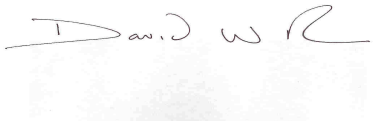
Public Document Pack

Executive Board

Thursday, 3 December 2009 2.00 p.m.
Marketing Suite, Municipal Building



Chief Executive

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

PART 1

Item	Page No
1. MINUTES	
2. DECLARATION OF INTEREST Members are reminded of their responsibility to declare any personal or personal and prejudicial interest which they have in any item of business on the agenda no later than when that item is reached and, with personal and prejudicial interests (subject to certain exceptions in the Code of Conduct for Members), to leave the meeting prior to discussion and voting on the item.	
3. CORPORATE SERVICES PORTFOLIO	
(A) ANNUAL AUDIT LETTER	**1 - 16**

Please contact Angela Scott on 0151 471 7529 or
Angela.scott@halton.gov.uk for further information.

The next meeting of the Committee is on Thursday, 17 December 2009

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PART II		

Item	Page No
ITEMS CONTAINING "EXEMPT" INFORMATION FALLING WITHIN SCHEDULE 12A OF THE LOCAL GOVERNMENT ACT 1972 AND THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985 In this case the Board has a discretion to exclude the press and public but, in view of the nature of the business to be transacted, it is RECOMMENDED that under Section 100(A)(4) of the Local Government Act 1972, having been satisfied that in all the circumstances of the case the public interest in maintaining the exemption outweighs the public interest in disclosing the information, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A to the Act.	
(C) RE-COMMISSIONING OF THE YOUNG CARERS AND CARE LEAVERS SERVICE	**276 - 302**

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

Agenda Item 3a

REPORT TO: Executive Board

DATE: 3 December 2009

REPORTING OFFICER: Strategic Director – Corporate & Policy

SUBJECT: Annual Audit Letter

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To present the Annual Audit Letter 2008/09 for approval.

2.0 RECOMMENDATION: That the Annual Audit Letter be approved.

3.0 SUPPORTING INFORMATION

3.1 The Annual Audit Letter summarises the findings from the 2008/9 audit completed by the Council's external auditors. It includes messages arising from the audit of the financial statements and the results of the work undertaken in assessing the Council's arrangements to secure value for money in the use of its resources.

3.2 A copy of the 2008/9 Annual Audit Letter is attached to this report. The report is in a different format to previous years in that it focuses on audit rather than inspection issues. Inspection has been replaced by the Comprehensive Area Assessment (CAA) and the output on this will be published on 10 December 2009. CAA will be published via the Oneplace website and it will include both the organisational and the area assessment.

4.0 POLICY, FINANCIAL AND OTHER IMPLICATIONS

4.1 The Council is a publicly funded body and as such is required to receive and consider annual reports from externally appointed auditors. The external audit function makes an important contribution to the stewardship of resources and the corporate governance of public services.

4.2 The Annual Audit Letter provides an unqualified opinion on the Council's 2008/09 financial statements. It also provides an unqualified conclusion that the Council has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

4.3 The cost of the external audit for 2008/09 is set out on page four of the Annual Audit Letter.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 The economic, efficient and effective use of the Council's resources is a major factor in delivering better and sustainable outcomes for local people and therefore contributes to all of the Council's priorities.

6.0 RISK ANALYSIS

6.1 The Annual Audit Letter states that no significant weaknesses were identified in the Council's internal control arrangements. However, the key risks identified through the audit process are reflected in the recommendations for improvement made in the report.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None identified.

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

8.1 None.

Annual Audit Letter

Halton Borough Council

Audit 2008/09

November 2009

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Status of our reports

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors/ members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
- any third party.

Key messages

This report summarises the findings from our 2008/09 audit. It includes messages arising from the audit of your financial statements and the results of the work I have undertaken to assess your arrangements to secure value for money in your use of resources.

Audit Opinion

1 I issued an unqualified audit opinion on the Council's 2008/09 financial statements on 30 September 2009. My draft audit report was included as Appendix 2 of my Annual Governance Report, as reported to the Business Efficiency Board on 30 September 2009.

Financial Statements

2 The audit of the Council's 2008/09 financial statements was less straightforward than in previous years. In our 2007/08 Annual Governance Report we raised the issue of the accounting treatment of the development costs on the Mersey Gateway scheme. In essence our view is that the majority of the costs incurred to date should have been treated as revenue costs rather than capitalised. The Council sought a capitalisation direction from the Department for Communities and Local Government (DCLG) regarding the costs incurred to date. The late receipt of this direction meant that the Council's draft abstract of accounts whilst available for audit on 30 June 2009 could not be approved by the Business Efficiency Board until 12 August 2009.

3 The DCLG decision was received in late July and allowed the Council to capitalise up to £3.7m of 2008/09 expenditure. In addition the Department for Transport (DfT) amended the terms of £3m of capital grant to enable this to be used for revenue purposes during 2008/09. The outcome of the decisions from DCLG and DfT did not allow the Council to capitalise any of the expenditure incurred in previous years. As a result a material amount of expenditure from earlier years remained, in my view, incorrectly accounted for as capital expenditure. The majority of this expenditure had been incurred in 2006/07 and 2007/08.

4 Following significant input from finance officers and agreement of the amendments with my audit team the draft abstract was revised to reflect a prior period adjustment of £8.43m. This related to the development costs on the Mersey Gateway scheme incurred during 2006/07 and 2007/08. Costs capitalised before 2006/07 remain in the balance sheet but are in total below our materiality gauge and go back to 2001 and for some elements of these there could be a justifiable case to argue that they could be accounted for as capital expenditure. The amount of this expenditure is £4.675m. I have agreed with the Operational Director – Financial Services not to amend the accounting treatment of this earlier expenditure.

5 My audit also identified a further material adjustment on fixed assets of £11.4m. Several voluntary aided and voluntary controlled schools, not owned by the Council, had been incorrectly included on the Council's balance sheet since the transfer of these assets from Cheshire County Council in 1998. The schools had been shown as assets in the accounts of the former County Council on transfer and therefore included in the Council's asset register. The 2008/09 abstract was amended to remove the schools from the Council's balance sheet.

Use of resources

6 Use of Resources is a scored judgement which determines how well councils manage and use their financial resources. I concluded that the theme and KLOE (key lines of enquiry) scores reflect a council that is performing consistently above the minimum standards specified by the Audit Commission, level 3 performance.

Mersey Gateway

7 The Council has continued to make good progress in managing the Mersey Gateway project. It has received reconfirmation of 'Programme Entry' status from the DfT, secured additional grant funding towards preparation costs and is awaiting the results of the Public Inquiry carried out earlier this year. Its preparations for the next key stage of the DfT approval process are well underway.

Value for Money Conclusion

8 I issued an unqualified conclusion stating that the Council had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

Comprehensive Area Assessment and Organisational Assessment

9 The Audit Commission introduced a new assessment regime during 2009, Comprehensive Area Assessment (CAA). This aims to review the performance of local partners in delivering better outcomes for local people. The assessment is designed to focus attention on areas that need attention in order to deliver additional and sustained improvement. Our work in this area is being led by the local Comprehensive Area Assessment Lead (CAAL). The CAAL has shared draft findings with officers and he is due to formally report on 10th December 2009. Alongside the CAA report we will issue our organisational assessment which combines our judgements on your use of resources and managing performance. Any issues arising will be discussed with you and planned into future years audit and assessment activity.

Key messages

Audit Fees

10 My fee proposals were communicated to the Business Efficiency Board in my Audit Plan for 2008/09. In my updated Opinion Plan, presented in June 2009, I reported that I was satisfied that the audit fee was appropriate and no adjustment was required. I expect to contain the 2008/09 audit fee within the £222,554 total agreed with you.

Actions

11 Recommendations are shown within the body of this report and have been agreed with the Business Efficiency Board.

Independence

12 I can confirm that the audit has been carried out in accordance with the Audit Commission's policies on integrity, objectivity and independence.

Financial statements and annual governance statement

The financial statements and annual governance statement are an important means by which the Council accounts for its stewardship of public funds.

Significant issues arising from the audit

13 The accounting treatment adopted by the Council for the development costs on the Mersey Gateway scheme was the most significant issue during the 2008/09 audit. I had ongoing discussions during the year with the Operational Director – Financial Services on the accounting treatment. The DCLG and DfT decisions in July 2009, and the financial statements approved by members on 12 August, dealt with the 2008/09 in year costs of £6.7m. It did not however resolve the costs which had been incurred in previous years, in particular the costs incurred in 2007/08 and 2006/07 which totalled £8.430m. My view was that these costs should be accounted for as revenue expenditure rather than capital expenditure. I agreed with the Operational Director – Financial Services that the financial statements would be amended to reflect the correct accounting treatment.

14 The amendment of previous years' expenditure on Mersey Gateway required a prior period adjustment (PPA). This PPA corrected the £8.430m of expenditure previously charged to capital in 2006/07 and 2007/08 and included in the Fixed Assets balance as infrastructure costs, which should have been charged to the Income and Expenditure Account as revenue expenditure. To enable this adjustment to be made officers have utilised £4.930m from the capital reserve and £3.5m from NWDA grant funding. Various other accounting entries have been affected by this PPA, the detail of the amended entries is provided at note 38 to the abstract. It is essential that officers continue to review the costs incurred on the scheme to ensure that proper accounting practice is followed in future years.

15 My audit also identified another material error in the Council's 2008/09 financial statements. This related to fixed assets on the balance sheet. Audit testing of the Council's operational assets (land and buildings) highlighted two voluntary controlled schools valued at £4.8m which were not owned by the Council but were included on the Council's balance sheet. Following further testing carried out by Council staff, a further two voluntary controlled schools and two voluntary aided schools were found to have been incorrectly included on the Council's balance sheet. The six schools totalled some £11.4m in value. The 2008/09 accounts have been amended to correct this error, again via a PPA. These schools have been accounted for in this manner since their transfer from Cheshire County Council when Halton Borough Council was established as a unitary council.

Material weaknesses in internal control

16 I did not identify any significant weaknesses in your internal control arrangements.

Accounting Practice and financial reporting

17 I considered the qualitative aspects of your financial reporting.

18 My audit identified several issues including:

- Scope to further enhance compliance with the disclosure requirements of CIPFA's Statement of Recommended Practice (the SORP).
- The need for more accurate categorisation of expenditure between capital and revenue on all capital schemes.
- Using prior period restatements to correct only material adjustments arising from either changes in accounting policies or to correct fundamental errors in the previous years' accounts.

I have included several recommendations for improvement within the Annual Governance Report presented to the Business Efficiency Board on 30 September, these are included below. Officers are currently finalising the agreed action plan.

Recommendation	
R1	Further develop year end closedown arrangements to ensure that the 2009/10 abstract of accounts meets all relevant disclosure requirements.
R2	Ensure staff follow year end procedures relating to the coding of expenditure.
R3	Review and strengthen processes to ensure the correct categorisation of expenditure between revenue and capital.
R4	Restate prior year figures only where there is a material change in accounting policy or to correct a fundamental error.

International Financial Reporting Standards (IFRS)

19 In March 2008 the Treasury announced that the annual financial statements of government departments and other public sector bodies would be prepared using International Financial Reporting Standards (IFRS) from 2009/10 onwards. For local government bodies the first full year of application is the 2010/11 financial statements but the starting period for this (the transition date) is 1 April 2009. Local government bodies will be required to produce their 2009/10 Whole of Government Accounts return on an IFRS basis. The expected deadline for the WGA return is 1 October 2010.

20 As part of my 2008/09 audit I have completed an Audit Commission survey on the Council's progress in preparing for the implementation of the IFRS. Whilst the Council has started its preparation it is at a very early stage and behind where it expected to be at this time. A significant amount of work will be needed during 20009/10 to meet the new IFRS information requirements and the timeframes for restatement. Capacity is a particular risk given the other changes, such as the internal restructure, that are taking place within the Council.

Recommendation	
R5	Review arrangements in place for implementing IFRS to ensure appropriate processes, people and skills are in place to meet the new accounting requirements and the associated deadlines.

Value for money and use of resources

I considered how well the Council is managing and using its resources to deliver value for money and better and sustainable outcomes for local people, and gave a scored use of resources judgement.

I also assessed whether the Council put in place adequate corporate arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the value for money (VFM) conclusion.

Use of resources judgements

21 In forming my scored use of resources judgements, I have used the methodology set out in the use of resources framework. Judgements have been made for each key line of enquiry (KLOE) using the Audit Commission's current four point scale from 1 to 4, with 4 being the highest. Level 1 represents a failure to meet the minimum requirements.

22 I have also taken into account, where appropriate, findings from previous use of resources assessments (updating these for any changes or improvements) and any other relevant audit work.

23 The Council's use of resources theme scores are shown in Table 1 below. The key findings and conclusions for the three themes, and the underlying KLOE, are summarised in Appendix 5.

Table 1 Use of resources theme scores

Use of resources theme	Scored judgement
Managing finances	3
Governing the business	3
Managing resources	2

24 Overall the Council has performed well scoring level 3, exceeds minimum requirements - performs well, in two of the three use of resources themes.

Managing finances

25 The Council continues to manage its finances well to deliver value for money and it continues to deliver services that achieve high satisfaction ratings from local people.

26 The Council has a proven track record of robust financial management and good financial standing. Its previous prudent approach to managing its finances has meant that it has sufficient balances and reserves to deal with the Mersey Gateway amendment discussed earlier in this report. It is now in the process of revisiting its medium term financial strategy (MTFS) and reserves and balances strategy to reflect the impact of the Mersey Gateway accounting treatment.

27 I found established treasury management processes in place at the Council with no exposure to foreign bank investments in 2008/09. Following the Icelandic bank issue, the quarter 3 treasury management report included a review of the approved counter party list. This was not due until January 2010 but because of the rapidly changing circumstances and volatility in credit ratings officers felt it was prudent to rework the list on an interim basis. Internal Audit's review of the Council's treasury management arrangements highlighted a couple of areas to further strengthen including the need to review treasury management arrangements against recently produced CIPFA guidelines. I understand that officers are in the process of doing this.

28 The Council has a good understanding of its costs and comparative performance and it has achieved both cost and service efficiencies in 2008/09. It is currently going through a major efficiency programme which should help deliver significant efficiency savings to the local community by 2011/12. It is essential that the Council is able to demonstrate achievement of the first stage of the efficiency programme in 2009/10.

29 At the time of my review in early 2009 the Council did not have a systematic approach to reviewing services to ensure they deliver value for money. It is developing this as part of the wider efficiency programme.

Governing the business

30 The Council has well established governance arrangements in place which are well understood by both officers and members. There is a strong ethical framework and culture within the organisation and a real commitment to deliver good quality services which meet the needs of the local community. Satisfaction levels with Council services are good. The Council has continued to develop its commissioning and procurement functions and we have seen good evidence of joint procurement initiatives with partners and neighbouring organisations. There is generally good use of data to inform decision making and service delivery with some good examples of improved outcomes being delivered.

31 Data quality arrangements continue to develop but further progress is needed to evidence good data quality arrangements across all service areas. In addition officers should progress the plans in place to further strengthen commissioning and procurement, including the third sector.

Managing resources

32 I concluded that the Council's management of its natural resources is adequate and continues to develop. It has put in place some good energy saving and green initiatives but it now needs to ensure its baseline information on its environmental impact is complete and comprehensive. This needs to be supported by appropriate targets, and more systematic monitoring and reporting arrangements.

33 Over the past year the Council has strengthened its strategic approach to asset management. It has continued to manage and use its assets well at an operational level with some good examples of Council assets being used to benefit the local community and enhance service delivery. Progress is ongoing in updating the asset management information database.

Recommendation	
R6	Revisit the MTFS and reserves and balances strategy to reflect the impact of the Mersey Gateway accounting treatment.
R7	Ensure that a service review framework and programme is agreed in 2009/10.
R8	Progress the plans in place to further strengthen commissioning and procurement arrangements and evidence improved outcomes.
R9	Develop plans to ensure a corporate approach to supporting the third sector in commissioning and procurement.
R10	Develop a complete and comprehensive baseline of the Council's environmental impacts.
R11	Establish a more strategic and systematic approach to managing natural resources, including the setting of targets and monitoring and reporting of performance against these periodically through the year.
R12	Ensure the asset management information database is complete and up to date.

Mersey Gateway

34 I have continued to review the Council's arrangements for managing the Mersey Gateway project to build a new toll bridge over the River Mersey.

35 In March 2006, DfT granted the Mersey Gateway Project 'Programme Entry' status and awarded provisional financial support in the form of £123m PFI Credits and £86m grant for land acquisition and some decontamination works, subject to a number of conditions. Final confirmation of funding support will be given by DfT immediately prior to contract award to the successful bidder, currently planned for 2012.

36 The Council has continued to make good progress during the year, in particular it has:

- obtained reconfirmation of 'Programme Entry' status following a further review of value for money by DfT;
- secured additional grant from DfT of £6.4m towards preparation costs;

- completed preparations for the Public Inquiry of the statutory orders and planning applications required for the scheme, and this was held in May and June 2009;
- made preparations for the next key stage of the DfT approval process, being submission of the Outline Business Case required to secure 'Conditional Funding Approval' from the DfT and the HM Treasury Project Review Group; and
- made plans for the formal procurement process to ensure it can commence as soon as practical after the Secretary of State decision on the planning process, expected early in 2010.

37 I will continue to review the Council's arrangements as it proceeds with this large and complex procurement.

VFM Conclusion

38 I assessed your arrangements to secure economy, efficiency and effectiveness in your use of resources against criteria specified by the Audit Commission. From 2008/09, the Audit Commission will specify each year, which of the use of resources KLOE are the relevant criteria for the VFM conclusion at each type of audited body. My conclusions on each of the areas are set out in Appendix 1.

39 I issued an unqualified conclusion stating that the Council had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

Closing remarks

40 The economic downturn, public sector funding and the banking crisis is having a very significant impact on public finances and the bodies that manage them. It is envisaged that there will be wide ranging and more fundamental impacts on the ability of public sector bodies to fund service delivery and capital programmes in the short to medium term, including pressures on income streams. There are further challenges for policy priorities where patterns of demand for services are also changing. In addition the Council is going through its own wide ranging efficiency review including a fundamental internal restructuring exercise. These changes and the Council's response will be a key focus of my attention for future audits.

41 I have discussed and agreed this letter with the Chief Executive and the Strategic Director Corporate and Policy. I will present this letter at the Executive Board on 3 December 2009 and will provide copies to all board members/committee members.

42 Further detailed findings, conclusions and recommendations in the areas covered by our audit are included in the reports issued to the Council during the year.

43 As in previous years the Council has taken a positive and constructive approach to our audit. I wish to thank the Council's staff for their support and co-operation during the audit.

Michael Thomas

District Auditor

November 2009

The Audit Commission

The Audit Commission is an independent watchdog, driving economy, efficiency and effectiveness in local public services to deliver better outcomes for everyone.

Our work across local government, health, housing, community safety and fire and rescue services means that we have a unique perspective. We promote value for money for taxpayers, auditing the £200 billion spent by 11,000 local public bodies.

As a force for improvement, we work in partnership to assess local public services and make practical recommendations for promoting a better quality of life for local people.

Copies of this report

If you require further copies of this report, or a copy in large print, in Braille, on tape, or in a language other than English, please call 0844 798 7070.

For further information on the work of the Commission please contact:

Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ

Tel: 0844 798 1212 Fax: 0844 798 2945 Textphone (minicom): 0844 798 2946

www.audit-commission.gov.uk

REPORT TO: Executive Board

DATE: 3rd December 2009

REPORTING OFFICER: Operational Director – Financial Services

SUBJECT: Determination of Council Tax Base

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 There is a requirement for the Council to determine the 'Tax Base' for its area and also the tax base for each of the Parishes.

1.2 It is required to notify the figure to the Cheshire Fire Authority, the Cheshire Police Authority and the Environment Agency by 31st January 2010. The Council is also required to calculate and advise if requested, the Parish Councils of their relevant tax bases.

2.0 RECOMMENDED: That

(1) The Executive Board recommend to the Council that the 2010/11 Council Tax Base be set at 38,200 for the Borough, and that the Cheshire Fire Authority, the Cheshire Police Authority, and the Environment Agency be so notified; and

(2) The Executive Board recommend to the Council that the Council Tax Base for each of the Parishes be set as follows:

Parish	Tax Base
Hale	**729**
Halebank	**594**
Daresbury	**142**
Moore	**343**
Preston Brook	**352**
Sandymoor	**938**

3.0 SUPPORTING INFORMATION

3.1 The Tax Base

The 'Tax Base' is the measure used for calculating the council tax and is used by both the billing authority (the Council) and the major precepting authorities (the Cheshire Fire Authority and the Cheshire Police Authority), in the calculation of their council tax requirements.

The tax base figure is arrived at in accordance with a prescribed formula, and represents the estimated full year number of chargeable dwellings in the Borough, expressed in terms of the equivalent of Band 'D' dwellings.

3.2 The Council Tax Base for 2010/11

The tax base is calculated using the number of dwellings included in the Valuation List, as provided by the Listing Officer, as at 14th September 2009. Adjustments are then made to take into account the estimated number of discounts, voids, additions and demolitions during the period 14th September 2009 to 31st March 2010.

An estimated percentage collection rate is then applied to the product of the above calculation to arrive at the tax base for the year.

Taking account of all the relevant information and applying a 99% collection rate, the calculation for 2010/11 gives a tax base figure of 38,200 for the Borough as a whole.

The appropriate tax base figure for each of the Parishes is as follows:

Parish	Tax Base
Hale	729
Halebank	594
Daresbury	142
Moore	343
Preston Brook	352
Sandymoor	938

4.0 POLICY AND OTHER IMPLICATIONS

4.1 There are no direct policy or other implications arising from this report.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

There are no direct implications arising from this report

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

There are no direct implications arising from this report

5.3 **A Healthy Halton**

There are no direct implications arising from this report

5.4 **A Safer Halton**

There are no direct implications arising from this report

5.5 **Halton's Urban Renewal**

There are no direct implications arising from this report

6.0 RISK ANALYSIS

6.1 Loss of income to the Council if Council Tax Base not agreed.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 There are no direct implications arising from this report

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

Document	Place of Inspection	Contact Officer
Working Papers	Catalyst House	P. McCann

REPORT: Executive Board

DATE: 3rd December 2009

REPORTING OFFICER: Chief Executive

SUBJECT: Proposed Closure of Widnes Magistrates Court

WARDS: Boroughwide

1.0 PURPOSE AND CONTENT OF REPORT

1.1 To advise Members of responses received from Councillors and relevant partners in order to formulate a response to the consultation.

