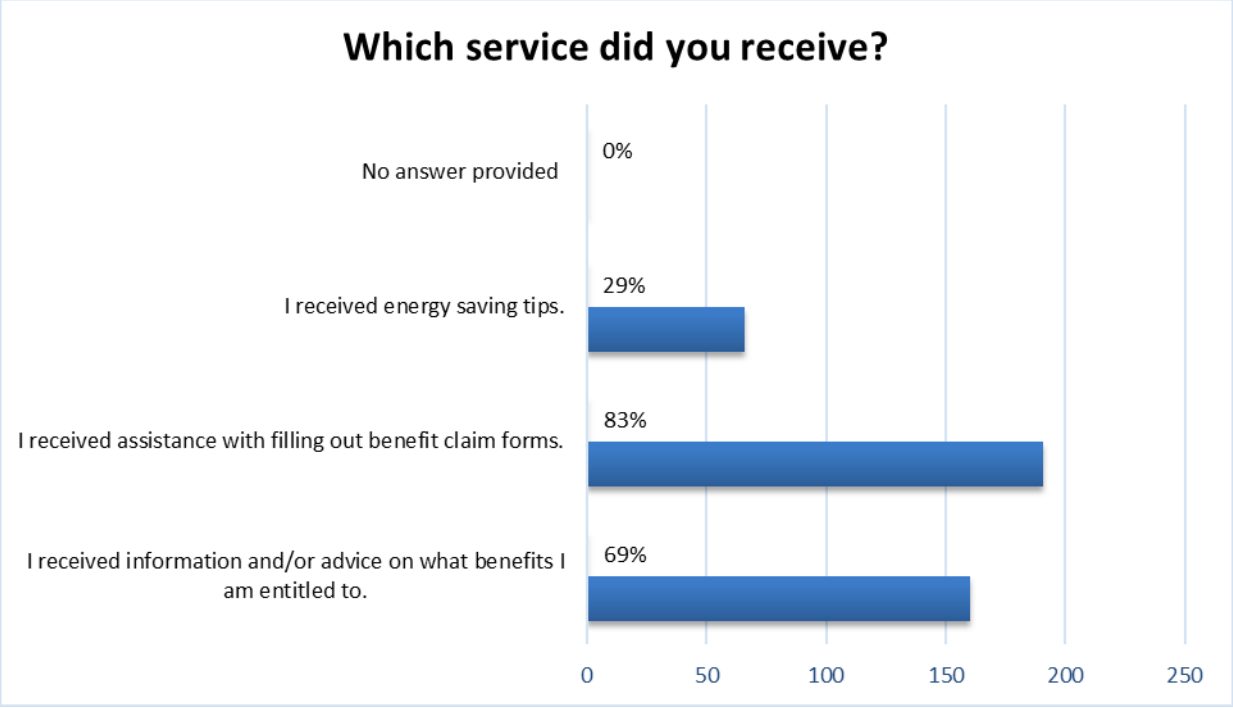
**Background Information**

- Number of partners – 73 partners
- Number of people we sent the surveys to – 1,144
- Return rate – 20% (231 responses)

## Summary of results

### 1. Which service did you receive?

Clients received a range of Information & Advice services with 69% of respondents receiving information on what benefits they could be entitled to, 83% receiving assistance with filling out benefit forms and finally 29% receiving energy saving information.

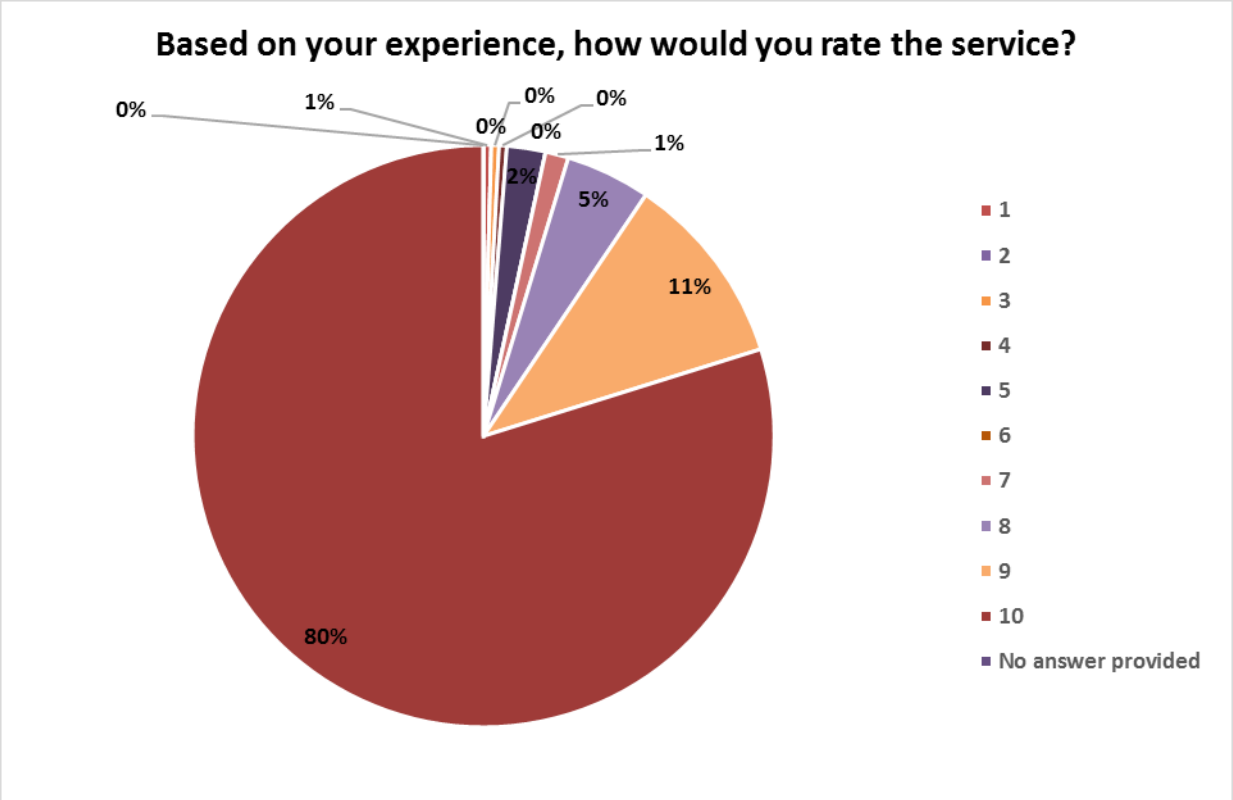



### 2. Would you recommend this service to a friend or family member?

All respondents would recommend the service to their relatives and friends, having received 100% 'Yes' responses.

3. **Based on your experience, how would you rate this service? Please circle one number with 0 being Very bad, 5 being OK, and 10 being Excellent.**

95% of respondents rated the service 8 or more, showing clients' satisfaction with the service is very high and the service provided is of high quality.




**Clients have provided comments as to why they have scored the service high:**

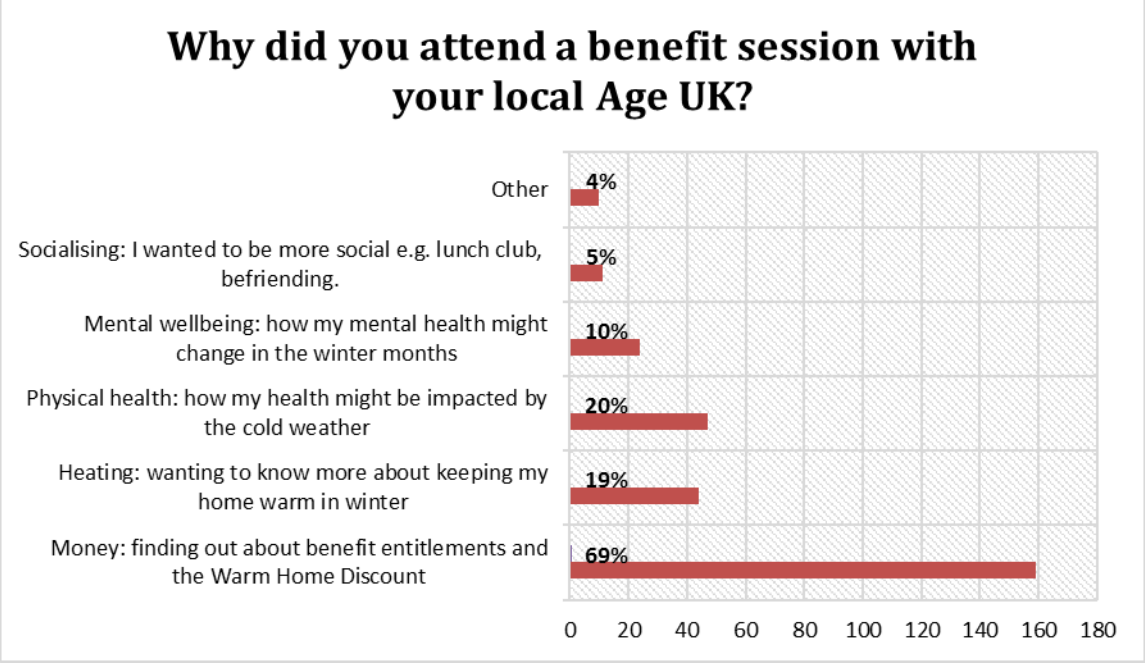
- "Very helpful, kind and considerate manners. Service was outstanding**."**
- "The benefits adviser gave me information which I was not aware of and enabled me to claim extra benefits"
- "All the people were fantastic – great help!"
- "An excellent service - so much help for the elderly."
- "Very helpful at a difficult time."
- "Very pleased with the help my wife and I received. We were very happy with the staff at Age UK and would recommend them to everyone I know."

4. **Was your claim successful?**

79% of respondents' benefit claims were successful (14% still awaiting results, only 3% unsuccessful).

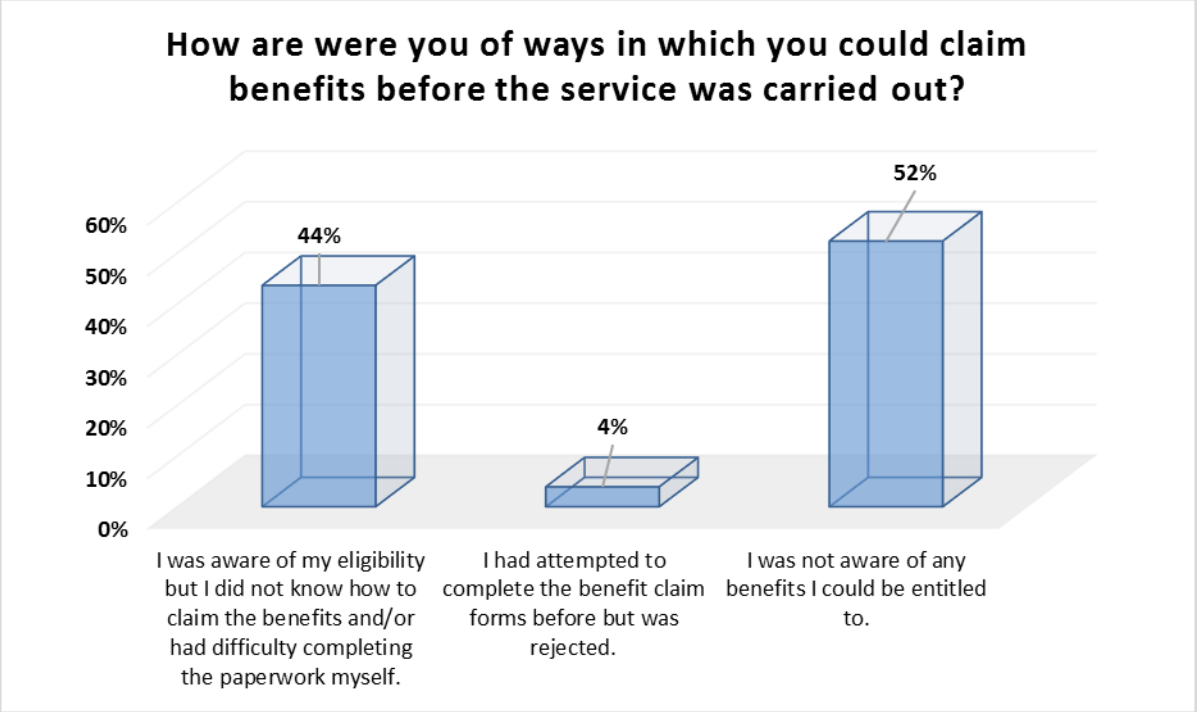

5. **Why did you attend a benefit session with your local Age UK? Please tick all that apply.**

69% of respondents wanted to find out more about their benefit entitlements and the Warm Home Discount, 20% were interested to know how the health might be impacted by the cold weather, and 19% wanted to know how to keep their home warm in the winter months.



6. **How aware were you of ways in which you could claim benefits <u>before</u> the service was carried out? Please tick one that applies.**

- 52% of respondents were not aware of any benefits they could be entitled to.
- 44% were aware of the benefits they were entitled to but did not know how to claim and/or had difficulty completing the paperwork
- 4% had attempted to complete the benefit claim forms before but were rejected

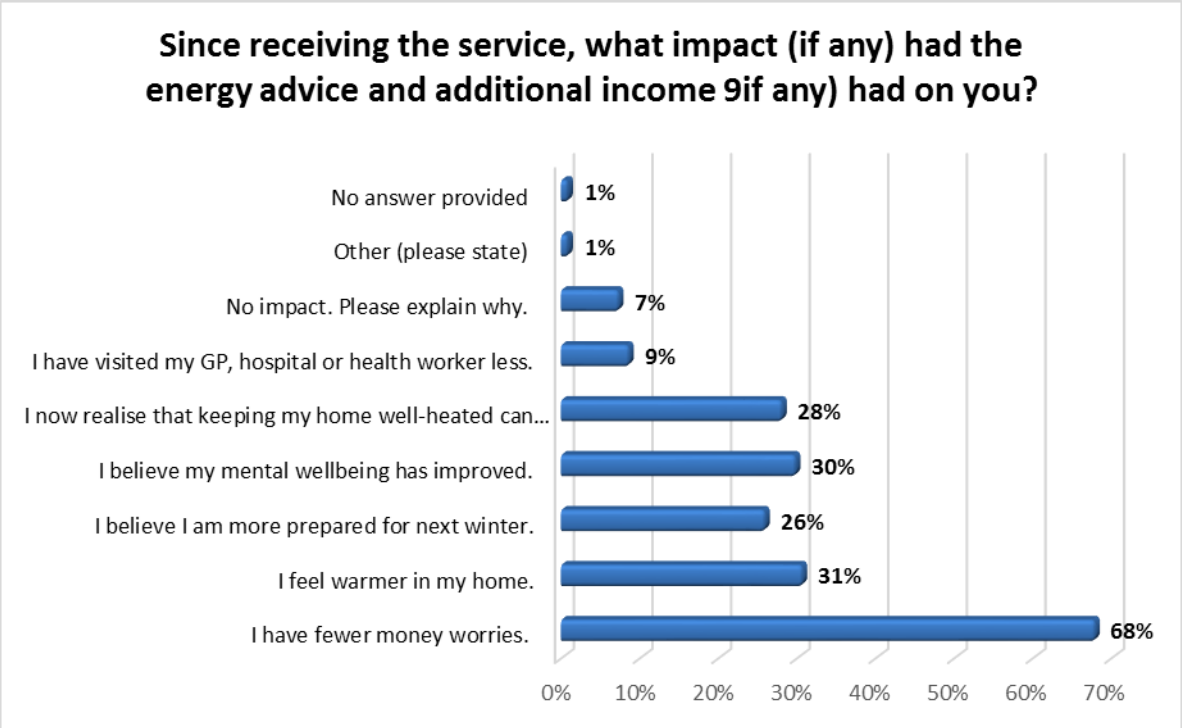


7. **Since receiving the service, what impact (if any) has the energy advice and additional income (if any) had on you? Please tick all that apply.**

68% of respondents have fewer money worries and 26% feel more prepared for next winter.

With regards to keeping well and warm in winter, 28% of respondents realised that keeping their home well-heated can have a positive effect on their health, with 30% reporting improved mental wellbeing and 31% feeling warmer in their homes.

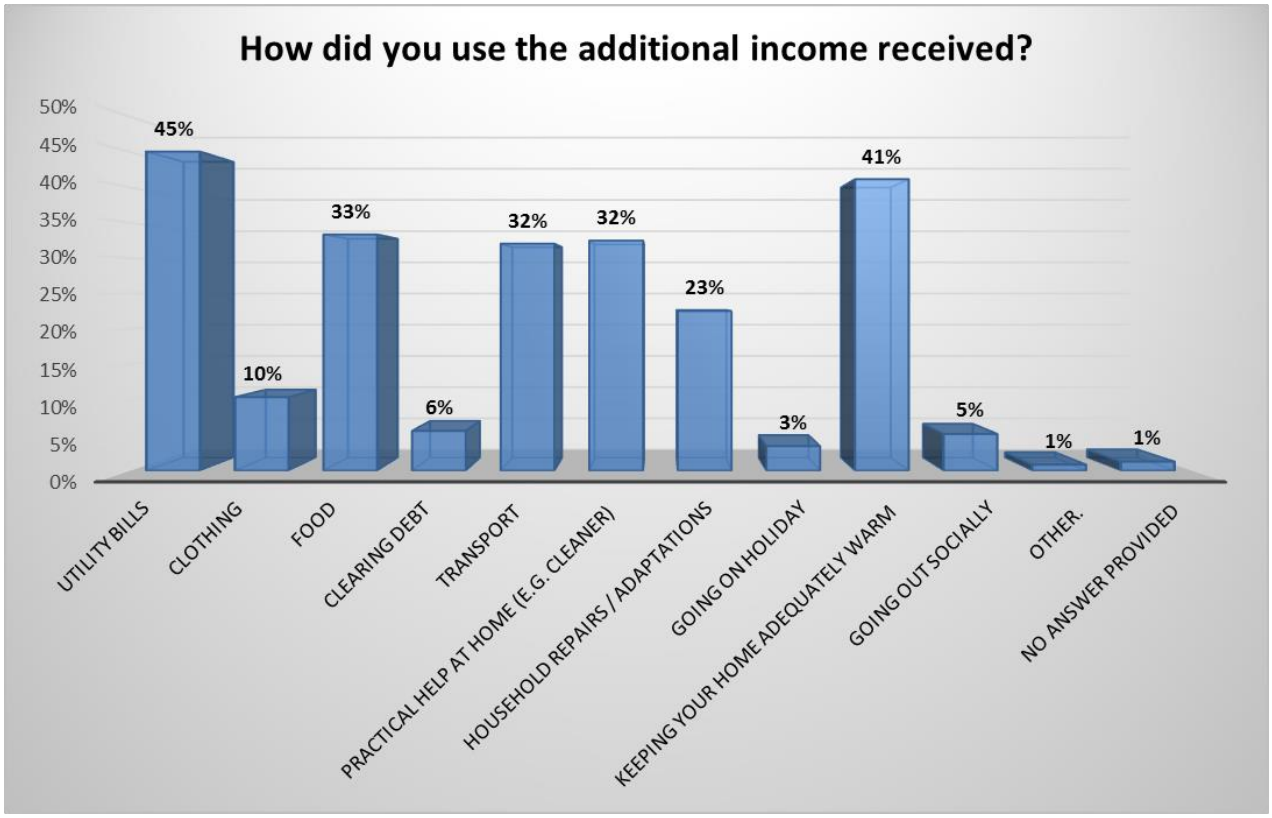
Please note that 7% of respondents stated 'No impact', the principal reason for this being that they were either not entitled to any benefits or are still waiting to hear the outcome of their benefit application or appeal.




8. **How did you use the additional income received?**

The four principal ways in which respondents used the additional income are as follows:

- 45% of respondents used the income to pay for their utility bills
- 41% of respondents used the income to keep their home adequately warm
- 33% of respondents used the income to purchase food
- 32% used the income to pay for practical help at home (e.g. cleaner) and for paying for transport




**9. Please provide any other comments you would like to make about the service.**

- "I am more grateful with getting a new boiler as it has taken away a big worry. Thank you!"
- "We didn't realise that we may be entitled to anything so being told we may be entitled was a shock! The staff were so helpful."
- "A very good service we could not have done without."
- "Very efficient service that I would recommend to anyone."
- "I wasn't made to feel like a nuisance and the money has made a big difference."
- "I think Age UK are brilliant."
- "Very helpful service. It would have been too difficult to do the forms on my own."
- "After receiving my attendance allowance my everyday life has not been such a financial worry, I can't thank this service enough for what it has done for me."
- "The advice received from your colleagues was one of encouragement and with genuine understanding and sympathy for our health issues. I was delighted when both of our applications were accepted."

Age UK
Love later life

NHS

# A practical guide to healthy ageing

# Contents

# Who is this guide for?

The advice in this booklet will help improve the health and general fitness of people of any age, but it is written to be particularly relevant for people who are about 70 years or older.

People of this age, and sometimes younger, begin a 'slowing-down' process related to the effects of ageing on their body.

We cannot stop the process of ageing, but the advice given here will help to keep you fit and independent.

## Mrs Drakos: My Story

"Looking back, I can see I've been a bit worried about myself for a while. It's not as though I was ill or anything, but just a feeling that I've sort of slowed down – things being more of an effort. Like doing the weekly wash seemed to take all day. Or doing the family Sunday lunch would knock the stuffing out of me. And Doreen, the Post Office lady, seemed to be mumbling all the time. Anyway, I came across this guide.

Got my daughter to help with the walking speed test. Was surprised at how slow I turned out to be. But there it was! It was a real wake-up call! So I checked out the guide and sure enough found I needed new glasses, and the hearing aid has been a real boon. Rang Age UK in the town and they put me onto a local "Get Fit" group. Love the company and chat. All-in-all, feel I'm back in control again. Thank goodness."

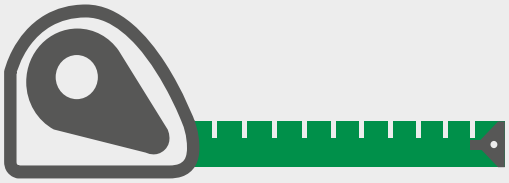
# Try this at home

Have you noticed it's taking longer to get to the bus stop than it used to? Or that your weekly supermarket shop takes longer than before?

**These can be signs that you've started slowing down.**

If you've noticed you're a little slower than you used to be, or even if you haven't, you may want to try the simple test opposite which will let you know if the 'slowing-down' process of later life is affecting you. It is called the Walking Speed Test. You can do it easily at home. All you need is a tape measure and a watch with a second hand or a mobile phone with a stopwatch function.

Using a tape measure, mark out on the ground two lines 4 metres (13 feet) apart.



Stand next to the first line.

Your friend/helper should say **"Go"** and start timing you.

Walk at your usual speed (using a walking aid if you usually use one) until a few steps past the 4-metre mark (don't slow down as you approach the mark).

As you pass the 4-metre mark, your friend/helper should **stop** timing you.

Repeat three times, allowing sufficient time to recover between tests.

x3

If you take more than 5 seconds, it's likely you're affected by the slowing-down process of later life. Of course, some of us walk slowly for other reasons, such as arthritis, but the test will give you a good indication of your general fitness. If you have slowed down then this guide will help improve your health and general fitness.

# Look after your feet

Your feet have been constant fellow travellers throughout your life, but they may be showing signs of strain. Healthy feet are essential for comfort and safe walking and the good news is that there are lots of things you can do to look after them.

**Painful and uncomfortable feet** aren't a natural part of growing old or something to put up with.

# A lot can be done to improve comfort, relieve pain and maintain mobility.

## Wash your feet often

Wash your feet daily to help prevent any infections. If you leave dirt on the skin, it can become irritated and infected. Dry them well, especially between the toes to help prevent Athlete's foot. If you have some hard skin, apply moisturising foot cream (not body lotion).

## Toenails

It can get harder to cut toenails as you get older, but keeping them short will help keep you mobile. When cutting your nails, trim them straight across, never at an angle or down the edge as this may cause an ingrown nail. You may need help with this from your chiropodist or a toenail cutting service. Ask your local Age UK if they provide or know of a local service.

## Keeping warm

Try to keep your feet warm. Warm stockings or socks can help. Avoid anything too tight which can restrict your circulation or cramp your toes. Wearing fleece-lined boots or shoes or even an extra pair of socks will keep you warm but make sure your shoes aren't too tight as a result. Bed socks are also a good idea when the weather is particularly cold.

If your feet are cold, don't try and warm them up by putting them close to a fire or on a hot radiator as this risks chilblains.

## Choosing the best footwear

If your shoes fit well they protect and support your feet and may improve your balance and stability. Poorly-fitting shoes or slippers can easily trip you up and cause a fall. Look for shoes with uppers made of soft leather or a stretchy man-made fabric which is also breathable.

Avoid plastic 'easy clean' uppers which don't allow the foot to breathe and won't stretch to accommodate your own foot shape. Check that the heel is held firmly in place. You'll find that a lace-up or Velcro fastening shoe will give more support than a slip-on.

Shoes should be comfortable in the shop. If they don't fit well, they can make even minor foot problems worse. Don't buy them if they're too tight thinking you can break them in.

If your feet swell during the day, it's a good idea to put your shoes on as soon as you wake up, before your feet have had a chance to swell. Also, try shopping for shoes in the afternoon and make sure they have adjustable fastenings so that they can adjust to your foot shape.

**Speak to your GP to find out if you are eligible for NHS treatment. If you are not or need urgent treatment, you should contact a private chiropodist.**

# Look after your eyes

## Your eyes should give you a lifetime's service, but sometimes they can be affected by conditions that develop as you grow older.

It's easy to neglect your eyes because they rarely hurt when there's a problem. Having an eye test will not only tell you if you need new glasses, it will also check the health of the eye and can spot eye conditions before you become aware of them so they can be treated early. If you have a low income, you may be eligible for help with the cost should you need glasses or contact lenses.

An eye test can pick up eye conditions, such as glaucoma and cataracts, as well as general health problems, such as diabetes and high blood pressure.

**You can help keep your eyes healthy by:**

- not smoking – smoking damages the eye, making it more likely to develop age-related macular degeneration and cataracts
- eating lots of fruit and vegetables
- protecting them from the sun by wearing sunglasses.

**The good news** is that if you're 60 or over, you can have a free NHS eye test every two years. You can have a free test every year if you're 70 or over.

# Look after your mouth

Maintaining good oral health is important. It contributes to general wellbeing and allows you to eat, speak and socialise without discomfort or embarrassment.

**Some top tips to improve your oral health:**

- Reduce the amount and frequency of sugary foods and drinks you consume and avoid eating or drinking sugary foods and drinks just before bedtime.
- Using fluoride toothpaste is an effective way of preventing tooth decay.
- Brush your teeth at least twice a day, last thing at night and on one other occasion, with fluoride toothpaste.
- Your dentist may prescribe a toothpaste with a higher fluoride content if you have tooth decay or are at particular risk of tooth decay.
- Spit after brushing, and do not use mouthwash straightaway as this will rinse away the fluoride in the toothpaste.
- Avoid excess alcohol consumption and do not smoke (or use smokeless tobacco such as paan, chewing tobacco and gutka), as this can increase the risk of mouth cancer. If you would like help to stop smoking, ask your dentist to refer you to your local stop smoking service.

Whether you have your own teeth or wear dentures, you should see your dentist regularly for an overall check of your mouth, teeth, gums and fit of your dentures.

**A dry mouth can increase your risk of dental decay and can impact on your quality of life through its effect on your ability to speak, eat and enjoy your food. It can also affect the comfort of your dentures, if you wear them.**

- Take regular sips of water.
- Suck on sugar-free sweets or chew sugar–free gum.
- Suck on ice-cubes.
- Avoid alcohol (including alcohol-based mouthwashes).
- Ask your dentist, GP or specialist to suggest/prescribe an artificial saliva substitute.

**For more information:**
**www.nhs.uk/conditions/dry-mouth/pages/introduction.aspx**

# Make your home safe

It is important to feel safe and comfortable in your home. There are some simple things you can do to ensure that you keep yourself and your possessions safe and reduce the risk of accidents, fires and other issues.

## Have a look round your home and check for some simple things you can do to make your home as safe as possible:

- Consider getting and wearing a personal alarm, particularly if you live on your own. This will let you contact a 24-hour response centre at the touch of a button should you fall or become unwell. Don't be afraid or embarrassed to push the button if you need to. The response centre will be glad to reassure you or call for help.
- Have smoke alarms installed in hallways and living rooms of your home and a heat alarm in the kitchen. If you have a gas boiler or a coal or wood burning fire or stove you also need a carbon monoxide alarm. Test all alarms regularly (at least once a month).
- To receive a free home visit contact your local fire and rescue service who will provide fire and safety advice and fit smoke alarms.

- If you have an electric blanket, get it tested every year and replace it every ten years. Check for danger signs such as frayed fabric and scorch marks. You can ask the shop where you bought it about testing and servicing, or contact trading standards.
- It's easy to slip in the bathroom. Get a non-slip bath mat and a handrail to help you feel more stable.
- Remove any clutter on the stairs that might trip you up and ensure stair carpets or stair runners are secured in position.
- Use plug-in night lights that turn on automatically at night. They provide a low light so you can see your way to the bathroom or stairs.
- Coil up any long or trailing electric leads, particularly around doorways or stairs, or tape them close to the wall. Don't overload sockets and make sure leads and cables aren't damaged – if they are, then have them replaced.

- Don't walk in socks, tights or bare feet. Wear well-fitting slippers.
- Don't wear loose-fitting, trailing clothes that might trip you up, such as a long dressing gown.
- Loose rugs and mats can be a trip-hazard and should be avoided. Replace frayed carpets or repair with double-sided carpet tape.

**Read Age UK's free guide *Home safety checker* for more information.**

Call **0800 169 6565** or download it from **www.ageuk.org.uk**

# Keep active

## It can be easy to retreat into the pleasing comfort of an armchair, particularly during the colder months.

But taking life too easy can actually speed up the slowing-down process of later life. It's never too late to start being more active or begin an exercise program.

# Keeping active is the key to staying fit, mobile and independent.

Regular exercise can help reduce the impact of several diseases, such as osteoporosis, diabetes, high blood pressure, heart disease and stroke. Regular exercise can also reduce arthritis-related pain, improve sleep, prevent falls and fractures, and improve low mood and memory.
In fact, taking regular exercise is one of the best things you can do to remain independent.

The good news is that any exercise is good for you. You don't need to go to a gym! Try to find things that can be part of your everyday routine, such as simple chair-based exercises, walking to the shops, or things that are fun, such as dancing or playing bowls.

**Why not contact your local leisure, community centre or Age UK to see what they've got on, or if possible see if you can find an activity to do with friends or other people, such as walking and dancing. This is especially important if you are finding that you are spending a lot of time on your own.**

**If you haven't been very active,** you should aim to minimise the amount of time spent sitting down for extended periods. You could do this by reducing the time you spend watching TV, taking regular walks around the garden or street, or swapping a bus or car journey for walking part of the way.

Your next aim should be to increase your activity so you build up to about 30 minutes activity on three to five occasions a week. Each activity should be sufficient to raise your heart rate and make you breathe faster and feel warmer.

### Examples of the sorts of activity that improve or maintain health include:

- Brisk walking
- Ballroom dancing
- Climbing stairs
- Swimming

### You should also aim to undertake activity to improve muscle strength on at least two days a week, such as:

- carrying or moving loads such as groceries
- gardening jobs such as pushing a lawn mower, digging, or collecting grass and leaves
- activities that involve stepping and jumping such as dancing
- chair-based exercises.

**Read Age UK's free guide *Healthy living* for more information.**

Call **0800 169 6565** or download it from **www.ageuk.org.uk**

# Talk about your medicines

You may be taking several different medicines, especially if you have a condition such as diabetes or asthma. It's important that your medicines and the doses are reviewed regularly.

Your GP, nurse or pharmacist will do this for you. They may recommend alternative medicines or lower doses, or sometimes suggest the medicine is stopped altogether.

**Did you know** that your pharmacist can help you with queries you might have about your medicines? They are experts on medicines, and often have extended opening hours and no appointment is necessary.

Don't simply stop taking a prescribed medicine if you are worried about side effects. If you think a medicine is causing side effects (perhaps dizziness, a fuzzy head, dry mouth, loss of appetite, nausea or constipation), get advice from your GP, practice nurse or pharmacist.

**You should see your GP, nurse or pharmacist if you have not had your medicines reviewed for more than one year, or if you are concerned about the medicines you are taking.**

# Get your vaccinations

As we age, our immune system becomes less efficient at protecting us. A number of different vaccinations are available for older people. These are free on the NHS.

If you're 65 or over, get a free flu jab every year.

- Flu vaccination, commonly known as the flu jab, protects against influenza. Flu can be particularly serious in older people and cause complications such as pneumonia. It is free to people aged 65 and over and also to carers and younger adults with conditions that make them susceptible to complications if they have flu. So ask at your GP service if you think you could be eligible for an annual flu jab.
- People who are aged 65 and over should have a single pneumococcal vaccination which will protect you for life. This is a one-off jab that will protect you from pneumococcal infections caused by bacteria.
- People who are aged 70, 78 or 79 should be offered a single vaccine to prevent shingles, a common and painful skin disease. Talk to your GP practice for further information.

# Preventing falls

Falls are a common concern as we get older, but they are not inevitable and there is much that can be done to reduce the chance of a fall, even if you have already had one.

The slowing-down process of later life affects our balance and makes our muscles weaker. This increases the risk of falling. But both balance and muscle strength will be improved simply by taking some of the actions already described in this guide.

**Preventing falls**

- Looking after your feet (see page 5)
- Looking after your eyes (see page 7)
- Making your home safe (see page 9)
- Staying active (see page 11)
- Getting your medicines reviewed (see page 13)
- Looking after your hearing (see page 16)

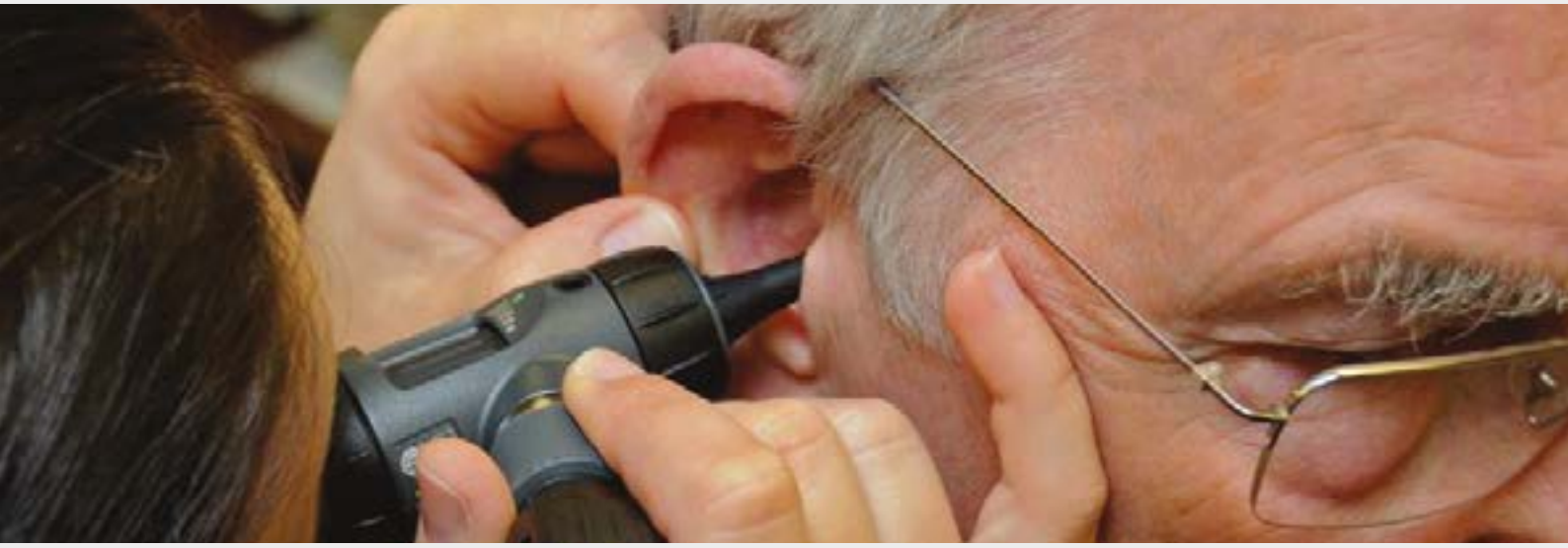
**So each of these actions has a double benefit. All the more reason to consider them!**

**Dizzy spells** or faints can be related to too much medication and should be discussed with your GP or pharmacist.

**Read Age UK's free guide *Staying steady* for more information.**
Call **0800 169 6565** or download them from **www.ageuk.org.uk**

**Read SAGA's free guide *Get up and go.***
For more information download it from **www.saga.co.uk**

# Get your hearing tested



## Losing your hearing is a normal part of the ageing process, but because it happens gradually you may not notice any change.

You may realise that you need to have the TV on louder or find you can't always follow conversations, especially in a group.

Having trouble hearing can make it hard to understand and follow a doctor's advice, to respond to warnings, and to hear doorbells and alarms. This can sometimes be frustrating, embarrassing, and even dangerous.

**NHS hearing tests are free and can be arranged through your GP.**

It is important to identify hearing loss early as treatment is more likely to be effective when problems are diagnosed early. The problem may be as simple as earwax, which after removal can restore hearing.

To do a quick hearing check before seeing your GP, use the free hearing check provided by Action on Hearing Loss. It only takes five minutes and you can do it at home either by phone (0844 800 3838 (local rate), or online for free (www.actiononhearingloss.org.uk/hearingcheck). This check will indicate if you have hearing loss. If you have any concerns, speak to your GP.

**Hearing aids** are much more discrete than ever before and will enhance your hearing.

# Keep warm and well

Keeping warm over the winter months can help to prevent colds, flu and serious health problems such as heart attacks, strokes, pneumonia and depression.

- Heat your rooms to a minimum of 18°C (65°F). If you can't heat all the rooms you use, heat the living room during the day and the bedroom just before you go to sleep.
- Keep your bedroom window closed at night. Breathing in cold air is bad for your health and could put you at risk of a chest infection.
- Use a wheat bag or hot water bottle to keep warm.
- Make sure you are receiving any benefits you are entitled to. Your local Age UK can provide advice and even help you to fill out forms.
- Hot meals and drinks help to keep you warm, so have regular hot drinks and eat at least one hot meal a day if possible. Eating regularly helps keep energy levels up during winter.
- Wear several light layers of clothes (rather than one chunky layer). Thermal underwear can be good as a base layer.

**Read Age UK's free guides *Winter wrapped up* and *More money in your pocket* for more information.**

Call **0800 169 6565** or download them from **www.ageuk.org.uk**

# Get ready for winter

There are practical things that you can do to prepare for winter weather, which may bring cold, ice, snow and high winds. Remember that cold weather can start in October.

- Icy pavements and roads can be very slippery. Take extra care if you go out and wear boots or shoes with good grip on the soles. Rubber snow/ice grips that attach to outdoor shoes are very effective.
- Consider fitting a grab rail if you have steps at your front or back door.
- Have your heating system serviced before winter arrives.
- Have some food supplies in a cupboard or freezer in case you can't go out for a few days.
- Ask your family, neighbours or friends if they could call or visit you more often if a period of cold weather stops you getting out and about.
- Keep simple cold, flu and sore throat remedies in the house.
- Speak to your friends, family or carer if you are feeling under the weather, down or need some practical help. They may be able to help you.
- Order repeat prescriptions in plenty of time, particularly if bad weather is forecast.
- Local pharmacists can help you manage long-term conditions and can offer advice if you have a bad cough, a cold or a sore throat. They have longer opening hours than GP practices, and most have a private consultation area. They'll also tell you if they think you should see a doctor.

**Read Age UK's free guides *Winter wrapped up* and *Save energy, pay less* for more information.**

Call **0800 169 6565** or download them from **www.ageuk.org.uk**

# Eat well and drink plenty

Hot meals and drinks help to keep you warm, so eat at least one hot meal each day and have hot drinks during the day, especially during cold weather.

Wholesome soups make a warming snack. Include a good range of foods in your diet (for example wholegrain cereals, milk and cheese for calcium).

Aim for five portions of fruit and vegetables each day, so that you're getting plenty of nutrients and vitamins.

**Remember that frozen vegetables are as good as fresh.**

Having a glass of water within reach during the daytime will remind you to keep up your fluid intake. Having a hot drink before bed and keeping one in a flask by your bedside can be good ideas too.

It's important to eat enough, especially in winter. If you're worried about a poor appetite or losing weight, speak to your GP.

**Read Age UK's free guide *Healthy eating* for more information.**
Call **0800 169 6565** or download it from **www.ageuk.org.uk**

# Bladder and bowel problems

People of all ages can experience bladder control problems – including over 2.5 million people over 60 – yet many people keep it a secret for years.

Bladder and bowel problems are not an inevitable part of ageing, or something you have to put up with. Start by talking to your GP. Symptoms such as frequency, urgency, not getting to the toilet quickly enough, or having to get up at night to pass urine are common so there's no need to feel embarrassed. Your doctor will assess your symptoms, identify the cause, and discuss what treatments or exercises may help. Or you could refer yourself directly to your local NHS continence service for an assessment, where a continence adviser can help you.

**There are things you can try that may help improve your symptoms too.**

- Drink normally, as cutting down on liquids will usually make urinary incontinence worse, not better.
- If you notice that tea, coffee and cola make your symptoms worse, cut down or try decaffeinated versions.
- Check whether any medicines you're taking could be affecting your bladder.

**Urinary infections** can be serious. Consult your GP or pharmacist if you think you have a urinary infection.

Symptoms include needing to urinate more often, pain when urinating, cloudy urine or blood in your urine, an unusually unpleasant smell, or back or groin pain.

**Read Age UK's free guide *Bladder and bowel problems* for more information.**

Call **0800 169 6565** or download it from **www.ageuk.org.uk**

# Look after your mental health

## Good mental wellbeing is important for all of us. Here are some things you can do to help or improve your mental wellbeing:

- **Begin a conversation –** Communication is key to wellbeing and we all respond to a friendly face
- **Invite friends for tea –** Make time for friends
- **Keep in touch by phone –** The next best thing to catching up in person
- **Learn to love computers –** Connect with others and browse the web
- **Get involved in local community activities –** Singing, walking, book clubs, bridge, bingo
- **Try do something every day –** Plan things to look forward to
- **Help others –** Volunteering can be a great way to stay involved and meet new people
- **Age UK's befriending services –** The service works by assigning each older person a befriender, who provides friendly conversation and companionship. Ask your local Age UK if they provide this service.

## Depression

We all feel down from time to time, but if you are feeling low and out of sorts for longer periods of time, you may be suffering from depression.

**Symptoms include:**

- loss of confidence and feeling down
- feeling anxious or panicky
- not being able to enjoy the things you usually do
- unexplained aches and pains
- avoiding people, even those you're close to
- sleeping badly
- loss of appetite
- feeling bad or guilty, or dwelling on things from the past.

With the right help you stand a very good chance of getting better, whatever age you are and however long you've felt this way.

Depression is just as significant as a physical illness, so speak to your GP and explain how you're feeling. You can then agree on the best treatment for you, such as talking to a counsellor who can help you manage your thoughts and feelings and the effect they have on you.

