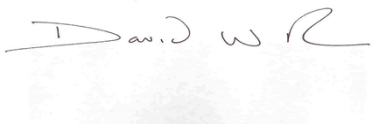
Public Document Pack

Health Policy and Performance Board
Tuesday, 23 February 2021 at 6.30 p.m.

To be held remotely, contact Clerk for access



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 confirmed.

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

Part I

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

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 24 November 2020 held remotely

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

Apologies for Absence: Councillor June Roberts

Absence declared on Council business: None

Officers present: S. Wallace-Bonner, M. Vasic, A. Jones, D. Nolan and E. O'Meara

Also in attendance: L. Bloomfield – North West Boroughs Healthcare NHS FT, Dr. A. Davies – NHS Halton & Warrington CCG, L. Gardener – Warrington & Halton Hospitals NHS FT, L. Thompson – NHS Halton CCG and one member of the press

ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HEA20 MINUTES

The Minutes of the meeting held on 29 September 2020 were signed as a correct record.

HEA21 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA22 COVID-19 RESPONSE AND RESTORATION & RECOVERY OF CLINICAL SERVICES

The Board welcomed Lee Bloomfield from North West Boroughs Healthcare NHS Foundation Trust (FT), who provided an update in respect to North West Borough's Healthcare NHS FT's response to Covid-19 and the subsequent restoration and recovery of clinical services for the local population of Halton.

The report gave an overview of the current Trust and local Borough service delivery, patient activity including referral rates, activity levels, waiting list sizes and how and

where care was being delivered. It also detailed the process the Trust had undertaken to restore services in the short term and detailed the process for the medium and long term.

It was noted that the report was produced using a snapshot approach, focussing on two points – weeks commencing 2 March 2020 and 10 August 2020.

On behalf of the Board the Chair thanked the presenter and queried the position with regards to Child and Adults Mental Health Services. This information would be made available to the Board following the meeting.

RESOLVED: That the presentation be received and comments made noted. | Director of Adult Social Services

HEA23 CREATION OF A 'HEALTH HUB' DELIVERING SOME OUTPATIENT HOSPITAL SERVICES FROM RUNCORN SHOPPING CITY

The Board considered a report from the Clinical Chief Officer NHS Halton CCG and the Director of Strategy, Warrington and Halton Teaching Hospitals (WHTH) NHS Foundation Trust (FT) on the creation of a 'Health Hub', delivering some outpatient hospital services from Runcorn Shopping City.

It was reported that a partnership between WHTH NHS FT, Halton Borough Council and the Liverpool City Region (LCR) had developed a plan to utilise unused retail space in Runcorn Shopping City to deliver a number of clinical services. The report outlined the context, the progress made to date and described the next steps with regard to undertaking a patient, public and staff pre-engagement and consultation exercise to consider the proposal and detail within these plans. Appended to the report was the '*Draft Consultation FAQ's – Runcorn Shopping City'*.

Following the presentation the *Healthwatch* Co-optee Member to the Board offered their assistance with the promotion of the pre-engagement work and the 8-week consultation through their networks, as well the opportunity to carry out engagement using their online Zoom sessions. One Member suggested that the Council's Customer Intelligence Unit may be able to assist with the survey as they had experience of conducting these in the past.

RESOLVED: That the Health Policy and Performance Board receives the proposal outlining the

proposed actions to proceed with engagement and consultation relating to the proposed service expansion and/or relocation of services at Runcorn Shopping City as outlined.

HEA24 HALTON HOSPITAL AND WELLBEING CAMPUS STRATEGIC OUTLINE CASE

The Board considered a report which provided an overview of progress to date of the plans for new hospital developments in Warrington and Halton, and sought support to continue to progress the plans for Halton Hospital site redevelopment and to ensure the provision of hospital services in a modern fit for purpose estate.

Members welcomed Lucy Gardener, from Warrington and Halton Teaching Hospitals NHS Foundation Trust, who presented the update.

The Board was advised that following the Warrington and Halton Teaching Hospitals NHSFT's publication of its *Estate and Facilities Strategy 2019-2024*, the need for modernisation and reconfiguration on both the Warrington and Halton sites was reiterated. This included the provision of a new hospital for Warrington and the completion of the development of a hospital and wellbeing campus on the Halton site.

It was reported that the Strategic Outline Cases (SOCs) had been developed for both and reviewed by NHSE with positive feedback received. Further, the SOCs had been approved by the Warrington and Halton Teaching Hospitals NHSFT's Board and by Warrington and Halton CCGs. In order to further progress the planning for the new hospitals to the next stage, Executive Board was asked to give their support to the programme and support in progressing to the next state of business case development, this was agreed at the last meeting of the Executive Board in November.

Following Members queries, it was confirmed that the new extension to Halton Hospital would be completed before the demolition of buildings where services were currently being delivered. So there would be no loss of services from the Halton site, including the Brooker Centre. More information would be provided in the full business case once this was available.

One Member requested sight of the Strategic Outline Cases. It was noted that once final NHSE approval had

been given, they would be shared with the Board.

Director of Adult Social Services

RESOLVED: That the Board notes the report.

HEA25 PUBLIC HEALTH RESPONSE TO COVID-19

The Board received a report and accompanying presentation from the Director of Public Health and Protection, which updated them on the Public Health response to Covid-19 Coronavirus.

The presentation included the most recent data; the latest update on the Halton Outbreak Support Team and the testing approach in the community, including mass testing.

Members welcomed the news that Halton's infection rate was now below the North West average and hospitals had seen a reduction in the numbers of beds occupied by Covid-19 patients.

RESOLVED: That the report be noted.

HEA26 WINTER PLANNING

The Board considered a report from the Chief Commissioner – NHS Halton CCG, appraising them of the Winter Planning 2020 requirements and the Mid Mersey system Winter Plan submissions.

The Mid Mersey Winter Planning document was attached to the report and the Board was advised that the two local system Winter plans had been derived from local system partnerships of St Helens and Knowsley, and Warrington and Halton and were attached to the report as appendices one and two respectively.

It was noted that the two local plans had been aggregated to form a Mid Mersey introduction into the system response to Winter. The local systems would need to continuously assist local delivery for any new challenges for the winter planning task ahead.

RESOLVED: That the Board

1) acknowledge the Winter planning requirements; and

2) supports the two local system winter plans and the Mid Mersey submission.

HEA27 PERFORMANCE MANAGEMENT REPORTS, QUARTER 2 2020/21

The Board received the Performance Management Reports for quarter 2 of 2020-21.

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 2020-21. This included a description of factors, which were affecting the service.

The Board was requested to consider the progress and performance information and raise any questions or points for clarification; and highlight any areas of interest or concern for reporting at future meetings of the Board.

It was reported that the emergence of the Coronavirus had disrupted reporting with some areas being suspended and some being reported differently. Officers advised that since publication of the agenda, the financial information had become available and would be circulated to Members following the meeting.

The Chair suggested that the commentary in the report should include reference to the good work that was being done by all staff at this unprecedented time, as they deserved recognition for their dedication and hard work.

RESOLVED: That the Performance Management Reports for quarter 2 be received.

Director of Adult Social Services

Meeting ended at 7.30 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 25 February 2021

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 2021

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes of the Health and Wellbeing Board's meeting of 7 October 2020 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, 7 October 2020 held remotely.

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and S. Bartsch, N. Bunce, P. Cooke, G. Ferguson, T. Hemming, T. Hill, P. Jones, M. Larking, R. Macdonald, E. O'Meara, K. Parker, D. Parr, C Pritchard, S. Quinn, S. Semoff, M. Stanley, M. Vasic, I. Whiley, D. Wilson and S. Yeoman.

Apologies for Absence: K. Parker, L. Thompson and S. Wallace Bonner

Absence declared on Council business: None

Also in attendance: One member of the press

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB1 MINUTES OF LAST MEETING

The Minutes of the meeting held on 15 January 2020 having been circulated were signed as a correct record.

HWB2 CRF ACTION PLAN IN RESPONSE TO RAPID INCREASE IN COVID-19 CASES

The Board received a report on the Cheshire Resilience Forum Action Plan in response to a rapid increase in COVID 19 cases. It was noted that all areas of Cheshire had seen an increased incidence of COVID-19 cases in the last week (as at 14 September) with more significant increases being observed in Warrington and Halton.

In response to these concerns, the Cheshire Resilience Forum had produced an action plan, a copy of which had been previously circulated to the Board. The plan set out a summary of the epidemiological evidence for Cheshire and steps that were being taken now in response to the rapid increase in COVID-19 cases and also what steps were under consideration. The appendix at the back of

the action plan provided a more detailed summary of COVID-19 surveillance data for both Cheshire and Merseyside.

RESOLVED: That the contents of the report be noted.

HWB3 WINTER PLANNING

The Board considered a copy of the Mid Mersey Winter Planning document and the two local system winter plans which had been derived from local system partnerships of Warrington and Halton and St Helens and Knowsley. On receipt of the plans the Urgent and Care Network and the Cheshire and Merseyside Health and Care Partnership would aggregate the plans up as a Cheshire and Merseyside response.

It was recognised within the plan that winter was likely to place unique pressures on the health and care system. COVID-19 remained a concern with seasonal flu and other viruses, seeing an increase in transmissions over the winter period. Additional challenges were set out in the plan that would exacerbate pressures on the health and social care system in Winter 2020/21, increasing demand on usual care as well as limiting surge capacity. These factors had all been considered in the winter plans and mitigations of COVID-19 this winter had substantially changed the local response to that used for previous winter planning and the first wave of infection in Spring 2020.

RESOLVED: That the Board

1. acknowledge the winter planning requirements; and

2. support the two local system winter plans and the Mid Mersey submission.

HWB4 INITIAL REPORT ON THE IMPACT OF THE CORONAVIRUS ON HALTON'S ADULT SOCIAL CARE MENTAL HEALTH SERVICES

The Board considered a report of the Director of Adult Social Services, which provided a summary of the impact of the coronavirus on people known to the adult social care mental health services in Halton. The report set out the work of the Mental Health Social Work Services and the Mental Health Outreach Team. It included some of the adjustments to service delivery that had been made as a result of the pandemic.

The early indications were that the impact of the coronavirus on people's mental health and wellbeing in Halton had been considerable, although it would take at least another quarter before this was more fully understood. A further report could be brought to the Board in the near future which would provide more detailed information about referral rates and mental health outcomes in the subsequent quarter.

On behalf of North West Boroughs' Specialist Mental Health Services, T. Hill provided a brief update of their work and agreed to provide a more detailed update to a future meeting.

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

HWB5 LLOYDS BANKING UPDATE

The Board considered an update on the work of the Lloyds Banking Foundation in Halton. In November 2019, Halton was confirmed as one of the areas supported by the Lloyds Banking Foundation. In early March, colleagues from Lloyds came to Halton for a two day study visit and met with several key Partners. Since then some of the anticipated activities had been impacted by COVID-19 but colleagues from Lloyds had continued to support partners in Halton with:

- A small grant and advice to the Halton VCA;
- Ringfenced two development grants for Halton charities;
- Assisting with the Halton Foundation; and
- Information gathering on future initiatives in Halton.

RESOLVED: That the report be noted and the work of the Lloyds Foundation in Halton be supported.

HWB6 HBC LOCAL LOCKDOWN EMERGENCY PLAN TO SUPPORT SHIELDED, VULNERABLE AND THOSE SELF-ISOLATING

The Board considered a report that detailed Halton's Local Lockdown Emergency Plan to support shielded, vulnerable and those self isolating for shielded and vulnerable individuals. The plan had been produced in response to a risk of a local lockdown and the impact on these vulnerable individuals who resided within the Borough.

The Authority had developed a suite of Contingency

Plans in response to a virus outbreak occurring, copies of which had been shared with the Board. Should the mitigation measures detailed within the Outbreak Plans not be sufficient to reduce the spread of the virus, a Local Lockdown may be required. Therefore, the aim of the plan was to support the individuals and provide guidance for the Authority and partner agencies in response to the lockdown.

RESOLVED: That the Emergency Plan be noted.

HWB7 ONE HALTON - UPDATE REPORT

The Board received an update report on work relating to the One Halton Forum, the Integrated Commissioning Group and the Provider Alliance. The report summarised recent initiatives involving NHS Phase Three, Cheshire and Merseyside Health and Care Partnership, the potential for a Cheshire and Merseyside CCG, the Mersey Thought Session held on 16 September, future One Halton Priorities and One Halton Finance (a budget statement was shared with the Board).

RESOLVED: That the report be noted.

Meeting ended at 3.00 p.m.

REPORT TO: Health Policy & Performance Board (HPPB)

DATE: 23rd February 2021

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing
Children, Education & Social Care

SUBJECT: Health Reforms

WARD(S): Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 Jackie Bene (Chief Executive) and Alan Yates (Chair) from the Cheshire and Merseyside Health and Care Partnership (C&MHCP) will attend the Board to advise members on the proposed reforms regarding integration of health & social care reforms.

1.2 They will advise on the following and take questions from the Board.

i) National Framework - the NHSE/I paper: Integrated Care: Next steps to building strong and effective integrated care systems across England and the potential implications for NHS arrangements for the Liverpool City Region (LCR).
ii) Local Application of the Framework – through the C&MHCP Memorandum of Understanding (MOU).
iii) The implications for Local Authorities and the Health care system generally.

1.3 These two matters are intrinsically linked – one is the national development of Integrated Care Systems – the other relates to how this is to be implemented locally, across Cheshire & Merseyside.

2.0 **RECOMMENDATION: That the Board :**

i) Note the contents of the report and associated appendices; and
ii) Welcome Jackie and Alan to the meeting, receive a verbal presentation from them, followed by a Q & A session.

3.0 **SUPPORTING INFORMATION**

Background

National – Integrating Care: Next steps to building strong and effective integrated care systems across England – published by NHSE/I

3.1 The NHS has been on a journey with partners since 2016 (with the creation of System Transformation Partnerships (STPs)) to establish system wide integrated and collaborative working aimed at improving population health, reducing inequalities, and managing resources effectively.

3.2 The NHS Long Term Plan, published in 2019, further set out the direction for health and care to join up locally to meet population needs and for greater collaborative working and for all STPs to work towards being formally approved by NHSE as an ICS (Integrated Care System).

3.3 In December 2020, NHSE/I produced this paper which set out proposals for significant legislative reform that would give ICSs statutory functions and change Clinical Commissioning Group (CCGs) and the way NHS providers work together. The consultation on this paper closed on 8th January 2021 and the Council in conjunction with the LCR responded as set out in ***Appendix 1***. This was developed with the support of the Directors of Adult Social Services from across the LCR.

Locally - the Cheshire & Merseyside Health & Care Partnership (C&MHCP) Memorandum of Understanding (MOU) and the implications for Halton and other Local Authorities

3.4 The Health and Social Care Act 2012 resulted in the creation of CCGs and also an overt separation in the NHS between the commissioning and the provision of services. However, in recent years there has been a growing recognition that integration and collaboration are more effective at driving improved population health and reducing inequalities than competition and division. There is also evidence demonstrating the benefits of health and social care working together with other key partners such as housing, schools, businesses, and voluntary sector to support individuals and communities to be more independent and resilient.

3.5 Therefore, since 2016 the NHS has been on a journey to embed system wide integration and collaboration and to support local (Place/Borough) areas to bring together key partners to have a collective approach on improving outcomes for local people. There has been a drive to have integrated health and social care commissioning at a local level and to work with all relevant partners on improving outcomes locally and reducing inequalities. In Halton, this has been driven by ONE HALTON.

3.6 In Cheshire and Merseyside, the Health and Care Partnership (C&MHCP) is working, as directed by NHSE/I, towards formal designation as an ICS by April 2021. As part of this process the C&MHCP have produced a Memorandum of Understanding (MOU) and although not legally binding, that has been shared for information and comment.

3.7 Each of the Local Authorities are one of nine Places within Cheshire and Merseyside and collectively the nine places make up the Cheshire and Merseyside Health & Care Partnership. The C&MHCP needs to be formally designated as an ICS by 2021, in line with national policy.

3.8 An ICS is a system where: NHS bodies (commissioners and providers), local authorities and third-sector providers each take collective responsibility for the management of resources, delivering NHS standards and improving the health of the population they serve.

3.9 The national research shows that when different organisations work together in this way, local services can provide better and more joined-up care for patients. ‘Systems’ can

better understand data about local people's health, allowing them to provide care that is tailored to the needs of local communities and individuals. For staff, the improved collaboration can help to make it easier to work with colleagues from other organisations.

