DRAFT

Halton Prevention and Early Intervention Strategy

February 2010

Contents

Executive Summary

Halton Borough Council and NHS Halton and St Helens have drawn up this Joint Prevention and Early Intervention Strategy to establish a clear framework and rationale to support an increased shift to improving preventive and early intervention services in the borough. The document is a local response to the National picture and is informed by a number of National documents 'Making a strategic shift to prevention and early intervention – a guide' Department of Health (2008), 'Our health, our care, our say' (2006), 'Putting People First' (2007), 'Transforming Social Care (2008) and 'High quality care for all' ('the Darzi report', 2008).

The strategy defines the three distinct areas of prevention as:

- Primary Prevention / Promoting Wellbeing

This is aimed at people who have no particular social or health care needs. The focus is on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc.

- Secondary Prevention / Early Intervention

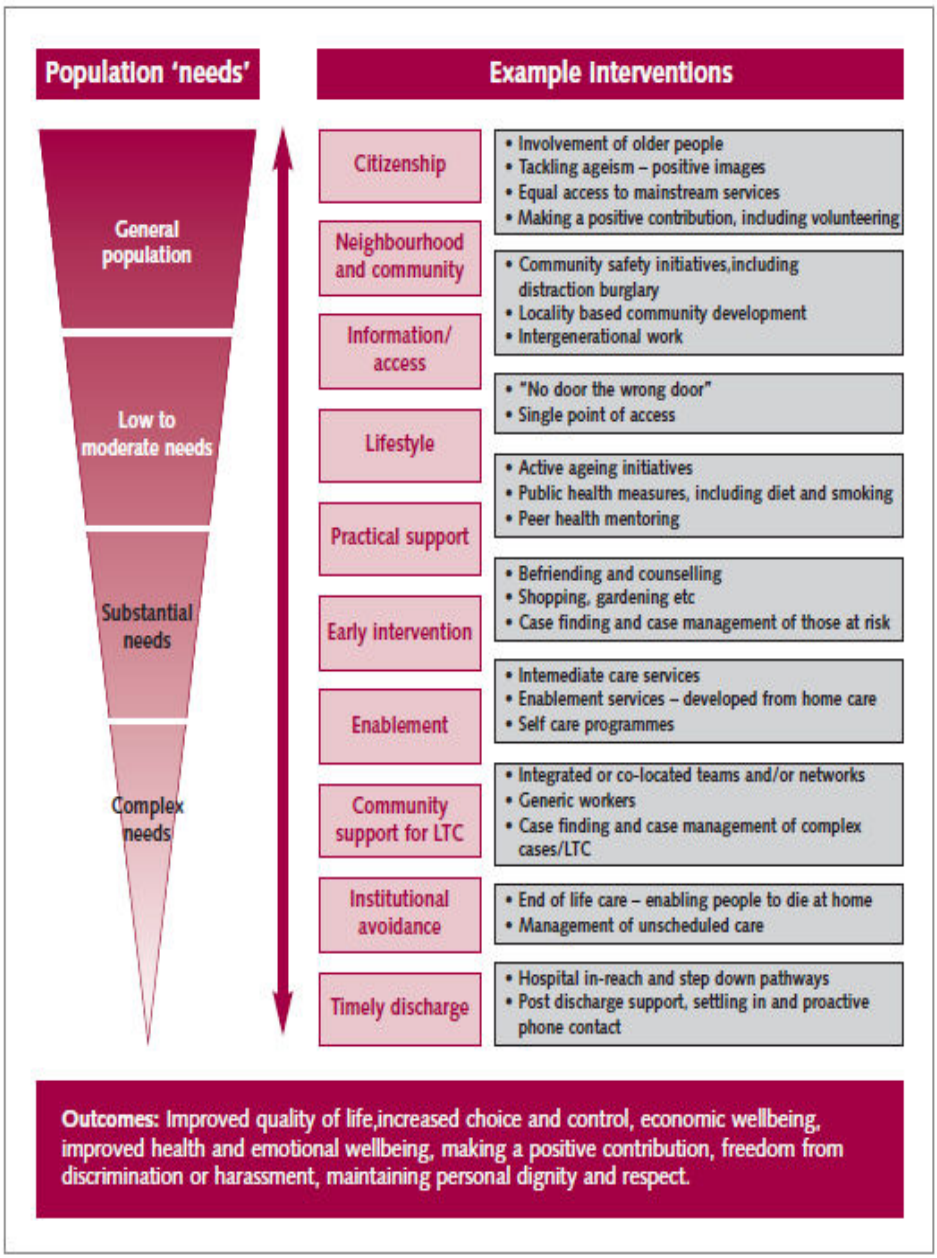
This is aimed at identifying people at risk and to halt or slow down any deterioration, and actively seek to improve their situation. Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those that they have existing low level social care needs.

- Tertiary Prevention

This is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus is on maximising people's functioning and independence through interventions such as rehabilitation / enablement services and joint case-management of people with complex needs.

By clearly defining prevention in this way we can begin to consider how addressing people's low-level needs and wants we can begin to shift service provision from high cost complex care to more cost effective low-level support. The strategy is structured around a spectrum of interventions that is illustrated in figure 1 later in the document. The **'Triangle Framework'** outlines ten example interventions that can support people regardless of their health and social care needs.

Figure 1 'Triangle Framework' showing the relationship between different levels of population need and a relevant range of intervention



The prevention and early intervention strategy maps the current activity in Halton against one of the ten headings. The first five headings Citizenship, Neighbourhood and Community, Information / access, Lifestyle, Practical Support fall under primary prevention. Secondary prevention includes early intervention and enablement. Tertiary prevention includes Community support for long-term conditions, institutional avoidance and timely discharge.

There is emerging evidence from the evaluation of the Partnerships for Older People Projects (POPP) that by funding more services at the top of the triangle then the greater the impact on acute services. For example the Department of Health evaluation of POPP suggests that for every £1 spent on prevention services an average of £0.73 is saved on the per month cost of emergency hospital bed days (an overall benefit to the health and social care economy of £1.73). This is the first major piece of evaluation that adds a financial element to demonstrate and further enhance the benefits enjoyed by most service users.

When we consider the local context in Halton there is no shortage of low-level services, information provision on a generic or specialist level is widely available, carers support, Advocacy, practical tasks, health improvement the list is endless and the mapping that has been carried demonstrates the huge level of services that are being delivered. However, the clear gap is the co-ordination of these services. This strategy sets out to address this and consider the benefits of developing a system of improved partnerships (by further developing the Partnerships in Prevention work) and increased navigation through the system to improve an individual's service experience.

Halton Joint Commissioning Strategy for Prevention and Early Intervention

1. Introduction

This strategy has been drawn up to establish a clear commissioning framework to support the development of a coherent system for prevention and early intervention, informed by and consistent with current Department of Health guidance: '*Making a strategic shift to prevention and early intervention – a guide'* (2008). The objective is to make communities safer and more supportive, provide earlier and more appropriate support and care to enable citizens to remain independent for longer.

The strategy is also intended to be consistent with and promote the objectives of *'Our health, our care, our say'* (2006), *Putting People First* (2007), *Transforming Social Care* (2008) and *'High quality care for all'* ('the Darzi report', 2008.)

It is a 3-5 year joint health and local authority strategy that is broadly based and which has been developed with a wide range of partners. The focus, in accordance with the Department of Health guidance, is on promoting the independence of all adults.

The strategy places particular emphasis on the development of 'low level' arrangements to support prevention. This reflects the fact that while there has been some significant development of earlier and lower level interventions there has been more investment and greater focus, in recent years on developing higher level, more focused and intensive interventions.

Current provision for prevention and early intervention in Halton has been looked at through a mapping exercise, and considered alongside national guidance on the development of a balanced array of interventions. This has helped to identify gaps in provision, areas where services need further strengthening and priorities for the commissioning programme.

2. Background

There has been a significant and growing emphasis, in recent national strategy reports, on the need to change the way adult social care services are delivered in response to the demographic challenge of an ageing population, and on the need for

a whole system response built around personalised services with increased emphasis on prevention, early intervention and enablement.

The change in the structure of the population presents a significant challenge to health and social care services. Life expectancy has increased considerably with a doubling of the number of older people since 1931. Between 2006 and 2036, the number of people over 85 in England will rise from 1.055 to 2.959 million, an increase of approximately 180%. Ill health and disability increase with age and this is reflected in the forecast that the number of people over 65 with a limiting long term illness in England will increase from 3.9 million in 2009 to 6.1 million in 2030 (DH, www.poppi.org.uk) which is likely to be accompanied by an increase in the demand for support across the continuum of need.

The 3 'Wanless reports' (DH, 2002, and 2004, Kings Fund, 2006) showed that the cost to the public purse is greater when services are focussed on intensive interventions to manage complex health and social care needs, and that it is cost effective to shift the focus to prevention and the promotion of good health, supporting people in the community and reducing reliance on residential and acute hospital care.

'Our health, our care, our say,' outlined the reform needed in both social and health care services to respond to the demographic challenge and rising expectations in the population. 'High quality care for all', the Darzi report, building on the direction set in the White Paper highlighted the need to improve prevention, deliver services as locally as possible, and deliver patient choice and personalisation. Putting People First and Transforming Social Care have provided clear direction for the required transformation of social care and have made it clear that the new adult care system requires a collaborative approach with a broad range of partners to redesign local systems around the needs of citizens.

In Putting People First the development of this collaborative approach to the transformation of adult social care was formally acknowledged through a 'concordat' 'between central and local government, the sector's professional leadership, providers and the regulator.' This collaborative approach reflected the recognition that while some of the transformational reforms could be made through local adult social care policies 'others required adult social care to take a leadership role within local authorities, across public services and in local communities.'

A central objective of the transformation is that 'ultimately every locality should have a single community based support system focussed on the health and wellbeing of the local population. Binding together local Government, primary care, community based health provision, public health, social care, and the wider issues of housing, employment, benefits advice and education training.' The local approach should therefore utilise all relevant community resources especially the voluntary sector so that prevention and enablement become the norm, supporting people to remain in

their own homes for as long as possible, with the alleviation of loneliness and isolation as a major priority.