## Bereavement

**A common trigger for depression can be bereavement. People are affected by bereavement in many different ways. Remember that there is no right or wrong way to feel, and it can take time to adjust. However, if you feel things aren't improving for you, you might need help if:**

- you neglect yourself or your family, for example you don't eat properly
- you feel you can't go on without the person you've lost
- the emotion is so intense it's affecting your life, for example you can't face getting out of bed or you're taking your anger out on someone else.

If you feel that you are not coping it is important that you talk to someone about it and share your feelings with someone that can help. For some the best way to cope is to discuss feelings with family or friends but if you don't feel this works for you then you can always contact local bereavement services through your GP.

**Read Age UK's free guides *Healthy living* and *Bereavement* for more information.**

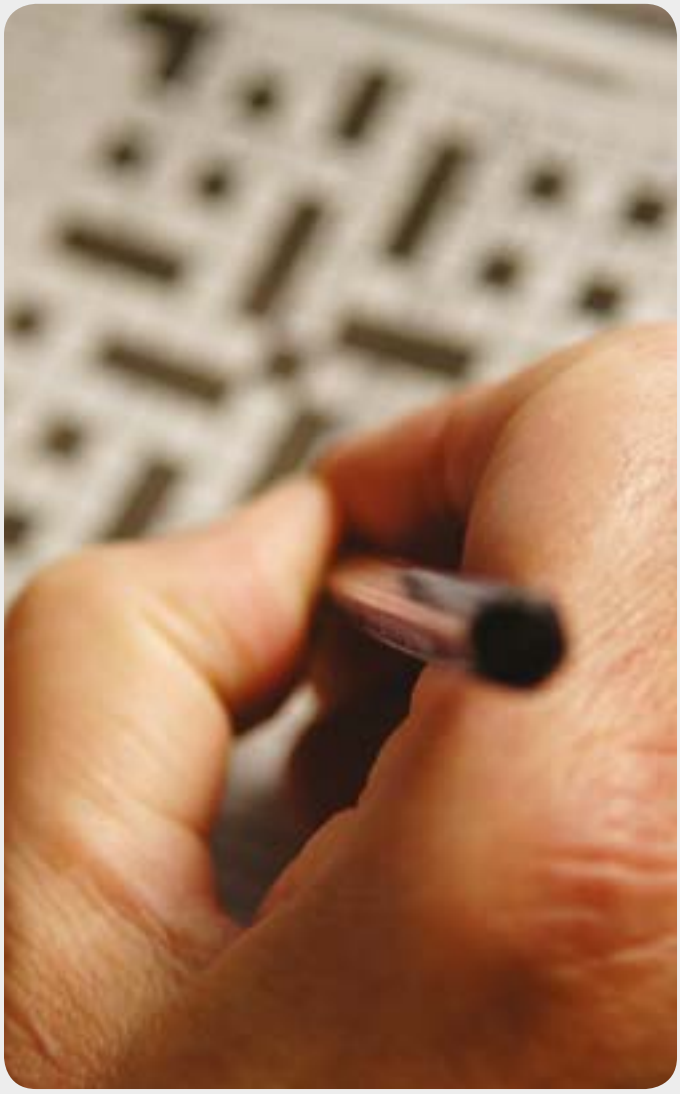
Call **0800 169 6565** or download it from **www.ageuk.org.uk**

# Looking after your brain

There's a lot we don't know about how to keep our brain healthy but we do know that what's good for our body is good for the brain.

**There are some simple things we can do. These include:**

- eating a healthy diet
- maintaining a healthy weight
- exercising regularly
- not drinking too much alcohol
- stopping smoking (if you smoke)
- making sure to keep your blood pressure at a healthy level
- getting enough sleep, including a day time nap if you need one
- keeping socially active with friends and family
- keeping your mind busy: learn new things; hobbies; volunteering; clubs; gardening; read books; attend plays; solve puzzles; learn a language



**Memory loss** can be annoying if it happens occasionally, but if it's affecting your daily life or is worrying you or someone you know, you should seek help from your GP.

# Caring and looking after yourself too

Lots of older people care for a family member or friend; this might be helping someone with eating, getting dressed or washed, or reminding them how to do day-to-day things. You may also be looking after the home or doing the shopping.

This is an important role which can be tough, and may affect your physical or mental health. Make sure you look after yourself. You should ask your local authority for a carers assessment to find out if you are entitled to any support, including time off from caring. Your GP or local carers group can support you too and help you get the information and support you need.

**To find support in your local area, visit www.carers.org**
**For further information and advice, visit www.carersuk.org**

**Read Age UK's free guides *Advice for carers* or *Caring for someone with dementia* for more information.**
Call **0800 169 6565** or download it from **www.ageuk.org.uk**

# Action plan

## Five things we recommend you do:

1. Check your walking speed.
2. Stay active or become more active.
3. Socialise regularly, spend time with other people and have regular chats.
4. Keep on top of your health (get your eyes and ears tested, have your vaccinations and get your medicines reviewed).
5. Look after yourself (keep your home warm, eat well and don't put off asking for help).

# Five things I am going to do:

1.

2.

3.

4.

5.

To reorder this guide please order for free online via **www.orderline.dh.gov.uk** or call **030 0123 1002** quoting reference HA2.

This guide has been prepared by NHS England and Age UK with support from CFOA, Carers Trust, Carers UK, Public Health England and older people themselves and contains general information which we hope will be of use to you.

Your individual case may well have specific circumstances that apply to it and so this guide should not be read as specific advice given to you, it should not be relied on as a basis for any decision or action you take in respect of the matters it covers and it should definitely not be used as a substitute for seeking specific advice from an appropriately qualified and experienced professional (generally, your GP).

Neither NHS England nor Age UK nor any of their respective subsidiary companies or charities accept any liability arising from this guide or its use by you, except where the law states otherwise. We aim to ensure the information contained in the guide is as up to date and accurate as possible as at the time of publication, but it is inevitable that certain areas will be subject to change from time to time. Please see our website or contact us for more up to date information.

Age UK registered charity number (1128267)

Publication date 01/10/15.

# Halton 2018-19 QU.4 Case Study

## About the person

Mrs H is a family orientated woman who works full time whilst helping her older relatives. Mrs H has Lasting Power of Attorney for an elderly uncle and is strict on respecting his wishes and principles in life.

## What was the problem?

Mrs H approached the office one evening after work as she was in a great deal of distress due to her uncle's situation. Mrs H's uncle had already been in hospital for two months after receiving medical treatment and was not being discharged as they were awaiting a care package to be arranged by the local authority. Due to the prolonged wait and being left in a bed or chair throughout the day Mrs H's uncle, who already had reduced mobility due to his health conditions, had found his mobility had significantly deteriorated and he had become very low in mood.

Mrs H explained to us that further stress was being caused by the request for a financial assessment by social workers at the hospital. Mrs H's uncle already felt that his independence had been taken away so he felt that keeping his finances private was the last piece of dignity he had. Mrs H and her uncle were happy to fund the care and support themselves but felt they were getting nowhere with waiting for a local authority care package and did not know if there was anything else they could do. The emotional exhaustion of the combined stress relating to the care package and worrying about her uncle had begun to severely affect Mrs H's own wellbeing.

## What did you do to make a positive difference?

During Mrs H first conversation with our service we discussed in depth the different avenues of rehabilitation when discharged from hospital and the many different ways in which care can be funded, including non-means tested forms of funding. For further information and reference for Mrs H to look back at later we provided her with copies of Age UK Factsheets.

- Factsheet 20 describing NHS funded nursing care was given as Mrs H's uncle may become eligible in the future should his health become unpredictable or unstable.
- Factsheet 10, paying for permanent residential care, was also given so that should the client's uncle need to use these facilities in the future they would have the information surrounding all options.
- Factsheet 24, personal budgets and direct payments in social care, was provided to the client so that she was aware of all the options for accessing care and support.
- Discussing Factsheet 24 with Mrs H allowed us to provide information and advice on the choice and types of care and support, and the choice of providers, available to those who are in the local authority area and how to access that care and support, as outlined in The Care Act 2014.
- Factsheet 48 on Pension Credits was provided to allow Mrs H to check if uncle was receiving his full benefit entitlement.

We advised her that her uncle did not have to have a financial assessment and was entitled to refuse it. We explained that the family could, if they wished, organize their own care for their uncle, eliminating the need to wait for a care package and remain in hospital too much longer. We provided Mrs H with a list of domiciliary care agencies that cover the local area.

During Mrs H's first visit we also discussed possible avenues of maximizing her uncle's income so that he didn't face too heavy a burden paying for care.

We explained the eligibility criteria for pension credits and how it is calculated, providing our client with Age UK Factsheet 48 "Pension Credit" to allow her to see whether she could calculate whether her uncle is entitled to pension credit.

We also agreed that her uncle was likely to be eligible for Attendance Allowance and ordered the claim forms. As our client has Lasting Power of Attorney and advised that when the form arrive she should come and see us again so that we can assist in the completion of the form as Age UK Mid Mersey I & A are all trained and experienced on completing Attendance Allowance forms.

We also advised that Mrs H could request to speak with an occupation therapist within the hospital to discuss her uncle's prior abilities within his home. This way Mrs H would be able to talk about and arrange for aids to be provided within the home.

As Mrs H works full time we adjusted our office times slightly to allow us to provide her a long enough appointment to be supported with the application.

Shortly after completing the application for Attendance Allowance Mrs H had to again contact us regarding her uncle being pressured to have a financial assessment. We reassured Mrs H that her uncle could refuse a financial assessment and still have the needs focused assessment as the two are independent assessments and under The Care Act 2014 local authorities must carry out an assessment of anyone who appears to require care and support, regardless of their eligibility for state-funded care, and focus the assessment on the person's needs and how they impact on their wellbeing.

## What outcomes did you achieve?

Within seven days of Mrs H initially reaching out to us for support she had managed to speak to the occupational therapist and social worker in the hospital, agreeing to make all the care arrangements herself, and all the required aids were arranged and delivered to her uncle's property. Nine days after the initial discussions the client's uncle was discharged to his home from the hospital. Mrs H explained that just five days after he was discharged her uncle was starting to regain his mobility and independence that he had before his hospital stay.

There was a visible improvement in Mrs H's emotional wellbeing too as a large amount of worry and stress had been lifted by identifying the various options and avenues that were open to her and her uncle.

The information, advice and support we had given had empowered Mrs H to help her uncle regain his dignity, independence and confidence back in a much shorter time span than she had expected and via means she had been unaware of.

The information provided gave Mrs's H and her uncle choice on the types of care and support available and the choice of providers in their local area

Using the provided domiciliary care agency list, Mrs H had been able to get a variety of quotes and packages to identify the most suitable agency to support her uncle in the short term while he rehabilitated at home. Mrs H and her uncle did not have to face the intrusion of a financial assessment and were able to feel confident and comfortable with their own choice of care provider.

## Quotes from Mrs H.

Mrs H wrote:
*"This experience has made a huge difference to my uncle's recovery, and without the help of Age UK Mid Mersey would not have been the case! Thank you."*

Mrs H's last statement was *"Now I know what I can do and what choices are available I can get things done for my uncle."*

**REPORT TO:** Health Policy and Performance Board

**DATE:** 25th February 2020

**REPORTING OFFICER:** Simon Constable

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** An introduction to Simon Constable – Chief Executive: Warrington & Halton Hospitals NHS Foundation Trust

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

To provide the Health Policy and Performance Board with an opportunity to meet Simon Constable, the new Chief Executive of Warrington & Halton Hospitals NHS Foundation Trust.

2.0 **RECOMMENDATION: That:**

**i)** The Board note the contents of the report**.**

3.0 Simon Constable will attend the Board to outline his vision for Warrington & Halton Hospitals NHS Foundation Trust and provide the Board with the opportunity to ask questions.

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 paper provided to the Board will directly link 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**

9.1 None under the meaning of the Act.

| | |
|---|---|
| **REPORT TO:** | Health Policy & Performance Board |
| **DATE:** | 25th February 2020 |
| **REPORTING OFFICER:** | Dave Sweeney – Director of Partnerships, C&M HCP |
| **PORTFOLIO:** | Children, Education and Social Care |
| **SUBJECT:** | Cheshire & Merseyside Health & Care Partnership Update |
| **WARD(S)** | Borough-wide |

## 1.0 PURPOSE OF THE REPORT

1.1 This report has been prepared at the Board's request, to provide an update on the Cheshire & Merseyside Health & Care Partnership.

## 2.0 RECOMMENDATION: That:

**i)** Members are asked to note the report and continue to promote and support the Partnership and delivery of the Five Year Strategy for Cheshire and Merseyside.

## 3.0 NHS LONG TERM PLAN

3.1 Cheshire & Merseyside Health & Care Partnership successfully submitted its first Five Year Health & Care Strategy into NHS England / Improvement (NHSE/I) on 15 November. The strategy was developed from the ground up, taking its feed from the nine Place Plans. It will become our rolling five year strategy, updated annually. This submission comprised a strategic narrative and two technical templates – a strategic planning tool (SPT), covering finance, activity and workforce figures and an LTP metrics collection template, which set out trajectories to show how we intend to ensure delivery of key commitments within the Long Term Plan. All Partnership members received copies of the strategic narrative at each stage of the submission process and comments received were reflected in the final submission.

3.2 Going forward we are keen to identify ways to involve Place more in leading the aggregation of each local system's plans to help join up granular organisational annual planning with partnership working efforts.

3.3 The submission has been a beneficial process for the Partnership and we have taken learning from this process. The strategy provides clarity regarding how we will tackle systemic health and

care issues and work better together with key partners to achieve shared goals. Next steps are to publish the strategy as an easy read summary, which is currently in development. The strategy will be socialised over the coming weeks so its message is well understood and communicated to ensure that the opportunity is not missed to truly evolve how services are delivered and improve how the system supports people to live longer, healthier lives.

3.4 **COMMUNICATION AND ENGAGEMENT**

3.5 The communications and engagement team have been out meeting with all Place communication leads to discuss ways of working and an improved approach to health and care communications across the Partnership. Current key activities include the Change Together public awareness raising campaign, a review and refresh of the Health and Care Partnership identity and stakeholder engagement, Voluntary Sector engagement on the Five Year Strategy and support to a variety of collaborative programmes, including GovRoam.

3.6 **OUR JOURNEY TO BECOMING AN INTEGRATED CARE SYSTEM (ICS) AND DEVELOPING OUR INTEGRATED CARE PARTNERSHIPS (ICPs)**

3.7 The NHS Long Term Plan set out plans for all Partnerships nationally to become an ICS. In addition to our strategy, a key evidence of our growing maturity will be a Partnership Memorandum of Understanding (MOU). The Partnership's System Management Board has tasked the ICS Governance Steering Group to produce a Partnership MOU. The MOU will be used to capture the commitment of our partners to system working and will need to be signed up to by all partnership member organisations to take effect. Achieving this will evidence how Cheshire & Merseyside is ready to take the next steps in our journey to become more responsible and more accountable for the health and care of our population.

3.8 Comments on the first draft are being worked through and addressed to be clearer on the following areas:

- The purpose of the Partnership.
- How decisions are made (which were Place, which were Programmes and which were Partnership).
- The composition of the Partnership Board - recognising the primacy of Place.

3.9 Discussions are progressing regarding the continued development of Integrated Care Partnerships across Cheshire & Merseyside and how we support these Place based partnerships to successfully deliver on their ambitious Place Plans. We have engaged with the Place and Programme Forum to consider key success factors for an Integrated Care Partnership and what the critical steps are in

developing mature Integrated Care Partnerships.

3.10 **SYSTEM LEADERSHIP DEVELOPMENT PROGRAMME**

3.11 A system leadership programme titled 'Doing things Differently' has been developed to support leaders from across the Partnership to work effectively in a changing landscape that demands new ways of working and much greater collaboration and cross organisational working.

3.12 In line with our ambition to become a 'Marmot Community' the purpose of the 'Doing Things Differently' programme is to:

- Improve health and reduce health inequalities - Improve people's experience of using our services
- Engage existing and emerging leaders from across the system in a programme that produces real actions
- Provide leaders with the tools to effect change
- Develop and deepen the relationships between networks of leaders – creating sustainable communities of practice

3.13 The programme is based around themes relating to the strategic priorities for Cheshire and Merseyside (agreed at the previously held Marmot session). The first cohort will have a focus on CVD. Places will choose their own participants with the aim of having approx. 10 participants per place. Participants should be chosen from cross sectors/organisations/roles including community group leaders, Police, Housing Fire & Rescue etc. to encourage the development of cross sector talent pipelines. The aim will be to identify people who are personally and professionally motivated by the priority areas and have a day job that impacts and enables transformation on these priority areas. All partners are encouraged to consider who best to put forward and ensure they take their opportunity for places on the cohort.

3.14 **COLLABORATION AT SCALE PROGRAMMES**

3.15 The Partnership supports front line staff delivering quality patient care by enabling organisational collaboration 'at scale' across Cheshire & Merseyside. These collaborations deliver standardisation in corporate and clinical support functions that improve clinical and financial sustainability of the system. We continue to identify and deliver improvements through the following portfolio of programmes:

- Corporate Services
- Medicines Optimisation
- Diagnostics
- Clinical / Clinical Support service collaborations

3.16 The Corporate Services programme scope is aligned to the following functional services:

- Payroll - Single automated Payroll
- Procurement
- Finance – single ledger
- Human Resources – Optimised Agency spend
- Complaints & Legal services
- Information Management & Technology (IM&T)

3.17 Last year the corporate collaboration at sale projects received £1.25m of investment with an expectation of delivering £6.7m of benefit in year. The latest reported view shows a year end expectation of £24.16m. Work is underway to validate, mobilise and progress the relevant projects and programmes in readiness for 20/21 delivery.

3.18 **CHAIR APPOINTMENT**

3.19 The Partnership welcomes Alan Yates, appointed as the new Chair for Cheshire & Merseyside Health & Care Partnership. Alan started in November 2019 and has been busy getting out and speaking with leaders from across the Partnership. Alan will oversee recruitment of a substantive Lead following the departure of Mel Pickup.

4.0 **POLICY IMPLICATIONS**

4.1 None.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None.

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**
This report is associated with this priority.

6.4 **A Safer Halton**
N/A

6.5 **Halton's Urban Renewal**
N/A

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

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

9.1 None identified.

**REPORT TO:** Health Policy and Performance Board

**DATE:** 25th February 2020

**REPORTING OFFICER:** Dr Andrew Davies

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** NHS Halton CCG Structures & Commissioning at Scale

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

To provide the Health Policy and Performance Board with an update regarding NHS Halton Clinical Commissioning Group's (CCG) – Commissioning at Scale Programme.

2.0 **RECOMMENDATION: That:**

**i)** The Board note the contents of the presentation**.**

3.0 **SUPPORTING INFORMATION**

3.1 The Board have previously received information relating to NHS Halton CCG's Commissioning at Scale programme. Today's presentation by Dr Andrew Davies, Clinical Chief Officer of NHS Halton CCG, is intended to provide an update for the Board on progress; see attached presentation slides for further detail.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None Identified at this present time

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 paper provided to the Board will directly link 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**

9.1 None under the meaning of the Act.

NHS
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# Commissioning at Scale…

# "How Integrated Commissioning and Primary Care Networks will be supported by the CCG"

Dr Andrew Davies, Clinical Chief Officer

Involving everybody in improving the health and wellbeing of the people of Halton

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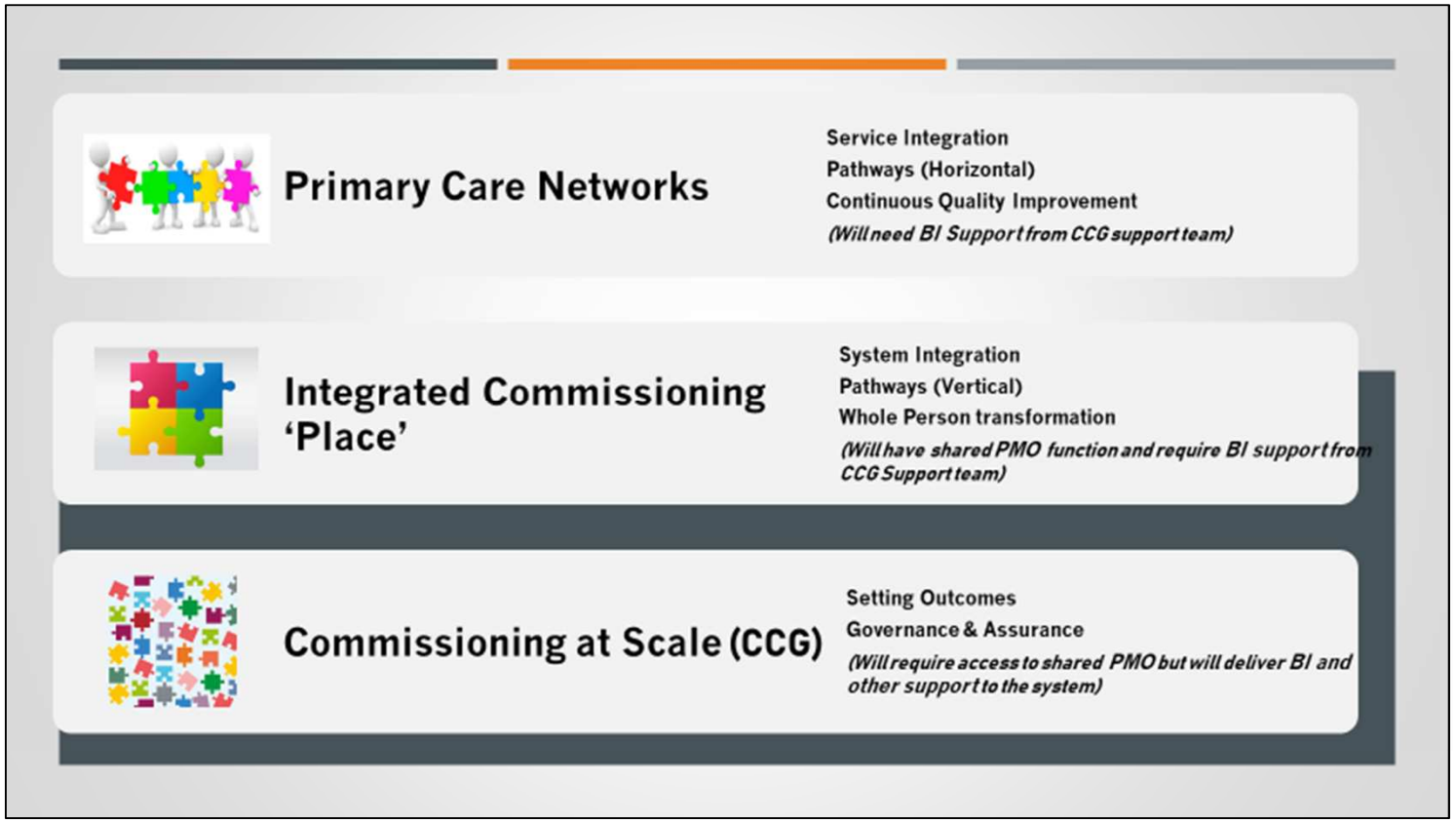

# The Principles…

NHS
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- ✓ Primacy of Place
- ✓ Sovereignty
- ✓ Listening to the patient voice
- ✓ Relationship with stakeholders
- ✓ Enhancing the Clinical Voice & Leadership
- ✓ Engagement of Member Practices
- ✓ National Direction of travel - NHSE/I (now/future proof)
- ✓ Statutory & Legislative Requirements
- ✓ Financial Impacts and risks
- ✓ Minimising costs of conformity

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# Questions Please



Dr Andrew Davies, Clinical Chief Officer

Involving everybody in improving the health and wellbeing of the people of Halton

| | |
|---|---|
| **REPORT TO:** | Health Policy and Performance Board |
| **DATE:** | 25th February 2020 |
| **REPORTING OFFICER:** | Chief Commissioner for Halton, NHS Halton CCG |
| **PORTFOLIO:** | Health and Wellbeing |
| **SUBJECT:** | Urgent Treatment Centres : Update |
| **WARD(S)** | Borough-wide |

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a paper updating members of the progress to date of the Widnes and Runcorn Urgent Care Centres.

2.0 **RECOMMENDATION: That:**

**i) The Board note the contents of the report**

3.0 **SUPPORTING INFORMATION**

3.1 As the board and its members have received several papers outlining the intentions of the CCG in regards to the 2 UCC's the updated paper is intended to keep members informed of the decision made by Halton CCG's Governing Body following the decision to not re-procure the service.

4.0 **POLICY IMPLICATIONS**

4.1 NA

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None Identified at this present time.

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 paper provided to the Board will directly link 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**

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

Urgent Care Centre Progress Report

1.0 Background and Information

The purpose of this report is to update the Health Policy & Performance Board on the development of the Widnes and Runcorn Urgent Care Centres following the decision to not re procure the services.

At the time of writing the report a series of weekly operational meetings have taken place with the incumbent providers to improve service delivery and to deliver the requirements of the Service Development Improvement Plan (SDIP, Schedule 6D). The aim of the plan is to support current service delivery and improve performance in both UCC's. It is important to note that the SDIP was varied into contracts from November 2019 for the remainder of 19/20 financial year. There will need to be further consideration given for 20/21 contracts which negotiations will commence February 2020.

The SDIP allows the parties to record actions which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned.

SDIPs are generally about developing an aspect of the service beyond the currently agreed standard. Once included in the Contract, commitments set out in SDIPs are contractually binding.

Unless specifically mandated in the guidance below, SDIPs are for local agreement between the parties. SDIPs may for instance include:

- productivity and efficiency plans agreed as part of the provider's contribution to local commissioner QIPP plans; or
- any agreed service redesign programmes; or
- any priority areas for quality improvement (where this is not covered by a quality incentive scheme).

SDIPs offer an excellent route through which commissioners and providers can agree a programme of work to implement innovation projects – from medical technologies to service and pathway re-design. Further detail on the different ways in which NHS England is supporting innovation in practice can be found at https://www.england.nhs.uk/ourwork/innovation/.

The UCC SDIP as below describes the actions required to improve service delivery and to increase the state of readiness for all parties to deliver the National Urgent Treatment Centre specification.

## Service Development and Improvement Plan

| | Milestones | Timescales | Expected Benefit | Consequence of Achievement/ Breach |
|---|---|---|---|---|
| **Redesign of the current UCC operating model to the national Urgent Treatment Centre specification** | 1. Develop and agree a mobilisation plan for the quality improvement and redesign of the UCC to UTC, together with SOP. | 13th December 2019 | 1. Managing capacity and demand | 1.Mobilisation plan and SOP produced in Draft. |
| | 2. Ensure robust system partnership working and involvement in the redesign/mobilisation programme. | 1st December 2019 - Ongoing | 2. Improved quality and safety | 2. Partnership weekly meetings established. |
| | 3. Opening hours agreed as 8am-9pm. | 1st December 2019 | 3. Improved patient access to urgent care | 3. Providers working towards 8-9 |
| | 4. Develop robust communication plan to provide the public with accurate information on opening times and what they can attend the UTC for. | 1st February | 4. Improved patient and carer experience | 4,Draft plan in place |
| | 5. Agree appropriate staffing levels to accommodate existing hours and move to new UTC hours, ensuring appropriate skill mix is available post 6pm so that full treatment is provided. | By 31st March 2020 | 5. Meeting the requirement of the UTC specification | 5.Workforce plans being agreed |
| | 6. Secure GP leadership and improved hours of clinical leadership to offer an improved model in line with new specification. | 1st December 2019 | 6. Brokering of greater partnership and system-wide joint working | 6.PCN clinical leads and FP leads identified |
| | 7. Use of ECDS data along with local agreed KPI's as per the new specification. See appendix 2 of revised UTC service specification | By 31st March 2020 | 7. Reduce onward referrals from UTC to A&E by 20%. | 7. On going |
| | 8. Ensure implementation of further digital requirements. | By 31st December 2020 | 8.Seamless care and shared care records | 8. On going |
| | 9. Use of direct booking for UTC system has been enabled via NHS 111 team. | By 1st February 2020 | 9. Seamless appointments and improved access | 9. On going |
| | 10. Review and refine pathways for paediatrics and adults to ensure a consult and complete model can be introduced and comply with the 2 hour UTC pathway. | 31st December 2019 | 10. Improved pathway and performance | 10. Complete |
| | 11. Review onward referral pathways into StHK/Warrington Acute trust and offer direct access into appropriate speciality, rather than through A&E. | 1st December 2019 | 11. As above | 11. On going |
| | 12. Increase ambulance conveyances 20%. Requirement to engage with WAS to develop appropriate clinical thways to ensure lower acuity appropriate mbulance calls can be seen and treated in e UTC. | 31st March 2020 | 12.Improved patient services and wider system response | 12. On going |

End

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# Service Specification

# For the

# Halton Urgent Treatment Centres ( previously known as Urgent Care Centres)

**As Primary Care Networks continue to be developed in Halton and Integrated Urgent Care services are being developed across Cheshire & Merseyside, there may be a need to refine the service specification for the new UTC to be in line with any new recommendations and developments. Halton CCG reserves the right to make necessary changes during the procurement process and subsequently in discussion with the preferred provider.**

**Document Control**

**July 2018**

| | |
|---|---|
| **Document Title** | Service Specification for Halton Urgent Treatment Centres |
| **Document Status** | Draft |
| **Document Version** | 0.12 |
| **Date** | 12th February 2019 |
| **Prepared by** | Nicky Ambrose-Miney, Senior Commissioning Manager, Urgent Care |
| **Clinical Lead** | Dr Joe Banat |

| Version | Date | Name | Comment |
|---|---|---|---|
| 0.1 | 28th July 2018 | Nicky Ambrose-Miney | 1st draft |
| 0.2 | 30th August 2018 | Louise Wilson | Amendment to references made to local authority services |
| 0.3 | 7th September 2018 | Dr Sangeetha Steevart | Amendments re clinical model. |
| 0.4 | 15th September 2018 | Nicky Ambrose-Miney | Updates to model |
| 0.5 | 1st October 2018 | Nicky Ambrose-Miney | Incorporated comments from Head of Primary Care |
| 0.6 | 8th October 2018 | Nicky Ambrose-Miney | Updated documents with clinical model |
| 0.7 | 15th October | Lucy Reid | Medicine Management updates |
| 0.8 | 9th November | Nicky Ambrose-Miney | Editing and formatting |
| 0.9 | 1st February 2019 | Nicky Ambrose-Miney/Di Armstrong | Updates to specification areas following bidder specification feedback session 31/1 and 1/2 |
| 0.10 | 12th February 2019 | Di Armstrong | Incorporated comments from Designated Safeguarding Nurse for Adults |
| 0.11 | 26th June 2019 | Di Armstrong | Updates to section 4.4 (Consultation, Communications & Engagement) |
| 0.12 | 3rd October 2019 | Nicky Ambrose-Miney | Updates to throughout following clarification questions received during 1st procurement. |

## 1. Introduction

The Halton Urgent Care Centres are a highly accessible community-based facility providing care for a large population area. The UCC has been in operation since 2013 and is located within the two towns of Halton, Widnes and Runcorn. The UCC currently operates 15 hours per day, 365 days per year.

In 2017-18, some 80,000 patients were treated at the UCCs, approximately 60,000 of those were Halton residents and a further 20,000 were from neighbouring boroughs.

Within Halton and Cheshire & Merseyside, the vision is to create an urgent and emergency care system (one system multiple facilities) that is capable of delivering equitable access to the right care, first time for the majority of patients through a networked model with services provided along robust pathways 24/7. As this model develops, and the national guidance and local context around Urgent Treatment Centres (UTCs) there will be a need to refine the service specification for the Halton UTC. Halton CCG reserves the right to make necessary changes during the procurement process and subsequently in discussion with the preferred provider.

Halton CCG continues to implement the whole systems integrated programme which covers Cheshire & Merseyside and is also actively working with commissioners and providers to consider what accountable care partnership/s could look like. The provider of the UTC would be expected to participate in the discussions to develop this model of care and consider how they could operate within this. Alignment to this vision of healthcare delivery is critical for Halton CCG.

Urgent Treatment Centres form an important access point on the urgent care network with key interdependencies with general practice, NHS 111, North West Ambulance Service (NWAS), the Intermediate Care Services, social services , GP Out of Hours service (GP OOH), GP extended hours hubs and hospital Emergency Departments.

It is important that Halton UTC is fully integrated with every other part of the local health community and that it operates as part of the overall evolving urgent and emergency care strategy for the local health economy. Pathways from NHS 111, GP OOH and NWAS are of key importance as are referral routes on to GP extended hours and community and other services. The Halton UTC provider(s) will be expected to be a full and active participant in the Urgent Care Operational Group, A&E Operational and Delivery Board and other committees and board as appropriate.

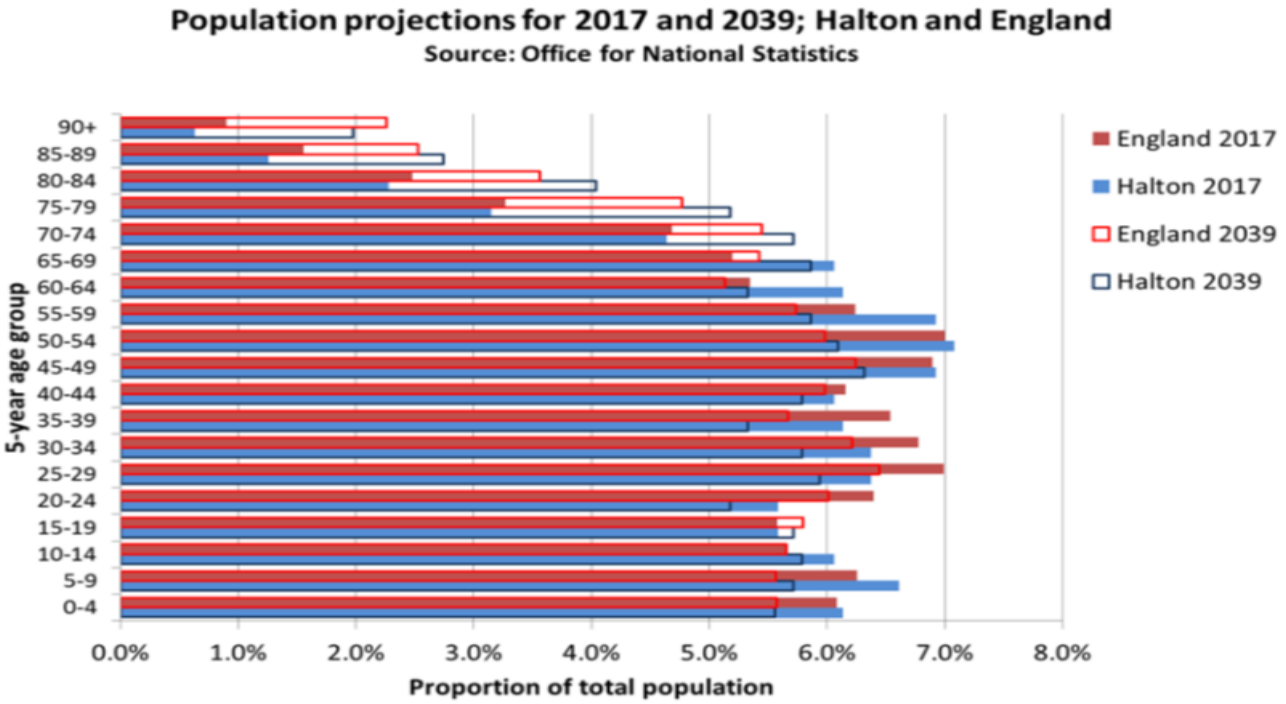
## 2. Background

Halton is a district in the county of Cheshire in North West England, with borough status and administered by a unitary authority. Since 2014 it has been a member of the Liverpool City Region Combined Authority. The borough consists of the towns of Runcorn and Widnes and the civil parishes of Hale, Daresbury, Moore, Preston Brook, Halebank and Sandymoor. The district borders Merseyside, Warrington and Cheshire West and Chester. The borough straddles the River Mersey – the area to the north (including Widnes) is historically part of Lancashire, that to the south (including Runcorn) part of Cheshire.

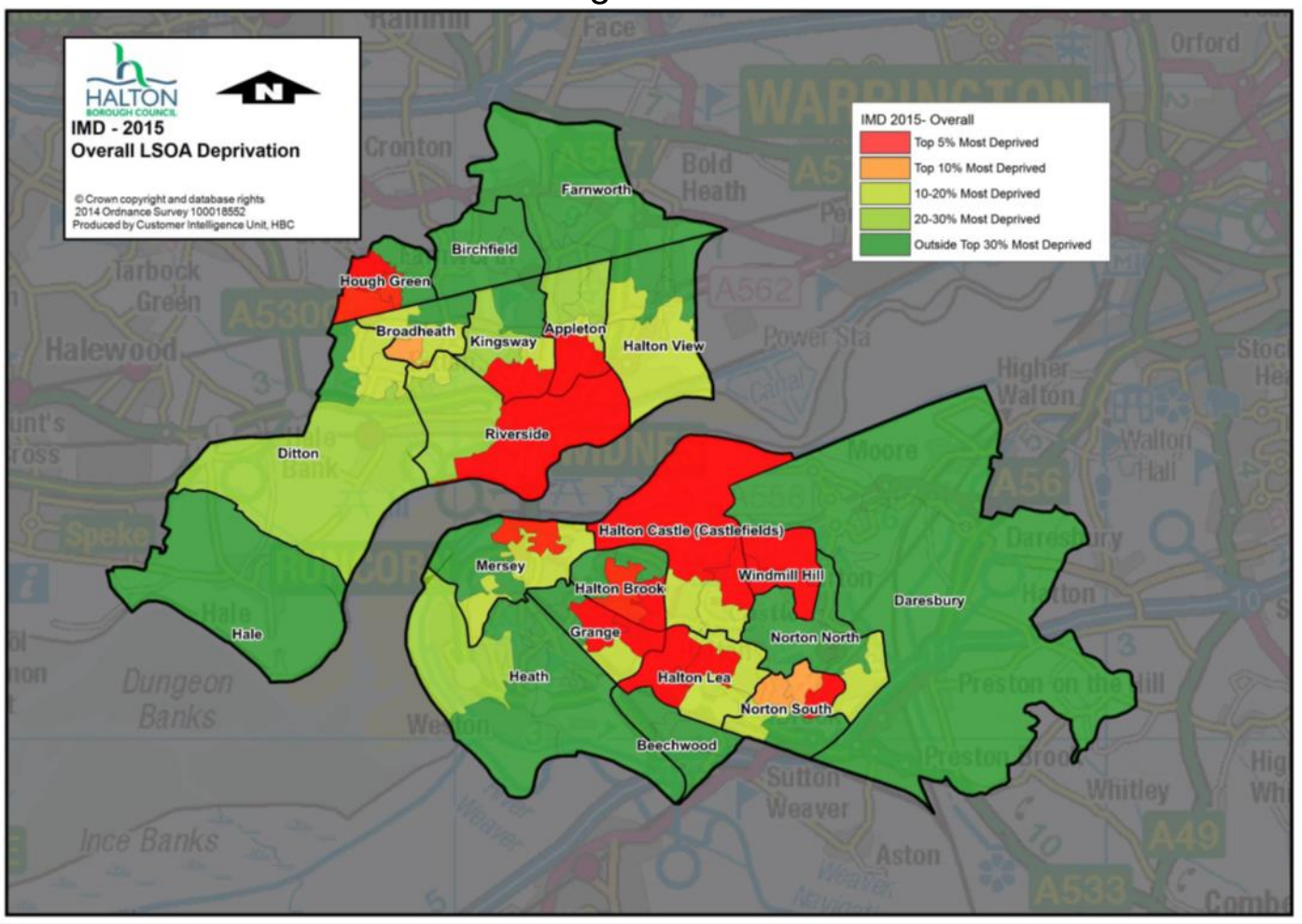
Halton is an industrial and logistics hub with noticeably higher than average levels of employment in manufacturing (particularly of chemicals and advanced manufacturing); energy; wholesale and retail; and transport and storage compared to the average for England. The wages of employees in Halton are slightly higher than the average for England and significantly higher than the average for the North West and the Liverpool City Region

Based on the Office for National Statistics (ONS), the Halton population in 2017 is 127,595. Population growth across all ages remains flat which is consistent with the projected growth of neighbouring CCGs as demonstrated in the chart below.

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 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.




The borough of Halton has a varied demography. Halton has 21 of its 79 small areas (LSOAs) that fall within the top 10% most deprived nationally. This is around 26% of its population.
In terms of Health Deprivation and disability, Halton is ranked 13th most deprived out of 326 Local Authorities, with 37 small areas falling in the top 10% most deprived nationally for Health Deprivation and Disability. A pictorial map represents the Borough on the next page.