2.0 RECOMMENDED:

2.1 That the Chief Executive in consultation with the portfolio holder for Corporate Services be authorised to finalise and despatch the. Council's response to the consultation

3.0 SUPPORTING INFORMATION

3.1 Members will recall that at its meeting on 15th October 2009, Executive Board received an urgent item of business relating to a consultation document received from the Ministry of Justice on their proposed closure of the Widnes Magistrates Court. The formal consultation period would end on 5th January 2010.

3.2 Executive Board resolved as follows:

The Consultation Document be sent to all council members and relevant external partners inviting comments or views on the proposal by 30 November 2009.

The Chief Executive be asked to present a Report to the Executive Board in December 2009 with a summary of comments and a recommendation for the Council's response to the Ministry of Justice.

The Chief Executive be asked to meet with the Court Service to discuss the proposal and the possible future use of the building.

3.3 Following that decision, the Operational Director and Monitoring Officer (Legal Organisational Development & Human Resources) wrote to all Councillors and to the Warrington and Liverpool Law Societies, the Court Users Group and the Magistrates User Group to seek their views.

3.4 This report has been prepared just prior to the 30th November dead line, in order that it may be brought to this meeting of the Board,

3.5 At the time of writing, the relevant partners had not responded to the letter, and representations have been made from five elected members.

3.6 Two members feel that there are two principal problems with the proposals:-

1. Social Inclusion – there is an issue with potentially already disadvantaged residents who may already have problems with transport, being asked to go to Warrington, Runcorn, or Northwich in order to access the Judicial System which was hitherto easily reached.

2. Whilst it is realised that these are financially straitened times due to the recession, Consultees are being asked to discuss the issue in a financial vacuum without a real idea of the current running costs and the benefits or otherwise which might accrue as a result of the Court being closed or indeed being kept open. This is felt to be an intrinsic flaw in the consultation document and should be addressed to enable stakeholders to reach a more informed conclusion. Further financial details should be forwarded to those people involved in the consultation.

   If ultimately the Court is closed, those two members request that the land is provided to Halton Council so that residents of the Borough can derive some benefit.

   A Further Councillor has expressed concern as to what will happen to the building if it is closed, and asked whether the Council will have any say in what happens to it.

   A further Member expresses the view that the term 'Consultation' is inappropriate as it is felt that the real decision to close the Court in Widnes has already been taken as it was last used in 2008, and the Member would like to know at what capacity the Runcorn Courts operate and if they are capable of taking on additional work.

3.7 As requested in the resolution, the Chief Executive met with Court Service Staff along with the Leader on 10th November 2009. He expressed the view that should the proposal to close take effect the Council would wish to see the site utilised for the benefit of Community Regeneration. It was recognised that the site is in the ownership of Cheshire Police Authority and the Council would pursue the issue with them if the opportunity became available following completion of the consultation process. The possibility of greater utilisation of the Stobart

Stadium Widnes by the Criminal Justice / Court Service was discussed at the meeting.

3.8 In the event that further representations are received prior to the meeting, they will be reported to Members. In the meantime, a draft response is included as Appendix 1.

4.0 POLICY IMPLICATIONS

4.1 The Report does not have any implications of itself in terms of Council Policy.

5.0 OTHER IMPLICATIONS

5.1 There are no other implications arising out of this Report

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

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

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

There are no specific implications for any of these priorities arising from this Report, with the proviso, though, that the implications for certain sectors of the community of having to travel elsewhere to have access to the Justice system will form part of the Council's response to the consultation.

7.0 RISK ANALYSIS

N/A

8.0 EQUALITY AND DIVERSITY ISSUES

The proposal to close Widnes Magistrates Court will have implications for members of the community who will have to travel further to access the court system.

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

9.1 Consultation Documents

Proposed closure of Widnes Magistrates' Court
Consultation Paper

Question 2. Please describe any particular impacts that should be taken into account and why.

The closure would have particular impact on members of the community who maybe disadvantaged and less able to access transport. They will be required to travel substantially further to access the judicial system, and this consideration needs to be weighed up very carefully in the review of the Equality Impact Assessment.

Question 1. **Proposed closure of Widnes Magistrates' Court** Consultation Paper

Questionnaire
We would welcome responses to the following questions set out in this consultation paper.

Question 1. What comments would you like to make on the proposal to Magistrates' Court.

The Council does not believe that Widnes Magistrates Court should be clo issue of Social Inclusion, in that Residents who may be potentially disadvant have problems with transport are effectively being asked to go to Warringt Northwich in order to access the judicial system which was hitherto easily rea The point should be made that the consultation document does not financial information, and leads to consultees effectively being asked to cor a vacuum, without a real idea of the current running costs and the benefits o might accrue of the Court being closed, or indeed being kept open. This is an intrinsic flaw in the consultation document and should be addressed holders to reach a more informed conclusion. Further financial details shoul those people involved in the consultation.

The Council notes that the Widnes Court was last used in 2008. This lead behalf of Members,who would seek reassurance that the Runcorn Court taking additional work on a permanent basis, and they would like to know those courts operate.

If the final decision is that Widnes Magistrates Court should be closed, th very keen to make sure that some benefit for residents of the borough is se future land use, particularly for regeneration purposes. It is recognised tha ownership of the Cheshire Police Authority, and the Council would pursue th if the opportunity became available following completion of the consultati Authority would also be keen to ensure that its own buildings are utilised to a the Criminal Justice/Court Service.

Question 3. Will the closure of Widnes Magistrates' Court have a direct impact on you? If yes please provide further details. (Your information will assist in reviewing the equality impact assessment)
The closure will have a direct impact on a substantial number of residents of the borough. The reply to question two above applies.

Proposed closure of Widnes Magistrates' Court
Consultation Paper

About you

Please use this section to tell us about yourself

Full name	Mark Reaney
Job title or capacity in which you are responding to this consultation exercise (e.g. member of the public etc.)	Operational Director Monitoring Officer (Legal Organisational Development & Human Resources)
Date:	24th November 2009
Company name/organisation (if applicable):	Halton Borough Council
Address	Municipal Building, Kingsway, Widnes
Postcode	WA8 7QF
If you would like us to acknowledge receipt of your response, please tick this box	√ (please tick box)
Address to which the acknowledgement should be sent, if different from above	

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

REPORT TO: Executive Board

DATE: 3 December 2009

REPORTING OFFICER: Strategic Director – Corporate and Policy

TITLE: Changes to the Constitution

WARDS: Borough Wide

1.0 PURPOSE OF REPORT

1.1 To amend the Constitution in respect of the exercise of powers in relation to Halton Transport.

2.0 RECOMMENDED: That Council amend the Constitution, as set out in paragraph 3.3.

3.0 BACKGROUND

3.1 Under the Council's Constitution all matters in relation to Halton Transport are reserved to the Council (page 245). The Council is the major shareholder of Halton Transport and the exercise of voting rights as a shareholder is delegated to the Chief Executive (page 277).

3.2 Halton Transport wishes to minimise its potential liability in relation to oil and is in the process of arranging a fuel hedging arrangement with a bank. However, the bank requires a guarantee from the Council. Under the constitution this decision would be reserved to Council. However, the Council meetings take place five times each year and could lead to delay and financial loss to Halton Transport.

3.3 Accordingly, it is proposed to change the Constitution as follows:

Existing

Delegations to Officers

11 To exercise voting rights on behalf of the Chief Executive of the Council where the Council is the shareholder of a company.

Proposed

Delegation to Officers

11 To exercise voting rights on behalf of the Council where the Council is the shareholder of a company and to take any other action which may be considered appropriate from time to time.

4.0 POLICY IMPLICATIONS

4.1 There are no Policy Implications associated with this report.

5.0 OTHER IMPLICATIONS

5.1 There are no Other Implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

Children and Young People in Halton
Employment, Learning and Skills in Halton
A Healthy Halton
A Safer Halton
Halton's Urban Renewal

6.1 The proposal will improve the efficiency of the Council and its partners.

7.0 RISK ANALYSIS

7.1 Potential delays and costs would be avoided.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no Equality and Diversity issues associated with this report.

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

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

REPORT TO: Executive Board

DATE: 3rd December 2009

REPORTING OFFICER: Strategic Director Corporate and Policy

SUBJECT: Halton Borough Council Corporate Plan Mid–Term Review

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

The purpose of this report is to present the Council's Corporate Plan mid –term review for consideration by the Executive Board.

2.0 RECOMMENDATION: It is recommended that: -

2.1 the Executive Board considers the attached Corporate Plan mid-term review; and

2.2 the Plan is presented to Full Council for Final Approval

3.0 SUPPORTING INFORMATION

Halton Borough Council's Corporate Plan runs from 2006 until 2011.

Its purpose is to outline key actions that the Council is undertaking during this five-year period, to contribute to the delivery of the Borough's Sustainable Community Strategy, (SCS), and Local Area Agreement outcomes.

We are now mid-way through the implementation of the Corporate Plan and, therefore, it is appropriate to consider and reflect on changes that have taken place since the Corporate Plan was written in 2006.

Given the nearness in content and purpose of the SCS and Corporate Plan, as well as the fact that the document still has two years to run, it has not been the intention to re-write the document. A new Corporate Plan will be prepared during the second part of 2010. It is likely that the new Corporate Plan would run from 2012 until 2017.

The principle amendments to the plan are:

1. The Corporate Plan takes as its starting point the shared partnership vision priorities objectives and targets as set out in the Sustainable Community Strategy. These were updated to reflect the new Local Area Agreement and other changes when the mid term review of the Sustainable Community Strategy was adopted

by Council in July 2009. These changes now need to be reflected in the Corporate Plan.

2. The Corporate plan then sets out how the Council will contribute to the achievement of these shared priorities and objectives. This is done by identifying a number of areas of focus for Council activity, together with examples of the actions that will be taken to deliver these areas of focus. Where appropriate, Areas of Focus and Improvement targets have now been updated to reflect the adoption of the updated Sustainable Community Strategy in July as well as recognising the changing environment in which Local Authorities operate. In addition, the "Making Progress" section has been updated to highlight areas where the Council is making good progress to support the delivery of the Borough's key priorities and initiatives.

Executive Board is invited to provide initial comments on the document. It is suggested that the Policy and Performance Board Chairs should be invited to consider the revised document, and if they so wish, to discuss it at a meeting of their Board. Comments could then be fed into a further Executive Board meeting on 28th January. To meet Standing Order requirements, it is intended to submit the document to Full Council on 12th February.

4.0 POLICY IMPLICATIONS

The Corporate Plan represents sets out how the Council will support the implementation of the Borough's Sustainable Community Strategy.

5.0 OTHER IMPLICATIONS

There are no other direct implications from the adoption of the updated plan. It is implemented through the departmental service plans, which each link back to the Corporate Plan Areas of Focus. The financial and other resource consequences of the Corporate Plan are addressed during the preparation of the service plans alongside the budget process.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

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

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

The Corporate Plan sets out the Council's six priorities, including the five listed above, and provides an overall guide and framework for the activities of the Council over the medium term. It allows us to focus on those priorities that matter most to the people of Halton and on actions that will have the greatest impact.

7.0 RISK ANALYSIS

The risk of not producing a Corporate Plan would lead to a lack of clarity of purpose for the organisation and the danger that resources would not be allocated to meet priorities.

8.0 EQUALITY AND DIVERSITY ISSUES

One of the guiding principles of the current Corporate Plan is to promote equal access for all to the opportunities and facilities that the Council provides.

9.0 REASON FOR DECISION

The Corporate Plan sets out the Council's priorities and how it will contribute to the shared priorities for Halton. It is an essential part of the organisation's planning and performance management framework. The changes incorporate in this mid-term review reflect a previous decision of Council.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10.1 To leave the Corporate Plan unchanged. This would leave the Corporate Plan inconsistent with the Sustainable Community Strategy leading to confusion of purpose.

10.2 Undertake a full review of the Corporate Plan. This would also risk a divergence between the Corporate Plan and the Sustainable Community Strategy, and would not give sufficient time for the longer term objectives in the plan to be fulfilled.

11.0 IMPLEMENTATION DATE

From its adoption by Council, expected on 12th February 2010.

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

	Document	Place of Inspection	Contact Officer
None			

REPORT TO: Executive Board

DATE: 3rd December 2009

REPORTING OFFICER: Strategic Director – Children & Young People

SUBJECT: **Provision of Youth Work and Targeted Youth Support Services in Halton**

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT:

1.1 To appoint the preferred supplier for the provision of Youth Work and Targeted Youth Support Services in Halton.

2.0 RECOMMENDATION: That:

Executive Board appoint an approved supplier following consideration of the tender evaluation.

3.0 SUPPORTING INFORMATION

3.1 Halton Borough Council Children and Young People Directorate have been contracting out the provision of its Youth Service since 2002/3. This service has been delivered by the Greater Merseyside Connexions Partnership.

3.2 Since this contract was awarded in 2002/03 a number of new pieces of legislation and guidance has been produced namely Youth Matters: Next Steps, Halton's revised Children and Young People's Plan with revised priorities and the ongoing development of Integrated Youth Support locally.

3.3 In December 2008 Executive Board were presented with a report outlining the proposals for the future commissioning of the Youth Service. This allowed us to proceed with the commissioning of the Youth Service so young people are able to receive a seamless service as these arrangements are transferred.

3.4 The contract for the Youth Service is in excess of £1million per annum. It was therefore necessary to embark on a tendering process. This followed the stringent rules defined by the EU Procurement regulations.

3.5 This is also viewed as an important opportunity to test the market and to fully investigate future providers in terms of quality of service and value for money in relation to impact on outcomes.

3.6 Pre Qualifying Questionnaire stages carried out across the summer

months have resulted in comprehensive proposals being submitted. We are now proceeding to interview the three providers short listed. This will consist of a multi agency Children's Trust panel at which potential suppliers will make a presentation followed by a question and answer session. Following this a specific young people's panel will host a 'hot seat' question and answer session.

3.7 The contract award date is 27th November 2009, with the contract due to start on 1st February 2010. The contract will run until 31st March 2012.

4.0 DETAILS OF THE SPECIFICATION

4.1 In building the specification for our new Youth Service we have consulted with young people across the spectrum of need and background. We have asked what they would like to see from a future provider in terms of activity, venue and times and dates.

4.2 The specification is detailed, comprehensive and inclusive and makes it explicit that our Youth Service will be exemplified by the following aspects:

- Working with young people to help them learn about themselves, each other, their families, their communities and the society they live in.
- A development process which sees us providing opportunities to build up the skills of young people so they are able to influence decisions and be active members of their community.
- Young people are offered safe spaces to explore their own identity, to experience decision-making, increase their confidence, develop inter-personal skills
- Develop young people's personal effectiveness through building their ability to arrive at their own choices and solutions to problems and think through the consequences of their actions.
- The relationship between youth worker and young person is central to this process will be the key to making this work being the skills, knowledge and abilities of the youth worker and their ability to establish an effective working relationship with the young person.
- Working and growing with young people as they make the tricky transition into adulthood.
- Working hard to sustain young people's involvement over time and encourage them to work with us to create an integrated youth support service that meets their needs now and will have the capacity and flexibility to respond to their changing needs and wishes over time.

4.3 To do this effectively we will expect any future provider to also demonstrate their abilities in:

- Involving Children and Young People in decision making
- Encouraging young people to become involved in positive activities
- Ensuring all young people are able and supported to attend activities in order to secure Equality of Access
- Supporting young people to access additional support as and when needed.

4.4 **We also expect the future provider to be able to provide s**pecific support to vulnerable groups, for example:

- Care Leavers
- Teen Parents
- Substance misusers
- Young Carers
- Runaways
- Young Offenders
- BME groups
- Lesbian Gay Bisexual and Trans young people
- Provision for the co-ordination of Halton Youth Cabinet
- Provision of the co-ordination of Halton Youth Bank
- Specific provision for targeted street based activities (with a focus on Friday & Saturday evenings)
- Provision for the management of youth centres across Halton
- Specific provision for the delivery of youth work activities from youth centres across Halton

4.5 As noted in the report presented to the Executive Board in December 2008 The contract will accommodate an appropriate break clause in the event of poor performance or reduced financial capacity to commission the service to the level agreed.

4.6 The provider will also be subject to increased scrutiny and performance management to ensure it meets the needs of our young people and makes the required impact on the outcomes and ambitions we have for our young people.

5.0 POLICY IMPLICATIONS

5.1 We are required to provide a youth service for our young people. How this is delivered is determined locally. In Halton we have made the decision to award this contract externally.

5.2 As described in both the National Indicator Set for Children's Services and Local Authorities PSA 14 (numbers of young people engaged in positive activities) and associated targets regarding the numbers of young people in education, employment and training, the numbers of under 18 conceptions, attainment levels, first time entrants into the youth justice system, a comprehensive and effective youth service will be an important aspect to ensure we can

make a real difference to young people across the range of indicators related to these particular indicators.

5.3 To achieve these goals in addition to making sure the provider is able to respond and make an impact against our key local ambitions and priorities as outlined in our Children and Young People Plan the process of awarding the contract has been devised to be thorough, inclusive and challenging.

We have made sure this process represents both the views and wishes of young people. We have also brought together a panel of young people who will question and challenge providers as part of the interview process.

In this respect the provider who is awarded the contract will be able to deliver the requirements of this contract comprehensively and will ensure, as the purchasing body, we can be confident of their skills, knowledge and commitment to our young people.

6.0 OTHER IMPLICATIONS

6.1 None noted

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 **Children & Young People in Halton**

An effective and efficient Youth Service which is both able to address the needs and wishes of young people in the borough will be essential in achieving our ambitions and improving the outcomes for children and young people in the borough.

The day to day work undertaken by frontline staff will be a significant resource to achieve these ambitions and in improving outcomes for children and young people. This will be based on making sure through the tendering process the staff team are skilled, qualified and able to address the many challenges our young people face.

Moreover the role of the organisation in shaping the strategic arrangements which place the active participation of children and young people in the design, delivery and review of services at the heart of everything we do will be important in maintaining and building on the progress made in recent years.

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

One of the many benefits of an effective and efficient youth service will be the impact it has on building the self esteem and confidence of young people as they live their every day lives.

Building these attributes is important for young people as they make the tricky transition from adolescence to adulthood and all the challenging aspects which make this journey with them, such as

leaving school starting college, making the leap to finding work, going to university or leaving home.

Consequently the Youth Service will be an important partner in achieving our goals within this priority.

7.3 **A Healthy Halton**

One of the many benefits of an effective and efficient youth service will be the impact it has on the health and well being of our young people. They will be key players in providing information, advice and guidance for young people and will be able to work effectively with partners so they can signpost young people to specific services.

This will be particularly relevant for the health needs of young people because we know locally there are particular issues for young people in relation to substance use, sexual health, teenage pregnancy and smoking cessation.

7.4 **A Safer Halton**

One of the many benefits of an effective and efficient youth service will be the impact it has on providing positive activities for young people and offering them safe places to go.

One of the many issues our communities tell us is that they feel intimidated by groups of young people and are concerned about the levels of anti social behaviour. Our Youth Service will address many of these concerns so will address some aspects within the broader framework of making our communities feel safer.

7.5 **Halton's Urban Renewal**

8.0 RISK ANALYSIS

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

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

Any assessment of risk will be carried out as part of the tendering process. Any highlighted risk will need to be addressed by the interviewed provider during the interview process.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 Equality Impact Assessments have been completed to date and each provider through the tendering interviews will be expected to demonstrate their commitment and abilities in engaging with young people across the spectrum of need, background, culture, identity, disability and sexuality.

Additionally the young people's panel will explore and challenge in detail the abilities, knowledge and skills of the frontline staff in addressing these aspects as a means of making sure the new provider is committed and able to achieve equality of access and opportunity.

10.0 REASON(S) FOR DECISION:

To comply with recommendations as contained in Youth Matters and Youth Matters Next Steps.

To continue to address specific issues for young people in Halton such as to increase the numbers of our young people who are engaged in education, employment or training and to reduce the numbers of under 18 conceptions.

The service will also ensure young people in Halton receive services and support that encourage and promote their self esteem and self confidence and provide them with the skills, knowledge, choices and opportunities that will allow help them in making the tricky transition into adulthood and to become the future Halton needs as it moves further into the 21st century.

11.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

None

12.0 IMPLEMENTATION DATE

1st February 2010

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

Document	Place of Inspection	Contact Officer
Invitation to Tender Pack	Grosvenor House	Lorraine Crane

REPORT TO: Executive Board

DATE: 3 December 2009

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: Redesign of Day Services for People with Physical and Sensory Disabilities and Older People with Additional Needs

WARD(S) Borough-wide

1.0 PURPOSE OF REPORT

1.1 To outline progress in modernising and redesigning Day Services for adults to report, the outcome of the consultation with stakeholders on these developments and to recommend the formal decommissioning of Bridgewater Day Centre.

2.0 RECOMMENDATION

2.1 **It is recommended that:**

i) In response to the consultation with stakeholders day activities in the community are further developed to more fully utilise local resources.

ii) Bridgewater Day Centre is decommissioned as a base for the delivery of traditional Day Services for Adults with Physical & Sensory Disabilities by 1st January 2010.

iii) Following the decommissioning of Bridgewater Day Centre the Strategic Director for Health & Community to report progress and further service developments to the Healthy Halton Policy and Performance Board.

3.0 SUPPORTING INFORMATION

3.1 On the 4th June 2009 a report on the redesign of day services for people with physical and sensory disabilities and older people with additional needs was presented to the Executive Board. Approval was given to consultation with all stakeholders about the decommissioning of Bridgewater Day Centre as a base for day services and the further development of day service activities in the community. It was also agreed that the Strategic Director for Health and Community should return to the Board with recommendations having considered the feedback from the consultation.

3.2 Developments similar to those proposed for physical and sensory disability

services and services for older people have already taken place within services for adults with learning disabilities. The redesign of Day Services for people with learning disabilities in response to the Government's Agenda, 'Valuing People, A New Strategy for Learning Disability for the 21st Century' began in 2004 and led to the closure of Astmoor Day Centre in 2007. This development clearly demonstrated the value of community based day services as a more effective and preferable model of service delivery. Putting People First in 2007 further challenged traditional day service provision and advocated access to universal services for all.

3.3 In 2008 a project to develop a community based model for services for people with physical and sensory disabilities began. At the time it was estimated that it would take 12 months to explore this option, consult with stakeholders and move away from traditional building based services.