The system-wide nature of the transformation envisaged in Putting People First requires clear linkage with the local strategic planning arrangements provided by the Sustainable Community Strategy and Local Area Agreements, and to be informed by the picture of need established through the local Joint Strategic Needs Assessment.

The central themes of Putting People First were reinforced in Transforming Social Care which said that 'the direction is clear: to make personalisation, including a strategic shift toward early intervention and prevention the cornerstone of public services.'

More recently in *'Building a society for all ages'* (DWP, 2009) the government has set out for consultation a broadly based programme of action to achieve a 'shift in attitude and behaviour across society so that old age is no longer perceived as a time of dependency and exclusion.' The programme is intended to support changes for individuals, families, for the workplace and economy and for public services and communities. The proposals include:

- More support to assist people who want to keep working for longer, and to enable businesses to tap into the experience and commitment of older people
- Improved access to support for mid-life decisions on such matters as financial and health concerns through an interactive 'one-stop shop'
- Initiatives to help people as they get older take advantage of sporting, educational or social opportunities including 'all-in-one cards' to give access to a range of local activities
- A 'grandparents summit' to consider the changing structure of families, with more active grandparents having the opportunity to play a greater role in their families lives including caring for grandchildren, and to consider what extra help they may need
- A health prevention package focusing on preventative services for conditions that affect people in later life (such as footcare, falls prevention, continence care, depression and arthritis)
- Recognition for the key role that people fulfil in later life in providing the lifeblood of communities through volunteering, caring and playing an active role in community life, through support for intergenerational projects to breakdown barriers and challenge negative stereotypes

To assist localities to achieve the strategic shift outlined in Putting People First and Transforming Social Care, the Department of Health has provided practical guidance for local authorities and health communities on how to make the shift to early intervention and prevention in 'Making a strategic shift to prevention and early intervention – a guide' (DH 2008) (hereafter referred to as 'the Guide'), and more

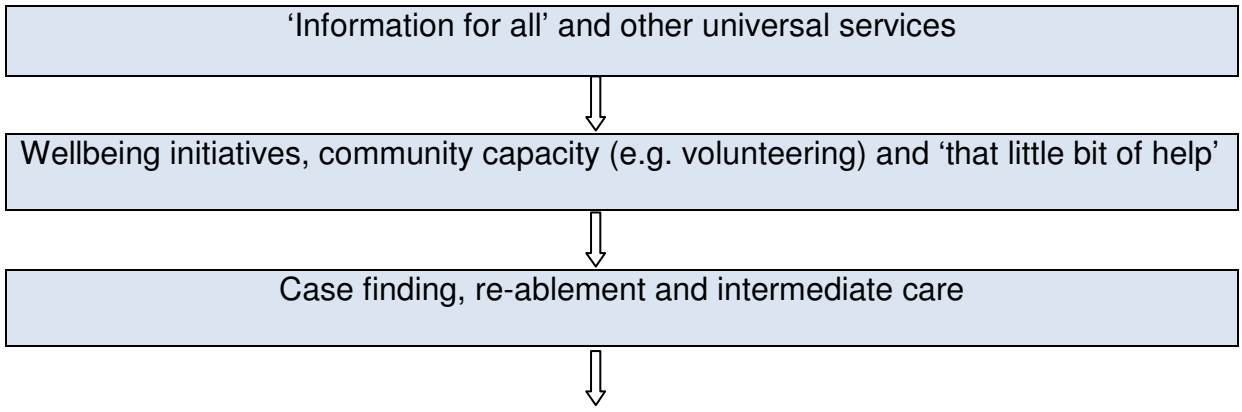
recently has published 'Prevention Package for Older People Resources' which provides examples of successful approaches in relation to such areas as falls and fractures, footcare, telecare/telehealth, hearing services, accidental injuries and intermediate care. Both documents provide evidence based examples of best practice with reference to the evaluation of demonstrator sites, the Partnerships for Older People Projects (POPPs) and the LinkAge Plus projects.

The focus of the Guide is on promoting the independence and wellbeing of citizens.

The following sections follow the framework that is set out in the guidance, which builds on the model of four interdependent themes at the heart of the vision for social care in Putting People first:

- Facilitating access to **universal services**[1]
- Building **social capital**[2] within local communities
- Making a strategic shift to **prevention and early intervention**
- Ensuring people have greater **choice and control** over meeting their needs

These interdependencies can be considered as a pathway. Initially people access *mainstream or universal services,* then as their needs progress and they prepare for old age they are likely to require a wide range of support and *capacity developed within local communities*. A rapid deterioration or crisis may occur, leading them to benefit from *preventative work* – such as enabling or rehabilitative support which helps people to regain a level of their previous functioning. Any ongoing needs are then met in a personalised way through the provision of an individual budget which gives them maximum *choice and control* over how they arrange their support.



[1] Services such as Education, Transport, and Leisure and services that may be available to all older people in an area such as handyman schemes, gardening, shopping, and signposting services.
[2] 'Key indicators of social capital include social relations, formal and informal social networks, group membership, trust, reciprocity and civic engagement.' Office of National Statistics (2001)

Ongoing support: Individual budget / Choice and control over how they are deployed / Personalised care plan for those with Long Term Conditions

3. What is 'Prevention'

Health England the national reference group for health and wellbeing (established to oversee the evidence base for the strategic shift envisaged in 'Our health, our care, our say') has proposed that in this context 'prevention' is defined as:

'*a clinical, social, behavioural, educational, environmental, fiscal or legislative intervention or broad partnership programme designed to reduce the risk of mental and physical illness, disability or premature death and/or to promote long-term physical, social, emotional and psychological wellbeing*'.

The approach in the Guide, on the other hand, is to propose a framework which has a broad focus and which identifies three categories of prevention:

3.1 Primary Prevention / Promoting Wellbeing

This is aimed at people who have no particular social or health care needs

The focus is on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc

3.2 Secondary Prevention / Early Intervention

This is aimed at identifying people at risk and to halt or slow down any deterioration, and actively seek to improve their situation

Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those that have existing low level social care needs

3.3 Tertiary Prevention

This is aimed at minimising disability or deterioration from established health conditions or complex social care needs

The focus is on maximising people's functioning and independence through interventions such as rehabilitation / enablement services and joint case-management of people with complex needs.

The key message is that interventions are required across the whole spectrum of need, to help older people who are healthy to continue to live independently for longer and to assist older people who are unwell to regain their independence or to prevent or delay the onset of further health problems.

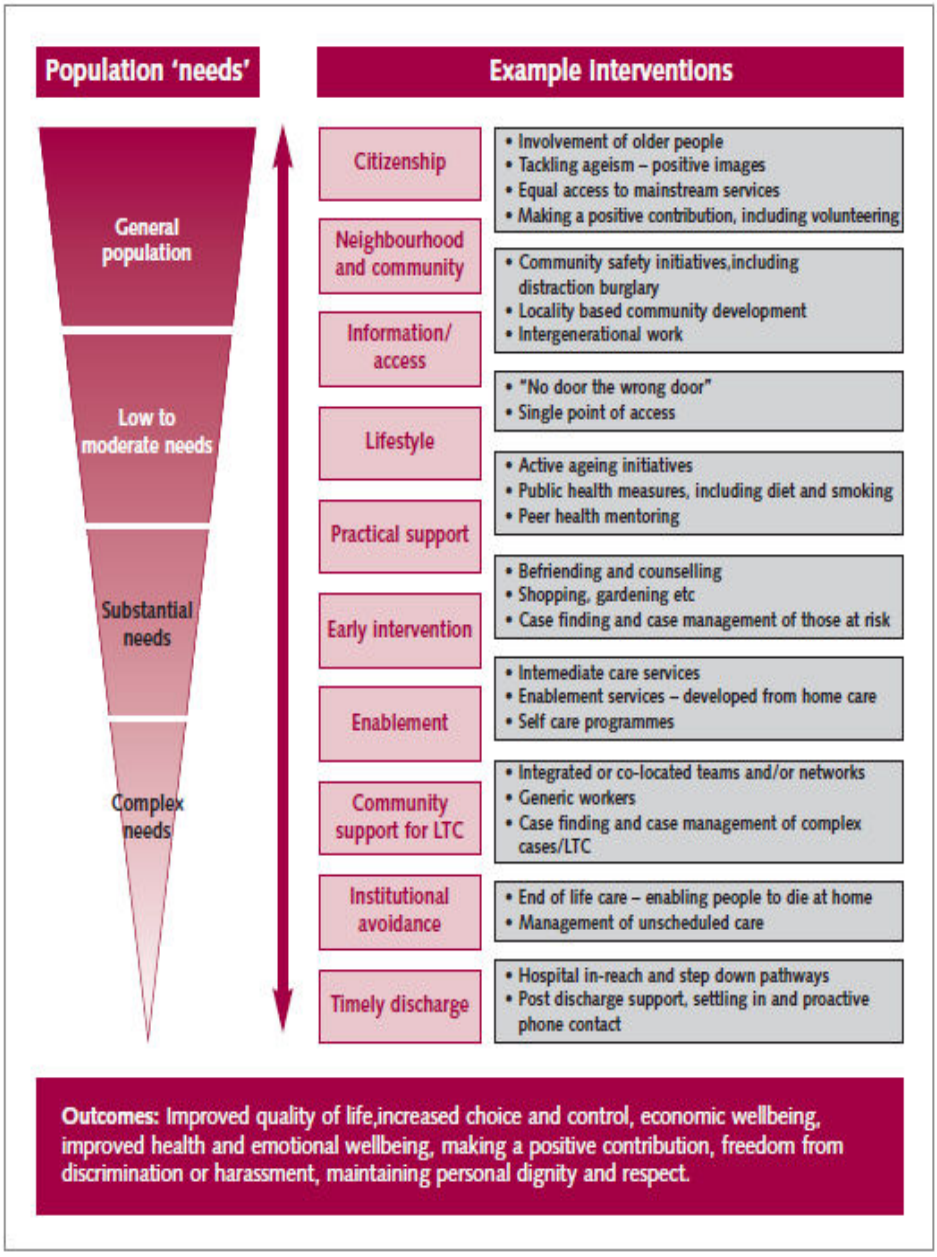
4. A Broad Spectrum of Interventions is Required