3.10 The C&MHCP have developed an MOU and is seeking to shape this with all partners.

3.11 The aim of the MOU is to capture the required commitment across Cheshire & Merseyside to work together and it is important that each one of the nine Places/Boroughs in this system consider the MOU and play an active role in shaping the C&MHCP journey to becoming an ICS.

3.12 The MOU was a key area for discussion at the scheduled C&MHCP Political Assembly on the 18th January 2021. This was attended by the Leader as the Chair of the Health & Wellbeing Board and Cllr Wright as the Health & Wellbeing Portfolio Holder.

3.13 ***Appendix 2*** proposes some areas for consideration at the HPPB meeting.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this stage.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Not Applicable.

6.2 **Employment, Learning & Skills in Halton**
Not Applicable.

6.3 **A Healthy Halton**
The need to have effective and efficient commissioning and delivery of health and social care provision in Halton is directly linked to this priority.

6.4 **A Safer Halton**
Not Applicable.

6.5 **Halton's Urban Renewal**
Not Applicable.

7.0 RISK ANALYSIS

7.1 A detailed risk analysis has not yet been carried out, however as part of the consultation response, as outlined at ***Appendix 1***, a number of issues have been highlighted. For example, the proposal to put ICSs on a statutory footing from 2022 means there is a danger of reducing or replacing established place based leadership, best placed to achieve greater investment in prevention and community-based health and wellbeing

services by addressing the wider determinants of health.

7.2 Further work on associated risks will need to be undertaken at the appropriate time.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

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

Document	Place of Inspection	Contact Officers
Integrating Care: Next steps to building strong and effective integrated care systems across England	https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf	David Parr David.parr@halton.gov.uk Milorad Vasic Milorad.Vasic@halton.gov.uk

Appendix 1

LCR response to proposals set out in" Next Steps to building strong and effective integrated care systems across England" December 2020

Q1	**Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next Decade?**

In general, we support the direction of travel of the proposals towards joining up health and care support around the individual, based on collaboration between organisations, and where decision-making is at the most local level. However, the proposals are in danger of reducing or replacing established place based leadership, best placed to achieve greater investment in prevention and community-based health and wellbeing services by addressing the wider determinants of health: safe and affordable housing, access to training and good jobs, a safe and healthy environment, support for early years, and infrastructure to support resilient communities. Place must be recognised and understood by local communities and for local communities 'place' is the Local Authority in which they live.

We support the move away from a centralised arrangement towards one which places resources and decision making with local communities. However, we are concerned that the proposals set out in the NHS consultation document will just result in new NHS led regional and local command and control governance and systems that bypass or replace Health and Wellbeing Boards which are established, locally accountable place based partnerships, best placed to lead on population health. The aim to devolve power and resources at a local level would best be achieved by ICSs joining existing locally accountable Health and Wellbeing Boards as a partner within this established wider system partnership.

Appendix 1

LCR response to proposals set out in" Next Steps to building strong and effective integrated care systems across England" December 2020

Q2	**Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?**

We support option 2 and would welcome CCG functions being transferred into the ICS and also NHSE commissioning functions as this would be the most streamlined model for the system (we believe option 1 would leave too many potentially competing layers at a system level and be too complex and may not facilitate the level of whole system working that is required).

We welcome the recognition in the paper of the importance of Place and neighbourhoods and of the principle of subsidiarity but some of this needs to be made clearer over the next 12 months regarding how budgets will be delegated to Place by the ICS and for CCG staff affected by these changes (we welcome the employment promise) and who will they be employed by at Place when their CCG is dissolved.

We would also recommend that some of the other functions of CCGs e.g. safeguarding, CHC, Primary Care delegated functions are all left in the remit of Place based integrated commissioning teams and that the traditional performance and assurance functions of CCGs are simplified.

In addition, whilst both options set out in the consultation document recognise the need for local government representation, neither option proposes local government as an equal partner. The aim is to accelerate integration of health and care through statutory reform, which should legislate local authorities as equal partners. We would suggest that ICSs to be a statutory joint committee acting as strategic partnership bodies for the whole system, with a parity of esteem and representation between local government and the NHS, within which there should be a reciprocal duty of cooperation to address health inequalities on the NHS and local government. The accountability of the statutory ICS joint committee should be established within existing democratic structures and Directors of Adult Social Care (DASS) should be included as mandatory members of 'place' integrated care partnerships; and DASS representation on the ICS joint committee should be mandated. We would suggest that partners within the statutory joint committee should take on current clinical commissioning group (CCG) functions, as determined at a local level, recognising the maturity of local systems.

The statutory joint committee should delegate commissioning to place unless there is an exceptional business case to commission at a scale greater than place. To ensure the success of place-based commissioning resources will be devolved at a local level.

LCR response to proposals set out in" Next Steps to building strong and effective integrated care systems across England" December 2020

The integration of health and care will be best delivered through the development of place-based partnerships. Different performance and legislative frameworks are barriers to true integration. If local government remain subject to the Public Contracts Regulations this proposal will introduce new barriers to joint commissioning and risks commissioning activity being inappropriately channelled through the NHS. If the aim of legislative change is to progress integration, the whole of the public sector, but social care, should operate within the same legal framework. The local system needs to be incentivised with clear duty on HWB's to hold providers to account- we would want to see the role of HWBB strengthened in the option 2. If this option is progressed, we would want to see a duty of collaboration built in with reciprocal focus on the importance of addressing health inequalities and wider determinants of health. Collaboration can be a great lever for change and to improve outcomes, however there needs to be an acknowledgement that there are significant variations both in terms of service delivery and in funding gaps across the region – the paper does not sufficiently address how funding gaps and inequalities will be prioritised and rectified and how resources will be distributed.	
Q3	**Do you agree that other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?**
We agree it is important at a Place level that there is the flexibility / freedom to form partnerships that are best suited to a local Place, however we would welcome some guiding principles to support this as not all systems are as mature as others and may need support / guidance to establish effective local and larger system boards / partnerships. We welcome the mandatory participation of Local Authorities as well as the NHS as this recognises the vital and pivotal role local government play in their communities and acknowledges that social care, health, community safety and economic regeneration are interlinked and all key factors in terms of improving health & wellbeing and reducing inequalities. It will be important that the relevant government departments are supportive of this to ensure the NHS and all aspects of local government come together on this agenda.	

LCR response to proposals set out in" Next Steps to building strong and effective integrated care systems across England" December 2020

As the proposed legislative change progresses, we would welcome clarity regarding Place Boards that are outlined in the paper – would these replace Health & Wellbeing Boards? Will they be afforded any statutory footing as a criticism of Health & Wellbeing Boards has been that they have no real decision-making powers? Will the potential governance relationships between the ICSs and integrated commissioning functions at Place be specified or will each system be allowed to work these out? We agree with the premise that statutory direction should be sufficiently permissive as to allow systems to shape their own governance but would argue that the statutory role and leadership of DASSs must be recognised as mandatory within ICSs and ICPs. New governance should include local accountability through existing local systems including health and wellbeing boards and scrutiny committees. We recognise that some integrated partnerships at place and integrated systems are more developed than others. Therefore, if ICSs are created in all parts of England by April 2021, statutory partners at place, including health and local authorities should be provided with the necessary support and resources to ensure some places are not disadvantaged and that all places are in a position to take on delegate powers as an Integrated Care Partnership. Local authorities / HWBB need to be represented at ICS level - there is a strong reference to place leaders and the role of provider collaboratives, but we would want to see democratic decision making enshrined in legislation, policy and process.	
Q4	Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?
Yes, we agree that services commissioned by NHSE should transferred (not delegated) to ICSs. This relates back to question 2 in that by transferring these services to ICSs the system will be simpler to understand by the public and accountability will be in one place. We would also recommend that the legislative change allow the commissioning of Primary Care to remain at Place as it does now through delegated commissioning from NHSE to CCGs.	

Appendix 1

LCR response to proposals set out in" Next Steps to building strong and effective integrated care systems across England" December 2020

We strongly support delegation of NHSEI commissioning to ICSs, where appropriate. Furthermore, we would like to see an equal emphasis on delegating commissioning to place level, ensuring the application of the principle of subsidiarity. We would suggest that a new statutory reciprocal duty of collaboration to improve population health and address health inequalities is required of all NHS organisations and local authorities and that a legal requirement on ICSs to involve Health and Wellbeing Boards in the development of plans is implemented and the development of place or locality plans be devolved to HWBs. A new power for HWBs to 'sign off' on all ICS plans should be introduced, together with arrangements for commissioning to continue to have a strong place-based focus, with a strong and proactive role in HWBs in approving commissioning plans. There should be a statutory duty on ICSs to be accountable to their local communities through existing democratic processes. Greater control at a local level of specialised services and inclusion in the overarching wider pathway of services would be welcomed.

Appendix 2

Issues for Consideration

1. Is Cheshire & Merseyside the right footprint? Is it a 'done deal'?

2. Should each local Authority 'place' be represented in future governance arrangements for the Cheshire and Merseyside Integrated Care System? There are different political views about whether politicians should be implicated in C&MHCP decision making (as there are some tricky decisions ahead) or should the political role be to scrutinise them.

3. What would be the role for the Health and Wellbeing Board in each Place? Formal recognition of Health and Wellbeing Boards as the strategic decision-making body for Integrated Care Partnerships in each place, given they are best positioned to support improved outcomes in the wider determinants of population health.

4. What would be the arrangements for the democratic scrutiny of health and social care provision both at Place and 'at scale' across the Cheshire and Merseyside footprint?

5. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **commissioning and delivery of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

6. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **funding of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

7. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **quality of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

8. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **clinical robustness of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

9. Formal assurance that budgets will be devolved to place; and that residual budgets retained at Cheshire and Merseyside level will be agreed in advance by each place.

10. Seek reassurance that the delivery of health & social care services will be closest to home wherever possible and only at scale where this is more appropriate.

11. How does the system structure encourage the shift away from spending money on fixing sick people to keeping them well? Increased focus on prevention and population health.

12. How/will the system structure encourage community provision rather than expensive acute provision?

13. Is there a role for expanded s75 agreements in each Place (children's, adult's and public health together with out of hospital NHS)?

14. Legislative barriers to change – 2022 looks, very ambitious … is the legislation ready to go (and where do foundation trusts exist in this)?

15. What about facilities like major trauma centres? Walton Centre? Alder Hey - is there a NW or NHSE residual role?

16. Greater involvement of social care (Adult and CYP) to achieve a whole system approach to wellness, health and social care.

REPORT TO:	Health Policy & Performance Board
DATE:	23 February, 2021
REPORTING OFFICER:	Director - Public Health and Protection
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Public Health response to COVID-19 Coronavirus
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on the public health response to COVID-19 Coronavirus with a presentation covering the most recent data; latest update on Halton outbreak support team activity, Testing and Vaccination.

2.0 **RECOMMENDATION: That:**

The presentation be noted.

3.0 **SUPPORTING INFORMATION**

3.1 This public health response is dynamic and in order to provide the most up to date information a presentation will be provided.

3.2 The presentation will cover the most recent COVID-19 Coronavirus figures for Halton. An update on how the Halton outbreak support team are working to successfully identify and manage local outbreaks and the presentation will also detail the most recent information on testing and vaccination for people in Halton.

4.0 **POLICY IMPLICATIONS**

4.1 There are no specific implications in respect of Council policy.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There is ring fenced allocated funding for outbreak response.

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

6.1 **Children & Young People in Halton**

The outbreak response will protect the health of children and young people in Halton.

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

N/A

6.3 **A Healthy Halton**

The outbreak response will protect the health of people in Halton.

6.4 **A Safer Halton**

The outbreak response will protect the health of people in Halton.

6.5 **Halton's Urban Renewal**

None identified at present.

7.0 **RISK ANALYSIS**

7.1 The outbreak response team will reduce the risk to local people from an outbreak.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no equality or diversity issues as a result of the actions outlined in the presentation, however among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those from minority ethnic groups, in particular those of Black and Asian heritage.

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: 23 February, 2021

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Population Mental Health including Suicide Prevention

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 Provide update regarding population mental health prevention work that has been taking place during Covid 19 pandemic including suicide prevention

2.0 RECOMMENDATION: That:

i) Report be noted

3.0 SUPPORTING INFORMATION

Mental Health population prevention involves an upstream approach targeting the majority of the population to keep people well. It uses a whole systems approach to improving mental health and wellbeing and involves working in partnership with both statutory and voluntary organisations. Kate Bazley, from the Health improvement Team, leads this area of work with a team of two staff. The majority of work falls into the following categories:

- Developing the workforce and communities
- Tackling stigma and increasing awareness of support available
- Supporting organisations to make positive changes in how they operate
- Suicide prevention
-

3.1 Developing the workforce and communities

3.1a-Mental Health training offer by Health Improvement Team

To improve knowledge of front line staff and communities positively by influencing how they look after their own mental health and the mental health of those they work with the following training had taken place

3.1b-Numbers trained from April 2020- Dec 2020

Table 1-For Adults who work with Adults

Training	Numbers attending
Mental health Awareness	136

Mental Health Awareness training for Managers	157 *Majority of training delivered to HBC managers
Suicide Awareness training	125
Stress Awareness training	59* majority of training delivered to early years settings
Stress Awareness training for Managers	0 *this training is delivered to workplaces

Table 2-For Adults who work with Children and Young people

Training	Numbers attending
Mental health Awareness	139
Self-Harm Awareness	139
Resilience Workshop	34
Staff wellbeing workshop	25 *this workshop is aimed at schools

Prior to the pandemic all training was delivered face to face in a classroom setting. From April 2020 all sessions were available virtually online. As a result of delivering virtually, cohort numbers for each training session had to be reduced to ensure quality was maintained. Delivering training virtually has resulted in a reduction of approximately 50% in the numbers we have been able to train.

3.1c-Training outcomes

To ensure the training is having an impact and delegates who attend are utilising the information they have learnt, each cohort is contacted 3 months after attending the training to see what changes they have made

Comments below are take from 3 month post training evaluations

‘I have been able to provide young people and their parents with appropriate strategies’

‘The information on signposting to various places has assisted in sharing this information with children. My perception of risks to children's mental health has helped me identify children who might need support’

‘Neighbours son took his own life since training. I was more aware of implications and found the confidence to speak to his parents rather than just avoiding them. Still found the situation awkward but felt a lot more confident talking to his family’

‘I have been mindful of staff MH particularly during pandemic and ensure there are enough times to catch up with staff through ad hoc calls, calling into team meetings and a monthly get together for fun conversation and an activity’

‘After completing the training I spoke to a couple of Shielded Individuals, on the H.B.C. register, who had found the Covid 19 "lockdown" particularly difficult severely impacting upon their mental wellbeing. I gave them information & contact details for the Mental health crisis team and recorded their need for a wellbeing call back’

‘With the covid-19 pandemic it has felt even more important to be aware of the mental health of staff that I work with. I have been able to ask open ended questions and start conversations with people which I learnt from the training’

3.1d-Developments during the pandemic

A virtual practical application session for HBC staff who have attended any of the adult mental health training sessions has been piloted. The monthly sessions allow staff to discuss concerns they have with peers and are facilitated by the trainer who delivers the sessions. The sessions are solution focussed and support staff to implement what they have learnt. To help staff who support children and young people a resilience workshop was developed based on an evidence based resilience framework providing practical ideas to support children and young people's resilience

'The session was really useful. It helped us to recognise a lot of what we are already doing to build resilience without even realising and provide some ideas and identify areas we can focus on to build resilience further. I think the resources for signposting and finding out more about what is already out there will be very helpful' **Feedback from St Peters and Pauls on resilience workshop**

Virtual awareness sessions for parents and carers has also been piloted but take up has been low.

'I thought the presentation was very informative and look forward to going over this tonight with my son and I will definitely be looking up the hidden chimp book **Feedback from parents workshop on supporting their child's emotional health**'

3.1e-Public Health England Psychological First Aid e learning training

Early on in the pandemic Public Health England developed e learning training to skill the workforce and community up regarding psychological first aid. This training was promoted far and wide to partners and also to HBC staff.

3.1c-Champs Public Health Collaborative suicide awareness training review

A member of Kate Bazley's team has been supporting Champs to review suicide awareness training that is available across Cheshire and Merseyside and locally. The review is hoping to develop the training offer further so it meets the needs of specific cohorts such as ambulance staff and police. The review is part of a wider programme of work looking to reduce suicides across Cheshire and Merseyside and funded by NHSE.