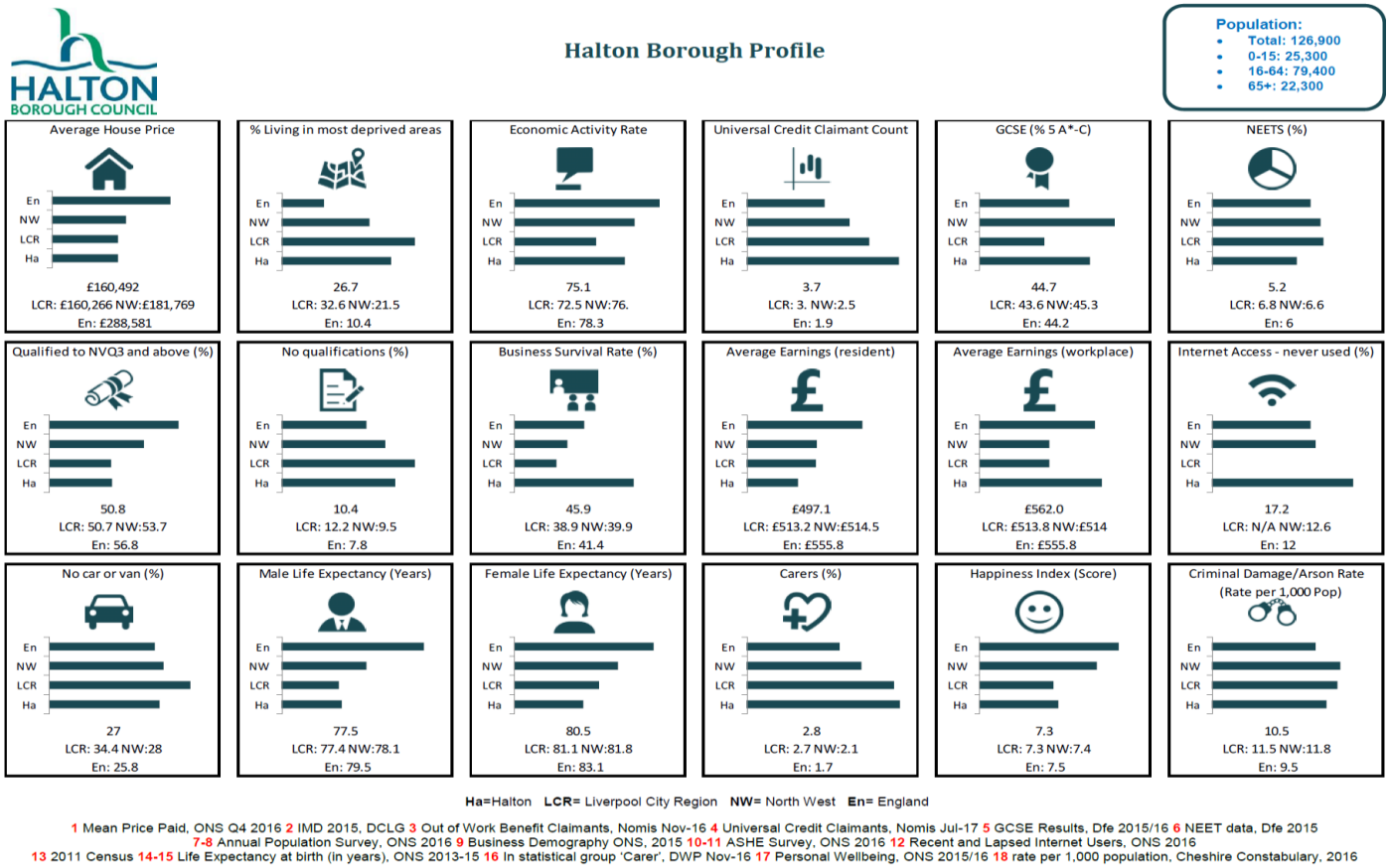

The table below shows the breakdown of population for Runcorn and Widnes towns in Halton, by age and sex based on 2017 borough ward data. The data source is from the JSNA and is available via the website. https://www4.halton.gov.uk/Pages/health/JSNA.aspx

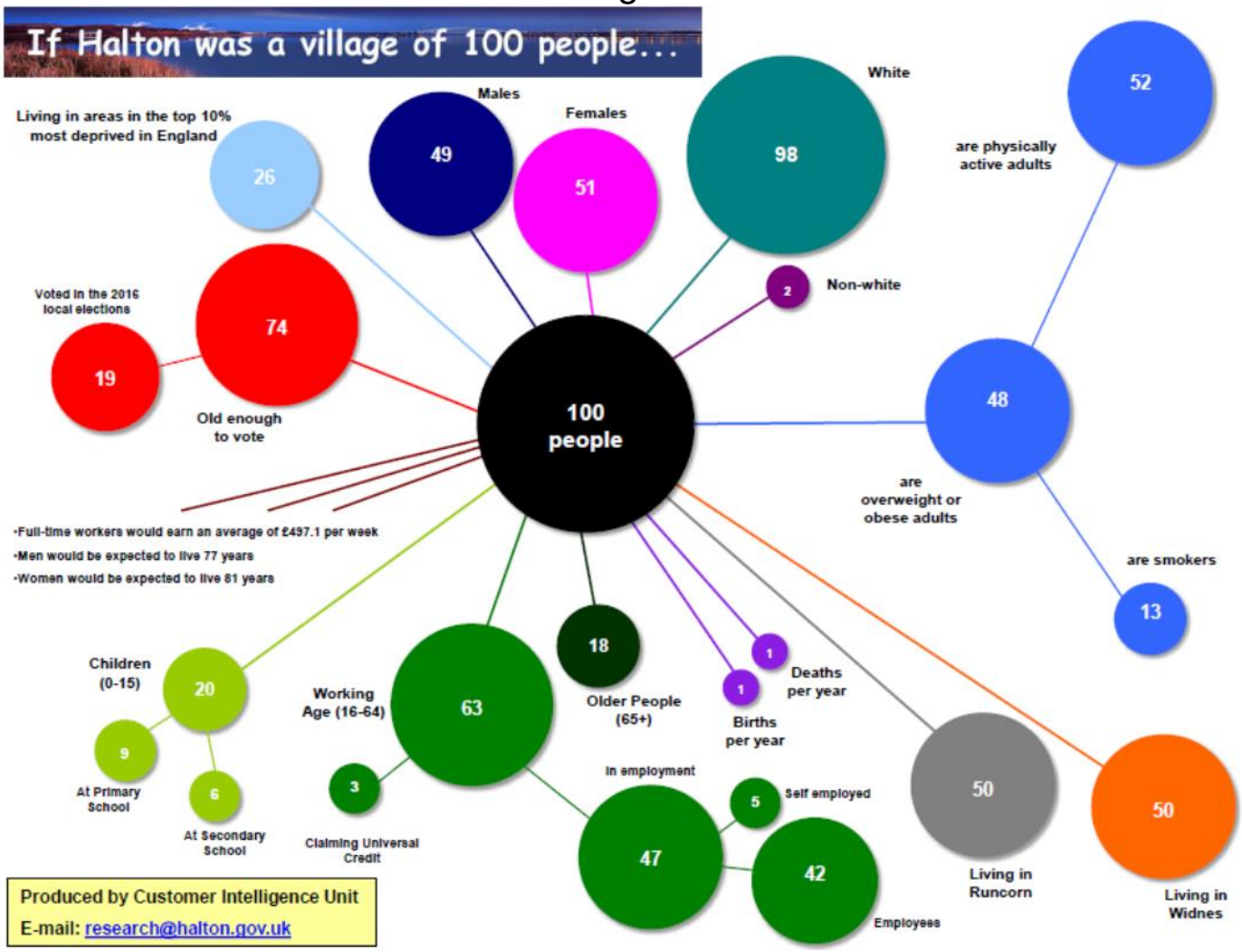
| | Runcorn | Widnes | Total |
|---|---|---|---|
| **Age 0-4** | | | |
| Male | 2000 | 1990 | **3,990** |
| Female | 1920 | 1900 | **3,820** |
| **Age 5-18** | | | |
| Male | 5840 | 5410 | **11,250** |
| Female | 5580 | 5250 | **10,830** |
| **Age 19-64** | | | |
| Male | 17,850 | 18,580 | **36,430** |
| Female | 19,190 | 19,320 | **38,510** |
| **Age 65-80** | | | |
| Male | 4,520 | 4,320 | **8,840** |
| Female | 4,780 | 4,620 | **9,400** |
| **Age 81-100** | | | |
| Male | 930 | 1,160 | **2,090** |
| Female | 1,400 | 1,730 | **3,130** |
| **Total** | **64,010** | **64,280** | **128,290** |

**Inequalities in Life Expectancy**

Life expectancy in Halton is lower than life expectancy in the North West which is in turn lower than life expectancy across England. The reduced life expectancy in the Riverside ward of Widnes means that females living there can expect to live 5.0 years fewer than the general Halton population and males can expect to live 5.8 years fewer.
The inequalities are emphasised by the Beechwood ward; Riverside's counterpoint in life expectancy. Females living in Beechwood can expect to live for 9.8 years longer than the general female population of Halton; males in Beechwood have a 4.4 year greater life expectancy.

Halton is within Liverpool City Region and the below pictorial shows key demographics of the population compared to Liverpool City Region, Northwest and National data. Appendix 1 at the end of the specification, provides a snap shot and easy read pictorial of Runcorn and Widnes health outcomes compared to the England average for 2017 as detailed in the JSNA.






The above diagram shows the population breakdown if Halton was a village of a 100 people. The diagram clearly articulates the demographics spilt by age, sex, ethnic minority, employment, lifestyle, births and deaths.

Further information regarding Halton can be found from the following hyperlinks:

Joint Strategic Needs Assessment:
https://www4.halton.gov.uk/Pages/health/JSNA.aspx

Joint Strategic Needs Assessment Summary:
https://www3.halton.gov.uk/Pages/health/JSNA/JSNASummary.pdf

## 3. National Context

The NHS Five Year Forward View (5YFV) explains the health services in England for people of all ages with physical and mental health problems, and sets out the new models of care needed to deliver this. The 5YFV highlights that the traditional divide between primary care, community services, and hospitals is increasingly a barrier to the personalised and coordinated health services required for patients. The management of long-term conditions is now a central task for the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single unconnected 'episodes' of care.

The FYFV sets out a clear programme of change to better connect care across organisational boundaries for these patients, including;

- Delivering care through a system approach using networks of care not just single organisations
- Increasing the focus on out-of-hospital care
- Integrating services around the patient, ensuring health, mental health and social care services (housing) are co-ordinated, supporting carers (of all ages)
- Continually evaluate new models of care and develop them to provide the best
- experience for patients and best value for money

The inclusion of community services is fundamental in delivering this programme of change and provider(s) will deliver against the objectives set out above whilst continually working alongside partners to evolve the model in accordance with the strategic direction of NHS Halton CCG and Halton Local Authority.

**3.1 NHS Outcomes Framework Domains and Indicators**

| | | |
|---|---|---|
| **Domain 1** | **Preventing people from dying prematurely** | |
| OUTCOME 1 | People are assessed, provided with advice and/or treatment and discharged from the service within the specified timeframe by appropriately skilled and qualified staff leading to an appropriate clinical outcome | ✓ |
| OUTCOME 2 | People who use the Urgent Treatment Centre have access to the right care, in the right, place, by those with the right skills, the first time | ✓ |
| **Domain 2** | **Enhancing quality of life for people with long-term conditions** | |
| OUTCOME 3 | People with long-term conditions are treated in-line with their care records and wishes and are provided with the most appropriate treatment for their needs first time | ✓ |
| **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | |
| OUTCOME 4 | People receive a holistic and personalized service which responds to their immediate need in a timely fashion and also arranges for any follow-up care and support required within a single episode of care | ✓ |
| **Domain 4** | **Ensuring people have a positive experience of care** | |
| OUTCOME 5 | People have access to a service 24/7 which supports them in effectively navigating the urgent and emergency care system | ✓ |
| OUTCOME 6 | People's perceived urgent care need is dealt with in a personalised way that takes into account their holistic need | ✓ |
| OUTCOME 7 | People are provided with information and options for self-care and are supported to manage an acute or long-term physical or mental condition | ✓ |

| | | |
|---|---|---|
| OUTCOME 8 | People received improved patient care, experience and outcome by ensuring the early input of the most appropriate senior clinician when required. | ✓ |
| **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | |
| OUTCOME 9 | The service is accessible and provides the same quality of care to all patients who access the service. | ✓ |
| OUTCOME 10 | People who use the service have their care needs responded to within a single episode of care which minimises the need for handovers and retriaging between services. | ✓ |

### 3.2 One Halton Context

The Health and Social Care Act 2012 placed a statutory duty on the NHS and local authorities to promote and enable integrated care, further reinforced by the Care Act 2014. A raft of policy initiatives and incentives have been implemented to support greater integration and partnerships including the Better Care Fund, a national pioneer programme and, most recently, actions to support the vision for the NHS in England described in the Five Year Forward View. The new care models proposed in the Five Year Forward View are particularly aimed at overcoming barriers between hospital and community services. They are aligned with the wider policy direction of organising care in the community around the needs of service users, shifting the focus from episodic and acute care to whole life care, expanding preventative support that encourages "self-care", independence and wellbeing.

In 2014/15 Halton as a borough started its journey towards an integrated model of care with a shared vison across health and social care.

#### 3.2.1 One Halton Strategic Vision

To improve the general health and wellbeing of the people of Halton, working together to provide the right level of treatment close to home, so that everyone in the borough can live longer, healthier and happier lives.

Our values are based on strong partnerships; Collaboration (engagement & participation), System leadership (values based approach) Strong relationships, shared goals and an agreed set of outcomes.
Ultimate responsibility for the implementation of One Halton lies with the Halton Health & Wellbeing Board, however, in order to deliver our vision and priorities we need everyone who lives and works in Halton to take an active role. We are passionate about improving the health and wellbeing of people living in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in achieving this goal.

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

A governance structure for One Halton oversees the development and delivery of our priorities. Specific groups are responsible for the development of an action plan setting out what all

stakeholders will do to deliver the outcomes we want. A life course approach is used and ensure each action plan includes action to maximise "self-care" prevention and early intervention, provide high quality treatment and care based on need close to home where this is possible and supports people in both the short and long term.

The key design principles and objectives of One Halton are:

1) Manage demand for services by promoting self-care independence and prevention.
2) Enable health and social care integration wherever possible and appropriate.
3) Design services around users and not organisations.
4) Incentivise providers to work together to meet the needs of the whole person.
5) Treat people in their home and community for as long as it is possible and appropriate.

The Halton UTC provider (s) will be expected to be a full and active participant in driving the vision and change within the One Halton agenda towards delivering integrated care partnerships.

## 4. Vision for Urgent & Emergency Care Services

The redesign of Urgent and Emergency (UEC) care services in Halton is an objective for 2018/19 and beyond. It is recognised that the current service model needs to be reconfigured to integrate with primary care and offer same day service for the population. It is necessary to reposition the current UEC across the Borough to deliver high quality, cost effective care to Halton residents:

- To ensure right care, in the right place, first time.
- To align and reduce the duplication of unscheduled care services, improve accessibility and the overall patient experience
- To ensure that diagnostic provision can be provided and where possible at a single site to reduce wasting resources and manage the workforce effectively.
- To manage patients effectively, reducing unnecessary steps and clinical risk
- To ensure that access to services is coordinated, avoiding the need for patients to navigate a complex and confusing system
- IT systems should be aligned to the community GP system ie EMIS and have access to the local community pathways. This should enable uniformity of the service delivery in the community
- For all services to be technically linked and/or inter and intra operable to an IT infrastructure that facilitates the sharing of patient records, referrals and booking of appointments, including GP practice appointments as part of a whole integrated system
- To create an integrated unscheduled care service that is coordinated between Primary, Planned, Urgent, Intermediate, Mental Health, Learning Disability, Social Care, Community and Paediatric care services and other parts of the local healthcare system
- To promote health and wellbeing
- To promote and support the delivery of self-care where appropriate
- To deliver appropriate referrals, information, advice and sign posting about other support available.

It is imperative that innovate approaches are used to deliver online integration in the future and will make it easier for the public to access urgent health advice and care. This will increasingly be in a way that offers a personalised and convenient service that is responsive to people's health care needs when:

- They need medical help fast, but it is not a 999 emergency
- They do not know whom to contact for medical help
- They think they may need to go to A&E or another NHS urgent care service
- They need to make an appointment with an urgent care service

- They require health information or reassurance about how to care for themselves or what to do next

Where online triage facilities are made available for local patients the provider should have the ability to book appointments into the UTC or from UTC to GP practices, primary care hubs, OOH service.

**4.1 Principles**

Urgent treatment centres (UTCs) are community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as "Type 3 and Type 4 A&E Departments".
Urgent treatment centres are to be led by general practitioners, and are ideally co-located with primary care facilities, including GP extended hours / GP Access Hubs or Integrated Urgent Care Clinical Assessment Services (formerly known as "GP out of hours" services).

A core set of standards for urgent treatment centres (UTC) to establish as much commonality as possible to ensure patients and the public will:

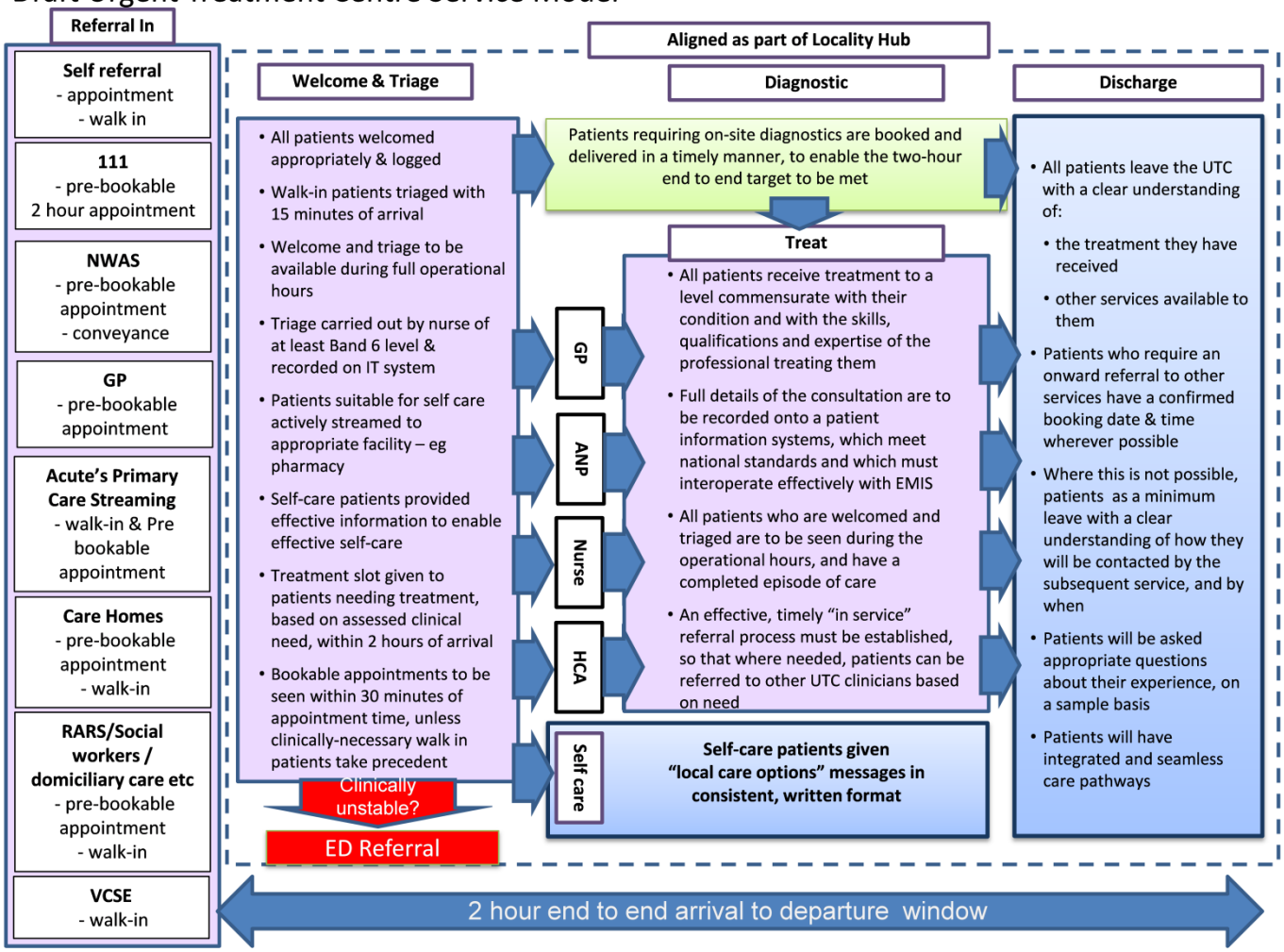
1. Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
2. Have a consistent route to access urgent appointments offered within 4hrs and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
3. Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
4. Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

The local provider will have to ensure that the new service meets all the requirements of the Urgent Treatment standards: Principles and standards (July 2017) available on
https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards

**4.2 Proposed model**

The local Urgent Treatment Centre model ensures that this facility is integrated into local primary and community care hubs and delivers same day urgent needs to the population ensuring a consult and complete episode of care is provided, as opposed to see and refer. The below diagram describes the local process and expectations of a patients journey.

Draft Urgent Treatment Centre Service Model




### 4.3 Service Aims and Intended Outcomes

The UTC will be both an open-access and a referred-in service, operating on the principle that all patients should receive a consistent and rigorous assessment of the urgency of their need and an appropriate and prompt response.

The aims and intended service outcomes are:

- The service model will be based upon the need to provide improved patient access to urgent, unplanned care, while ensuring that the patient's ongoing healthcare needs are met in the most appropriate setting within primary and community care. This may involve facilitating a small cohort of patients back into services to meet their long term complex needs.

- The UTC will integrate and develop the distinctive culture and approach of a primary care service and be integral to support the development of primary care networks. The UTC will operate with experienced primary care clinicians and practitioners working alongside emergency care clinicians and practitioners undertaking assessments and seeing and treating patients.

- The UTC will not constitute a further access point for routine NHS care in the health economy e.g. management of long term conditions, medication reviews, etc. ; neither will it allow duplication of existing commissioned services or by primary medical services contractors: patients attending with long term complex primary care needs will be appropriately and actively navigated back into core primary/community services.

- The UTC should ensure patients receive a consistent and rigorous assessment of the urgency of their needs and an appropriate and prompt response, including but not limiting to prompt engagement with the Local Authority with regard to safeguarding concerns for children and adults. UTC must be able to provide direct pre-booking of appointments from NHS 111, NWAS and patients' clinicians.

**4.4 Consultation, Communications and Patient Engagement**

NHS Halton CCG conducted a series of pre-consultation and public consultation activities and events (during August 2018 to March 2019).

Pre-consultation activity ensured the local population were aware of the new model of urgent care. It also provided an opportunity for the local population to get involved in the development of a localised UTC model, share their initial views on the proposals to reduce opening hours, which then fed into the formal public consultation process and provide the CCG with sufficient evidence and information to ensure the new model is fit for purpose and meets the needs of the population.

The outcome of the formal 8 week public consultation (via online/paper-based surveys and engagement events) confirmed that 52.09% of respondents agreed or agreed somewhat to the reduction in hours for the new UTC model.

Other notable key themes included:

- 77.3% of respondents were in favour of a mental health offer within the new model of urgent care
- Waiting times for initial triage and from triage to treatment are too long. Experiences were shared of 45 minute wait times for triage and a 4 hour wait for subsequent treatment
- Workforce. Respondents voiced concern about the lack of GP provision available and some believed that a GP was only available (currently) for 2 hours a day
- Signage and car parking at current sites were seen as an issue. Respondents advised road signage and car parking facilities needed improving in the new UTC model
- Comfort was also highlighted as a concern. Patients asked whether free water dispensers could be made available in the UTC waiting areas, as well as more comfortable seating and a separate area for children or those at risk of infection
- Customer care. Respondents advised that nursing and reception staff (on occasions) lacked empathy, compassion and could be quite dismissive regarding the patients presenting condition.
- When respondents presented with one or more family members requiring treatment, they advised the approach could be more joined up i.e. Parent being seen and treated at the same time as the child – reducing anxiety levels and wait times.

**4.5 Future Service Developments**

NHS Halton CCG is committed to improving services to patients and responding to the changing landscape of the NHS and the needs of population, these are aligned with the strategy of the One Halton and Cheshire & Merseyside STP.

The CCG and One Halton programme is currently working to redesign the model of same day urgent care and Urgent Integrated care. The provider will work with the CCG to accommodate service development changes and improvements.

The provider will be required to be receptive and adaptable to change and to manage the change process quickly and efficiently to deliver future services and drive financial efficiency within the current financial

envelope. The future services should contribute and provide seamless integrated same day urgent care for the population of Halton.

Future anticipated changes could include:

- Use of local response car to transport patients to the UTC to reduce pressure on ambulance services and support patient education.
- Local front door online triage tool such as EConsult.
- Use of Information technology within centres to promote public health messages and accessible services within the borough.
- The use of a wider and varied clinical and professional skill mix
- The implementation of alternative operational and clinical pathways
- Contribution to the management of long term conditions.
- Further development of Virtual Wards and Intermediate Care Step up/down beds
- Further development of community based provision i.e respiratory, COPD.

The future model of care will be a whole systems integrated care approach to the delivery of healthcare across the locality with integrated and close working links to NHS 111, other Urgent Treatment Centres, Out of Hours services, Clinical hubs, community, intermediate, primary and secondary care services with pathways to mental health services to form a functionally integrated, effective and networked model.

## 5. The UTC Service Model

### 5.1 General

The Halton UTC will be open 8am – 9pm 7 days a week, 365 days per year.

### 5.2 Key functions

The main elements of the service will include:

- Triage, on line and clinical triage
- Observation of UTC patients who are awaiting treatment to identify any deterioration
- Treatment, including medications provided directly or prescribed and discharge
- Support self care and patient education.

The UTC consists of the following main functions:

- Reception
- Triage
- Assessment and treatment including prescribing of appropriate medication.
- Associated diagnostic tests/investigations
- Discharge, including necessary communications to the patient's registered GP
- Provision of self-care and wellbeing advice and information
- Helping patients with registration with a local GP if required
- Onward referral only if clinically required (e.g. Assessment units, speciality services within Acute)

### 5.3 Patients

The age range of the patients, attending the UTC will be from 0-100, these include:

- Patients who self-present or are bought by another (such as peer) will include patients with minor illness/ailment and/or injury and will be triaged as appropriate.
- Patients who have contacted the 111 service and been advised to attend with or without an appointment time.

- Patients who are transported/transferred by the North West Ambulance Service using the agreed Appropriate Care Pathway (ACP) protocol for patient management/disposition e.g. UTC
- Vulnerable patients in a crises e.g elderly patients becoming confused due to a UTI requiring antibiotics
- Patients from care/nursing homes

**6. Scope of Clinical Services**

**6.1 General**

The scope of the UTC will include both minor illnesses and minor injuries. The UTC will assess and treat patients who have a minor illness or injury that require same day urgent care treatment by a Health Care professional in the community.
The UTC will include open access patients and may include scheduled or appointed patients (e.g. via 111 or local booking system) with an urgent need. UTC patients are either:

- Patients with minor injury or illness or
- Patients with a problem that may need further investigation but who are not regarded as requiring ED services

**6.2 Conditions suitable for the UTC**

Patients suitable for the UTC are those who satisfy the following criteria:

- Must be mobile and fully conscious
- Must not need to lie on a trolley (other than for examination or short treatment)
- Do not need investigation outside the agreed diagnostic menu
- Do not need (or are not expected to need) hospital admission
- Do not require regular observations
- Non-complex fractures without manipulation
- Exclude certain treatments such as manipulations (except digits), peripheral lines, urethral catheterisation
- May require a specialist opinion without further investigation or admission

**6.3 Clinical Exclusions (adults)**

The UTC will not assess and treat patients who are traditionally referred to as “majors” patients. Major patients will be seen in an Acute and are those who are clinically unstable in one or more respects. This means that the patient has one or more of the following symptoms:

- haemodynamically unstable and/or arrhythmia or significant risk of this
- significant trauma
- fluctuating level of consciousness
- breathing unsafe or abnormal (compared with patient’s normal breathing)
- acute severe abdominal pain
- suspected stroke (as per local stroke pathway)
- non traumatic chest pain for high risk groups
- acute severe headache
- suspected injury preventing ambulation above knee
- overdose with risk of compromising circulation, consciousness level or breathing
- Patients who are presenting with a condition who have been referred by a GP - when their clinical condition warrants their presence in an ED.

Patients with the following conditions will go to an ED and not the UTC:

- Self-harm (adults) or any self-harm (children)

- Severe withdrawal, delirium tremens and withdrawal seizures (as these are very likely to require medical admission).

**6.5 Clinical Exclusions (children)**

A triage protocol will be agreed between the UTC and hospital paediatric team based on the following guidelines for conditions that are not suitable for the UTC. This protocol will have been agreed by the Joint Clinical Governance Group.

**Basic principles**

- Clinical assessment as not suitable for UTC – redirected immediately to an ED
- Markedly abnormal baseline signs – redirected immediately to an ED

**Additional condition-specific guidelines for children (exclusions)**

- Complex fracture of upper and lower limbs and likely to require manipulation
- Procedure requiring sedation
- Overdose / intoxicated and not able to mobilise
- Deliberate self-harm
- Fever with oncology
- Sickle cell crisis
- Multiple pathologies deemed to be complex

A protocol shall be in place to ensure direct referral and transfer of care of children, as appropriate. Triaging of children within urgent care will be conducted using a common approach to assessment and common standards. The protocol underpinning this immediate assessment/triaging decision will have been agreed by the Joint Clinical Governance Group and by the Clinical Lead.

**6.6 Mental Health**

Most of the patients with the following problems would be expected to be seen by the UTC, unless their clinical state dictates otherwise. Patients with the following conditions will be triaged directly to the ED:

- Overdose
- Other significant self-harm (adults) or any self-harm (children)
- Severe withdrawal, delirium tremens and withdrawal seizures (as these are very likely to require medical admission).
- People expressing suicidal intentions

A robust model for community mental health provision is still in development and the CCG would expect the provider(s) of the UTC to work with commissioners in developing a robust mental health crisis offer and ensure patients have access to urgent and same day services.

**6.7 Major Incidents**

Providers of the UTC service will ensure that staff involved in the delivery of the service are aware of the Major Incident Policy and Procedures. The UTC will be expected to be flexible in the event of a major incident and potentially see and treat patients who would under normal circumstances be seen and treated in the ED. This will enable the ED to be cleared to take patients involved in the major incident.

**7 Arrival, Triaging and Registration**

**7.1 General**

As a part of the arrival and triage process, the following activities will take place:

- Patients' basic demographic data will be recorded immediately on arrival at the UTC. For Children & young people recording school and Looked After status.
- Patients will be registered on UTC clinical records system
- The Provider must agree a process for urgent escalation of concerns raised by the commissioners of the service.

**7.2 The Role of the Triaging Clinician**

The Provider will be expected to develop a cohort of staff to undertake this role based on an agreed minimum competency framework. The Provider will take full management responsibility for the clinical triaging phase of the patient journey and will provide a clinically appropriate workforce to meet the required demand. This will include gaining consent taking into account Fraser Competency. All clinical staff will be trained in line with intercollegiate competency framework for Children and Adult Safeguarding.

Clinicians with suitable competencies may include GPs, Emergency Care Consultants, Medical Practitioners with ED experience, Primary Care Nurses, Emergency Nurse Practitioners and other suitably qualified clinicians to meet case-mix demands. The UTC provider(s) will need to put in place mechanisms so that a Clinical Lead will assume management responsibility for all clinical staff. All staff will be assessed against a suitable competency framework owned by the Provider and approved by the Joint Clinical Governance Group.

The triaging clinician has the responsibility for ensuring the safe and effective direction of patients to the most appropriate clinician.

**7.3 Patients presenting at UTC with Emergencies**

Patients self-presenting at UTC with emergencies that require them to need care in an ED will be identified immediately by the triaging clinician. Protocols shall be in place to ensure direct referral and transfer of care, as appropriate.

Triaging within urgent care will be conducted using a common approach to assessment and common standards, irrespective of the triaging clinician.

**7.4 Unregistered patients**

Patients attending the UTC who are not registered with a GP will be managed by the UTC according to the same criteria as a registered patient. In addition, they will be supported by staff in the UTC to register with a local practice of their choice, within their home address practice catchment area. By linking and liaising with the relevant GP practice the UTC staff will support patients with registration.
For children and young people not registered with a GP, consider safeguarding issues, such as sexual exploitation or trafficking etc.
If the patient chooses a local practice as part of this process and the practice is open, the UTC will contact the practice and arrange a convenient appointment for completion of the patient's preliminary health checks necessary for registration. UTC reception staff will assist patients in completing the required GMS1 form in readiness for registering with the practice. The UTC will electronically forward details of any diagnosis and treatment administered at the UTC to the practice. All outcomes will be recorded in the patient's notes / records.

If the patient does not wish to choose a practice while at the UTC, or if the practice of their choice is not open, UTC staff will supply the patient with hard copy information about practices in their area and a copy of their attendance summary for presentation to the GP.
Unregistered patients from outside Halton will be asked to contact the Registration Department in their local area. Hard copy information about this process should be available for neighbouring boroughs.

**7.5 Communication of episode to the patient's GP**

The UTC will pass the patient's details, information of the care provided by the UTC and any further information (for example, the need for the GP to follow up with the patient) in electronic format by 8am the next day.

The summary of the episode of care should include:

- The patient's demographic details and NHS number
- The patient's presenting condition and diagnosis
- Details of any diagnostics conducted and, where possible, their results.
- Any treatment provided and full details of any medicines prescribed in the UTC and/or to take home with them, including details of any follow up needed for these medicine.
- Details of any referral made to specialist services to address the patient's immediate needs
- Any recommendations made to the patient for services to which they might self-refer
- Any recommendations about appropriate services (including social care services) that the GP might wish to refer the patient for their ongoing needs
- Safety netting advice issued to the patient
- Patients will be provided with a printed summary of their episode of care that summarises their presenting condition, diagnosis and the advice/treatment provided. Patients should also be given appropriate printed materials relating to their specific condition.

The IT system used by the UTC provider(s) will be inter-operable with national NHS systems (e.g. Summary Care Record), GP (EMIS Web) and Trust systems (Acute, Community and Mental Health Trusts) in order to facilitate effective information sharing (including care plans) and to avoid the need to re-enter patient data at any point in the patient's journey through the service. Inter-operability will also allow UTC to identify any vulnerable children or adults who may have been "red flagged" by other services. This will also be same for other vulnerable groups such as learning disabilities or Autism.

**7.6 Management of Waiting Times**

Waiting times will be managed as part of the triaging clinician function. The triaging clinician will work in partnership with all parties to ensure compliance with targets and will escalate within procedures as appropriate. Patients will be informed on arrival of the expected waiting time.
Patients who self-present will be clinically assessed and triaged within 15 minutes of arrival (the standard for paediatric patients is 15 minutes). For Children & young people who present alone or with a peer, assessment must take into account safeguarding and Fraser Competency.

Patients transferred from the NWAS Ambulance Service will be handed over to UTC staff for clinical assessment and triaging within 15 minutes of the ambulance arriving at the UTC.

Patients accessing the service via 111 will present their reference number to the UTC staff and will be seen according to their appointment time or within 30 mins of their appointment time.

In some cases, a diagnostic test or investigation will be required. Where a diagnostic test or examination is requested the test must be ordered and patient seen with the results within 2 hours.

**8 Care Delivery**

**8.1 Minor illness / injury**

Patients identified by the triaging clinician will be registered on the UTC clinical IT system by the reception staff and be seen by an appropriate clinician.
All patients will be seen in order of arrival unless the triaging clinician or consulting clinician feels they should be seen more urgently.
All adult, children and young people will wait in the main waiting room.

**8.2 Paediatric care delivery**

The Provider must deliver appropriate and responsive care to all children in accordance with the requirements set out in Section 11. This must be in accordance with the standards set out in the Children Act 2004, National Service Framework for Children

Children suitable to be seen in the UTC will be seen by a suitably qualified clinician.

The Provider shall be responsible for ensuring that their staff:

- Have relevant professional registration, indemnity and have an up to date enhanced Disclosure and Vetting (DBS) checks.
- All staff caring for children shall have appropriate paediatric experience, including core paediatric competencies
- Know who to contact for advice on child safeguarding matters at all times
- Are compliant with their safeguarding duties and responsibilities under Section 11 and all staff have up to date Child Safeguarding training, in line with the intercollegiate competency framework for Child Safeguarding.

For children and young people it is expected that the episode of care will be communicated to their health visitor or school nurse (and the Halton LAC team for Halton LAC children and young people, where known to be LAC) no later than 8am on the second working day following the child or young person's episode of care. There is an expectation to communicate with the Liaison Health Visitor and to take part in any relevant child protection meetings.

**8.3 Streaming to / from UTC**

As part of the development of integrated care provision, an internal transfer process will be developed to ensure that patients receive care from the most appropriate clinician. Following clinical triaging in the UTC any patient found to require more complex urgent care will be referred directly to an ED or Paediatric ED as necessary within a 60 minute timeframe.

Conversely, if a patient arrives at an ED and is able to be treated in the UTC, the patient will be directed to the UTC. A 'Patient Transfer' protocol for establishing the appropriate transfer of patients between services will be agreed between the Provider and Acute Trusts prior to service commencement and where possible the patient will be given an appointment slot. This protocol will support services in delivering the 4-hour standard, and will not put either the UTC or the ED at Acute Trusts in a detrimental position to be able to treat a patient safely and appropriately.

As part of this protocol, patients transferring from the UTC to the ED should have their arrival time noted and verbally communicated to the ED staff. The 4-hour waiting time standard will commence from the patients arrival to the UTC and NOT from the time of their transfer; e.g. patient arrives at UTC at 0900, is transferred to ED at 1000, treatment and discharge to be completed by 1300 (4 hours from 0900).

As part of this process the patient's details will be transferred from the UTC clinical system to the Acute Trusts IT system (or vice versa) by staff without the need for the patient to reregister:

- Patient details to be transferred between Provider and Trust IT systems
- Provider and Trusts must ensure safeguarding and information governance measures are taken to protect patient information and have policies and processes in place to ensure the correct transfer of details from one IT system to the other.
- Patient information will be tracked for data collection and future planning purposes. The utilisation of this pathway will be subject to regular audit by the Joint Clinical Governance Group.

The internal transfer protocols and processes must delineate where accountability sits at each stage of the transfer and must delineate where responsibility and accountability will sit i.e. with UTC or ED for any waiting time breaches. Any waiting time breaches seen as the responsibility of the UTC must be reviewed and analysed to determine remedial actions.

**9. Access to Diagnostics and Investigations**

**9.1 General**

UTC will arrange access to diagnostic tests and investigations. These diagnostic tests and investigations will be available to the UTC on the same day, and within two hour period which will allow the result of the diagnostic/ investigation to inform a treatment decision before the patient returns home. The results of any tests requested from the UTC will be made available to the patient's own GP.

All diagnostic tests will be available for both adults and children attending the UTC, where applicable. Diagnostic tests will be available to clinicians for UTC patients as described in the table below. The principle is that the only diagnostics to be carried out are those that are necessary to assist in acute management of the patient and complete the episode of urgent care.

Only clinicians who are competent to interpret results of tests should request tests and this should be documented in the procedures manual competence section.
All tests are to be requested using the electronic order communication system, and the UTC provider(s) must ensure staff are appropriately trained and that IT systems have connectivity with the acute system.

All appropriate consent (Fraser Competence) and chaperone policies must be adhered to as well as health and safety requirements regarding the handling and transport of body fluids.

**9.2 Menu of Available Diagnostic Tests**

There is the option for UTC provider(s) to undertake Point of Care Testing if required and is necessary depending upon clinical need. Point of care testing can include the following:

| | |
|---|---|
| **Point of Care tests (Near Patient test)** | Blood sugar<br>Troponin<br>CRP – in agreement with the commissioner.<br>INR<br>Potassium<br>Urine dipstix<br>Pregnancy urine test<br>ECG<br>Doppler<br>Ultrasound<br>BP<br>Pulse oximetry |

The following is a proposed set of diagnostic tests which the UTC should have access to:

| | |
|---|---|
| **Haematology:** | Full Blood Count (FBC)<br>Erythrocyte Sedimentation Rate (ESR)<br>C-reactive protein (CRP)<br>Serum HCG<br>D-Dimer<br>Clotting studies |
| **Biochemistry:** | Urea and electrolytes (U&E)<br>Blood Glucose<br>Liver Function Tests (LFTs)<br>Thyroid Function Test (TFT)<br>Amylase<br>Pregnancy Test |
| **Microbiology:** | Urine<br>Stool<br>Throat, wound swabs etc. |
| **Radiology:** | Plain film for limbs and chest |
| **Ophthalmology:** | Slit lamp |

**9.3 Appropriate use of diagnostics**

To ensure effective use of resources the UTC provider(s) should conduct a quarterly audit of requests for diagnostic tests and present the findings to the Joint Clinical Governance Group and to the commissioners. Urgent patients presenting to the UTC may require access to diagnostics where this would assist the clinician in a decision regarding either the patient's immediate treatment or for a decision or requirement for admission.

**9.4 Interpretation and Reporting**

The UTC is expected to interpret all diagnostics and investigations it requests, except for those which it requests as part of an onward referral to a specialist clinic. This applies to Radiology as well as Pathology. For Radiology, the UTC is required to develop a process through which X-rays can be subject to a medical interpretation, as part of the episode of care. There is expectation that current SLA's with acute providers, with regards to diagnostics, will be reviewed and ensure fit for purpose in the new model.

Measures must include having an abnormal results review process in place. The interpretation of all plain films by UTC staff must be clearly recorded on the patient's care record in the UTC. The provider must implement a system whereby all films reported are checked against the UTC clinician's interpretation and any differences in interpretation likely to affect the patient's treatment or outcome must be reported to the patient's own GP.

**10 Discharging Patients from the UTC**

**10.1 General**

Patients will be discharged at the end of their episode of care. It remains the requesting clinician's responsibility to ensure that all abnormal diagnostic results are followed up and actioned appropriately. Care should be taken when discharging unaccompanied children, other vulnerable (eg Young Offenders (YOS, LAC where known) children and other vulnerable people depending on the time of day.
A discharge summary is to be offered to the patient by the clinician responsible for their treatment. This is a summary record of the patient's visit to the UTC outlining what happened to them.

There are also other staff groups who may need to be informed for example:

- Community matrons
- Ambulance clinical support desk
- Discharge support team
- Rapid Response Team
- Adult Psychiatric Liaison Service
- Social services
- Paediatric Liaison Nurses
- Health Visitors
- School Nurses
- LAC Team
- District Nurses
- Probation Service
- Independent Domestic Violence Advocate
- Police
- Mental Health Team
- Learning Disability Team
- Care Homes (with Consent)

It is the responsibility of the appropriate UTC professional to ensure the information is passed to the appropriate service within 24 hours of the episode of care.

The provider will issue discharge summaries to the patient and send electronically to the GP practice providing relevant clinical and treatment information, medicine administered or prescribed and any necessary follow-up care within the agreed timeframe.

Many UTC patients will be seen, treated and discharged from the UTC with no specific coordination of or access to community support services. However, a significant proportion of UTC patients will need to be assessed to ensure they can be safely returned to their usual community setting with the appropriate community support (or a temporary alternative such as an intermediate care facility). These patients may need input from the Rapid Access Rehabilitation Service (RARS) and therefore a patient pathway between UTC and the RARS Team will be established by the UTC provider(s).

**10.2 Follow up care**

If further follow-up care is required, the UTC should transfer the patient appropriately, for example, back to their GP, care at home or other intermediate care services, and will need to agree processes for this to happen.

The UTC will need to establish referral mechanisms for patients requiring community physiotherapy as a part of their on-going care, should this be considered to be appropriate.

The UTC provider(s) will also be responsible for arranging any patient transport deemed necessary at the time of their discharge.

The Provider will work collaboratively with any new services relevant to Halton patients which are established during the contract duration.

**10.3 Referrals for first Outpatient Appointments**

With the exceptions below, clinicians in the UTC will NOT refer patients for first outpatient appointments.

Exceptions are:

- Suspected cancer (the patient needs to know that this is an urgent 2 week wait appointment)
- Referral to the Rapid Access Chest Pain clinic
- Referral to Early Pregnancy Assessment Unit
- Referral to Fracture Clinic
- Ophthalmology out-patient clinic

Referral guidelines and protocols regarding referral to these services will be drawn up and adhered to. The UTC provider(s) will be expected to agree direct referral pathways to additional specialist services and clinics including specialist gynaecology services and genito-urinary medicine.
Where an admission is required this will be made directly to the specialty concerned. Patients will not be referred back to an ED for diagnostics or admission.

**11 Medicines Management**

**11.1 Medicines management services required in the UTC**

The UTC provider will be responsible for providing the following:

- A supply of stock medicines for use or administration as part of immediate treatment or assessment. This stock will need to be comprehensive and align with the clinical pathways agreed for the UTC. The stock formulary and any future changes to it will need to be agreed with the commissioner as well as via the UTC clinical governance processes.
- A supply of pre-labelled stock medicines for supply under a Patient Group Direction (PGD) in line with the Pan Mersey Area Prescribing Committee (APC) formulary, recommendations and guidelines. The PGDs will need to be agreed with the commissioner and must be aligned with the clinical pathways agreed for the UTC.
- Access to FP10 prescriptions for use by medical and non-medical prescribers where clinically appropriate, including the use of EPS where available. The Provider will be expected to adhere to the APC formulary, recommendations and guidelines as agreed by NHS Halton CCG. This is available via the APC website. A budget is currently available for the current UCC aligned to primary care for prescribing costs.

**11.2 Formulary**

NHS Halton CCG is part of the Pan Mersey Area Prescribing Committee (APC). All prescribing within the locally should be in line with the Pan Mersey APC formulary, guidance and recommendations as agreed by the CCG. Any deviation from this formulary must be agreed by the commissioner in advance.
Prescribing of antibiotics is likely to be a common intervention within the UTC and as such it is essential that the Provider adheres to the Pan Mersey APC antimicrobial guidance to support effective antimicrobial stewardship and reduce antimicrobial resistance.