The generally prevalent model of care in the recent past has been shown to have developed an increasing focus on providing intensive interventions for a relatively small number of people with the greatest needs (*All Our Tomorrows – Inverting the Triangle of Care',* (ADSS, 2003) and *Cutting the cake fairly: CSCI review of eligibility criteria for social care* Commission for Social Care Inspection (2008.))The strategic shift required to deliver the transformation envisaged in Putting People First requires an approach that 'inverts the triangle' and addresses the whole population of citizens. This approach requires a broad spectrum of interventions ranging across:-

- **Citizenship Rights**: promoting active involvement, ensuring equality of access, tackling discrimination
- **Neighbourhood and Communities:** that have a clear identity and vibrancy, that are safe to live in, with cohesion across the generations
- **Information:** about ways to maintain independence or to access support to do so, with help available to 'navigate' around the system. Access routes and information systems joined up so that 'no door is the wrong door' and support to make sense of information.
- **Health Lifestyles Promotion:** working with Public Health promotion and including mental wellbeing and emotional health
- **Practical Support:** through a range of low cost services that may include emotional help as well as low cost practical support, that generally involve 'simple' eligibility criteria or fall outside social care eligibility criteria and are principally delivered by the voluntary and community sector
- **Early Intervention:** working proactively to identify people whose independence is at risk, using tools to predict risk and case finding
- **Enabling** or rehabilitative response: maximising peoples functioning, through for example 're-engineering home care' and intermediate care developments
- **Community Support for Long Term Conditions:** which is best delivered through health and social care working closely together
- **Institutional Avoidance:** through initiatives to prevent inappropriate admissions to care homes or hospital. Intensive care management and extra care housing are examples
- **Timely Discharge:** interventions which enable people to spend no longer than is necessary in hospital and to return safely to their own homes, for example hospital Inreach services

The following diagram illustrates the spectrum of interventions and the relationship to the areas of need to which the interventions relate, although it is important to note that even those with complex needs will want to make use of many of the 'lower level' interventions.

Figure 2 'Triangle Framework' showing the relationship between different levels of population need and a relevant range of intervention



5. Key interventions for generating the strategic shift to prevention and early intervention:

Within this broad range of interventions the Guide identifies the following as the key interventions required to create the shift to prevention and early intervention:

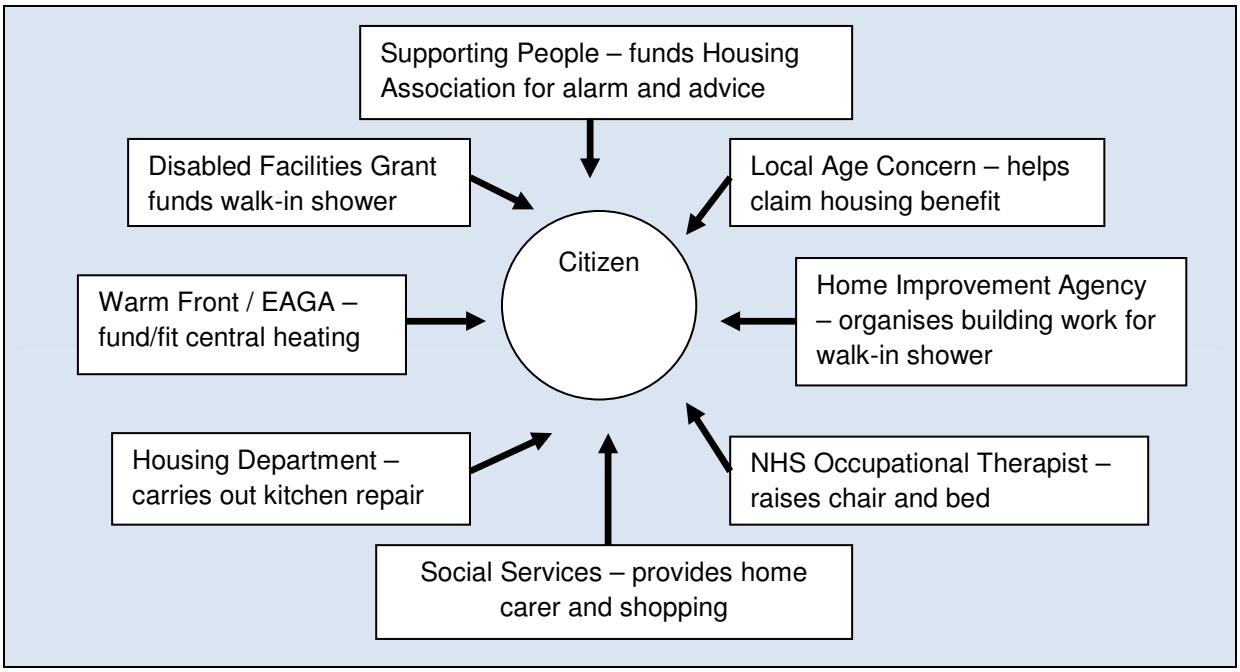
- Age proofing mainstream services
- Range of wellbeing services
- Providing information to all
- Case finding
- Case co-ordination / service navigation
- Managed pathway for those not eligible for ongoing social care
- Building capacity in local neighbourhoods
- Re-ablement
- Joint health and social care community support for people with long term conditions / complex needs
- Support to care homes
- Crisis response / out of hours services
- Telecare
- Extra Care Housing
- Supporting People Programme
- Falls
- Carers

6. Engaging with Partners in a Whole System Approach

Delivering the strategic shift to prevention and early intervention requires a 'whole system' approach that does not just involve health and social care, it needs to involve a broad range of other council departments or statutory organisations 'with a responsibility to act, and with money to invest' including supporting people, public health, community safety, leisure and cultural services, together with community and voluntary organisations and other stakeholders such as the Pensions Service, and the Fire and Rescue Service.

The contributions of resources from partners in the whole system is well illustrated in the following figure taken from *'Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing in an ageing society'* (CLG, 2008)

Figure 2: Resource Contributions from a Whole Systems Perspective



6.1 Promoting independence, active citizenship and participation

The model of the vulnerable adult as simply the passive recipient of support is inappropriate and unhelpful in this context. The prevention and early intervention model should be one in which there is 'a shift in the perception of vulnerability from one of dependency and decline into one of active citizenship, participation and independence. Underpinning this is a move towards earlier intervention to make communities safer and more supportive, provide earlier and more appropriate support and care to enable vulnerable adults to remain independent for longer, reduce social isolation and exclusion, maximise income and the ability to work, and encourage healthier more active living.' *LinkAge Plus National Evaluation: End of Project Report'* (DWP – 2009)

As Age Concern has observed in a recent report on prevention projects 'Services that promote interdependence and social involvement may be more effective than those that encourage self-sufficiency. Timely provision of practical support, which enables older people to maintain their homes and gardens in a safe, comfortable and attractive state, sustains a sense of competence and wellbeing. Services that provide opportunities for social engagement, or which facilitate access to social and community facilities, enable older people to lead more fulfilling and rewarding lives. Opportunities for older people to contribute can be more beneficial than the passive

receipt of help. Familiar services may need to be re-examined, with commissioners, service providers and older people jointly clarifying the purpose, intended outcomes and methods used.' *'Prevention in Practice, service models, methods and impact'* (Age Concern, 2009)

Similarly the LinkAge Project evaluation noted that 'A key feature of the pilots is the way in which they have engaged older people in activities that help them to develop and sustain social networks, are enjoyable and/or educational and/or involve physical exercise, and help improve the experience of growing older. These include initiatives designed to improve physical and mental health, education and lifelong learning, leisure, employment, welfare entitlements, social benefits and access to transport.'

7. Measuring the Impact of Prevention and Early Intervention – Evidence of Effectiveness

A wide range of effective interventions have been demonstrated through programmes such as the Partnership for Older People Projects (POPP) and LinkAge Plus which have been used to stimulate innovative approaches and to encourage innovative partnership working.

7.1 The POPP Programme

The POPP programme, funded by the Department of Health has supported 470 projects in 29 pilot sites aimed at creating a sustainable shift in resources and culture away from institutional and hospital-based crisis care for older people towards earlier, targeted interventions within their own homes and communities. The projects have been stratified into those focused toward Universal Services, Additional Support and Specialist Support. The interim national evaluation has shown that:

- For every £1 spent on POPP, an average of £0.73 is saved on the per month cost of emergency hospital bed-days (an overall benefit to the health and social care economy of £1.73)
- Analysis of those sites where data was currently available (October 2008 - 11 out of 29 sites) appeared to demonstrate the cost-effectiveness of POPP projects.
- Service users reported that their health-related quality of life improved in five key domains

The recent Department of Health guide on the 'Use of Resources in Adult Social Care' (October 2009) concludes that: 'Findings from the POPPs pilots are beginning

to provide a stronger evidence base that demonstrates that particular approaches can save money for both the health and social care economy.'

Evidence from the evaluation of the POPP projects suggests the savings are most pronounced with interventions focused on:

- Hospital Avoidance interventions such as intermediate care, rapid response, hospital in-reach, case management of long term conditions etc

And that that they have also demonstrated a 'discernable' savings effect when focused on:

- Improving peoples quality of life such as befriending, peer support, practical assistance etc

Key learning from the POPP programme is that:

- A balanced portfolio of investment across the full range of interventions is needed
- Engagement with older people is an essential requirement for successful service redesign

7.2 The LinkAge Plus Programme

The LinkAge Plus programme was funded by the Department of Work and Pensions, and involved support for 2 years for over 100 initiatives in 8 pilot areas. The initiatives were characterised by joining up services and partnership working. The approach was preventative with a focus on providing a 'little bit of help' to enable older people to remain independent for longer. They adopted a 'whole person' approach, going beyond adult social care and health to promote wellbeing and independence including practical support to improve the take up of benefits and reduce social exclusion. They also had a focus on developing 'single access channels' avoiding duplication and making it easier for people to contact services with an emphasis on 'no wrong door'.

The national evaluation findings were that:

- The initiatives broke even in the first year after the investment period
- The net present value of savings up to the end of the five-year period following the investment was £1.80 per £1 invested.
- LinkAge Plus helped to facilitate services that are cost effective in their own right, including fire and crime prevention, and reduced falls associated with balance classes and home adaptations

- Combining the costs and benefits of these services in LinkAge Plus areas with the holistic approach to service delivery was shown to increase the net present value to £2.65 per £1 invested;
- In addition to taxpayer savings they calculated that there were benefits to older people that could be monetised at £1.40 per £1 invested.