3.1d-Samaritans training

Champs Public health Collaborative funded Samaritans to deliver training on how to have conversations with vulnerable people and managing suicidal conversations. Both training cohorts are fully booked and will be taking place in January. The training was commissioned due to the pandemic and lack of

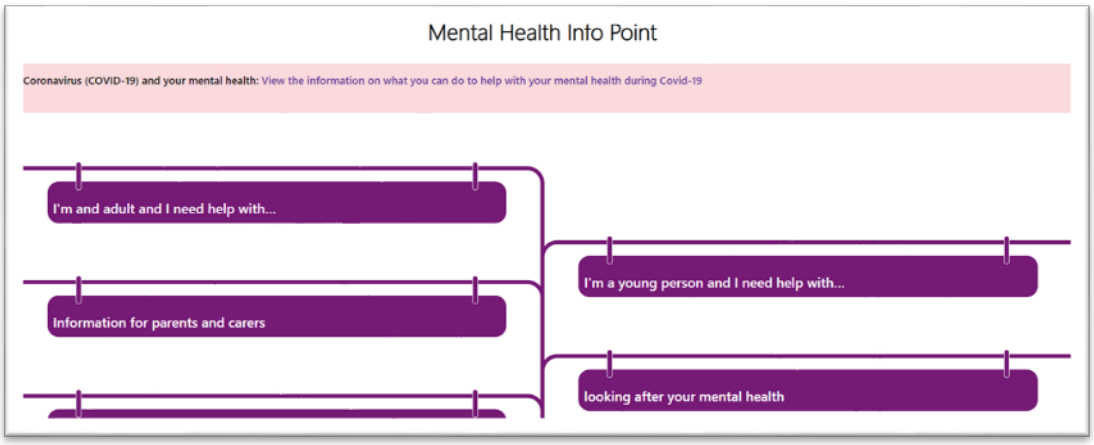
training available across Cheshire and Merseyside however in Halton we have made our training virtual. Specific teams were targeted who are supporting adults who are vulnerable. A Health Improvement staff member will attend both sessions to enable any learning to be incorporated into current training sessions.

3.2 Increasing awareness of support available and tackling stigma

3.2a-Mental health Signposting

The Mental Health info point was developed in response to both members of the public and staff not knowing what support was available to help with mental health concerns. It was originally meant to be a standalone website but unfortunately this couldn't be done and it was included in the HBC website but with its own URL.

www.halton.gov.uk/mhinfopoint



The need for the development of an online resource for both members of the public and professionals was included in both local Mental Health transformation plans for adults and Children and Young People. The Mental Health info point provides details of support available both nationally and locally for a variety of concerns which impact mental health such as bereavement, stress, anxiety, money worries and more.

The mental health info point was completed just before national lockdown in March. Information was quickly adapted to include mental health and Covid. The mental health info point is actively promoted on social media.

Table 3- Analytics of Mental Health info point from March till 5th of January 2021

Total page views	**4642**
Total number of users	**2046**
Number accessing info on mental health and covid	**758**
Number accessing info for young people	**177**

Number accessing info for parents	**156**
Number accessing information on needing help now (need support for MH crisis)	**309**

*Over **50%** of the page views were a combination of the web link being accessed either directly or via face book promotion due to targeted marketing

During the pandemic a section for professionals and workplaces was created to provide information and resources for staff supporting children and young people and local workplaces. The mental health info point continues to be developed, marketed via social media and promoted during training.

3.2b-Marketing

Every new financial year a marketing plan is developed to help promote key information and services to help keep the population of Halton mentally well. This financial year the plan had to be adapted to meet the needs emerging due to the pandemic which were increases in isolation, loneliness, bereavement, alcohol intake and domestic abuse. Information is shared via HBC social media platforms and with partners.

Table 4-Statistics for Twitter from April 2020 to December 2020

Impressions	engagements
346503	**4092**

Table 5-Statistics for Facebook from April to date

Reach	Impressions	Engaged users
553916	**623782**	**6631**

3.2c-Mental health Awareness Week

For mental health awareness week in May 2020 Halton's Time to Change coordinator for Halton's Time to Change hub developed a social media mental health toolkit which the Health Improvement Team shared with over 150 local partners to promote what people can do to look after their mental health. Partners were encouraged to share on their social media to further increase reach.

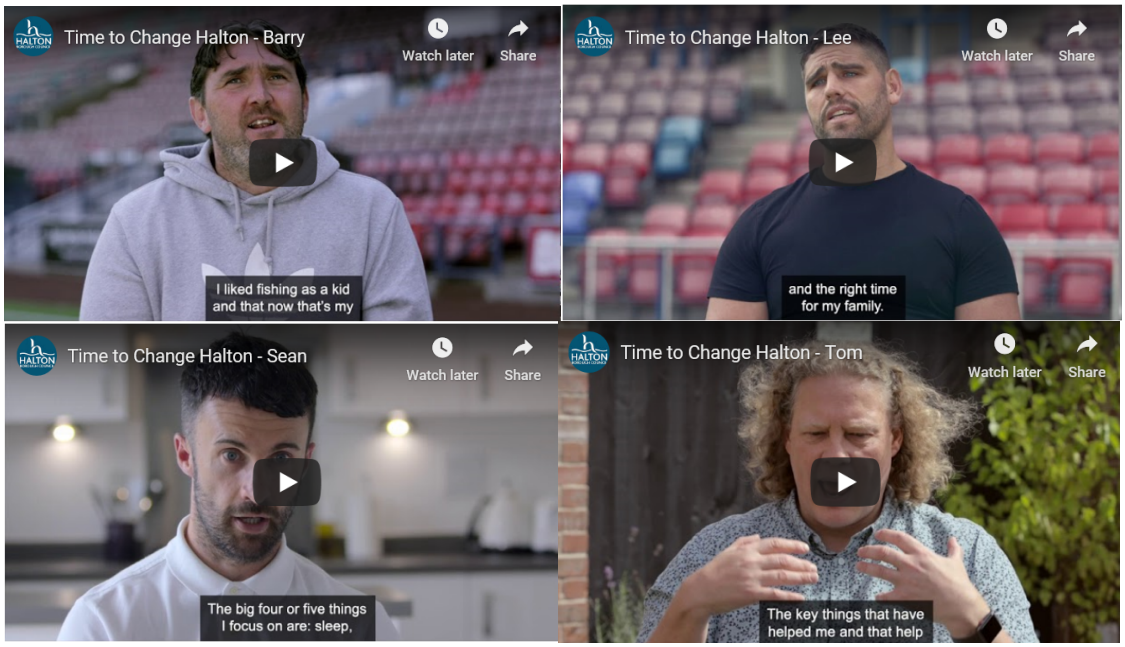
3.2d-Champs Public health Collaborative Stay Alive App awareness campaign

Champs developed and delivered a campaign to raise awareness of the free Stay Alive App across Cheshire and Merseyside from October to December 2020. The Stay Alive app is a pocket suicide prevention resource for the UK, packed full of useful information to help people stay safe. You can use it if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide. The aim of the campaign was to encourage people to download the App that signposts to local Crisis helplines. A full evaluation will be available at the beginning of February demonstrating how many downloaded the app in Halton. The initial figures very encouraging, with **2000** new users and

over **14,000** clicks to services in the first 3 weeks.

3.2e-Tackling Mental Health Stigma with Halton's Time to Change hub

Time to Change Halton is a local hub, set up in partnership by Halton Borough Council, Mind Halton, other local organisations and Time to Change champions. The aim is to change how those who live and work in Halton think and act about mental health problems reducing mental health stigma. The focus of the hubs work has been to reduce mental health stigma in middle-aged men due to this cohort making up 75% of suicides both locally and nationally. Local Time to Change champions, who are people with lived experience of mental health problems, drive the direction of local work campaigning to challenge mental health stigma. The local coordinator recruits and supports Time to Change champions there are now **50** champions locally. Evidence shows the best way to challenge mental health stigma is by sharing lived experience stories. Funds previously received from National Time to Change were used to pay for the development of lived experienced videos and a targeted radio campaign aimed at middle aged men. The targeted social media campaign began in September 2020 and finished in October 2020. The targeted Radio campaign began in September 2020 and ended in December 2020



All 4 videos can be found on the HBC YouTube channel: https://www.youtube.com/watch?v=CRVBJol2yUI&list=PLeXIVsKOQx2ar4upCpH5-TJBaKnmxvTxU

3.2f-Outcomes

Statistics for Facebook

People Reached
84868

Views
23,920

Engagements
8638

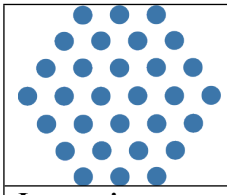
Statistics for Twitter

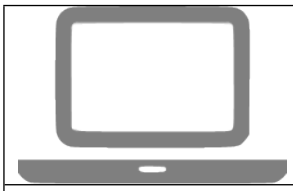
Impressions
9787

Views
2421

Engagement
573

Analysis of Radio Campaign

	
Impressions 50,000 to 6116 individuals	**Listen Through Rate** **96.6%**

		
Laptop/PC **9%**	**Phone / Tablet** **36.6%**	**Other Devices** **(e.g. gaming platforms)** **54.7%**

3.2g-Feedback

Social media comments

'All of this is so very true, Lee. The lessons you're able to share with others from your own personal experiences, are so important and empowering. You're a real beacon of hope, and you're helping dismantle that damaging stigma about toxic masculinity. It's not weak to speak'
'Such an important message from @timetochange champion Barry "that openly talking about it can make things better". Great to see signposting to'
'It's definitely #timetochange so that men feel more than ok to speak up and

get help. Thank you to all those guys who are speaking out'

'Such a great story Tom'

"I attended one of Sean's classes (circuit training) last night and so too see this and hear what he's been through and then see him last night is just amazing! I have changed my whole career to re- train in mental health care because it's so important to everyone and it shouldn't be stigmatised!"

Feedback from Champion involved

'I've had a really good response to the video. I can't believe how many people have come up to me and said that they've gone through something similar. It just shows that speaking out definitely works, cause people have actually come up to me and told me their own struggles. So by watching our videos men are starting to talk about their own struggles and know it's nothing to be ashamed about. So just in the short time the video has been out it's started to work, which is why I volunteered to tell my story. It makes me feel very proud in what I've achieved' **Barry Halton Time to Change Champion**

3.2h-Potential reduction in Suicides

Throughout 2020 we have seen a potential reduction in local suicides. We won't know if this reduction is accurate until all inquests have been completed and a verdict of suicide has been given therefore it could be a further 6-12 months before we are certain. There has also been delays in receiving some data from the coroner's office. For the period of 2020 we have been notified of **9** potential suicides with a **50% reduction** in male suicides. please see table below regarding how this compares to last year's data

Table 6-Potential suicides

	2019	**2020**
Males	10	5
Females	3	4
Totals	13	9

3.2i-Future anti stigma work

Halton's Time to Change hub has secured funding to develop 20 second videos utilising footage previously filmed by Time to Change Champions. The 20 second video clips will engage with middle aged men via a video display campaign. The messages will be aimed at sharing what helps keep people mentally well and also what other people can do to help someone who is struggling.

3.3 **Supporting organisations to make positive changes**

Prior to the pandemic support was provided to workplaces, educational settings and early years settings to help them make positive changes to how they work

subsequently improving the mental health and wellbeing of everyone. Due to the significant pressures workplaces have been under they haven't been in a position to engage however we have still provided them with information

3.3a-Supporting HBC staff

A significant amount of work has already taken place to improve the mental health and wellbeing of staff prior to the pandemic due to the Time to Change Employer pledge steering group which is chaired by Kate Bazley. At the beginning of the pandemic the Health improvement team developed a health and wellbeing portal providing a wealth of health information to help staff stay healthy and well. The health and wellbeing portal has been promoted regularly to HBC staff. Training available to HBC staff has been increased resulting with a significant number being able to access this offer including teams which may not have accessed this previously such as admin support. Public Health England's Psychological First Aid e learning training was promoted by David Parr to all staff. FREE tailored mental health support provided by Remploy was promoted throughout the pandemic to help support staff who were struggling with their mental health. HBC Employer pledge steering group continued to meet continuing to tackle mental health stigma and improve mental health of staff.

Table 7 HBC staff accessing interventions and training

Number accessing intervention/training	Intervention accessed
26	Remploy mental health support
157 managers	Mental Health awareness training for managers
89	Mental health awareness training
60	Suicide Awareness training

3.3b-Support to shielded individuals during lockdown 1

During the first lockdown Kate Bazley and her team of two spoke to **52** shielding individuals to discuss their mental health concerns and connect them to appropriate support and information. This was part of the wider piece of work taking place supporting individuals who were shielding. Although this isn't part of their normal role, as they improve mental health by working at a population level not an individual level, they identified the need and provided support. They also trained **25** staff who were making calls to shielded individuals so they had a better understanding of those shielded individuals mental health needs.

3.3c-Supporting Educational settings

The mental health offer for primary and secondary schools is part of the healthy schools work that has been imbedded in Halton for years. All schools receive a healthy schools visit to discuss their needs and decide what support they require from a multi-agency offer. Schools that want to focus on improving the mental health and wellbeing of the whole school are connected to Kate Bazley's staff member to discuss what support they can offer and the support of other partners

such as; Educational Psychology, Behaviour Improvement Team, CAMHS and Nurture. **5** schools have been supported during the pandemic

Table 8- Schools and staff accessing interventions and training

Number accessing intervention/training	Intervention accessed
7 schools	Completed Mental Health and Resilience in schools (MHARS) self-assessment
42 staff	Mental health awareness training
23 staff	Self-harm awareness training
15 staff	Resilience workshop

3.3d-Supporting Early years settings

The mental health offer for early year's settings is part of the Healthy Early Years (HEYS) work that has been imbedded in Halton for years. All early years settings are provided with a HEYS visit to discuss what they have in place to keep the whole setting healthy. As part of this visit settings are also provided with a mental health offer to help them improve the mental health of the whole setting. During the pandemic this offer has been made virtual with early year's settings having access to virtual training. Thirteen early years settings have had at least 1 staff member accessing mental health awareness training for early year's staff with the following settings accessing training for all their staff Little Dragons, Ditton Nursery School, Warrington Road Nursery School, Weston Point Pre School and Gorsewood Pre School. Other training that was planned had to be cancelled due to attendees needing to focus on responding to the pandemic and some preferring to wait until face-to-face training can go ahead. Brief advice and guidance has been provided to early years settings signposting to Remploy and the Mental Health info point.

Table 9- Early Years Settings accessing training

Number training	Training Accessed
39	Mental Health Awareness training for early years
2	Stress Awareness training

Post 3 month feedback for early years training

Some great information regarding various places to signpost parents and staff, lots of good ideas for strategies for children think it will come in very useful when we start back In our setting we will be implementing some new calming down activities. We will ask the children to stop what they are doing and to take some deep breaths this will help the children to relax and keep the room a lot calmer. Thinking more about how we can build 'down time' into routine for children

Thinking about how ACE's affect the mental health of children. Lots of ideas for support and signposting for staff and also parents

3.3e-Partnership working

Kate Bazley has supported with the following pieces of work

- Supporting Educational Psychology with Education for wellbeing return project funded by the DFE.
- Contributed to the return to school campaign along with Educational Psychology
- Supported Everton in the Community to engage with 2 primary schools to deliver tackling the blues project
- Continue to support ACES project led Behaviour Improvement team supporting pilot engagement with 2 schools to imbed trauma informed approach
- Continue to support Halton's Nurture strategy including evaluation and future development

3.4 Suicide prevention

3.4a-Suicide prevention partnership board

The Suicide Prevention Partnership Board is made up of a variety of partners and meets quarterly to drive the suicide prevention action plan. The March meeting was cancelled due to it falling in the first week of lock down and all other meetings have been carried out virtually. Evidence was established early on in the pandemic that suicides weren't increasing however, key risk factors were highlighted due to the pandemic from research carried out by NCISH. These risk factors included; increase in isolation and loneliness, increase in domestic abuse, increase in alcohol intake, bereavement and financial worries. To help mitigate against the increased risk factors and prevent suicides from rising a task and finish group was formed to focus on reducing the risk of suicide in those at greater risk. The task and finish group developed a recovery and resilience social media tool kit which was shared with over 150 partners locally focussing on key risk factors heightened during the pandemic.

https://www3.halton.gov.uk/Pages/health/hit/pdf/recoverypr.pdf

3.4b-24 hour crisis line

Early on in the pandemic NHSE tasked mental health providers to develop a 24 hour crisis line. NWBP with other mental health providers managed to develop the local crisis line by March 2020. Since its launch the crisis line has been continuously developed and by November had recruited 4 staff members who

will solely provide this service. Prior to November this additional service had been an extra duty for existing staff. Since its launch, the crisis line has supported over **6000** people across the NWBP footprint. Unfortunately, at the moment NWBP doesn't have the ability to break down callers by the area they live in so we are unable to understand how many people from Halton have accessed the service. Once NWBP are able to provide us with this data we will be looking to see which ages and gender aren't accessing so we can target other support available.