**11.3 Clinical governance**

The Provider is responsible for clinical governance and compliance with applicable national legislation and guidance for all aspects of medicines management, including prescribing and supply.
Providers must engage and participate in any prescribing audits when deemed necessary by the CCG. It will be expected that the provider will carry out a full antibiotic audit twice a year working as agreed with CCG medicines management team and will be able to demonstrate activities that support good antimicrobial stewardship. .

The UTC provider must ensure compliance with all legal, clinical and governance procedures regarding the use of PGDs.

Any incidents related to medicines and prescribing, including use of PGDs, must be investigated by the UTC provider, with outcomes reported following the provider and commissioner reporting processes along with shared learning as a result of the investigations.

**Supply of Medication**
The Provider is expected to have a mechanism available through which a full course of medicines can be supplied or administered where clinically appropriate.
The Provider should also implement a mechanism for reporting all medicines prescribed and provided as part of the UTC service to the CCG on an annual basis.

Although not routinely recommended the UTC can issue repeat prescriptions, where this is deemed appropriate as determined by clinical assessment.

**Medicines policies**
The provider is expected to have in place a full set of policies and protocols relating to safe use of medicines and safe management of controlled drugs within the UTC. These policies must be audited on a regular basis to support adherence to legislation and best practice.

**12 Arrangements for Adult & Paediatric Care**

**12.1 General**

Protocols should be in place to manage critically ill and injured children and adults who arrive at an urgent treatment centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance *'Quality standards for cardiopulmonary resuscitation practice and training*[1], should be immediately available. At least one member of staff trained in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of 'design for the usual, and plan for the unusual'.

**13. Arrangements for Paediatric Care**

**13.1 Service design – an integrated unscheduled care system**

The Provider shall ensure that the arrangements for paediatric care comply with recommendations of Services for Children in Emergency Departments[2] and the National Service Framework for Children, Young People and Maternity Services[3].

All front-line staff delivering unscheduled care to children must be competent in the basic skills required for safe practice, in whichever setting they work.
The UTC provider(s) must work with the commissioning organisation to provide safe, unscheduled care for children taking local needs into account.
In order to smooth the interface between organisations, commissioners and providers should encourage shared or rotational posts, or regular secondments to the acute unit.
Notification of the child's attendance at the UTC should be made in a timely way to their primary care team.
The UTC should prevent unnecessary hospital admissions by being aware of alternative options, and developing care pathways for common conditions with community and paediatric colleagues.

**13.2 Child and family-friendly care**

The UTC must accommodate the needs of children and accompanying families as far as is reasonably possible.
The UTC should regularly seek comments from children, young people and separately their carers to improve services and facilities. Information for children and young people must be suitable for their age and developmental stage to enable and encourage self-care.
Children and young people up to the age of 25 years, with a learning disability or with complex needs and or with Education, Health and Care Plan who are transitioning into adult services will need be considered.

**13.3 Initial assessment of children**

All children attending the UTC are to be visually assessed by Reception staff within 15 minutes of arrival to identify an unresponsive (or in a confused state) or critically ill child and alert a clinician. Protocols should be in place to guide reception staff in the UTC.

A brief clinical assessment, including heart rate, respiratory rate and temperature, by an appropriately trained nurse or doctor will occur within 15 minutes of arrival (the Initial Assessment) if it is not possible for a full clinical assessment to be conducted in this time period. A system of prioritisation for full assessment should be in place if the waiting time for a full clinical assessment exceeds 15 minutes.

The Initial Assessment should include an assessment of the requirement for analgesia using an appropriate pain score and, if required, the UTC should ensure that treatment of pain is delivered within 20 minutes of such Initial Assessment. The Initial Assessment shall include consideration of whether there are any child protection concerns and whether checks should be made as to whether a child protection plan is in place. All records should be kept safely and be made available when required.

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[2] Royal College of Paediatrics and Child Health (2007) Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments

2 National Service Framework for Children, Young People and Maternity Services, Department of Health, September 2004

3 https://www.resus.org.uk/quality-standards/acute-care-equipment-and-drug-lists/#_blank

Registration details completed in respect of each child seen at the UTC shall include specific additional information (e.g. name and relationship of accompanying adult, who can legally give consent to treatment, school, health visitor, LAC, where known, social worker). Details of any child's visit to the UTC should be sent to the health visitor or social worker regardless of the reason for the visit.

**13.4 Treating the sick child**

All UTC staff will be trained in paediatric basic life support. At least one member of the UTC team should have training in advanced paediatric life support (APLS) and the UTC should establish and monitor guidelines and protocols to ensure the safe transfer of any child from the UTC to an ED at the hospital. The UTC provider(s) will have a named paediatrician with designated responsibility for UTC liaison including safeguarding children.

Systems must be in place to ensure safe discharge of children, including advice to families on when and where to access further care if necessary.
All unscheduled care attendances by children shall be notified to that child's primary care team: the GP and the health visitor or school nurse and where known the LAC teams.

**13.5 Staffing and training issues**

All UTC staff shall be trained in recognising serious illness in children. All clinical staff caring for sick and injured children shall have the same basic competencies in caring for children as they do for adults e.g. recognition of serious illness, basic life support, pain assessment, and identification of vulnerable patients. All clinicians should have the same competencies - Nurses caring for sick and injured children in the UTC shall have at least basic competence in both emergency nursing skills and in the care of children. Nurses caring for children in the UTC shall be competent in:

- Communicating with children and their families
- The assessment and recognition of the sick child
- Basic life support skills
- Recognition of vulnerable children , the ability to identify when safeguarding procedures are necessary, and the ability to implement the ED child protection policy
- Pain assessment and management
- Prescribing and administration of medication by appropriately trained Nurse Prescribers
- The current legal and ethical issues pertaining to children, including consent and confidentiality issues

Minimum competencies in relation to caring for children and young people have been defined by Skills for Health[4], the Department for Education and Skills[5], the RCN[6], and the Faculty of Emergency Nursing (FEN)[7] and the UTC must ensure that all relevant staff meet the requirements set out in this guidance.

Where emergency nurse practitioners (ENPs) work autonomously to see and treat children in the UTC, the UTC must ensure that the nurses have received specific education in the anatomical, physiological and psychological differences of children.

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4 Skills for Health, www.skillsforhealth.org.uk
5 Department for Education and Skills 2004 Common core of skills and knowledge for the Children's Workforce
6 Royal College of Nursing 2012 Core competencies for nursing children and young people
7 Faculty of Emergency Nursing Competency Framework

They must also have specific training in history-taking, examination skills and diagnostic reasoning in children, including interpretation of investigations. When nurses prescribe medication for children, they shall have the necessary knowledge of paediatric pharmacology.

The UTC shall have an RN (Children) lead nurse responsible for the care of children and a lead nurse responsible for safeguarding children. All clinical staff fulfilling these roles shall liaise closely with their counterparts at the EDs at the hospitals for the purpose of ensuring that there are consistent processes across both the UTC and EDs at the hospitals.

The UTC shall agree with an Acute Trust the availability of an paediatric consultant whose remit includes paediatric emergency medicine. Access by UTC staff to this consultant must be agreed as and when may be required to provide clinical supervision, or the UTC must otherwise employ its own consultant with sub-specialty training in paediatric emergency medicine.

**13.6 Safeguarding Children in the UTC**

The UTC will provide quarterly reports using the Safeguarding Children Health Outcome Framework (SHOF), to the CCG as part of their Contract Quality monitoring process. UTC will also be required to complete self-assessment audits in line with the local Safeguarding Assurance Framework.
Evidence of compliance with the above will be included in the Annual Report to the CCG Outcome 7, Regulation 11 of the Health and Social Care Act 2008 & 2012 (Regulated Activities) Regulations 2009).

Access to safeguarding advice must be made available to UTC staff from a paediatrician and social services 24-hours a day. The UTC must ensure that there is direct or indirect access in place to the list of children with child protection plans (engagement with CP-IS). This system will give access to children and unborn with CP Plans and Looked After Children (LAC). UTC should have a paediatric liaison Health Visitor and School Nurse Professional. Systems must be in place to identify children who attend frequently.

**13.7 Information systems and data analysis**

The information systems at the UTC will enable a child's attendance at the UTC to be notified automatically to their primary health care team (both the GP and health visitor or school nurse and LAC, where relevant and known). The UTC must ensure that surveillance of local patterns of injury is possible.
Further guidance may be found in Standards for Children in Emergency Care Settings.[8]

**14 Staffing**

**14.1 General**

The establishment of the UTC provides a significant opportunity to develop and enhance the skills and competence of health care professionals across the local health economy.

The planned establishment must recognise the need for a strong primary care and emergency care presence in all assessment, diagnosis and treatment roles. It is anticipated that the band/role mix may change and include a wider range of practitioners with varying competencies as the UTC becomes established and protocols implemented and reviewed. It is expected that clinical staff will rotate through primary care hubs and UTCs and ensure training, workforce and skill mix to create a resilient and stable workforce for Halton.

[8]Royal College of Paediatrics and Child Health 2012 Standards for Children in Emergency Care Settings

The clinical model recognises that outside of rota planning there will still be peaks and troughs of activity within the UTC.

Drawing on recommendations made by the College of Emergency Medicine[9] commissioners are defining the minimum competencies for UTC staff as follows:

| **Area** | **Competence** |
|---|---|
| Standard Clinical Competencies | All staff should have the ability to carry out basic life support for adults<br>Minimum staff education and competency requirements for all clinical staff working in the UTC include:<br>• Recognition of serious illness<br>• Intermediate life support training<br>• Pain assessment<br>• History taking, examination, formulation of a diagnosis and treatment plan<br>• Prescribing (if a qualified prescriber) or use of Patient Group Directions (PGDs) (if legally allowed to work under a PGD).<br>• Competence in the recognition of acutely ill patients<br>• Identification of vulnerable patients and their multidisciplinary pathways of care (vulnerable patients include, but are not limited to, frail elderly, adolescents and children, people with mental health<br>• issues or learning disabilities)<br>• Level 3 Adult Safeguarding Training for all front line clinical staff.<br>• Level 2 Safeguarding Adult training for all qualified staff<br>• Level 1 Adult Safeguarding training as mandatory at induction for all staff, in line with adult safeguarding intercollegiate competency framework |
| Minor Injuries Competencies | Clinical staff dealing with minor injuries must possess the practical skills necessary to identify and manage noncomplex soft tissue and bone injuries, for example:<br>• Wound closure<br>• Plaster casting<br>• Assessment of burns |
| Paediatric competencies | The UTC must have a minimum level of competence, skill and experience for treating adolescents and children including:<br>• Paediatric intermediate life support training<br>• All discharging clinicians/main deliverers of care need to have level 3 child protection training in line with the children's safeguarding intercollegiate competency framework<br>• Recognition of sick children, including Paediatric Early Warning System |
| Diagnostic Competencies | Clinical staff must be able to assess the need for, and order, diagnostics that the UTC will provide and must be able to interpret results of any tests that they order. |

[9] College of Emergency Medicine 2011 Emergency Medicine: the way ahead

| | |
|---|---|

**14.2 Management of UTC**

Management of the UTC will be undertaken by the UTC provider(s). The UTC provider(s) will be solely responsible for the employment of staff, payment of benefits and any disputes arising from employment-related matters.

It is expected that some staff within the current UCC facilities may be affected by TUPE regulations. Commissioners will work with providers to identify which staff may be affected. Providers of the UCC service will be expected to comply with TUPE regulations for transferring staff.

**14.3 Clinical leadership**

The UTC provider(s) will be expected to develop a model for clinical leadership and clinical governance. As part of this, a local, designated Lead GP/Clinical Director will be appointed by the UTC provider(s).
The designated Lead GP/Clinical Director(s) will take responsibility for the practice of all staff who treat patients autonomously. The Led GP/Clinical Director(s) will also take responsibility for the development, approval and implementation of developed care pathways and protocols working with the Joint Clinical Governance Group to do so.

**14.4 Skill mix**

As part of the development of an integrated service the UTC provider(s) will work closely with partner organisations to develop an appropriate skill mix of staff to ensure patients are seen and treated.

The UTC should also seek to work closely with commissioners and other partner organisations to realise any potential for collaborative working or innovative staffing models which would enhance patient care.
It is expected that the UTC will demonstrate a workforce that can competently deliver either skills in or integration with, providers of:

- Emergency Care
- Primary Care
- Paediatrics
- Obstetrics and Gynaecology
- Mental Health
- Social Care
- Third Sector
- Safeguarding
- Learning Disabilities

**14.5 Specialist Input**

UTC clinicians should be able to access input from a range of specialists at Acute Trusts, including ED consultants, orthopaedic specialists, paediatric specialists and radiologists. This may require a contractual agreement. Where specialist input has been sought, clinical responsibility for the patient remains with the UTC clinician unless and until the patient is formally transferred to an alternative service.

**14.6 Training and Development**

The UTC provider(s) is expected to develop the capacity for staff training, including for example, junior clinicians. This applies both to those specialising in primary care, such as GP Registrars, but also to those

specialising in acute medicine. Clinicians are expected to take part in the local clinical teaching as well as A&E teaching to develop clinical competencies within primary / secondary care

All staff working in an UTC must be competent in the basic skills required for safe practice as a first responder in caring for the acutely ill. These competencies include providing immediate life support, paediatric life support and primary survey assessment.

Further guidance on the competencies expected of all staff working in facilities providing unscheduled care is available in the Unscheduled care facilities guidance produced by the College of Emergency Medicine and Emergency Nurse Consultant Association.

Appropriate competency frameworks should be used for staff development and training, but they are not minimum requirements for staff being employed in UTC teams. Relevant competency frameworks include : Guidance and competencies for the provision of services using GPs and practitioners with special interests (GPSIs/PwSIs) – Urgent and Emergency Care

- Competence and Curriculum Framework for the Emergency Care Practitioner
- Advanced Nurse Practitioners – an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation.
- All nurses working in the UTC must adhere to the principle of the Nursing and Midwifery Councils code.
- The College of Emergency Medicine, Emergency Nurse Consultant Association and Faculty of Emergency Nursing (2009) Unscheduled care facilities
- Department of Health (2009) Guidance and competencies for the provision of services using practitioners with special interests (PwSIs) – Urgent and Emergency Care
- Department of Health (2007) Competence and Curriculum Framework for the Emergency Care Practitioner
- Royal College of Nursing (2008) Advanced nurse practitioners – an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation or most up to date versions.
- Nursing and Midwifery Council (2015) The Code: Standards of conduct, performance and ethics for nurses and midwives.
- Prescribing competencies for all prescribers including non-medical prescribers (NMPs)
- Adult and children safeguarding intercollegiate competency frameworks

The National Poisons Information Service (NPIS) is commissioned by Public Health England to support the handling of accidental poisoning and overdose calls in urgent care (http://www.npis.org/index.html ). Toxbase is a web based resource provided by NPIS for health care professionals to support clinicians handling suspected incidents of toxic ingestion.

Feedback from NPIS and the Toxbase service indicates that training of clinicians working in urgent care contact centres is essential to support safe decision making and managing patients who can be advised to stay at home or need to attend Emergency Departments for clinical assessment. The Provider(s) shall ensure that clinicians in the Service have undertaken the NPIS Toxbase training and are able to use the tools provided by the NPIS. The eToxbase learning module is a minimum requirement of training for all clinicians supported by additional medicines and Electronic British National Formulary (eBNF) training in the context of therapeutic overdose. Further Information can be found at https://www.toxbase.org/

**15 Quality Standards and Clinical Governance**

**15.1 General**

Governance is the mechanism to provide accountability for the way an organisation manages itself. Clinical Governance is a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment

in which clinical excellence will flourish. Clinical governance is therefore an integral part of a provider's overall governance arrangements.

NHS Halton CCG will wish to ensure that the quality of the service to be provided in the UTC is in line with these standards and of a consistently high standard. All professionals will be expected to abide by the guidance of their professional regulatory body. The UTC provider(s) is expected to outline clinical governance mechanisms to be applied when concerns about the quality of the service are raised.
At the time of writing this service specification, the UTC provider(s) will be expected to comply with regulations and standards contained within:

- Health and Social Care Act 2008(Regulated Activities) Regulations 2009,
- Care Quality Commission (Registration)Regulations 2009 ,
- Care Act 2014,
- Counter Terrorism and Security act 2015,
- Mental Capacity Act 2005 including Deprivation of Liberty Safeguards and adherence to the updated Summary Mental Capacity Guidance of March 2017 and The Mental Health Act 2014
- Medicines Act 1968 and any associated amendments
- Misuse of Drugs act 1971 and any associated amendments .

However, for the avoidance of doubt and without prejudice to any other provision in the Agreement, the provider shall deliver the services in accordance with any relevant legislation and standards in force during the terms of the Agreement.

It is required that the provider also ensures that they adopt any guidance or standards that are:

- Issued by the Care Quality Commission, e.g. *Essential Standards of Quality and Safety*
- Issued by the National Institute of Clinical Excellence from time to time
- Issued by any relevant professional body and agreed between the parties
- Connected with the reporting or audit of Serious Incidents
- Included within locally or nationally agreed service specifications, guidance or protocols
- Issued by the DH that cover urgent or emergency care
- Takes into account any guidance issued by Monitor
- Issued by the Pan Mersey Area Prescribing Committee and agreed by NHS Halton CCG

**15.2 Integrated Clinical Governance**

The UTC provider(s) will be required to have, or adopt, a system of integrated governance, that incorporates key elements of clinical governance and organisational learning, to ensure the safe delivery of services to patients.

The UTC should also be integrated with primary care and secondary care and operate within a common framework of standards and governance therefore ensuring the services primarily respond to the needs of patients. The whole systems approach to the way in which the UTC will integrate will mean that the patient experiences a seamless patient pathway through all urgent care services.

It is recognised that providers delivering urgent care will have discrete transactional systems such as those involving clinical leadership and financial reimbursement, but the vision is that the UTC provider(s) will be able to establish a service where the patient is not aware of moving across transactional or organisational boundaries.

There must be clear tangible commitment to working in this way and therefore, the UTC provider(s) will be expected to put forward clear plans on how integrated clinical governance will work practically across two or more separate provider organisations. These plans will include how operational systems will support the following principles:

- Clear lines of responsibility and accountability both within and between provider organisations
- Clearly defined handovers of care between providers
- A programme of quality improvement activities that transcends organisational boundaries
- Clear policies aimed at managing risk and procedures to identify and remedy poor professional performance

**15.3 Joint Clinical Governance Group**

A Joint Clinical Governance Group is a mandate and should be in line with the national guidance. This enhances existing clinical governance structures within UTC provider(s). It is proposed that the chair, membership and terms of reference are revised to meet the needs of the UTC provider(s) as described in this service specification.

The Group will include clinicians from the UTC provider(s), Acute Trusts, a paediatrician and the commissioner with associated membership from other providers such as social care and mental health providers, as appropriate.

Terms of reference for the group will include:

- Creation and regular review of the Joint Clinical Policy, including:
    - Assessment guidelines for Clinical Triaging clinicians
    - Staff competency framework
    - Pathways and transfers
    - Reception triage for identifying immediate ED cases
    - Diagnostics – both completion and following up when transferred
    - Staff resilience when increased activity
    - Use of joint spaces
    - Management of complaints when includes more than one provider

 Service audit, including:

- On a case by case basis, the appropriateness of the initial clinical navigation where a patient's treatment is begun in the UTC and subsequently transferred to an ED
- On a case by case basis, the appropriateness of the initial clinical navigation where a patient's treatment is begun in an ED and subsequently transferred to the UTC
- Review of re-directions back to primary care and other community services
- Review of diagnostic tests/investigations
- Review of prescribing and management of medicines within the service including controlled drugs
- At overview level, patient case mixes will be reviewed regularly to assure clinical governance and standards and retain confidence in both services
- On a regular basis, audit against staff competency framework, SUIs, complaints and professional feedback
- Recommendations for service improvement.

Note that the requirements as set out above supplement rather than replace the performance and contract management arrangements between the UTC provider(s) and the commissioner. The terms of reference of the group may be modified as part of the contract management process. It will be the

responsibility of the UTC provider(s) to convene this meeting on a regular basis (frequency to be determined) and ensure that accurate minutes are recorded.

**15.4 Patient Involvement**

The UTC provider(s) will make arrangements to carry out regular patient experience surveys in relation to the service and will co-operate with such surveys, including surveys of an ED that may be carried out by the Commissioner. In discharging its obligations under this clause the provider shall have regard to any Department of Health guidance relating to patient experience.

The UTC provider(s) will be expected to demonstrate evidence of having used patients' experience of using the service to make improvements to service delivery. Specifically, the service will be required to undertake an annual patient's survey. The results of the survey will be discussed with service users, and evidence of the survey results, recommendations and action plan to implement the recommendations will be submitted to NHS Halton CCG.

**15.5 Clinical Risk Management and Legal Protection**

The UTC provider(s) will ensure that clinical risk management is an integral part of daily management. The provider will use clinical risk management to improve decision-making and encourage the continued improvement of service delivery and the best use of resources. It will be necessary for a comprehensive risk assessment to be undertaken by the provider to ensure that the patient journey is safe and appropriate.

**15.6 Business Continuity and Resilience**

The Provider will implement mechanisms for managing risk, including disaster recovery, contingency and business continuity plans. The provider must ensure business continuity plans are available at service level. The provider will keep the CCG informed about detail of the risk management structures and processes that exist, and how they are implemented.

**15.7 Accountability**

The UTC provider(s) contract will be accountable to the NHS Halton Clinical Commissioning Group as commissioners of this service.
The UTC provider(s) will be responsible for performance, clinical and financial management of the service. Halton CCG expects an open and transparent relationship with the provider in line with the Duty of Candour.

**15.8 Incident Reporting**

All incidents (both clinical and non-clinical) must be reported. The service will ensure that there are appropriate reporting mechanisms for all incidents and that these reports feed into the relevant monitoring and reporting systems. If an incident meets the NHS England framework for Serious Incidents and Never Events then it will require reporting via STEIS (Serious Incident Management System). The provider will be expected to meet the timeframes for reporting and investigation as per the framework and submit the final investigation report to the CCGs Patient Safety team.
There will also be effective procedures for the management of all Serious Incidents that dovetail existing requirements for reporting and investigating SI's and that safeguarding concerns are considered with each incident report and appropriate referrals made as indicated.

**15.9 Safeguarding of Children**

The UTC must provide the same level of service as currently provided by A&E to ensure appropriate safeguarding of children and must adhere strictly to current national safeguarding policy.
The provider (s) must have arrangements in place to enable full compliance with the legislation governing safeguarding children (Children Act 1989 & 2004) and guided by the principles embodied in Working together to safeguard children (August 2018). The Provider has a duty of care to ensure that children and young people who use the service(s) are protected from harm or neglect, and must take appropriate action to respond to any concerns about their well-being or allegations of abuse.
This includes:

- Have an established leadership and accountability framework for safeguarding children within the organisation that meets the statutory requirements for safeguarding children. This will include having Board level leads and Named Professionals for Safeguarding Children.
- Have up to date policies and procedures in place for staff to follow in relation to safeguarding children and must be in line with local multi-agency policy and procedure under the local safeguarding children's board (LSCB).
- Have clear systems in place for ensuring that staff are able to recognise children and young people at risk of harm and respond appropriately
- Have arrangements in place to deliver and monitor the training of all staff in relation to safeguarding children in accordance with the Intercollegiate Competency Framework (January 2019).
- Compliance with the Local Safeguarding Children Board and assist with any safeguarding children matters and Serious Case Reviews

Provide quarterly reports as per the North West London Safeguarding Standards and the
NHS Standard service conditions.

**15.10 Safeguarding Adults**

The provider (s) must have arrangements in place to enable full compliance with the legislation governing safeguarding adults (Care Act 2014). The Provider must ensure that Service Users as well as staff are protected from abuse and improper treatment in accordance with the Law, and must take appropriate action to respond to any allegation of abuse.

This includes:

- Have an established leadership and accountability framework for safeguarding adults within the organisation that meets the statutory requirements for safeguarding adults, Prevent and Mental Capacity Act. This includes having Board Level leads and named professionals in place to cover these aspects of care.
- Have up to date policies and procedures in place for staff to follow in relation to safeguarding. Prevent and Mental Capacity Act (MCA) in line with local multi-agency policy and procedure under the local safeguarding adult board (HSAB).
- Have clear systems in place for ensuring that staff are able to recognise adults at risk and respond appropriately in line with the Adult Safeguarding Procedures (2016) and Care Act 2014.
- Arrange, deliver and monitor the training of staff in relation to safeguarding. Prevent and MCA in line with the Intercollegiate Competency Framework.
- Compliance with the Local Safeguarding Adult Board in safeguarding enquiries and safeguarding adult reviews and other Multi Agency Safeguarding meetings.

Provide quarterly reports as per the safeguarding Standards and the NHS Standard service conditions.

The UTC must ensure that vulnerable adults are safeguarded and must adhere strictly to current national policy, NHS Halton CCG Adult Safeguarding Policy and Local policy and procedures .

It is the responsibility of UTC to ensure that staff are trained in Mental Capacity and Deprivation of Liberty Safeguards. It is expected that all staff accessing patients will considered the mental capacity act and if required will assess a patients mental capacity in relation to specific decisions that is required.

If UTC staff are aware of a patient with a Learning Disability who has died they must report the death on the national reporting system on the following link.
http://www.bristol.ac.uk/sps/leder/notify-a-death/

It is expected that UTC will have a Learning and Disability Mortality Reviewer who will contribute to learning and disability mortality reviews, if required. Further information regarding this can be found at: http://www.bristol.ac.uk/medialibrary/sites/sps/leder/LEDER%20governance%20paper%20v0.8%20Final%20(1)%20(1). Pdf and http://www.bristol.ac.uk/sps/leder/

Key messages from the recent Domestic Homicide Review (DHR) highlighted areas of improvement within the health care setting. Key messages include; professional curiosity is conducted and maintained to ensure that all risks are identified and acted upon. The full report can be accessed below as well as further compliance requirements. Domestic Violence is a category of Abuse under the Care Act 2014.

Information systems should enable the flagging of high risk victims of domestic abuse and that the system is utilised to flag patients of high risk domestic abuse in line with your current policy, and that you read code patients with Domestic Violence in line with your policy.

A Domestic Violence and abuse policy which ensures staff are aware of the issue of domestic violence, how to identify and access perpetrators of domestic violence, local information regarding current pathways and the referral pathway.

You should also have an Adult Safeguarding Policy which is cross referenced to your domestic violence policy and which reflects the information which is in the NHS Halton CCG Adult Safeguarding Policy.

**15.11 Complaints**

The lead clinician of the UTC should deal with all complaints in line with the provider's complaints policy. The complaints should be given to the most relevant lead to respond to depending on the issue (nursing, medical or admin staff). All complaints should be logged and escalated to the Joint Clinical Governance Group where appropriate with a safeguarding consideration being part of the process.
The volume and content of complaints should be regularly analysed and used to inform internal continuous improvement processes.

**15.12 Policies and Procedures**

All services will be required to have in place policies and procedures which comply with general legislation and any relevant NHS guidance affecting the service in force throughout the duration of the contract, including:

- The Health and Safety at Work Act 1974 including Needle Stick Management
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Clinical waste and sharps disposal
- Infection control
- Incident reporting
- Human Rights Act 1998
- Race Relations (Amendment) Act 2000
- Equalities Act 2010
- Disability Discrimination Act 1995

- Information Governance
- NHS Code of Practice on Confidentiality 2003
- Medical records and storage
- Consent to treatment
- Data Protection, GDPR and Freedom of Information
- Discrimination
- Accessible information standard
- Working Time Regulations 1998 (as amended)
- Safer Recruitment
- Mental Capacity Code of Practice
- Deprivation of Liberty Code of Practice
- Mental Health Code of Practice
- NHS England Prevent Training and Competencies Framework
- Learning Disability and Mortality Review Guidance
- The Care Act 2014 Operation Guidance 2017
- Safe management of medicines including ordering, receipt, storage, supply, and disposal;
- Safe management of controlled drugs including implementation of the Shipman recommendations Management and control of secure stationery incorporating recommendations from the Counter Fraud Authority guidance March 2018

The UTC provider(s) will ensure that all policies are reviewed as appropriate and will state the review date clearly.
The provider will carry out pre-employment checks to ensure that all GPs, employed or otherwise engaged to work in the UTC, are registered on the Performers List, in accordance with the National Health Service Performers List Regulations 2013. An enhanced DBS check will be carried out for all staff working in UTC.

Providers are to have in place people management policies such as Disciplinary, Grievance, Capability, Harassment and Bullying at work to ensure there are mechanisms to address performance or conduct issues in the workplace. A recruitment policy must be in place that is in line with the NHS Employment Check Standards. These standards exist to outline the type and level of checks employers must carry out before recruiting staff into NHS positions.

The provider will demonstrate how they are achieving the recommendations set out in *Take Care Now* (2010) issued by the Care Quality Commission.

**15.13 Information Systems and Data Analysis**

The UTC staff will participate in the national information technology agenda, and engage proactively with local service providers on the strategy and design of local IT systems. It is a mandate that the UTC will have appropriate attendee and participate at the Halton IT group which meets bi-monthly.
A minimum dataset for the information system used by the UTC will be specified and should incorporate the specific needs of children.
The information systems at the UTC will link up with other health information systems such as NHS 111, GP OOH, GP Surgeries, Hubs as a minimum so that data on all local health service contacts are available within the UTC.

**16 Supporting Infrastructure**

Commissioners are seeking innovation in the introduction of new technologies and ways of working that may enhance the Service over the term of the contracts for the Integrated Urgent Care Service(s) to enrich patient experience which will support the wider urgent care system.
The provision of this service will be significantly dependent on the use of Information Management Technologies in support of integrating information and business processes in support of care delivery. This

innovation aims to place the patient at the centre by making all relevant information on the patient available by appropriate sharing and fast, safe and efficient ways of communication with all clinicians in the local health economy.

The Provider will be expected to demonstrate that its core clinical system and business processes meet the requirements below and that an appropriate and robust IT infrastructure is in place to support this. These should include

- A robust and resilient IT infrastructure
- A fit for purpose core clinical system
- Adequate and secure access to clinical systems
- Electronic Prescribing and use of EPS (where available)
- Clinical Decision Software e.g INR Star
- Full compliance with Information Governance
- Robust Business Continuity and disaster recovery plans and processes

**16.1 Information Technology and Information Governance**

The provider(s) of UTC will need to ensure the interoperability of their IT systems and core clinical system across each other and across wider IT systems within the local geography. This is particularly applicable to EMIS as the GP system of choice across Halton.

The Provider will need to interface with the application stated following the guidance of the ITK. The UTC should be mindful that under GP system of choice that the GP system landscape can change rapidly and the Integrated Urgent Care Service(s) should be able to integrate with any of the menu of systems as stipulated by HSCIC.

The Provider(s) shall adhere to the national interoperability with locally determined functionalities and standards that are in force at the time of this procurement and future updated standards (National and Local) which may be varied from time to time.
The Provider shall adhere to all NHS standards for Information Governance and be compliant with the Information Governance toolkit, achieving a minimum of level 2. The Provider shall evidence robust plans for maintaining and improving achievement.

**16.2 Access to patients records and clinical records**

The provider(s) of the UTC(s) must ensure that the patient record is shared with clinicians across organisational boundaries, where appropriate, to support patient care. The main system used across primary care Halton is EMIS. SystmOne and Adastra is also used across the wider Cheshire & Merseyside urgent care provision.

To support this aim all clinicians within the UTC should have access to relevant aspects of a patients' care records, where the Patient has consented to this being available. The provider(s) of UTC will be required to ensure that their system(s) are interoperable with EMIS.

The provider(s) will also need to ensure their system(s) have the interfacing capability to view, retrieve in real time, store and remove notes that were not generated in EMIS. The number of notes this applies to will change during the life of the contract. Access to these records and databases will require a number of systems or gateways including but not limited to:

- Adastra
- Summary Care Record
- Medical Interoperability Gateway (MIG)
- Child Protection Information Sharing (CP-IS) system
- End of life / Co-ordinate my Care (CMC)

- Access Special Patients Notes (SPNs) for Out of Area patients as and when they are made available
- Previous encounters data base
- Mental Health Crisis Plans
- Agreed emergency care / Crisis plans

The Provider will also be required to ensure that all staff login with Smart cards and that their system(s) connect with the NHS Spine.

**16.3 Functionality in support of Interoperability expected**

- A system for Special Patient Notes must be in place for provider(s) and other providers to receive, upload and manage all notes.
- Ability to share and view agreed data sets from all systems listed above e.g. care plans, patient status alerts
- A system for special patient notes must be in place for provider(s) and other providers to receive upload and manage all notes
- Ability to perform e-prescribing via electronic system and Electronic Prescribing System (EPS)
- Ability to book appointments directly into other local systems
- Ability to send/receive defined and agreed tasks including notifications to/from other local systems and clinicians
- Ability to send text messages from within the system
- Ability to electronically pass on referrals to other local clinicians clinical systems
- Ability to integrate and or interface with the Directory of Services.

**16.4 Directory of Services**

The Directory of Services (DoS) provides access to service information, which is a critical element of the service. The Provider(s) IT system will need to be able to interrogate the DoS to identify the local service best able to meet the patient's assessed needs and present a list of services to the Health Advisers, Nurses and Clinicians.

The DoS will also help in redirecting any patient into appropriate services in or out of hours to meet patient's requirements. The DoS will clearly indicate the agreed local referral protocols for each service and the message to relay to the patient will indicate the agreed approach to local clinical assessment i.e. whether the local service accepts the type and timescale of the disposition or accepts the type and continues the assessment locally to agree the timescale and setting for any further patient contact (advice, appointment or visit).

All clinicians involved in supporting the Integrated Urgent Care Service(s) will use the mobile DoS to identify the most appropriate service to refer the patient to.

**16.5 Applicable National Standards**

The UTC in Halton must meet all national standards of service quality including, but not only, those set out in the following policy documents:

- NHS Integrated Urgent Care Commissioning Standards, NHS England, October 2015;
- NHS 111 Interoperability Standards 2.3
- The Interoperability Toolkit (ITK) set of national standards
- National Quality Requirements in the Delivery of Out-Of-Hours Services, DH, July 2006, Gateway ref: 6893;
- DH fact sheet 7: commissioning out-of-hours services, December 2005, Gateway ref:5917;
- Recommendations from Dr David Colin-Thomé and Professor Steve Field report on Out of Hours (2010);

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- National Service Frameworks (NSFs);
- Department of Health Direction on Confidentiality (DH 2000);
- NHS England Serious Incident Framework 2015;
- Data Protection Act 1998;
- General Data Protection Regulation (GPDR) 2016/679
- Freedom of Information Act 2000; and,
- Information Governance standards as set out in National Programme for Information Technology 2006 – 2007
- Out-of-Hours Services A Commissioning Hand book
- NHSE (2015) Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework.
- Care Act 2014

Provider(s) must be compliant to Level 2 for the Information Governance Statement of Complaint (IGSoC) toolkit or above to enable record sharing with other IGSoC compliant organisations without the need for a data/record sharing agreement.

**17 Anticipated Service Demand and Associated Required Performance**

**17.1 General**

The following information is provided to assist with identifying staffing requirements for the service. Assumptions included in the estimates are given; however, it should be noted that the anticipated activity levels do not represent a guaranteed level of work for the Provider.
The baseline for both of the UTCs will be 250 treated patients per day.
Potential providers are encouraged to conduct their own research and due diligence with regards to likely demand for the service.

**17.2 Demand Management**

In keeping with the stated Service Aims, the Provider of the UTC service will be expected to work within care pathway guidelines to implement processes which effectively manage demand in accordance with the defined Scope of Clinical Services to be offered by the UTC.

It is expected that the number of patients attending the UTC will remain consistent and clinically appropriate over time through the following:

- Establishing systems and processes to signpost patients to access local primary care services e.g. local pharmacies and pharmacy services e.g. Minor Ailments Service (Care at the Chemist), Minor Eye Conditions Service, Treatment Rooms, NHS dentist etc. by using the Directory of Service (DoS)
- Reduce the numbers of patients attending the UTC who are not registered with a GP by supporting and facilitating registration with local GP practices to ensure complex/long term conditions are managed appropriately.
- Reduce the numbers of patients who attend the UTC on a regular or frequent basis through close collaboration with other relevant providers, such as Mental Health and Social Services and the Rapid Access Rehabilitation Service to ensure appropriate care plan is in place.
- Encouraging the use of the 111 service.
- Providing information to enable self-care in line with locally and nationally agreed approaches/policies.

**18 Performance Measurement and Key Performance Indicators**

**18.1 General**

The UTC provider(s) will have a named Information Lead, a named Quality Lead and a named Clinical Lead. The UTC provider(s) will be responsible for ensuring the data quality of all returns and that any issues are resolved speedily and internally.

**18.2 Quality Metrics**

The UTC provider(s) will take part in patient experience surveys in accordance with policy. Routine local audit plans will be agreed with commissioners and undertaken on a regular basis. The audit terms of reference will be shared and agreed with the commissioner prior to commencement. The commissioner retains the right to review and agree the audit findings and outcomes and to be updated on the progress against the improvement/implementation plans. Audits involving peer review or the Urgent and Emergency Clinical Audit Toolkit, are examples of the types of audit activity that the commissioner will be expecting the UTC provider(s) to undertake.

The UTC provider(s) will need to pay particular attention to care of children and young people, the elderly and those with special needs and vulnerabilities. The UTC provider(s) will need to demonstrate that they will work with other local healthcare and social care providers to develop care plans for patients who frequently attend regularly.

The Commissioner may wish joint audits to be undertaken to investigate issues or quality areas. This will include agreeing the terms of reference, report findings and outcomes and agreeing and monitoring any performance improvement plans. The commissioner will want to make sure that all patients receive care that is evidence-based and provides a service that is safe and of the highest quality.

Together, the UTC provider(s) and commissioners will agree the reporting format of quality metrics.

**18.3 Operational Metrics**

The UTC provider(s) will be expected to provide all mandated datasets, which are from time to time amended by the Department of Health and the National Commissioning Board in the format required by each of the requesters. At the time of writing, it is expected that the following data returns will be made on a timely basis:

- Emergency Care Data Set (ECDS)
- Daily Situation Reports

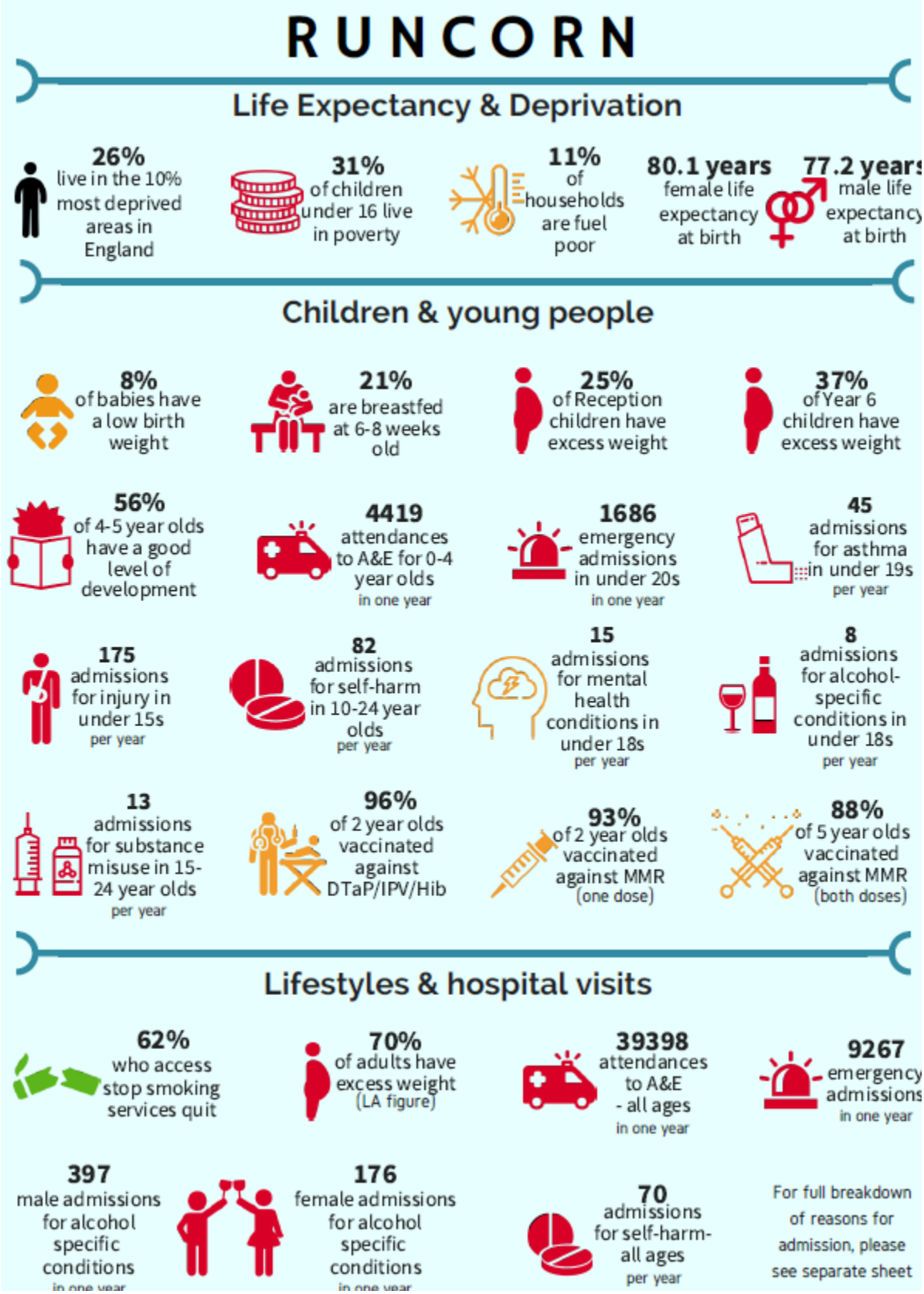
The UTC ECDS will be submitted by the UTC provider(s) according to an agreed timetable. To ensure that the patient journey can be tracked, it is expected that the UTC provider(s) will have the Patient Demographic Service (PDS) in place so that the NHS number is always used as the unique patient identifier. All parts of the patient pathway will be recorded, at a minimum, in accordance with the data dictionary where national codes are provided (www.datadictionary.nhs.uk).