In its conclusion the evaluation report says that 'Preventative services are likely to lead to improved quality of life and a reduction in the need for more costly interventions in the longer term. Partnership working has helped local services to be more 'joined up', particularly between the voluntary and community and statutory sectors, resulting in a reduction in duplication and overlap' and that the LinkAge projects have 'demonstrated a range of activities that help older people grow older in strong and supportive communities in a cost effective way.' 'LinkAge Plus is providing 'that little bit of help' (Joseph Rowntree Foundation, 2005) which enables older people to retain choice, control and dignity in their lives and is helping to deliver services that are contributing to the improvement of older people's quality of life and healthy life expectancy and active participation.'

A clear indication of the perceived value of the POPP and LinkAge Projects can be seen in the fact that only 4% of the projects across the POPP programme have indicated that they do not intend to sustain their service after the end of DH funding and that local funding has been secured to continue all of the LinkAge projects.

8. A Whole System Perspective on Investment and Impact

It is important for partners to understand how investments in one part of the system can produce benefits in another part. The recent Department of Health publication on making the best use of resources in adult social care points out that 'the POPP programme has shown that investment in social care interventions can produce capacity gains in the acute health sector (DH, 2009). This strengthens the case for working together and to make best use of the sectors' collective resources, with an agreement on which party invests its money in which areas.'

The DH Guide advises that social care and health commissioners should work together to 'consider how resources may be released from across the whole system and redirected to enable investment in early intervention and prevention for all levels of need'. It also encourages engagement with Practice Based Commissioning, for example, 'in relation to people with long term conditions, where there may be a possibility of initiating a 'virtuous cycle' of investment, - i.e. re-investing savings from reduced hospital admissions into more joint working on preventative approaches. In relation to which case finding and joint health and social care teams may be of particular relevance'

The LinkAge Projects have shown that investment across a very broad range of organisations can impact on the health and wellbeing of older people and the degree to which their communities are 'strong and supportive.'

9. The Local Context

9.1 Demographic Factors

From the 2005 Housing Needs Survey and 2001 Census statistics we can estimate that 1 in 5 people in the Borough (24,920) have a Limiting Long-term illness. Locally, research undertaken to support the implementation of the NSF for Long-term neurological conditions (LTNC) estimates that 2.5% of the population across the PCT footprint have a LTNC excluding those who have suffered a stroke – for Halton this is just under 3000 people.

Population projections for people over 65 for Halton and for St Helens from 2009 – 2030 are shown in the table below along with the projections for limiting long-term illness. (The Office for National Statistics data for people below the age of 65 appears in bands from 45-55 and 55-65, it is not possible therefore to extract data for the 'over 50' population.)

Table 1: Population and Long-Term Illness Projections

Total population 65 and over					
	2009	**2015**	**2020**	**2025**	**2030**
Halton	17,100	20,500	23,100	25,500	27,900
St Helens	30,200	34,500	37,200	39,800	43,200
Total population aged 65 and with a limiting long-term illness					
	2009	**2015**	**2020**	**2025**	**2030**
Halton	9,464	11,299	12,742	14,188	15,566
St Helens	17,123	19,573	21,195	22,887	24,845

As can be seen, the Office for National Statistics forecast is that that there will be a very significant growth in the population of older people in the boroughs between 2009 and 2030 with an increase in the number of people over 65 in Halton of 63% and in St Helens of 43% compared to a national average increase of 53%. This is anticipated to be accompanied by a corresponding increase in limiting long-term illness, for people in this age range, of 64% for Halton and 45% for St Helens, the national average increase being forecast to be 55%. Without further development of prevention and early intervention measures the increased numbers of older people, many with limiting long-term illnesses will be likely to significantly increase the local demand for residential and acute hospital care

The increase in the number of older people and in the number of people with long term conditions will put additional pressure on carers. This pressure will be experienced particularly by older carers as over the same period the available pool of younger carers will be shrinking as the population of people aged 18-64 is forecast to reduce by 4.3%.

Nationally the number of adults with learning disabilities is around 2% of the population and it is estimated that around 20% of these people are known to social care. The remaining 80% have mild/moderate learning disabilities and may not be known to services needing little support beyond their own families, friends and social networks. Projections by the Centre for Disability Research (2008) suggest that more people with mild to moderate learning disability will become known to and start using services and it is anticipated that by 2018 the number of people accessing services will increase by 50%. Thus it is crucial to provide information about and access to a range of preventative or early intervention services to ensure that existing informal support networks can continue.

9.2 Local Drivers, Priorities and Targets

9.2.1 Sustainable Community Strategies

Sustainable Community Strategies provide the overarching strategic framework for local authority areas setting out key stakeholders' locally agreed priorities for long term programmes of development.

Considerable identity of purpose is evident in the development of community strategies and the development of prevention and early intervention strategies with both concerned to prevent ill health and disability and promote well-being in the local community. Similarly both recognise the need to look at the wider determinants of health, to respond to the needs of an ageing population, to encourage community engagement and social inclusion, recognise the key role of the voluntary and community sectors, and the need to develop safer neighbourhoods. There should therefore be a strong positive interaction between achieving the objectives of the Prevention and Early Intervention Strategy and achieving the objectives of the local community strategies.

9.2.2 Local Area Agreements

A Local Area Agreement (LAA) is an agreement between Central Government and the local authority and its partners about the priorities for the local area, expressed in terms of a set of targets taken from a National Indicator set of 198 targets. They are integral to the Sustainable Community Strategies and have been identified as fulfilling the role of a delivery plan for them.

9.2.3 NHS Halton and St Helens 'Our Ambition for Health – Commissioning Strategic Plan' (2009)

'Our Ambition for Health' sets out a clear direction for commissioning health provision in Halton and St Helens based on:

- Helping people to stay healthy
- Detecting illnesses earlier
- Improving the quality and safety of services

This translates into 6 Ambition for Health goals:

- Supporting a healthy start in life
- Reducing poor health resulting from preventable causes
- Supporting people with long term conditions
- Providing services to meet the needs of vulnerable people (including older people and people with physical and sensory disabilities)
- Making sure our local population has excellent access to services and facilities
- Playing our part in strengthening disadvantaged communities

The strategic plan for the commissioning of health services for Halton has a clear focus on prevention and early intervention, on responding to the needs of the ageing population and to people with long-term conditions, and providing services accessible to people in their local communities. It is clearly consistent with the objectives of this strategy, which should contribute to the achievement of its goals.

9.2.4 Advancing Well – Improving the Quality of Life for Older People in Halton, 2008-11

Halton's 'Advancing Well' Strategy was developed to promote more independent living and reduce the social isolation often experienced by older people, with a focus on those aged 50 or older. It promotes joint action by the various departments of the Council with partners in organisations such as transport, job centres, colleges, health facilities, sport and leisure facilities, and housing with an approach based on ensuring older people have a say in the development of their local services.

The strategy aims to ensure that older people:

1. Are helped to get around through better **transport** links

2. Are given opportunities for **employment** whether paid or volunteer work

3. Remain in **good health** longer

4. Feel **safe** and secure and are given support to **live independently** both inside and outside their home

5. Have easy access to **advocacy services and financial advice**

6. Receive effective **communication** and **information**

Advancing Well has provided a sound foundation for the closely related work that is now being developed around prevention and early intervention. The focus on promoting independent living and reducing the social isolation of people aged 50 and over through joint action by a range of local organisations is reflected in a number of the key themes of this strategy, which in turn will help to consolidate and progress the earlier strategy's objectives.

9.2.5 Joint Commissioning Strategy for Older People, 2009-2014

This provides an overarching strategy for the commissioning, design and delivery of services to older people in Halton. The theme of prevention and early intervention is central to the section of the strategy on 'Quality of Life' which commits partners to a 3 year programme of developing and implementing the 'prevention agenda,' a process which is being initiated through the development of the strategy set out in this paper.

9.2.6 Halton and St Helens Joint Commissioning Strategy for Dementia 2009

Currently there is a lack of awareness and a cycle of stigma that prevents or delays people with dementia and their carers from getting the help that they need. As a result most people with dementia never receive a diagnosis, increasing the likelihood that they will need admission to hospital and residential or nursing home care. The services available to support those that are referred for assessment and treatment are acknowledged to be limited and under-resourced. The National Dementia Strategy 2009 (NDS) recognised these failings in current health and social care systems and produced a set of recommendations to remedy these systemic failings and enable local commissioners develop to develop comprehensive local services

The Joint Commissioning Strategy for Dementia addresses all of the recommendations of the NDS and sets out a broad programme of development for the boroughs that is intended to address public health issues, raise awareness,

combat stigma, facilitate the development of peer support, and provide comprehensive early assessment, care and treatment to all who need it.

As the number of older people in the population rapidly increases this will be accompanied by a proportional increase in the number of people with dementia. The development programme set out in the Joint Commissioning Strategy for Dementia will therefore play an increasingly important role within the boroughs' overall prevention and early intervention strategy.

9.2.7 Intermediate Care Services

The National Service Framework for Older People promoted intermediate care services as a way to impact on unnecessary hospital admissions, reduce length of hospital stay and prevent unnecessary admissions to long term care in residential establishments. The key role played by Intermediate Care services in supporting secondary and tertiary tier prevention and early intervention is highlighted in the Guide. In the spectrum of interventions they can be seen as playing a key role, in particular in relation to the 'Early Intervention', 'Enablement' and 'Timely Discharge' categories.

Intermediate care services have played a significant part in achieving improvements in overall outcomes for people in Halton over the past 5 years. This has been reflected in a steady reduction in emergency admissions and acute hospital bed utilisation, the reduction being greater in the over 65 population. The number of people living in care homes has more than halved. Over the same period of time the number of people over 65 supported at home has tripled, so Halton is now one of the highest performers in England. This approach has also reduced the size of on-going care packages so that people are able to live more independently with lower levels of support.