3.4c-Anti-stigma campaign

Time to Change anti-stigma campaign delivered in September 2020 aimed at middle-aged men potentially helped to reduce suicides. Outcomes discussed previously.

3.4d-Champs Public Health Collaborative

The Champs Public Health Collaborative coordinates the joint actions for Cheshire & Merseyside (CM) to prevent suicide through the NO MORE Suicide Strategy. In 2018, NHS England (NHSE) announced a 3-year suicide prevention funding programme worth £25 million that will reach the whole country by 2021. It forms part of the government's commitment to reduce suicides in England by 10% by 2021 and will support the zero suicide ambition for mental health inpatients announced by the Secretary of State in January 2018. Cheshire & Merseyside have secured £615,000 for 19/20 and an additional £295k specifically for middle-aged men's health.

Champs are leading on the following areas of work across Cheshire and Merseyside with support and input from local authority public health leads:

- Reducing Self Harm
- Reducing the risk of suicide in middle aged men-
- Supporting mental health trust to implement safer care standards
- Pilot supporting primary care in Sefton and St Helens
- Workforce development reviewing training
- Developing lived experience network

3.4e-Bid to reduce suicides in Veterans

Halton and Warrington CCG and Warrington public health were supported by Kate Bazley to submit a North West bid to secure funds to tackle suicide in veterans

3.4f-Raising awareness of debt and Mental Health

Kate Bazley is working in collaboration with Halton CAB, Warrington CAB and Warrington Public Health to develop and deliver a webinar on mental Health and debt to try and improve partners and the public's knowledge of the relationship between MH and debt including some of the reasons why people struggle to access support. Once debt starts to be collected the risk of suicide potentially

increases.

4.0 POLICY IMPLICATIONS

4.1 There are no new Policy implications as a result of this report.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Time to Change Halton is actively looking for further funds to continue its anti-stigma work with middle-aged men.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The population mental health work driven by public health aims to improve the mental health and wellbeing of children and young people as well as reducing suicides

6.2 Employment, Learning & Skills in Halton

The population mental health work driven by public health improves knowledge and skill of those who live and work in Halton via a variety of training available

6.3 A Healthy Halton

Population mental health work driven by public health improves the mental health and wellbeing of those who work and live in Halton as well as reducing suicides.

6.4 A Safer Halton

Population mental health work driven by public health improves the mental health and wellbeing of those who work and live in Halton as well as reducing suicides.

6.5 Halton's Urban Renewal

No implication on Urban Renewal

7.0 RISK ANALYSIS

Covid has impacted population mental health negatively, the following cohorts have been specifically impacted; women, children and young people, adults who were shielding, adults living with children and lone mothers, BAME, adults with pre-existing mental health conditions, adults with low household income, and unemployed. Risk of suicide has increased during the pandemic in the following: those isolated and lonely, those bereaved, those who have increased alcohol intake and those being domestically abused. Population mental health work that has taken place throughout Covid has aimed to mitigate against these risks.

7.1 *The key risks/opportunities associated with the proposed action and an outline of the key control measures proposed in relation to these risks should be included.*

*A statement must be made as to whether proposals are so significant as to require a full risk assessment. If a full risk assessment is required, please describe high risk areas and control measures. (NB **all** key decisions automatically fall into this category of requiring a full risk assessment.)*

8.0 **EQUALITY AND DIVERSITY ISSUES**

Population mental health work driven by Public Health aims to support organisations who work with clients with protected characteristics

8.1 *Any Equality and Diversity implications arising as a result of the proposed action should be included*

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.

REPORT TO: Health Policy & Performance Board

DATE: 23rd February 2021

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Children, Education and Social Care
Health and Wellbeing

SUBJECT: Intermediate Care Services in Halton

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide the Board with an update on Halton's Intermediate Care Services Review and progress towards the development of a new model for Intermediate Care in the Borough.

2.0 RECOMMENDATION

RECOMMENDED: That the Board

(1) Note contents of the report and associated appendices.

3.0 SUPPORTING INFORMATION

Introduction

3.1 For a number of years, Intermediate Care (IC) Services within Halton has comprised of four services, as follows:-

- Rapid Access Rehabilitation Service (RARS);
- Oakmeadow (Intermediate Care Unit);
- Halton Intermediate Care Unit (HICU); and
- Reablement

Services have been resourced by multi-disciplinary teams of clinicians, nurses, therapists and social care staff, who provide rehabilitation services for people needing rehabilitation, to promote independence, prevent unnecessary hospital and care home admissions and facilitate discharge from Hospital.

3.2 In 2019, Halton commissioned a review of IC Services comprising of:-

- an independent review, via the Local Government Association (LGA), by Dennis Holmes ***(see Appendix 1)***;
- a North West Association of Directors of Adult Social Services (NW ADASS) Peer Review (***see Appendix 2)***; and
- an 'organisational raid' to Rochdale, to view the service pathways and models operating in that borough.

Essentially, in summary, the work identified the following issues/recommendations in relation to IC Services in Halton:-

- Adopt a more community focused 'home first' model providing services in people's own homes – this essentially incorporates the 'reablement first' and 'discharge to assess' approach with a focus on recovery through functional assessment and intervention work;
- Develop a pathways approach to hospital discharge;
- Reduce length of stay in short-term bed based services and therefore increase capacity, allowing for a reduction in actual bed numbers;
- 'Reset the system' by addressing issues in long term care provision; and
- The Peer Review suggested HICU (Ward B1) was more aligned in its functioning and physical space as an 'in-hospital' service and was not intermediate care.

An action plan was developed, with a system wide oversight group, and various work streams commenced, including work on reviewing the IC criteria and associated pathways and a 'case for change' in respect to a future model for the delivery of IC services in Halton.

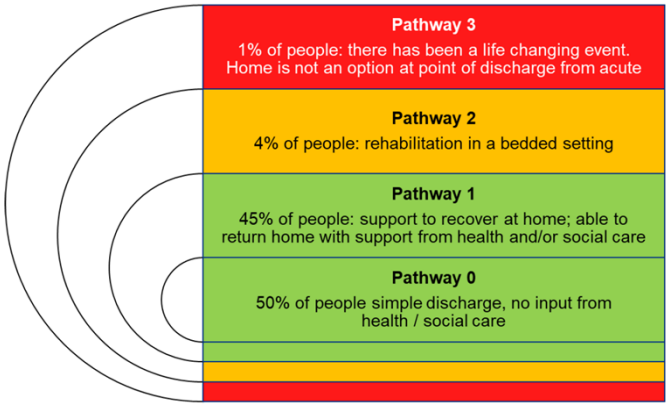
However, this work was 'paused' in March 2020, due to the priority focus being the management of the Coronavirus pandemic.

3.3 **Impact of the Coronavirus Pandemic**

As a result of the Pandemic and the need to ensure health and social care services could continue to effectively respond, there was a need to rapidly review service provision and introduce new ways of working.

As such, a key element of this was the national introduction of the COVID-19 Hospital Discharge Service Requirements on 19th March 2020.

In essence, this guidance provided a renewed focus on the Discharge to Assess model based on four clear pathways for discharging patients from hospital, as shown below:-



3.4 Systems and processes within our local Acute Trusts needed to be realigned to support this approach. In Halton, the Care Management Service, including resources from the existing Capacity and Demand Team and RARS, were merged and redesigned to support the approach. This was to ensure that a capacity and demand led approach could be taken, in order to create sufficient and robust capacity to manage a predicted spike in hospital admissions.

3.5 One of the unexpected outcomes of the Pandemic in Halton and the approach needing to be taken was the ability to 'reset' the system in respect to being able to create capacity within Intermediate and Domiciliary Care Services and change pathways and associated processes.

3.6 The reconfigured services within the Borough and the alignment with Acute Trusts have had a high degree of success in creating capacity within service areas, from which we have taken learning to help support the development of a new approach to IC within Halton. For example:-

- Rapid assessment and a speeding up of the pathway through IC bed based services utilising discharge to assess approaches has significantly reduced both the number of people in these bed bases and reduced length of stay.
- The Reablement first approach has facilitated more people out of hospital into the community with support. Processes through the service have reduced length of stay and therefore increased available capacity.
- Focus in the acute sector on daily management of people has enabled earlier identification of people in process and advanced planning to achieve discharge, when medically ready and safe to do so.

3.9 Although it is recognised that we are still in the depths of the Pandemic and the system is under some considerable pressure, we felt that we needed to capitalise on the success creating capacity in the system had brought us and as such felt it was appropriate to revisit the recommendations of the previous IC review, taking into account the impact that the Pandemic has had on current structures, processes and pathways and move forward, at pace, with the development and implementation of a new model/approach to IC in Halton, which would deliver necessary and appropriate services.

3.10 As such, work has been taken forward via the IC Review Steering Group (Multi Agency group), chaired by Halton's Director of Adult Social Services, supported by an IC Model Development Group and although work hasn't been progressed as quickly as liked, due to operational pressures, positive progress has been made and we are on schedule to introduce a new model for Intermediate Care from 1st April 2021.

New IC Model

3.11 One of the main elements of the new model is the planned introduction of a Single Point of Access (SPA) for IC Referrals (from Hospital and the Community), both those requiring support within the community and those requiring a bed.

3.12 The aim of the SPA will be to ensure people receive the necessary interventions for those needing rehabilitation, to promote independence, prevent unnecessary hospital admission and facilitate discharge from Hospital.

The key objective of the SPA is therefore to ensure the seamless, safe management of referrals for people requiring Adult Community Services, either to potentially prevent an admission, support early discharge or coordinate care 'closer to home.'

An integral part of the SPA will be its Rapid Response Function (RRF).

Benefits to Service User of introducing the SPA include:

- Reducing the number of inappropriate referrals into services: right care first

time.
- Reducing duplication of assessments and visits to people's homes through better care co-ordination.
- Facilitating discharge and preventing unnecessary admissions.

Benefits to the Halton system of the SPA:
- Alternative referral route for GPs and healthcare professionals.
- Simplified, efficient referral process which includes assessment and planning of care.
- Reduces the time currently spent by the referrer in identifying and arranging appropriate treatment, care and support across a range of disciplines.
- Improved access to a range of services.
- Communication of agreed plan of care back to referrer and to GP if not the referrer.
- Supports people to stay at home and minimises the need for admission to hospital.
- Increase activity in community services as a result of GPs referring into SPA rather than admitting people to acute hospitals.
- Having the seamless sharing of data and information across services/organisations.
- Increase face to face clinical time.
- Reduces the amount of Delayed Transfers of Care.

3.13 The SPA will be resourced by a multi-disciplinary team consisting of clinicians, nurses, therapists, dietician, administrative and social care staff and at the time of writing this report further work is being carried out on the exact numbers and skills mix required, in addition to the hours of operation.

The SPA will hold the role of "care co-ordinator" until the relevant onward referrals have been made/individual discharged from SPA. An individual will have a named care co-ordinator from within the SPA.

3.14 As referenced in paragraph 3.12 there will be a RRF of the SPA which will provide place based, multi-disciplinary proactive community support to help people remain at home **or** return home as soon as possible from hospital.

This RRF will respond when people are:-
- Experiencing a crisis.
- At risk of hospital attendance/admission or residential care admissions.
- Medically safe to be treated/cared for in a community setting.
- In need of assessment/intervention with two hours (safe to wait for up to 2 hours).
- Returning home from hospital and who may need extra support.

3.15 The service will provide immediate treatment, encompassing a rapid holistic assessment (covering clinical, therapy and pharmacological elements where appropriate) and co-ordinate healthcare, social and voluntary interventions in the community to enable people with frailty to be supported at home including care homes.

The main elements of the RRF will be:

- Clinical triage
- Initial triage of presenting people by an appropriate clinician
- Treatment and admission avoidance care plans
- Advanced care planning involving DNACPR and PPC
- Clinical medication review
- Optimising physical function
- Discharge plans
- Supporting self-care and peoples education

3.16 The plan is that the RRF of the SPA will manage people on virtual ward principles. The virtual ward will operate in the same way as a normal hospital ward; the difference is the person will stay comfortably and safely in their home.

People will be admitted and discharged from the virtual ward whilst they are at home, proactively case managed, or targeted to prevent deterioration in condition and avoid admission to hospital. The person's condition will be assessed and monitored on a daily basis, or more frequently if required, by a multi-disciplinary work force including input from a Consultant in the Care of Older People. People will remain on the virtual ward from 24 hours up to an average of two weeks, dependent upon the complexity of the care needs, and will then be discharged to the most appropriate community service.

In cases where effective treatment cannot be achieved, the person will be referred to A&E, frailty assessment unit or acute frailty hub, as appropriate for the degree of deterioration in health.

3.17 The long term ambition would be for those individuals with complex requirements to be referred onto and managed via the Primary Care Hub MDTs, however until these are developed further individuals would remain on the service for up to two weeks receiving the necessary interventions.

It is recognised that the introduction of a new model from 1st April 2021 will not be the end of developments and it is anticipated that during 2021/22 further work will take place to assess the potential to expand the SPA to include Community Nursing and Community Therapy referrals from Hospital and the community, as well as linking in with the Primary Care Hub developments referenced above.

4.0 POLICY IMPLICATIONS

4.1 Associated changes in processes/operating procedures will be required to support the new approach/model and these are in development.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any changes in approach/model provision are being made from within current resources available.

5.2 At the time of writing this report discussions are ongoing with colleagues within NHS Halton Clinical Commissioning Group, Bridgewater Community Health NHS Foundation Trust and Warrington & Halton Hospital's NHS Foundation Trust regarding the future contract arrangments which will be introduced to support the new model.

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 effective and efficient provision of IC Services in Halton is directly linked to this priority.

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 We need to capitalise on the opportunity the Pandemic has provided us with i.e. the creation of capacity within Intermediate and Domiciliary Care Services and change pathways and associated processes. This will ensure that the IC Service in Halton is in a strong position to be able to effectively deliver necessary and appropriate services to those who require it within the Borough.

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.

Appendix 1: LGA - Halton Intermediate Care Review

Appendix 2: NW ADASS - Peer Review Report on Intermediate Care

Dennis Holmes for YHC Ltd

for the Better Care Fund/ Local Government Association

Final Report

1 November 2019

Halton Intermediate Care Review

Introduction.

This review of Intermediate Care services in Halton commenced in June 2019 with a short 'diagnostic' phase. The review was conducted alongside a LGA 'Peer Challenge" and 'Organisational RAID' programme that examined different aspects of the Intermediate Care system in the Borough. This summary should be read in conjunction with the outputs of those other work programmes.

The assignment took place over the course of 4 months and included 16 days fieldwork conducted on site including interviews with key stakeholders, visits to Intermediate care facilities, visits to local acute hospital trusts, attendance at stakeholder board meetings, engagement with LGA peer review team and the facilitation of two workshops. The outputs from the diagnostic phase of this work are described in the following section and the discharge home to assess pathway (D(h)2A) which was co-produced with the system is attached as a descriptor and flowchart.

Monthly progress updates have been provided to the stakeholder board and to the LGA co-ordinator during the assignment.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

Executive Summary

1.0 Assignment Brief

The agreed LGA workplan for this review (June 2019) recommended that the review take place in three stages, a short diagnostic phase, then to bring forward some proposals for actions that could be taken by the system to address issues identified in the diagnostic phase, followed by some support for implementation.

The diagnostic phase was completed in June and, at the request of the system, covered 6 discrete areas described below:

a) Service Provision, including quality. -
The review identified that Halton Intermediate Care services have achieved **broadly consistent outcomes** for people over the last 6 years, namely, about 1/3rd retain independence with no additional care input, another 1/3rd retain independence with formal care support with the remaining 1/3rd receiving a range of other interventions. ***However,*** the number of referrals into the service has reduced over the same period and the number of people receiving an intermediate care service has reduced by 1/3rd.

b) Eligibility Criteria for Intermediate Care Services.