3.4 In February 2009 there were 58 people attending Bridgewater Day Centre. Some people attended for one day a week while others attended for up to three days per week. Some people had been attending Bridgewater Day Centre for many years, including people who began to attend when they left school, were first diagnosed or experienced the trauma that resulted in their disability. At the time there was an expectation that people would attend a day centre long-term and in some cases "for life". This policy promoted dependency amongst service users, influenced staff practice and contradicted the principles of the Government's agenda in Valuing People and more recently Putting People First.

3.5 The need to modernise was evident and a small working party was established to explore options with service users, carers and staff. To begin the modernisation process the needs and requirements of the people attending Bridgewater Day Centre were identified and analysed. Following individual consultation and discussion it became clear that only a very small minority of people attended and purely to access bathing services and plans were put in place for this provision to be made, more appropriately, in their homes. The majority of service users had been provided with a service to relieve social isolation and provide the carer with a break. Gradually, these people have been linked to satellite units providing day activities in the community.

3.6 Members will recall that a range of Satellite Units were already operational and further sites are being considered. Some of these sites require some remedial works and adaptations and these are currently being developed.

3.7 By developing the satellite units all users have been linked to at least one community activity. There is now only one service user whose needs have not yet been fully met in the community. In this case progress on home adaptations is being undertaken.

3.8 Consultation

3.8.1 In response to the Executive Board recommendations in June 2009 and as

part of the move away from the traditional bricks and mortar centre it was important to consult about developments with all stakeholders. We included:

- Service Users and their Carers;
- Staff;
- Councillors;
- Unions; and
- Other interested individuals and organisations.

3.8.2 It was agreed that service users and carers should be individually consulted as part of the development process. This was a not insignificant investment in terms of staff hours, with 50 individual visits and 79 1 to 1 questionnaires filled in. Additionally, in November 2009 the Divisional Manager, Independent Living Services visited each of the satellite units and met with 43 service users to discuss the changes in day services and to further discuss the issue of the possible closure of Bridgewater Day Centre. Questionnaires were given to service users for them to feedback their views. Service users interviewed described how initially they had felt reluctant to leave the familiar environment of Bridgewater but the overwhelming message was that people are enjoying the new settings, are benefiting from these and now feel it would be appropriate for Bridgewater to close. The main themes and outcomes of the consultation will be fed back to all those who participated and a further consultation programme will be arranged in 12 months time. The initial consultation report is attached as Appendix 1.

3.8.3 Comments were generally positive about the changes and refocus of the service. What emerges is an acknowledgement that while Bridgewater as an establishment is thought of with affection the benefits of community-based activity is ultimately a superior method in delivering a vibrant, interesting and confidence building service. There is already evidence that service users have maintained and regained skills in the new community based settings. There is an opportunity to build on these achievements and further strengthen the focus on rehabilitation and increasing independence.

3.9 **Consultation with service users and carers**

3.9.1 To undertake the consultation Individual visits by two members of staff to the homes of users and carers took place between mid June and the end of July. A total of fifty service users and thirty-two carers were interviewed and a questionnaire was completed with each individual.

3.9.2 Of the service users interviewed the majority was positive about the changes. Telling comments made by them included:

"Enjoy small groups in the community activities. More personal than large groups and you get to know people (staff) better."

"It has brought X out more socially since he has been attending community groups. He interacts more. At Bridgewater he preferred to keep his own company.

"Liked activities such as crafts and computers at Priory View, cookery at the Independent living Centre, healthy living cookery sessions at Upton community Centre, Tai-Chi at Churchill Hall".

"I enjoy Churchill Hall. It has a great atmosphere and I am looking forward to attending there on another day."

"I felt apprehensive and unsure about community groups but since coming to Churchill Hall I find I socialise more and meet new people. I attend the ILC cupcake project they have both given me a new lease life."

A service user who has attended Bridgewater for 32 years made the following comment about community activities:

"Initially I didn't like the change as I have been at Bridgewater for 32 years. It has taken me sometime to settle in but I am now finding the smaller groups beneficial and friendly. I am able to access the shops which I really enjoy, we are more able to get out and socialise."

Another service user said:

" Bridgewater was a stepping stone to other things, before I went there my disability consumed my life. After attending it became a small part of my life. It gave me the chance to heal and when I felt better in myself I could try different things like the community groups. Churchill Hall has worked well due to the dynamics of the group, service users and staff work well together."

A minority of carers preferred the service provided at Bridgewater Day Centre and their comments included:

" *I would prefer my wife to be able to stay at Bridgewater, as I do not feel that Churchill Hall is the best community venue for her " and*

" I thought that the service was great years ago but understand that change happens. I do think the service was better in the past."

3.9.3 More recently these carers have felt more positive about the changes and made helpful suggestions about how the current services can be further improved. They feel their partners are happy with the services and enjoy the activities available, for example cooking and visiting the street market.

3.9.4 The general consensus was that people are enjoying the social opportunities that community activities bring despite initial apprehensions. The commitment, professionalism and caring attitude of the Bridgewater staff was frequently referred to during the consultation. They are held in high esteem by users and carers alike.

3.9.5 People raised a range of other issues as part of the consultation interviews

including the need to maintain friendship circles, lack of knowledge about carer assessments, the poor accessibility of some buildings and matters relating to transport. These concerns have been taken seriously and addressed. An opportunity for users to meet up at Christmas has been arranged and other one off events could be arranged in future. Some service users have gained the confidence, through the changes in day services, to meet with their day service friends in their own homes outside the normal day service arrangements. Referrals for carer's assessments have been made where appropriate. Building accessibility is being improved as required, for example, automatic doors and adaptations to the toilets are planned for Churchill Hall. Individual transport issues have been resolved.

3.9.6 The ongoing modernisation of Bridgewater has demonstrably increased the confidence of many service users. Some people, initially reluctant to try services in the community, are now requesting further sessions and are socialising in each others homes as a result. Others who were insular and reserved in Bridgewater have become more outgoing since using the service in the community.

3.9.7 The modernisation of day services will enable people to be more actively involved in the community and will promote independence and confidence. Longer-term, these developments will help people to participate fully in mainstream services bringing benefits for them and the wider community.

3.10 **Consultation with day service staff**

3.10.1 Consultation with staff has also been extremely important. The response from them has been very positive. Fortnightly consultation meetings with staff have taken place and a team day for all staff was held in early August. They enjoy being involved in the satellite units. Their organisational and imaginative skills previously untapped have been used to great effect. They were naturally concerned about their future job security. Although it is not possible to give any guarantees regarding the longer-term position it has never been the intention to cease providing day services, with an associated loss of job security, but rather to provide these services in different ways.

3.10.2 Staff are enjoying the flexibility of the satellite units and feel that they have got to know some of the service users more by providing the service in this way and have described it as "giving service users more of a voice especially people who are quiet". They have also noticed developments in terms of some users' independence and confidence. One user described how she now "enjoys shopping and meeting old friends and the tea dance". Another asked "When can I have another day in the community?"

3.11 **Consultation with Healthy Halton Policy and Performance Board**

3.11.1 A report on the progress on the modernisation of data services and the outcome of recent consultation was presented to the Healthy Halton Policy and Performance Board on the 15th of September 2009. The Board supported the plan to continue to modernise the service.

3.12 **Consultation with Trade Unions, other interested bodies and individuals**

3.12.1 A meeting has taken place with a representative of the trade unions and the development was received positively. Key individuals in the community have also been interviewed and some of their concerns and anxieties addressed.

3.12.2 Halton and St Helens NHS have been contacted to identify formal mechanisms to consult with staff about the modernisation of day services. Some Health personnel have already been involved due to their membership of interested groups, such as the Older People's Local Implementation Team.

3.12.3 The Older People's Local Implementation Team has been briefed and was encouraging about the developments in Day Services. They were particularly interested in the number of venues now available to users of day services and how these are being improved and further developed. They welcomed the range of activities available to service users. Members of the Local Implementation Team recognised that providing services in this way has improved the confidence and independence of many service users. They were also reassured that day service staff enjoy the challenges and opportunities of providing services in this way, noting they have developed an improved knowledge of the individual service users through the smaller community groups enabling them to provide a more personalised service, a benefit also recognised by service users.

3.13 **Summary**

3.13.1 The consultation concentrated on the option of continuing to develop day activities in the community. Comments about the need to improve access and facilities for disabled people in some environments were acted on and where people were unhappy about their initial day service venue alternatives were identified. The actions taken in response to issues raised are summarised in Table 1. For some people the consultation process enabled them to express their anxieties about the changes and to have these alleviated. In general the results and feedback from all parties gave a mandate for this option and as a result this process continued.

Table 1: Summary of issues raised during consultation

Issues raised	Strategy	Outcome
Need to retain friendship circles.	• Meetings to be arranged and open to all users. • Some users meet up in own homes. • New groups developed.	Friendships maintained. New friendships developed.
Building accessibility to be improved.	• Ideal standard for community centres developed. • Specific work identified and completed.	Improved access for all.
Carers Assessments	• Referrals made for carers	Carers needs identified

	assessments as appropriate.	and met.
Transport	• Individual issues identified. • Close liaison with Transport established.	Transport issues resolved.
Satisfaction with specific satellite units.	• Consultation with service users about level of satisfaction.	Alternative, more suitable satellite units identified.
Range of activities	• Service users consulted about new activities to be developed.	A range of activities provided to meet needs of service users.

4.0 POLICY IMPLICATIONS

4.1 The proposals are in keeping with the national modernisation agenda and the aspirations embedded in the recent 'Valuing People Now' paper and the documents, Putting People First and Supporting People with Long Term Conditions.

4.2 The move from Bridgewater into the community satisfies almost all of Halton's priorities identified in the Annual Self Assessment. In particular Health and Emotional Wellbeing as people become involved in activities they themselves choose and are more meaningful; Improved Quality of Life as people feel more valued and located in the community. Making a positive Contribution – for example Cup Cake Caterers who are a group of service users from Bridgewater who now regularly bake cakes and confectionaries for sale via Country Garden Kitchens at Norton Priory. The rise in the number of community venues and associated activities significantly increases the level of Choice and Control identified as a priority for Halton and all of these increase peoples' level of dignity and self respect.

5.0 FINANCIAL IMPLICATIONS

5.1 This proposed action will generate some efficiency savings. However, the closure of the building should not be interpreted as a dissolution of the service. On the contrary the service will continue in a greater variety of venues and settings and consequently continue to require support officers and staff to deliver. This is a process of modernisation and providing relevant services fit for purpose.

5.2 It is inevitable that some of the community venues will need additional investment to ensure accessibility for disabled people.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 CHILDREN & YOUNG PEOPLE IN HALTON

The potential closure of Bridgewater and the delivery of the service from community bases is a far more attractive proposition to younger service users in the Borough. It is noteable that no young people who have experienced transition access the building.

6.2 **EMPLOYMENT, LEARNING AND SKILLS IN HALTON**

These proposals will increase the opportunities of service users seeking volunteering and employment. So far Cup Cake Caterers have been set up with service users from Bridgewater. The enterprise consists of some 8 service users who bake cakes and confections for sale at Country Garden outlets. These include, Norton Priory, Murdishaw Café and the buffet service. These service users no longer attend Bridgewater and will be in receipt of permitted earnings once their production levels can meet the bill. In other areas a stained glass project has been set up and photography classes all of which are underpinned by a desire to engage in activities with value to the individual and others.

6.3 **A HEALTHY HALTON**

It is difficult to evidence actual physical health improvements as a result of moving the service into the community but what is clear is that those who have moved out are happier and more fulfilled – and this must have a positive impact on physical health

6.4 **A SAFER HALTON**

The movement out of the centre will have an impact on transport and Fleet Transport in particular. Close liaison with transport and ALD services to prevent doubling up is essential.

6.5 **HALTON'S URBAN RENEWAL**

There may be many options to re-develop the site but one option could be to use the existing centre or land for an Extra Care Housing facility.

7.0 **RISK ANALYSIS**

7.1 It will be important to ensure that those service users who currently attend the centre for bathing or personal care are found alternatives before their current service is discontinued.

7.2 While many sites in the community e.g. Pickering Pastures, are DDA compliant the reality is that they are not suitable for all types of wheelchairs. The Department may need to consider further upgrades to substantiate claims of fair access and non-discriminatory services.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 As mentioned above in 7.2 It is important to ensure that alternative venues and activities in the community are as readily accessible as the service provided within Bridgewater itself. Some necessary adaptations have been identified and there will be resource implications as a result of these**.** Any improvements in accessibility of the environment achieved as a result of this

initiative will benefit the wider community now and in the future.

8.2 Any improvements in accessibility of the environment achieved as a result of this initiative will benefit the wider community now and in the future.

8.3 An Equality Impact Assessment has been completed and circulated for further amendment.

9.0 REASON(S) FOR DECISION

Bridgewater Day Centre currently has no service users attending due to the success of the initiative to link day service users to community facilities. It is therefore inefficient, impractical and contrary to the philosophy of social inclusion to continue to run the day centre.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

The option to return to providing traditional building based day services was rejected due to the success of the community based model and the outcome of the consultation with users, carers and other stakeholders, as detailed earlier in this report.

11.0 IMPLEMENTATION DATE

January 2010

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

Document	Place of Inspection	Contact Officer
Valuing People, A New Strategy for Learning Disability for the 21st Century	Runcorn Town Hall	Audrey Williamson, Operational Director , Health & Community
Supporting People with Long Term Conditions. DOH pub. 9th Feb 2007	Runcorn Town Hall	Audrey Williamson, Operational Director, Health & Community
Redesign of days services for people with physical and sensory disabilities and older people with additional needs. Report to Executive Board 4 June 2009.	Runcorn Town Hall	Audrey Williamson, Operational Director, Health & Community
Modernisation of Day Services. Report to Healthy Halton Policy and Performance Board 15 September 2009	Runcorn Town Hall	Audrey Williamson, Operational Director, Health & Community

Appendix 1

Bridgewater Consultation Process. Carers and Service Users.

The direction of travel for Social Service Departments nationally has been one of developing socially inclusive, person-centred, needs led services. Pressure groups, Politicians and lobbyists for people with disabilities and, in particular physical disabilities, have campaigned for years to encourage local services to offer a broader choice of relevant training and support to lessen the impact that disability has on social inclusion. The result of this work culminated in the vision outlined in detail in the 2001 White Paper 'Valuing People'.

As part of the modernisation of day services re-evaluation of individual need has been the starting point for service redesign. Users of day services in Halton have been through a reassessment of needs with specific emphasis on how individuals themselves would like to see their lives develop.

This has been the blue print upon which all local authorities, including Halton, have redesigned services. This has affected traditional 'bricks and mortar' day care services in a very visible way; namely the movement of services from the day centre itself to venues of delivery with much closer links to everyday social integration. From a financial and organisational point of view it would be much easier to continue with the traditional day centre but this would be to perpetuate a model of social isolation.

As part of the service development outlined by Government and endorsed by stakeholder groups across the UK it was agreed that two of its major stakeholders groups (service users and carers) should be individually consulted as part of the planning process.

Eileen Clarke (Performance Manager) and Cath Williams (Senior Day Service Officer) carried out a series of home visits. A total of 50 visits have been completed, which incorporated 47 service users questionnaires and 32 carer questionnaires, out of a total of 53 who currently use Bridgewater services.

During the visits other related issues were identified which have been passed to the relevant teams (e.g. carers assessments, adaptations, respite). This recognises the value of the visits as having a holistic view of individual need.

Carers

Each carer was asked 7 questions:

1. **What is the most important aspect of the services to you the carer?**

No of Carers	Carers responses and quotes
20	Carers said that the service provided them with respite: "Two days of breaks for me to go out without worry ". " Gives me time to go out shopping and having time to myself I get very tired".
13	Carers said that the service gave the cared for person an opportunity to be socially integrated: "N…enjoys mixing socially with other people in community groups it gives me a break and gives me the opportunity to socialise with others ".
12	Carers said that they felt safe in the knowledge that the cared for person was well looked after: "I am able to do things for myself and have peace knowing is in a safe environment."
1	The service enabled her to go to work.

2. **What has been the main benefit for you the carer and has it made any difference to your life.**

No of Carers	Carers responses and quotes
13	That they felt peace of mind knowing that the person is well cared for.
7	Said that they could catch up on everyday things such as shopping, cleaning and socialising.
7	That it takes away some of the dependency on their caring role.
4	That it gave them an opportunity to relax.

3. Has the service improved your quality of life e.g. my caring responsibilities have been reduced or shared to an acceptable level

No of Carers	Carers responses and quotes
25	A resounding yes to this question to quote the following: " Yes if our son was at home all the time we would struggle with each other, being in one another's company all the time " "Yes I have flexibility to do other things in my life when … attends community groups "
5	that the service definitely improved their quality of life.

4. Are there any changes you, as a carer would like to see?

No of Carers	Carers responses and quotes
10	None at present.
7	Happy with the service they received.
4	That they preferred the service at Bridgewater
3	Would like to be kept more informed of changes: "I want to be informed and involved in the planning process and decision making in the future. I do not feel that Carers and service users where consulted about changes within Bridgewater".
3	Would like the cared for person to have another day.
	Other comments included: • ***Improvements to transport arrangements.***

	• would like home adaptations so that their wife can have a bath at home. • communication between services should be improved. • services for the over 65 should be improved. • activities for young people should be developed.

5. What difference does the service makes for the person you care for e.g. improves social contact, takes part in activities of their choice.

No of Carers	Carers responses and quotes
18	That social contact with their peers and friends makes a difference for the person they care for especially since the move from Bridgewater. "The service has kept …… motivated. I feel that people who will not go to community groups are losing out so much as the community groups are helping him to cope with his illness" "More opportunities to socialise with other people, gives stimulation for. Attending the ILC on Fridays ". "Son is more talkative and enjoys socialising in community groups."
12	That the person they cared for looked forward to community group activities: "It has brought … out more socially since he has been attending community groups he interacts more, at Bridgewater he preferred to keep his own company. "As long as appropriate safety measures are put into place I am happy for my husband to attend community groups "
4	That the person they cared for was happier attending Bridgewater:

	"For my mum to return to Bridgewater and go back to how things where. I cannot see any rhyme or reason of why the service users are going into community groups other than to save money. I feel the facilities in community centres are not of the same high standard as what they were at Bridgewater. "

6. Is there anything else that you think the service could or should do for you as a carer?

No of Carers	Carers responses and quotes
20	***Not at the moment happy with the way things are.***
2	Suggestions included: • Holding a carers forum. • Asked for further information regarding the criteria for carer's assessments. • Additional sessions to be made available. • An evening sitting service. • Service they receive to be maintained. • More social events organised • Continue with the bathing service at Bridgewater. • Would like more available transport.

7. Do you have any ideas, suggestions or comments about community-based activities that might be useful in helping the planning process?

No of Carers	Carers responses and quotes

7	Said they had no comments to make at this moment in time.
3	Recommended that all HBC facilities are made fully accessible.
3	Others suggested: • More social events such as tea dances and music & dancing events. • Social outings for younger people. • Sessions to access further leisure and education activities. • Carers forums • IT sessions. "Don't change things for change sake filter out the things that don't work at Bridgewater? ***That the questionnaires are just a formality and nothing will change.*** More accessible transport. Activities should be reviewed on a regular basis To organise more Art sessions. Swimming sessions. More staff needed. More outside activities. "Keep Bridgewater open and use it as a community centre offering adult learning classes with specialised tutors"

Of the 32 completed, positive comments were recorded on community activities such as.

"I think community groups have helped my husband cope with his illness and kept him motivated"

"I think community activities will be a change and improve my mother's social contact"

> “I think at the moment carers are being recognise for their role”
>
> “Develop further different community groups across the borough for my husband to access”

Of the 32 questioned 9% of Carers preferred the service when it was Bridgewater based:

> “I would prefer my wife to be able to stay at Bridgewater, as I do not feel that Churchill Hall is the best community venue for her”
>
> “Thought that the service was great years ago but understand that changes have to happen. I do think the service was better in the past”

Service Users.

Each service user was asked the following seven questions.

1. What current community activities are going well

No of Service Users	Service user responses and quotes
33	Liked activities such as crafts and computers at Priory View, cookery at the Independent living Centre, healthy living cookery sessions at Upton community Centre, Tai-Chi at Churchill hall.
14	That they preferred Bridgewater with comments such as, Bridgewater is better than community groups.

2. Are there activities that need to change?

No of Service Users	Service user responses and quotes
33	People who use the service were more than happy with the benefits of community activities and had no wish to change anything at this time.
14	Preferred activities at Bridgewater
10 of 14	Said in general they enjoyed the community activities at present.
	Others suggested: Improving the standard of the meals at Churchill Hall, more choice of activities at Churchill Hall, develop the photography group at Priory View, start a genealogy group at the library.

3. What new community activities would you like to do in the future?

No of Service	Service user responses and quotes

Users	
12	Suggested volunteering/training opportunities including gardening and computers.
12	Wanted healthier lifestyle activities such as swimming, exercise and the gym.
8	Said leisure activities to include, music workshops, theatre trips, socialising with their peers.
7	Said arts and crafts, knitting, and pottery.

Other individual suggestions included, sign language, digital photography and local history groups.

4. What specific support needs/environmental factors need to be taken into consideration?

No of Service Users	Service user responses and quotes
35	Had minimal support needs with personal care and mobility.
33	Had high support needs and are dependant on staff to meet their personal care, mobility and assisted feeding.
9	Had medium support needs with personal care, mobility and some assisted feeding.

There was an overwhelming need recorded to ensure peoples personal safety when in community venues due to the nature of their disability and the types of mobitly aides required for access e.g. wheelchairs, walking frames and symbol sticks.

Space was another key issue along with suitable adaptations. Which prompted such answers as Bridgewater has tailor made facilities, the doors in Churchill hall are too heavy to open, The corridors in Priory View are to narrow for certain types of wheelchairs.

5. How much support does the person need to access community activities

No of Service Users	Service user responses and quotes
23	Used a manual wheelchair with a small percentage requiring staff support to push the chair.
7	Use a walking/symbol cane staff support and guidance needed
6	Use an electric wheelchair no support required
5	Used a walking/Zimmer frame staff guidance needed.

The remaining people had minimal physical support needs.

Based on the information gathered it would suggest that despite peoples disability the majority had a degree of independence and control.

6. What transport arrangements does the person need/could transport be arranged in another way.

No of Service Users	Service user responses and quotes
31	Use HBC fleet transport systems to get to community venues
6	Are transported to community venues by their carer.
5	Use both fleet and dial a ride.
3	Use dial a ride (Halton Community Transport)
2	Are transported via taxi and escort.

Below is a sample of comments recorded on individual questionnaires

"Mum main carer unable to drive"

"Could not travel independently"

"Carer unable to take me, as she would not get any respite"

"Carer has no form of transport."

"Carer unable to take me due to work commitments."