Intermediate Care services in Halton have been delivered through 4 main services:

- Rapid Access Rehabilitation Services (RARS)
- Residential intermediate care beds
- Nursing intermediate care beds
- Domiciliary re-ablement service

Recently further service developments have been approved in response to identified pressures such as the ageing population projections and increasing levels of demand on the existing service to:

- Reduce the age criteria for RARS down to 18+

- Establish a sub-acute Intermediate Care Unit on the Halton Hospital campus, and decommission the nursing intermediate care beds.
- Develop an assessment service to manage community, A&E and hospital referrals.
- Implement the Gold Standard and Performance Management Framework for Intermediate Care in Halton

While there maybe potential for further developments in Intermediate Care services in Halton, it is clear that the current service is already making a significant contribution to secondary and tertiary tier prevention.

9.2.8 Telecare and Telehealth Services

Telecare and telehealth services use technology, typically sensors/ monitors linked to contact centres or health professionals to help people live more independently at home. They include environmental and health-monitoring devices and personal alarms and are especially helpful for people with long-term conditions, as they can give the user and their relatives peace of mind that they are safe in their own home. They can also help people to live independently in their own home for longer, avoiding the need for hospital admissions and delaying or preventing the need to move into a residential care home. The key role that telecare/telehealth can play in the further development of prevention services is emphasised in the Guide.

Halton B. C. has been providing a Telecare service for over 3 years and has experienced year on year growth in the number of people receiving the service. The technology has developed rapidly in recent years and the range of applications is steadily expanding.

A Service Evaluation report on Telecare has recently been completed for the Health and Community Directorate which clearly demonstrates the positive impact that the service has had and details areas that will need to be addressed as the service expands and develops.

The Widnes Practice Based Commissioning (PBC) Consortium, Halton and St Helens Primary Care Trust (PCT) and HBC are currently commissioning a community based integrated care service known as the 'Virtual Ward.' This will actively support the most vulnerable individuals and those with long-term conditions at home, in order to reduce unnecessary hospital admissions making use of Telehealth devices to support self-management and the close monitoring of physiological observations.

Local developments in Telecare and Telehealth services can play a significant role in the developing spectrum of preventive interventions.

9.2.9 The Carers Strategy

It is important that Carers have access to services based on recognition of their rights as individuals, choice in their daily lives and real opportunities to have a life of their own outside of the caring role.

The Joint Commissioning Strategy has been developed via ongoing consultations and contributions from stakeholders who provide services to carers as well as carers themselves. We have listened to what carers have told us about the help and support that they need and have responded by addressing the issues throughout the Strategy.

This Strategy is written as a practical document, including an action plan, to support services in Halton move towards a more focussed way of commissioning services over the next three years

We are committed to working jointly and in partnership with the voluntary sector within Halton, providing where possible an integrated response based on services which meet assessed needs and which are designed to improve lives and give new opportunities.

We are proud of what we have achieved for Carers within Halton since the production of the last Carers Strategy, but we also recognise the need for continual improvement and Halton Borough Council and Halton and St Helens Primary Care Trust, together with their partners have made a pledge to continually improve services and the quality of life for carers

We recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community and we believe that this Strategy demonstrates our commitment to recognising, valuing and working with local carers.

9.2.10 Halton Healthcare for All Group

This group is hosted by NHS Halton and St Helens and was set up to address locally the recommendations in the Healthcare for All report (DH, 2008) relating to access to healthcare by people with learning disabilities. Membership includes the local authorities, acute hospitals and service users and their carers. It also oversees work in the Borough to promote well-being and prevent ill health among people with learning disabilities as required by Valuing People Now (DH 2009). This will be achieved by generic services making reasonable adjustments in how they operate to ensure equitable access by disabled people including those with learning disabilities.

10. Mapping and Gap Analysis

A mapping exercise has been undertaken in Halton to map current interventions, identify gaps or unmet needs and consider how best to meet those needs. The methodology employed has been to analyse the current position with regard to the 10 'spectrum of intervention categories' as detailed above in Section 4 and illustrated in Figure 1.

The detailed findings of the mapping exercises can be found in Appendix 1

11. Developing a Local Strategic Commissioning Framework

Analysis of the key themes that run through the DH Guide, and the evaluations of the POPP and LinkAge Plus Pilots, together with the analysis of the mapping exercise have provided the basis for the development of an outline framework within which local commissioning decisions can be effectively developed, together with a number of broad strategic objectives. The framework sets out key structures and actions required to achieve the shift to prevention and early intervention, while the key strategic objectives clarify the direction of travel

11.1 The Commissioning Framework

To make the shift to prevention and early intervention commissioners will:

- Adopt a whole system approach involving a broad range of partners
- Involve citizens at all stages in the planning and delivery of services
- Ensure that there is agreement with partners on the 'shared responsibility for resourcing' which underpins the approach
- Establish appropriate planning structures to oversee and implement the development programme, ensuring that it is effectively managed and sustainable
- Ensure integration with other areas of the Transformation of Social Care agenda and that the developments support the personalisation of health and social care
- Systematically analyse and apply the learning from, the POPP and LinkAge projects and other prevention work (such as that set out in Age Concern's 'Prevention in Practice, service models, methods and impact' 2009)
- Ensure the programme of interventions is aligned with and contributes to the Sustainable Community Strategy and Local Area Agreement priorities and is linked to the relevant National Indicators

- Make use of the Social Care Reform Grant and other relevant funding opportunities as they arise
- Adopt an 'Investment' approach to funding (to achieve a return)
- Ensure performance requirements and measures are outcome focused (measuring the return on investment)
- Use both quality of life and financial impact measures – for many services at the primary intervention end of the spectrum the financial impact will inevitably be more difficult to measure

11.2 Strategic Commissioning Objectives

In making the shift to prevention and early intervention commissioner will:

- Focus initially on meeting the needs of all adults.
- Develop a balanced spectrum of provision across the 3 levels of intervention and the intervention types
- Give particular focus to the development of primary tier and 'wellbeing' services
- Encourage investment in the third sector and stimulate the market to develop innovative approaches to prevention and early intervention
- Support participation and active citizenship and help to foster independence.
- Encourage intergenerational projects / activities
- Achieve more effective use of investment by reducing overlap or duplication within current preventive interventions
- Further develop the efficiency and effectiveness of current prevention services / activities through joint work and improved coordination
- Ensure there is greater focus on providing quality information and advice - simplifying access with an emphasis on 'no wrong door'
- Look for opportunities to shift investment from high level interventions where a clear cost benefit can be established across the system
- Recognise the significant contribution that can be made by health promotion and promoting active lifestyles
- Encourage initiatives that help to alleviate loneliness and isolation
- Improve people's access to employment and volunteering opportunities

11.3 Partnerships in Prevention (PIP)

The PIP group was developed to improve partnership working between agencies working in the field of prevention. At present membership of the group includes The Red Cross, Age Concern, Sure Start to Later Life, Community Bridge Builders and The Health Improvement Team. The group meets quarterly with a flexible agenda around partnership working and prevention issues in Halton. This group needs to expand to include many more prevention organisations such as the Fire Service, Telecare and Community Wardens with service level agreements likely to be developed in the near future. The Early Intervention and Prevention Strategy action plan will include actions around making this group more inclusive, effective and robust. PIP will be the operational arm of the strategy while the strategy implementation group will steer the project at a strategic level with an emphasis on a whole systems approach to shifting resources from crisis orientated provision towards prevention and improved well being.

Intergenerational Strand of the Strategy

“Intergenerational practice aims to bring people together in purposeful, mutually beneficial activities, which promote greater understanding and respect between generations, and contributes to building more cohesive communities. Intergenerational practice is inclusive, building on the positive resources that the young and old have to offer each other and those around them.” (Beth Johnson Centre for Intergenerational Practice 2010)

Changes in society have caused generations to becoming segregated from one another. Lack of positive interaction between these generations leads to negative stereotypes developing of younger and older people. However, anyone working within the intergenerational arena can’t help but observe that both generations have shared areas of concern e.g. community safety, and have valued resources available to offer one another.

In the past 12 months Halton Borough Council has been promoting intergenerational projects across the borough. These have included an intergenerational conference, intergenerational Halloween events and intergenerational radio programmes. Many departments within the council have been involved in these initiatives. These include Health and Social Care, Community Development, Sports Development, Libraries Service and Children and Young People. These initiatives now need developing into a more strategic and coordinated approach towards intergenerational activities.

The aim of the intergenerational strand of the EIP strategy will be to bring younger and older people together in purposeful, mutually beneficial activities, which promote greater understanding and respect between generations and contribute to building more cohesive communities. The objective of this strand will be to embed intergenerational work as a key well-being and prevention activity of Halton Borough

Council and to develop and promote intergenerational work and its benefits. Key activity will be the development of the council's intergenerational group into a robust strategic body that meets regularly to coordinate intergenerational activity across the borough.

APPENDIX 1 – Mapping of existing provision.

The mapping contained within the following attachment uses the 'Triangle Framework' (figure 1 page 5) as a basis to describe what is already in place, where there is an identified gap or unmet need and any plans that have already been developed for the future. The framework takes ten key elements to describe the varying levels of prevention and the range of interventions available.

CITIZENSHIP

Involvement

Current Position

Halton currently have in excess of 700 older people as signed up members of Halton's Older People's Empowerment Network (OPEN). Although this is an extremely positive position to be in there is a question over the number of people involved regularly and effectively. Halton OPEN has it's own constitution and is supported administratively through Age Concern Mid Mersey. There is an Executive Committee of between 15 and 20 people who meet on a regular basis (monthly). In addition a number of these committee members also represent Halton OPEN in other forums, e.g. Older People's Local Implementation Team, Carer's Sub-group, Stroke Core Strategy group etc.

Gaps or unmet needs

To ensure that all 700 members and beyond are involved in planning and having their say. It is clear that the members of the Executive are the most active people in Halton OPEN and therefore their involvement is not fully representative of all local older people. More needs to be done to ensure that being a member of Halton OPEN is more inclusive and offers anyone an opportunity to be involved.

Future plans

Halton OPEN and local commissioners are working together to develop new and innovative methods of ensuring that more people are involved. The Joint Older

People's Commissioning Manager will now attend all Executive meetings of Halton OPEN along with an agreed local Councilor. In addition OPEN and Commissioners will agree each year what the priorities are and work together to carry out quarterly focus groups that will be available to all of the wider membership and facilitated by the Local Authority. These focus groups will then feed into the Older People's Local Implementation Team, Halton Health Partnership etc.