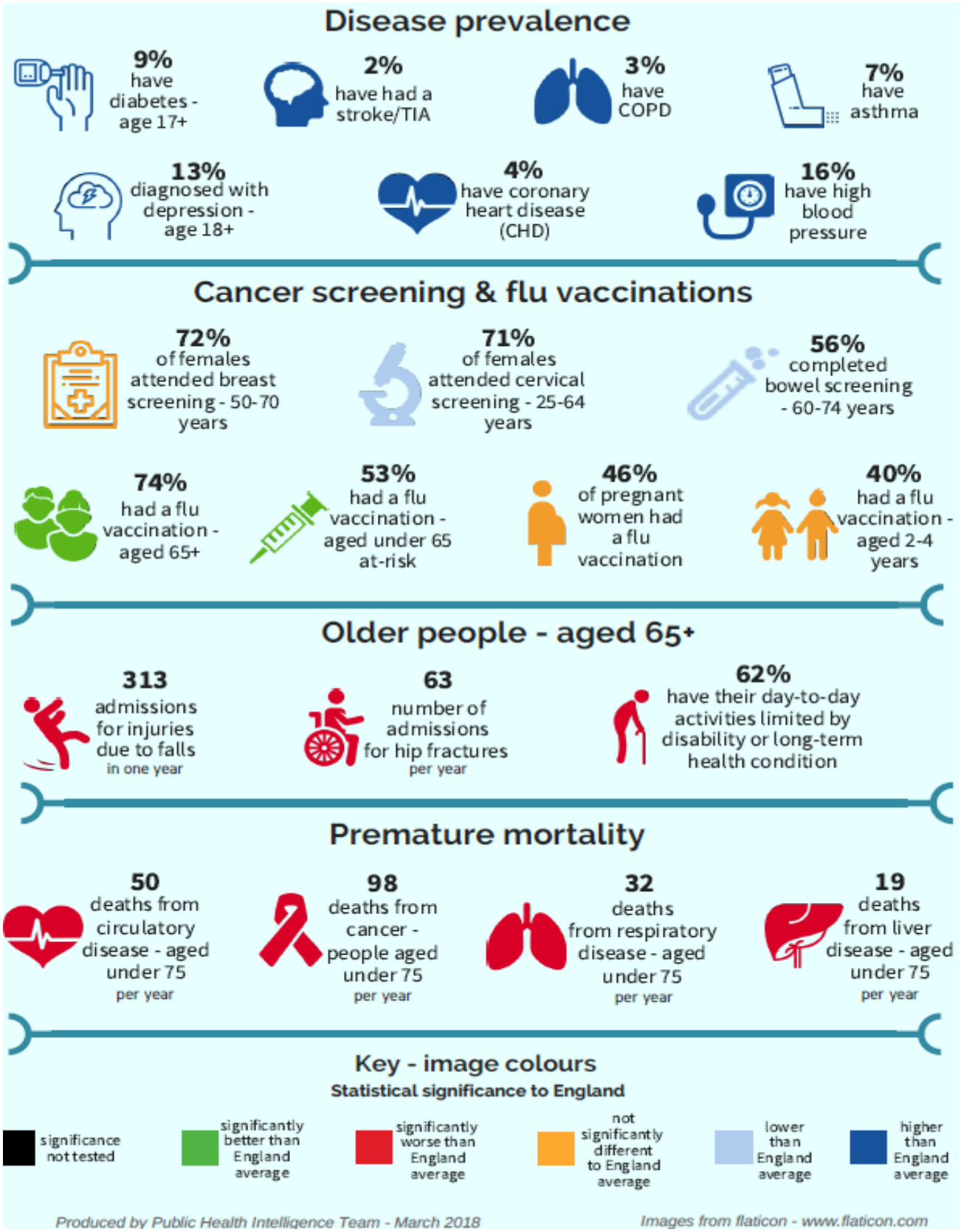
A detailed minimum data set will be finalised and agreed with the UTC provider(s) in advance of service go-live. This will be based on the ECDS current at the time of service go-live, but may include other locally agreed data.

**18.4 Key Performance Indicators**

The performance and success of the UTC service will be measured against a set of national and local performance indicators. An indicative set of KPIs is set out in the financial outcome based model and can be further developed and agreed with the provider. Where national quality requirements are either amended or rewritten, the UTC provider(s) will be expected to meet these where mandated by NHS England. The outcome KPIs are set out in Appendix 2

**Appendix 1**


RUNCORN
Life Expectancy & Deprivation
26% live in the 10% most deprived areas in England
31% of children under 16 live in poverty
11% of households are fuel poor
80.1 years female life expectancy at birth
77.2 years male life expectancy at birth
Children & young people
8% of babies have a low birth weight
21% are breastfed at 6-8 weeks old
25% of Reception children have excess weight
37% of Year 6 children have excess weight
56% of 4-5 year olds have a good level of development
4419 attendances to A&E for 0-4 year olds in one year
1686 emergency admissions in under 20s in one year
45 admissions for asthma in under 19s per year
175 admissions for injury in under 15s per year
82 admissions for self-harm in 10-24 year olds per year
15 admissions for mental health conditions in under 18s per year
8 admissions for alcohol-specific conditions in under 18s per year
13 admissions for substance misuse in 15-24 year olds per year
96% of 2 year olds vaccinated against DTaP/IPV/Hib
93% of 2 year olds vaccinated against MMR (one dose)
88% of 5 year olds vaccinated against MMR (both doses)
Lifestyles & hospital visits
62% who access stop smoking services quit
70% of adults have excess weight (LA figure)
39398 attendances to A&E - all ages in one year
9267 emergency admissions in one year
397 male admissions for alcohol specific conditions in one year
176 female admissions for alcohol specific conditions in one year
70 admissions for self-harm- all ages per year
For full breakdown of reasons for admission, please see separate sheet


Disease prevalence
9% have diabetes - age 17+
2% have had a stroke/TIA
3% have COPD
7% have asthma
13% diagnosed with depression - age 18+
4% have coronary heart disease (CHD)
16% have high blood pressure
Cancer screening & flu vaccinations
72% of females attended breast screening - 50-70 years
71% of females attended cervical screening - 25-64 years
56% completed bowel screening - 60-74 years
74% had a flu vaccination - aged 65+
53% had a flu vaccination - aged under 65 at-risk
46% of pregnant women had a flu vaccination
40% had a flu vaccination - aged 2-4 years
Older people - aged 65+
313 admissions for injuries due to falls in one year
63 number of admissions for hip fractures per year
62% have their day-to-day activities limited by disability or long-term health condition
Premature mortality
50 deaths from circulatory disease - aged under 75 per year
98 deaths from cancer - people aged under 75 per year
32 deaths from respiratory disease - aged under 75 per year
19 deaths from liver disease - aged under 75 per year
Key - image colours
Statistical significance to England
significance not tested
significantly better than England average
significantly worse than England average
not significantly different to England average
lower than England average
higher than England average
Produced by Public Health Intelligence Team - March 2018
Images from flaticon - www.flaticon.com

**Appendix 1**

# WIDNES

## Life Expectancy & Deprivation

**28%** live in the 10% most deprived areas in England

**21%** of children under 16 live in poverty

**11%** of households are fuel poor

**80.9 years** female life expectancy at birth

**77.4 years** male life expectancy at birth

## Children & young people

**7%** of babies have a low birth weight

**24%** are breastfed at 6-8 weeks old

**27%** of Reception children have excess weight

**38%** of Year 6 children have excess weight

**62%** of 4-5 year olds have a good level of development

**7738** attendances to A&E for 0-4 year olds in one year

**1591** emergency admissions in under 20s in one year

**57** admissions for asthma in under 19s per year

**180** admissions for injury in under 15s per year

**78** admissions for self-harm in 10-24 year olds per year

**10** admissions for mental health conditions in under 18s per year

**8** admissions for alcohol-specific conditions in under 18s per year

**13** admissions for substance misuse in 15-24 year olds per year

**98%** of 2 year olds vaccinated against DTaP/IPV/Hib

**98%** of 2 year olds vaccinated against MMR (one dose)

**92%** of 5 year olds vaccinated against MMR (both doses)

## Lifestyles & hospital visits

**51%** who access stop smoking services quit

**70%** of adults have excess weight (LA figure)

**53586** attendances to A&E - all ages in one year

**9609** emergency admissions in one year

**461** male admissions for alcohol specific conditions in one year

**175** female admissions for alcohol specific conditions in one year

**70** admissions for self-harm- all ages per year

For full breakdown of reasons for admission, please see separate sheet

# Disease prevalence

**8%** have diabetes - age 17+

**2%** have had a stroke/TIA

**2%** have COPD

**6%** have asthma

**10%** diagnosed with depression - age 18+

**4%** have coronary heart disease (CHD)

**15%** have high blood pressure

# Cancer screening & flu vaccinations

**73%** of females attended breast screening - 50-70 years

**72%** of females attended cervical screening - 25-64 years

**56%** completed bowel screening - 60-74 years

**69%** had a flu vaccination - aged 65+

**49%** had a flu vaccination - aged under 65 at-risk

**55%** of pregnant women had a flu vaccination

**36%** had a flu vaccination - aged 2-4 years

# Older people - aged 65+

**331** admissions for injuries due to falls in one year

**87** number of admissions for hip fractures per year

**61%** have their day-to-day activities limited by disability or long-term health condition

# Premature mortality

**54** deaths from circulatory disease - aged under 75 per year

**93** deaths from cancer - people aged under 75 per year

**25** deaths from respiratory disease - aged under 75 per year

**17** deaths from liver disease - aged under 75 per year

## Key - image colours

**Statistical significance to England**

- significance not tested
- significantly better than England average
- significantly worse than England average
- not significantly different to England average
- lower than England average
- higher than England average

*Produced by Public Health Intelligence Team - March 2018*
*Email: health.intelligence@halton.gcsx.gov.uk*

*Images from flaticon - www.flaticon.com*
*Produced using canva - www.canva.com*

**Appendix 2**

| No | Outcome Domain | No. | Outcome Goal | Outcome Indicator | Outcome Measure | Incentivise / Monitor / Subjective |
|---|---|---|---|---|---|---|
| 1 | *Description* | | *Description* | | | |
| *Patients and service users* | | | | | | |
| 1 | I received my treatment in the right service in the right place at the right time | 1.1 | Number/Percentage of Patients attending the UTC who are | 1.1.1 | >98% Triaged within 15 minutes of attendance at UCC | I |
| | | | | 1.1.2 | < 3% Referred onward to A&E | I |
| | | | | 1.1.3 | Referred directly to Speciality | S |
| | | | | 1.1.4 | >95%cDischarged with appropriate information for care | I |
| | | | | 1.1.5 | Discharged with guidance for self-care/management; | M |
| | | 1.2 | The % of adult patients who had initial clinical triage within 15 minutes | 1.2.1 | >98% are triaged within 15 minutes | I |
| | | 1.3 | The % of children who had initial clinical triage within 15 minutes | 1.3.1 | >98% are triaged within 15 minutes | I |
| | | 1.4 | The % of non emergency handovers from ambulance service taking less than 15 minutes | 1.4.1 | > 95% are handed over within 15 minutes of arrival | I |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | 1.5 | The % of patients treated and discharged within 2 hours in accordance with consultant complete model of care | 1.5.1 | >98% are discharged within 2 hours | I |
| | | 1.6 | The % of all patients presenting due to a mental health condition receive appropriate treatment and follow the mental care plan in line with Nice guidance | 1.6.1 | >90% receive appropriate treatment for mental health within agreed treatment plan | I |
| | | 1.7 | % of people leaving the UTC without being seen | 1.7.1 | <5% of attendances leave without being seen | I |
| | | 1.8 | The % of adults over 65 presenting due to a fall receive appropriate treatment and falls assessment takes place in line with Nice guidance | 1.8.1 | >98% of adults receiving treatment and assessment | I |
| | | 1.9 | The % of patients with booked appointments to be seen within 30 minutes | 1.9.1 | >98% of adults re seen within 30 mins of the prebookable appointment time | I |
| 2 | I was treated with high quality, safe, evidence based clinical care and by an appropriately qualified, knowledgeable and trained workforce who regularly up date their skills in line with the most up to date practice. | 2.1 | Comprehensive clinical pathways are developed and signed off via a robust and transparent governance process which must include oversight from senior clinical and medical staff as well as input from the commissioner . | 2.1.1 | 100% The service can provide details of the process in writing and can demonstrate it in progress. | M |
| | | 2.2 | Clinical pathways are in place, are up to date and accessible to all staff. | 2.2.1 | 100% of agreed pathways are in place and can be evidenced. | M |
| | | 2.3 | All prescribing within the clinical pathways is in line with the CCG formulary and guidance (Pan Mersey) and where this is not the case there has been discussion | 2.3.1 | 100% of agreed pathways are in line with CCG formulary and guidelines | M |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | with the commissioner to agree this deviation and the clinical rationale for it. | | | |
| | | 2.4 | The service performs regularly clinical audit of the clinical pathways and of prescribing to ensure adherence and to support learning. Schedule to be agreed with commissioner in Q1 of each year. | 2.4.1 | 100% clinical audits agreed with commissioner and completed within the agreed timescales with a submission of outcomes, actions and learning. | M |
| | | 2.5 | The service will audit antimicrobial prescribing (both PGD, PSD and FP10) at least annually and will demonstrate actions to evidence good antimicrobial stewardship within the service. To include peer discussion and challenge, data analysis, education and links to the CCG AMR programmes of work. Audits to be agreed with the commissioner in Q1 of each year. | 2.5.1 | 100% Agreement of audits, submission of audit reports and evidence of AMS?AMR activities as detailed. | M |
| | | 2.6 | The service will demonstrate a robust approach to management of clinical incidents and will positively support a culture of reporting and shared learning. | 2.6.1 | 100% evidence of incident management policy | M |
| | | | | 2.6.2 | 100% quarterly incident reports detailing themes and trends, actions taken and lessons learnt. | M |
| | | 2.7 | All Non-medical prescribers within the service undergo regular clinical supervision, have access to a mentor and work within their areas of competence. There will be a robust governance process to | 2.7.1 | 100% NMP policy in place | M |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | support the safe and effective uset of this skill mix. | | | |
| | | | | 2.7.2 | 100% ATP forms in place, clinical supervision records up to date and all prescribers registered with NHSBSA. Detailed via an annual report. | M |
| 3 | I had a positive experience of services and I feel confident in my treatment and the knowledge and understanding to manage my on-going care | 2.1 | % of patients with overall satisfaction of the service | 2.1.1 | >90% of responses from survey indicated an overall patient satisfaction of service - satisfactory indication or above | I |
| | | 2.2 | % of patients who's complaints or issues where followed up in a timely manner | 2.2.1 | 100% of complaints and issues where dealt within inline with complaints policy within contract | I |
| | | 2.3 | Identification of patients who are high intensity users of UTC's , ensuring they are accessing more appropriate local health and social care services for continued support | 2.3.1 | Identification of patients who have attended 5 times or more over a 3 month period | I |
| | | | | 2.3.2 | Those patients identified are supported with more appropriate wellbeing or care plans to manage conditions | I |
| | | 2.4 | Identification of patients who would benefit from short term rapid access rehabilitations to avoid unnecessary admission into secondary care. | 2.5.1 | Identification of patients who would benefit from short term rapid access rehabilitation | I |
| | | 2.6 | | 2.6.1 | Those patients identified are supported with onward referral into the short term rapid access rehabilitation team | I |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4 | I expect my treatment outcomes to be shared with relevant health and social care professional in a timely manner and ensure continuation of my care | 3.1 | Number of patients aged under 18 who's attendance information and treatment outcome is shared with relevant health visitor and school nurse by 8am 2 working days following attendance at the UTC | 3.1.1 | >98% of children's attendance is reported to the relevant healthcare professional | M |
| | | 3.2 | % of patients identified with mild to moderate mental health problems are furnished with the relevant information on the local IAPT service as party of the discharge | 3.2.1 | 100% of patients identified with mild to moderate mental health issues are given information on the local IAPT services | I |
| | | 3.3 | % of patients identified with acute mental health issues are referred for mental health assessment within 60 minutes of attendance at the UTC | 3.3.1 | >95% of patients with acute mental health are referred for assessment within 60 mins | I |
| | | 3.4 | | 3.3.2 | 100% of patients in mental health crisis are referred to the mental health crisis response team within 60 minutes of attendance at UTC | I |
| | | | Number of patients with a known learning disability had a discharge summary sent to the community team for learning disabilities by 8am the 2nd working day following attendance | 3.4.2 | 100% of LD patients have a discharge summary sent to LD community team within 2 working days of attendance at UCT | M |
| | | 3.5 | Number of patient contacts for children with known child protection plans notified to child protection services within an hour of attendance at the UTC | 3.5.1 | 100% of children with known child protection plan are notified to social services within an hour of attendance at UTC | M |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | 3.6 | Number of patients attending the UTC identified as a vulnerable adults to be notified to the safe guarding adults co-ordinator within an hour of attendance at the UTC | 3.6.1 | 100% of vulnerable adults are notified to the safeguarding co-ordinator within an hour of attendance at the UTS | M |
| 5 | I expect my NHS record to be updated correctly and concisely and data is being used appropriately and within guidelines to support service improvement. | 5.1 | % of patients over 18 asked smoking status and status recorded | 5.1.1 | >98% of patients are asked their smoking status and this is recorded | M |
| | | | | 5.1.2 | >98% of those recorded as a smoker are offered brief intervention and referral opportunity | M |
| | | 5.2 | % of non registered patients are helped to register with a GP | 5.2.1 | >98% of non registered Halton patients are helped to register with a local GP | M |
| | | 5.3 | Ensure all KPI's and outcome measures are recorded within agreed time schedules | 5.3.1 | 100% of measures are reported within agreed timescales as per the contract | I |
| | | 5.4 | Ensure NHS number of recoded all patients records | 5.4.1 | 100% of patients will have a recorded NHS number | M |
| | | 5.5 | Total number of serious untoward incidents are reported to STEIS on a monthly basis | 5.5.1 | 0 incidents are reported on a monthly basis | M |
| | | 5.6 | The maximum number of patient safety incidences per month | 5.6.1 | Less than 5 incidents per month | M |

**REPORT TO:** Health Policy & Performance Board

**DATE:** 25 February 2020

**REPORTING OFFICER:** Strategic Director, People

**PORTFOLIO:** Children, Education and Social Care

**SUBJECT:** Draft Scrutiny Review Report – Deprivation of Liberty Safeguards

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with the draft report written in conclusion to the Scrutiny Review of the Deprivation of Liberty Safeguards.

2.0 **RECOMMENDATION: That:**

***i) The Board comment on the findings of the Scrutiny Review; and***

***ii) The Board endorse the Scrutiny Review and its recommendations to go forward to the Executive Board; and***

***iii) The Board consider scrutiny topics for 2020.***

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 in response to the continued focus on Deprivation of Liberty Safeguards (DoLS) on the Council's Risk Register.

3.1.2 A scrutiny review topic group was called to action by Councillor Joan Lowe as Chair and operational support being led by the Helen Moir, Divisional Manager – Indepedant Living Services. The Principal Manager for the Integrated Adult Safgeuarding Unit and the Senior Service Development Officer from the Policy, Performance and Customer Care Team were present at each meeting to contribute information and record considerations towards recommendations.

3.1.3 As part of considerations by the topic group information and requirements for policy and procedural change were considered in respect of amended legislation. The Liberty Protection Safeguards (LPS) are to replace DoLS arrangements and, at the time of the

report being written, further Government Guidance was anticipated.

3.1.4 The topic group met between July and December with an open invitation to Members to participate throughout. Those Elected Members involved in the review are named in the report.

3.2 Scrutiny review

3.2.1 The review involved the participation of six Elected Members, including the Chair.

3.2.2 Activity undertaken included:

- Monthly meetings of the scrutiny review topic group;
- Reports and presentations made by key members of staff as well as services and partners involved in the DoLS process;
- The minutes for each review meeting were circulated to participants to check for accuracy.

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

3.3 Scrutiny Review 2020/21

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 2020/21:

3.3.2
- **'In-House' Care Homes –** What difference is it making?
- **The G.P. Hub** – Integration of Adult Social Care with GP practices (One Halton).
- **Are we Protecting People?** – The impact of finances on individuals who receive Adult Social Care.

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

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 New policies and procedures are already planned as part of implementation of the new Liberty Protection Safeguards (LPS) legislation. A further framework was requested as part ofhte topic group recommendations in relation to identification of self-funders.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The recommendations highlight a need to consider resource imlications of the new legislation.

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 safeguarding measures implemented in support of those most vulnerable in Halton's community.

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 current practice and planned transformation towards new legislative requirements. Taking on board the recommendations from the report will strengthen the Council's position in relation to recognition and understanding of their legal duties.

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.

HALTON BOROUGH COUNCIL

# Health Policy & Performance Board

# Scrutiny Review of Deprivation of Liberty Safeguards (DoLS)

# Report
# January 2020

## Contents



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# 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 Deprivation of Liberty Safeguards (DoLS), when and why they are enacted and what protections they offer individuals who lack mental capacity.
- To appreciate the Council's role in authorising DoLS and examine the resource implications of this.
- To consider the risks associated with non-fulfilment of DoLS authorisation duties and the control measures in place to mitigate risk.
- To recognise the performance monitoring processes for maintaining an overview of fulfilment of DoLS and the mechanisms for reporting back to Senior Management Team.
- To ensure the process and procedures for achievement of the Council's duties are effective and efficient.
- To reflect on those at risk of unlawful deprivation and the need to offer protection through interim processes (emergency authorisation).
- To evaluate the Council's work in partnership with care settings across the borough in communicating the legal requirements associated with DoLS.
- To benchmark Halton Borough Council's performance in the authorisation of DoLS in comparison to neighbouring authorities.
- To identify the change management process required to implement impending legislative changes.

# 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 2019 meeting.

2.2 This report will be presented to Health PPB in February 2020. The report will also be presented to Adult Social Care Senior Management Team, the Executive Board and boards or committees of stakeholders, as appropriate.

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# 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

| **Name and Title** |
|---|
| Councillor Joan Lowe – Scrutiny Chair |
| Helen Moir – Divisional Manager – Independent Living |
| Claire Richards – Registered Manager – Halton View Care Home |
| Councillor Eddie Dourley |
| Councillor Geoff Zygadllo |
| Councillor June Roberts |
| Councillor Margaret Ratcliffe |
| Councillor Pauline Sinnott |
| Dean Tierney – Principal Managers – Safeguarding |
| Dr Syed Javaid – Section 12 Doctor |
| Gill Valentine – Healthwatch Advocate |
| Marion Robinson – Group Solicitor – Legal Services |
| Neil Miller – Finance Officer |
| Nicola Hallmark – Senior Service Development Officer |
| Steve Westhead – Practice Manager - Safeguarding |
| Suzanne Salaman – Practice Manager – Policy, Performance and Customer Care |

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:

- Monthly meetings of the scrutiny review topic group;
- Reports and presentations made by key members of staff as well as services and partners involved in the DoLS process;
- The minutes for each review meeting were circulated to participants to check for accuracy.

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# 5.0 BACKGROUND

## 5.1 The Mental Capacity Act (2005)

5.1.1 Deprivation of Liberty Safeguards (DoLS) sit as 2009 amendments within The Mental Capacity Act (2005).

5.1.2 The Mental Capacity Act aims protect and empower those people who lack the mental capacity to make their own decisions. The law applies to those 18 years and over and operates under five key principles:

1. A person must be assumed to have capacity unless it is established that they lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

5.1.3 Those who lack decision making capacity may have dementia, a severe learning disability, acquired brain injury, have suffer a stroke or have other condition which affects their cognition. However, just because a person has a specific health conditions that affects the mind or brain does not automatically mean they lack the capacity to make a specific decision. Decision making capacity is considered under a two-part assessment:

1. Does the individual concerned have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

2. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make the specific decision.

   A person is unable to make a decision if they cannot:

   a) understand the information relevant to the decision, or
   b) retain that information for long enough to make the decision, or
   c) use or weigh up that information as part of the process of making the decision, or
   d) Communicate that decision.

## 5.2 Deprivation of Liberty Safeguards (DoLS)

5.2.1 Deprivation of Liberty Safeguards (DoLS) provide a legal framework under which adults in certain care settings (including care homes, nursing homes and hospitals) may have their freedom of movement restricted. They were brought into statute as part of the 2009 amends to the Mental Capacity Act and the legislation is implemented against a related Code of Practice.

5.2.2 DoLS apply to those people (aged 18 and above) who lack mental decision making capacity and who may be placed at harm if they were to be left unsupervised. DoLS represent a legitimate infringement of person's 'Right to Liberty' – Article 5 of the Human Rights Act 1998 – whilst considering a set of checks to ensure that arrangements are appropriate and in the person's best interests.

> "The Safeguards ensure that arbitrary decisions are not being made about a person's care and treatment because of their lack of capacity; that they are not subject to unnecessary supervision and control; that the person's wishes and interests are advocated in the most appropriate way; that all other options are explored and the least restrictive option is applied; and that there is a right of appeal against any decisions made."
>
> Source: *Halton Borough Council Mental Capacity Act – Deprivation of Liberty Safeguards Policy – May 2019*

5.2.3 For a DoLS to be lawful a rigorous process with six different assessments must be completed to define whether:

| | |
|---|---|
| 1. | The deprivation in the person's **best interests** |
| 2. | They fulfil the **age criteria** for detention under the Mental Capacity Act (age 18 years plus) |
| 3. | There are **no prior refusals** to the proposed care and treatment (Advanced Decisions/Lasting Power of Attorney) |
| 4. | The person lacks **mental capacity** |
| 5. | The person is suffering from a **mental health** disorder as defined by Mental Health Act 2007 |
| 6. | They meet **eligibility** criteria for detention under the Mental Health Act (as opposed to under the Mental Capacity Act) |

5.2.4 Within this process there are designated statutory responsibilities for which Halton Borough Council fulfil the role of 'Supervisory Body' and have accountability for authorisation of DoLS arrangements.

5.2.5 DoLS are non-transferrable and authorisation relates to a singular care setting. This means that a transfer of care (for example, a care home resident under a

DoLS is admitted to hospital) requires a new assessment and authorisation process to be embarked upon.

5.2.6 Following landmark case law in 2014 (P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council) the definition of what constitutes a deprivation of liberty was widened and clarified with two 'acid test' questions being set to define the need for the safeguards:

1. Is the person under continuous supervision and control?
2. Are they free to leave?

5.2.7 This ruling broadened the threshold under which a DoLS authorisation must be made, (included considering DoLS in relation to 'Supported Living' settings and the requirements to apply to the Court of Protection for authorisation of these) and resulted in a significant increase in applications for assessments. This has resulted in DoLS being repeatedly cited on the 'Corporate Risk Register' as posing concern for the Council. An ongoing backlog of applications and assessments is being managed to ensure that unlawful deprivation does not occur.

5.2.8 The Supervisory Body responsibilities for DoLS arrangements within Halton are manage through the 'Integrated Adult Safeguarding Unit'. This involves using a screening tool to support prioritisation of cases.

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## 5.3 Liberty Protection Safeguards

5.3.1 In response to common law changes the Government appointed the 'Law Commission' to report on the future of DoLS and the requirements for legislative amendments. Their recommendations concluded to repeal the existing DoLS authorisation process and replaces it with a new regime, 'Liberty Protection Safeguards' (LPS).

5.3.2 The new LPS aim to reduce the bureaucracy of current processes and applies safeguarding protections to all care settings. The body responsible for the care and treatment of a person will authorise the safeguards as 'necessary and proportionate', with a second tier of safeguards being performed should the person object to the arrangements. Here, objection will be further investigated by the new role of 'Approved Mental Capacity Professional'.

5.3.3 Where the subject of a deprivation is undergoing treatment in a hospital setting or as part of Continuing Health Care the relevant NHS Trust, Clinical Commissioning Group or private healthcare setting will assess and authorise arrangements; thereby relieving pressure on Local Authorities.

5.3.4 Other changes involve the Mental Capacity law being aligned to Mental Health legislation in terms of age criteria (applying to those 16 years of age and older), arrangements being transferable to different care settings, and review periods being extended (in certain circumstances).

5.3.5 The 2018 Mental Capacity (Amendment) Bill gained Royal Ascent in May 2019 with a view to implementation going 'live' in October 2020. This will involve a period of transition (and cross-over) with DoLS, finishing in October 2021. Currently care settings are awaiting the related 'Code of Practice' for the LPS to look at implementation requirements.

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# 6.0 EVIDENCE, ANALYSIS AND CONCLUSIONS

## 6.1 The Council role in the DoLS process, and current position related to risk

6.1.1 At the start of the scrutiny process the Board were provided with a comprehensive overview of DoLS legislation by the Principal Manager of the Council's Safeguarding Adults Unit.

6.1.2 The Board learned that those eligible for DoLS are supported by the Local Authority area in which they have 'ordinary residence', and that this means that some out-of-borough placements require authorisation by the Council. It was confirmed that the resource impact of this was not great.

6.1.3 The implications of the 2014 judgement (See Section 5.2.6) were the subject of discussion around risk, both in terms of potential unauthorised deprivation and increased resource requirements against the backdrop of no additional funding from central Government.

6.1.4 Explanation was given of the Council's response to the increase in request for DoLS since 2014 and it was clarified that the Council's Integrated Adult Safeguarding Unit monitor a current backlog of cases (awaiting assessment and authorisation) against a robust screening tool. Halton Borough Council backlog figures were given in comparison to neighbouring authorities and while a backlog remains the comparisons were favourable.

6.1.5 Oversight of the Council's role in the DoLS process, including where cases require 'Court of Protection' authorisation (where the service user is in Supported Living accommodation), is maintained through the Integrated Adult Safeguarding Unit and monitored through monthly reporting and statutory performance data returns.

6.1.6 In all presentations heard by the topic group requirements for legislative change were made clear and proposed transformation was explored. Expectations and requirements under the LPS were cited, including their implications for the Council. These are further discussed in Section 6.7

### *Conclusions*

- The current legislative process serves a valuable role in safeguarding the welfare and liberty rights of the individual.
- Case law changes have impacted significantly on the resource requirements of Local Authorities and are a determinate factor in the need for legislation reform. Delivery against current caseload requirements, with current resources is unrealistic.

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## 6.2 Monitoring and reporting of DoLS

6.2.1 Accurate, timely and consistent record keeping was explored as a vital element to assuring that DoLS arrangements are legitimate. The Board were advised as to the monitoring mechanisms adopted by the Council and reporting requirements placed on the Authority.

6.2.2 As DoLS are a statutory arrangement annual data reporting from the Council is mandatory. It was reported to the Board that the impact of the increased caseload following the 2014 judgement has similarly increased the data involved in the annual return. As a result the Adult Social Care Performance Team work closely with the Integrated Adult Safeguarding Unit to ensure records are kept up-to-date.

### *Conclusions*

- Monitoring of performance data for statutory returns is unwieldy and while the implications of change under new legislation are not fully understood at present it is expected that they will ease administrative burden in the longer-term.

## 6.3 The role of the BIA

6.3.1 Within the Council's remit for DoLS the role of the 'Best Interests Assessor' (BIA) was further explored as a pivotal player in the assessment and authorisation process. It was reported that BIAs are registered professionals (Adults' Social Workers for the Council) who undertake additional post-graduate training, annual update training and an active responsibility in an ongoing rota.

6.3.2 While the Council had nine BIAs up to 2013/14 the impact of the 'Cheshire West and Chester' case has increased assessment and authorisation requirements to such an extent that now a team of 28 BIAs operate across Adult Social Care for the Council. Due to the current backlog of cases overtime has been authorised across the work area.

6.3.3 Conducting up to four of the six assessments within the DoLS process the BIA role was explained as a vital safeguarding measure which ensures that any deprivation is legitimate. The Board were apprised with the knowledge that the 'Best Interests' assessment would always look at the 'least restrictive' options for giving care and support. They were told that this may result in conditions being recommended on the DoLS which would be reviewed and, if agreed, authorised by an Adult Social Care Divisional Manger.

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6.3.4 An additional resource requirement was identified for Halton Borough Council in relation to the recent acquisition and internal management of four older people's care homes. Here it was explained that the Supervisory Body (the Council) and the 'Managing Authority' (the care setting) cannot be the same organisation. As such the Council are required to outsource those element of the assessments undertaken by the BIA. This currently incurs a cost of around £300 per assessment where a DoLS request is made for a resident of a Halton Borough Council Care Home.

6.3.5 The Board heard that those supported through Adult Social Services to access permanent care home placements go through a set of assessment processes. Any subsequent safeguarding needs can then often be dealt with responsively with supporting casefile information, and may even by picked up in assessment reviews.

'Self-funders' were highlighted to the Board as those who enter paid care placement through a private arrangement, without public funding and often without the support or prior involvement of Local Authority Social Services. For this group of people the Council is reliant on the care setting to flag safeguarding needs, and for those care providers under a commissioning contract with Halton Borough Council this is a requirement.

Early identification of safeguarding needs (by the care setting) was cited as pivotal to ensuring timely and lawful deprivation of liberties are made where self-funders are concerned.

6.3.6 Queries were raised around potential loss of tenancies for rented accommodation following detention under a DoLS. Confirmation was given that the majority of those entering care under a DoLS are older people and would not return home. Where a person is to go into full-time care arrangements and they reside in social housing and Supported Living a 'grace' period can be arranged before they have to vacate the property. It was reiterated that those coming through the Council's social work process are supported according to their individual needs.

## *Conclusions*

- Members acknowledge DoLS as a complex legal safeguarding requirement in which the Local Authorities are currently required to play a central role.
- Person-centred working is fundamental to assuring that deprivations are legitimate and that DoLS arrangements are applicable to the individual needs of the service user/patient.
- The requirement on care settings to communicate the safeguarding needs of 'self-funders', (often previously unknown to the local authority, and who subsequently require Mental Capacity assessment and deprivation arrangements) needs to be re-stipulated as part of wider promotion and understanding of DoLS.
- Halton now owns four Care Homes which incur a cost implication for deprivation arrangements (external BIAs). This needs to be fully understood.

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# 6.4 The role of the Section 12 Doctor

6.4.1 A multi-agency approach to deprivation was highlighted as essential to the safeguarding measures involved in a DoLS process. 'Section 12 Doctors' are medical professionals who are equipped to undertake the diagnosis of a 'mental disorder' and to assess whether that disorder results from a Mental Capacity of Mental Health need.

6.4.2 The Board were notified that the Council pay Section 12 Doctors, per assessment, as part of the DoLS process. It was confirmed that this is common practice and that a local agreement with neighbouring authorities has set charges for Section 12 Doctor's at £100 per assessment; however aligned to the overall increase in assessments and authorisations since 2014, a rise in costs for the appointment of Section 12 Doctor has been seen.

6.4.3 Good working relationships were emphasized in Halton between the BIAs and Section 12 Doctors. It was deemed that this retained the focus on the individual service user's needs and a person-centred approach to care and support.

6.4.4 The presentation delivered by one of the Council's commissioned Section 12 Doctors further emphasized the need for DoLS to be transferable between of care settings. At present re-assessment is required where the care setting changes and this incurs a financial cost.

## *Conclusions*

- The role of Section 12 Doctors adds a further element of scrutiny to the DoLS processes and is working well in Halton.

# 6.5 Advocacy and DoLS

6.5.1 Halton Borough Council currently contract with 'Halton Healthwatch' for the delivery of independent advocacy services. This was introduced as both a legal and moral requirement for supporting those people with no alternative representation (e.g. family, carers). The role was described as practical and diverse, catering for people's different needs.

6.5.2 Advocacy services were explained as a statutory obligations which can be invoked under the Mental Capacity Act, the Care Act, and the Mental Health Act. Current resource for the borough involves two full-time posts and one part-time worker who deliver paid advocacy support under particular circumstances and at different stages in assessment processes.

6.5.3 For DoLS an 'Independent Mental Capacity Advocate' (IMCA) may be instructed by the Supervisory Body (the Council) at the start of the assessment process or following implementation of a legitimate deprivation. The Board were interested to learn that advocates can work in support of a service user themselves or in support of their representative (Relevant Person's Representative or RPR) where further understanding of procedure is required

or where there are challenges to the DoLS arrangements. In this sense the Advocacy service offers a further safeguarding step as part of the DoLS processes, as well as acting as a voice for the services user and often as an intermediary between families and social care services.

6.5.4 Advocates may also be working with services users or their carers outside of the DoLS process and may identify a need for a DoLS. Similarly to the work of the Section 12 Doctor strong relationships with the Council's Integrated Adult Safeguarding Unit were found to be a central factor in delivering effective and person-centred provision.

6.5.5 Members queried the advocacy resource requirements for out-of-borough placements. Reflections were made on the need to give greater consideration to Article 8 of the Human Rights Act – the right to see family – in respect of care placements outside of 'normal residency' area. Further response revolved around the increased need for services across the board, and due to the volume of DoLS following 2014, resulting in an increased lag in response time for picking up cases. It was anticipated that the new legislation would alleviate strain.

## *Conclusions*

- Advocacy services are a vital commissioned life-line for independent support both within DoLS and wider social care processes.
- Services capacity in Halton is saturated under current legislation.

# 6.6 DoLS in practice – A CQC Registered service

6.6.1 Under current legislation the Council, as Supervisory Body in the DoLS process, authorise DoLS arrangements for Care Home and Hospital settings. During the course of the scrutiny review Members heard from the Registered Manager of a Residential Care Home in Widnes, receiving her account of working practices in the borough.

6.6.2 Details were given of the referral route for instigating DoLS and further endorsement was made of the support available through the Integrated Adult Safeguarding Unit, in particular looking at the training made available to Care Homes.

6.6.3 It was acknowledge that an authorised DoLS arrangement is seen as an integral part of a person's individual care plan and as such is regularly revisited and reviewed as part of the Care Home's casework audits. Where a DoLS arrangement comes under a standard authorisation (currently covering up to 12 months) the Home would report any change in care needs impacting on the arrangements as they arise.

6.6.4 Inquiry was made around turnover of staff across social care, nationally, and the potential impact this has on fulfilling training needs. For the particular Care Home showcased this wasn't deemed to be a problem.

6.6.5 Members asked about the involvement of family in choosing a Care Home in Halton. It was confirmed that information is made available on all Homes and settlement visits can be made prior to a decision being taken.

## *Conclusions*

- The Independent Adult Safeguarding Unit work well with the agencies involved in the DoLS process, acting under a hub-and-spoke approach. It was felt however that greater interaction between all agencies could support better outcomes for service users.
- A need for pubic-facing, accessible and jargon-free information on the DoLS process was apparent to Members.

# 6.7 Liberty Protection Safeguards (LPS)

6.7.1 Interwoven throughout the topic group were references to, and plans towards, the implementation of legislative change. The DoLS framework has been repealed and will be replaced by the Liberty Protection Safeguards (LPS). Statute underpinning the LPS has been passed under the Mental Capacity (Amendments) 2019 and a Code of Practice is due to follow. Details were presented on current known requirements.

6.7.2 It was reported to the Board that the timelines for the implementation of LPS has changed a number of times - with the current proposed schedule illustrated in Appendix Three. This includes a transition period between DoLS and LPS.

6.7.3 The topic group learned that legislative reform aims to alleviate pressure on local authorities in particular. This will come in the form of a reduction in assessment processes (from six to three assessments), and fewer cases to be authorised by the Council with health services being responsible for arrangements in health-based settings.

6.7.4 The legislative changes have indicated that Care Homes could be responsible for authorising their own LPSs. Members heard that Halton Borough Council intend to retain oversight and maintain completion of assessment arrangements with commissioning Care Homes across the borough.

6.7.5 It was stated that under the new processes the BIA role (See Section 6.3) will change to that of an 'Approved Mental Capacity Professional' (AMCP). This will be a specialist role which undertakes further assessment where objections to an LPS are made. For all Authorities this will involve re-training implications; for Halton a consideration may arise where the role needs to be looked at in terms of parity with the current Approved Mental Health Professional (AMHP) role in Mental Health Services. This role is set at an Advanced level against the Professional Capabilities Framework for Social Work and is graded accordingly.

6.7.6 Amendments to the legislation will see the age criteria brought in-line with the Mental Health Act. This was well-received by Members in consideration of support for those with complex learning disabilities and those transitioning from Children and Family Services to Adult Services.

6.7.7 The Board identified that no additional funding has been identified to date for the implementation of the LPS. Concerns were also raised around the shifting timescales for the Code of Practice and the potential impact this has on the Council's readiness for implementation. The Board were assured with knowledge that Halton Borough Council have already established a working group to look at the changes.

6.7.8 Further measures to ease the burden for Local Authorities revolve around renewal period for LPS. Whereas current DoLS arrangements can cover a maximum of 12 months the LSP can be extended to three years following two periods of 12 months under the same arrangements.

## *Conclusions*

- Measures to relieve caseloads on Local Authorities were welcomed.
- Intent for the Council to continue to oversee Care Home authorisations was acknowledged as an appropriate safeguard.
- No additional funding and condensed timelines for implementation place pressure on Local Authorities.
- The LPS implementation working group needs to consider the requirements in relation to re-training and staffing structures once the LPS Code of Practice is made available.

# 6.8 Financial Implications of LPS

6.8.1 As part of information presented to the Board details were given of the current budgetary requirements for fulfilling DoLS obligations in Halton. It was conveyed that a relatively static budget is currently allocated to DoLS in Halton. Members identified that this comes from the 'base' budget and no additional 'Grant Funding' from Central Government is given in relation to the requirements.

6.8.2 It was reported that the budget for DoLS is broken down into staffing and non-staffing costs. The former covering dedicated roles within the Integrated Adult Safeguarding Unit while the latter is allocated to the procurement of the services of Section 12 Doctors and Independent BIAs.

6.8.3 Recap was made of the anticipated increase in the need to pay Independent BIAs going forward as a result of the Council's in-house care home provision. (See Section 6.3). Confirmation was given that this is being considered as part of the LPS working group remit.

## *Conclusions*

- DoLS, under current legislation, costs the Council around £50,000 per year.
- The implications of LPS on budgets is to be further investigated through the Council-led multi-agency implementation group.

# 6.9 Legal Implication of LPS

6.9.1 Elements of the information presented to the Topic Group from the Council's Group Solicitor echoed previous speakers and a succinct summary of impending legislative change was made.

6.9.2 It was understood that the involvement of the Council's Legal Services, for the most part, are in relation to applications to the Court of Protection being made. This requirement has, again, stemmed from case law and operates in relation to Supported Living settings. Confirmation was given that the quarterly monitoring reports brought to Policy and Performance Board do not currently cover these cases.

6.9.3 Consideration was given to the need to take cases through the Court of Protection where challenges to DoLS arrangements arise from family members. It was suggested that informal resolution would always be explored prior to the need for this, and that Advocacy Services would be involved in those circumstances.

6.9.4 It was confirmed with Members that the Court of Protection operates as a further step in the scrutiny process of DoLS arrangements. While it will serve the same function with LPS there are additional safeguards in the new processes, regarding situations where objections are made to the deprivation and in relation to the proposed AMCP role (See Section 6.7)

6.9.5 Reiteration was made of the alignment of the LPS legislation with the Mental Health Act in relation to age criteria, covering individuals from 16 years of age.

## *Conclusions*

- Implementation of legislative change has further potential ramifications for the Council which Members would like to be kept informed of.

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# 7.0 OVERALL CONCLUSION AND RECOMMENDATIONS TO HEALTH PPB

The Board found the review interesting and informative and extend their thanks to all involved.

They established that delivery of DoLS against the current legislative framework has seen a significant impact as a result of case law. As a result the resource implications for the Council have been challenging and legislative reform is welcomed.

The topic group recognise that Council management of staffing, finances, risk and reporting has been difficult following the significant increase in applications for DoLS. They commend the effective structures in place across all teams involved in DoLS processes and Council oversight and control of this situation.

Recommendations from the Board are made in consideration of the forthcoming changes under the Liberty Protection Safeguards (LPS).

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# Recommendations to the Health PPB:

Members recommend that:

1. The Council continue to work with the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and other relevant bodies to direct pressure at Central Government level in relation to additional funding needs associated with the implementation of LPS.

2. Endorsement is given to the proactive approach being taken to consider the requirements of legislative changes and the multi-agency working group arrangements being developed towards implementation of the new practices.

3. The increased cost implication for assessments for those people resident in Halton Borough Council owned care homes is recognised and the requirements are further planned into budgets.

4. Simplified information is developed to provide a better public understanding of DoLS, and LPS as its successor, which is easily accessible and jargon-free; and Members have access to this as well as relevant referral points. This is to be accompanied with further awareness raising (through the 'Provider Forums', contract meeting with commissioned providers, and via other mechanisms) with care settings to ensure that early identification of safeguarding needs is made, particularly for those people previously unknown to Adult Social Services (e.g. self-funders)

5. Regular reports are brought back to the Health Policy and Performance Board to inform Member on the implementation of LPS and indicate other associated practice, such as the volume of Court of Protection (community DoLS) applications managed by the Council and what resource implications these have.