The review suggests that the criteria used in Halton is broadly in alignment with the criteria used in many other systems for similar services. However, in the absence of properly described care pathways, the broad nature of the criteria for the full range of Intermediate Care services means that it is likely that people are being misdirected within the system of care.

c) Access Criteria:
The review observed that the access criteria to elements of the Intermediate care services, ostensibly via a single point of referral, was, in reality, more complex, an observation also made by previous reviews. One consequence of this is a lack of clarity, particularly within the acute Trusts typically used by Halton residents, about the means to access different service responses. This could be assisted by the co-production of a suite of care pathways for people and a simplification of the access routes.

d) Pathways:
The review particularly noted the absence of a properly described "home first' pathway from the main hospitals service the Borough, Warrington and Whiston (St. Helens). Pathway routes into other elements of care at the Intermediate Tier were found to be described more as 'service specifications' rather than pathways of care for people.

e) Contracts and Performance:
This review has observed that seeking to manage flow through pathways in complex

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

adaptive systems via contractual mechanisms is likely to be sub-optimal. There are too few mechanisms for the system to employ in the event of a particular service under-performing. In other , commercial, contractual relationships, under performing contractors face the risk of replacement by other contractors in the market or face financial sanctions. For this range of services these sanctions are almost impossible to envisage being applied.

f) Success Criteria:
The overall conclusion of the initial phase of the work was that Intermediate care services for Halton residents have become 'stuck' with many people experiencing unacceptably extended lengths of stay in both acute hospital settings and also within intermediate care services themselves. The key success criteria therefore would be to improve out of hospital flow with the twin aims of:

i) Increasing the proportion of people returning to their own home to complete residual elements of assessment.

ii) Ensuring that the bedded intermediate care facilities were able to focus their rehabilitative efforts only on those people whose needs could not be safely managed in their own home.

2.0 Actions following on from the Review:

The review confirmed the significant demand pressures being exerted on the services which are contributing to much poorer flow through the different elements of the service than was the case 6 years ago. Improving flow for both acute and community services should be both a performance and quality aim for the system.

The review recommended that the current intermediate care offer in relation to discharge pathways out of acute hospital care becomes better aligned to nationally recognised current Discharge to Assess Pathways particularly in the adoption of 'Home First' pathway options, emphasising the importance of good inter-disciplinary planning for people within these pathways with clearly set therapeutic goals.

Establishing formal care pathways and organising service responses along those pathways can be seen as a means of better supporting the existing contractual arrangements that exist for services operating at the intermediate tier. Over time, it may well be that the system finds contractual arrangements are no longer necessary as the focus on organisations providing services shifts towards appropriate pathways of care and improving outcomes for people.

The review concluded that a practical first step would be to design (co-produce) a 'discharge home to assess' (D(h)2A) pathway for Halton residents who would be in-patients at Warrington and Whiston Hospitals. This recognised that there were currently no written pathways (or 'pathway descriptors' - or pathway maps) in use.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

The establishment of a 'home first' pathway and the process of co-design with key stakeholders from the system (both from within the acute Trusts and from community health, social, and other care services) were felt to be small scale practical actions that could be used as 'proof of concept' with the objective of scaling up over time. This in turn has the aim of creating some improved flow in the bedded units by diverting people who, in the absence of the remodelled D(h)2A pathway, would have defaulted to one of those beds.

In terms of 'co-production', a series of workshops were conducted with key stakeholders in the Halton, Warrington and St Helens system(s). The product of the workshops were the redesigned discharge home to assess pathway descriptor and flow chart which the system has agreed to adopt initially on one exemplar ward at Warrington Hospital and one ward at Whiston Hospital respectively.

3.0 Links to Other Work & Roadmap for Future Action.

The principal aim of the assignment, to co-produce a D(h)2A pathway supported by a 'standard operating protocol (SOP)' was achieved but can be seen as a starting position which allows the system to modify the pathway, and the associated service requirements in the light of it's use. Importantly it also allows the system to consider redesigning other, associated pathways in similar ways, most notably access to the bed bases, pathways into and out of the RARs team and the reablement service (and the relationship between the reablement service and community domiciliary care provision).

Clearly the organisational "RAID", LGA peer review and challenge have provided some recommendations of the types of service developments that the system would wish to consider, many of these recommendations compliment the outputs from this review.

Towards the beginning of the assignment the system requested that, at its conclusion, some indication should be given highlighting potential areas for future work by the system. In the following section I have highlighted three specific, inter-linked opportunities that the system may wish to consider prioritising for further work.

1. Initiating a 'joint commissioning' approach to designing (or co-producing) an integrated intermediate care service with clearly described care pathways with the different service offers organised along them.

2. To focus on continuing to develop and enhance therapeutic, recovery led services operating in person's own home.

3. With a locality focus, taking advantage of the developing primary care network 'hubs' to ensure that all the assets that exist within the localities of the Borough can be harnessed, alongside specialist professional care and support services, to maximise the independence of people living there.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

3.1 Co-Produced Pathway design & Recovery - Led Services.

At the D(h)2A design workshops it was clear that there is an appetite amongst frontline staff from across the whole spectrum of care and support services in the Borough to have further opportunities to work on developing and/or refining pathways of care . Three pathways in particular were identified:

- Pathways through reablement
- Pathways through the bed bases (Ward B1 at Halton Hospital in particular)
- Pathways into Domiciliary Care for people who's reablement needs have been met or who have no reablement needs.

The establishment of the D(h)2A pathway has already highlighted some of the ways in which an enhanced reablement offer will be required in the future, there are clearly many different ways in which this could be accomplished. As a starting point, staff attending the workshops began to articulate opportunities for closer working between the reablement service and community therapy services (especially those operating as part of the RaRs service), up to and including integrating the services. Staff also identified opportunities for enhancing reablement capacity by exploring the future use of Bridgewater healthcare assistants who are locality based.

Alongside the enhancement of the reablement offer, staff were really clear about the need to review the use being made of the current intermediate care bed-base. this review has already identified that the likelihood that many people who use the current bed base should have their ongoing needs more appropriately met in their own home or other venue of care. There is clearly an opportunity for the system as a whole, including the acute Trusts, to redesign pathways through the current bed base that place significantly more emphasis on the therapeutic needs of people who may need such a facility. For this reason, there is a compelling case to suggest that the proposed redesign process should be facilitated by community therapy staff.

Finally, all stakeholders interviewed in the course of the review, staff engaged in the workshops and the LGA peer review have all identified an urgent need to seek to improve flow into and through domiciliary care in the Borough. Ensuring a sufficiency of domiciliary care support is a long term strategic challenge for ***all*** local partners, not solely for the Local Authority, with virtually all elements of 'flow' ultimately depending on the eventual availability of care in the home. It is a long term strategic challenge because of the complex interplay of financial, workforce and geographic factors which require a co-ordinated response by all system partners. Without a co-ordinated strategic approach to ensuring sufficiency, redesigned pathways of care through domiciliary care services are unlikely to be more than marginally effective at improving flow.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

3.2 Locality Hub Opportunities.

It is recognised that system planning in relation to the creation of 'locality hubs' is at a very early stage, however, the opportunities presented by this particular strategic initiative are potentially significant.

Many other systems around the country, by virtue of either their scale or historic service configuration (or both in many instances), have a strategic wish to move to a population health management arrangement based around local primary care hubs, incorporating a range of integrated health, care and support staff. In many instances that strategic intent proves difficult to implement, in many instances requiring the large scale reorganisation of services and their associated workforce as well as addressing significant practical challenges around infrastructure.

In contrast, the geography and scale of Halton as well as its current service configuration suggests that organising around 4 discrete locality hubs is an attainable goal.

Organising the core intermediate care pathways (some of which are highlighted in the previous section) and associated service offers around locality hubs has a number of potential advantages which can be designed in:

- Community 'ownership' of patients needing acute hospital care - potential to move to an 'in-reach' model of care management.
- Easier community clinical oversight by GP's - ability to have greater focus on 'step up' into intermediate care services than at the present time.
- Locality MDT lead professional infrastructure would be in place, essentially becoming 4 'single local points of contact' - removes the need for extensive referral infrastructure.
- Capability to organise reablement and domiciliary care into the hubs, potentially ensuring more seamless flow between the two
- Expert locality knowledge of locality MDT likely to more effectively bring into play the whole range of community assets to support people to live independently.
- Has the potential to significantly shift the emphasis from the organisation responsible for a particular service towards the locality responsible for overall care and support.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

4.0 Recommendations

1. Setting about any redesign or reconfiguration programme generally requires some governance infrastructure and some practical apparatus to organise the associated work programmes. The stakeholder board arrangement for this assignment seems to have worked well and the system may wish to consider the continuance of that governance structure to oversee whichever work programmes suggested by this review and the LGA peer review that the system agrees to progress.

2. In taking any work programme forward, it will be helpful if the system can identify some project or programme management capacity to provide practical support in the design (co-production) of pathway(s) and service configurations suggested in this report.

3. Project management support would enable the facilitation of further workshops engaging front line staff (which seem to have worked well as part of this assignment) and could provide a model for bringing forward detailed proposals for those pathways set out in S 3.1.

4. Some project management infrastructure would also help in supporting the practical implementation and operation of new care pathways as well as helping to monitor and report their effectiveness.

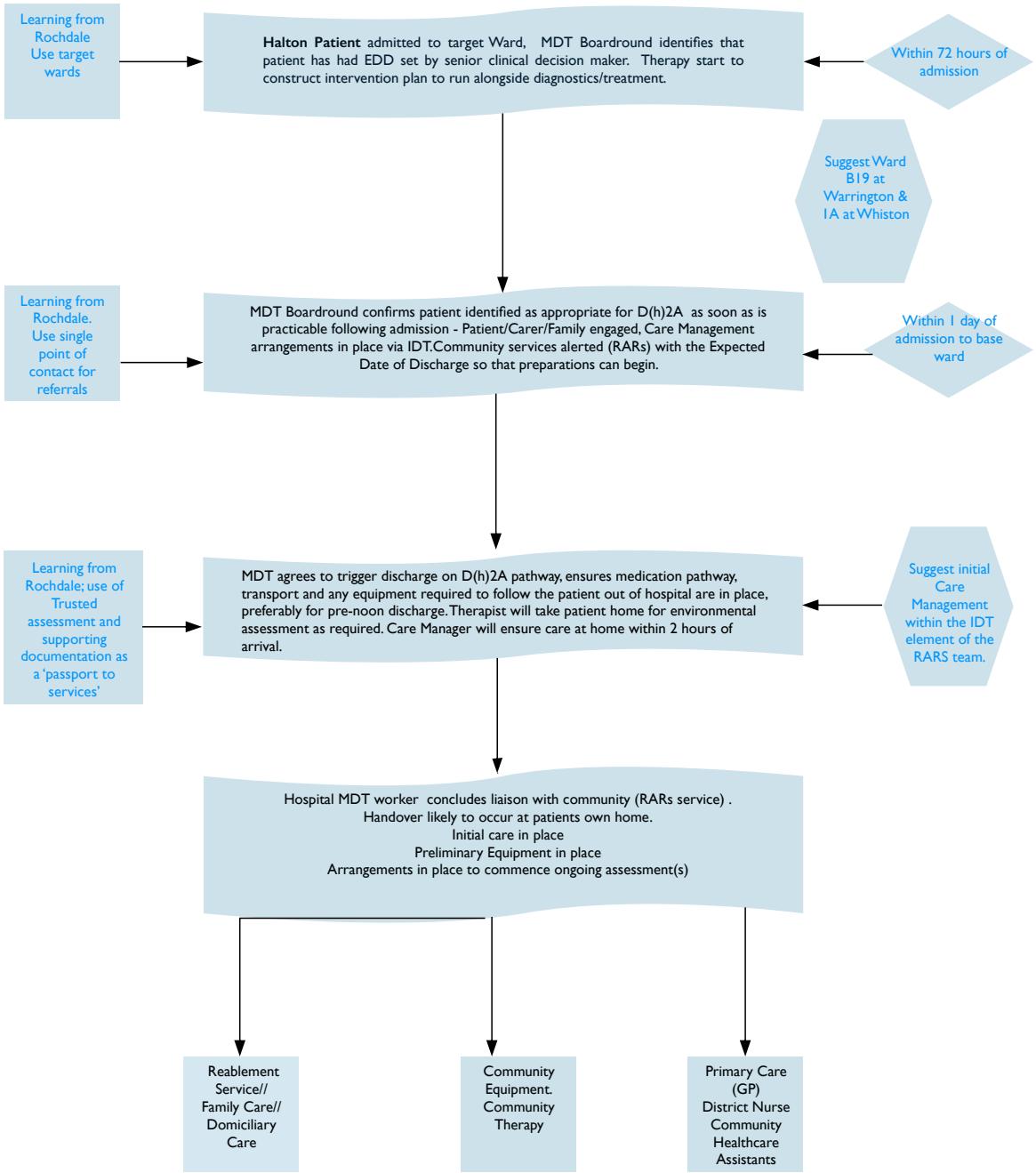
5. At a strategic level, there is a need for key elements identified in this review (set out in S3) and the LGA peer review to be brought together and presented to the appropriate local forum with the intention of system leaders formulating a plan of action in response. This will hopefully ensure that these recommendations can be incorporated into the wider strategic vision for Halton residents.

Dennis Holmes

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

Appendix 1

Halton D(h)2A Schematic Pathway (Draft 2)



Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

Appendix 2.

Halton System.

Discharge (Home) to Assess Pathway Descriptor.

October 2019.

1.0 Introduction - The Aim of Discharge (Home) to Assess. (D(h)2A - Pathway 1).

The overall *principle* underpinning all discharge to assess pathways (and reflected in the substantive Emergency Care Improvement Support Team 'Quick Guide' on D2A), is that no decision about a patients long term care needs is made in an acute setting and, as a default, systems should aim to ensure that patients should be supported to return to their own homes to complete assessment processes.

The overall *objective* of the pathway is to minimise the person's stay in acute care and to maximise their independence with care at their home, thereby:

- Supporting timely discharge from acute hospital care.
- Maintaining the independence of the individual.
- Reducing the frequency, duration and/or intensity of long term packages of care.
- Achieving a net neutral impact on health and social care expenditure and
- To complete assessments of need in a setting that reflects the capacity of the individual to build on their strengths and abilities to maximise their potential.

The pathway is ***deliberately*** not written to set out criteria that patients must meet for inclusion, rather, the pathway assumes that ***all patients*** should be considered for inclusion on the pathway and exclusions then applied contingent on the nature of the persons circumstances and the views of the MDT. There will be circumstances where the discharge needs of the patient are so straightforward that onward care planning is relatively straightforward. Some systems refer to these very straightforward pathway requirements as 'Pathway 0'.

Patients for whom it is clear that their overall needs cannot be safely met in their home environment at the point at which their medical needs no longer need to be met in an acute hospital setting, are likely to require being discharged to be assessed in an alternative bedded facility, the nature of which will depend on the complexity of their needs. These are usually referred to as D2A Pathway 2 and 3 with the lower number referring to lower levels of complexity.

1.1 Underlying Principles:

In the process of setting out this process descriptor, based on two workshops and co-produced with key stakeholders in the Halton system, a number of desirable underpinning principles and ambitions emerged, these can be summarised as:

- An ambition to improve the patient experience of acute care by reducing avoidable lengths of stay in acute care.
- An ambition to increase the numbers of people returning to complete assessments in their own home.
- A desire to make the Discharge Home to Assess pathway as easy (understandable and straightforward) to use as possible for those people using it and their relatives and carers and, importantly, for staff in acute and community settings.
- A desire to streamline the process (including documentation) and to minimise the number of 'handoffs' (referrals) within and between different services within both acute and community settings.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

- A desire to work with staff to accommodate greater levels of uncertainty and risk for some professional groups associated with the adoption of this pathway. (Agreed Risk thresholds).
- A desire to establish a 'Standard D(h)2A Operating Protocol' for Halton residents that capable of adjustment and amendment, to sit among a suite of properly designed intermediate care pathways.

2.0 Pathway Descriptor.

Attached is a flowchart which aims to summarise, for ease of reference, the following pathway descriptor. The pathway commences within the acute hospital(s) setting. Several enabling features (and processes) need to be in place on the wards within the acute Trust(s), without these enabling features and processes no D2A pathway or process can be expected to function effectively (or, in most instances, at all).

2.1 In Acute Hospital Care[1]

- Early (within 72 hours of admission) establishment of an Expected Date of Discharge (EDD) to provide a focus for discharge planning.
- The engagement of a Multi Disciplinary Team (***Must*** include IDT at Whiston and Halton IDT at Warrington Hospital) to co-ordinate these efforts. MDT representation should reflect a balance of clinical leadership, including senior decision makers, nurses and therapists alongside social care colleagues.
- It is within the earliest MDT ***board round*** following admission that Discharge Home to Assess patients can be identified[2] and progress through the pathway commenced.
- For D(H)2A patients the MDT should ensure that the earliest contact is made with the relevant community health and social care community teams with expected discharge dates so that they are prepared in advance.