In addition the findings will also be published in a quarterly newsletter that will be sent to the remainder of the Halton OPEN members.

Tackling Ageism

Current Position

Work to tackle ageism is sporadic and generally follows the National agenda. The NHS development plan: from good to great (2010-2015) does mention the need to change the culture in relation to Age discrimination throughout Primary, Secondary and Acute Care.

Locally we have the Dignity Co-ordinator post whose job is to ensure all people are treated with dignity and respect, one aspect of this is ensuring that there are no discriminatory practices within services.

The Government Equalities Office issued a policy statement **'Making it work: Ending age discrimination in services and public functions'** in January 2010. This document sets out consultees' views on planned proposals and the Government's response to those views. In particular, it makes clear that:

- Beneficial age-based treatment such as free bus passes, discounts for students and pensioners will still be allowed.
- The new law will ban harmful discrimination in health and social care, but allow a person's age to be taken into account where it is right to do so.
- Age will continue to be used in financial services provision, but only where it is related to risks or costs. Access to motor and travel insurance will be improved by the introduction of signposting and referral. People will be given confidence that their age is being used appropriately by the publication of aggregate industry data for motor and travel insurance that everyone can check.

This statement adds more detail to the White Paper published in June 2008 **Framework for a fairer future – The Equality Bill** that states: 'Promoting equlity is essential for individuals to fulfil their potential, for the creation of a cohesive society and for a strong economy. A substantial body of equality legislation has been introduced over the last four decades, protecting millions of people from discrimination and promoting greater equality. But the legislation has become complex and hard to understand. The Bill will de-clutter and strengthen the law.'

Specifically in relation to age discrimination the Bill will contain powers to outlaw unjustifiable age discrimination by those providing goods, facilities and services in the future. To allow businesses and public authorities to prepare, and to make sure the law does not prevent justified differences in treatment for different age groups.

More information is available at:

http://www.equalityhumanrights.com/your-rights/age/

Gaps or unmet needs

Although the way people are treated is an important part of tackling ageism, the major issue relates to how we change the image of ageing in Halton. Generally the health messages and lifestyle messages locally do not portray a positive image of aging and how we can value older people and the role they play in the local community.

Pre-retirement courses are available but they generally focus on what is on offer for an individual and not what they can still offer.

Future Plans

Culture change is required in relation to developing a positive image of ageing, this will be through the work of the dignity network and services such as sure start to later life.

Review the content and accessibility of the pre retirement courses with a focus on opportunities in later life.

We need to support people to continue to work for as long as they want to (although this will depend on National Legislation), all people will have access to the same information upon retirement and those who retire are supported to utilize their skills in different ways, volunteering, training, mentoring etc.

Equal access to mainstream services

Current position

The majority of services offer open and equal access to all service users, however there is enough anecdotal evidence to suggest that this is not always the case in practice. For the purposes of this strategy we would need to look beyond traditional Health and Social Care services and look at areas such as Sport, Arts, social clubs, libraries, housing, transport etc. It is clear that people with communication difficulties, mental health or long-term conditions and other disabilities that have an impact on them, do have difficulties accessing mainstream activities.

Gaps or unmet needs

This is not because of any discrimination or criteria constraints imposed by providers, but is generally training related and more needs to be done to look at how people and providers are equally supported to ensure they can participate fully in community or social activities that enhance their quality of life.

Future plans

The continued development of personalization, with increased uptake of individual budgets will help to support vulnerable adults to make the choices that are right for them. For example a recent local case study clearly demonstrated the positive health impact that yoga had on a service user with dementia. The service user demonstrated improved confidence, behaviour and communication and the carer attributed this to the weekly yoga session. It is clear that individual budgets will support further development of this type of approach.

Making a positive contribution, including volunteering

Current Position

Previous Adult Social Care Annual Performance Assessments ad highlighted that the Directorate needed a more coordinated approach to volunteering. It was therefore agreed that a volunteer strategy be produced, initially within the Health & Community Directorate, and then subsequently the strategy would be broadened out to apply across the Council.

As part of the development of the Strategy a 'Building Common Ground' workshop was held that involved staff from both the statutory and voluntary sector. The workshop spent some time looking at the vision for volunteering that they felt Halton should adopt and the way in which we could create an effective volunteer service, what was currently working well and ways in which current activities could be improved. The work undertaken by this Group formed the basis of the Strategy.

Gaps or unmet needs

During the development of the Strategy it became evident that informal volunteering is extensive despite the lack of a proper framework, for example within Bridgewater and Day Services, however in order to increase, promote and fill the range of volunteering opportunities available it was accepted that a clear framework and associated processes were needed.

Due to the Care Quality Commission's specific requirements for the Health & Community Directorate to increase volunteering activities within Adult Social Care, the Directorate commissioned Halton Voluntary Action (HVA) to undertake a 6 month project which would: -

- Establish an accurate baseline of current and potential volunteering across the Council, via a Staff Survey.
- Offer training in Volunteer Management to Managers in the Health & Community Directorate.
- Develop a volunteer recruitment and management system within the Health & Community Directorate.

Work has focused within the Directorate within two specific service areas i.e. Community Bridge Building and Sure Start to Later Life and the project would aim to demonstrate that the interventions undertaken in terms of training and the development of systems would lead to an increase in the number and quality of volunteering opportunities within those two areas.

Future plans

At the end of the six month project HVA, in conjunction with the Project Board set up to oversee the Strategy's development and implementation, will draw together the key findings and recommendations from the project and these will be presented back to Chief Officers for consideration, with a view to agree a plan for how the Strategy could be further implemented across the Council.

NEIGHBOURHOOD AND COMMUNITY

Community safety initiatives, including distraction burglary

Current Position

There is a range of work that is currently being developed to support improvements in crime and perceptions of crime for vulnerable adults in the borough, e.g. the Alleygates project, mischief night initiatives and ward based community safety projects.

Gaps or unmet needs

The links between Health and Social Care and community safety are limited and although there is data available through the corporate place survey, there are positive opportunities for improved partnership working to develop specific initiatives across the whole sector.

Future plans

To develop a partnership approach to community safety across the system.

Locality based community development

Current Position

Halton Borough Council already has a well established and vibrant Community Development department. A team of five full time equivalent Community Development officers are aligned to one of the seven area forum regions. The team sits alongside Sports, Leisure, Arts, Parks, Libraries and Community Safety. The embedded ethos in Culture and Leisure for joint working means there are established and intrinsic mechanisms to broad service delivery. This provides cost effective opportunities to utilize a broad range of themed and focused activity as a catalyst in building participative, engaged communities whilst maximizing our impact.

Gaps or unmet needs

There is a need to improve the links between community development and commissioning. Although this has developed in the last two years, more can still be done. Particularly in relation to examining the possibility of geographical commissioning and supporting the overall data collection that commissioning requires.

Future Plans

To develop an extended outcome based approach to the local Intergenerational work in Halton. This will include developing more Information Technology work between older and younger people, an ideas sharing workshop to support locally commissioned services and a intergenerational arts group.

Another key development will be agreeing the links and role of Community Development within the Partnerships in Prevention (PIP) work that is currently being led through Halton Borough Council, but already has involvement from NHS Halton & St Helens, 5 Boroughs Partnership and the voluntary sector.

Intergenerational Work

Current position

Community development have led an initial 12 month pilot that began in April 2009 to develop a range of projects relating to intergenerational work in Halton. This consisted of an initial conference that was attended by over 200 older and younger people taking part in a range of activities including family tree, facebook, Nintendo wii, bridge, table tennis and more. The idea behind the event was to get people's views on what they would like to see within our intergenerational work and also to break down some of the barriers that currently exist behind younger and older people.

In addition six intergenerational Halloween events took place across the borough and Castlefields are currently developing an intergenerational memorabilia group.

Gaps or unmet needs

As this is quite a new piece of work we are still in the process of establishing what people want. From the conference last year there was a real interest in IT, new technology and genealogy.

Future plans

Last year Halton applied for a Government pilot to develop a range of intergenerational projects in the borough. Although the application was unsuccessful it has given us the opportunity to use the proposal to inform our direction of commissioning. This will include more IT based work, a summer conference and use of the Mersey to create a history based intergenerational project. This work will stimulate education, volunteering and will tackle stereotypes and discrimination. Older People's services, Community Development and Children and Young People directorate are currently developing joint working processes to deliver on this agenda.

INFORMATION / ACCESS

No door the wrong door / Single Point of Access

Current Position

Halton has a range of services offering information to older people. Age Concern, Sure Start to Later Life, Reach for the Stars and Community Bridge builders all support low-level information provision in the borough. However, there are many other services that offer some level of signposting although they are not necessarily contracted to do so.

The following shows the number of contacts for each service:

Age Concern	2007/08:	5084 (people receiving signposting)
		1429 (people receiving full casework)
	2008/09:	2327 (people receiving signposting)

		1289 (people receiving full casework)
Sure Start to Later Life	2007/08:	108 (all full assessments)
	2008/09:	327 (all full assessments)
Reach for the Stars	2007/08:	315 (number of people supported)
	2008/09:	361 (number of people supported)

Sure Start to Later Life is the council's information service for over 55s. While it provides information on a range of activities and services for older people it also provides home visits from Information Officers who support people to engage in community activities and look again at some of their interests and dreams. The philosophy of the service is that the earlier people engage in physical, mental and social activities the less likely and later that they will need acute services. This has financial benefits for acute services but, just as importantly, it improves people's quality of life.

Gaps or unmet needs

There is more than enough information available and service provision / capacity is high. The issue is the co-ordination of the services. There are too many services that are offering similar, but not consistent, levels of information, signposting, assessment and referral. This can lead to discrepancies or delays in people reaching the services they really need.

Service users generally like to build up a trust with a member of staff or an organisation and there is anecdotal evidence to demonstrate that people prefer to stay with one organisation irrespective of their overall role. For example somebody might access the Stroke Association for specialist support, but six months later that individual might need different generic support, often that person will still go to the Stroke Association even though it might not be appropriate. It will be important to develop services that offer services the right level of support to ensure that in turn they can support their service users.