6. Backing is given to the Council's standpoint on retaining oversight of the assessment processes for Care Home once Liberty Protection Safeguards are implemented.

7. Additional opportunity is explored on a regular and ongoing basis, and past the implementation of LPS, to bring together all agencies involved in the deprivation process (including the Local Authority, Advocacy Services, Section 12 Doctors, and Care Homes) to share best practice and identify development needs. It is recommended that this takes place annually as a minimum standard.

8. The constraints on advocacy services are recognised and the considered as part of the re-commissioning of provision.

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# Appendix One: Scrutiny Topic Brief

**Topic Title:** Deprivation of Liberty Safeguards

**Officer Lead:** Helen Moir – Divisional Manager – Independent Living

**Planned Start Date:** June 2019

**Target PPB Meeting:**

**Topic Description and Scope:**

This scrutiny review will examine the topic of Deprivation of Liberty Safeguards (DoLS). The study will look at the Council's duties under legislation, the processes for fulfilling these duties and the protection arrangements that safeguards adults who lack mental capacity from risk of harm. The Board intends to understand the impact of DoLS on the Council, the plans to embed legislative reform in light of the proposed Liberty Protection Safeguards and feedback on the propose service improvement recommendations.

**Why this topic was chosen:**

Following landmark case law in 2014 the threshold for authorisation of a DoL was broadened resulting in a significant increase in applications to Halton Borough Council. This has created an ongoing pressure in relation to volume and capacity for case work, which has been highlighted as an area of risk by the HPPB. As such DoLS consistently remains a factors highlighted on the Council's Corporate Risk Register.

This Board aims to examine the risk factors associated with DoLS both in terms of impact on individuals and on the Council.

The Deprivation of Liberty Safeguards are embedded into the Mental Capacity Act 2005, being introduced as amendments in 2007 and brought into practice in 2009. The safeguards are aimed at protecting people's human rights and personal liberty in situations where mental capacity has been lost. The legal framework underpinning DoLs ensures that any decisions made on behalf of a person or actions being taken are in their 'best interests' and that they are not subjected to any unnecessary supervision, control or restrictions.

As part of its Adult Social Care functions the Local Authority authorises DoLS as the 'Supervisory Body' in the legally binding process. This involves a range of responsibilities within the assessment process and the development of Adults' Social Workers as 'Best Interests Assessors', a designated role within the process which requires ongoing maintenance of knowledge and experience.

The Board will examine Halton Borough Council's role within DoLS, looking at resource requirements and efficiency of process, with the view of ensuring those most vulnerable in our community have their rights protected and their liberty safeguarded.

**Key outputs and outcomes sought:**

- To understand the DoLS, when and why they are enacted and what protections they offer individuals who lack mental capacity.
- To appreciate the Council's role in authorising DoLS and examine the resource implications of this.
- To consider the risks associated with non-fulfilment of DoLS authorisation duties and the control measures in place to mitigate risk.
- To recognise the performance monitoring processes for maintaining an overview of fulfilment of DoLS and the mechanisms for reporting back to Senior Management Team.
- To ensure the process and procedures for achievement of the Council's duties are effective and efficient.
- To reflect on those at risk of unlawful deprivation and the need to offer protection through interim processes (emergency authorisation).
- To evaluate the Council's work in partnership with care setting across the borough in communicating the legal requirements associated with DoLS.
- To benchmark Halton Borough Council's performance in the authorisation of DoLS in comparison to neighbouring authorities.
- To identify the change management process required to implement impending legislative changes.

**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 create a healthier community and work to promote wellbeing and a positive experience of life with good health, not simply an absence of disease, and offer opportunities for people to take responsibility for their health with the necessary support available.

- Promote independence of older people and vulnerable groups
- Improve Safety, Equality and Efficiency: Planned and Urgent Care
- To safeguard adults who are more vulnerable to physical, financial, sexual and emotional abuse

**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.

Agreed and signed by:

PPB chair …….  Officer …….

Date ……  Date …….



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# Appendix Two: Schedule of Activity

Health Policy and Performance Board - Deprivation of Liberty Safeguards – Scrutiny 2019-20 – Schedule of Activity
Topic: Deprivation of Liberty Safeguards

| Meeting | Action | Objective/Outcome | Responsible Officer |
|---|---|---|---|
| Tuesday 18th June – Board Meeting | Board formally agree of Topic Brief | | |
| Date: Tuesday 23 July<br>Time: 5.30pm to 7pm<br>Venue: Committee Room 1, Runcorn Town Hall. | Overview of DoLS – policy, procedure and practice – highlighting associated risks | • To understand the DoLS, when and why they are enacted and what protections they offer individuals who lack mental capacity.<br>• To consider the risks associated with non-fulfilment of DoLS authorisation duties and the control measures in place to mitigate risk.<br>• To ensure the process and procedures for achievement of the Council's duties are effective and efficient.<br>• To benchmark Halton Borough Council's performance in the authorisation of DoLS in comparison to neighbouring authorities. | Dean Tierney – Principal Manager (Safeguarding) |
| | Performance monitoring of DoLs | • To recognise the performance monitoring processes for maintaining an overview of fulfilment of DoLS and the mechanisms for reporting back to Senior Management Team.<br>• To benchmark Halton Borough Council's performance in the authorisation of DoLS in comparison to neighbouring authorities. | Suzanne Shepherd – Practice Manager – Policy, Performance and Customer Care |

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| Date: Wednesday 11 September<br>Time: 5.30pm to 7pm<br>Venue: Civic Suite, Runcorn Town Hall. | Section 12 doctor – role in the process and experience of working with Halton<br><br>Independent Mental Capacity Advocate – role in the process and experience of working with Halton<br><br>Registered Manager – care and support service working with DoLs on a day-to-day basis | • To evaluate the Council's work in partnership with care setting across the borough in communicating the legal requirements associated with DoLS. | Dr Syed Javaid – confirmed (short presentation and questions)<br><br>Gill Valentine (Q and A)<br><br>Claire Richards, Halton View |
| Date: Wednesday 6 November<br>Time: 5.30pm to 7pm<br>Venue: Committee Room 1, Runcorn Town Hall. | Best Interests Assessor – role in the DoLS process<br><br>Resource implications for the Council<br><br>Legal implication for the Council | • To ensure the process and procedures for achievement of the Council's duties are effective and efficient.<br>• To ensure the process and procedures for achievement of the Council's duties are effective and efficient.<br>• To appreciate the Council's role in authorising DoLS and examine the resource implications of this.<br>• To consider the risks associated with non-fulfilment of DoLS authorisation duties and the control measures in place to mitigate risk.<br>• To reflect on those at risk of unlawful deprivation and the need to offer protection through interim processes (emergency authorisation). | Steve Westhead, Practice Manager<br><br>Neil Miller, Finance Officer<br><br>Marion Robinson, Group Solicitor |

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|---|---|---|---|
| Date: Tuesday 10 December<br>Time: 5.30pm to 7pm<br>Venue: Committee Room 1, Runcorn Town Hall. | Review and recommendations | | Chair – Cllr Joan Lowe |

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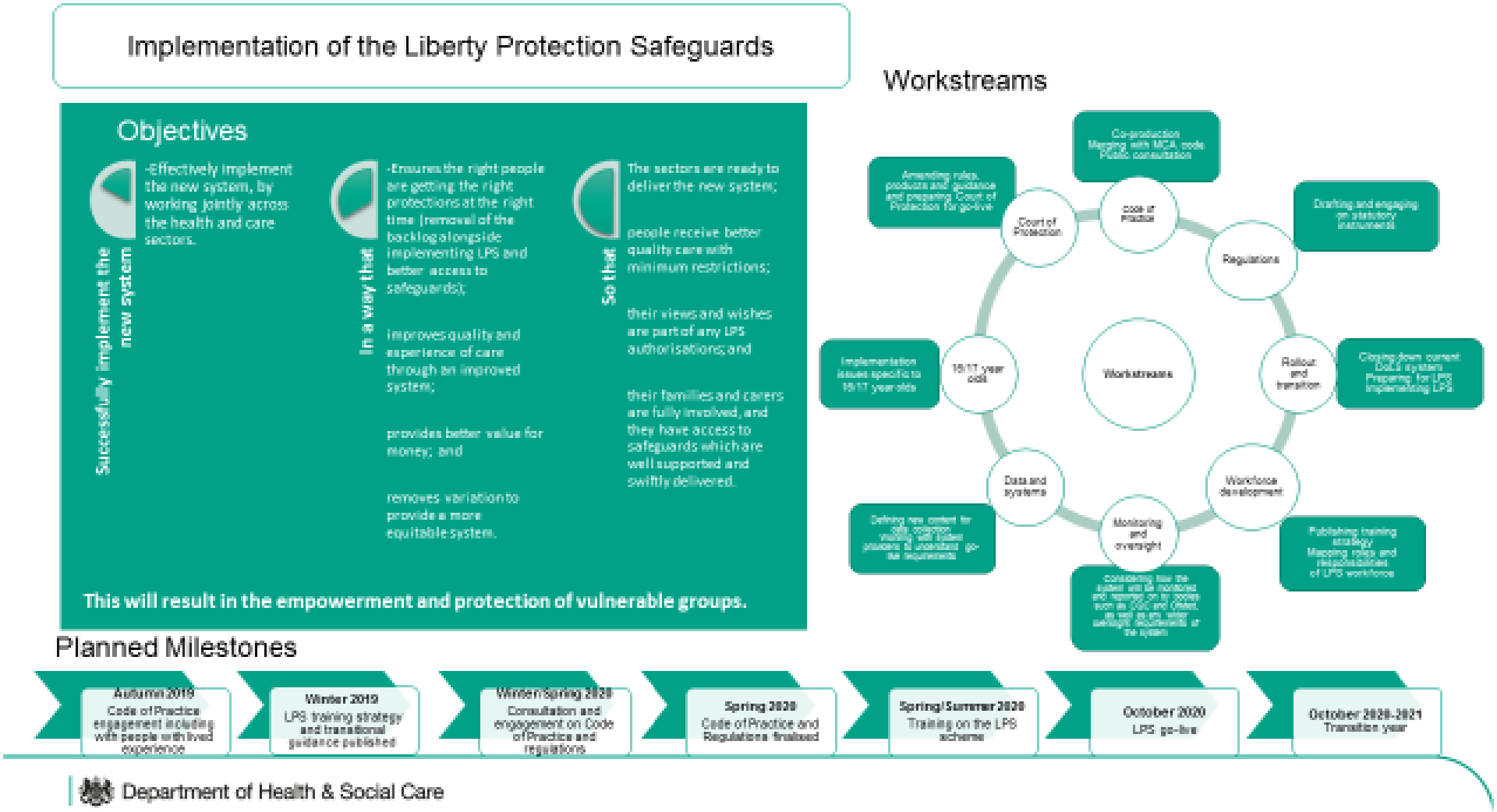
# Appendix Three – Government timescale for LPS implementation



## Appendix Four – Presentations (ATTACHED SEPARATELY)


IASU - DoLS presentation 23.07.1


Dr Javaid - 11 Sept 2019.ppt


6.11.19 A1 LPS IASU - BIA Presentation.p

## Appendix Five – Meeting Minutes (ATTACHED SEPARATELY)


Health Policy and Performance Board


Health Policy and Performance Board


Health Policy and Performance Board

## Appendix Six - Glossary of terms developed for Members (ATTACHED SEPARATELY)


GLOSSARY OF ACRONYMS.DOCX

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**Health Policy and Performance Board – Scrutiny Group**

**Topic:** Deprivation Liberty Safeguards

**Meeting Date:** Tuesday 23 July 2019

**Time:** 5.30-7.30pm (meeting finished at 6.25pm)

**Venue:** Council Chambers, Runcorn Town Hall

**Attendees:**

- Cllr Joan Lowe (Chair)
- Helen Moir (Lead Officer)
- Cllr Pauline Sinnott
- Cllr Margaret Ratcliffe
- Cllr Geoff Zygadllo
- Dean Tierney
- Suzanne Shepherd
- Nicola Hallmark – Policy support

Apologies:

- Cllr Julie Roberts
- Cllr Eddie Dourley
- Cllr Sandra Baker

| Discussions | Actions |
|---|---|
| **Topic group introduction**<br><br>Joan introduced topic area to be examined and thanked colleagues for their involvement in the scrutiny group.<br><br>Helen explained reasoning for choosing topic in relation to its place of the corporate risk register. She said that the scrutiny was timely due to imminent changes to process following legislative review. As a result the topic group should span over the period of change.<br><br>Helen briefly explained the structure of the safeguarding team, placing it as provision within her Divisional Manager remit. | |
| **Deprivation of Liberty Safeguards – Overview**<br><br>Dean introduced himself as Principal Manager of the Safeguarding team.<br><br>Dean went through his PowerPoint slide presentation.<br><br>Additional/supportive information given throughout: | |

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| Deprivation of Liberty Safeguards (DoLS) assessment are managed by the Supervisory Body (the Council) where the service user has 'normal residency'. (in the sense a DoLs may be managed by HBC where an out-of-borough placement is agreed but the person's normal residency is Halton).<br><br>HBC is currently the Supervisory Body for all DoLS which apply to care home or hospital placements.<br><br>When introduced in 2009 (as part of the Mental Capacity Act) the eligibility criteria (for what constitutes a deprivation) revolved around 'relative normality'.<br><br>Two types of application – standard or urgent – standard is the usual request.<br><br>No refusals assessment – Dean gave an example of a person who has previously (prior to loss of mental capacity) stated they do not want blood transfusions. This decision would stand where capacity is lost as it represents their advance wishes.<br><br>Up to 2013/14 Best Interest Assessors (BIAs) were primarily based in Mental Health.<br><br>Cheshire West and Chester case in 2014 defined the 'acid test' which opened up the criteria for application. At this time DoLS were additionally opened up to Supported Living.<br><br>Dean gave DoLS figures following case law representing a radical increase.<br><br>Dean explained an apparent dip in 2017/18 in relation to a backlog of applications.<br><br>BIAs gone from nine to 28 since the 2014 case – this has involved additional training and resource allocation.<br><br>Also increase in need for Section 12 Doctors – who are commissioning to undertake assessment to determine whether service user needs to be treated under Mental Health Act.<br><br>Dean explained that the Council have a need to monitor the backlog and that it creates a risk of litigation – hence being on Corporate Risk Register. He went on to say that other authorities have come under scrutiny following the Cheshire West and Chester case and while applications have substantially increase there has been no extra funding from Central Government.<br><br>Dean presented backlog figures in comparison to other areas. Request made for figures from similar size councils to Halton. | SS to supply |

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| Review of backlog explained by Dean and use of screening tool supports prioritisation.<br><br>Question raised in relation to situations where English is not first language. Dean explained that translation services would be sought and cited a bigger issue for Halton in relation to those who use sign language. He clarified that some upskilling was taking place across teams to support this.<br><br>Halton Borough Council Care Homes – Dean explained that DoLS legislation means that the Managing Authority and Supervisory Body cannot be the same person. As a result the Council will need to outsource part of the assessment process to external bodies where a DoLS application comes from one of our homes. Dean stated the going rate for external BIAs as £300 per assessment.<br><br>Section 12 Doctors – Dean explained the local agreement to set the charges and the savings made as a result.<br><br>Due to backlog overtime is currently authorised.<br><br>Dean referred to Liberty Protection Safeguards through, as forthcoming replacement for DoLS. He stated that once practice changes those on backlog would come under new assessment criteria, which is proposed to be less onerous.<br><br>Court of Protection (CoP) utilised for more complex case and for Supported Living applications. Dean gave an example of a case referred to CoP where a service user was placed out-of-borough following a 'best interests' assessment. He subsequently wanted to return to Halton and a Relevant Person's Representative (RPR) supported an appeal. Outcome was that care management are to continually review the case pending an in-borough placement (suitable to his needs) becoming available.<br><br>Dean expanded on the types of situations we could be criticised for and why it's important to continually risk assess.<br><br>Slides showed current Safeguarding Unit team setup – Dean explained expansion to meet changes.<br><br>Dean gave an overview of move towards Liberty Protection Safeguards (LPS) in response to widening of criteria as a result of Cheshire West and Chester case. He stated that the government commissioned the Law Commission to undertake a review and how this has led to legislative change. LPS guidance due to be issued Autumn 2019 and a period of transition will then take place. LPS are aimed at further embedding the Mental Capacity Act as a consideration from the start of care and support and puts the responsibility back on care managers | |

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| to get assessments right up-front. They will reduce the bureaucracy of the current assessment process with just three assessments.<br>Dean further explained that under LPS an assessment of mental disorder may be based on historical/retrospective assessment lessoning the need to commission Section 12 Doctors.<br><br>Dean and Helen confirmed that a steering group would be formed from September to plan and implement LPS.<br><br>Under the new processes BIA role will change to that of an Approved Mental Capacity Professional (AMCP) who would only conduct further assessment where a person is objecting to their arrangements.<br><br>Continuing Health Care (CHC) – where service users are full funded through CHC the Clincal Commissioning Group are responsible for making LPS arrangements.<br><br>LPS processes have previously indicated that care homes would undertake their own assessments and oversight of deprivations, however HBC is to remain supervision of this within the borough.<br><br>DoLS and LPS will run concurrently for a period of time to alleviate transition. Explanation given that this could impact on performance data submissions.<br><br>Potential recommendation proposed by Members – that more funding is required from central government to support the changes.<br><br>Question raised in relation to increase of applications following 2014 case and whether applications are warranted or whether organisations are acting with caution. Dean responded that the increase is due to the widening of who meet deprivation thresholds as a result of the 'acid test'. He stated that the test has been criticised as potentially subjective and this has been central to the need for legislative review.<br><br>Question raised about the need to protect social care staff from those who pose a risk and how this is dealt with for those who are under 18 years of age. Dean clarified that the Mental Health Act applies to all ages and that while the DoLs arrangements under the Mental Capacity Act currently on apply to those over 18 the LPS will reduce this threshold to 16 years.<br><br>Question raised around protecting others with vulnerabilities where DoLs would not apply. Dean explained that any incident of concern would be dealt with through safeguarding referrals, also coming under his team.<br><br>Question raised about people leaving a care home and the potential risks posed. Dean clarified that those with mental capacity are free to leave and where the Safeguarding Unit are made aware of potential illegal deprivations a letter is sent to settings and followed up. | |

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| **Performance – DoLS**<br><br>Suzanne explained that performance data on DoLS is collated for management and Member reporting and also for a statutory annual data return.<br><br>The annual return requires a lot of data to be captured and the increase in number of DoLS has had a substantial impact on achieving the return. Suzanne has worked closely with the Safeguarding Unit to assure capture of relevant requirements on the social care data management system (CareFirst6).<br><br>Suzanne stressed that the changes to data requirements following the introduction of the LPS are unknown as yet and further work will need to take place to look at this.<br><br>Question raised about impact of transition to LPS on quarterly monitoring reports. Suzanne agreed that a narrative would be added to explain the situation and figures for DoLS and LPS may need to run parallel for a period of time. JL requested some details of forthcoming changes in quarterly report so that Members can start to understand changes.<br><br>Helen reiterated that LPS would hopefully retain the value based of the Mental Capacity Act but reduce the administrative burden for the Council in the longer-term. | SS |
| **Proposed schedule of activity – topic group**<br><br>Member of the topic group reviewed the proposed schedule of activities and agreed the content for the September meeting.<br><br>Agreement reached that the agenda would be set on a monthly basis to acknowledge pending changes. | NH/DT to arrange speakers |
| **AOB**<br><br>No further actions were requested. | |
| **Next meeting:** Wednesday 11 September 2019 – 5.30 – 7.00 – Civic Suite, Runcorn Town Hall | |

Meeting closed 6.25pm

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# Deprivation of Liberty Safeguards (DOLS)

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Dean Tierney

Principal Manager

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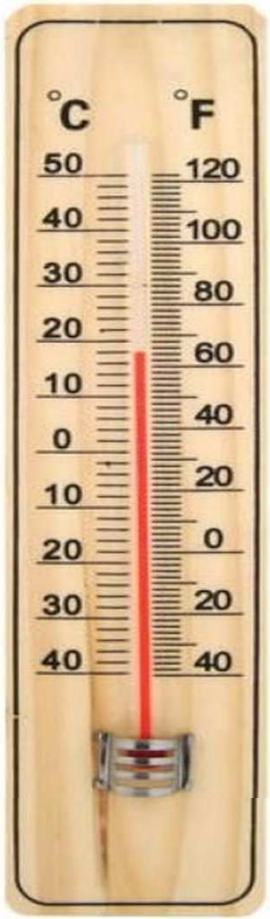
# DoLS – what do you know?




I know a lot?

I don’t know anything!

# Areas Covering today

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- When DOLS came into force and who they apply to.
- What is a DoL?
- DOLS process
  - Assessment phase
  - Authorisation phase
  - Review phase
- Current Climate
- Future

# Who will DoLS apply to?

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The deprivation of liberty safeguards will cover people in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements

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# When did DoLS commence?

## April 2009

## (as part of the Mental Capacity Act 2005, implemented in 2007)

# DoLS Law and Criteria (2009)

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- A deprivation of liberty is not in itself illegal, but it is, if not sanctioned by legal processes. (Article 5 of the ECHR)
- 2009 – Criteria for a DoL – occurs as a result of a number of restrictions placed on a person who lacks the capacity to consent these arrangements.
- Examples – restraint, forced care, electronic surveillance, medical restrictions, other restrictions.

# Requests

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- The Managing Authority (care home or hospital) requests authorisation to the Supervisory Body (the Local Authority who made the arrangements for care homes and the Local Authority where the Relevant Person is ordinary resident)
- Request for Standard Authorisation – planned admissions – 21 days
- Request for Urgent Authorisation – emergency admissions – 7 days (can extend to 14 if needed)

# Assessment Criteria

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- Conducted by a Best Interests Assessor (BIA) and Mental Health Assessor (MHA) (Section 12 Dr)
- **Age** – 18+
- **Mental Disorder** – any disorder of the mind or brain
- **Lack of Capacity** – consenting to care/arrangements
- **Eligibility** – is the Mental Health Act more appropriate? Risk to others?
- **No Refusals** – Advanced Decisions and right to refuse treatment
- **Best Interests** – least restrictive, proportionate given risk
- As part of the assessment process, the BIA needs to nominate someone to act on behalf of the Relevant Person – RPR
- Authorisation / non authorisation – criteria not met.

# Halton – referrals

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| Year | No of DoLS |
|---|---|
| 2009/10 | 12 |
| 2010/11 | 11 |
| 2011/12 | 34 |
| 2012/13 | 17 |
| 2013/14 | 33 |

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# Supreme Court Judgement March 2014

- CWAC Case
- Re-defined criteria for a DoL
- 'Acid Test'

- Lack capacity to consent to care and accommodation arrangements
- Not free to leave
- Under constant supervision and control

Floodgates opened – increase in referrals, no additional resource from Govt

- November 2014 – Re X Procedures
- Early 2015 – responsibility passed to IASU

# Halton Referrals

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| Year | No of DoLS |
|---|---|
| 2009/10 | 12 |
| 2010/11 | 11 |
| 2011/12 | 34 |
| 2012/13 | 17 |
| 2013/14 | 33 |
| 2014/15* | 183 |
| 2015/16 | 420 |
| 2016/17 | 623 |
| 2017/18 | 584 |
| 2018/19 | 630 |

- Not enough BIA's – now 28 trained – issues – time, pressures etc
- More resource for commissioning Section 12 Doctors
- Majority of people in care subject to a DoLS
- Litigation – unauthorised DoLS in place

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# Unlawful deprivation – Court of Protection case
# Essex County Council v RF & Ors (2015)

- P was 91 year old gentleman, a retired civil servant, who had served as a gunner with the RAF during the war. He had lived alone in his own house with his cat **Fluffy** since the death of his sister in 1998
- In May 2013 P was removed from his home by the local authority and placed in a locked dementia unit. It was not clear that P lacked capacity at the time and he was removed without any authorisation. The local authority eventually accepted that that P had been unlawfully deprived of his liberty for a period amounting to approximately 13 months
- A compromise agreement which included £60,000 damages for P's unlawful detention was agreed between the parties.
- https://www.39essex.com/cop_cases/essex-county-council-v-rf-ors/
- **Others**

- London Borough of Hillingdon v Neary [2011] EWHC 3522 (COP), a period of 12 months' detention resulted in an award of £35,000
- A Local Authority v Mr and Mrs D [2013] EWCOP B34, District Judge Mainwaring-Taylor approved an award of £15,000 (plus costs) to Mrs D for a period of 4 months unlawful detention

**an indication that the level of damages for the unlawful deprivation of an incapacitated person's liberty was between £3,000 and £4,000 per month**

# Backlogs – how are Halton doing?

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- June 2018 – 150 – backlog project – gone by October 2018
- June 2019 – 125

| LA Name | Backlog/unallocated assessments |
|---|---|
| Lancashire | 5000 |
| Hertfordshire | 5000 |
| Essex | 3467 |
| Hampshire | 4500 |
| Kent | 1686 |
| Birmingham | 1900 |
| Nottinghamshire | 1245 |
| West Sussex | 4400 |
| Devon | 2786 |
| Oxfordshire | 1400 |
| Leicestershire | 1200 |

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# Backlog case – Local Ombudsman Staffordshire

- Staffordshire Council - ombudsman report
- Decided not to carry out assessments of medium and low priority cases
- 3000 cases – unlawful deprivation
- Staffordshire – 'lack of financial resources'
- 74% of all standard requests were not assessed or assessed late and 92% of urgent requests were not assessed or assessed late.
- https://www.communitycare.co.uk/2019/04/03/councils-decision-stop-majority-dols-assessments-left-3000-without-legal-protection-ombudsman-finds/

# Extra Resource from Government 1 of 2

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- on the application of Liverpool CC (1) Nottinghamshire CC (2) LB of Richmond-upon-Thames (3) Shropshire Council -and- Secretary of State for Health, and Secretary for Communities and Local Government (Interested Party)[2017] EWHC 986 (Admin), Garnham J, 2 May 2017
- A judicial review brought by local authorities challenging the government for failing to fund them to meet the extra costs of the deprivation of liberty safeguards after the UKSC decision in the Cheshire West case was dismissed
- Liverpool, Nottingham, Richmond Upon Thames, Shropshire challenged CWAC case – Govt not providing resource to meet demand.
- Government created an unacceptable risk of illegality – New Burdens Doctrine
- The councils referred to the costings exercise undertaken by the Law Commission, arguing that in order to fund the deprivation of liberty safeguards properly the government would need to provide between £405,664,343 and £651,564,435.

# Following on

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- The court held:
- the claim was out of time and relief should be refused for that reason in any event;
- the councils are not unable to meet the costs of complying with their duties under the DoLS regime, although doing so is extremely difficult and involves diverting sums from other part of the councils' budgets;
- it followed that the government had not created a risk of illegality;
- the New Burdens Doctrine does not promise that local authorities will receive more funding from the government if a court judgment alters the understating of what is required of local authorities; there was therefore no breach of the doctrine.

Government therefore refused to offer additional resource to address backlogs following Supreme Court Judgement of March 2014

**https://www.gardencourtchambers.co.uk/news/social-welfare-updates/a-judicial-review-brought-by-local-authorities-challenging-the-government-for-failing-to-fund-them-to-meet-the-extra-costs-of-the-deprivation-of-liberty-safeguards-after-the-uksc-decision-in-the-cheshire-west-case-was-dismissed**

# Trained BIA's

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- In order to become a BIA, you need the following
- Social worker, Nurse, Psychologist, Occupational Therapist with over 2 years post qualification experience,
- Complete a post grad course at a university – 6 weeks (comparison – AMHP – course is over a year)
- Yearly legal update required for BIA's
- Halton in 2014 – 9 trained BIA's
- Halton in June 2019 – 28 trained BIA's

- Areas of concern
- BIA's unable to complete assessments due to other commitments/demands
- When the Managing Authority is the same as the Supervisory Body (care homes owned and managed by Halton Borough Council), the BIA needs to be someone who isn't employed by the LA (3.21 of the DoLS Code of Practice) = additional resource of £300 per assessment by a BIA plus £100 per assessment by Section 12 Doctor.

# Section 12's local agreement

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- Prior to January 2018, Section 12 Drs were paid £180 per assessment, plus mileage.
- A joint approach from neighbouring authoritiers (St Helens, Halton, Knowsley, Warrington) agreed to approach Section 12 Dr's to agree a new rate of £100 per assessment
- Section 12 Dr's have signed up for this.
- 2018 – approx. 300 assessments completed by Halton – saving of £24,000.00 for the year

# Measures to address backlog

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- Overtime – local agreement – implemented June 2019
- 3.21 code of Practice – council owned care homes – employ 1 BIA to complete assessments
- ADASS Screening Tool – rag rating – implemented 2017, updated 2018.

# Screening Tool for DoLS Requests

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| VERY HIGH | HIGH | MEDIUM | LOWER |
|---|---|---|---|
| • **Potential for Section 21(a) Challenge**<br>• **Continuous 1-1 during day and/or night, requiring restraint used frequently**<br>• **Restrictions on family/friend contact (or other Article 8 issue)**<br>• **Active attempts to leave**<br>• **Clear and active objection from person (Physical/Verbal) /friends/family**<br>• **Seclusion**<br>• **Physical restraint used regularly – equipment or persons** | • Psychiatric or Acute Hospital and not free to leave<br>• Continuous 1:1 care during the day and / or night<br>• Objections from family /friends<br>• Attempts to leave<br>• New or unstable placement<br>• Already subject to DoL about to expire<br>• Sedation/medication used frequently to control behaviour<br>• Section 17 leave | • Asking to leave but not consistently<br>• Not making any active attempts to leave<br>• Appears to be unsettled some of the time<br>• Restraint or medication used infrequently.<br>• Appears to meet some but not all aspects of the acid test<br>• DoLS and CTO<br>• Need for 39a IMCA to support with assessment process | • Minimal evidence of control and supervision<br>• No specific restraints or restrictions being used. E.g. in a care home not objecting, no additional restrictions in place.<br>• Have been living in the care home for some time ( at least a year )<br>• Settled placement in care home/hospital placement, no evidence of objection etc. but may meet the requirements of the acid test.<br>• End of life situations, which may meet the acid test but there will be no benefit to the person from the Safeguards |
| **Allocation/timeframes**<br>• **Very High Priority – allocated to BIA's within IASU. Timeframes need to be to.** | Allocation/timeframes<br>• High priority – allocated to Best Interests Assessors on BIA Rota to complete, within timeframes of requests for Urgent and Standard Authorisation – if IASU BIA's have no Very High cases, these can be allocated to them. Given priority over medium cases | Allocation/timeframes<br>• Medium Priority – allocated to Best Interests Assessors on the BIA Rota and given priority over lower priority cases | Allocation/timeframes<br>• Low priority – allocated to Best Interests Assessors on the BIA rota when there are no medium priority cases needing allocation<br>• Allocated to Overtime/Backlog arrangements within the Local Authority. |

# The IASU Team

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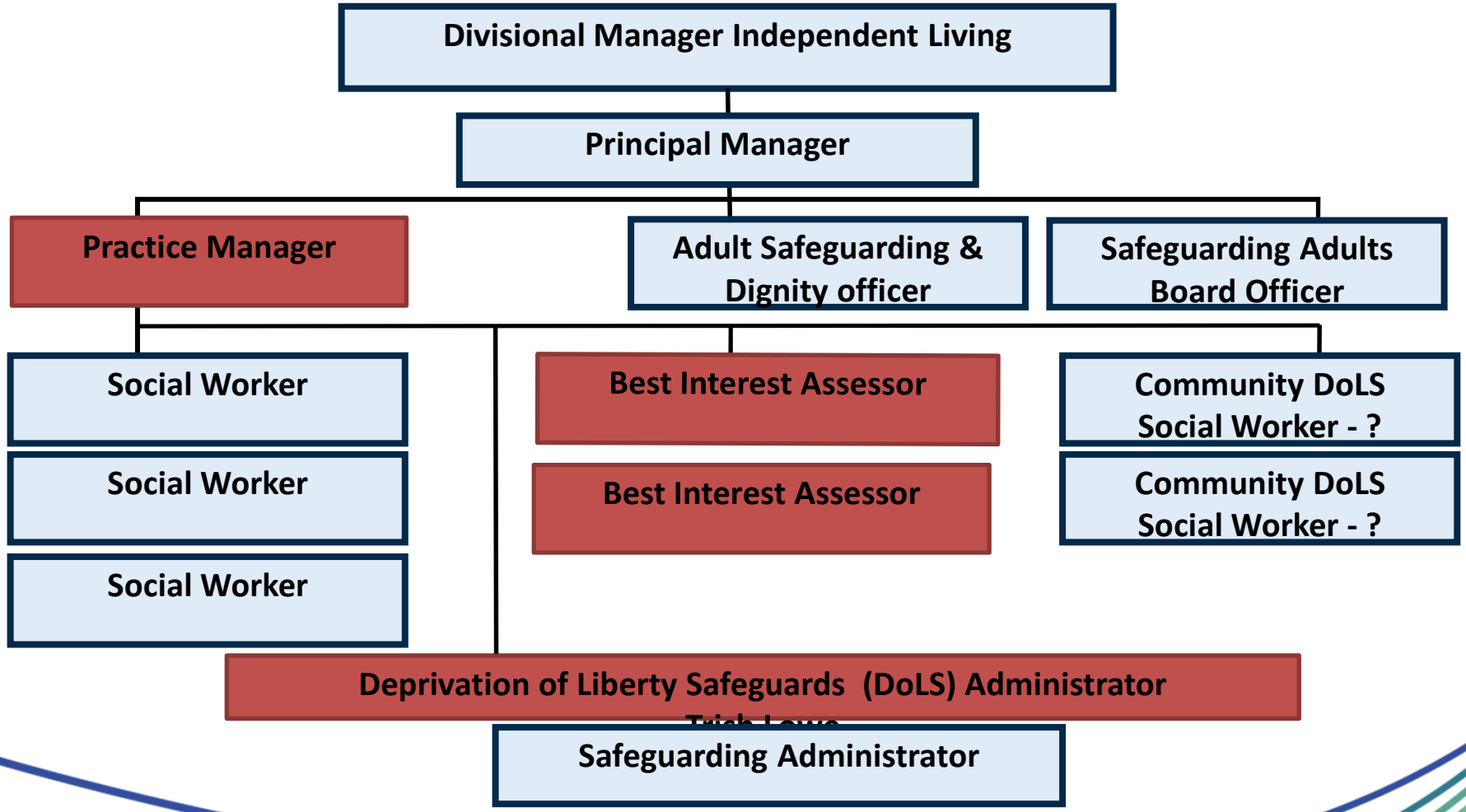

# DoLS being scrapped - LPS

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- CWAC case – DoLS not fit for purpose
- Law Commission commissioned to review Autumn 2014
- Findings - early 2017 – scrap DoLS and replace with LPS
- Mental Capacity (Amendment) Bill 2017-2019 passed by parliament 2019.
- Liberty Protection Safeguards – new process of proper embedding the Mental Capacity Act at the beginning of the assessment process
- BIA – AMCP
- 16/17 year olds – children's services / transition
- Independent hospitals – Local Authority in which they are living (not ordinary residence/commissioned by as in DoLS)
- Objection
- CCG/ Hospitals – do their own
- Code Of Practice – October 2019
- LPS implementation October 2020
- DoLS and LPS to run side by side for a year
- Assessments – Age, Mental Disorder, Necessarily and proportionate
- Section 12's – replaced by GP's – no additional resource.
- BIA – AMCP training – Local approach with ADASS MCA Lead

**A busy next 12-18 months for Local Authorities.**

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# Finally

Leaflets

- Your Rights
- Case Law – DoLS
- DoLS – easy read

Any questions?

**Health Policy and Performance Board – Scrutiny Group**

**Topic:** Deprivation of Liberty Safeguards

**Meeting Date:** Wednesday 7 November 2019

**Time:** 5.30 to 7.30pm (meeting finished at 6.45pm)

**Venue:** Civic Suite, Runcorn Town Hall

**Attendees:**

- Cllr Joan Lowe
- Cllr Geoff Zygadllo
- Cllr Margaret Ratcliffe
- Cllr Pauline Sinnott
- Cllr Eddie Dourley
- Helen Moir
- Steve Westhead
- Dean Tierney
- Marion Robinson
- Neil Miller
- Nicola Hallmark

**Apologies:**

- Cllr June Roberts

| Agenda/Discussions | Actions |
|---|---|
| Cllr Lowe led Introductions and thanked all for attending.<br><br>Minutes of the last meeting agreed | |
| **The Role of the Best Interests Assessor**<br><br>Steve Westhead, Practice Manager with the Safeguarding Unit gave a presentation.<br><br>6.11.19 A1 LPS IASU - DoLS presentation<br><br>Steve reviewed the context of Deprivation of Liberty Safeguards (DoLs) in order to highlight where the Best Interests Assessor (BIA) role sits.<br><br>Steve's presentation went through the six assessments that currently take place under DoLS.<br><br>He indicated that generally speaking the Section 12 Doctor would undertake assessments of: | |

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- Mental Disorder
- Eligibility

This leaves the other four assessment under the role of the BIA:

- Age
- Capacity
- No refusals
- Best Interests

He gave an overview of these assessments stating that the capacity and best interests may have already been undertaken as part of the care management process. This means that those people known to services and supported by the Local Authority may have had these assessments through social work intervention prior to a DoLs being sought. However, as part of the DOLS process they would have an additional capacity and best interests assessment.

Steve said that the role of the BIA was a safeguarding measure. The BIA ensures the deprivation is legitimate.

He stated that while those coming through social services with the Local Authority will already be picked up for assessment there is a potential gap where service users are self-funders. Here there is a reliance on the care setting to flag the requirements to assess.

Steve further explained the individual assessments:

Capacity – is a two stage test:

1. 'Does the person have impairment or disturbance in the functioning of the mind or brain?'
2. Where the answer to question one is 'no' then the person holds capacity. Where the answer to question one is 'yes', 'can the person make the relevant decision or not?'

No refusals – looks at whether an existing 'Last Power of Attorney' (LPA) for health and welfare matters is in place and whether this objects to any conditions of the DoL.
This raised a query around the different LPAs – Steve confirmed there are two aspects to them, one looking at financial decisions and one looking health and wellbeing issues. LPA covering both would need to state this.

Best Interests Assessment – examines the views and wishes of the individual prior to loss of capacity in terms of any contradictions to the proposed arrangements. This may involve discussions with family or carers and considers what is 'necessary and proportionate' to safeguard the welfare of the individual.
Steve pointed out that the Best Interests assessment may result in certain conditions being put on the DoLs arrangement and gave an example of a person heavily sedated where a DoLS might recommend a review of their medication if the sedation was disproportionate to need.