"Object to being charged for transport when they have been informed not to come."

"On occasions my wife might be able to take me to community groups."

"Not confidant to drive independently."

"Carer takes me because the transport charges are too high."

7. Do you have any ideas, suggestions or comments about community-based activities that might be useful in helping the planning process?

Overall response given

- More social events;
- Woodwork activities;
- Health and safety related workshops;
- More Tai- chi sessions;
- College courses;
- Involve service users at an earlier stage;
- Stay at Bridgewater missing friends;
- Keep groups and staff together;
- Develop activities for younger people;
- Start a newsletter.

SUMMARY

Summary of Responses to users questionnaires:

Of the 47 questionnaires completed by service users 70% of the comments were positive such as.

"I enjoy Churchill Hall it has a great atmosphere and I am looking forward to attending there on another day."

> "Enjoy the small groups in the community activities more personal than large groups and you get to know people (staff) better."

A service user who had previously attended Bridgewater for 32 years made the following comment about community activities:

> "Initially I didn't like the change as I have been at Bridgewater for 32 years. It has taken me sometime to settle in but I am now finding the smaller groups beneficial and friendly. I am able to access the shops which I really enjoy, we are more able to get out and socialise."

Another service user said:

> "Bridgewater was a stepping-stone to other things, before I went there my disability consumed my life after attending it became a small part of my life. It gave me the chance to heal and when I felt better in myself I could try different things like the community groups, Churchill Hall has worked well due to the dynamics of the group, service users and staff work well together."

An 86-year-old service user who had previously attended Bridgwater for 21 years made the following comment:

> "I felt apprehensive and unsure about community groups but since coming to Churchill Hall I find I socialise more and meet new people. I attend the ILC cupcake project they have both given me a new lease life."

Mr E previously attended Bridgewater for four years and found it difficult to engage and interact with his peers due to the volume of people accessing the service and basically spent most of his day isolated through choice from others. Since attending community groups Mr E feels more confident in mixing with his peers and getting involved in activities he is now able to use a computer this is due mainly to the small groups, which offers a more personalised service.

A small section of people questioned preferred Bridgewater mainly due to congregational style service and familiarity of the building.

Other key issues recorded during the visits are:

- Friendship circles need to be maintained.
- Accessibility needs to be improved.
- Transport and charges needs improving.

Below are the key priority areas highlighted during the visits, which incorporates constructive development and continual development.

- Positive working relationships with Staff.

- Retaining friendships with peers.
- Lack of social opportunities/gatherings
- Benefits of carer's assessment.
- Entrance doors to Churchill Hall difficult to manage.
- Limited space to manoeuvre at Priory View.
- Restrictions on personal care facilities at Churchill Hall.
- Frequently asked questions are as follows.
- Why consult after the changes have been initiated.
- Is Bridgewater closing
- Why move to other community activities when Bridgewater is a purpose built facility.
- What will happen to Bridgewater when everyone's moves out?
- Is Pingot moving into Bridgewater?

The general consensus is that the people we provide services for are enjoying the social opportunities that community activities bring despite initial apprehensions.

One of the most referred to topics discussed was the commitment, professionalism and caring attitude that Bridgewater services staff have they are held in high esteem by carers and service users alike.

It is the aim of the service to consult with its major stakeholders as part of the on going continual improvement process, which recognises the value, and worth of co partnership with stakeholders. In the delivery of quality services and in line with good practice we will undertake a further consultation in 12 months time.

The overall response to changes in how services are delivered in community activities as opposed to building based services has been positive.

Since the visits there have been more positive comments volunteered to staff from users. One in particular is from a 69 year old woman who previously attended Bridgewater for 27 years and had major anxieties about the move into community activities due to her visual impairment who said " **I absolutely love Priory View its feels like home from home and I am glad that I made the move from Bridgewater** " This quote demonstrates a natural level of anxiety and the positive outcome achieved.

Eileen Clarke
Performance Manager
Daytime Community &
Residential Support

and

Cath Williams
Senior Day Services Officer
Bridgewater Day Centre

August 2009

MODERNISATION OF DAY SERVICES – IMPACT ASSESSMENT

Community Impact Reviews and Assessments (formerly EIAs) are a means by which we can maximise opportunities for embracing diversity and supporting community cohesion. They prove our knowledge of the needs, expectations and aspirations of our existing and potential service users and help us deliver services through an increasingly diverse range of channels.

SECTION 1 – Context & Background

What is the title of the policy/practice?
Modernisation of Day Services for Disabled and Older People

What is the current status of the policy/practice?
The programme began with initial service user and staff consultation in 2006, and taster sessions started in February 2009. The programme has been ongoing since then.

Who are the main stakeholders and who has primary responsibility for delivery?
The main stakeholders include users of Bridgewater Day Centre and their carers; day service staff; other disabled people; care managers; elected Members and other professionals.

Are there any other related policies/practices?
Consultation Plan
Activities timetable
Improvement programme for community centres

Who is the policy intended to affect?
Disabled people generally, and specifically current and potential users of Bridgewater Day Centre.

What are the principal aims and the intended outcomes of the policy/practice?
Aim:
To promote independence and enable people to participate more fully in community activities and to exercise more choice and control over how they spend their time. Ultimately, the modernisation programme aims to allow day service users the opportunity to lead a life, with support where necessary, which is no different to the lives of other residents of the Borough.
Objectives:

- *To identify with service users and carers preferred day activities*
- *To identify and assess the suitability of a range to satellite venues and pilot the use of these venues as alternatives to traditional building-based day services*
- *To ensure that the homes of all service users, and specifically Bridgewater service users, are suitably adapted to meet their needs*
- *To make recommendations to improve the accessibility of community venues to improve provision to the wider community*
- *To enable people to participate more fully in universal services*
- *To enable service user to gain/regain confidence to participate as valued members of the community*
- *To help service users to prepare for the arrival of Individualised Budgets*

SECTION 2 – Consideration of Impact

Is there sufficient evidence to determine if the policy has or could have an impact on any of the diversity groups?
Modernisation of Day Services is likely to have an impact on disabled people who currently use Bridgewater Day Centre, potential day service users, and those disabled people in the wider community who wish to access community centres and alternative venues and who have been unable to.

On the basis of the evidence, has the potential impact of the policy/practice been judged to be positive or negative?
The Modernisation of Day Services has the potential to have a series of impacts:

a) *Positive impacts on disabled people in the wider community who will benefit from improved physical access to mainstream community centres.*
b) *Positive impacts on current and potential Bridgewater service users who will benefit from improved physical access to mainstream community centres and various activities.*
c) *Positive impacts for community cohesion as the wider community (including staff at centres) use community centres alongside disabled and older people.*
d) *Potential negative impacts on current service users include: bathing facilities at Bridgewater no longer accessible; transport issues getting to new activity centres; possible isolation, having been accustomed to seeing the same people each day, often for many years; upheaval and changes to routine; fear of harassment and bullying outside of 'comfort zone' provided by Bridgewater.*
e) *Potential negative impacts on the wider community may mean a reduction in the time available to other groups to use community centres.*
f) *Staff will see an impact in terms of getting accustomed to new ways of working; varied locations and the resulting transport issues; and additional responsibility/risk management for service users in 'mainstream' community centres.*

Is the level of impact judged to be High, Medium or Low?

a) *Low – while the positive impact of improved access to mainstream facilities will be long-term, potentially a small number of disabled people in the wider community will make use of these improved facilities.*
b) *High – the potential positive impact on service users will be both long-term and will affect a significant number of people within that group.*
c) *Low/Medium – there will be a range of activities for service users that are open to the public. Both groups will develop understanding and empathy, supporting community cohesion.*
d) *Low – the process of modernisation will seek to ensure that individual issues are dealt with effectively and personalised solutions, including home adaptations, put in place for service users who require them.*
e) *Low – activity timetables have been and will continue to be devised taking into account other activities taking place at community centres. The modernisation programme will in fact lead to increased usage at the centres.*
f) *High – all day services staff will be affected by the changes in service delivery. Since the programme of modernisation began staff have risen to the challenges, appear to enjoy their work more and indications suggest that sickness absence has reduced.*

What information has been used to determine the potential impact of the policy/ practice?
Consultation with service users and other stakeholders has been ongoing since before the start of the initiative, with individual concerns addressed as part of the

process. Each service user has been visited at home to discuss their requirements and these have been taken into account when planning the new service. Carers and staff will continue to work with service users to ensure that the modernisation process realises the potential positive impacts for all service users.

How will the positive impacts of the policy be monitored? Who will be responsible for monitoring and how will be arranged?
Actions arising from the modernisation programme will be input into the Directorate Equality Action Plan and monitored on a quarterly basis by the Directorate Equalities Group. Any high priority actions will be documented as part of the annual service plan and monitored through the service planning process. The Divisional Manager will be responsible for updating both plans as requested.

What actions have been identified to promote equality of opportunity and community cohesion?
The current programme of activities includes a regular 'Tea Dance' for service users, which is also open to the public. These afternoons have proved popular with both service users and the wider community. There is a target in place to ensure that 50% of those attending the stained glass tutorial group are members of the public. Extending 'joint' activities will be explored with service users, their carers and staff and attendance will be monitored.
There are currently five community centres which have been adapted as part of the programme of modernisation, and a sixth centre has adaptations planned. Some of these venues are utilised by day services on more than one day per week. As demand increases, further venues and days will be identified.
A number of the centres are located in areas in which the outside environment is accessible to most users. This has meant that service users have been able to visit local shops and the market, while one group has met with residents from a nearby sheltered housing project (St George's). One of the residents at St George's has offered to stage weekly guitar recitals for day service users and other residents to attend.
Volunteers from the community support two of the activity groups, and it is hoped that this number will increase.

SECTION 3 – Stage 2 Assessment

On what grounds is a Stage 2 Assessment being carried out?
Recommendations following the pilot modernisation programme are likely to include the possible closure of Bridgewater Day Centre. In these circumstances it has been considered that a detailed Impact Assessment would be required should this option be adopted. This document provides background detail to support the recommendations.

Where consultation is required, please provide details below:
Service users, staff and carers have been consulted on a number of occasions throughout the process to date. Further consultation will take place in six months time, and annually thereafter. The aim of this ongoing consultation will be to establish if the day service activities and locations are continuing to meet the needs of the service users, and to enable them to put forward ideas and suggestions.

What were the principal findings of this research/consultation?
Initial findings suggested that service users were reluctant to consider any changes to existing day service provision. However, in line with current Government thinking, it was thought to be important to ensure that service users had an opportunity to

experience proposed alternative provision to enable an informed final decision. Management and staff recognised that any changes to current provision would represent an upheaval in the lives of service users, which in some instances could be traumatic.
As a result of initial conversations and consultation with service users and their carers, a 'taster' programme of activities was established.
Prior to this, necessary physical improvements were made to community centres to ensure that each service user, regardless of their needs, could access the physical environment. This programme of improvement has been extended to further community centres, improving access to facilities for the wider community and going above and beyond the requirements of the Disability Discrimination Act. There is a programme of continuous improvement in place.
Service users were involved in the process of selecting activities, and these were scheduled. Feedback from service users has been positive, and of 58 original service users, only 2 continue to access services at Bridgewater Day Centre and there are plans to move these service users into alternative community venues before Christmas.

Where a negative impact has been identified, please provide details below:
Potential negative impacts have been identified as follows:

a) *Bathing facilities – a limited number of service users are unable to bathe in their own homes due to a lack of appropriate equipment and/or adaptations. There are accessible bathing facilities at Bridgewater.*
b) *Transport – offering transport to small groups to a variety of locations across the Borough has been difficult to arrange.*
c) *Isolation – a number of service users and carers indicated that they were concerned about becoming isolated, having been accustomed to spending time with the same group of people for a number of years in the Day Service setting.*
d) *Fear – service users expressed concern about the reaction of the wider community if they were away from the 'safe' environment at Bridgewater.*

In the light of this negative impact, it is considered appropriate to take specific actions (identified below) to minimise or remove the potential negative impact.

a) *Bathing facilities – service users who have been making use of bathing facilities at Bridgewater have been assessed and appropriate funding has been identified to allow adaptations which will enable bathing in their own homes. This solution is preferable to continuing to use the facilities at Bridgewater. While service users are awaiting adaptations, alternative bathing facilities are available at Oakmeadow.*
b) *Transport – Staff have and continue to work closely with Transport Coordination to ensure that service users are able to access the activities available at community centres. If service users have specific requirements, these are managed on a case-by-case basis. Younger disabled people are signposted to organisations to support them to learn to drive.*
c) *Isolation – staff will be assisting service users to maintain social contact with peers outside of the usual contact time. This may involve meeting up independently of Day Services and is akin to 'normal' social contact with friends.*
d) *Fear – Community centre and care staff will support service users to access the changed services, and will monitor and report any negative reaction. To date, this has not been an issue but is something staff remain aware of. Community centre staff are undertaking a programme of training in Disability Awareness.*

How will the impact of these actions be monitored? Who will be responsible for these actions and how will this be arranged?
Actions arising from the modernisation programme will be input into the Directorate Equality Action Plan and monitored on a quarterly basis by the Directorate Equalities Group. Any high priority actions will be documented as part of the annual service plan and monitored through the service planning process. The Divisional Manager will be responsible for updating both plans as requested.

REPORT TO: Executive Board

DATE: 3 December 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Dual Diagnosis Strategy

WARDS: Borough-wide

1.0 PURPOSE OF REPORT

1.1 To inform members of the Executive Board of the development of a Joint Dual Diagnosis Commissioning Strategy 2009 - 2012 for Halton and St Helens.

2.0 RECOMMENDATION

i) That the Executive Board endorse the Joint Dual Diagnosis Commissioning Strategy.

3.0 SUPPORTING INFORMATION

3.1 The strategy, attached at Appendix 1, documents the current services already in place for people with both substance misuse and mental health problems, with a view to identifying and analysing the gaps in services and any blockages to delivering a more integrated care pathway.

3.2 Early in 2009 conducted a number of consultation meetings with all stakeholders in both mental health and substance misuse services were undertaken. In addition, a number of one to one interviews with key stakeholders were undertaken to gain views on current services and to discuss how services could be improved.

3.3 In response to the analysis and consultation, the Dual Diagnosis Commissioning Strategy describes the commissioning intentions over the next 3 years in improving services for people with a dual diagnosis of substance misuse and mental health problems. It identifies the actions and resources required to improve services, in line with the Dual Diagnosis Good Practice Guide (Department of Health, 2002).

3.4 The strategy recommends more integrated working between substance misuse and mental health services, with earlier identification and treatment of dual diagnosis problems in primary care and an increase in skills and knowledge in both mental health and substance misuse staff, to enable them to provide care to people with dual diagnosis problems.

3.5 The model of services ensures that whichever service an individual is referred to for help, whether in substance misuse or mental health, they will experience the same care pathway. This is designed to improve the care experience for people with Dual Diagnosis and reduce waiting times between services.

4.0 POLICY IMPLICATIONS

4.1 The Commissioning strategy implements the recommendations from The Mental Health Policy Implementation Guidance: Dual Diagnosis Good Practice Guide.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 Resource implications are identified within the strategy. The most significant costs are organisational and individual officer time. The additional funding required has been allocated from NHS Halton and St Helens adult mental health budget to support workforce planning and development.

6.0 OTHER IMPLICATIONS

6.1 The development of a multi-agency group to agree joint commissioning decisions between substance misuse, alcohol and mental health commissioners is a recommendation in the strategy and will, therefore, require commitment from NHS and Local Authority Commissioning staff to work in partnership.

7.0 IMPLICATIONS FOR THE COUNCIL PRIORITIES

7.1 Children & Young People in Halton

This initiative will help support families and young carers who support family members.

7.2 Employment, Learning & Skills in Halton

The overall effect will support people who can be encouraged to return back to employment.

7.3 A Healthy Halton

Earlier detection and treatment of both substance misuse and mental health problems, plus improvements in providing more integrated services, will ensure that people with dual diagnosis receive the right level of care, delivered by the most appropriate services to enable them to recover.

7.4 **A Safer Halton**

None identified.

7.5 **Halton's Urban Renewal**

None identified

8.0 RISK ANALYSIS

8.1 Not implementing the actions documented in the Dual Diagnosis Commissioning Strategy is likely to lead to significantly poorer outcomes for people with mental health and substance misuse issues.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 None

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

None.

Mental Health STRATEGIES

St.Helens Council

HALTON BOROUGH COUNCIL

NHS Halton and St Helens

Halton and St Helen's PCT

Joint Dual Diagnosis Commissioning Strategy 2009 - 2012

1st September 2009
MHS1165

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EXECUTIVE SUMMARY

Introduction

This document constitutes the Dual Diagnosis Commissioning Strategy for Halton and St. Helens Primary Care Trust.

The Strategy sets out the commissioning intentions of Halton & St. Helens Primary Care Trust in partnership with strategic partners and stakeholders over the next three years

It is based on both the requirements of national policy, and a clear understanding of what local people want from services.

Strategy objectives

Halton and St Helens Mental Health Commissioners wish to develop and deliver a dual diagnosis strategy for mental health and substance misuse (drug and alcohol), specific to the needs of the people of Halton and St Helens.

Scope

This document takes account of the above, but focuses upon the needs of those individuals who have a substance misuse problem (including alcohol) ***and*** an identified mental health need. 'Substances' in this context include illicit drugs of all classifications, prescribed medication, and legal substances including alcohol.

The strategy covers the whole adult age range of people Halton and St Helens and all tiers of support (i.e., public health, primary care, social care, secondary care and tertiary care). It is concerned with prevention, awareness, early intervention, treatment, after care and recovery.

Method

This strategy has been developed using the following activities:

Questionnaires: Service-mapping questionnaires circulated to local service providers. These were reviewed to identify services and interventions available matched against 'Tiers of Service' as identified by NTA.

Focus groups: three focus groups were organised an attended by primary, secondary, and 3rd Sector staff fror health, social care and criminal justice agencies. A separat commissioning focus group was well attended. Themes fror these group discussions are detailed later in this report

Interviews: a number of one-to-one interviews have been completed as well as small group interviews and site visits to services. The emerging themes are detailed later in this report.

Desk-based analysis: A national demographics and prevalence analysis has been undertaken.

Best Practice review: A best practice review has been completed.

Service user engagement: Two separate engagement meetings were held with services users with a dual diagnosis, one organised by CIC and the other by Arch. In both meetings

approximately fifteen people attended and gave consistent feedback.

Definition

The Dual Diagnosis Strategy Development steering group agreed the following definition for the project.

> ***Dual Diagnosis is the 'The co-existence of mental health and substance misuse problems'.*** (*Dual diagnosis: Mental health and substance misuse*. Rethink and Turning Point, 2004)

It is the view of the Dual Diagnosis Strategy Development Steering Group that this definition covered the widest number of people with dual diagnosis issues.

This definition is in line with the 'Changing Habits' report and the 'Commissioning Behaviour Change (Kicking Bad Habits)' report[1]

Principles and Values of Commissioning

This section examines the influencing policy and guidance on commissioning. It has established that the 'Fitness for Purpose' processes will be adopted. That, World Class Commissioning competencies, will be utilised. It identifies the principle commissioning priorities and high level outcomes it wishes to achieve. These, together with the 'future focus of commissioning and service development' set the strategic direction of travel for the next three years.

Best Practice Review

In this section, tables are presented demonstrating the best practice issues or interventions for alcohol and substance misuse.

The table covers the Tiers of intervention, typical service user, point of access, interventions, who delivers the intervention, the outcome for the service user and finally the effectiveness of the intervention.

A diagram demonstrating a good practice pathway for dual diagnosis is presented. This diagram supplements the 'model of care' and 'care pathway' as described in the relevant sections of this strategy.

A key message throughout the review is that 'communit based support and recovery' is the expectation and tho residential and inpatient care is for those people where th severity and risks posed require a period of continuous 24hour care.

DRIVERS FOR CHANGE

National Context

In this section a review of key policy has aimed to give an overview of the national perspective and highlight the key drivers for change. Particular note should be taken of the

[1] Boyce T. et al. (2008) *Commissioning and Behaviour Change: Kicking Bad Habits Final Report*. King's Fund

Models of Care, Substance Misuse and Alcohol and the NTA's review of treatment effectiveness [2](2002).

Local Commissioning Context

The commissioning context is complex. There is one Primary care Trust, two Local Authorities, two DAAT's and two LITs

There is value in developing a joint commissioning board to commission services for those with both mental health and substance misuse issues.

Provision of Services

A range of agencies currently provides, dual diagnosis services, across the two localities. Service provision would appear to be inequitable across the two localities with different service availability, range, and choice.

Population / Deprivation

In this strategic document, the main issues of population and deprivation will be highlighted. A more detailed account of Halton and St. Helens demographics may be found in the respective Joint Strategic Needs Assessments, or local authority data.

[2] *Models of Care for the Treatment of Drug Misusers. National Treatment Agency for Substance Misuse*. National Treatment Agency for Substance Misuse. 2002
Models of Care for Treatment of Adult Drug Misusers: Update 2006. National Treatment Agency for Substance Misuse. July 2006
D. Raistrick et al. *Review of the Effectiveness of Treatment for Alcohol Problems*. National Treatment Agency for Substance Misuse. November 2006

The total population is 297k composed of 119.5k in Halton[3] and 177.5k in St Helens.

The population of Halton is projected to increase by 6% to 126,500 by 2021. An increase of 43% of the 65 plus age group is estimated to grow from 16,400 in 2006 to 23,500 in 2021.

The Population of St Helens is currently 177,600[4] and is projected to increase by 1% up to 2015. St Helens mirrors the national trend. Like Halton will see an increase in the 65 plus population. By 2015 1:5 people will be over 65 years old.

Deprivation

Twenty three percent of the Lower Super Output Areas (LSOA in St. Helens are in the top 10% most deprived areas in Englan and 27% for Halton. However, some areas are ranked as muc less deprived. For both Halton and St. Helens 8% of their LSOA are in the top 25% least deprived areas.

Prevalence

Based on our analysis within Halton and St Helens Primary Care Trust footprint there is projected to be, be 36,900 cases of neurotic disorder (one individual may have more than one type of neurotic disorder). Of this identified population, 590 cases are likely to be moderate to severe alcohol dependence.

[3] http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

[4] http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

The analysis further identifies a projected 3096 cases of neurotic disorder and some form of drug dependence.