Future plans

The first step to improve the co-ordination of information and the navigation through the system will be to develop a closer partnership arrangement between the two main providers Age Concern and Sure Start to Later Life. This will ensure more full assessments will be undertaken, more consistency on paperwork, information provision and training.

The service is only available to people aged 55+, we will amend the criteria to ensure the service is available to all adults.

LIFESTYLE

Well being and Active Ageing Initiatives – this covers all elements of the lifestyle heading

Current Position

- APEX – Accident Prevention Exercise – 15 week programme of education and exercise to improve muscle and bone strength, balance, co-ordination and confidence. For individuals who have had a recent fall, fear of falling or osteoporosis.
- APEX Follow-on – Ongoing weekly classes of strength and balance exercises to maintain gains achieved during 15-weeks at APEX
- Recharge – Ongoing programmes for over 50s, carers and those recovering from health conditions. Activities at each session include physical activity, healthy eating, arts and complementary therapy.
- Diamond Lives is a BIG Lottery funded project and is part of the Target Wellbeing Grant. The project is a joint venture between NHS Halton & St Helens Health Improvement Team and Age Concern Mid Mersey.
- Diamond Lives works with socially isolated and vulnerable older people to develop and implement personal lifestyle plans, focussing on improving physical activity levels, and improving weight management and nutritional knowledge.
- Age Concern's Participation Organiser works with sheltered accommodation providers, registered social landlords, and existing Age Concern networks. All individuals sourced as suitable for intervention through the service are then referred on to the Lifestyle Advisor, who will work with the participant to identify their key health issues, and develop an individual lifestyle plan.

Reach for the Stars supports the following aims and objectives.

- Decrease social isolation particularly amongst those most isolated through bereavement, low confidence & anxiety, illiteracy, mild mental illness, mobility/fear of falling concerns including those people who are new to the area
- With the support of a Health Trainer, Older People through motivational behaviour change methods are given the opportunity to receive a higher level of intervention to achieve their health goals. (Personal Health Plans and ongoing support).
- Support people into activities of their choice with or without Volunteer Buddies.

- Recruit & train Volunteer Peer Health Champions (STARS) to work on placement across the borough delivering healthy lifestyle sessions supporting people to access services across the borough to improve their quality of life and general wellbeing

Community Bridge Builders

The Community Bridge Building Team support people with disabilities, older people and carers who are socially isolated. They also work with children with disabilities in transition to adulthood. They work in a person centred way to promote social inclusion, this enables people to participate and feel valued within their local community carrying out meaningful activities that promote self-esteem and well being and therefore prevents social isolation.

Halton Borough Council Culture and Leisure Department

The department organises many prevention type activities for vulnerable adults and older people across the borough. These include New Age Bowling, Boccia, Chair based exercise, gentle exercise, Tai Chi, Table Tennis and Health Walks. Free swimming sessions for people over 60 have been introduced across the borough as have free swimming lessons. An “Older Adult Olympics” is planned for the future.

Halton Borough Council Community Development Department

Community development workers are aligned to one of the seven area forum regions and work in that locality with the community. This helps to establish current activity, issues and develop new initiatives e.g. Castlefields memorabilia group.

A range of projects relating to intergenerational work in Halton has been developed by the department. This consisted of an initial conference that was attended by over 200 older and younger people taking part in a range of activities including family tree, facebook, Nintendo Wii, bridge, table tennis and more. The idea behind the event was to get people’s views on what they would like to see within our intergenerational work and also to break down some of the barriers that currently exist between younger and older people.

In addition six intergenerational Halloween events took place across the borough and Castlefields are further developing an intergenerational memorabilia group.

As you can see there are a number of services that support an active ageing and well being agenda. In addition Age Concern have developed five social participation groups and a men’s health project to help with a range of issues relating to

remaining active. Although the numbers of people accessing the services above are high, more data needs to be collected on the impact the service has had on an individual. This also has to be measured over a longer period as most of the interventions will relate to behaviour or lifestyle changes.

Gaps or unmet needs

Again the major opportunity relates to the overall coordination of active ageing and well being services in the borough. The main source of information available is the public health annual report 2008/09 from the NHS Halton & St Helens website.

Future plans

It is the aim to continue to develop the Partnerships in Prevention work that Health promotion, reach for the stars and health trainers are all part of the group and they will be supporting the information partnership between Age Concern and Sure Start as well as helping to develop robust and pathways for all service users.

Future plans for intergenerational work include closer partnership working between Health and Social Care, Community Development and Children and Young People departments around an intergenerational strategy.

PRACTICAL SUPPORT

Befriending and counselling

Current Position

Age Concern Mid Mersey offer a befriending and telefriending service (not funded through Local Authority or health).

In relation to counselling, Halton Voluntary Action have run a successful Voluntary Sector Counselling Partnership for a number of years. This partnership is an umbrella for any voluntary sector organisation offering counseling in Halton.

The partnership ensures that each organisation who applies reaches the relevant standard and information is collected on their performance and the level of counseling that they can reach. This service is also available for commissioners to help them collect evidence to establish what services are available and where the gaps are in the local borough.

Gaps or unmet needs

There is limited provision of befriending in the local area, however there needs to be some work carried out to establish if befriending is the correct solution for all people.

Some volunteers have expressed that they feel trapped once they have been introduced and it can sometimes be detrimental if the service creates some level of dependency. It would be more beneficial to start looking at how people can be supported to access other services and activities within the borough and not be reliant on an individual member of staff or volunteer.

Although the counseling partnership has been extremely successful there are specific issues relating to the performance monitoring of the overall project. For example if an organisation joins the partnership they are expected to reach a particular level, however they are not rechecked and there is a risk of services not maintaining an acceptable standard.

Future plans

Review existing befriending provision in the borough, analyse need and identify best practice in other areas to establish the direction of future commissioning of these services.

Shopping, Gardening etc.

Current Position

Four major services are provided by Age Concern and British Red Cross to deliver a range of low-level practical support for older people in Halton. **Home Safety service** offers in depth checks into an individual's environment and suggests solutions to improve the home in relation to falls, fire and crime. The **Traders Register** is a list of local traders who have been recommended who have received some training and support on understanding the needs of older people. The Helping Hand service is a volunteer led service that offers low-level handyperson jobs to older people in the borough. British Red Cross offer a low-level **shopping service** to people who have no other means of getting their own food.

The table below shows the number of people who have accessed each service over each of the last three years.

	2006/07	**2007/08**	**2008/09**
Home Safety	358	690	816
Traders Register	1115	1366	1464
Helping Hand	N/A	N/A	67
Shopping Service	166	222	261

Gaps or unmet needs

The main gap is in relation to gardening, however previous services have been difficult to operate and have never been able to manage the demand for a pure gardening service. There also remains an issue in relation to how the services above are funded and what is there exit strategy. The issue in relation to practical tasks is not gaps or unmet needs, but the future sustainability of the individual elements of the service.

Future Plans

Halton Borough Council is currently developing a local handyperson service, that will offer a service that will enhance the existing service provision as described above.

ENABLEMENT

Intermediate Care Services

Current Position

Intermediate Care services have played a significant part in achieving improvements in overall outcomes for people in Halton over the past six years. This has been reflected in a steady reduction in emergency admissions and acute hospital bed utilization, the reduction being greater in the over 65 population. The number of people living in care homes has more than halved. Over the same period of time the number of people over 65 supported at home tripled, so Halton is now one of the highest performers in England. This approach has also reduced the size of on-going care packages so that people are able to live independently with lower levels of support.

There are a range of community and bed based services available within Halton to support peoples needs for reablement, rehabilitation, telecare and falls.

Gaps or unmet needs

The capacity available is often insufficient to meet demand.

The falls service is not currently fully integrated with other reablement services within the section 75-partnership agreement.

Implementation of the revised criteria

Future plans

To review capacity available within the services, and develop a business plan for further investment as required.

Complete a review of the current falls service, with the aim of further integration.

To bench mark all services against the revised guidance for Intermediate Care and implement any changes required.

Self Care Programmes

Current position

There is some provision of self care programmes in Halton. The Expert Patient is an approach that aims to enable people to cope better with long term conditions through improved self-management. It is designed to help:

- Improve ability to cope with pain,
- Manage medication,
- Reduce levels of depression, fatigue and anxiety,
- Improve communication with Health workers,
- Enhance relaxation, exercise and diet.

The programme offers two trainers who are themselves living with a long-term condition, they run the courses. The courses are participatory and follow a workshop style. Topics are introduced by the tutors and people attending the course are involved in the discussions, share their ideas about the different topics, problem solve and try to find solutions.

The topics included in the course include:

- Relaxation techniques
- Healthy Eating
- Exercise and Fitness
- Symptom Management Techniques
- Communication Skills
- Problem Solving
- Goal Setting
- Action Planning

Gaps or unmet needs

There are a number of gaps that need to be addressed in relation to Self care, there is limited support for people with Mental Health diagnosis, stroke survivors, people diagnosed with dementia. There also needs to be an improved link between self care

and peer support services to ensure that there is ongoing support for service users and their carers.

Future plans

Need to develop improved working policies and protocols to support an enhanced level of self care programmes in the borough. This would include completing a full mapping exercise on current provision.

COMMUNITY SUPPORT FOR LTC

Integrated or co-located teams and / or networks

Current Position

Over the past three years Halton has developed a vibrant Telecare service to support the needs of vulnerable people in their own home. Telecare is a set of electronic sensors installed in a person's home. These include: temperature sensors, falls detectors, smoke alarms, motion detectors, a personal alarm pendent and a 24 hour 7 days a week emergency response service. When coupled with an appropriate support plan Telecare helps individuals to live more independently and safely at home. Once installed, it can reduce risk by providing reassurance that help will be summoned quickly if a problem occurs. Telecare in Halton comprises three components: an emergency response, environmental monitoring and lifestyle monitoring.

The Stroke Association offers the following aims and objectives of there services:

- Provision of a Dysphasia support group to be operated on a weekly basis in Runcorn and Widnes.
- To undertake assessment of communication support needs of service users attending the groups.
- Develop appropriate goal orientated support plans
- Define desired outcomes of support plan with target date/s
- To signpost and support access to appropriate support services including, Housing, Welfare benefits, socialisation opportunities with support, Health related support, home insurance support, budget management support, support to manage debt, support to access legal services, Advocacy etc.
- Referral on to other agencies and services
- Participation in Multi agency planning processes around the need of stroke services e.g. the stroke core strategy group.