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| Steve said that the Best Interests assessment would always look at the 'least restrictive' options for delivering care and support.<br><br>Steve reiterated the DoLS 'acid test' at this point reminded Members that the subject of the DoL would need to be under continuous supervision and control and not free to leave.<br>He also reminded Members that currently a DoLS can be authorised for up to 12 months only – and open to review if changes occur.<br><br>Confirmation was given that BIAs must be a qualified professional with additional learning. He said that prior to the 2014 case law changes Halton has nine trained BIAs, they now currently have a rota of 22. These people, following qualification, additionally require a legal update on an annual basis.<br><br>Steve highlighted that BIAs employed by the council cannot assess individuals in our council owned care homes. It is not permitted that the statutory body and the managing authority are the same organisation. As a result additional funding is required for independent BIAs if a DoL is required in Madeline McKenna Court, Millbrow, St Luke's, St Patrick's or Oak Meadow.<br><br>Information was given around the role of the Relevant Person's Representative (RPR) who fulfils a monitoring role of the DoLS following authorisations. This is generally a family member or love one who is eligible to undertake the role. Where no RPR is available an advocate would be appointed.<br><br>Steve went on to say that once all assessment are complete they go to a signatory (relevant qualified Divisional Managers for Halton) for authorisation. If the BIA recommends conditions on the DoLS the signatory has to agree these for them to be enacted.<br>He stated that the signatory can also reduce the period of the DoLS if they feel there may be a change in circumstances.<br><br>Helen recapped that the DoLS were brought in to give an additional level of scrutiny. She asked Steve whether he thought they led to positive outcomes for the individual.<br>Steve expressed that it is important to add 'an extra set of eyes on the situation'.<br><br>The issue of self-funders being potentially overlooked was further brought up. Member suggested a recommendation that there needs to be some sort of procedure to capture self-funders in the borough and make sure they have access to the safeguards the framework provides. It was suggested that this needs to be something in writing to require managing authorities to inform the Local Authority (as Statutory Body) of self-funders. | |

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| Members raised queries around people with their own home who are taken into care. In particular where people rent could their tenancies be at risk?<br>Helen confirmed that the majority of people entering care under a DoLS are older people who will not return home. They are given six weeks grace for agreement to the arrangements before their property is vacated.<br>Further concern was raised around empty properties and possibility of vandalism. Helen specified that in the majority of cases there can be a lengthy Court of Protection process for family members to go through to gain ownership of the property.<br><br>The implications of the new Liberty Protection Safeguards (LPS) were discussed in relation to the suggestion of care home undertaking their own assessments. Helen confirmed that Halton will continue with assessment and will not be going down the route of having care homes authorise their own deprivations.<br>Recommendation: Members endorse the approach the Local Authority are intending to take in relation to the new Liberty Protection Safeguards and continuing to support care homes with assessment of deprivations. | |
| **The financial/resource implications of DoLS**<br><br>Neil Miller, Adult Social Care Finance Officer, gave an overview of the budget requirements related to the delivery of the Council's duties around DoLS.<br><br>He said that the monetary side of the arrangements was relatively uncomplicated and involves a staffing budget and a non-staffing budget. The latter is currently set at £50K and covers costs for Section 12 Doctors and Independent BIAs.<br><br>Neil confirmed that this budget is relatively static and last year a total of £45K was paid out.<br><br>He said that the Section 12 Doctors have a set fee of £100 and that this cost has reduced as a result of a negotiated local agreement.<br><br>Confirmation was given that there will be an increase in the need for BIAs going forward to account for our in-house homes.<br>Helen established that this situation is to be monitored through the LPS working group and that a scoping exercise has already taken place to look at the numbers of DoLS within these settings.<br><br>Cllr Lowe asked whether we are up-to-date with DoLS or whether there is still a backlog.<br>Dean said that the current backlog is around 150 cases but that this was good in comparison to neighbouring authorities.<br><br>Neil clarified that funding for DoLs comes from base budget and that there is no central government grant funding related to the requirements. | |

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| **Legal Perspectives**<br><br>Marion Robinson, Group Solicitor for Halton Borough Council gave a handout with an overview of the legal aspects of deprivations of liberty.<br><br>She echoed previous speakers to the group by saying that the DoLS amounts to a legitimate breach of Article 5 of Humans Rights.<br><br>She gave an overview of proposed differences between DoLS and LPS, stating that LPS covers:<br><br>• 16-18 year olds (bringing it in-line with the Mental Health Act)<br>• A wider range of settings<br>• Is portable between settings<br>• A longer authorisation period (in certain situations/cases)<br><br>She suggested that the LPS look to be a simpler and quick process but that further requirements are still to be defined in the Code of Practice.<br>Dean shared a suggested timeline for implementation of the LPS.<br><br>  <br>LPS implementation<br>- DHSC plan on a pa<br><br>It was confirmed that cases are currently being taken through legal processes in relation to Court of Protection applications. This is mainly for those in supported living accommodation. Helen confirmed that the quarterly monitoring forms taken to PPB do not cover these but that the LPS should alleviate the burden of going through this process.<br><br>Marion indicated that the current backlog would not reduce significantly in the short-term following the implementation of the LPS, but will take time.<br><br>Members asked whether many challenges were made by family members. Dean stated that very few cases go through to the Court of Protection as a result of disagreement/objection to a DoL and that the Council would always look to resolve situation informally first.<br><br>Member went on to ask whether any objections were successful. Dean said that the majority of objections are due to conditions places on the DoL and that the Court of Protection adds additional scrutiny to the arrangements.<br>Dean stressed that the team look to manage family expectation in relation to DoLS, particularly where they may expect a higher level of care and may make a complaint around this. He confirmed that social services can't restrict family member from contact with the service user but the Court of Protection can.<br><br>Further information was given that the LPS will require three assessments instead of the current six and that if there is an element of objection the | |

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| new Approved Mental Capacity Professional role will deal with this, rather than the current BIA.<br><br>A concern was raised over the welfare of a particular young person in the borough. Dean reiterated that the LPS will come in-line with the Mental Health Act in that it will cover 16-18 years of age. He said this adds a level of scrutiny for cases involving younger people who may have conditions such a learning disability or an acquired brain injury.<br><br>Marion recapped that the LPS is predicted to come in from October 2020.<br><br>Member suggested a recommendation: PPB needs to be kept up-to-date of changes and their implications as they occur. | |
| **Next meeting**<br><br>The Chair agreed that the next meeting would involve an overview of the information to date and the proposed recommendations coming from discussions.<br><br>Recommendation will then be agreed to be incorporated into the final report.<br><br>**Cllr Lowe requested that Member endeavour to attend the December meeting where possible to ensure the recommendations agreed are unanimous and therefore robust. She acknowledged the close proximity to the election and expressed appreciation of colleagues' time.** | HM to liaise with NH to look at a synopsis of information to date. |

Meeting closed: 18.45

Next meeting: Tuesday 10 December – 5.30 to 7pm – Committee Room 1

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# Deprivation of Liberty Safeguards (DoLS)

## Role of the BIA

# Who will DoLS apply to?

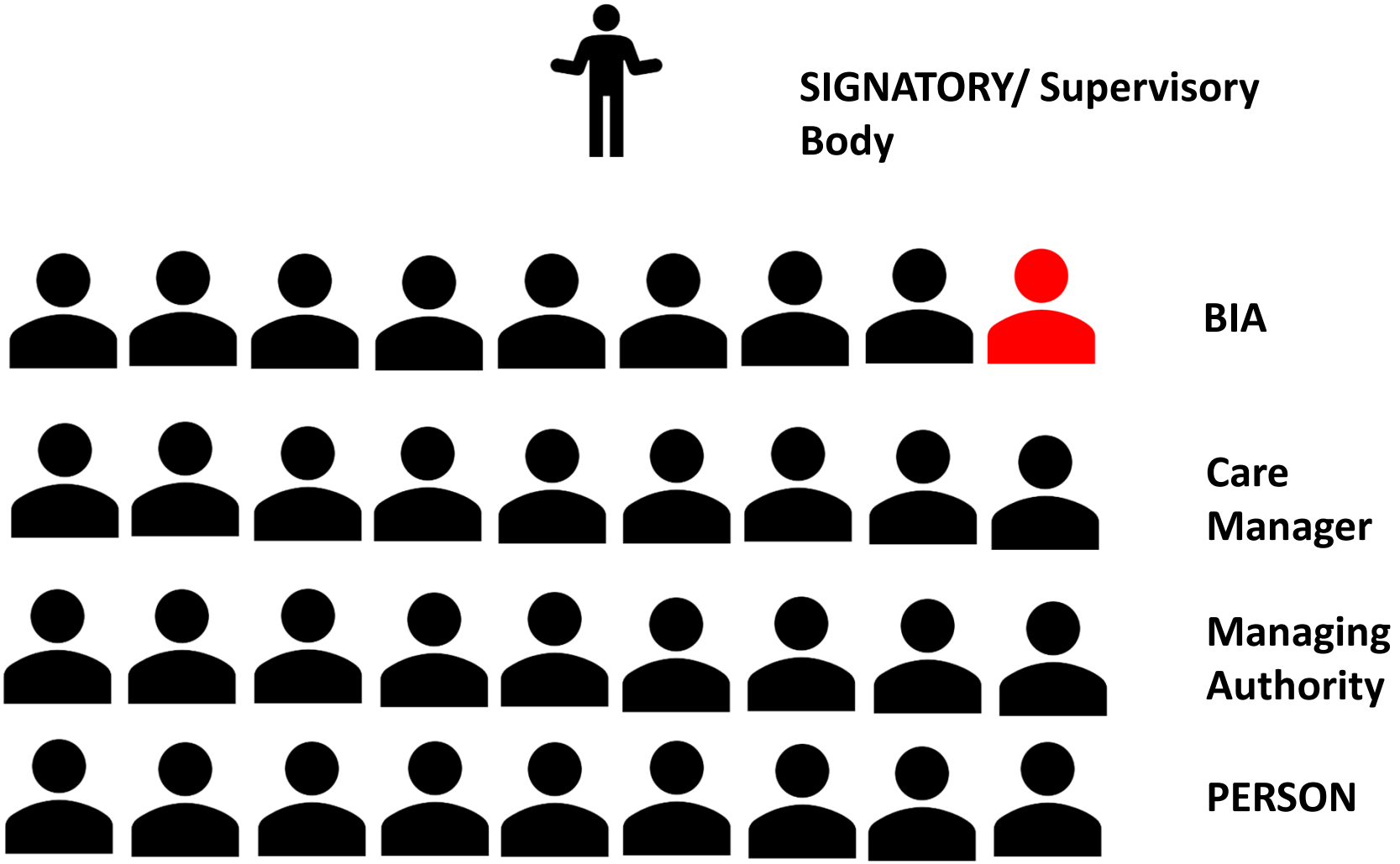
The deprivation of liberty safeguards will cover people in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements

# Requests

- The Managing Authority (care home or hospital) requests authorisation to the Supervisory Body (the Local Authority who made the arrangements for care homes and the Local Authority where the Relevant Person is ordinary resident)
- Request for Standard Authorisation – planned admissions – 21 days
- Request for Urgent Authorisation – emergency admissions – 7 days (can extend to 14 if needed)

# Assessment Criteria

- **Age** – 18+
- **Mental Disorder** – any disorder of the mind or brain MHA83
- **Lack of Capacity.**
- **Eligibility** – is the Mental Health Act more appropriate? Risk to others?
- **No Refusals.**
- **Best Interests.**
- **Assessments are completed by a Best Interests Assessor (BIA) and Mental Health Assessor (MHA) (Section 12 Dr)**


SIGNATORY/ Supervisory Body
BIA
Care Manager
Managing Authority
PERSON

# Trained BIA's

- In order to become a BIA, you need the following
- Social worker, Nurse, Psychologist, Occupational Therapist with over 2 years post qualification experience,
- Complete a post grad course at a university – 6 weeks (comparison – AMHP – course is over a year)
- Yearly legal update required for BIA's
- Halton in 2014 – 9 trained BIA's
- Halton in June 2019 – 28 trained BIA's

- Areas of concern
- When the Managing Authority is the same as the Supervisory Body (care homes owned and managed by Halton Borough Council), the BIA needs to be someone who isn't employed by the LA (3.21 of the DoLS Code of Practice)

# Mental Capacity

- **Stage One:** What is the impairment of, or disturbance in the functioning of the mind or brain?
- **Stage Two: (functional test);**
- **The person is unable to understand the information relevant to the decision**
- **The person is unable to retain the information relevant to the decision**
- **The person is unable to use or weigh that information as part of the process of making the decision**
- **The person is unable to communicate their decision**
- **Stage Three:** *Explain why the person is unable to make the specific decision because of the impairment of, or disturbance in the functioning of, the mind or brain.*

# No Refusals Assessment

- To the best of my knowledge and belief the requested Standard Authorisation **would not** conflict with an Advance Decision to refuse medical treatment or a decision by a Lasting Power of Attorney, or Deputy, for Health and Welfare.
- To the best of my knowledge and belief the requested Standard Authorisation **would** conflict with an Advance Decision to refuse medical treatment or a decision by a Lasting Power of Attorney, or Deputy, for Health and Welfare.
- There is not a valid Advance Decision, Lasting Power of Attorney or Deputy for Health and Welfare in place.

# Best Interests Assessment

- **BACKGROUND INFORMATION**
- **VIEWS OF THE RELEVANT PERSON**
- **VIEWS OF OTHERS**
- **ACID TEST:** *Do they meet the acid test of continuous (or complete) supervision AND control AND are not free to leave.* The placement is imputable to the State.
- **It is necessary to deprive the person of their liberty in this way in order to prevent harm to the person.** *Describe the risks of harm to the person that could arise which make the deprivation of liberty necessary. Support this with examples and dates where possible. Include severity of any actual harm and the likelihood of this happening again.*
- **Depriving the person of their liberty in this way is a proportionate response to the likelihood that the person will otherwise suffer harm and to the seriousness of that harm.** *With reference to the risks of harm described above explain why deprivation of liberty is justified. Detail how likely it is that harm will arise (i.e. is the level of risk sufficient to justify a step as serious as depriving a person of liberty?). Why is there no less restrictive option? What else has been explored? Why is depriving the person of liberty a proportionate response to the risks of harm described above?*

# Best Interests Assessment

- **This is in the person's best interests.**
- *Remember that the purpose of the person's deprivation of liberty must be to give them care or treatment. You must consider whether any care or treatment can be provided effectively in a way that is less restrictive of their rights and freedom of action. You should provide evidence of the options considered. In line with best practice this should consider not just health related matters but also emotional, social and psychological wellbeing.*
- **Option 1:**
- Benefits and Burdens
- **Option 2:**
- Benefits and Burdens
- **The reasons for choosing this period of time are:** *Please explain your reason(s)*
- **RECOMMENDATIONS AS TO CONDITIONS**

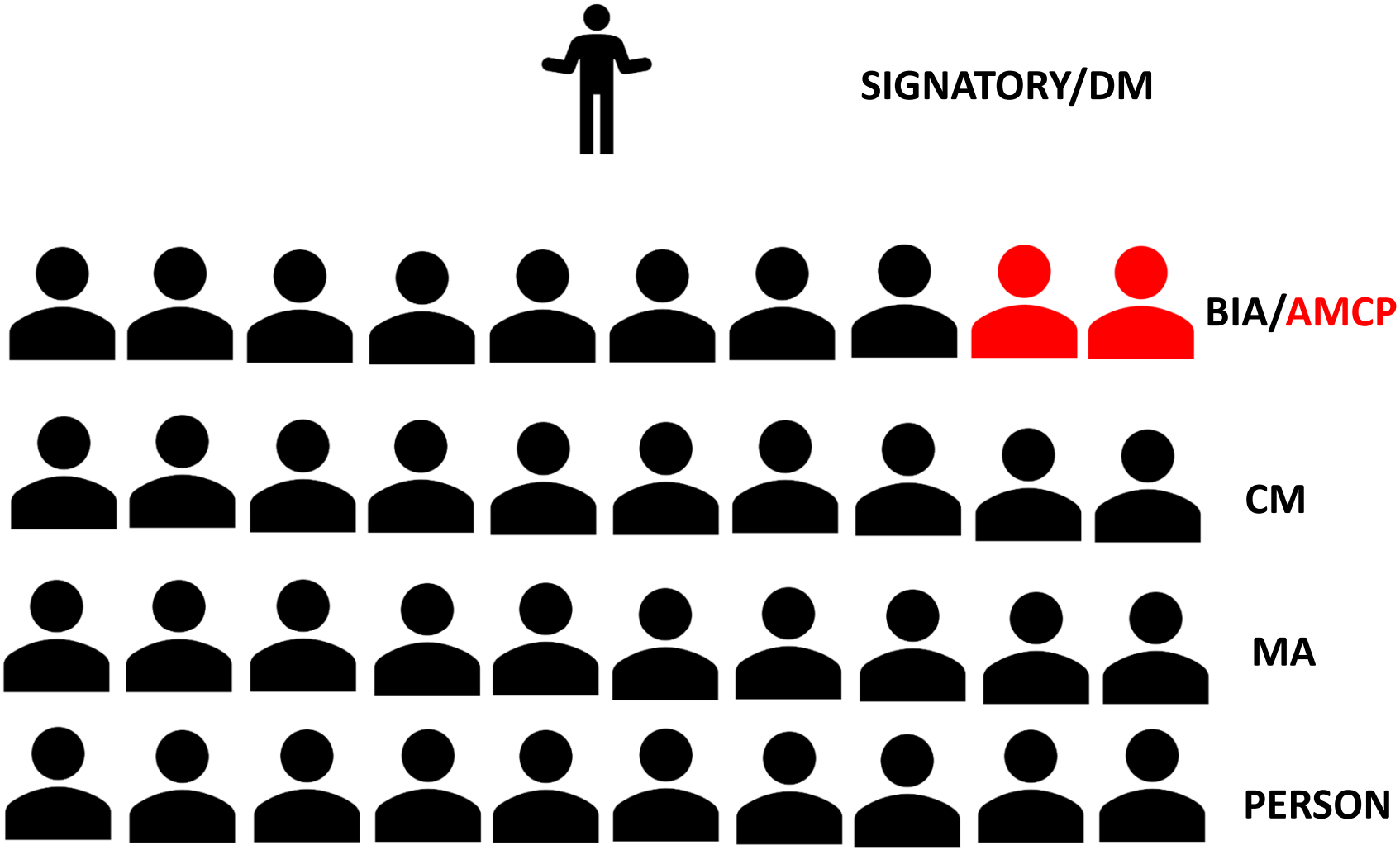
# Selection of Representative

- I have selected and recommend that the Supervisory Body appoints the representative identified below. In so doing I confirm that:
- the person this assessment is about (who may have capacity but does not wish to select a representative) and / or their Donee or Deputy does not object to my recommendation;
- the proposed representative agrees to act as such, is eligible, and would in my opinion maintain contact with the person, represent and support them in matters relating to or connected with the Standard Authorisation if appointed. (*Read guidance notes for clarification of eligibility).*
- ***PAID Relevant Persons Representative.***

# Authorisation

- Signatory from Supervisory Body (HBC).
- Scrutinises assessments to see if legal criteria met.
- Agrees conditions.
- Agrees time period.
- Gives authorisation on behalf of Supervisory Body.

# LPS



Any questions?

**Health Policy and Performance Board – Scrutiny Group**

**Topic:** Deprivation of Liberty Safeguards

**Meeting Date:** Wednesday 11 September 2019

**Time:** 5.30 to 7.30pm (meeting finished at 6.55pm)

**Venue:** Civic Suite, Runcorn Town Hall

**Attendees:**

- Cllr Joan Lowe
- Cllr Geoff Zygadllo
- Gill Valentine – Healthwatch Advocate
- Cllr Margaret Ratcliffe
- Cllr June Roberts
- Dr Javaid
- Helen Moir
- Steve Westhead
- Claire Richards

| Agenda/Discussions | Actions |
|---|---|
| Introductions made<br><br>Minutes of the last meeting agreed<br><br>Recommendation following last meeting discussed in relation to having a guide for Members and public that is accessible and jargon-free | <br><br><br><br>HM/DT |
| **The Role of a Section 12 Doctor**<br><br>Dr Syed Javaid gave a presentation as an experienced Section 12 Doctor which the Council currently uses.<br>  <br>Dr Javaid - 11 Sept 2019.ppt<br><br>Dr Javaid explained that he is an NHS consultant and a later life psychiatrist. He has been a DoLS/Mental Health assessor since 2015. He undertakes work for Halton and other authorities and has gained wide experience over this period.<br><br>Dr Javaid stated that the notion of individual liberty rights goes back to wording in the Magna Carta and is a fundamental right within current legislation.<br><br>Dr Javaid explained the requirements for a multi-agency approach to depriving a person of their liberty and this is where DoLS have been established, as an amendments to the Mental Capacity Act in 2009. | |

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| He clarified that decision making is both time and decision specific. Where a person's decision-making is questioned it needs to be considered in relation to the specific decision and their state of mind at the time.<br><br>He talked through principles of Mental Capacity Act and cited a 2-stage test for Mental Capacity. He pointed out that stage one doesn't automatically bring about stage two – and that this is a diagnostic test where both criteria have to be fulfilled to move forward with further assessment of the specific decision making.<br><br>For an individual to be deemed to have mental capacity for decision making they must then pass all four further thresholds – being able to understand the information being presented to them, being able to retain it, being able to use it appropriately to make the decision and being able to communicate their decision as a result.<br><br>He discussed the many forms that deprivations can take and gave case law details following on from the Cheshire West and Chester case which have altered the DoLS landscape.<br><br>Dr Javaid explained that continuous supervision and control during care and treatment involves managing a person's whereabouts and in doing so this restricts their liberties. He stressed the importance of 'objection' as key to whether a person might be deprived or their liberty of not.<br><br>Dr Javaid referenced the current restrictions of the system in terms of a DoLS being non-transferrable/setting specific.<br><br>Dr Javaid expressed that he felt that the awareness and understanding of DoLS has improved over the past few years and talked about the interaction with the BIA role.<br><br>Questions arising:<br><br>How does Halton differ from other areas? – Dr Javaid said Halton is one of the few Local Authorities that ask for Mental Capacity as well as Mental Health assessments. He prefers this as it gives options to explore wider than one or other. He said that Best Interest Assessors in Halton tend to be more forthcoming about discussing outcomes for the individual and this assures him that services are person-centred. He said that he would rate Halton highly as still maintaining human element.<br>Members commended this approach. | |
| **The Role of the Advocate**<br><br>Gill Valentine introduced herself as working for the Healthwatch Halton Advocacy Hub, contracted to provide advocacy under Care Act, Mental Capacity Act and Mental Health Act. She said that the Hub hosts two full time and one part-time post. | |

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Gill is the main Independent Mental Capacity Advocate within the team and the role is required in certain circumstances.

She confirmed that advocacy can be offered under the Care Act but it is not necessarily a requirement. With Mental Capacity cases there may be a requirements for an IMCA under:

- Section 39a
- Section 39c
- Section 39d

Also as:

- A Relevant Persons Representative (RPR)
- A litigation friend
- Or a 1.2 Representative

Gill went on to explain these roles further.

Section 39a – where a care home manager requests support for an individual going through a standard DoLS authorisation – advocate checks assessments have taken place appropriately – can raise concerns with BIA/Sec 12 Dr. 39a ceases once authorisation in place.

39c – standard authorisations in place and no RPR. Often times there has been an RPR in place but they are unable to continue; that's when 39c comes in.

39d – RPR in place – advocate can go in to support RPR or the service user themselves where there are challenges or where the RPR is not acting in their best interests. An application can be made to the Court of Protection to remove an RPR.

Instruction is made through the supervisory body to take up a position as a paid RPR – where no other available – the advocate will then support and represent and ensure conditions of DoLS are being delivered upon. (i.e. least restrictive)

Gill said the team work closely with the Safeguarding unit in Halton and will identify where people haven't got support or where they feel an unauthorised deprivations may be taking place. This can result in safeguarding referrals being made, or can see a Court of Protections case being brought.

Gill finds teams in Halton very approachable – with the individual at the core of the work. It's always person-centred

Litigation friend – 'not a role we in Halton at present'.

Gill went on to say that the new legislation coming into effect presents new challenges but DoLS will run alongside Liberty Protection Safeguards for 12 months so there will be time to embed new practices. She expressed that the new legislation should streamline processes and

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| reiterated that code of practice is an awaited document and that this will give greater detail on how advocacy services may be affected.<br><br>Gill said that her role is a very practical and diverse one and that people need support at different levels.<br><br>She went on to say that because of limits to available care provisions in Halton there are some out of borough placements that are supported. Demand is getting higher and it is hoped the new legislation will alleviate the strain.<br><br>Question raised:<br><br>Can Members have a glossary of terms? – agreed<br><br>Caseload level questioned – Gill said that being a statutory provisions the advocacy service have to provide support within a particular period however due to volume of cases this may require liaison with other services e.g. LLAMS, EMI provision. Occasionally a lag on provision does occur.<br><br>Are there many out of borough placement? - Gill said that at present there are around 12. She said that these do take additional time as co-ordination and travel demands are greater.<br><br>Gill reiterated that DoLS last for 12 months and support can be given throughout this full period.<br><br>Do out of borough placements impacts on the service financially? Gill confirmed that out of borough impacts on timeframes for achieving workload. She cited that she always considers Article 8 of Human Rights Act when discussing out of borough placements (right to see family).<br><br>Gill concluded saying that her role is very interesting but a complex job – this can be particularly pertinent in relation to family members and their impact on the sustainability of the person's placement.<br><br>In handover to Claire she said that HealthWatch advocacy services are currently supporting Halton View with two cases where the family are challenging – she felt that these situations are being managed extremely well. | |
| **The Role of the Registered Manager**<br><br>Claire Richards introduced herself as Registered Manager of Halton View, Widnes. She has been the Registered Manager there for just two months but has worked for Halton View previously, around 3 years ago.<br><br>Claire opened by saying that there is a lot of support with the DoLS process in Halton, particularly in relation to training. | |

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| Claire explained that process in that when a resident moves in (normally from a hospital where the current DoLS cannot be transferred) a standard authorisation is sought through the Statutory Body.<br><br>Claire reiterated the points from Dr Javaid's talk that just because a person had dementia doesn't mean they lack capacity.<br><br>She said that all service users coming in to a home have a person-centred plan drawn up against their individual needs. From this referrals are made where it is felt appropriate and assessment processes are triggered.<br><br>She confirmed that conditions can be put on a DoLS in relation to the individual's specific needs and that these are then discussed reguarlly and reviewed in the home.<br><br>Claire stipulated that training within the home is always face-to-face, rather than e-learning.<br><br>She said that Halton Best Interest Assessors are supportive.<br><br>DoLS authorisation – form 5 – incorporated into an individual's care plan. They only last for 12 months and the home has a process in place for triggering review.<br><br>Questions raised:<br><br>Do you have problems with training people and then they leave? Claire confirmed that Halton View has a good core of staff and training is given across the board rather than having one or two seniors trained up as specialists<br><br>Are members of family given information about processes? Yes, if members of a family are looking for a place in a home for a loved one they are given information and a visit takes place with the service user to assess needs and plan care. Social Workers are involved where there are perceived issues.<br><br>Liberty Protected Safeguards – the consultation indicated that home managers would sign off on parts of the assessment and authorisations – how do you feel about this? Claire expressed that she would need to have all the information to hand and know about the residents' needs.<br>Concerns were raised about the lack of scrutiny and oversight this could result in. i.e. managers 'marking their own homework'<br>Steve Westhead clarified the situation as resolved within the new legislation with a requirement to go to AMCPs where there is an objection to deprivation plans.<br>Claire also clarified that any concerns raised by families can be taken to advocacy services.<br>Steve expressed the importance of the advocacy service in being the voice of the service users and an intermediary between families and the statutory body. | |

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| Does the Local Authority have regular meetings with the advocacy services? Helen Moir said not a present though there is a multi-agency group set-up currently (as task and finish) towards to the implementation of the Liberty Protection Safeguards.<br>Possible recommendation – develop closer relationships between the care settings (homes), advocacy services, Section 12 Doctors and the Local Authority.<br>Gill confirmed that on coming into her post she felt welcomed and able to develop a good relationship with the Local Authority.<br>Gill added that advocates will do an end-point assessment towards the end of working for a person where recommendations are drawn up. | NH to note |
| **Close**<br><br>The Chair thanked contributors for the time and involvement.<br><br>She clarified the possible recommendations coming out to date as:<br>• DoLS in practice document required for 'lay person'<br>• Glossary of terms for Members<br>• Closer working between agencies involved<br>• Information for Cllrs on who first port of call is and how they can get relevant information when speaking to Ward constituents. | |
| **Next meeting**<br><br>Agreed BIA, Finance and discussion on the implications of the new legislation. | HM to liaise with NH |

Meeting closed: 18.55

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# Deprivation of Liberty Safeguards

**Syed Javaid**
**Consultant in Later Life Psychiatry**
**Honorary Clinical Lecturer, Liverpool University**
**Approved DoLS MH Assessor**
**11 September 2019**

# Background

- *"No freeman shall be taken or imprisoned, or disseised of his freehold, or liberties, or free customs, or outlawed, or exiled, or any otherwise destroyed; nor will we not pass upon him, nor condemn him, but by lawful judgment of his peers, or by the law of the land."*

# Synopsis

- A discussion about the basic concept of mental capacity and related legislations.
- DoLS in practice

# What does ‘capacity’ mean?

- Can the person make this decision at the time it needs to be made?

# Mental Capacity: Historical Approaches

- **The status approach**
  - If a person was deemed to lack capacity, this assessment would apply to all decisions that person could make.

- **The outcome approach**
  - Focuses on the result of the decision-making process. Any outcome deemed to be unreasonable, unwise, against conventionally held values or against medical opinion could be considered as evidence of incapacity.

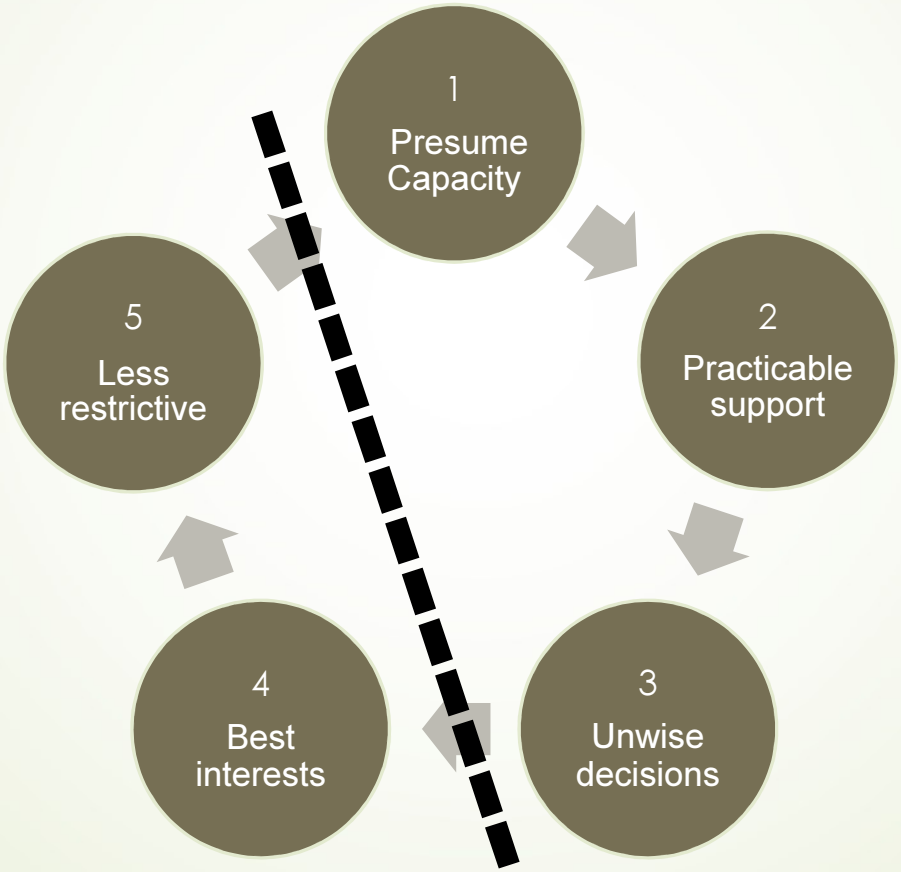
# Legal frameworks for protection

- European Convention on Human Rights
- Mental Health Act 1983
- Human Rights Act 1998
- **Mental Capacity Act 2005**
- Deprivation of Liberty Safeguards 2009

# Mental Capacity Act 2005

- Aims to empower and protect vulnerable people who may not be able to make their own decisions
- The Act clarifies…What "lack of capacity" is:
- A person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for himself in relation to the matter because of an impairment of the mind or brain.

# Underlying Principles




Capacity

Lack Capacity

# Assessing Capacity

- The **2 stage** test:

1. Does the person have an impairment of the mind or brain?
2. If so, does that impairment mean the person is unable to make the decision at the time it needs to be made?

# “Inability” to make a decision

**A person is unable to make a decision if they cannot:**

1. ***understand*** relevant information about the decision to be made
2. ***retain*** that information in their mind
3. ***use or weigh*** that information as part of the decision-making process
4. ***communicate*** their decision by any means.

# Deprivation of Liberty Safeguards

- Introduced into MCA through the Mental Health Act Amendments 2007
- Only applies to people who lack capacity (as defined in MCA)
- Safeguards cover people in hospital and care homes

# What is deprivation of liberty

- Request by carers to discharge is refused
- Unable to maintain social contact due to restrictions
- Not allowed to leave without permission
- Contact with family and friends is restricted by staff
- Sedation
- Restraint

# The ‘Cheshire West’ judgement

- MIG (17)-Learning disability- Lived with foster mother-attended a further education unit every day-Never tried to leave the foster home.
- MEG (17)-Learning disability-moved from foster home to a residential home-occasional restraint and sedation use.
- P (38)-Cerebral palsy and Down’s syndrome-lived in a staffed bungalow-one to one support to help with day to day care and frequent outside visits-episodic challenging behaviour.

# The Acid Test for Deprivation of Liberty

- The Supreme Court held that the acid test to determine if a deprivation is occurring is:

***'Whether the patient is under continuous supervision and control AND not free to leave'***

# Continuous Supervision and Control

- The concept has to be interpreted broadly
- Law Society guidance

***'Does the person or body responsible for the care of the person always broadly know where that person is and what they are doing at that time?'***

***'What would the responsible person or body do if they did not know where the person was, or what they were doing?'***

# Not Free to Leave?

- ***'How staff would react if the person did try to leave or if relatives/friends asked to remove them.'***

# Other points to consider

- Objection

  ***'A gilded cage is still a cage.'***

- Relative normality
- Reason/Purpose
- Comparator

# Limitation of DoLS

- DoLS can't:
- Be transferred
- Extend beyond the care home or hospital
- Authorise actual treatment

- Any Comments??

- Thank You

# GLOSSARY OF ACRONYMS

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| **BIA** | **Best Interests Assessor.** An independent qualified and registered social worker, nurse, OT or psychologist who assess mental capacity, determines best interests and recommends conditions |
| **CoP** | **Court of Protection.** Its role is to make decisions about people who do not have capacity to make them. The CoP can decide if a person has capacity, can decide if a person is being deprived of his or her liberty and if it is in the person's best interests, can decide a course of action in the best interests of an incapacitous person. |
| **DoLS** | **Deprivation of Liberty Safeguards**. Came into force 2009 to provide a lawful process by which a person who does not have mental capacity to decide on how and where their care needs are met to be detained if it is in their best interests and is proportionate to the degree of harm were they not. DoLS is a scheme which means deprivations of liberty – in care homes and hospitals only. |
| **ECHR** | **European Convention on Human Rights**, created 1950 after World War 2, came into effect 1953. One of the key people drafting ECHR was David Maxwell Fyfe, chief prosecutor at the Nuremberg trials. Britain is a founder member of the Council of Europe. Only Belarus and Kazakhstan are not signatories. |
| **ECtHR** | **European Court of Human Rights** is where human rights cases are heard. Based in Strasbourg. |
| **EPA** | **Enduring Power of Attorney.** Must have been signed and witnessed before 1 October 2007. Can be used if the person has capacity to make decisions about financial and property matters. Must be registered when the person loses capacity in order to be valid. |
| **HRA** | **Human Rights Act 1998**, came into force 2000. Protects British sovereignty and the freedoms and rights of British people who can have their matters heard without having to go to Europe. |
| **IMCA** | **Independent Mental Capacity Advocate**. Represents a person in certain circumstances who does not have capacity to make the decision. IMCA will ensure all parties acting in accordance with the law and challenge unlawful practices. May take matters to the CoP if not resolved. |
| **LPA** | **Lasting Power of Attorney**. Two separate types, Property & Finance and Health & Welfare. Person with capacity can have their attorney make financial decisions if LPA is registered. But attorney can only make decisions for a person about health and welfare matters where the donor lacks capacity to make the decision (and the LPA is registered) |
| **LPS** | **Liberty Protection Safeguards** – replacement scheme, which will replace DoLS in October 2020. |

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| **MA** | **Managing Authority.** In DoLS this is the care home or hospital ward applying for authorisation of deprivation of liberty. |
| **MCA** | **Mental Capacity Act** 2005, an Act of Parliament which came into force 2007. |
| **MHA** | **Mental Health Act** or Mental Health Assessor in DoLS |
| **OPG** | **Office of the Ministry of Justice**, the OPG registers LPAs and investigates concerns about attorneys. |
| **OPG 100** | a means by which you can check the existence of and powers of an LPA, EPA or Court Appointed Deputy. |
| **RPR** | **Relevant Person's Representative**; independent person who supports a person protected by DoLS, for example brings an appeal against deprivation of liberty to the Court of Protection or raises matters with the MA or SB. Often a family member. |
| **SB** | **Supervisory Body**. In DoLS this is the Local Authority |
| **Section 12 Dr** | **Mental Health Assessor** – completes 2 of the 6 DoLS assessments and has to be a GP with appropriate training |
| **UNCRPD** | **United Nations Convention on the Rights of People with Disabilities**, came into force 2008. Challenges discrimination against people with disabilities and promotes human rights for people with disabilities which are not mentioned in ECHR, for example. Britain is signed up to CRPD but it is not as yet directly enforceable, though the CoP appears to have regard for it in its judgments. |

**REPORT TO:** Health Policy & Performance Board

**DATE:** 25th February 2020

**REPORTING OFFICER:** Strategic Director, People

**PORTFOLIO:** Health & Wellbeing

**SUBJECT:** Performance Management Reports, Quarter 3 2019/20

**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 2019/20. 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, 2019/20.

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 – Period 1st October – 31st December 2019

## 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 2019/20 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**

**Mental Health Services:** redevelopment and refurbishment of the Mental Health Resource Centre in Vine Street, Widnes, is now complete. The bottom floor is now occupied by a team of nurses, doctors and administrative staff from the North West Boroughs, specialising in crisis intervention and home treatment. The top floor contains two teams managed by the Borough Council: the Mental Health Outreach Team and the Community Bridge Building Team. In addition, there are now a number of social workers based on this floor, as well as the specialist mental health carers assessor. This mix of mental health professionals has allowed for improved working relationships, a greater flow of information between the NHS staff and those of the local authority, and has resulted in a more efficient flow of referrals and assessments between the services, thereby providing a much greater set of options for people using the service.

**Public Health**

We are starting to see a significant reduction in pregnant women smoking. It has reduced from 17.3% last year to 15.5% so far this year. We are also starting to take forward the lung health check programme which will pick up local residents at risk of lung cancer from smoking.

The HaltOnLoneliness campaign has been successfully launched with all partners. We have also launched the new Healthy Weight Strategy which is a whole system approach developed with Leeds University.

## 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**

**Mental Health Services**

The Review of the Mental Health Act: this review was initiated by the previous government, triggered by concerns that, around the country, too many compulsory admissions to hospital may have been taking place, and that certain disadvantaged groups have been targeted for compulsory admission. Nationally, much work has taken place to provide input into any potential changes. Following the recent General Election, this review remains on the government's agenda and has been included in the Queen's Speech for consideration in this Parliament. It is understood however that further revisions are being considered, and it is likely that any final implementation of a new Act will not be for at least two years. This will require considerable revision of local policies and procedures.

The North West Boroughs Mental Health Trust: this Trust is the current provider of specialist mental health services to the local area, as well as a number of other local authority areas in the region. In the last Quarter, we were notified that the Trust is in negotiation with a neighbouring mental health Trust, Merseycare (which covers the Liverpool and Sefton areas), for Merseycare to take over the running of the North West Boroughs' mental health services. This will be the subject of extensive consultation and is not likely to take place for around eighteen months. if it does happen, then existing working relationships with the specialist mental health services will need to be renegotiated.

**Intermediate Care:** Following a joint review of Halton's Intermediate Care Services, supported by the Local Government Association and North West Association of Directors of Adult Social Services, Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (CCG) held an Implementation Workshop on the 4th November 2019 where the information gathered from the review was examined and a comprehensive action plan for improvements was developed.

The focus of the action plan has been the areas where the system can improve patient flow in and out of intermediate care services (both community and bed based services) ensuring that the quality of care offered to Halton residents is being maintained.

The action plan will be progressed via the Intermediate Care Operational Group (multi-agency group), chaired by the Director of Adult Social Services. The first meeting of the Group was held on 9th January 2020.

**Public Health**

There have been a number of delays and issues across this flu season with access to vaccination supply including national stock supply issues affecting the vaccinations available for under 65 at risk groups and the children's vaccination. The season is not yet finished and we are continuing to encourage people to attend their GP and pharmacy for supply. We also need to encourage staff and all at risk groups to be immunised. This will improve health, reduce flu admissions to hospital and reduce A&E waiting times.

## 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 2018/19 Directorate Business Plans.

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

## 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.

***Commissioning and Complex Care Services***

***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 | ✓ |

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| | Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. | |

**Supporting Commentary**

1A. Work is ongoing to review our overall approach to managing the financial risks in the pool.

1B. This work continues with the Primary Care Networks and Bridgewater community NHS trust.

1C. The Autism Action Alliance continues to meet regularly to review progress against the delivery plan. Significant progress has been made across many key areas of the delivery plan, in particular education. In adult services there is work currently underway to set up a social group for adults with autism (for all adults but specifically trying to target adults with no learning disability) and Bridge Builders, Halton Day services and CHAPs are working closely together to identify a venue and establish a group, additional creative solutions to the current lack of support for adults with autism and no other diagnosis are being considered and are likely to fall out of this work.

1D. Work has been underway to identify priority areas for Adult Social Care, based on recommendations from the Alzheimer's Society local profile, NICE and Prime Ministers challenge on dementia. A number of key actions have been approved by SMT, and a detailed delivery plan is under development for 2020/21 and beyond.
The Halton dementia community pathway has been recommissioned for a 12 month period (1.10.19-30.09.20), with Alzheimer's Society delivering 1:1 dementia care advisor support, information provision, connecting people to local assets and health and social care services navigation.

1E. Completed.

1F. Ongoing.

3A. No data available.

***Key Performance Indicators***

**Older People:**

| Ref | Measure | 18/19 Actual | 19/20 Target | Q3 | Current Progress | Direction of travel |
|---|---|---|---|---|---|---|
| ASC 01 | Permanent Admissions to residential and | 623.3 | 635 | TBC | TBC | TBC |

| | | | | | | |
|---|---|---|---|---|---|---|
| | nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric*** | | | | | |
| ASC 02 | Delayed transfers of care (delayed days) from hospital per 100,000 population. ***Better Care Fund performance metric*** | 673 (Nov) | 423 | 389 (Nov 19) |  |  |
| ASC 03 | Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric*** | 4721 | 5005 | 4997 (Q3 to Nov) |  |  |
| ASC 04 | Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) ***Better Care Fund performance metric*** | 85% | TBC | N/A | N/A | N/A |
| **Adults with Learning and/or Physical Disabilities:** | | | | | | |

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|---|---|---|---|---|---|---|
| ASC 05a | Percentage of items of equipment and adaptations delivered within 5 working days (HICES) | N/A Merged data in 18/19 | 97% | 96% | ✓ | ↓ |
| ASC 05b | Percentage of items of equipment and adaptations delivered within 7 working days (VI/DRC/HMS) | N/A Merged data in 18/19 | 97% | 60% | U | ↓ |
| ASC 06 | Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support) (Part 1) SDS | 78% | 78% | 72% | ✓ | ↑ |
| ASC 07 | Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support) (Part 2) DP | 36% | 45% | 24% | U | ↑ |
| ASC 08 | Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G) | 86% | 89% | 88.08% | ✓ | ↓ |
| ASC 9 | Proportion of adults with learning disabilities who are in Employment (ASCOF 1E) | 5.0% | 5% | 5.11% | ✓ | ↑ |

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| **Homelessness:** | | | | | | |
| ASC 10 | Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2017. Relief Prevention Homeless | 117 | 500 | N/A | N/A | N/A |
| ASC 11 | LA Accepted a statutory duty to homeless households in accordance with homelessness Act 2002 | 10 | 100 | N/A | N/A | N/A |
| ASC 12 | Homelessness prevention, where an applicant has been found to be eligible and unintentionally homeless. | 6 | 17 | N/A | N/A | N/A |
| ASC 13 | Number of households living in Temporary Accommodation Hostel Bed & Breakfast | N/A | N/A | N/A | N/A | N/A |
| ASC 14 | Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework | 1.64% | 6.00% | N/A | N/A | N/A |

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| | intervention resolved their situation (the number divided by the number of thousand households in the Borough) | | | | | |
| **Safeguarding:** | | | | | | |
| ASC 15 | Percentage of individuals involved in Section 42 Safeguarding Enquiries | N/A | 88% | 76% |  |  |
| ASC 16 | 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). | 61% | 56% | N/A | N/A | N/A |
| ASC 17 | 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) | 89% | 82% | N/A | N/A | N/A |
| **Carers:** | | | | | | |
| ASC 18 | Proportion of Carers in receipt of Self | 100% | 99% | 72% |  |  |

| | | | | | | |
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| | Directed Support. | | | | | |
| ASC 19 | *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)* | 7.6% | 9% | N/A | N/A | N/A |
| ASC 20 | *Overall satisfaction of carers with social services (ASCOF 3B)* | 52.1% 2018/19 | 50% | N/A | N/A | N/A |
| ASC 21 | The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C) | 77.6% 2018/19 | 80% | N/A | N/A | N/A |
| ASC 22 | Do care and support services help to have a better quality of life? (ASC survey Q 2b) ***Better Care Fund performance metric*** | 89.1% | 93% | N/A | N/A | N/A |

Supporting Commentary:

**Older People:**

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| ASC 01 | We cannot complete due to the fact that panel is still incorrect from the teams |
| ASC 02 | Delayed Transfers of Care continue below plan and in line with activity seen in August 2018 |
| ASC 04 | Annual collection only to be reported in Q4.<br>Data published October 2019, the latest data for 19/20 will be available in October 2020 |

**Adults with Learning and/or Physical Disabilities:**

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| ASC 05a | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have been used for this report, we have compared these to where we were in November 2018 for the direction of travel. |
| ASC 05b | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have been used for this report, we have compared these to where we were in November 2018 for the direction of travel. |
| ASC 06 | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have been used for this report, we have compared these to where we were in November 2018 for the direction of travel. |
| ASC 07 | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have been used for this report, we have compared these to where we were in November 2018 for the direction of travel. This figure will fluctuate due to the data available at the end of each period and the timing of services started and ended on the reporting system, we also need to be mindful that this figure does not represent a full quarter. |
| ASC 08 | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have been used for this report, we have compared these to where we were in November 2018 for the direction of travel. |
| ASC 09 | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have |

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|---|---|
| | been used for this report, we have compared these to where we were in November 2018 for the direction of travel. |

**Homelessness:**

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|---|---|
| ASC 10 | Data unavailable |
| ASC 11 | Data unavailable |
| ASC 12 | Data unavailable |
| ASC 13 | Data unavailable |
| ASC 14 | Data unavailable |

**Safeguarding:**

| | |
|---|---|
| ASC 15 | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have been used for this report, we have compared these to where we were in November 2018 for the direction of travel. While this figure is lower than the same time last year and lower than the target, this is largely due to data loading, this will be rectified within the coming weeks. |
| ASC 16 | Data unavailable |
| ASC 17 | Annual collection only to be reported in Q4, (figure is an estimate). |

**Carers:**

| | |
|---|---|
| ASC 18 | We have not been able to provide December performance data due to the timing of this meeting. Data provided is to 30/11/2019 and will be updated to include the full quarter for the next meeting.Where November figures have been used for this report, we have compared these to where we were in November 2018 for the direction of travel. |
| ASC 19 | This is the Biennial Carers Survey which will commence in December 2020 |
| ASC 20 | This is the Biennial Carers Survey which will commence in December 2020 |
| ASC 21 | This is the Biennial Carers Survey which will commence in December 2020 |

| | |
|---|---|
| ASC 22 | This is the Biennial Carers Survey which will commence in December 2020 |

***Public Health***

**Key Objectives / milestones**

| Ref | Objective |
|---|---|
| **PH 01** | **Prevention and early detection of cancer, CVD and respiratory disease. Working with partner organisations to prevent disease onset and improve early detection of the signs and symptoms.** |

| 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 | Work with partners to continue to expand early diagnosis and treatment of respiratory disease including Lung Age Checks, and improving respiratory pathways. | ✓ |
| PH 01d | Increase the number of people achieving a healthy lifestyle in terms of physical activity, healthy eating and drinking within recommended levels. | ✓ |
| 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 and develop an enhanced offer through the 0-19 programme for families requiring additional support, For example: teenage parents (through Family Nurse Partnership), Care leavers and support (when needed) following the 2 year integrated assessment. | ✓ |
| PH 02c | Maintain and develop an offer for families to help their child to have a healthy weight, including encouraging breastfeeding, infant feeding support, healthy family diets, physical activity and support to families with children who are overweight. | ✓ |
| PH 03a | Continue to develop opportunities for older people to engage in community and social activities to reduce isolation and loneliness and promote social inclusion and activity. | ✓ |

| | | |
|---|---|---|
| PH 03b | Review and evaluate the performance of the integrated falls pathway. | ✓ |
| PH 03c | Work with partners to promote the uptake and increase accessibility of flu and Pneumonia vaccinations for appropriate age groups in older age. | U |
| PH 04a | Work in partnership to reduce 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 in the community and within secondary care. | ✓ |
| PH 05a | Work with schools, parents, carers and children's centres to improve the social and emotional health of children. | ✓ |
| PH 05b | Implementation of the Suicide Action Plan. | ✓ |
| PH 05c | Provide training to front line settings and work to implement workplace mental health programmes. | ✓ |

**Supporting Commentary**

**PH 01a** Halton Stop Smoking Service works continually to help support local people quitting smoking, extra emphasis is placed on routine and manual workers and pregnant women where extra support is required. To date Halton Stop Smoking Service has received 68 referrals from maternity services and achieved a quit rate of 50% for pregnant smokers. Among the Routine and Manual group, there have been 96 smokers accessing the service and 53 smokers quitting which is a quit rate of 55%.