To the informed reader these figures may appear the wrong way around.
For the avoidance of doubt however, 590 cases (an individual may have more than one disorder –see page 30) will experience a moderate to severe **alcohol dependence. Whereas 3096 cases will experience a drug dependence. In this context drug dependence refers to 'any drug' and will include those who are drinking alcohol at harmful / hazardous levels.**

These figures were calculated as follows:
4% of men with any neurotic disorder had moderate/severe alcohol dependence and 0% for women (see http://www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf page 66). Halton and St Helen's male neurotic disorder population is 14,756 and so, 4% of 14756 is **590**.

There is estimated to be 12% of males with any neurotic disorder who have ***any*** drug dependence (inc. cannabis, amphetamines, crack, cocaine, ecstasy, tranquillizers and opiates) and 6% for females (see page 70 of Tobacco report).

Applied to Halton and St Helen's male neurotic population this equals 0.12 x 14,756=**1771** and for female neurotics 0.06*22,097=**1326.** Therefore, the total for males and females equals **3096** as documented.

Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months based on **current eligibility criteria**. Should eligibility change to be more inclusive the expectation would be that this figure would increase. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

It is acknowledged that the numbers of individuals experiencing some form of dual diagnosis is likely to be higher than that identified here. This is likely to be the result of a restrictive definition and / or eligibility criteria. The demand therefore for appropriate services is not captured.

Halton and St. Helens reported 116 appropriate referrals to their Substance Misuse Service team. The figures in the table below are calculated using the 116-referral figure and the prevalence rates from the COSMIC study

Estimated Number of Mental Health Cases in Halton and St. Helen PCT's SMS Service April 08 to October 08 (6 months period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

Performance

Substance Misuse service users retained in treatment

Halton and St. Helens DAAT NTA data suggests that they perform less well than their statistical neighbours (ranked 8 out

of 11) but better than the England average. It also shows us that Halton and St Helens are keeping more drug users in sustained treatment (12 weeks+) than they were the previous year in 2006/7 (but all of the neighbours did better than the previous year except for Ashton PCT.) All of Halton and St Helen's statistical neighbours outperformed their local PCT plan for how many drug misusers they would have in treatment. Halton and St. Helens outperformed less than the comparator average but more than the England average.[5]

The table below show data from '2008/09 quarter 2 adult drug treatment partner information reports' St Helens and Halton 31st October 2008. This table shows the difference in performance between Halton and St Helens.

Data from 2008/09 quarter 2 adult drug treatment partner information reports. Halton & St Helens 31st October 2008

	St Helens	Halton
Adults in effective treatment 1/7/07 to 30/6/08	1025	709
% retained in treatment 12 weeks or more period 1/7/07 to 30/6/08	85%	76%
% not in effective treatment period 1/7/07 to 30/6/08	13%	23%

Stakeholder Feedback

As one would expect from such a wide stakeholder mix there was a wide range of views expressed, yet there were some striking themes that emerged as issues in a consistent manner, these included the following.

- Alcohol rather than substance misuse was the major issue
- The blocks and gaps in service provision were at Tier 2 and the interface with Tier 3.
- People with dual diagnosis are far more prevalent than definitions record. Few people who abuse alcohol or other substances do not have some underlying mental health need. Likewise, very many people with a mental health diagnosis will 'self prescribe' with othe substances – be that alcohol, variations on the medication routine or illicit drugs.
- Many services were difficult to access due to th exclusion (rather than inclusion) criteria of many service This meant there was little ownership: all service recognised the need to help the individual, but felt it was not their responsibility to deal with it.
- Too often, the above situation meant interventions only occurred when a crisis presented itself and the criminal justice system was invoked.
- Staff groups work in a silo culture of mental health, substance misuse or alcohol workers without recognising their skills and the needs of their service users were far more cross cutting than that.

There was also a consensus articulated as to how future services should be developed, as follows.

[5] *Drug Misusers in Treatment: Primary Care Trusts Overview – New National Targets 2007/2008*. Healthcare Commission. Available from http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisusersintreatment.cfm

- Services should work much better together and 'share the care' more often.

- Services need to be more holistic and recognise the wider needs, including;
  - The family context
  - Worklessness and its impact on the individual and their family
  - The underlying causes of offending behaviour
  - Housing issues
  - Domestic Violence
  - Looked After Children
  - Education and social problem solving

- Services should be recovery and outcome focused.

- There is need for services to be consistent across the Halton and St Helen's footprint and therefore they should be commissioned consistently to eliminate service gaps and provide equity.

- There needs to be better performance management systems to ensure services deliver what they are supposed to do.

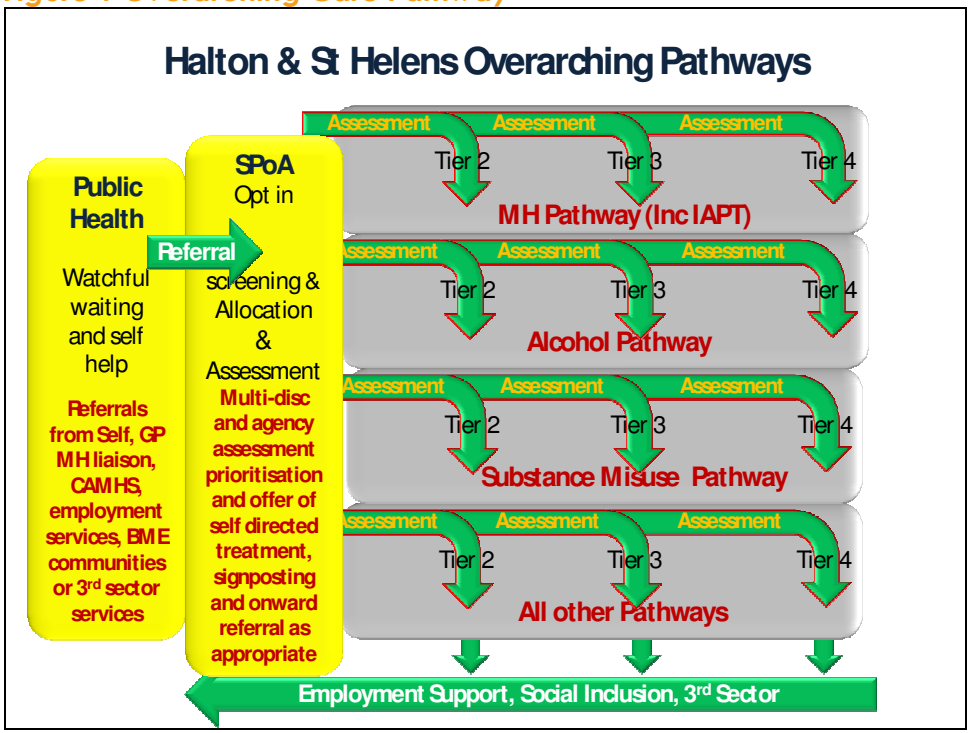
- More resources need to be devoted to primary care with an emphasis on promotion, prevention, and early intervention.

Where we need to get to

Model of Care / Care Pathway

The proposed model of care to be adopted based on a 'shared care – integrated approach' is set out. It has stated the basic principal of Dual Diagnosis Care being led by Mental Health Services whether this is in Primary or Secondary Care. To facilitate this, the role of Advanced Practitioner will be developed and work in conjunction with Dual Diagnosis Workers in Secondary Care. Figure 1 shows a Care Pathway that is aimed at ensuring an equitable and integrated approach is delivered.

Figure 1 Overarching Care Pathway



Conclusion – Commissioning Intentions

This strategy has set out the definition of Dual Diagnosis to be adopted. This definition embraces the principle of inclusion. That is, those who need a service will be offered care and treatment and that eligibility criteria will not stand in the way of accessing care.

The model of care to be adopted is based on best practice and the principle of 'mainstreaming'. This model is based on the practice of 'integrated and shared care.' The care pathway to be adopted seeks to reinforce the practice of integration. Mental Health will take a lead in the coordination of care for those experiencing both a mental health probler and a substance misuse dependency. The report recognise that alcohol, especially at the Tier 2/3 interface presents th greatest pressures for current services. To facilitat improvement in this deficit the role of Advanced Practitioner i Primary care will be developed and a review of the role c. Dual Diagnosis Worker in secondary care will be undertaken.
A range of actions is now necessary to implement this strategy. A more detailed account of these actions can be found within the chapter entitled Conclusion and Commissioning Intentions

Actions

These action include:

- Reconfigure the current commissioning mechanisms.
  Aim. To develop coordinated commissioning and a performance management process equitable across

Halton & St Helens, including all stakeholders delivering care along the pathway.

- Establishing the model of care and single care pathway
  Aim. To establish clarity of entry and exit points within services.

- Implementation of the single point of entry.
  Aim. To ensure service users access the right services at the right time.

- The development of a work force plan.
  Aim. Ensure that all staff at all levels have the appropriate skills and qualification to deliver the care and treatment required.

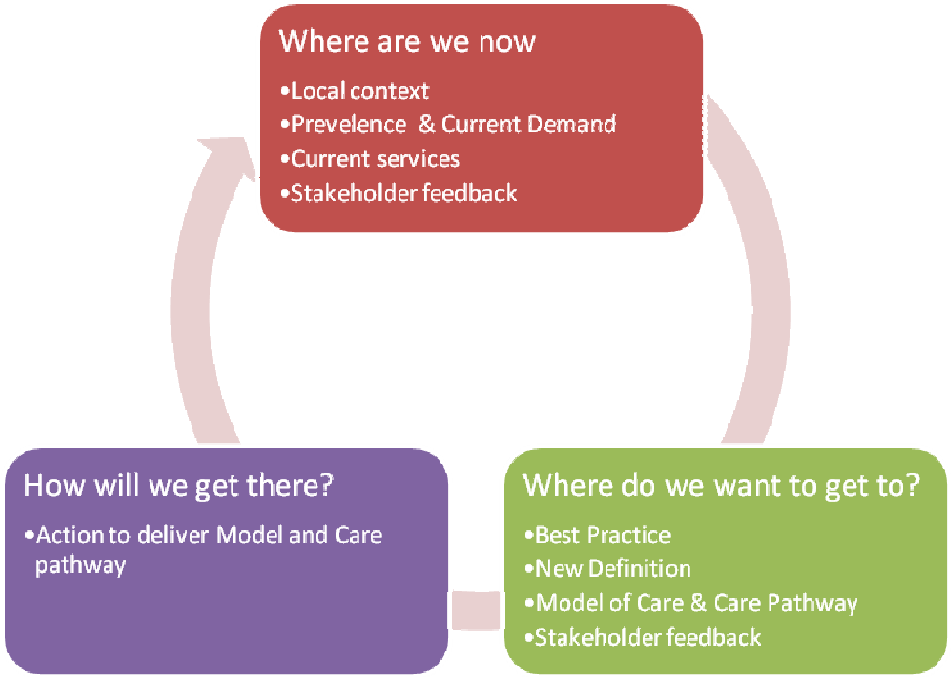
- The development of service specifications in line with the new NHS standard contract
  Aim. To ensure appropriate and inclusive eligibility criteria, and smooth interface between services. That all individuals have access to crisis services when required, irrespective of their dependence on substances.

- The development of a specific Dual Diagnosis service user forum in Halton
  Aim. To facilitate service user engagement and the provision of peer support.

- The development of a Provider Forum.
  Aim. To promote integrated working between providers, to assist identify blockages and barriers to service delivery.

- Commissioning will be based on the priorities identified to meet the identified capacity and capability issues of delivering the future model of care and care pathway.
  Aim: Prioritisation of commissioning. Achieve best value.

- To ensure that this strategy is complemented and a 'strategic fit' it is recommended that the current Mental Health Strategy be reviewed/updated as soon as practicable.



INTRODUCTION

This document constitutes the Dual Diagnosis Commissioning Strategy for Halton and St. Helens Primary Care Trust.

The Strategy sets out the commissioning intentions of Halton & St. Helens Primary Care Trust in partnership with strategic partners and stakeholders over the next three years

It is based on both the requirements of national policy, and a clear understanding of what local people want from services

This dual diagnosis strategy will provide an overall framework for performance and service improvement. The aim is to provide a contextual background, consider organisation' priorities, benefits, risks, and contain action plans to deliver programme of work on dual diagnosis. It will set out a visio and general principles that all the partners can sign up to, an help develop services for service users and carers that w have a positive impact on their health and quality of life.

The report will approach the subject in the following sequential order.

- Identifying the strategies objectives and scope
- Methods
- Review of literature and best practice, including government policy directions
- Review the local context, including what is currently provided and by whom
- Demographics and performance
- Identify themes from stakeholder engagement events
- Describe a new model of care and care pathway

- Provide the framework to list initiatives to achieve the desired outcomes
- Appendices include more detailed supporting evidence.

STRATEGY OBJECTIVES

The purpose of this strategy is to develop a strategic approach to meet the needs of those with a dual diagnosis (drug and alcohol) across the whole of Halton and St Helens locality.

STRATEGIC CONTEXT & SCOPE

Halton, St Helens and the surrounding areas have complex needs. There are pockets of high levels of deprivation, sitting alongside the relative wealth of some commuters, all within well established and relatively newly developed communities.

The recent reconfiguration of PCT boundaries, coupled with increasingly stronger links to the Local Authority and more robust commissioning frameworks (including World Class Commissioning), all provide the opportunity to better co-ordinate services to meet the needs of those individuals with the complex range of needs associated with mental health, substance and alcohol misuse and their related health and social care/welfare domains.

Like most areas, previously each locality and service sector has developed services in relative isolation. However, this new context provides the opportunity to achieve economies of scale and scope, to build upon 'what works', and better integrate successful interventions for individuals along the 'whole dual diagnosis pathway'.

Mainstream mental health services have a responsibility to address the needs of people with a dual diagnosis. Substance misuse services should not be ghetto services. Where they exist, specialist teams of dual diagnosis workers should provide support to mainstream mental health services.

It is therefore essential that local care pathways be fully integrated be they in primary, secondary, mental health or substance misuse in their orientation. Robust care planning procedures at an individual level and clear strategic integration at a corporate level all need to be achieved.

The mechanism to accomplish all of this is robust integrate commissioning at a local level.

By its very nature any dual diagnosis, or co-morbidity, spans more than one domain and excludes others. The current mental health strategy for Halton and St Helens is due for review and work has commenced within the locality negotiating a '**single point of access' (SPoA)** its scope, role and function**. Each DAAT has a Harm Reduction Strategy.** At the time of writing an Alcohol Strategy is also being developed.

This document takes account of the above, but focuses upon the needs of those individuals who have a substance misuse problem (including alcohol) ***and*** an identified mental health need.

Individuals who have a mental health need but who do not have a substance misuse problem are excluded from the strategy. Similarly, those who have a substance misuse problem but do not have identified mental health problem are also excluded.

'Substances' in this context include illicit drugs of all classifications, prescribed medication and legal substances including alcohol.

The strategy covers the whole adult age range of people Halton and St Helens and all tiers of support (i.e., public health, primary care, secondary care and tertiary care). It is concerned with prevention, awareness, treatment, after care and recovery.

The development of a Dual Diagnosis Commissioning Strategy would in the normal course of events 'follow on' from an over arching **Mental Health Strategy.**

At the time of writing the mental health, strategy is due for review. Consequently reference to overall mental health policy and general health and social care policy and guidance needs to be stated. These significantly affect a developing model of care, and integrated working.

METHODS

This section will outline the strategy's process of development and methods used.

Questionnaires: Service-mapping questionnaires were circulated to local service providers. These were reviewed to identify services and interventions available and matched against 'Tiers of Service' as identified by the NTA.

Focus groups: three focus groups were organised and were attended by primary, secondary, and social care staff as well as 3rd Sector staff, from a wide range of health, social care and criminal justice agencies. A separate commissioning focus group was well attended. Themes from these group discussions are detailed later in this report

Interviews: a number of one-to-one interviews have been completed as well as small group interviews and site visits to services. The emerging themes are detailed later in this report.

Desk-based analysis*:* A national demographics an prevalence analysis has been undertaken.

Best Practice review: A best practice review has bee completed.

Service user engagement: Two separate engagement meetings were held with services users with a dual diagnosis, one organised by CIC and the other by Arch. In both meetings approximately fifteen people attended and gave consistent feedback.

DEFINING DUAL DIAGNOSIS

At its most simple, the *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings* (DH 2006 p.1) document, defines it

as ". a diagnosis of mental illness and a diagnosis of substance misuse disorder".

The term "dual diagnosis" poses many problems as it simply refers to the presence of more that one clinical diagnosis. Historically this has referred to those individuals with a severe and enduring mental health problem and a substance misuse problem. This term does not inform commissioners or providers in any detail of the health and social care needs of this group of service users. Dual Diagnosis is a term used to define an increasingly large section of service users that have both a mental health and substance use problem. This term is progressively including people with substance use problems such as alcohol dependence that also have anxiety disorders, and people with schizophrenia who have problems with cannabis use.

The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (2002 p.7) states that the term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex.
Possible mechanisms include:

A primary psychiatric illness precipitating, or leading to, substance misuse.

Substance misuse worsening or altering the course of a psychiatric illness

Intoxication and/or substance dependence leading to psychological symptoms.

Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.

These definitions are secondary care focussed and would limit the range of service users who would be considered under these definitions / description.

The Changing Habits[6] report brings together intelligence from the North West region on the treatment needs and current service provision for service users with a 'dual diagnosis'. The aim of this is to promote the recovery of individuals.

This report illustrates

'Dual Diagnosis is a 'whole system' multi-agency issu affecting a broad cross section of adults, with varying levels o severity and impact on the individual, their friends and famil as well as local communities

A population based approach to commissioning and managing integrated Dual Diagnosis service provision, which utilises existing resources to support the maximum number of people across broad spectrum of need within local Dual Diagnosis treatment populations.'[7]

[6] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West
[7] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West

The 'Changing Habits' report suggests a more encompassing and wide ranging description of who may benefit from accessing services.

The needs of children and young people experiencing these difficulties will be different to those experienced by adults and to older adults. There, will also be cultural and ethnic differences within dual diagnosis, as well as gender and sexuality issues.

For the purposes of this report the Dual Diagnosis Strategy Development steering group agreed to adopt the following definition.

> ***Dual Diagnosis is the 'The co-existence of mental health and substance misuse problems'.*** (From *Dual diagnosis: Mental health and substance misuse*. Rethink and Turning Point, 2004)

It is the view of the Dual Diagnosis Strategy Development Steering Group that this definition covered the widest number of people with dual diagnosis issues.

This definition is in line with the 'Changing Habits'[8] report and the 'Commissioning Behaviour Change (Kicking Bad Habits)' report[9]

[8] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report*. CSIP North West
[9] Boyce T. et al. (2008) *Commissioning and Behaviour Change: Kicking Bad Habits Final Report*. King's Fund

PRINCIPLE AND VALUES OF COMMISSIONING

The guiding principles by which the project was conceived, developed and evaluated were cognisant of wider imperatives including the following.

World Class Commissioning[10]: places Primary Care Trusts and their commissioning partners at the forefront of leading the future NHS at a local level. Great emphasis is placed on quality interventions that meet the local demand, provide value for money, and are measured by their outcome rather than mere activity.

The 'Darzi' Review[11]: Lord Darzi's review of the NHS, ***High Quality Care for all***, sets the agenda for future NHS services, ensuring they are fair, effective, personal and safe. It called fo PCTs to commission comprehensive well-being and preventio services, in partnership with local authorities and local partner based on local identification of need. It called for the NHS t focus on six key goals: reducing smoking rates, tackling obesit treating drug addiction, improving sexual health, improvin mental health and reducing alcohol harm.[12]

Putting People First[13] and Transforming Social Care[14]: sets the vision for the radical reform of social care by promoting strong

[10] DH. (2007) *World Class Commissioning: Vision*
[11] Lord Darzi. *High Quality Care for All: NHS Next Stage Review Final Report*. (Cm 7432, 2008)
[12] DH. (2008) *The Operating Framework for 2009/10 for the NHS in England*
[13] DH. (2007) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*
[14] *LAC(DH)(2008)1: Transforming Social Care*

local leadership in the promotion of individualised care build upon the principles laid out in **Our Health Our Care Our Say[15].**

Various mental health strategies[16] [17] highlight the need to develop better treatment responses for dual diagnosis.
Halton and St Helens Primary Care Trust 'Ambition for Health Strategy' sets out the Primary Care Trust outcomes and ambitions. These ambitions have come from understanding of the needs of our local population, and our desire to ensure that we are able to deliver two critical outcomes: These are:

Improving health and tackling inequalities in health
"To work with partners and local people to promote a positive experience of good health and equal opportunities for health, not simply an absence of disease".

Delivering effective and efficient health and related services
"To provide effective and efficient health care services that place the needs of the patient at their core"

Our ambitions are:

- To support a healthy start in life
- To reduce poor health that results from preventable causes
- To ensure that when people do fall ill from some of the major diseases, they get the best care and support
- To provide services which meet the needs of vulnerable people
- To make sure people have excellent access to services and facilities
- To play our part in strengthening disadvantaged communities

Fitness for Purpose

Commissioning a Patient-led NHS saw the reconfiguration of PCTs as the first stage in delivering a robust infrastructure from which to strengthen the commissioning function of PCTs. Stage two focuses on ensuring that PCTs are fit for purpose. This process looks at Strategic Planning, Care Pathway Management, Provider Management and Monitoring an Remediation.

Changing Habits[18]

This report offers a direction of travel to enable local stakeholders to test out how to overcome some key issues:
Ensuring individuals engaged with Community Drug Teams receive access to mental health treatment including psychological therapies, improving joint working and co-ordinating service provision/investment such as Primary Care Mental Health Services and 'shared care' services and promoting treatment choice such as abstinence from cannabis through wider smoking cessation initiatives.

[15] DH. *Our Health, Our Care, Our Say: A New Direction for Community Services.* (Cm 6737, 2006)
[16] DH. (1999) *National Service Framework for Mental Health*
[17] Appleby, L. (2004) *National Services Framework 5 years on*. DH

[18] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West

Kicking Bad Habits:

This report assesses existing and innovative methods the health service can use to persuade people to live more healthy lifestyles, including providing information and personal support and offering financial incentives. This report aims to help those within the NHS
and beyond who are tasked with finding cost-effective solutions to the problems caused by unhealthy lifestyles and behaviour. It examines four bad habits; smoking, alcohol misuse, poor diet and lack of exercise.

New Contract Guidance

Wherever possible a coordinated approach to commissioning is to be adopted. This will assist in best value and a coordinated care pathway approach.
A Stepped Commissioning Framework for Dual Diagnosis[19] will be developed in Halton and St Helens. This will facilitate a 'whole system approach' to the development of services. This commissioning strategy is the first phase of this process.