Internal Triggers to progress discharge

- ***Addressing Medical issues:***
  - Are there any ongoing medical /nursing needs for the patient that ***can only*** be provided in an acute hospital? If not, progress with D(H)2A pathway.
  - Identify any medical care that could be continued at home, for example, IV antibiotics, home oxygen, diuretics etc. which would facilitate movement on the pathway.
  - Can the patient eat and drink to keep nourished?

- *Addressing Mobility issues:*
  - Has the patient sufficient mobility to be cared for in their own home?
  - An environmental visit is arranged with a therapist to oversee the person managing in their home environment (environmental assessment including stairs and falls risks) and to initiate an overall therapy plan.
  - Therapy provide aids/equipment to make them safe and reduce falls risk.
  - Home visit may determine whether the person would benefit from a falls clinic or ongoing community physiotherapy?

- ***Addressing Social Support and other issues:***
  - What matters to the patient and what does the patient want?
  - How much help is needed and who will provide it?
  - Is anyone able to stay overnight on discharge to provide support on the day of discharge?

---

[1] (Contains extracts from South Warwickshire Clinical Pathway Model)

[2] See section 2.2 for some parameters for the identification of patients most appropriate for this pathway.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

- Psychosocial & any Carer Needs:

- ***Precautions:***
- If there are concerns that the home environment visit may expose safety issues then retain the hospital bed for a few hours until the OT has called in to give the outcome of the assessment.
- Be prepared for re-admissions, this is inevitable in this group of If the patient is re-admitted it should be to the same team so the discharge momentum is carried through. It is not necessarily a failure of discharge.
- Do not hesitate to discharge the patient again on the day of readmission if you are confident of your assessment.

- ***Care Management:***
- It is essential to provide ***active care management*** for patients following the discharge home to assess pathway, this should enable follow up contact and a telephone check up the day after discharge so that support for patient and carers is maintained, new issues may be identified that can be pro-actively managed in advance to avoid a crisis and unplanned out of hours admissions.
- Social Assessment, reablement (implementation of therapy plans), any community nursing interventions as well as direct care should be commenced as soon as is practicable and, in the case of meeting direct care needs, ***within 2 hours*** of the person returning home.

- ***Supporting Features - Incorporating Observations from Rochdale.***
- Single point of contact for D(h)2A pathway to be initiated.
- Trusted Assessor/ Assessment within and between Therapy and other Services.
- Supported by brief discharge summary information sufficient to initiate care and support at home
- Standard and bespoke Community equipment easily accessible by different professional groups.
- Organisation of Ward activity to focus on D(h)2A (Rochdale 'home in a day team' - Physio/OT & Support planner).
- *Alignment and staffing of Reablement services to support within 2 hours of discharge and for a minimum of 2 weeks afterwards*
- *Therapy support to and leadership of Reablement Service.*

2.2 *Identifying patients for discharge to assess*

In other systems this has been achieved by undertaking a case file review, for example, this might start by a retrospective review of patients admitted over the age of 85 years. After reviewing the case notes each patient can be allocated to one of the boxes in the 2x2 matrix below (Clinical Audit Template). The data can provide information about the characteristics of patients who could have benefitted from inclusion on the D(H)2A pathway (and, importantly, those who could not). It is important to be challenging, perhaps, by involving an external partner in the case file review.

Going forward, the total number of patients managed on D(H)2A & the number of success appropriate to and managed on the D(H)2A pathway should be plotted on a daily run chart to understand variability and step changes in how the system is functioning. The aim should be to see a gradual increase in use with the gap between the two lines reducing over time and less variability between days.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

	Managed in discharge to assess	Not managed in discharge to assess
Appropriate for discharge to assess	**Success** (expect some readmissions , admit to the same team & maintain the discharge momentum)	**Missed opportunity** (patient not identified or services not available)
Not appropriate for discharge to assess	**Wasted capacity** (patient did not require more than a simple discharge)	**Success** (appropriate inpatient or day care)
	Potential clinical risk (patient's clinical needs could not be met at home)	

3.0 Acute MDT to Community MDT.

In the previous section emphasis was placed on the importance of a ward based, multi-disciplinary team (MDT) agreement on those patients for whom Discharge Home to Assess is likely to be the most appropriate pathway to follow as part of the discharge plan.

Whilst the person remains under treatment in acute care, this pathway envisages that a member of the ward based MDT retains accountability for ensuring that all the features set out in S2 of this descriptor are appropriately addressed as discharge planning progresses towards the Expected Date of Discharge. Members of the MDT in the respective acute Trust(s) need to determine who is best placed to manage this pathway process, in many instances this is likely to be a Therapist.

3.1 Role of the RARS team.

Contact needs to be made with the Halton RARS team (contact details??) at the earliest opportunity to alert the team that a patient in acute care has been identified for the D2A (Home) pathway and the EDD shared along with any other preliminary information that might be helpful.

3.2 Arrangements for Discharge.

It's important to remember that this pathway is envisaged to be used for people who have had their presenting episode of acute care need treated but are deemed to have recovered sufficiently to complete the remainder of any assessment(s) required back in their own home. As the discharge planning process proceeds toward the EDD it is essential the practical arrangements for timely discharge are in place, this is likely to include:

- A therapist to accompany the person back to their own home to undertake preliminary assessment of the person in their own home.
- Transport appropriate to the persons needs being available to get them home at an appropriate time of day.
- Discharge medication and Discharge letter arrangements are in place.
- Preliminary equipment needs will be met.

Active prior liaison with the community MDT (RARS team) will clearly be essential in relation to these features.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

3.3 Documentation:
A summary of the person's care and treatment in the acute setting (alongside a summary of other key information) will need to be made available to the Community MDT (RARs service) either prior to or at the handover of the person once they are back in their own home. (this needs to be sufficient to satisfy basic regulatory requirements but be brief enough to enable timely completion and/or transmission. (Work is taking place during the remainder of October to agree this summary).

3.4 Handoff(s).
This pathway, as described, envisages only one handoff, from a member of the acute hospital MDT (likely to be a therapist) to a member of the community MDT (RARS service, also likely to be a therapist).

Accountability for care co-ordination (care management) transfers at the point it is agreed that the persons needs can be safely managed in their home environment.

Once this agreement is reached the accountable worker from the community MDT will ensure that the immediate practical care arrangements will be met and that the arrangements for the necessary ongoing assessment at home are in place.

The Halton reablement service and, potentially, demand and capacity team, clearly have important roles to play in supporting people transiting this pathway. In line with the underpinning principles, this is felt to be most appropriately co-ordinated by the accountable RARS worker.

4.0 Supporting Features for Early Implementation.

This pathway descriptor summary has been co-produced with key stakeholders in the Halton system, it represents an initial set of principles and actions which provide a framework for a small scale 'test of change'.

For the system to gain confidence that the pathway can be used effectively (and therefore scaled up), it is proposed that:
a) Its use is initiated on **2** exemplar wards in the first instance, Ward A2 at Whiston Hospital and Ward B19 at Warrington.

b) There was a belief that, for a variety of reasons, the system may find that, in the first instance, more people re likely to be able to smoothly access the pathway from Whiston (since they are more likely to live in Widnes where it was felt providing care at home within 2 hours of discharge was more achievable than in Runcorn). However, it was felt to be important that all efforts were made to embed the pathway at Warrington hospital even if numbers of people accessing the pathway were small to begin with.

c) The availability of reablement services to support this pathway is essential. To create some additional capacity within the team (to accommodate people using this pathway, in addition to the existing cohort of people needing reablement) it is likely that a proportion of current work within the team will need to transfer to the independent sector provider(s). The demand and capacity team will have an important role to play in this and the system will need to monitor if additional costs are being incurred in the short term.

d) In further support of this, the system may wish to consider whether more efficient and effective methods could be adopted to ensure better utilisation of domiciliary care hours, with the aim of releasing more care hours through managed reductions in long term packages.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

e) To support the implementation of the pathway, some changes may need to be made to the range of basic and key equipment available to be accessed quickly from community bases, some changes may need to be made to the way some specific items of equipment may need to be pre-ordered as a precaution and some relaxation of the equipment prescribing requirements may also be needed.

f) Finally, to enhance the opportunity to successfully implement this pathway and to progress the scale of its implementation, system leaders will need to carefully consider ongoing project management arrangements. It is likely that this will require the full-time oversight of one person working with an extended group of key stakeholders to hold to the objectives of this work programme. In addition, it is likely that the system will wish to adjust the pathway in the light of its use and that this project is likely to become one element of a larger programme of work (yet to be described) aimed at larger scale system redesign.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

Acknowledgements:

Di Armstrong (Halton CCG) provided invaluable support during the whole course of this assignment and my particular thanks for organising the pathway design workshops , Karen Irvine (Halton CCG) assisted in writing up and administrating the workshops. Louise Wilson (Halton BC) assisted in providing performance data and administrating the peer review process.

As well as this specific support, I'd like to thank all those people in the Halton, Warrington and St. Helen's system for giving their time to help my understanding and develop the proposals generated in the course of this work.

Dennis Holmes.

Registered Office 41 Gledhow Wood Avenue, Leeds LS8 1NY
E dennisholmes@yhconsulting.co.uk
T 0113 430 0314 M 0772 0049181 W www.yhcconsulting.co.uk

Appendix 2

Issues for Consideration

1. Is Cheshire & Merseyside the right footprint? Is it a 'done deal'?

2. Should each local Authority 'place' be represented in future governance arrangements for the Cheshire and Merseyside Integrated Care System? There are different political views about whether politicians should be implicated in C&MHCP decision making (as there are some tricky decisions ahead) or should the political role be to scrutinise them.

3. What would be the role for the Health and Wellbeing Board in each Place? Formal recognition of Health and Wellbeing Boards as the strategic decision-making body for Integrated Care Partnerships in each place, given they are best positioned to support improved outcomes in the wider determinants of population health.

4. What would be the arrangements for the democratic scrutiny of health and social care provision both at Place and 'at scale' across the Cheshire and Merseyside footprint?

5. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **commissioning and delivery of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

6. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **funding of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

7. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **quality of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

8. How the proposal for a single ICS and ICPs for Cheshire and Merseyside would impact on the **clinical robustness of health and social care provision** at Place and 'at scale' across the Cheshire and Merseyside footprint.

9. Formal assurance that budgets will be devolved to place; and that residual budgets retained at Cheshire and Merseyside level will be agreed in advance by each place.

10. Seek reassurance that the delivery of health & social care services will be closest to home wherever possible and only at scale where this is more appropriate.

11. How does the system structure encourage the shift away from spending money on fixing sick people to keeping them well? Increased focus on prevention and population health.

12. How/will the system structure encourage community provision rather than expensive acute provision?

13. Is there a role for expanded s75 agreements in each Place (children's, adult's and public health together with out of hospital NHS)?

14. Legislative barriers to change – 2022 looks, very ambitious … is the legislation ready to go (and where do foundation trusts exist in this)?

15. What about facilities like major trauma centres? Walton Centre? Alder Hey - is there a NW or NHSE residual role?

16. Greater involvement of social care (Adult and CYP) to achieve a whole system approach to wellness, health and social care.

REPORT TO: Health Policy & Performance Board

DATE: 23rd February 2021

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Safeguarding

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board and highlight key issues with respect to the impact of Covid 19 on safeguarding in care homes.

2.0 **RECOMMENDATION: That:**

The report be noted.

3.0 **SUPPORTING INFORMATION**

3.1 The current global Covid 19 pandemic is unprecedented and the impact for individuals, families, communities and wider society is significant and long lasting. It has touched every part of people's lives and has required individuals and organisations to adapt to new daily interactions, social distancing, shielding, undertaking assessments by phone or using digital solutions to continue essential business. Many of the existing protective factors in the lives of adults at risk of abuse and harm have been temporarily absent or limited.

3.2 COVID-19 has had a significant and sustained impact on the care homes and domiciliary care sectors, for both residents and staff. There is concern that both sectors are under pressure in terms of current sustainability and longer term financial viability, as well as issues around Personal Protective Equipment (PPE) and the risks associated with a reduction in visiting and face-to-face contact.

3.3 There is a high potential for compassion fatigue as well as emotional and physical stresses among all those continuing to provide support, both formal and informal, in highly volatile times leading to increases in safeguarding risks.

3.4 The insight project was established to understand the national picture regarding safeguarding adults' activity during the COVID-19 pandemic. The report was developed from voluntary contributions

from 92 single tiered or county councils who shared their quantitative data. Of these, 45 local authorities also provided qualitative information, which informed the narrative about safeguarding activity and more in-depth insights into either trends that were emerging or disparities that were developing. Information compared data and trends between 2019 and 2020. They concluded that:

3.5 The majority of local authorities saw a marked drop in safeguarding concerns during the initial weeks of the COVID-19 lockdown period, only to return to, and then exceed, normal levels by June 2020. This surge was anticipated by local authorities as lockdown restrictions were relaxed. A few local authorities, conversely, experienced significant increases in safeguarding concerns early on during the lockdown. These concerns were mainly attributed to high levels of anxiety and distress and often did not meet the criteria for a safeguarding enquiry (under Section 42(2)). There was some evidence that one of the sources of increased levels of reporting came from blue light services, who were often at the forefront of dealing face-to-face with the public.

3.6 The trend of safeguarding enquiries showed a similar decline during the initial weeks of the COVID-19 lockdown period. Contributors suggested that this may have been due to being unable to undertake and complete safeguarding enquiries during this period, or that practitioners were still catching up on the backlog of safeguarding concerns generated in the lockdown period. Along with the lower number of local authorities submitting June 2020 data than for any other month, this suggests that it is too soon to accurately gauge the full impact of COVID-19 and the lockdown on safeguarding enquiries. There was some evidence of increased levels of complexities of safeguarding enquiries under lockdown conditions. There was an upturn of enquiries in June, although this upturn did not increase at the same rate as the number of safeguarding concerns.

3.7 The percentage distribution of types of abuse identified in safeguarding enquiries did not appear to change considerably overall. There was evidence that some forms of abuse, particularly domestic abuse, increased slightly overall and significantly within some local authorities, as well as psychological abuse and self-neglect. The percentage of safeguarding enquiries, where the risk is located in the individual's own home has increased markedly since the start of the COVID-19 lockdown period, with evidence from local authorities that this is a direct result of the confinement of people in their homes. Enquiries with risk located in care homes has decreased as a percentage in the same period; the narrative suggests that this is because of the relative lack of outside scrutiny in those environments during the lockdown period.

3.8 Halton supported the project and the findings reflected the activity locally. During the first lockdown CQC changed their approach to inspection and monitoring of care providers. Implementing a risk based approach to visiting and only approving visits if there is a risk to life and limb. This was also reflected locally with Quality Assurance team limiting visits and developed a risk based approach to assessing the requirements of a visit.

3.9 In order to address the potential gap in reporting 'Every Covid Visit' approach was devised to target professionals visiting care homes to encourage them to report on what they saw both positive practice and areas that may need improvement. This has enabled the Quality Assurance team access to additional information to support analysis and inform risk ratings.

3.10 A Care Home Resilience Group has been established chaired by Sue Wallace Bonner and oversees the work undertaken by all partners within the Borough in relation to care homes. This includes Identifying key pieces of work to bring systems together for the benefit of residents and proactive support for care homes at increased risk and harnessing the learning to share across the sector.

3.11 The pandemic has also impacted on the implementation of the replacement for Deprivation of Liberty Safeguards (DoLS). The Liberty Protection Safeguards (LPS) has been delayed until April 2022. The impact assessment had been promised for December and has yet to be published and the Code of Practice for the Spring.

3.12 During the pandemic the requirement for DoLS had not been amended and the restrictions remain robust. During the first wave there were lower number of referrals as the care homes battled with the virus and addressed essential care needs. The referrals started to increase from June and have continued to do so to normal levels.

4.0 POLICY IMPLICATIONS

4.1 New policies in respect of LPS will be developed once the Code of Practice is published.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at present.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Halton Safeguarding Adults Board (HSAB) membership includes a Manager from the Children and Enterprise Directorate, as a link to

Halton Children and Young People Safeguarding Partnership (HCYPSP). Halton Children and Young People Safeguarding Partnership membership includes adult social care representation. Joint protocols exist between Council services for adults and children. The SAB chair and sub-group chairs ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

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

None Identified.

6.3 **A Healthy Halton**

The safeguarding adults whose circumstances make them vulnerable to abuse is fundamental to their health and well-being. People are likely to be more vulnerable when they experience ill-health.