In addition Rapid Access and Rehabilitation Service carries out Case Management for crisis intervention, community support and hospital discharge.

Social Care in practice is based on a number of organisational links, integrated working, understanding of roles, and the avoidance of duplication. Underpinned by a collaborative, integrated working between a Social Care Manager and Primary Care Team (usually District Nurse). The approach adopts the following principles:-
• Close links between the Practice and Acute hospitals
• Timely information about admissions, A&E attendance and other inpatient services
• The adoption of an 'in reach' approach with early discharge as an underpinning philosophy
• Case finding - the identification of vulnerable patients
• The use of shared eligibility criteria
• Case Management of people with chronic disease
• Active review of pharmacy needs
• Attention to impairment of the daily living routines

Community Matrons offer a proactive case management / case finding role to support clear access to services and improved referral processes.

Gaps or unmet needs

There needs to be further work on how we progress community support for people with long term conditions, the evidence is available to support the development of integrated working, including Telecare and Telehealth, district nurses/community matrons and social care.

Future plans

The existing Telecare service has been evaluated, this will feed into the overarching Telecare strategy that will be developed and implemented alongside the evaluation.

Progressing towards using virtual sensor technology and lifestyle monitoring technology to enable us to identify changes in individual circumstances, and therefore deliver early intervention to changing needs and potential crisis to maintain independence. Consideration is being given to joint work between the Borough and PCT/Practice based commissioner in the use of Telehealth applications to monitor and manage long-term conditions. Telehealth provision is currently being piloted by the PCT.

A case Management tool is being developed Nationally to support professionals across Health and Social Care. This use of this tool would be considered at a local level.

Case Finding and Case Management of Those at Risk

Current position

Crossroads for Carers provides respite care for carers where suitably trained Care Support Workers will take over the role of the regular carer for an appropriate period of time, as determined by the agreed eligibility criteria to allow the carer to take a break from caring and to use the free time to take up whichever pursuit they wish. The service is aimed at reducing the levels of stress, which exist within the family home of their dependent and to avoid crisis admission into hospital or residential care or breakdown of the carer situation. The service is available to residents of Halton only and service provision will be agreed as part of the care plan supplied through Halton Borough Council's Care Management.

The Alzheimer's Society established a local branch in 2005 and currently employs one Family Support Worker who provides practical and emotional support, advice and information, support groups and social activities for carers in that area. They liaise with Health & Social Care on behalf of carers, attend relevant local meetings and are currently involved in devising training packages for care staff.

The business case to develop a virtual ward has been completed and agreed. The service is supported by the Widnes Practice Based Commissioners who are seeking to provide a mobile integrated Health and Wellness service, seeking out illness, and delivering prevention in the heart of the community. The mobile service will focus on hard to reach groups and those who do not regularly attend the registered practice using practice information.

Gaps

There needs to be more support offered to carers and although there is a separate commissioning strategy for carers there are specific gaps in relation to telecare and assistive technology.

Future plans

Develop telecare service to support the needs of carers.

INSTITUTIONAL AVOIDANCE

End of Life Care – enabling people to die at home

Current Position

A multi-professional group of specialists in Palliative Care, Older People's Mental Health services, the Alzheimer's Society, General Practice, Dietetics, Speech Therapy and Care of the Elderly met to formulate symptom control guidelines for health care professionals caring for patients with end stage dementia. These focus on symptoms, which are common or troublesome in this patient group. The Care Pathway, symptom control guidelines developed will be followed up by a series of educational events for health care professionals. The Care Pathway aims to help provide continuity of care for this patient group, whose care needs are often provided by a range of carers.

Homecare End of Life service is funded through NHS Halton & St Helens to offer up to 13 weeks of support to people in their own homes. Referrals are received from District nurses.

The palliative care and end of life strategy has recently been completed and agreed.

Gaps or unmet needs

Clarity around direction of service provision and multi-agency working. Also need to ensure future funding is in place for Homecare End of Life service.

Future plans

Full implementation of the Palliative Care and End of Life Strategy in partnership between Health and Social Care.

Management of Unscheduled Care

Current Position

A number of work areas contribute to the management of unscheduled care, Intermediate Care as mentioned earlier in the mapping alongside the walk-in centres, community extra care housing and the Single Point of Acccess all play a role in this.

Gaps

Although the Single Point of Access is available it still requires further work to ensure that it is a fully integrated service. If this was the case the quality and efficiency of the service and the navigation through the system would improve significantly.

Future plans

To ensure a fully integrated Single Point of Access is in place.

TIMELY DISCHARGE

Hospital In-reach and Step Down Pathways

Current Position

We currently operate an integrated pathway linked to the Effective Care Coordination policy delivered through the 5 Boroughs Partnership. This is an admission and discharge procedure with an overall objective of ensuring that we have in place an entire pathway from admission to discharge and that this is supported in a timely manner.

In addition to the above there is a Multi-disciplinary Team that offers care reviews to discuss care as well as plan appropriate discharge. This is further supported by weekly monitoring of any delayed discharges. All service users are followed up within seven days to ensure that service users have resumed normal functioning after discharge.

The Intermediate Care Assessment Team proactively identifies people in need of assessment no matter where they are placed. The service is able to work across Accident and Emergency and Hospital wards to ensure complete access to assessment for all patients.

Currently the Adult Hospital team manage the discharge pathway in relation to social care, with a separate team for the hospital and District Nurses.

Gaps

Although the existing systems work well together there is still a significant opportunity to develop an integrated discharge team.

Future plans

To develop and implement an integrated hospital discharge team.

Post Discharge Support, Settling In and Proactive Phone Contact

Current Position

The British Red Cross offer low-level support for six to eight weeks to persons discharged from Hospital and those with non critical illnesses within the community to support and maintain their independence in their own homes. Practical tasks are undertaken and help to support the emotional wellbeing of the service user. The service works on enabling and prevention to build up resilience for service user, family carer etc. Service Users are supported to appointments and social activities

as appropriate during the period the service is in place. In addition work is carried out to support confidence building and improving mobility. They link in with other agencies and partner services within the Red Cross e.g. medical loan, equipment services and therapeutic care as appropriate.

Gaps or unmet needs

There are capacity issues within the existing service that need to be addressed and there needs to be additional support to the provider in relation to the referral process and navigation of services. This will be taken forward by the Partnerships in Prevention project.

Halton currently as no designated telephone contact to review people's assessment of their own care or to determine if their needs have been adequately addressed.

Future plans

Merge the existing service with the Red Cross shopping service to increase existing capacity within the service.

Assess existing review mechanisms across the system to support people on discharge.

Appendix 2

No	Action	Tasks	Lead	Timescale
1	Agree overall coordination of the prevention agenda for older people	• Agree roles & responsibilities • Agree Capacity • Agree Lead Organisation	Prevention Steering Group	April – June 2010
2	Develop infrastructure within existing services to ensure partnership and pathway development	• Agree Current Capacity • Agree Data Sharing • Develop & Implement Pathway	Partnership in Prevention	July – Oct 2010
3	Develop Performance Management Framework	• Agree parameters of work • Agree governance arrangements • Agree reporting mechanism	Older People's Commissioning Manager OP LIT	July – Oct 2010
4	Develop Marketing Strategy (For Low Level Services)	• Agree implementation of segmentation information • Agree Outcomes • Develop joint activity plan within borough.	Partnership in Prevention	July – Dec 2010
5	Complete service delivery diagram	• Agree scope of diagram • Link to finance • Complete data collection	Older People's Commissioning Manager	April – June 2010

6	Develop Financial plan	• Map current spend against each heading within the prevention and early intervention strategy	Older People's Commissioning Manager / Finance department	April – June 2010
7	Develop falls pathway	• Agree process to integrate falls service into Intermediate Care • Develop pathway • Agree data sharing protocols • Complete shared paperwork to facilitate integration	Divisional Manager Intermediate Care	April – June 2010
8	Pre – Retirement Courses	• Ensure courses are available to a wider range of people in the borough • Review the content of the courses to ensure people have opportunities available.	Partnership in Prevention	March 2011
9	Implement Dignity Action plan	• By fully implementing the dignity action plan this will support a culture change within services to tackle discrimination	Dignity Co-ordinator	March 2011
10	Volunteering pilot	• Evaluate the findings from the six month pilot projects in Sure Start to Later Life and Community Bridge Builders • Report recommendations for future	Halton Voluntary Action	October 2010

		work		
11	Community Safety	• Develop Partnership approach to community safety across the whole system.	Community Development / Community Safety Team	Ongoing
12	Intergenerational Work	• Complete commissioning plan for intergenerational work. • Ensure intergenerational work is embedded in the Partnerships in Prevention project.	Commissioning Manager's and Partnership in Prevention	May 2010 for the plan, implementation of initial phase by March 2011
13	Information provision	• Agree joint working protocols for Sure Start to Later Life and Age Concern Mid Mersey • Explore opportunities with other information providers in relation to joint working	Older People's Commissioning Manager	October 2010
14	Review existing befriending services in the borough	• Work across commissioning to establish the need and provision of befriending services across all service areas • Report findings and recommendations to relevant Boards	Commissioning Managers	December 2010

15	Intermediate Care Services	• Review capacity available within the services, and develop a business plan for further investment as required • Complete a review of the current falls service, with the aim of further integration • Benchmark all services against the revised guidance for Intermediate Care	Divisional Manager Intermediate Care	March 2011
16	Telecare services	• Complete and implement telecare strategy • Develop enhanced telecare services for carers	Divisional Manager Intermediate Care	March 2013
17	End of Life Care	• Full implementation of the Palliative Care and End of Life Strategy	NHS Halton And St Helens	March 2013
18	Unscheduled Care	• Review existing processes in relation to the Single Point of Access • Ensure processes and pathways in place to deliver a fully integrated Single Point of Access	NHS Halton & St Helens	2011/2012
19	Timely Discharge	• Develop a fully integrated Hospital Discharge Team	Multi-agency partnership to be established	2011/2012

20	Post Discharge Support	• Merge existing Red Cross Services • Assess existing review mechanisms to support people on discharge	Commissioning Managers	Point 1 by April 2010, point 2 by March 2011