The priorities of Halton & St. Helens Dual Diagnosis commissioning group include:

- The further development of mechanisms for involving service users and their carers in the commissioning reform of Dual Diagnosis services

- To deliver the complete commissioning cycle in relation to the services covered by this approach

- Undertake commissioning at a number of levels and bring them into a cohesive whole system approach.

- Review commissioning mechanisms and structures to facilitate a coordinated approach and to achieve best value. Developing a governance framework to ensure there is clarity and agreement about where decisions and commitments are made. Working towards a focus on commissioning for the outcomes set out in the national commissioning framework.

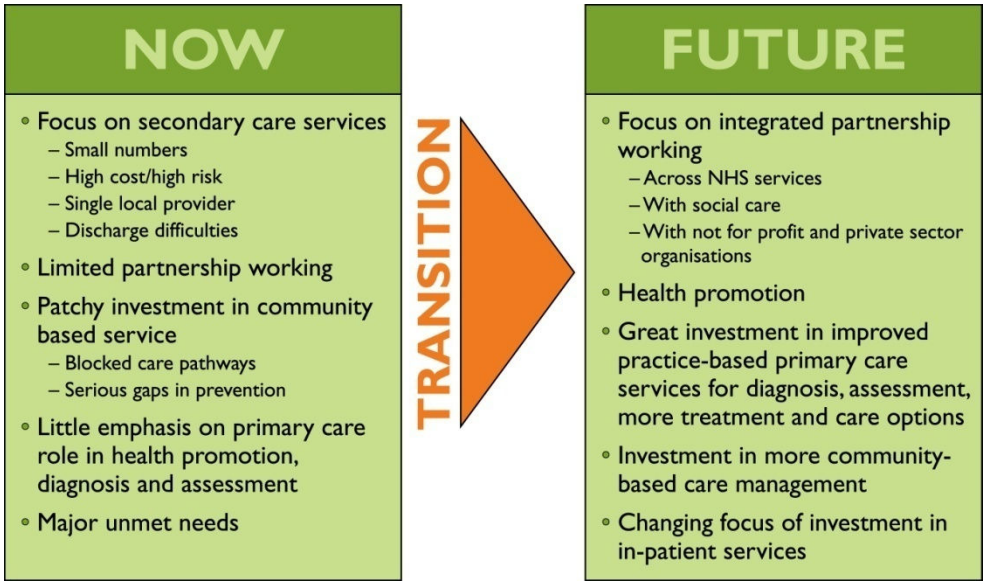
- Ensure that national policy is implemented in a way that takes account of local circumstances and needs.

- The commissioning partners will ensure that there ar improvements in health and well being and reductions i health inequalities and social exclusion. This will includ improved quality, effectiveness, and efficiency c services, together with increased choice and a bette. experience of care. Critical to the improved experience of care is the continued partnership working across health and social care and further developing a shared and integrated model of care.

The following diagram adapted from 'The Commissioning Friend for mental health services' indicates a broad direction of travel for the development and commissioning of future dual diagnosis services.

[19] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report*. CSIP North West

Figure 2 Future focus of commissioning and service development



Outcomes

Halton and St Helens are moving toward a more 'outcome focussed' approach toward commissioning and the table below begins to identify key outcomes that will be measured.

The mechanism for monitoring these outcomes will be subject to a key action plan to implement the strategy. This will entail the setting of these outcomes as core markers within the new contracts and agreeing the core KPI that show progress on these outcomes.

HIGH LEVEL OUTCOME
Improved patient outcomes
Increased independent living
Recovery and socially inclusive focus
Improved vocational and social outcomes
Decreased hospital admissions and readmissions
Increased patient choice
Increased positive risk taking
Local, agreed, targets met
Best value
Training of staff in assessing use of alcohol and drugs and how to handle patients who are drunk or under the influence of drugs

NATIONAL CONTEXT

Accurate diagnosis and selecting the appropriate treatments for dual diagnosis can be difficult as symptoms can overlap. It is therefore essential not to make early assumptions.

Weaver et al (2002): Substance misuse is often not picked up by mental health teams, similarly substance misuse teams often failed to spot mental health problems, thus highlighting a need for more staff training and routine assessment

Prevalence

Rethink's Briefing (2006) highlights the psychiatric problems commonly associated with dual diagnosis as Depressive disorder, Anxiety disorder, other psychiatric disorders such as schizophrenia and personality disorder

Substance misuse among those with mental health problems is common. A study by Weaver et al (2002) reported that 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems. 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels within the past year.

In terms of co-morbidity, alcohol is the most commonly misuse substance. S. Banejee et al. *Co-existing Problems of Ment Disorder and substance Misuse (Dual Diagnosis)* Colleg research Unit, 2002 found that people diagnosed with mental health problem have a significantly greater risk of substance misuse, those with schizophrenia are more likely to misuse alcohol

The Weaver study (2002) came up with the following prevalence estimates

	Prevalence estimates	
	% Drug treatment pop.	% Alcohol treatment pop.
Psychotic disorder	7.9	19.4
Personality disorder	37	53.2
Depression and/or anxiety disorder	67.6	80.6

Severe depression	26.9	46.8
Mild depression	40.3	33.9
Severe anxiety	19	32.3

The *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice* (2002) found prisons have a high prevalence of drug dependency and dual diagnosis.

D'Silva & Ferriter. *Substance use by the mentally disordered committing serious offences –a high-security hospital study*. The Journal of Forensic Psychiatry & Psychology Vol 14 No 1 April 2003 178–193 reports that in high secure hospitals, between 60 and 80% of patients have a history of substance use prior to admission.

Impact on Individuals

Both substance misuse and untreated mental illness are linked to higher levels of suicide. Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide.

National Audit of Violence 2003-2005, Healthcare Commission and Royal College of Psychiatrists, identified alcohol and drug misuse as the main trigger for violence in mental health services

Treatment

Historically substance misuse and mental health problems were dealt with separately, clients with both problems were usually treated by one service provider or the other, meaning that some areas of their problems went undiagnosed or not dealt with effectively. The Weaver study (2002) reported that 38.5% of drug users with psychiatric disorder were not receiving any treatment for their mental health problem.

The *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice* (2002) introduced the 'mainstreaming'. The term was used to recommend that the care co-ordination for people with severe and enduring mental illness and substance misuse should be the responsibility of a mental health team. The idea was that patients should not be moved between different services where there could be a risk of the whole problem not being treated. It recommended more collaboration between mental health teams an substance misuse teams.

Hindrances to overcome

Homelessness is frequently associated with substance misus problems, *Mental Health Policy Implementation Guide: Dua Diagnosis Good Practice, 2002*. Homelessness almost trebles a young person's chance of developing a mental health problem. Assertive outreach to these groups and in-reach to hostels are necessary.

The Weaver study (2002) highlighted the typical characteristics of co-morbid patients and the subsequent impact this has on treatment adherence. The study found that co-morbid patients were perceived as more chaotic and aggressive, making them less compliant with care plans.

The Mental Health Policy Implementation Guidance, Dual Diagnosis Good Practice Guide[20]

This guide summarises current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse. The substances concerned include legal and illegal drugs, alcohol and solvents, but not tobacco. It represents an addition to the Mental Health Policy Implementation Guide which supports implementation of the NSF for Mental Health.

Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems, deserve high quality, patient focused, and integrated care. **This, should be delivered within mental health services.** This policy is referred to as "mainstreaming." Patients, should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services, which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis, are dealt with effectively by mental health and substance misuse services, these services as a whole will fail to work effectively.

Dual diagnosis in mental health inpatient and day hospital settings[21]

This guidance covers the assessment and clinical management of patients with mental illness being cared for in psychiatric inpatient or day care settings who also use or misuse alcohol and/or illicit or other drugs*. It also covers organisational and management issues to help mental health services manage these patients effectively.

The key message is that the assessment and management of drug and alcohol use are core competences required by clinical staff in mental health services.

The guidance aims to:

- encourage integration of drug and alcohol expertise and related training into mental health service provision:
- provide ideas and guidance to front-line staff an manages to help them provide the most effectiv therapeutic environments
- help mental health services plan action on du diagnosis†.

The management of dual diagnosis is a significant concern for both mental health policy and practice.

This was highlighted by the National Director for Mental Health, Professor Louis Appleby, in his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health‡:

[20] DH. (2002)*The Mental Health Policy Implementation Guidance, Dual Diagnosis Good Practice Guide*

[21] DH. (2006) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*

Services for people with 'dual diagnosis' – mental illness and substance misuse –are the most challenging clinical problem that we face.[22]

Closing the Gap (DH, 2006)

Closing the Gap: A Capability Framework for Working Effectively with People with a Combined Mental Health and Substance Use Problems draws on existing national occupational standards in mental health,
substance misuse and other fields to bring together one set of competencies for working with people with a dual diagnosis. There are three levels: core, generalist and specialist.[23]

[22] DH. (2006) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*
[23] Hughes, L. (2006) *Closing the Gap*. DH

BEST PRACTICE REVIEW

Informed by the above research and guidance, this section captures the best practice issues or interventions for mental health, alcohol and substance misuse. The following tables cover the Tiers of intervention, typical service user, point of access, recommended interventions, who delivers the intervention, the outcome for the service user and finally the effectiveness of the intervention.

A diagram demonstrating a good practice pathway for dual diagnosis is also presented. This diagram will supplement the 'model of care' and 'care pathway' as described in the relevant sections of this strategy.

Alcohol

Figure 3 Best Practice Review Alcohol – The Four Tiers of Intervention

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
Tier 1: Alcohol-related information and advice, screening, simple brief interventions and referral	Hazardous, harmful and dependent drinkers	Includes: Primary healthcare services A&E Social services Homelessness services General hospital wards Police settings Prison service	Includes: Alcohol advice and information Targeted screening and assessment for those exceeding government alcohol limits Simple brief interventions for hazardous and harmful drinkers Referral for those requiring specialised alcohol treatment Partnership with specialised alcohol treatment services	A wide range of agencies, the main focus of which is not alcohol treatment. GPs, nurses or trained non-medical practitioners	Reduction of alcohol consumption (abstinence or moderation goal)	Brief interventions ar effective in reducin alcohol consumptic among hazardous an harmful drinkers at lov risk levels Effects of brief interventions last for up to 2 years after intervention and perhaps as long as 4 years There is no evidence that opportunistic brief interventions are effective among people with more severe alcohol problems and

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
		Education services				levels of dependence *Review of the Effectiveness of Treatment for Alcohol Problems* (2006)
Tier 2: Open access, non-care planned, alcohol-specific interventions	Harmful and dependent drinkers	Includes: Specialist alcohol services Primary healthcare services Acute hospitals Psychiatric services Social services Domestic abuse agencies	Includes: Alcohol-specific information, advice and support Extended brief interventions and brief treatment to reduce alcohol –related harm Alcohol-specific assessment and referral of those requiring more structured alcohol treatment Partnership with staff from Tier 3 and 4 provision or	Competent alcohol workers	Improvement in health and reduction of alcohol consumption (abstinence or moderation goal)	There is mixed evidence on whether extended brief interventions in healthcare settings add anything to the effects of simple brief interventions There is some evidence that extended brief intervention is effective among male hazardous or harmful drinkers in the contemplation stage of change *Review of the Effectiveness of*

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
		Homelessness services Probation services Prison services Occupational health services	joint care of individuals attending other services providing Tier 1 interventions Triage assessment			*Treatment for Alcohol Problems* (2006)
Tier 3: Community-based, structured, care-planned alcohol treatment	Dependent drinkers	Includes: Specialist alcohol treatment services (in the community or within a hospital site) Outreach services Primary healthcare services	Includes: Comprehensive substance misuse assessment Care planning and review for all those in structured treatment Community care assessment and case management of alcohol misusers Evidence-based prescribing interventions in the context of a package of care, including community-based medically assisted detoxification Evidence-based psychosocial therapies	Competent drug and alcohol specialist practitioners	Reduction of alcohol dependence Improvement in alcohol related social problems	The community reinforcement approach is an effective treatment modality, particularly relevant to service users with severe alcohol dependence. I is particularly effective with socially unstable and isolated service users with a poor prognosis for traditional forms of treatment Social behaviour and network therapy is an effective treatment for alcohol problems Behavioural self-control training is the most effective treatment available for service users considered

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
			within a care plan to address alcohol misuse and co-existing conditions such as depression where appropriate Structured day programmes and care-planned day care Liaison services with other services			suitable for a moderation goal Coping and skills training is an effective treatment among moderately dependent drinkers *Review of the Effectiveness of Treatment for Alcohol Problems* (2006)
Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation	Severely dependent drinkers	Includes: Specialist statutory, independent or voluntary sector inpatient facilities For medically assisted detoxification Residential rehabilitation units for alcohol misuse	Includes: Comprehensive substance misuse assessment Care planning and review for all inpatients residential structured treatment Evidence-based prescribing interventions in the context of a package of care, including medically assisted detoxification in inpatient or residential care Psychosocial therapies to address alcohol misuse Provision of information,	Alcohol specialist in specialist setting	Reduction of alcohol dependence Improvement in alcohol related health problems	

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
			advice and training to others delivering Tier 1, 2 and 3 services			

Substance Misuse

Figure 4 Best Practice Review Substance Misuse: The Four Tiers of Intervention

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment	Wide range of clients including drug and alcohol misusers	Includes: General healthcare settings Social care Education settings Criminal justice settings Drug treatment is not the main focus for any of the above	Includes: Drug and alcohol screening, assessment and referral mechanisms to drug treatment services from generic, health, social care, housing and criminal justice services Management of drug misusers in generic health, social care and criminal justice settings (e.g. police custody) Health promotion advice and information Hepatitis B vaccination programmes for drug misusers and their families	Wide range of professionals including: Medical services Social workers Teachers Community pharmacists Probation officers Homeless person units All need to be sufficiently trained to deal with drug misusers
Tier 2: Open access drug and alcohol treatment services	Wide range of drug and alcohol misusers referred from a variety of	Includes: Primary care settings Outreach Pharmacy settings	Includes: Drug-related information and advice Triage assessment and referral for structured drug treatment Interventions to reduce harm and risk	Competent drug and alcohol specialist workers

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
	sources including self-referral	Criminal justice settings Tier 2 interventions may be delivered separately from Tier 3 but will often be delivered in the same setting and by the same staff as Tier 3 interventions	due of infections for active drug users eg needle exchanges Brief psychosocial interventions for drug and alcohol misuse Brief interventions for specific target groups including high-risk and other priority groups Drug-related support for clients seeking abstinence Drug-related support for clients who have left care-planned structured treatment Outreach services engaging clients into treatment	
Tier 3: Structured community-based drug treatment services	Drug and alcohol misusers in structured programme of care	Includes: Specialist drug services within their own premises, the community or hospital Outreach Primary care settings Pharmacies Prison settings	Includes: Comprehensive drug misuse assessment Care planning, co-ordination and review for all in structured treatment Community care assessment and case management for drug misusers Harm reduction	Competent drug and alcohol specialist workers

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
			Prescribing interventions Psychosocial interventions Liaison services for acute medical and psychiatric health services and for social care services	
Tier 4: Residential services for drug and alcohol misusers	Drug and alcohol misusers with a high level of presenting need	Includes: Dedicated inpatient or residential substance misuse units or wards Those with co-existing medical needs may be being services in the setting of those medical needs Prison detoxification units	Includes: Inpatient specialist drug and alcohol assessment, stabilisation and detoxification/assisted withdrawal services Inpatient detoxification/assisted withdrawal provision directly attached to residential rehabilitation units	Medical staff with specialised substance misuse competency

Mental Health

The NSF Mental Health 1999 set the scene for major investment in mental health services and there are now many Policy Implementation Guides for mental Health. The 'stepped care model' is referred to in, NICE Guidance on Treatment of Depression and in the Improving Access to Psychological Therapies programme. This stepped care model can be utilised across mental health care systems and provides a cross reference point for alcohol and substance misuse interventions.

Figure 5 Best Practice Review Mental Health: Stepped care model

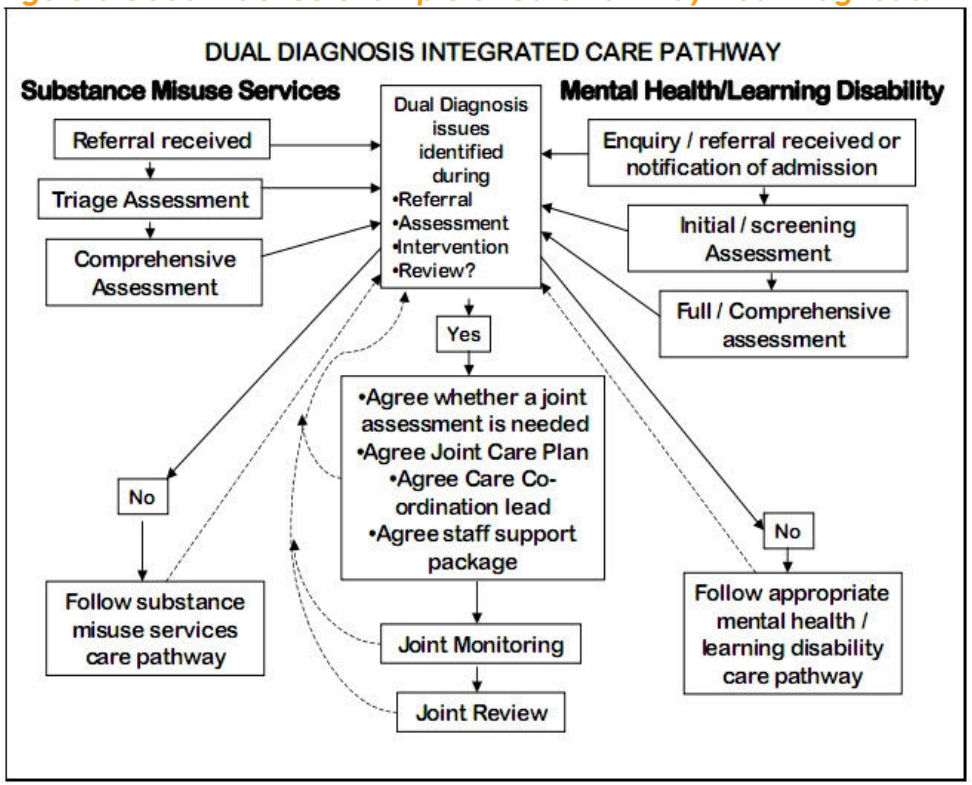
Step	Point of Access	Level of Mental Health Problem	Involves/Intervention	Carried out by
Step 1	Primary care and general hospital setting	Recognition (either the patient refuses treatment or the health professional thinks they will recover without treatment)	Watchful waiting	GP Practice nurse
Step2	Primary care setting	Mild	Guided self-help Computerised CBT Brief psychological interventions	Primary care team Primary care mental healt worker
Step 3	Primary care setting	Moderate to severe	Medication Brief psychological intervention Social support	Primary care team Primary care mental health worker
Step 4	Specialist mental health setting	Treatment-resistant Recurrent Atypical and psychotic depression Those at significant risk	Medication Complex psychological interventions Combined treatments	Mental health specialists including crisis teams

Step 5	Specialist mental health setting	Risk to life Severe self-neglect	Medication Combined treatments ECT	Inpatient care teams Crisis teams

Dual Diagnosis

As the care and treatment of a Dual Diagnosis, or co morbidity of substance misuse (including alcohol) and mental health problems is the combination of best practice from the relevant services the figure 6 below is suggested as a mechanism for ensuring that the 'shared care' 'Integrated approach is achieved. Discussion of this model of care can be found at 'Model of Care' section. Although this diagram references only substance misuse for Halton and St Helens' purposes this should be read to include alcohol too.

Figure 6 Good Practice example of Care Pathway Dual Diagnosis.



(Source Dual Diagnosis A multi – agency strategy for County Durham and Darlington -2005)

This pathway would ensure that any service user who had been referred directly to any service would not 'fall through the net'.

For the avoidance of doubt, the principles of integrated care as drawn in figure 6 can be applied both in primary and secondary care and include alcohol and substances. With the development of the single point of access where, comprehensive multi-disciplinary assessments occur, the expectation would be that the majority of service users requiring a coordinated approach to their care are identifie much earlier in the care system.

Within the Halton and St. Helens Dual Diagnosis Model, ment health services either primary care or secondary care woul take a lead in ensuring that the service user had both the substance and mental health care needs met.

WHERE ARE WE NOW?

LOCAL CONTEXT

This section describes the local commissioning, and provider arrangements
outlines the demographics of the Halton and St Helens footprint.

Overview

At the time of writing this strategy, a number of initiatives were taking place in parallel. Notably the development of a 'single point of access' into mental health services and the development of an Alcohol Strategy. The Mental Health Strategy itself is now due for a review.

Commissioning

Halton and St. Helens Primary Care Trust has recently evolved from the merger of Halton Primary Care Trust and St Helens Primary Care Trust. It currently operates in a complex commissioning context: there are two Local Authorities (Halton Borough Council and St Helens Council), there are two Drug and Alcohol Action Teams (DAAT) and two Local Implementation Teams (LITs mental health). Currently these organisations are responsible for the commissioning of Mental Health, Alcohol, and Substance Misuse Service Services.

Dual Diagnosis provision is a combination of these services led by mental health.

Providers of Service

A range of agencies currently provide dual diagnosis services, across the two localities. Service provision would appear to be variable across the two localities with different service availability, range, and choice.

From the information obtained, from the self -report questionnaires, and subsequent interviews with staff. Greater clarity is required regarding the outcomes services are commissioned to deliver.

A distinction between the tiers of service, service delivery, an outcomes would assist providers and commissioners manag the gaps in service provision.

Insufficient data regarding Halton services required a 'be.. guess' approach to determining the current care pathway.