6.4 **A Safer Halton**

Halton Safeguarding Adults Board (HSAB) membership includes a Manager from the Children and Enterprise Directorate, as a link to Halton Children and Young People Safeguarding Partnership (HCYPSP). Halton Children and Young People Safeguarding Partnership membership includes adult social care representation. Joint protocols exist between Council services for adults and children. The SAB chair and sub-group chairs ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 Failure to consider and address the Statutory duty of the Local Authority could expose individuals to abuse and the Council as the Statutory Body vulnerable to complaint, criticism, and potential litigation.

8.0 **EQUALITY AND DIVERSITY ISSUES**

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

policies and plans. Policies and procedures relating to Safeguarding Adults are impact assessed with regard to equality.

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

9.1 None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 23rd February, 2021

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Scrutiny Topic – 2021/22

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with a draft Topic Brief (attached) for the 2021/22 Scrutiny Review looking at local implementation of the recommendations from the North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission report into 'The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'.

2.0 **RECOMMENDATION: That:**

i) The draft Topic Brief is approved as reflective of the lines of enquiry the Board wish to pursue;

ii) Members consider their availability for involvement in the Scrutiny Group.

3.0 **SUPPORTING INFORMATION**

3.1 A NWADASS Elected Member Commission was established to investigate the impact of Covid-19 on adults aged 18+, their families and communities and what this tells us about the role communities play in supporting people to live independently at home.

3.2 The report of the Commission (available on the NWADASS website via the link provided within the Topic Brief) sets out a number of recommendations for councils that look beyond the pandemic at how the learning can shape future service design.

3.3 The Scrutiny Review will look at these recommendations more closely and consider how they should be implemented locally.

3.4 The draft Topic Brief is presented for Board approval. The Scrutiny Review will commence in March 2021 with a final report and recommendations being presented at the Health PPB in June 2021.

3.5 Members are requested to consider their involvement in the Scrutiny Review Group and their commitment to the meetings which are to be scheduled.

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**
This scrutiny topic links to the healthy Halton priority, as set out in the topic brief attached.

6.4 **A Safer Halton**
None identified

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

7.0 **RISK ANALYSIS**

7.1 The role of scrutiny within Adult Social Care is a key function to ensure transparency, accountability and consistency within all areas and make sure that the residents of Halton have the best outcomes possible.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified

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

None identified.

Scrutiny Review 2021/22: Topic Brief

Scrutiny topic:	Recommendations of the NWADASS report 'The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'
Officer lead:	Sue Wallace-Bonner, Director of Adult Social Services
Start date:	March 2021
Target PPB meeting:	June 2021

Topic description and scope:

The scrutiny topic will focus on the outcomes from the ***'North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission: The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'***[1] with a view to making recommendations for Halton.

The Elected Member Social Care Commission was established as part of a North West ADASS approach to learning lessons from the Covid-19 pandemic. In particular, the role of The Commission was to investigate the impact of the pandemic on people and communities in the North West and what lessons could be learnt for further waves of infection and future service design.

The Commission investigated the following question:

"*What has been the impact of the pandemic on people who use adult social care services, their families and our communities and what does this tell us about the role our communities should play in supporting people to live independently at home?"*

Why this topic was chosen:

The NWADASS Elected Member Commission was established to investigate the impact of Covid-19 on adults aged 18+, their families and communities and what this tells us about the role communities play in supporting people to live independently at home.

The report of the Commission provides a broad account of what was learned through eye-witness accounts from people/organisations and it identifies lessons learned. Recommendations are made for councils that look beyond the pandemic at how the learning can shape future service design.

The Commission's report will be scrutinised in order to consider how Halton will implement the recommendations.

Key outputs and outcomes sought:

The topic group will consider the recommendations set out in the report in order to determine implementation at a local level. The report recommendations for councils are summarised below (the NWADASS report should be consulted for full details):

---

[1] The full report and additional information regarding the commission can be found on the NWADASS website; https://www.nwadass.org.uk/elected-member-social-care-commission

- Councils should say a public 'thank you' to adult social care and support services (commissioned and voluntary) and unpaid carers for their hard work and sacrifices during the pandemic and beyond;
- Councils should take active steps to build the capacity of the community and voluntary sector to provide health, care and wellbeing services (the report details six suggestions in relation to this);
- Councils should strengthen the wellbeing support available to informal/unpaid carers (there are three suggestions sitting under this point);
- Councils should seek to substantially increase the use of direct payments, making them quick and easy to obtain, and allowing for much greater flexibility for people in how they can be used;
- Councils should use their place-based leadership role to facilitate communication with and across organisations helping vulnerable and isolated people
- Councils should build upon the new capacity for volunteering in the community (which people have demonstrated during the pandemic) to create stronger preventative and community solutions;
- Councils and other organisations should accept that digital becomes one of the primary mechanisms for service delivery in the future (there are four suggestions sitting under this recommendation);
- Councils can provide more local leadership and should collaborate with care home providers and relatives to design approaches to safe visiting in care homes which allows visiting to take place safely and in line with government guidance and the NWADASS statement on visiting
- Councils should work with providers and people who use services to redesign day services and to shape the market to allow for greater choice, flexibility and accessibility for people.

Following full consideration of the recommendations, an Action Plan will be developed to ensure that they are implemented locally, as appropriate.

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

This topic contributes to the 'Healthy Halton' priority within the Council's Corporate Plan and the Sustainable Community Strategy.

Halton Borough Council Corporate Plan

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

Halton Strategic Partnership Sustainable Community Strategy

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.

Nature of expected/desired PPB input:

Member-led scrutiny review of the NWADASS report, particularly the recommendations made for councils and consideration of how these could be implemented locally.

Preferred mode of operation:

- Desk-top review of the NWADASS report;
- Meetings/discussions with relevant officers from within the council and partner organisations;
- Review of current service provision in areas outlined within the recommendations in order to identify gaps and develop action plan for improvement.

Agreed and signed by:

PPB chair:		Date:	
Officer lead:		Date:	

REPORT TO: Health Policy & Performance Board

DATE: 23 February, 2020

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 3 2020/21

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 2020/21. 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, 2020/21.

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

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 2020/21 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:

The Halton Women's Centre: this service has continued to remain active during the coronavirus pandemic. As reported in the previous Quarterly Monitoring Report, the Centre was awarded a substantial sum to support women who have had contact with the criminal justice system, with the intention of providing probation support in a more relaxed setting and providing services and supports designed to help them engage with their communities. Many of these women have long-term mental health needs, poor self-esteem, emotional issues and complex lives, which may include experience of domestic violence. This funding has been used to employ an additional support worker, part of whose role will be to develop the service more widely and particularly to provide active support in the Widnes area.

Throughout the pandemic, the service has been able to keep in touch with a considerable number of women by telephone, providing them with regular support and advice. In addition, it has been possible to reopen the centre to a number of groups, following strict guidance from the Council's Property Services about the safety measures that have had to be put in place.

Mental Health Services:

North West Boroughs (NWB) Mental Health Trust: extensive work has been taking place within the NWB and Merseycare to move forward the takeover of Merseycare of the NWB's mental health services. This is scheduled to be completed by 1st April 2021. Although a Steering Group was intended to be in place, involving very senior officers and Members from all partner organisations, this has not taken place. Once the formal takeover is in place, further work will need to take place with Merseycare to ensure that the currently good working front line relationships between the Borough Council social work staff and the NWB teams continue effectively.

Review of the Mental Health Act: this has been in development for some time, but progress was delayed for a number of reasons: the coronavirus pandemic, the Brexit negotiations and the general election. It was announced in the latest Queen's Speech, however, that this would be taken forward during the current parliamentary session, and it now seems likely that a White Paper will be published in the New Year. The national AMHP network, of which Halton is a part, is contributing to and influencing these developments.

Breathing Space (mental health support for people in debt): this is an extension of an existing scheme for other service areas, and will allow support for people in financial debt who are experiencing a mental health crisis. The scheme is to be implemented by the Treasury in May 2021. This is likely to lead to additional work pressures for AMHPs, who will be expected to take the lead in taking people through the process, at a time when they are already stretched, and the impact of this will need to be closely monitored.

Public Health

Public health programmes have continued to deliver during the COVID 19 pandemic despite a reduction in staff capacity due to it being required to work on the pandemic and increased sickness levels. In particular we have recently seen extra emphasis placed on pregnant smokers, routine and manual smokers, smokers with respiratory disease, and smokers with mental health.

We have also noted a particular requirement for mental and physical health support. This has been across all age ranges but especially amongst younger and older people. A new service called "ChatHealth" has now been developed and implemented by the 0-19 Child Health Programme and will support that age range with emotional and general health issues. Sure Start to Later Life continue to support older people with regular calls and welfare requirements as well as supporting their physical and mental health.

All screening programmes are now open again and we are working with local groups to increase awareness of this and encourage re-engagement, including targeting material and engagement at local COVID vaccination centres.

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

No update for Q3

Public Health

Services that have been paused during the pandemic are starting to reopen but there is a backlog of appointments. This is particularly true of screening and may impact on cancer rates. It is also the case with the 0-19 services regarding new birth visits. These visits have taken place virtually but there is an issue around digital poverty and physical examinations. As the COVID vaccination programme rolls out we will see a reduction in infected cases and a return to usual practice.

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.

The Council needs to consider an increase in health inequalities due to COVID and build that into our Health & Wellbeing Strategy

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.	U
1D	Continue to implement the Local Dementia Strategy, to ensure effective services are in place.	U
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.	U
3A	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.	U

Supporting Commentary

1A.

1B. No update for Q3

1C.

1D. During Q 3 there was little movement from the Q2 update – RAG'd as amber due to not progressing the Dementia Strategy against projected timescale.
The Alzheimer's Society Dementia Care Advisor Service continues to deliver information, advice and signposting via telephone/email whilst COVID restrictions limit face to face support. The +12 month contract extension option has been put in place to ensure continuity of service during the COVID pandemic, with the contract in place until end of September 2021. Progress on the development of a refreshed local dementia strategy delivery plan has been halted due to COVID. It has been categorised as a priority 2 piece of work, with a time scale of 2-3 months (October) to be resumed. An adult social care dementia position statement was completed prior to COVID restrictions, which will help direct the development of the delivery plan when ONE Halton representatives reconvene, with support from Alzheimer's Society Policy representatives.

1E. Completed.

1F. No update for Q3

3A. No update for Q3

Key Performance Indicators

Older People:						
Ref	**Measure**	**19/20 Actual**	**20/21 Target**	**Q3**	**Current Progress**	**Direction of travel**
ASC 01	Permanent Admissions to residential and nursing care	TBC	635	TBC	TBC	TBC

	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***	N/A	TBC	TBC	TBC	TBC
ASC 03	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	4893	5182	TBC	TBC	TBC
ASC 04	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehab ilitation services (ASCOF 2B) ***Better Care Fund performance metric***	78%	85%	N/A	N/A	N/A
Adults with Learning and/or Physical Disabilities:						
ASC 05	Percentage of items of equipment and adaptations delivered within 7	39%	97%	76%	☑	↑

	working days (VI/DRC/HMS)					
ASC 06	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support) (Part 1) SDS	72%	80%	73%	✓	↑
ASC 07	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support) (Part 2) DP	35%	45%	34%	✓	↔
ASC 08	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	88.73 %	87%	88.47 %	✓	↑
ASC 9	Proportion of adults with learning disabilities who are in Employment (ASCOF 1E)	5.04 %	5.5%	5.18%	✓	↑
Homelessness:						
ASC 10	Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2017. Relief Prevention Homeless	1822	2000 1000 500 250	TBC	TBC	TBC
ASC 11	LA Accepted a statutory duty to	114	150	TBC	TBC	TBC

	homeless households in accordance with homelessness Act 2002					
ASC 12	Homelessness prevention, where an applicant has been found to be eligible and unintentionally homeless.	TBC	150	TBC	TBC	TBC
ASC 13	Number of households living in Temporary Accommodation Hostel Bed & Breakfast	105 15	150 80	TBC	TBC	TBC
ASC 14	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	6.62 %	7.0%	TBC	TBC	TBC
Safeguarding:						
ASC 15	Percentage of individuals involved in Section 42 Safeguarding Enquiries	TBC	TBC	32%	✓	↑
ASC 16	Percentage of existing HBC Adult Social Care	61%	85%	61%	✓	↑

	staff that have received Adult Safeguarding Training, including e-learning, in the last 3-years (denominator front line staff only).					
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%	90%	N/A	N/A	N/A
Carers:						
ASC 18	Proportion of Carers in receipt of Self Directed Support.	100%	99%	95.4%	U	
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%	8%	N/A	N/A	N/A
ASC 20	*Overall satisfaction of carers with social services (ASCOF 3B)*	52.1 %	52%	N/A	N/A	N/A
ASC 21	The proportion of carers who report that they have been included or consulted in	77.6 %	80%	N/A	N/A	N/A

	discussions about the person they care for (ASCOF 3C)					
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:

ASC 01 The performance team are unable to complete this indicator at this time.

ASC 02 No data received from CCG

ASC 03 No data received from CCG

ASC 04 Annual collection only to be reported in Q4.

Adults with Learning and/or Physical Disabilities:

ASC 05 The reduced figures are due to the impact of covid and the reduced accessibility to properties with non-urgent requests placed on hold

ASC 06 We are aware that this is an ongoing issue with reporting on service agreements, however due to COVID, we are not in a position to fully investigate this

ASC 07 We are monitoring this measure and are still above the NW averages when benchmarking.

ASC 08 We are aware of issues with data quality with Primary support reasons, this may change the numerator meaning the percentage of clients will be lower.

ASC 09 There are 22 people with a learning disability in paid employment. The percentage is based on the number of people with a learning disability "known to" the Council. The known to figure can fluctuate each month as people have been added to Care First or their assessments have been completed; this will have an overall effect on the percentage.

Homelessness:

ASC 10	No update received for Q3
ASC 11	No update received for Q3
ASC 12	No update received for Q3
ASC 13	No update received for Q3
ASC 14	No update received for Q3

Safeguarding:

ASC 15	Work being done looking at the Actual/ target.
ASC 16	We have exceeded this target and staff continue to access the appropriate training.
ASC 17	Annual collection only to be reported in Q4, (figure is an estimate).

Carers:

ASC 18	The reduced figures are due to the impact of covid
ASC 19	This is a biannual survey which would have been due to have been administered later in 2020, however due to COVID-19, this has been postponed and will not take place until 2021 and biannually thereafter
ASC 20	This is a biannual survey which would have been due to have been administered later in 2020, however due to COVID-19, this has been postponed and will not take place until 2021 and biannually thereafter
ASC 21	This is a biannual survey which would have been due to have been administered later in 2020, however due to COVID-19, this has been postponed and will not take place until 2021 and biannually thereafter
ASC 22	This is a biannual survey which would have been due to have been administered later in 2020, however due to COVID-19, this has been postponed and will not take place until 2021 and biannually thereafter

Public Health

Key Objectives / milestones

Ref	Milestones	Q3

		Progress
PH 01a	Increase the uptake of smoking cessation services and successful quits among routine and manual workers and pregnant women.	U
PH 01b	Work with partners to increase uptake of the NHS cancer screening programmes (cervical, breast and bowel).	U
PH 01c	Work with partners to continue to expand early diagnosis and treatment of respiratory disease including Lung Age Checks, and improving respiratory pathways.	U
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.	U
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.	U
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.	U
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).	U
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.	U

PH 05b	Implementation of the Suicide Action Plan.	✓
PH 05c	Provide training to front line settings and work to implement workplace mental health programmes.	U

Supporting Commentary

PH 01a	**Supporting commentary** Halton Stop Smoking Service has continued to deliver the service remotely throughout COVID 19 to support local people to stop smoking.The voucher scheme previously used by the service to request products from Pharmacies has now been replaced by requesting products for clients directly through the pharmacists database – PharmOutcomes. The intention is to continue using PharmOutcomes when services resume post COVID. CO monitoring and Lung Age checks had to be stopped as well as the pregnancy incentive voucher scheme due to COVID 19.Through the use of digital platforms and contact with all referring agencies we have continued to promote the service to encourage referrals into the service. However, there has been a decrease in all referrals during COVID. Extra emphasis is placed on pregnant smokers, routine and manual smokers, smokers with respiratory disease, and smokers with mental health, where extra support is required. To date Halton Stop Smoking Service has received 74 pregnant smoker referrals compared to 113 received in the same period last year. Out of 74 referrals, 61 clients engaged with the service and 21 pregnant smokers successfully quit - achieving a quit rate of 34%. In comparison out of 113 pregnant smokers referred last year, only 59 engaged with the service and 28 pregnant smokers successfully quit- achieving a quit rate of 47%. Among the Routine and Manual group, there have been 113 smokers accessing the service and 64 smokers quitting – achieving a quit rate of 57%. Again the service has seen a reduction in referrals into the service compared to the same period last year 157 accessing the service and 94 quitting –achieving a quit rate of 60%.The service has now set up a FB page where advice and tips on stopping smoking are available to smokers – 82 people currently access the FB page. To date the service has seen a total of 575 clients that have been referred into the service, either by professional partners or self-referred, only 35 out of 575 clients have not engaged with the service. The service has a quit rate of 62% currently.The service has also supported Contact Track and Tracing and supported the Health Trainer Assessment programme. Assessing the practicalities of resuming the delivery of the Stop Smoking Service in GP and Community settings as well as resuming CO Monitoring and COPD6 will remain on hold due to the current COVID climate.
PH 01b	**Supporting commentary** There has been a decline in the uptake of screening programmes across nationally and locally as a result of the Covid situation, with services slowing down for a period of time. All screenng programmes are now open again and we are working with local groups to increase awareness of this and encourage re-engagement, including targetting material and engagament at local covid vaccination centres and re-stablishing connections across Cheshire and Merseyside.