**PH 01b** We continue to work across partners on all screening programmes and are contrbuting to the development of 3 key programmes for which we jointly successfully bid and were awarded £1.2million across Cheshire and Merseyside. We will be helping to develop and locally implement 3 programmes including:
Text messaging cervical screening reminders
Patient navigator approach to increase uptake and support through breast and bowel screening programmes
Develop local campaign materials and a making very contact count approach to cancer screening.

We have recently taken on the lead role as chair of the Cheshire and Merseydside Cancer prevention group of the Cancer Alliance which will help strengthen the work we do locally.

**PH 01c** The Stop Smoking Service continue to deliver Lung Age checks to clients aged 35yrs and over as per NICE guidelines for COPD and refer appropriately those clients that may need further investigation to GP's

Health improvement Services are engaged with mulitple partners on a newly formed Respiratory Steering group co-ordinated by Halton CCG, aimed at improving respiratory pathways.

**PH 01d** Halton Weight Management Service has had over 215 new referrals this quarter. The service continues to provide healthy lifestyle advice and physical activity on a weekly basis to overweight Halton residents. The tier 2 group based approach is supplemented by an integrated tier 3 service for those requiring dietetic input.
Physical activity sessions continue to be provided for clients with a history of cardiac, respiratory, neurological or chronic pain diagnoses. Specialist gym based sessions have been added to assist with re-introducing clients to exercise that have had physical or mental barriers to engaging previously.
Active Halton meetings continue and action plan is continuously being worked on.
All school are offered health checks and training around healthy lifestyles. Healthy lifestyles for the staff is promoted as part of the healthy schools ethos.

**PH 02a** The Bridgewater 0-19 service, including health visitors, school nurses and Family Nurse Partnership (FNP) continues to deliver all the elements of the Healthy Child programme to families in Halton. This quarter the team have been busy delivering the seasonal flu vaccine in schools, which is now available for all children of primary school age. The programme currently has a health visitor working on the Talk Halton project, to improve language and communication in preschool children. We are also working early years settings and health visitors to improve the delivery of the two year integrated review.

**PH02b** The Family Nurse Partnership service continues to be operational with a full caseload and works intensively with first time, teenage mothers and their families. The national family nurse partnership programme is introducing new elements and guidelines for the programme, these will be incorporated into the Halton delivery model, and will increase personalisation of the FNP delivery model.

**PH 02c** The breastfeeding support team calls all new mums after discharge. This quarter they have supported 408 women over the telephone and 124 through home visits. In addition 48 women have attended an antenatal session

**Introducing Solid Foods** - 40 family units have attended the 6 sessions available this month

**Halton Healthy Early Years Status (HHEYS)** supports early year's settings to be healthy and role model healthy behaviours. 69 early years settings are currently signed up visits since September 2019. From this status the settings can access training, awards and events for staff and parents including; HHEYS EY Fit4Life, MECC for EY, Infant Feeding for EY settings, EY Mental Health awareness, 5 ways to wellbeing award and Celebration Event. HHEYS has also worked with multi agency colleagues to devise a transition booklet to support children to be ready for starting school, this includes development and health aspects and will be rolled out to early year's settings in January 2020.

**Halton Healthy Schools** – now an multi agency umbrella concept supporting schools to embed a healthy whole school approach, schools sign up to the commitment and access sessions for pupils and parents, staff training, frameworks and needs assessment, resources and support around new health policies. Since September 32 schools have already signed up and have an action plan in place, with other schools booked in for healthy school visits over this month. There are more partners than ever including; Health

Improvement, School Nurses, School Games, Sports development, Cheshire Police, Road Safety, British Red Cross, The Daily Mile, Adult Learning and Child Bereavement UK.

Bite size workshops for parents have been popular in schools and in other settings, these sessions are aimed at parents and cover healthy eating and sleep/ screen time/ physical activity. **11 sessions have been delivered with 94 attendees during Q3.**

**2 Fit 4 Life** - Is now split into 3 areas inorder to meet needs and build capacity, these below with figures for Q3:

| | |
|---|---|
| Fit 4 Life Camp – sessions for families who want to make healthy lifestyle changes or who are worried about weight gain. | No camps during Q3 |
| Fit 4 Life Outreach – sessions tailored for existing groups of children, yp, families or parents in the community | **7 sessions delivered with 122 attendees** |
| CYP Brief lifestyle intervention for practitioners (CPD accredited) aimed at the children and YP workforce and covers healthy eating, sleep and physical activity. | **3 sessions delivered with 26 attendees** |

**PH 03a** The Campaign to End Loneliness #HaltOnLoneliness continues to be rolled out across the borough with partner agencies. The Loneliness Steering Group continues to meet regularly to drive the campaign forward ensuring that materials are being distributed far and wide to various organisations and businesses across the borough to help raise awareness and promote a single point of access for people who have been affected by loneliness to get help and support.

There are a number of initiatives planned this year to raise awareness of loneliness across the Borough, which include the March Against Loneliness in the month of March. The Great Get Together In June, Healthy and Active Ageing week in September and Older Peoples Day in October. For Older Peoples Day in October we had over 150 older people attend the Sure Start to Later Life Get Together, which was a great turnout.

The loneliness Resource Tool that is aimed at raising awareness of the issues of loneliness to professionals has now been launched. It is a resource tool that they can use if they are planning to organise events or signposting to services aimed at supporting people affected by loneliness.

The Loneliness Strategy has been presented to Senior Management Team and a number of amendments are required before it can be signed off. This is to be completed by Quarter 4

The Age Well Training sessions has now been planned until the end of the year. This training is aimed at giving community staff the opportunity to build confidence and learn practical skills using tools to identify people at risk of falls, loneliness or memory loss. In this quarter, 25 people have completed the training.

The task group for care homes around tackling loneliness continues to meet. We are currently looking at various funding stream to increase the homes capacity to provide

activities that are more meaningful for resident in care homes. At Christmas, we ran a 'Shimmer my Zimmer' Competition that is proven to reduce falls in care homes by 60%. 16 residents across a number of the homes joined in the fun and 3 lucky winners won lovely prizes.

**PH 03b** The falls steering group continues to meet bi monthly to monitor progress made against the falls strategy action plan and to review the pathways.
The falls triage pilot started at the end of September. Since the start of the pilot we have received 140 falls incident forms, an average of 11 per week. Each of these individuals will have received some relevant falls prevention literature whether that be via a phone call or letter. Initial results from the pilot to date show that 1/4 of patients triaged required some further medical intervention. However, 20% did not require any further medical intervention and that social prescribing was more a more appropriate outcome. The pilot is proving to have some great outcomes however, it will require additional resources to continue and expand this service provision in the future. This is something that the Falls steering group are tasked with looking into.

**PH03c** We continue to run a joint Halton and Warrington Flu group to provide oversight and action of flu vaccination and flu activity during the season. This is working well at increasing collaboration and sharing of resources.

There have been a number of delays and issues across this flu season with access to vaccination supply including national delays and national stock supply issues affecting the vaccinations available for under 65 at risk groups and the childrens vaccination. Uptake in Halton, at mid December was lower than the same time last year, though the season is not yet finished and we are continuing to encourage people to attend their GP and pharmacy for supply. School vaccination provider are continuing to provide vaccine in schools whose sessions were disrupted into January.

**PH 04a** Halton continues to work through the objectives of the alcohol strategy and engage partners in approaches to reduce the impact of harmful drinking. We have been successful in a bid across C&M for the delivery of Fibroscan machines, which are able to identify early effects of alcohol harm on the liver. Two of these machines will initially be available in the Halton area and hope to identify liver problems early and further enable discussions about alcohol harms.

**PH 04b** Good progress is being made towards implementing the Halton alcohol strategy action plan.
Awareness is raised within the local community of safe drinking recommendations and local alcohol support services through social media campaign messages and promotion events across the borough. We are working with partner organisations to influence government policy and initiatives around alcohol: 50p minimum unit price for alcohol, restrictions of all alcohol marketing, public health as a fifth licensing objective.

The Stop Smoking Service continues to deliver Audit C screening and offers Brief Advice when appropriate to clients wishing to reduce their alcohol intake. To date over 200 clients have received Audit C screening from the Stop Smoking Service. Also Health Trainers continue to deliver Audit C screening as part of Health Checks.

**PH 04c** We continue to monitor activity of the commissioned drug and alcohol misuse service through CGL and see good numbers of people referred for treatment and support. The completion of treatment rate for Halton continues to be above the PHE and CGL national average.

**PH 05a** The Heath Improvement Team provide a whole setting approach to schools and early years settings to support them to improve the mental health and wellbeing of their setting.

- 14 schools are currently engaged
- 60 early years setting or child minders are engaged

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

Work is underway to develop a suicide prevention pathway for children and young people along with a training package aimed at front line staff who work and support children and young people. A suicide prevention campaign toolkit has been developed and has been implemented by a wide variety of partners. Additional funding has been secured to extend the Time to Change Halton campaign which is tackling mental health stigma in young people and adult men. Local Time to Change Champions (all of who are male) will be developing a series of videos to share their lived experience and tackle mental health stigma. Champs has received NHSE funding to reduce suicides in the Cheshire and Merseyside region, the focus will be on the following: self harm, middle aged men, quality improvement within mental health trusts, primary care staff, workforce development training and developing a lived experience network.

**PH 05c A variety of training is provided to early years settings, schools, workplaces and the community.**

| | |
|---|---|
| Mental health awareness training for adults | 70 |
| Mental health awareness for managers | 7 |
| Stress Awareness training for adults | 41 |
| Stress Awareness training for managers | 7 |
| Suicide Awareness training | 113 |
| Mental health awareness for early years settings | 41 |
| Mental Health awareness training for staff who work with CYP | 84 |
| Self Harm awareness training for staff who work with CYP | 110 |

***Key Performance Indicators***

| Ref | Measure | 17/18 Actual | 18/19 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 | 64.5% (2017/18) | 66.5% (2018/19) | Annual Data | U |  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | the end of reception) | | | | | |
| PH LI 02a | Adults achieving recommended levels of physical activity (% of adults aged 19+ that achieve 150+ minutes of moderate intensity equivalent per week) | 62.8% (2017/18) | 64.2% (2018/19) | Annual Data | U |  |
| PH LI 02b | Alcohol-related admission episodes – narrow definition (Directly Standardised Rate per 100,000 population) | 830.2 (2017/18) | 827.7 (2018/19) | 887.6 (Q3 2018/19-Q2 2019/20) Provisional |  |  |
| PH LI 02c | Under-18 alcohol-specific admission episodes (crude rate per 100,000 population) | 57.6 (2015/16-17/18) | 55.6 (2016/17-2018/19) | 65.6 (Q3 2016/17-Q2 2019/20) |  |  |
| PH LI 03a | Smoking prevalence (% of adults who currently smoke) | 15.0% (2017) | 14.8% (2018) | 17.9% (2018) |  |  |
| PH LI 03b | Prevalence of adult obesity (% of adults estimated to be obese) | 33.7% (2017/18) | 33.2% (2018/19) | Annual Data | U |  |
| PH LI 03c | Mortality from cardiovascular disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year,* | 88.4 (2016-18) | 88.9 (2017-19) | 88.8 (Q4 2016-Q3 2019) | U |  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | *please note year for targets* | | | | | |
| PH LI 03d | Mortality from cancer at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets* | 170.9 (2016-18) | 170.9 (2017-19) | 171.7 (Q4 2016-Q3 2019) | U |  |
| PH LI 03e | Mortality from respiratory disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets* | 53.5 (2016-18) | 50.5 (2017-19) | 54.1 (Q4 2016-Q3 2019) | U |  |
| PH LI 04a | Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population) | 340.0 (2017/18) | 337.7 (2018/19) | 366.0 (Q3 2018/19-Q2 2019/20) Provisional |  |  |
| PH LI 04b | Self-reported wellbeing: % of people with a low happiness score | 9.7% (2017/18) | 9.4% (2018/19) | Annual Data | U |  |
| PH LI 05ai | **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* | 17.5 (2015-17) | 17.6 (2016-18) | Annual Data | U |  |
| PH LI 05aii | **Female** Life expectancy at age 65 (Average | 19.3 (2015-17) | 19.4 (2016-18) | Annual Data | U |  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 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* | | | | | |
| PH LI 05b | Emergency admissions due to injuries resulting from falls in the over 65s (Directly Standardised Rate, per 100,000 population; PHOF definition) | 2937.1 (2017/18) | 2900.0 (2018/19) | 2998.7 (2018/19) Provisional |  |  |
| PH LI 05c | Flu vaccination at age 65+ (% of eligible adults aged 65+ who received the flu vaccine, GP registered population) | 74.0% (2017/18) | 75.0% (2018/19) | 72.0% (2018/19) |  |  |

**Supporting Commentary**

**PH LI 01 -** Data is released annually.

**PH LI 02a -** Data is released annually.

**PH LI 02b -** Provisional data for 2018/19 indicates that the target was not met for alcohol-related admissions episodes. The rate of admissions exceeded the target and was higher than the rate seen in 2017/18.
Data is provisional; published data will be released later in the year

**PH LI 02c -** Provisional data for 2016/17-2018/19 indicates that the target was not met for alcohol-specific admissions among those aged under 18. The rate of admissions exceeded the target and was higher than the rate seen in 2017/18.
Data is provisional; published data will be released later in the year

**PH LI 03a -** Data was fed back in the Q1 2019/20 QMR document and is published annually. The next smoking prevalence data (for 2019) should be available after April 2020.

**PH LI 03b –** Data is released annually.

**PH LI 03c -** Provisional data to Q3 2019 is on target; however, it is not possible to know whether the target will be met until March 2020.

**PH LI 03d –** Provisional data to Q3 2019 is higher than the 2017-19 target. Full 2017-19 provisional data will be available in March 2020.

**PH LI 04a -** Provisional data to Q3 2019 indicates that it is unlikely the 2017-19 target will be met. Full 2017-19 provisional data will be available in March 2020.

**PH LI 04b -** Data is released annually.

**PH LI 05ai -** Data is released annually.

**PH LI 05aii -** Data is released annually.

**PH LI 05b –** Too early in the year, and too close to target value to specify whether we will or will not meet the target for 2018/19. However, as of Q2 2018/19, we are marginally below the target for the year.
*Provisional figures are based on unverified data and as such caution is advised in their use*

**PH LI 05c -** The target for 2018/19 was not achieved and the achievement for this year remains below the national 75% target.

# APPENDIX 1 – Financial Statements

**ADULT SOCIAL CARE DEPARTMENT**

**Revenue Budget as at 31st December 2019**

| | Annual Budget £'000 | Budget To Date £'000 | Actual Spend £'000 | Variance (Overspend) £'000 | Forecast Outturn Position £'000 |
|---|---|---|---|---|---|
| **Expenditure** | | | | | |
| Employees | 14,043 | 10,396 | 10,312 | 84 | 110 |
| Other Premises | 310 | 247 | 252 | (5) | (10) |
| Supplies & Services | 506 | 375 | 384 | (9) | (10) |
| Aids & Adaptations | 113 | 84 | 81 | 3 | 0 |
| Transport | 186 | 140 | 170 | (30) | (30) |
| Food Provision | 173 | 126 | 113 | 13 | 10 |
| Contracts & SLAs | 536 | 455 | 450 | 5 | 0 |
| Emergency Duty Team | 644 | 466 | 477 | (11) | (5) |
| Other Agency | 100 | 50 | 51 | (1) | 0 |
| Payments To Providers | 1,443 | 1,082 | 1,079 | 3 | 0 |
| Revenue Contrib.To Capital | 44 | 44 | 44 | 0 | 0 |
| Care Homes | 4,119 | 2,482 | 3,006 | (524) | (676) |
| **Total Expenditure** | **22,217** | **15,947** | **16,419** | **(472)** | **(611)** |
| **Income** | | | | | |
| Sales & Rents Income | -353 | -281 | -297 | 16 | 10 |
| Fees & Charges | -677 | -510 | -489 | (21) | (15) |
| Reimbursements & Grant Income | -970 | -589 | -556 | (33) | (45) |
| Transfer From Reserves | -1,243 | 0 | 0 | 0 | 0 |
| Capitalised Salaries | -111 | -83 | -91 | 8 | 5 |
| Government Grant Income | -123 | -114 | -115 | 1 | 0 |
| **Total Income** | -3,477 | -1,577 | -1,548 | (29) | (45) |
| | | | | | |
| **Net Operational Spend** | **18,740** | **14,370** | **14,871** | **(501)** | **(656)** |

| | | | | | |
|---|---|---|---|---|---|
| **Recharges** | | | | | |
| Premises Support | 490 | 367 | 367 | 0 | 0 |
| Asset Charges | 13 | 0 | 0 | 0 | 0 |
| Central Support Services | 3,026 | 2,270 | 2,270 | 0 | 0 |
| Internal Recharge Income | -1,850 | -1,377 | -1,377 | 0 | 0 |
| Transport Recharges | 549 | 334 | 334 | 0 | 0 |
| **Net Total Recharges** | **2,228** | **1,594** | **1,594** | **0** | **0** |
| | | | | | |
| **Net Department Expenditure** | **20,968** | **15,964** | **16,465** | **(501)** | **(656)** |

**Comments on the above figures**

In overall terms, the Net Department Expenditure, excluding the Complex Care Pool, is £501,000 over budget profile at the end of the third quarter of the 2019/20 financial year. Expenditure is expected to increase during the final quarter of the financial year, resulting in a projected net overspend for the Adult Social Care Department (excluding the Complex Care Pool) of £656,000. The financial report includes expenditure and income related to the Housing Solutions division, which includes the Housing Solutions advisory service, 2 permanent and 1 temporary traveller sites, and the grant-funded Syrian Resettlement Programme. These services have a combined net budget of £604,000, and expenditure is currently projected to be to budget for the year.

Employee costs are currently showing spend of £84,000 under budget profile, due to savings being made on vacancies within the department. It is anticipated that a full-year underspend in the region of £110,000 will result by the end of the financial year. Employee budgets are based on full time equivalent staffing numbers of 427. The savings target in relation to vacant posts is £502,000, and this is anticipated to be achieved in full.

A number of new contracts in relation to transport for Adults With Learning Difficulties have commenced in the third quarter of the financial year, resulting in a projected overspend in the region of £30,000 for the year. Whilst this overspend will be offset by savings in staff costs, consideration will need to be given as to how these increased costs will be funded from the 2020/21 budget year onwards.

Income received from the Clinical Commissioning Group (recorded under the “Re-imbursements and Grants” heading) is projected to be below target. This income relates to Continuing Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user’s care packages. The shortfall is currently estimated to be in the region of £45,000 for the full year.

**CARE HOMES DIVISION**

| | Annual Budget £'000 | Budget To Date £'000 | Actual Spend £'000 | Variance (Overspend) £'000 | Forecast Outturn Position £'000 |
|---|---|---|---|---|---|
| **Expenditure** | | | | | |
| Madeline McKenna | 583 | 406 | 493 | (87) | (117) |
| Millbrow | 1,747 | 1,217 | 1,557 | (340) | (375) |
| St Luke's | 1,063 | 502 | 588 | (86) | (177) |
| St Patrick's | 726 | 357 | 368 | (11) | (7) |
| **Net Division Expenditure** | **4,119** | **2,482** | **3,006** | **(524)** | **(676)** |

**Comments on the above figures**

In overall terms, the Net Care Home Division Expenditure is £524,000 above budget profile at the end of the third quarter of the 2019/20 financial year. Current expenditure patterns indicate that spend will continue to increase during the remaining quarter and a net overspend of £676,000 is projected for the 2019/20 financial year.

The Care Homes Division was created during the third quarter of 2019/20 after the acquisition of 2 additional homes, St Luke's in Runcorn and St Patrick's in Widnes in October 2019. The new Care Homes Division contains 4 homes, Madeline McKenna and Millbrow which transferred from the Complex Care Pool Division, along with the new homes, St Luke's and St Patrick's. They have a combined budget of £4.12M based on 100% occupancy levels.

**Madeline McKenna Care Home**

Madeline McKenna is a 23 bed residential care home with a budget of £583,000. At the end of third quarter, Madeline McKenna's net expenditure is £87,000 over budget profile.

Employee related expenditure is £39,000 over budget profile, with £40,000 spent to date on overtime and £67,000 on agency staff covering vacant posts. Following an in year staffing restructure, vacancies have been advertised and most have been filled in quarter 3. However, the restructure included the harmonisation of terms and conditions that has added pressure to the staffing budget.

Premises related expenditure is £42,000 over budget profile. The main areas of concern are repairs and maintenance to the building and utility bills. It is anticipated that the costs for repairs and maintenance will continue to increase in the final quarter of the year.

**Millbrow Care Home**

Millbrow is a 44 bed residential and nursing care home with a budget of £1,747,000. At the end of third quarter, Millbrow's net expenditure is £340,000 over budget profile.

Employee related expenditure is £328,000 over budget profile, with £19,000 spent to date on overtime and £784,000 on agency staff covering vacant posts. Following an in year staffing restructure, vacancies have been advertised and most have been filled in quarter 3. However, the restructure included the harmonisation of terms and conditions that has added pressure to the staffing budget.

Premises related expenditure is £8,000 over budget profile. The main area of concern is repairs and maintenance to the building. It is anticipated that the costs for repairs and maintenance will

continue to increase in the final quarter of the year. However, a major refurbishment of the home is planned to start at the beginning of new financial year, which should in the medium-long term reduce expenditure in this area.

Expenditure on food provision is £6,000 over budget profile. This is despite an increase in budget from 2018/19 of £12,000. The council's increased portfolio of care homes will open up procurement opportunities which could produce cost savings in this area amongst others.

**St Luke's Care Home**

St Luke's is a 56 bed care home providing residential and nursing care specialising in support for older people with dementia. Halton Borough Council acquired the care home in October 2019. The budget is £1,063,000. At the end of third quarter, St Luke's net expenditure is £86,000 over budget profile.

Employee related expenditure is £61,000 over budget profile, with £18,000 spent to date on overtime and £133,000 on agency staff covering vacant posts. The transfer of staff to Halton Borough Council has left vacant posts in the current structure and spending on overtime and agency staff is expected to rise further during the final quarter of the financial year. Work is already underway to review the staffing requirements for rotas at the care home.

Premises related expenditure is £16,000 over budget profile. The main areas of concern are repairs and maintenance to the building and utility bills. It is anticipated that the costs for repairs and maintenance will continue to increase in the final quarter of the year. Halton Borough inherited the utility suppliers, but arrangements have been made to transfer to corporate contracts.

**St Patrick's Care Home**

St Patrick's is a 40 bed dementia care nursing home. Halton Borough Council acquired the care home in October 2019. The budget is £726,000. At the end of third quarter, St Patrick's net expenditure is £11,000 over budget profile.

Employee related expenditure is £6,000 under budget profile. Work is already underway to review the staffing requirements for rotas at the care home.

Premises related expenditure is £15,000 over budget profile. The main areas of concern are repairs and maintenance to the building and utility bills. It is anticipated that the costs for repairs and maintenance will continue to increase in the final quarter of the year. Halton Borough inherited the utility suppliers, but arrangements have been made to transfer to corporate contracts.

This new division needs to be carefully monitored throughout the remainder of the financial year and will continue to be a pressure area in 2019/20 and beyond.

**Capital Projects as at 31st December 2019**

| | 2019-20 Capital Allocation £'000 | Allocation To Date £'000 | Actual Spend £'000 | Total Allocation Remaining £'000 |
|---|---|---|---|---|
| Bredon | 30 | 26 | 26 | 4 |
| Carefirst Upgrade | 362 | 362 | 362 | 0 |
| Orchard House | 407 | 34 | 34 | 373 |
| Purchase of 2 Adapted Properties | 512 | 130 | 124 | 388 |
| Total | 1,311 | 552 | 546 | 765 |

**Comments on the above figures:**

The upgrade to the Carefirst system will result in significant annual savings to the licence fee. These savings are being utilised to fund the capital purchase costs over a 5 year period

The Orchard House allocation relates to the purchase and re-modelling of a previously vacant property, to provide accommodation for young adults who have a Learning Disability and Autism. The scheme was approved by Exec. Board on 15 November 2018. The £407,000 capital allocation in the current year reflects the projected remodelling and refurbishment costs of the property following its purchase in March 2019.

The capital allocation for the purchase of land and construction of 2 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 to meet the particularly complex and unique needs of two service users. The purchase of suitable land was completed in September 2019, and construction work is set to start imminently.

**COMPLEX CARE POOL**

**Revenue Budget as at 31 December 2019**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (overspend) £'000 | Forecast Variance (overspend) £'000 |
|---|---|---|---|---|---|
| **Expenditure** | | | | | |
| Intermediate Care Services | 5,890 | 4,070 | 4,203 | (133) | (232) |
| End of Life | 200 | 150 | 147 | 3 | 4 |
| Sub-Acute | 1,940 | 1,067 | 1,052 | 15 | 33 |
| Joint Equipment Store | 613 | 408 | 425 | (17) | (25) |
| CCG Contracts & SLA's | 3,458 | 437 | 395 | 42 | 49 |
| Intermediate Care Beds | 599 | 449 | 449 | 0 | 0 |
| BCF Schemes | 1,514 | 127 | 115 | 12 | 16 |
| Carers Breaks | 444 | 410 | 345 | 65 | 87 |
| Oakmeadow | 1,614 | 958 | 963 | (5) | (14) |
| B3 Beds | 1,226 | 866 | 945 | (79) | (131) |
| Adult Health & Social Care Services: | | | | | |
| Residential & Nursing Care | 18,883 | 14,873 | 15,516 | (643) | (941) |
| Domiciliary & Supported Living | 14,245 | 9,787 | 8,834 | 953 | 1,400 |
| Direct Payments | 8,022 | 7,614 | 9,226 | (1,612) | (3,016) |
| Day Care | 445 | 239 | 349 | (110) | (157) |
| **Total Expenditure** | **59,093** | **40,992** | **42,964** | **(1,972)** | **(2,927)** |
| **Income** | | | | | |
| Residential & Nursing Income | -6,966 | -4,523 | -4,620 | 97 | 121 |
| Domiciliary Income | -1,432 | -881 | -907 | 26 | 50 |
| Direct Payments Income | -581 | -357 | -436 | 79 | 151 |
| Winter Pressures | -639 | -479 | -479 | 0 | 0 |
| BCF | -10,377 | -7,782 | -7,782 | 0 | 0 |
| CCG Contribution to Pool | -15,112 | -11,217 | -11,217 | 0 | 0 |
| ILF | -656 | -328 | -328 | 0 | 0 |
| Oakmeadow Income | -604 | -453 | -450 | (3) | 0 |
| Income from other CCG's | -126 | -98 | -98 | 0 | 0 |

| | | | | | |
|---|---|---|---|---|---|
| Falls Income | -60 | -45 | -45 | 0 | 0 |
| **Total Income** | **-36,553** | **-26,163** | **-26,362** | **199** | **322** |
| | | | | | |
| **Net Department Expenditure** | **22,540** | **14,829** | **16,602** | **(1,773)** | **(2,605)** |
| HCCG liability | | | -850 | 850 | 1,138 |
| **Adjusted Net Dept. Expenditure** | **22,540** | **14,829** | **15,752** | **(923)** | **(1,467)** |

**Comments on the above figures:**

The overall position for the Complex Care Pool budget is £1,773k over budget profile at the end of the third financial quarter and the forecast year end position is expected to be approximately £2,605k. It should be noted that the CCG are financially responsible for their overspend under the current pool budget agreement, therefore this reduces the year end liability for the council to £1,467k.

**Intermediate Care Services** includes the Therapy and Nursing teams, Rapid Access Rehabilitation (RARS), Reablement service and the Hospital team. The projected overspend relates to the Reablement service delivering an additional 8,000 hours of care than originally planned due to increased demand for the service.

Expenditure on **Carer's Breaks** is under budget profile by £65k as at the end of December. A couple of contracts have ended and the personalised break costs from Halton Carer's Centre continue to be quite low.

**B3 beds** - Budgetary provision has now been identified to help fund the costs relating to B3 beds up to the end of November 2019 plus the new Community Reablement model. These costs will be circa £1.3m and will be met from the Better Care Fund Development Fund, and slippage relating to Winter Pressure schemes (Intermediate Care, Spot purchase Beds and Domiciliary Care Crisis) and Additional Better Care Fund scheme (Reducing Pressure,NHS).

**Health & Social Care** –
The Health and Social Care budget is a mix of residential, domiciliary and direct payments and is funded by both HCCG (Continuing Health Care (CHC) & Funded Nursing Care (FNC)) and HBC (Social Care). The financial performance by funding type is analysed below:

**HBC**

| Service Type | Annual Budget £000 | Projected Spend to Year-end £000 | Projected Out-turn Variance Under / (Over) £000 |
|---|---|---|---|
| Residential & Nursing Care | 14,939 | 15,585 | (646) |
| Domiciliary Care, Supported Living & Day Care | 8,284 | 7,857 | 427 |
| Direct Payments | 7,308 | 8,661 | (1,353) |
| Residential & Nursing Income | -6,933 | -7,054 | 121 |
| Domiciliary Care Income | -1,431 | -1,482 | 51 |
| Direct Payments Income | -581 | -727 | 146 |
| ILF | -656 | -656 | 0 |
| Residential Income from other CCG's | -126 | -126 | 0 |
| **SUB TOTAL** | **20,804** | **22,058** | **(1,254)** |

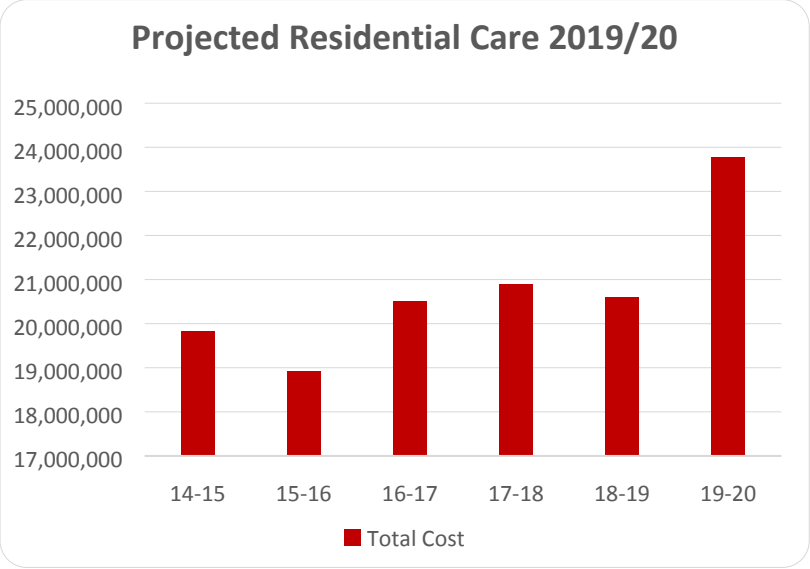
## HCCG CHC & FNC

| Service Type | Annual Budget £000 | Projected Spend to Year-end £000 | Projected Out-turn Variance Under / (Over) £000 |
|---|---|---|---|
| Residential & Nursing Care | 5,595 | 5,890 | (295) |
| Domiciliary Care, Supported Living & Day Care | 3,563 | 3,434 | (129) |
| Direct Payments | 1,414 | 2,377 | (963) |
| FNC - Residential & Nursing Care | 1,043 | 1,052 | (9) |
| **SUB TOTAL** | **11,615** | **12,753** | **(1,138)** |
| | | | |
| **TOTAL HEALTH & SOCIAL CARE** | **32,719** | **34,811** | **(2,392)** |

The Health and Social Care budget is very volatile as it is demand driven. The financial recovery working group remains in place to look at addressing/easing the current cost pressures within health and social care, whilst ensuring the needs of clients continue to be met. Expenditure has been analysed in more detail below:

### Residential/Nursing Care

The table below shows the total spend for residential and nursing care over the last 6 years, for both council and CCG funded care packages. Expenditure on these services has increased by 20% since 2014/15 and 14% in the last 2 years.




In 2017 the CCG committed to reduce the number of CHC eligible service users and this can be evidenced from the figures below. Although this results in a reduction of Continuing Health Care (CHC) costs, there is no saving to the pool budget, as the service users become funded by either the council & funded nursing care (FNC) or joint funded between both partners.The table below shows that the numbers of clients deemed eligible for CHC have halved since 2017/18.

### CHC ELIGIBLE NUMBERS

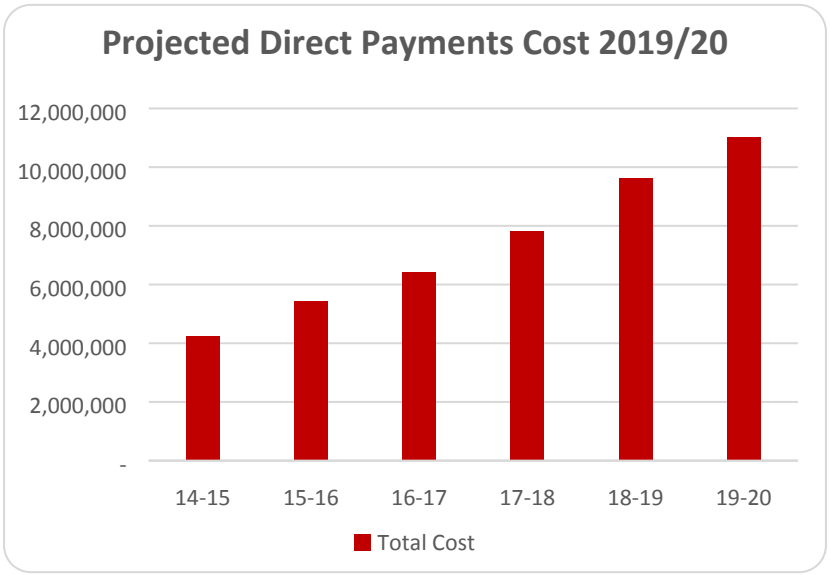
| Year | Client Numbers |
|---|---|
| 2017/18 | 63 |
| 2018/19 | 35 |
| 2019/20 | 30 to date |

**Direct Payments**

There has been a significant increase in the number of Direct Payments (DP's) in the last 6 years, see graph below. Expenditure on DP's has increased more than 2 fold since 2014 and in the last 2 years alone costs have risen by 150% exerting pressure on the pool budget The trend of service users choosing this service over a traditional commissioned domiciliary care package will conutine as it provides a more flexible, personalised service.

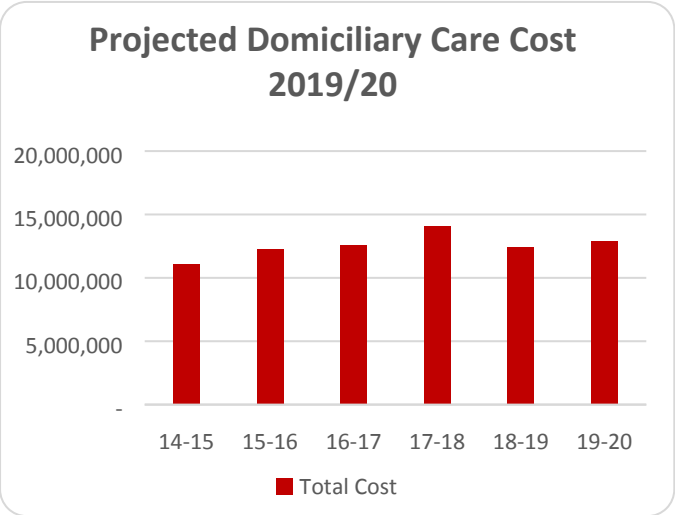
The number of Direct Payment awards as at 31 December was 605, compared to 564 at the start of the financial year. During the past quarter alone the net additional cost of Direct Payment care packages was £14k per week, equating to £728k over the course of the year.

There has also been an increase in the number of service users commissioning services from agencies, which charge more than the council's contract rate of £14.50 per hour. These are generally complex needs clients whose needs cannot be met by our contracted providers. The annual projection for these clients to date is over £162k.



**Domiciliary & Supported Living**

The number and associated costs of these services are reducing as service users take up Direct Payments. Expenditure from 2014 to date is shown below:




**Pooled Budget Capital Projects as at 31 December 2019**

| | 2019-20 Capital Allocation £'000 | Allocation To Date £'000 | Actual Spend £'000 | Total Allocation Remaining £'000 |
|---|---|---|---|---|
| Disabled Facilities Grant | 601 | 450 | 413 | 188 |
| Stair lifts (Adaptations Initiative) | 256 | 190 | 173 | 83 |
| RSL Adaptations (Joint Funding) | 260 | 190 | 181 | 79 |
| Oak Meadow Redesign | 105 | 70 | 70 | 35 |
| Millbrow | 107 | 80 | 80 | 27 |
| Madeline McKenna Care Home | 20 | 14 | 14 | 6 |
| St Luke's Care Home | 1,300 | 1,020 | 1,017 | 283 |
| St Patrick's Care Home | 1,100 | 1,040 | 1,037 | 63 |
| **Total** | **3,749** | **3,054** | **2,985** | **764** |

**Comments on the above figures:**

The scheme to refurbish Oak Meadow follows recommendations made in the Care Quality Commission report of December 2018. This scheme is wholly funded by government grant income, and an agreed contribution from St Helen's and Knowsley Teaching Hospitals NHS Trust. The project commenced in the winter of 2018/19; the £105,000 capital allocation in current year represents the funding carried forward from the previous financial year to enable the project's completion.

Both St Luke's and St Patrick's care homes were purchased by Halton Borough Council on 30 September 2019.The two establishments are now under the management of the Council's Adult Social

Care department. The capital allocations reflect funding for the purchases, and the initial refurbishment/remodelling costs.

**PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT**

**Revenue Budget as at 31st December 2019**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance to Date (under spend) £'000 | Forecast Outturn Position £'000 |
|---|---|---|---|---|---|
| **Expenditure** | | | | | |
| Employees | 3,690 | 2,768 | 2,720 | 48 | 67 |
| Other Premises | 5 | 0 | 0 | 0 | 0 |
| Supplies & Services | 296 | 227 | 165 | 62 | 80 |
| Contracts & SLA's | 6,586 | 4,281 | 4,348 | (67) | (95) |
| Transport | 10 | 7 | 6 | 1 | 1 |
| Other Agency | 18 | 18 | 19 | (1) | (1) |
| **Total Expenditure** | **10,605** | **7,301** | **7,258** | **43** | **52** |
| **Income** | | | | | |
| Other Fees & Charges | -86 | -82 | -76 | (6) | (8) |
| Government Grant | -9,919 | -7,442 | -7,442 | 0 | 0 |
| Reimbursements & Grant Income | -229 | -200 | -193 | (7) | (9) |
| Transfer from Reserves | -405 | -44 | -44 | 0 | 0 |
| **Total Income** | **-10,639** | **-7,768** | **-7,755** | **(13)** | **(17)** |
| | | | | | |
| **Net Operational Expenditure** | **-34** | **-467** | **-497** | **30** | **35** |
| **Recharges** | | | | | |
| Premises Support | 143 | 107 | 107 | 0 | 0 |
| Central Support Services | 786 | 589 | 589 | 0 | 0 |
| Transport Recharges | 23 | 17 | 16 | 1 | 0 |
| Support Income | -17 | -17 | -17 | 0 | 0 |
| **Net Total Recharges** | **935** | **696** | **695** | **1** | **0** |
| | | | | | |
| **Net Department Expenditure** | **901** | **229** | **198** | **31** | **35** |

**Comments on the above figures**

In overall terms, the Net Department Expenditure for the third quarter of the financial year is £31,000 under budget profile.

Employee costs are currently £48,000 under budget profile, due to savings on a small number of vacancies and reductions in hours, within the Health & Wellbeing Division. The staff savings target of £32,000 will be achieved in full by the end of the financial year.

Budgeted employee spend is based on full time equivalent staffing numbers of 87.

Supplies and services expenditure is being kept to essential spend only and Managers continue to closely monitor this controllable expenditure.

Contracts and SLA's expenditure is £67,000 above budget profile and this is expected to continue for the remainder of the financial year. As spend against the Public Health Grant must balance to nil at the end of the financial year, it is anticipated that funds will be drawn down from the balance sheet to meet these costs.

Income received is currently running below target and is projected to continue to do so for the remainder of the financial year. This is in the main due to savings of £50,000 being applied to income targets included in the Department's budget, which are not achievable.
There is also an underachievement of pest control income, which is expected to continue for the remainder of the financial year. Due to staff sickness, it has been difficult providing a full pest control service. However, this shortfall in income has been offset by the reimbursement from Wirral LA for services provided by the PH Consultant.

The expected outturn position for the department to 31 March 2020 based on the current levels of income and expenditure is anticipated to be circa £35,000 under budget.

## 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.* |