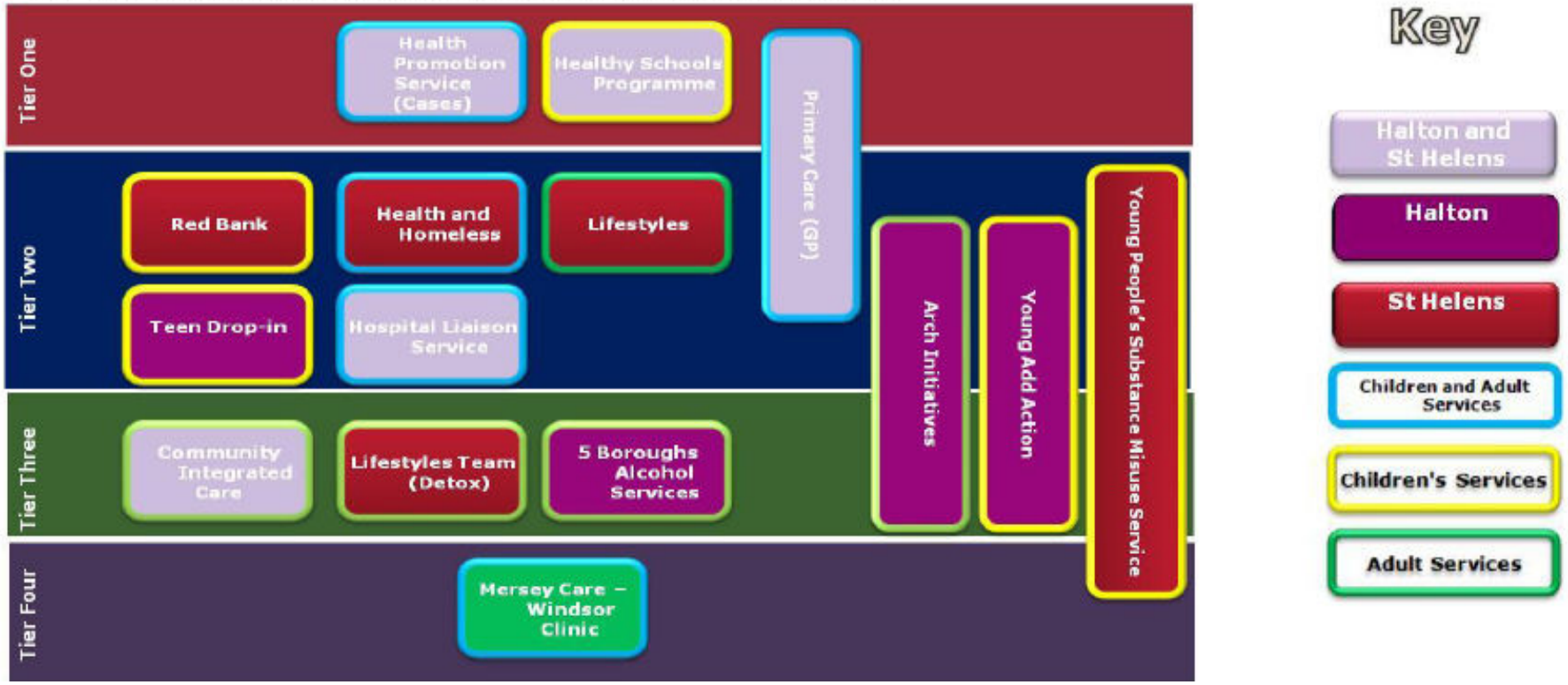
An existing pathway is present in Halton but requires a review in light of this document.

Residential Care recovery is available via the respective Local Authority Community Care Funding Panels.

A more detailed view of alcohol services is provided in the Alcohol Strategy and is reproduced here for convenience.

Figure 7 Alcohol Services by locality

- Tier 1 interventions: Alcohol related information and advice; screening; simple brief interventions (up to 4 interventions) and referral
- Tier 2 interventions: Open access, non care planned alcohol specific interventions and extended brief interventions
- Tier 3 interventions: Community based, structured, care planned alcohol treatment
- Tier 4 interventions: Alcohol specialist in-patient and residential detox



(Source Halton And St. Helens Alcohol Strategy 2008 p17)

The above diagram demonstrates that Halton services include Arch and Young Add Action across Tiers 2 and 3, an Alcohol service provided by the mental health trust for Tier 3 and Teen Drop In providing a Tier 2 service. This compares to St Helens that have a Young Peoples Substance Misuse service provided across Tiers 2, 3 and 4. Lifestyles provide a service to Tiers 2 and 3. Red Bank provide a service to Tier 2. Services shared across Halton and St Helens include; Primary Care, (Tier 1&2. Health Promotion (Tier 1) and Community Integrated Care (Tier 3). This does not indicate the capacity of these services within each of the localities.

DEMOGRAPHICS

In this section brief details of population and deprivation are given. This is followed by an examination of prevalence issues. A more detailed account of Halton and St. Helens demographics may be found in the respective Joint Strategic Needs Assessments.

Population

The total population is 297k composed of 119.5k in Halton and 177.5k in St Helens

The population of Halton is projected to increase by 6% to 126,500 by 2021. An increase of 43% of the 65 plus age group is estimated to grow from 16,400 in 2006 to 23,500 in 2021.

The Population of St Helens is currently 177,500 and is projected to increase by 1% up to 2015. St Helens mirrors the national trend. Like Halton will see an increase in the 65 plus population. By 2015 1:5 people will be over 65 years old.

The ONS mid year estimates for 2007 however, show that there is a significant difference in the 15-64 year populations. St Helens estimated as 116.9k and Halton as 80.2k[24]

Deprivation

Deprivation is linked to an increase in the prevalence of some mental health problems[25] The Index of Multiple Deprivation 2007 (IMD 2007) measures deprivation in small areas (known as super output areas), and consists of seven "domains" relating to income, employment, health and disability, education and training, housing and services, the living environment, and crime.

Twenty three percent of the LSOAs in St. Helens are in the to 10% most deprived areas in England and 27% for Halto However, some areas are ranked as much less deprived. F both Halton and St. Helens 8% of their LSOAs are in the top 25 least deprived areas. The respective Joint Strategic Nee Assessments and Local Authority data will give information that is more detailed.

Prevalence Estimates

[24] ONS Table 9 Mid-2007 Population Estimates: Quinary age groups and sex for local authorities in the United Kingdom.

[25] Amongst many studies, Meltzer H, Gill B, Pettigrew M and Hinds K (1996) **"The prevalence of psychiatric morbidity among adults living in private households: OPCS surveys of psychiatric morbidity in Great Britain"** Report 1 HMSO London: HMSO

According to the ONS, 1 in 6 of adults experience some sort of neurotic disorder, the most prevalent type being mixed anxiety and depression. This is described as a "catch all" category which includes people with significant neurotic psychopathology who could not be coded into any of the other five neurotic disorders. Estimates of life time prevalence range from 1 in 6 to 1 in 4.

At the time of writing, an audit of primary care services was under way in the locality. This audit is to establish the actual number of people within GP practices who would have a substance or alcohol problem co existing with an emotional or psychological difficulty.

Halton and St. Helens Prevalence Summary

1. **Alcohol dependence + any neurotic disorder in general population**

We predict that there are 590 people with moderate/severe alcohol dependence and one or more neurotic disorders. The neurotic disorders are listed below:

- Mixed anxiety and depressive disorder
- Generalised anxiety disorder
- Depressive episode
- All Phobias
- Obsessive compulsive disorder
- Panic disorder

2. **Any drug dependence + any neurotic disorder in general population**

In total it is estimated that 3096 people in Halton and St. Helens have one or more neurotic disorder/s and any drug dependence.

To arrive at the this figures in 1 and 2 above we used data from the psychiatric morbidity survey, Tobacco, alcohol and drugs use and mental health report (2000) and the ONS population estimates for Halton and St. Helen's.

To the informed reader these figures may appear the wrong way around.
For the avoidance of doubt however, 590 cases (an individual may have more than one disorder –see previous paragraph) will experience a moderate to severe **alcohol dependence. Whereas 3096 cases will experience a drug dependence.** I **this context, drug dependence refers to 'any drug'.**

These figures were calculated as follows:
4% of men with any neurotic disorder had moderate/severe alcohol dependence and 0% for women (see http://www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf page 66). Halton and St Helen's male neurotic disorder population is 14,756. And so 4% of 14756 is **590**.

There is estimated to be 12% of males with any neurotic disorder who have ***any*** drug dependence (inc. cannabis, amphetamines, crack, cocaine, ecstasy, tranquillisers and opiates) and 6% for females (see page 70 of Tobacco report).

Applied to Halton and St Helen's male neurotic population this equals 0.12 x 14,756=**1771** and for female neurotics 0.06*22,097=**1326.** So the total for males and females equals **3096** as documented.

3. Substance misuse + mental health disorder in substance abuse population

The prevalence rates of mental health disorder in drug and alcohol services from the COSMIC study (Weaver et al. 2003) and the number of referrals (116 in 6 months) in Halton and St. Helens were used to estimate the number of co-morbid cases.

Estimated Number of Mental Health Cases in Halton and St. Helens PCT's SMS Service April 08 to October 08 (6 month period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

Note: one person can be present in multiple disorder categories above.

4. Dual diagnosis in Adult CMHT and Inpatient services population

Assuming there is a similar level of referrals over time, the Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

The total number of referrals used to arrive at these figures was sourced from Halton and St. Helen's own activity data. The prevalence rates are taken from DH policy guidance.

Current Demand

The information available to date includes:

The numbers recorded in treatment for St. Helens 01/07/2007 to 30/06/2008 is 1025

The numbers recorded in treatment for Halton 01/07/2007 to 30/06/2008 is 709

Those in Alcohol treatment in Halton and St. Helen at November 2008 are No in treatment – 588
New Presentation – 41
No in Treatment YTD – 989

This equates to 2723 people who are or, have been treated for a substance abuse problem in the last year.

Commissioner feedback included the fact that 96 people were in treatment (Drugs Service) 20 of whom were in contact with mental health service the remaining 76 were considered to have anxiety and depressive problems but 73 were not in contact with any mental health service

Mental Health data informs us that

1. Halton and St Helens GPs have registered 2324 people with a severe and enduring mental health problem (Primary Care Trust Data)

From Tony Ryans & Associates: Case Load Audit of 5 Boroughs Partnership NHS Trust (5BP) report July 2007

2. Halton >65 population 606 people receiving a service from 5BP
3. Halton 16-64 population 1314 people receiving a service from 5BP

Total Halton 1920 people

4. St Helens >65 popn 1422 people receiving a service from 5BP
5. St Helens 16-64 popn people receiving a service from 5BP
6. Total St Helens 3367 people

Open cases to 5BP as at 20/01/09 5BP data
Halton = 4504
St Helens = 4700
Total 9204 people

This data would benefit from further analysis to begin t determine trends and a 'mostly likely' figure of actu incidence of Dual Diagnosis.

There would be some merit in determining prevalence or expected demand range against actual activity. This would highlight the success of the care pathway in identification, assessment, and treatment of those with co morbidity.

Performance

This section will consider the relationship between this strategy and substance misuse targets. The section will compare the performance of Halton and St Helens in relation to 'statistical near neighbours'.

The tables below show the relevant statistical neighbours as per CIPFA Model further information regarding this model can be found at: www.cipfastats.net

Figure 8 Statistical Neighbours of Halton UA

Position	Neighbour Authorities	Statistical Distance	Corresponding PCT
1	Stockton-on-Tees	0.05	North Tees Primary Care Trust
2	Middlesbrough	0.08	Middlesbrough Primary Care Trust
3	Telford & Wrekin	0.08	Telford and Wrekin Primary Care Trust
4	Hartlepool	0.10	Hartlepool Primary Care Trust
5	Darlington	0.11	Darlington Primary Care Trust

Figure 9 Statistical Neighbours of St. Helens LA

Position	Neighbour Authorities	Statistical Distance	Corresponding PCT
1	Rotherham	0.04	Rotherham Primary Care Trust
2	Wakefield	0.06	Wakefield District Primary Care Trust
3	Barnsley	0.07	Barnsley Primary Care Trust
4	Wigan	0.08	Ashton, Leigh and Wigan Primary Care Trust
5	Doncaster	0.09	Doncaster Primary Care Trust

Source: CIPFA Nearest Neighbours Model http://www.cipfastats.net/

The data in the tables below are derived from the HCC annual health check 2007/8. The HCC get the data from the National Treatment Agency.

Figure 10 An assessment of the 12 week retention rate for Financial Year 2007/2008 in comparison with the 12 week retention rate for Financial Year2006/2007

PCT	%
Ashton, Leigh and Wigan Primary Care Trust	92.2
Doncaster Primary Care Trust	101.0
Telford and Wrekin Primary Care Trust	103.8
Halton and St Helens Primary Care Trust	**105.0**
Middlesbrough Primary Care Trust	106.3
Wakefield District Primary Care Trust	107.1
Hartlepool Primary Care Trust	109.3
North Tees Teaching Primary Care Trust	111.0
Rotherham Primary Care Trust	113.9
Barnsley Primary Care Trust	115.9
Darlington Primary Care Trust	119.2
Comparator Average	108.0
England Average	104.4

Source: HCC http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9590

The above table compares the 12 week retention rate of service users in the years 2006 / 07 to 2007 / 08

Measuring the percentage of drug misusers who were retained in treatment for 12 weeks or more, focuses on the effectiveness of the local treatment system in engaging drug users and minimising early drop out.

Evidence suggests that drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more, resulting in reduced drug use, reduced morbidity and mortality associated with misuse, reduced crime and improved health and social functioning. Benefits include substantial

financial savings in both the criminal justice system through reduced offending and in the NHS through reduction in blood-borne diseases amongst drug misusers.[26]

This table tells us that Halton and St. Helens perform less well than their statistical neighbours (ranked 8 out of 11) but better than the England average. It also shows us that Halton and St Helens are keeping more drug users in sustained treatment (12 weeks+) than they were the previous year in 2006/7 (but all of the neighbours did better than the previous year except for Ashton PCT.)

Figure 11 The actual number of drug misusers accessing treatment divided by the planned number of drug misusers accessing treatment

PCT	%
Rotherham Primary Care Trust	107.6
Middlesbrough Primary Care Trust	125.0
Halton and St Helens Primary Care Trust	**131.7**
North Tees Teaching Primary Care Trust	132.4
Ashton, Leigh and Wigan Primary Care Trust	132.4
Wakefield District Primary Care Trust	134.4
Doncaster Primary Care Trust	134.6
Telford and Wrekin Primary Care Trust	141.1
Darlington Primary Care Trust	146.3
Barnsley Primary Care Trust	148.1
Hartlepool Primary Care Trust	165.7
Comparator Average	136.8
England Average	125.8

Source: HCC http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9590

The above table shows that all of Halton and St Helen statistical neighbours outperformed their local PCT plan fo how many drug misusers they would have in treatment. Halto and St . Helens outperformed less than the comparato average but more than the England average.[27]

[26]http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisuserssustainedintreatment.cfm

[27]http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisusersintreatment.cfm

STAKEHOLDER FEEDBACK

In this section stakeholder, views are recorded. Stakeholders in the Dual Diagnosis strategy cover a wide range of organisations and individuals. This includes; alcohol and drug misuse services alongside mental health services. These services are statutory and non – statutory in origin.

The key themes included the following.

Defining Dual Diagnosis: Most people when considering dual diagnosis as a topic immediately refer to the relative low prevalence, high cost, high risk, high complexity, highly dependent poly drug users with psychosis requiring multi-agency interventions. However, almost without exception, most went on to say...

Alcohol is greater concern than substance misuse: In terms of volume and impact upon the whole community alcohol was perceived to be a far greater issue. Alcohol impacted upon all age bands, economic classes, it has significant impact upon the criminal justice, public health and treatment agendas.

Shared Care: there were issues about the roles, responsibilities between statutory and 3rd Sector agencies. Services providers often work in silos: sometimes by choice, on other occasions out of necessity due to exclusion criteria (e.g., some mental health services refusing to work with individuals who were still drinking). All stakeholders acknowledged the need to 'share' the care for individuals both in the formal sense and in a more informal mutually supportive manner. In some areas clear protocol existed with clear structures of accountability in others this was not the case. In all cases appropriately qualified individuals needed to be engaged to ensure appropriate governance

Clarity in Commissioning intentions: the flip side of the shared care approach was the articulation that each service should have a clearly defined role and purpose and that these should be explicitly agreed in advance with commissioners. Currently due to a desire to collaborate (i.e., share the care) some services are providing support that they were never commissioned to do, or conversely they are not providing services due to the explicit documentation in their service level agreements or contracts. In both instances the gap in service provision is masked: where there is a gap in service provision should be provided for by appropriately funded an commissioned services. Commissioners contended in respons that there was not a lack of clarity regarding their intentior and expectations, rather there was on occasions a lack c providers 'hearing' what was being articulated.

Efficient and effective commissioning: in support of the above point stakeholders expressed a view that DAAT commissioning and Mental Health commissioning could be brought together or ***aligned***. This would maximise resources, attain best value, and address eligibility criteria. Performance management could also be unified across the commissioning process with providers being clear what key performance indicators were being measured. (see also alcohol strategy where this is also an issue)

Single point of Access: awareness of the emerging single point of access for mental health services is variable across the localities and consequently different practices of referral and routes into services persist. This results in too great a variation in who gets (or doesn't get) accepted into services, and for a perception that many people remain in the service of first contact regardless of whether that was the most appropriate one.

Crisis Access: A frequent comment from those who work in primary care services was that there is a need for an alcohol and substance misuse crisis service. Too often other agencies criteria for access will not intervene at the point of greatest need, resulting in an escalation of issues and risks.

Pathway gaps: For those who do access services there are not sufficiently robust care pathways for service users to navigate. Service offerings and therefore their outcomes vary significantly between services. The greatest articulated gap appears to be that between primary and secondary care services (between tiers two and three).

Pathway blocks: Even where there are defined pathways to access services there is too often a wait between referral and intervention. This is most notable in brief interventions in primary care that 'open up' deeper issues for individuals but then they have to wait up to 4 months to have their needs addressed in a distressed state. Similarly, there are still reported waiting issues in accessing detoxification and rehabilitation support resulting in a further deterioration in individuals, including on occasions fatalities. Tier 4 services are reported hard to access both in psychiatric and general hospital services.

Variation in provision and providers in each locality: Dual Diagnosis practitioners operate within St Helens CMHTs and recent appointments have been made to Halton CMHTs.. Stakeholders also debated the role and function of this role it was felt that this role should be more of a consultative function and a support to other workers and agencies, rather than 'hold a case load'. This was perceived to be a misuse of their expertise as they would soon become ineffective due to under capacity. In other words they would spend all their time working with single individuals they would not be able to tackle the wider partnership and interface issues needed to deliver seamless care.

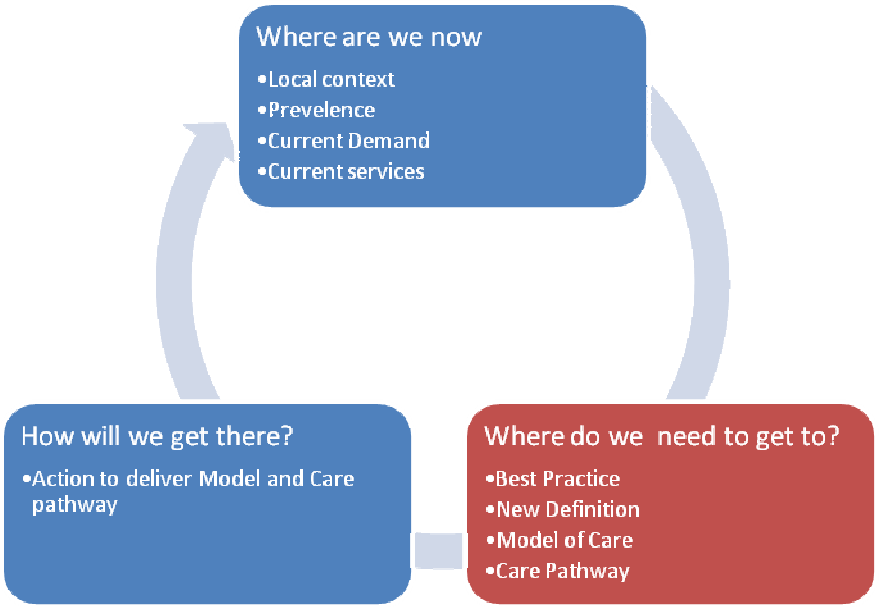
The Arch service operates in Halton and is based at Ashle House. Young Addaction and the 5 Bouroughs Partnershi Alcohol services also operate in Halton. The Lighthouse projec services St Helen's. CIC provide different services to th different localities. There was an articulation that a singl consistent pathway(s) should be developed in both areas even if the agencies that provide it are different.

Specialist verses generic?; Despite specialist dual diagnosis practitioners being funded, there was a strongly held view that give +75% of service users in secondary mental healthcare had some form of alcohol or substance misuse issue, then shouldn't all staff have addiction training as a core skill?

Need for more training: Whether, generic or specialist there was a clearly articulated view that greater addiction training was required for all staff grades tailored to the tier of care in which they operate.

Governance: The complexity of the client group's needs, the range of agencies concerned and the demographic and geographic issues there is a perception of a lack of leadership at a strategic level. The process of developing this strategy has been welcomed but stakeholders have expressed the view that clearer roles and responsibilities need to be established between the DAAT, the LIT, public health and the criminal justice system. More 'joined up' commissioning for all age groups is required and the consensus appears to be for this to be led by the PCT.

WHERE WE NEED TO GET TO!



MODEL OF CARE & CARE PATHWAY

In this section, a model of care is defined. This has been influenced strongly by the views of stakeholders and all the previous sections.

Key Features of Model

As stated above in the Stakeholder feedback emphasis on Integrated and shared care was a key theme

Shared Care

> Shared care is the joint participation of specialists and GPs [and other agencies as appropriate] in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange beyond routine discharge and referral letters. It may involve the day-to-day management by the GP of the patient's medical needs in relation to his or her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the patient's treatment and care. These may include prescribing substitute drugs in appropriate circumstances".[28]

> Medical practitioners should not prescribe in isolation but should seek to liaise with other professionals who will be able to help with factors contributing to an individual's drug misuse. A multidisciplinary approach to treatment is therefore essential."[29]

Integrated Care

Integrated care is an approach that aims to **combine** and **co-ordinate** all the services required to meet the assessed needs of the individual.
It requires:

- treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug and alcohol users;
- the service response to be needs-led and not limited b organisational or administrative practices; and
- collaborative working between agencies and servic providers at each stage in the progress of the individual i treatment, from initial assessment onwards

People who have drug or alcohol misuse problems will, in many cases, have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behaviour and debt. This means that a wide range of interventions and a range of organisations will need to be involved to assist any individual with substance misuse problems.

[28] Dept of Health 1995 and *Drug Misuse and Dependence: Guidelines on Clinical management*. Department of Health 1999)

[29] Drug Misuse and Dependence – Guidelines on Clinical Management 1999

An integrated care approach founded on co-operation and collaboration between all relevant providers will have a number of benefits for individual service users. It should:

- Promote early assessment and intervention: ensuring that services are accessible and appropriate to the service user's needs.
- Remove barriers to progressing towards recovery: supporting the service user to identify and achieve their own goals whilst acknowledging their own beliefs and culture.
- Provide consistent, co-ordinated and comprehensive care: ensuring that all care providers are working towards a shared aim and minimising unnecessary duplication of activity.
- Ensure a comprehensive and timely response: making sure that all the needs of the service user, physical, psychological and social, are considered and addressed appropriately.