PH 01c	**Supporting commentary** The Stop Smoking Service have had to cease delivering COPD6 Lung Age Checks to clients aged 35yrs and over as per NICE guidelines during consultations due to COVID and working remotely. The service has started working on the recently revived TLHC Targeted Lung Health Check Programme with Halton CCG and LHCH. This programme is in the early stages of development but it is envisaged the Stop Smoking Service will see an increase in throughput into the service of potentially 1,600 current and ex smokers in Halton aged bwteen 55 yrs and 75 yrs.
PH 01d	**Supporting commentary** Haltons Adult Weight Management Service received 80 new referrals in Q3. The service worked remotely throughout, providing an individual telephone based service. Fresh Start clients continued to receive healthy lifestyle and physical activity advice on a weekly basis. The Dietician led tier 3 weight management service operated face to face appointments throughout Q3, supporting local people with high BMI's and those considering bariatric surgery service for those requiring dietetic input, 282 appointments were completed in Q3. A Facebook group with over 400 active Fresh Start clients has been maintained throughout Q3. Work continued and was completed to develop a Fresh Start app for the delivery of the weight management service through smart phones, this will launch in Q4 2020/21. Telephone physical activity advice and online video sessions were provided for those clients referred to the HIT exercise referral service. Working predominantly with clients with a history of cardiac, respiratory, neurological or chronic pain diagnoses. The Active Halton steering group meetings have continued monthly, the group has focused on updating colleagues from across Halton on how services are being managed during the Covid-19 pandemic and changes to the availability of facilities during Q3. Face to face sessions on healthy lifestyles continued during Q3. The number of sessions was reduced due to Covid-19. Parent Bitesize sessions delivered remotely on healthy eating, physical activity and screen time, offered to parents monthly with good engagement. Healthy lifestyles for the staff is promoted as part of the healthy schools ethos. Resources available to all schools on health curriculum.
PH 02a	**Supporting commentary** At the end of Qtr.2 86% of families were receiving a new birth visit within 14 days, 71% received the 12 month check within 15mths, and 56% received the 2-21/2 year check. Restoration plans are in place to catch up any outstanding visits or checks and the 0-19 Service has continued to support local families through drop ins, visits and telephone support.
PH 02b	**Supporting commentary** During the quarter, the 0-19 Service (comprising the Family Nurse Partnership, Health Visiting and School Nursing) continued to deliver support to children, young people and families. The service provided support to schools and early years settings and focused particularly on the flu vaccination programme and school age immunisations,

	as well as continuing to support the increasing workload caused by safeguarding concerns.
PH 02c	**Supporting commentary** The Halton Early Years partnership has continued to meet remotely to consider how to support families and develop the local offer and is looking to re-establish the antenatal 'Your baby and you offer' remotely. Infant feeding support continues to be available to families from the HIT infant feeding team. The NCMP programme has been paused due to the pandemic.
PH 03a	**Supporting commentary** During Lockdown like many other teams, Sure Start to Later Life (SS2LL) were pivotal to the COVID19 response to support the shielded and most vulnerable individuals. The team worked tirelessly to offer a telephone befriender service to those people who were on their own, isolated from their families, friends and communities and who may be feeling lonely. During Lockdown and continuing we have managed to contact over 800 people to offer this service too. At the peak response time we have supported 230 people on a regular basis via the telephone befriending service which has been either on a fortnightly basis or in some cases weekly. As a means to build capacity to continue to deliver this service we have recruited an additional 23 telephone befrienders who are providing approx. 66 hours per week of support. We still have 30 applications to process. The Telephone befriending service has been a lifeline to the outside world for a lot of people and a means to tackle loneliness. These are some of the quotes from people who have accessed the service **"Im very grateful for all the support he has had from SSTLL staff during C19 shielding lockdown"** **Your calls are a blessing and your loveliness is shining bright (this lady is totally isolated with no family)** **"Thank you for your calls it's nice to know someone cares about you (this gentleman's family live abroad)** We work in collaboration with our partners in particular Age UK and more recently MIND as they too provide a similar service and we have referred people onto these services where appropriate. Towards the end of September we launched the Pen Pal Scheme where we asked people to write letters/ cards to people who reside in care homes as a means to tackle loneliness. We had a lot of interest from over 30 people. So far we have managed to match up 10 people. The feedback has been very positive.

	In the run up to Christmas we were involved in a number of projects supporting older people over the festive period. We matched up a number of early year settings with a number of local care homes. Some of the children did a virtual nativity where others sent Christmas cards and gifts. This was well received by our residents of Halton. We supported 85 people to receive a Christmas Hamper or a Christmas Meal which was donated by the community.
PPH 03b	**Supporting commentary** During the pandemic there have been significant changes made to the falls pathway. The Falls Intervention ceases to exist as does the Rapid Access Rehabilitation Service. This has left a gap in the service provision. The intermediate care service is currently under review and the outcome of this review will not be known until April 2021. A decision has been made to put the falls steering group on hold until further information is gathered about the future plan of the falls service. From an Age Well Falls prevention service perspective we have continued to offer a telephone consultation , where we have been contacting our existing clients pre covid to offer them either 1:1 falls prevention advise or to consult them as a group. This is some of the feedback from the people who receive calls: I'm always excitedly waiting for your call; I so look forward to it each week'. (Santosh) 'Thank you for bringing us all together, I've enjoyed chatting with the group. It makes you feel that you're not alone' (Harold) I hope the calls to will continue after Christmas, it's lovely hearing from you and the others in the group. Thank you for including me'. (Margaret) 'Thank you for all your efforts in doing these calls, I enjoy them and look forward to them each week. It makes me feel connected'. (Ian) 'When we've all had the vaccine and the weather gets warmer, let's all meet on a big field and do our exercises together' (Joan 91yrs old) At present we have over 100 people who are on our waiting list to start the Age Well Exercise class when we are allowed to restart. In the meantime they are being offered telephone advice about what they can do to stay active and promoting the Active at Home Booklet. The aim of the booklet is to help you to stay active at home to help prevent physical deterioration that increases your risk of falls, loss of independence and increased need for care during Covid-19. . In total we have sent out over 6000 copies of the Active at Home Booklet.
PH 03c	**Supporting commentary** Work on increasing the uptake of flu vaccination has continued throughout the flu season. Capacity and community engagement oportunities have been limited but we have been supporting practices to target eligible groups. The uptake of vaccine in the over 65 age group has increased this year compared to previous years although some of the other targetted cohorts has not achieved target uptakes.
PH 04a	**Supporting commentary** Work has continued to focus on reducing the rate of young people admitted to

	hospital due to alcohol, although this has been impacted due to COVID-19, lock down, and reductions in social interaction.
PH 04b	**Supporting commentary** Awareness is raised within the local community of safe drinking recommendations and local alcohol support services through social media campaign messages and the promotion of national campaigns via digital platforms. The Stop Smoking Service has continued to deliver Audit C screening remotely and offers Brief Advice and signposting, when appropriate, during consultations with clients who are stopping smoking and who also wish to reduce their alcohol intake To date over 345 clients have received Audit C screening from the Stop Smoking Service. Health Trainers have had limited opportunities to deliver Audit C screening as part of Health Checks due to COVID.
PH 04c	**Supporting commentary** The Substance Misuse Service has continued to find innovative ways in which to support clients affected by substance misuse, including digital consultations and socially distanced appointments. During Qtr.2, 185 assessments were completed, with 120 entering structured treatment and 65 requiring brief intervention. Those requiring support for alcohol represented 43% of overall assessments, with 18% non-opiate and opiate support 22% and 17% of assessments being for alcohol and non-opiate support. At the end of Qtr.2 there were 651 people engaged in structured treatment.
PH 05a	**Supporting commentary** 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. Due to the pandemic the number of educational settings able to engage with preventative work has reduced due to additional demands on them. However despite this educational settings have still engaged 3 schools are currently engaged 13 early years setting or child minders are engaged 22 Parents and carers engaged in parent workshop on childrens mental health and wellbeing
PH 05b	**Supporting commentary** The suicide prevention partnership board has continued to meet during the pandemic. There has been delays with the real time surveillance information which has been flagged as a concern with Champs. Champs have continued to work to address: self harm, middle aged men, quality improvement within mental health trusts, primary care staff, workforce development training throughout the pandemic. However the developement of a lived experience network has been placed on hold due to the pandemic.

A Halton Time to Change campaign using local male time to change champions was laucnhed in September and continued through to December. The campaign aimed at middle aged men shared lived experience to tackle mental health stigma and sign post to text support

Table 1-Results of targeted social media posts on facebook

People Reached	Views of the videos	engagements
84868	23,920	8638

Table 2- results of social media posts on twitter

Impressions	views	Engagement
9787	2421	573

Table 3-Targeted radio Campaign results

Impressions	Listen through rate
50,000 to **6116** individuals	**96.6%**

Champs Stay Alive App campain

Champs developed and delivered a campaign to raise awareness of the free Stay Alive App across Cheshire and Merseyside from October to December 2020. The aim of the campaign was to encourage people to download the App that signposts to local Crisis helplines. A full evaluation will be available at the beginning of February demonstrating how many downloaded the app in Halton. The initial figures very encouraging, with **2000** new users and over **14,000** clicks to services in the first 3 weeks.

Local Activity

The Mental Health Info Point continues to be promoted via social media and training. From october to December it has recevied **848** page views with **389** users, **59** visiting the need help now section for details of mental health crisis support. A new local mental health crisis telephone number has been continuously promoted aswell.

PH 05c

Supporting commentary

A variety of training is provided to early years settings, schools, workplaces and the community. Since the pandemic began face to face training has been cancelled and virtual training has been avialable in its place. To ensure quality is maintained numbers attending virtual training has been capped and is significantly lower than numbers attending face to face sessions. Also workplaces havent engaged with any of the training offer due to the pandemic however information has been provided to them and a workplace section established on the MH info point to help support with staff wellbeing.

Training	Numbers trained
Mental health awareness training for adults	53
Mental health awareness for managers	40
Stress Awareness training for adults	2

Stress Awareness training for managers	0
Suicide Awareness training	46
Mental health awareness for early years settings	39
Mental Health awareness training for staff who work with CYP	26
Self Harm awareness training for staff who work with CYP	17
Resilience Workshop for staff working with CYP	19
Total trained	186

Key Performance Indicators

Ref	Measure	19/20 Actual	20/21 Target	Q3	Current Progress	Direction of travel
PH LI 01	A good level of child development (% of eligible children achieving a good level of development at the end of reception)	66.1% (2018/19)	68%	N/A (Department of Education are not publishing 2019/20 data due to COVID priorities)	U	**N/A**
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)	66% (2018/19)	68.6% (2018/19)	✓	↑
PH LI 02b	Alcohol-related admission episodes – narrow definition (Directly Standardised Rate per	863 (2018/19)	848 (2019/20)	895 (2019/20)	✗	↓

	100,000 population)					
PH LI 02c	Under-18 alcohol-specific admission episodes (crude rate per 100,000 population)	58.6 (2016/17 - 2018/19)	55.6 (2017/18-2019/20)	59.4 (2017/18 – 2019/20) provisional		
PH LI 03a	Smoking prevalence (% of adults who currently smoke)	17.9% (2018)	16% (2019)	14.9% (2019)		
PH LI 03b	Prevalence of adult obesity (% of adults estimated to be obese)	74.4% (2017/18)	72% (2018/19)	70.6% (2018/19)		
PH LI 03c	Mortality from cardiovascular disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets*	85.3 (2017-19)	N/A (2018-20 target not set due to COVID pressures)	87.1 (Q4 2017- Q3 2020 provisional) (Public Health have not published latest data due to COVID)		
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*	166.1 (2017-19)	N/A (2018-20 target not set due to COVID pressures)	161.6 (Q4 2017- Q3 2020 provisional) (Public Health England have not published latest data due to COVID)		
PH LI 03e	Mortality from respiratory disease at ages	52.5	N/A	53.2		

	under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets*	(2017-19)	(2018-20 target not set due to COVID pressures)	(Q4 2017- Q3 2020 provisional) (Public Health England have not published latest data due to COVID)		
PH LI 04a	Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)	349.7 (2018/19)	N/A (2019/20 target not set due to COVID pressures)	388.3 (2019/20) provisional	U	
PH LI 04b	Self-reported wellbeing: % of people with a low happiness score	9.7% (2017/18)	8.0% (2018/19)	7.2% (2018/19)	✓	
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*	17.7 (2017-19)	N/A (2018-20 target not set due to COVID pressures)	N/A (2018-20 data not yet available nationally or locally)	U	**N/A**
PH LI 05aii	**Female** Life expectancy at age 65 (Average number of years a person would expect to live based on	20.3 (2017-19)	N/A (2018-20 target not set due to COVID pressures)	N/A (2018-20 data not yet available nationally or locally)	U	**N/A**

	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)	2970 (2018/19)	2,900	2834 (2019/20) provisonal	✓	↑
PH LI 05c	Flu vaccination at age 65+ (% of eligible adults aged 65+ who received the flu vaccine, GP registered population)	71.6% (2019/20)	75% (national target)	79.5% (Sept – Dec 2020)	✓	↑

Supporting Commentary

PH LI 01 - Department of Education are not producing 2019/20 data due to COVID priorities.

PH LI 02a – The target has been met for 2018/19 and the percentage of adults meeting recommended levels of physical activity has increased.

PH LI 02b – Hospital admissions for alcohol have increased in 2019/20 and the target has not been met. Rates have also increased nationally and regionally.

PH LI 02c – Hospital admissions for alcohol in under 18 year olds have increased slightly in 2019/20 and the target has not been met.

PH LI 03a – The latest smoking prevalence estimate has reduced for Halton, meeting the target for 2019.

PH LI 03b – Adult obesity has reduced in 2018/19, meeting the target.

PH LI 03c – Provisional 3 year data to September 2020 indicates the under 75 CVD mortality rate has increased slightly on 2017-19. We have yet to understand the impact on COVID deaths compared to other leading causes of death in 2020.

PH LI 03d – Provisional 3 year data to September 2020 indicates the under 75 cancer mortality rate has decreased slightly on 2017-19. We have yet to understand the impact on COVID deaths compared to other leading causes of death in 2020.

PH LI 03e - Provisional 3 year data to September 2020 indicates the under 75 respiratory disease mortality rate has increased very slightly on 2017-19. We have yet to understand the impact on COVID deaths compared to other leading causes of death in 2020.

PH LI 04a – Provisional data shows self harm hospital admissions have increased in 2019/20.

PH LI 04b – The percentage of people reporting a low happiness score had reduced in 2018/19, meeting the target.

PH LI 05ai – 2018-20 data is not yet available nationally or locally. The 2017-19 life expectancy at age 65 saw an improvement on the previous 3 year period.

PH LI 05aii – 2018-20 data is not yet available nationally or locally. The 2017-19 life expectancy at age 65 saw an improvement on the previous 3 year period.

PH LI 05b – Falls injuries hospital admissions in those aged 65 and over have reduced, based on provisional 219/20 data, meaning the target has been met.

PH LI 05c – The flu vaccination target has been exceeded, based on data for September to December 2020.**PH LI 01 -**

APPENDIX 1 – Financial Statements

ADULT SOCIAL CARE DEPARTMENT

No Finance statements for Q3.

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.*