The **overarching aim** of integrated care is to support drug or alcohol users to overcome their drug or alcohol problem and their associated health and social difficulties by providing effective, co-ordinated and timely treatment and care.[30]

As this strategy is also about individuals who experience mental health problems as well as drug or alcohol difficulties it is even more important to ensure that a 'shared care' 'integrated approach' is the foundation upon which we develop services and our approach to service delivery.

The main problem is in determining the referral pathway. When the severity of both mental illness and substance misuse is high, then shared care working between mental health and addiction teams might be the best solution. If the substance misuse and mental health issues are of a moderate nature then the agency first attended may be able to deal with both issues. However, the agency would need to be well supported and staff appropriately trained.

Figure 12 Allocation of care by need

[30] (2008) *Integrated Care for Drug or Alcohol Users: Principles and Practice Update* 2008 Available from http://openscotland.gov.uk/Publications

	Low degree of mental illness	High degree of mental illness
Low level of substance use	Mainstream or addiction service Anxiety spectrum disorders Depressive disorders Moderate severity personality disorders	Mainstream service only Korsakoff's psychosis and dementia Severe personality disorder Obsessive-compulsive disorder
High level of substance use	Addiction service only Withdrawal states including delirium Wernicke's encephalopathy Residual psychoses	Mainstream and addiction services Schizophrenia Bipolar affective disorder Post-traumatic stress disorder

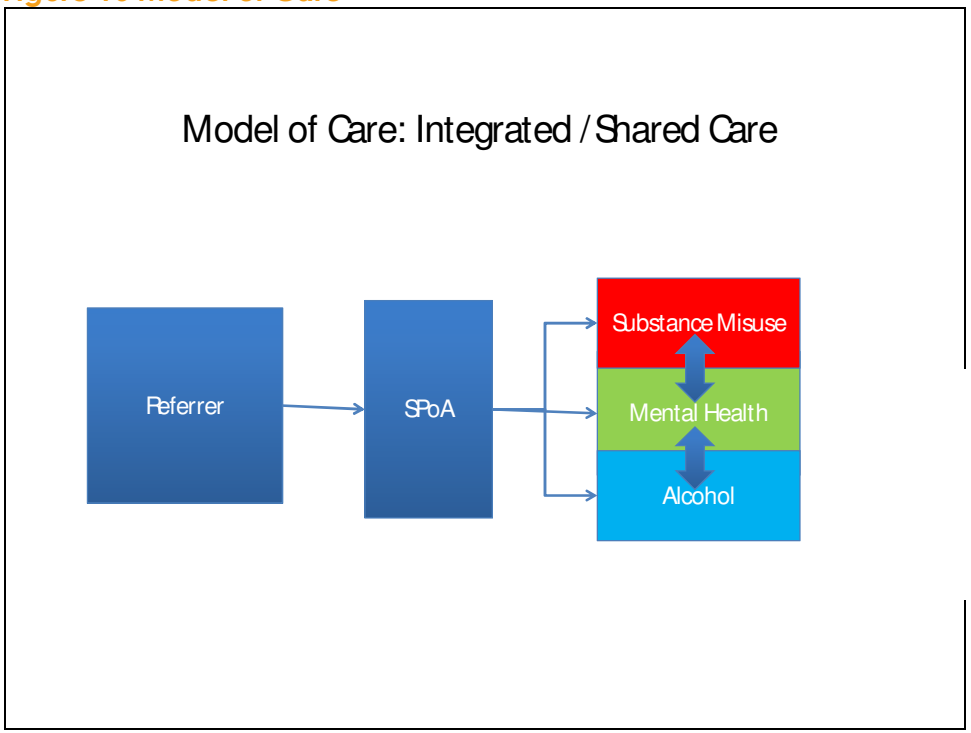
Table 13d: Example of possible allocation of care by diagnostic group

(Adapted from Department of Health (2002))

(source NTA for substance misuse –Review of effectiveness of treatment for alcohol problems Raistrick et al –DH 2006 p158)

The above table depicts a model for allocation of care. People with a low degree of mental illness can be supported by primary care. Whereas a high degree of mental illness must be supported by secondary care services.
This can mean a high number of people with mild /moderate dual diagnosis issue receive their care within primary care services and this is an area that requires further development in order to support primary care practitioners

Figure 13 Model of Care



(adapted from National Treatment Agency for Substance Misuse – Review of the effectiveness of treatment for alcohol problems (DH 2006) Raistrick D et al. Service models p157)

The above figure depicts the proposed model. Here referrers including self- referral are made through a single point of access. At this point a multi-disciplinary assessment is carried out. This will ensure that, the individual is assisted to engage, with all the relevant elements of service. As can be seen in the diagram mental health services overlap with both substance

and alcohol services, so indicating an integrated and shared care approach.

Commissioning integrated care pathways

An integrated care pathway (ICP) describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. A system of care should be dynamic and able to respond to changing individual needs over time. It should also be able to provide access to a range of services and interventions that meet an individual's needs in a comprehensive way. Previous consultation has shown that the majority of respondents found that the ICPs set out in Models of Care 2002 had been useful to them in their work. ICPs should be developed for drug and alcohol misusers for the following reasons:

- Drug and alcohol misusers often have multiple problems that require effective co-ordination of treatment.
- Several specialist and generic service providers may be involved in the care of a drug and alcohol misuser simultaneously or consecutively.
- A drug and alcohol misuser may have continuing and evolving care needs requiring referral to services providing different tiers of intervention over time.
- ICPs ensure consistency and parity of approach nationally (i.e. a drug misuser accessing a particular treatment intervention should receive the same response wherever they access care)
- ICPs ensure that access to care is not based on individual clinical decisions or historical arrangements.

Elements of integrated care pathways

Commissioners should ensure that each drug and alcohol treatment intervention should have an ICP. This should be agreed with and between local providers, and built into service specifications and service level agreements.

Integrated care pathways should contain the following elements:

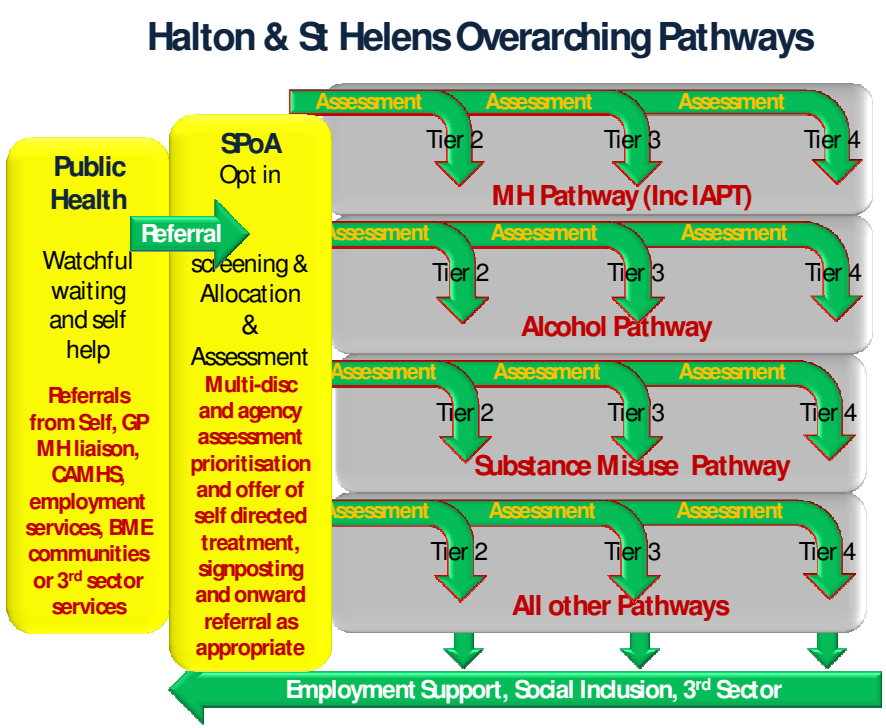
- A definition of the treatment interventions provided
- Aims and objectives of the treatment interventions
- A definition of the client group served
- Eligibility criteria (including priority groups)
- Exclusions criteria or contraindications
- A referral pathway
- Screening and assessment processes
- Development of agreed treatment goals
- A description of the treatment process or phases
- Co-ordination of care
- Departure planning, aftercare and support
- Onward referral pathways
- The range of services with which the interventions interface.[31]

[31] National Treatment Agency for Substance Misuse. (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*

Care Pathway

With the above in mind and taking into account the views of stakeholders, the following is the proposed care pathway

Figure 14 Overarching Care Pathway



The above diagram adds some detail to the 'Model of Care Diagram'. This shows that following a referral and assessment that there are a range of service options in various pathways of care at different levels of need to meet the individuals' needs for care and treatment. The expectation would be that Mental Health Services from either primary care or secondary care services would take a lead depending on the severity of the mental health issue.

NHS Contracting have developed a specific care pathway for alcohol services and this can be found at http://www.pcc.nhs.uk/204.php

The proposed role of Advanced Practitioner in Primary Car would be critical to the success of this model. The Advance Practitioner would carry out a similar role to that of the Du Diagnosis Worker in Secondary Care.

It is envisaged that these roles would provide support and supervision/consultation to staff across both the statutory and non - statutory services. They would take responsibility for ensuring appropriate protocols were in place and that compliance to these was ensured. The remit of the AP would be to ensure that the interface between primary and secondary care was clear and those individuals moving from one area of care to another did so with minimal disruption to their care. A primary role would be co-working with colleagues. It is not envisaged that these role would manage a case - load.

The above diagram now shows the specific care pathway for Dual Diagnosis.

Mental Health Services will lead this and from the Tier 3 point onwards be care coordinated from the secondary care mental health service. Access to Tier 4 services – inpatient detoxification will be via the crisis resolution and home treatment team in accordance with their role and function to ascertain that inpatient care is the only safe option and best meets the individual care needs. It is anticipated that this will be agreed in conjunction with the Dual Diagnosis Worker and Care Coordinator.

Figure 15 Halton and St Helens Dual Diagnosis Care Pathway

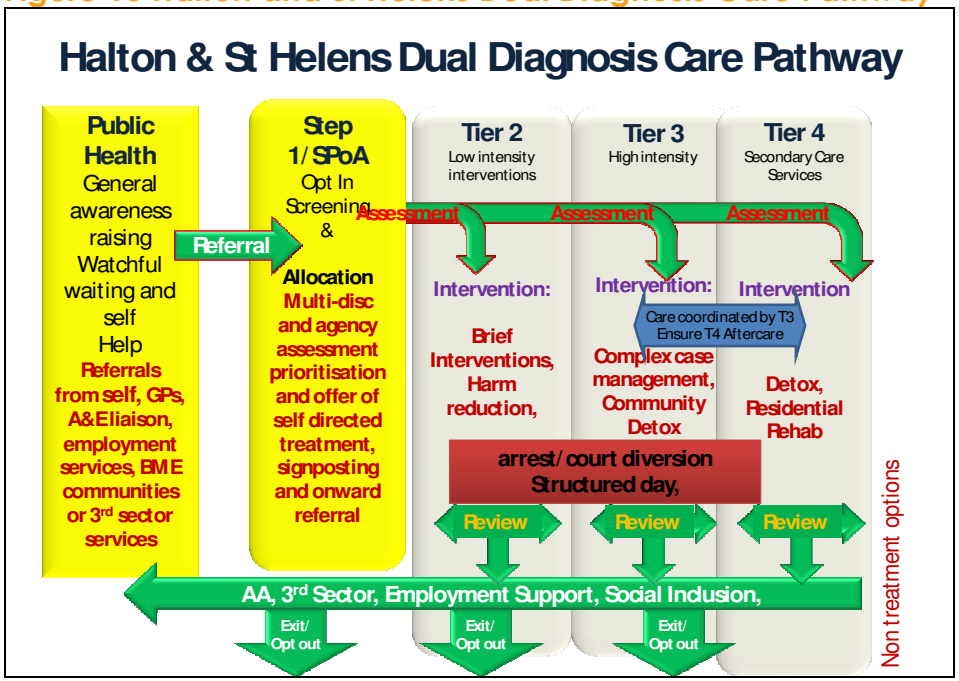


Figure 16 Operational Map – Care Pathway

T1 Primarily Public Health Information self help access to health trainers, lifestyle options
T2 Primary Care inc IAPT services Brief interventions low needs
T2/3 Advanced Practitioner - moderate to severe needs - provides supervision, consultancy, training to Primary care (equivalent to Mod Matron)
T3/ 4 Blue/Red = 5BP these services also include members of Local Authority Social Care Services
Consultant Nurse Practitioner provides link between 5BP and other services
T3 DD Worker
Moderate to severe need plus SMI.
(as Adv Prat but in 2° Care)
All inpatient services via CRHT inc Detox
3rd Sector includes structured day services

The diagram above shows how this model of care might look utilising current services and organisations.

The aim with this model of care and operational map is to highlight the need for one care pathway across the Halton and St Helens footprint. However, there may be different providers of service. The intention is to ensure equitable services across the localities. This may mean extending the remit of some service to include both Halton and St Helens.

The following features will underpin commissioning intentions and the further development of a 'whole systems approach' to commissioning dual diagnosis services

- A broad spectrum of provision which is primary and community focused.
- Access locally to a complete range of primary and secondary services
- Improved pathway of care between services irrespective of provider
- Non reliance on inpatient care
- Integrated pathways where these can improve outcomes.
- Jointly commissioned services by Primary Care Trust/Local Authority
- Broad range of providers giving service user choice
- Service Users and Carers pro-actively involved in the commissioning planning delivery and quality control of services.
- A focus on prevention and promotion of health and well being
- Development of a broader range of social prescribing
- Avoidance of large institutional settings
- Services and their delivery will be based on individual assessment of need.
- A needs led service irrespective of age, or disability

In order to implement an equitable service across the locality ensuring that each locality has access to the complete range of primary and secondary services (Tier 1 to 4) a review of contracted services will be necessary. The aim of the review will be to ensure that a 'whole systems approach' is being commissioned that ensures consistency, continuity, and collaboration.

Summary

This section has identified the proposed model of care to b adopted based on a 'shared care – integrated approach' .. has stated the basic principal of Dual Diagnosis Care being led by Mental Health Services whether this is in Primary or Secondary Care. To facilitate this, the role of Advanced Practitioner will be developed and work in conjunction with Dual diagnosis Workers in Secondary Care.

Figure 32/33 shows a Care Pathway that is aimed at ensuring an equitable, and integrated approach is delivered.

This section further identifies a number of features of the model that will underpin commissioning intentions to develop a 'whole systems approach' to 'Dual Diagnosis'

CONCLUSION - COMMISSIONING INTENTIONS

This strategy has set out the definition of Dual Diagnosis to be adopted. This definition embraces the principle of inclusion. That is, those who need a service will be offered care and treatment and that eligibility criteria will not stand in the way of accessing care.

The model of care to be adopted is based on best practice and the principle of 'mainstreaming'. This model is based on the practice of 'integrated and shared care.' The care pathway to be adopted seeks to reinforce the practice of integration. Mental Health will take a lead in the coordination of care for those experiencing both a mental health problem and a substance misuse dependency. To facilitate this role of Advanced Practitioner in Primary care will be developed and a review of the role of Dual Diagnosis Worker in secondary care will be undertaken.

Demand

Based on our analysis within Halton and St Helens Primary Care Trust footprint there is projected to be, be 36,900 cases of neurotic disorder (one individual may have more than one type of neurotic disorder). Of this identified population, 590 cases are likely to be moderate to severe alcohol dependence.

The analysis further identifies a projected 3096 cases of neurotic disorder and some form of drug dependence.

Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

Halton and St. Helens reported 116 appropriate referrals to their SMS teams. The figures in the table below are calculated using the 116 referral figure and the prevalence rates from the COSMIC study (Weaver et al 2002).

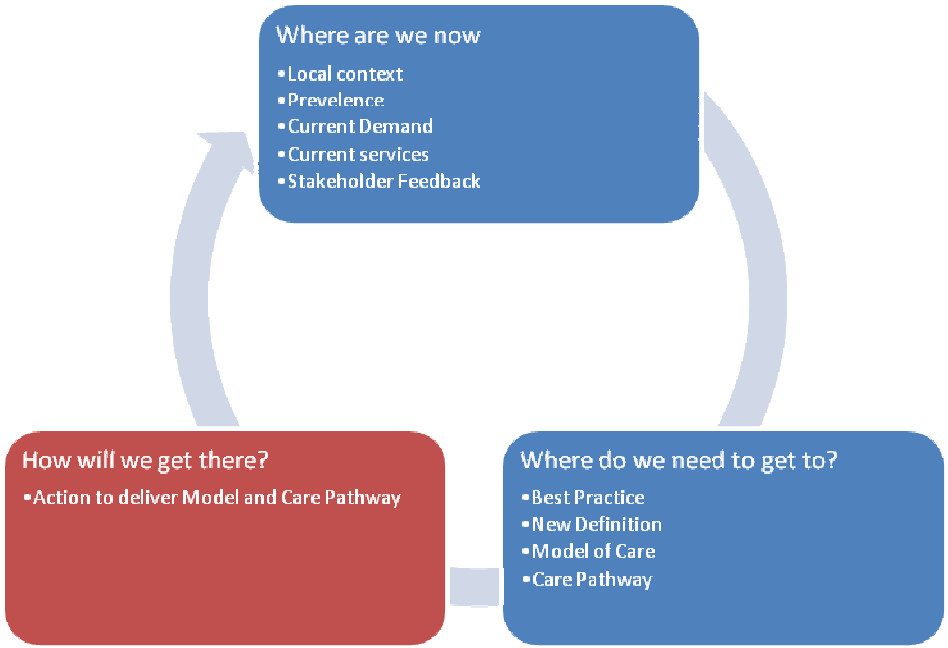
Estimated Number of Mental Health Cases in Halton and St. Helens PCT's SMS Service April 08 to October 08 (6 months period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

In this strategy document, we have used reported data in relation to the demand and estimates have been calculated accordingly. It must be noted however, that stakeholder feedback suggested that the majority people experiencing a mental health problem had an alcohol or drug problem. This may be due to individuals 'self-medicating' and that many people with a drug or alcohol problem also had a mental health issue.

A range of actions is now necessary to implement this strategy. A detailed account of these actions follows.

HOW WE GET THERE



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This section sets out the action now necessary to implement this strategy.

Each of these actions is set out within a template that describes the initiative to deliver the model.

Actions

The first of these actions will be to review the current commissioning mechanisms. Stakeholder feedback supported a move to a more aligned commissioning process. The proposal is to develop a joint commissioning board that will commission services that implement integrated care pathways for people who have both mental health and substance misuse (including alcohol) issues.

This would facilitate a coordinated approach to commissioning with a lead commissioner identified. A 'best value' approach will then be facilitated.

A performance management process equitable across Halton & St Helens with core key performance indicators and outcome measures to be delivered identified for each tier of service and provider.

Establishing the model of care and single care pathway will bring benefits to both service users and providers clearly establishing role and function This would demonstrate clarity of entry and exit points within services.

As part of this care pathway development, the implementation of the single point of entry to services will facilitate good assessment and care / treatment options being identified.

The development of a work force plan is integral to this strategy to ensure that all staff at all levels have the appropriate skills and qualification to deliver the care and treatment required. This work force plan will also include training, advice and support for primary care staff to ensure appropriate governance regarding 'shared care'

This workforce plan will also take account of the need to develop the role of Advanced Practitioner in primary care and the review of the role of Dual Diagnosis worker in secondary care and the role of Support, Time and Recovery (STaR) workers in primary care to develop an individual's capacity for adopting various strategies in relation to 'social problem solving'

The development of service specifications in line with the ne NHS standard contract will be developed as part of th process. Attention will be given to eligibility criteria an interface issues between services, Tiers of service deliver between organisations and between primary and secondai care. The principle adopted will be 'criteria for inclusion'.

Further reflection is required to ensure that all individuals have access to crisis services when required, irrespective of their dependence on substances.

The development of a specific dual diagnosis service user forum in Halton based on the model already in place in St Helens, will be undertaken.

The development of a Provider forum will be established to promote integrated working between providers, to assist identify blockages and barriers to service delivery. It will, also,

provide commissioners with the opportunity to discuss gaps in service and identify ways in which these may be filled.

As the Model of Care is developed and care pathway implemented commissioning will be based on the priorities identified to meet capacity and capability of delivering the model and care pathway.

To ensure that this strategy is complemented and a 'strategic fit' it is recommended that the current Mental Health Strategy be reviewed as soon as practicable.

An implementation plan to deliver this strategy will now be required.

INITIATIVES TO DELIVER THE NEW MODEL #1

Initiative Title **Review current commissioning process and mechanisms with a view to developing a joint commissioning group for mental health, alcohol, and substance misuse services.**
Rationale (including evidence base) Current commissioning is via several commissioning groups and sources of revenue. This leads to duplication and a lack of coordination A Dual Diagnosis commissioning group would facilitate a coordinated approach and achieve 'best value' across primary and secondary care This is in line with new contracting guidance
Current position There are two Local Authorities Two DAATs one Primary Care Trust. Two Local Implementation Teams, One Mental Health Provider Trust and numerous 3rd sector providers. Revenue sources are: Alcohol, Substance Misuse, Mental Health plus education, public health and other social care sources
Commissioner Issues Develop a project group which includes all commissioning partners including PCT, PbCs, Local Authorities Develop a strategic action plan Develop an implementation plan
Provider Issues Providers need to recognise the authority and position of commissioning organisations
Financial impact

The review will necessitate commissioners devoting time to undertake the review.
Cost will be in terms of organisational / individual time.
The review may identify some efficiency savings.

Timescale

Primary Care Trust and Local Authority Commissioners identify Dual Diagnosis Commissioning Group - September 2009
Agree Strategic Plan for change - October 2009
Implementation of Change - March 2010

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reduction in health inequalities
5. Manage knowledge and undertake robust regular needs assessments – develop a full understanding of current and future local health needs
10. Manage the local health system
11. Make sound financial investments to ensure sustainable developments and value for money

Also new contract guidance suggests a coordinated approach to commissioning is the preferred option.

Links to other local strategies and initiatives

Mental Health Strategy
Alcohol Strategy
Substance Misuse
Ambition for Health

Expected Outcomes

Reduction in the possible duplication of services commissioned by current substance misuse and mental health commissioning Boards.
Increased collaborative and integrated working between services.
Early intervention for people with dual diagnosis, especially those currently receiving care in primary care services only.
Clear and easily accessible care pathways.

Agreement on cordinated use of resources
How this will benefit service users and their carers By collaborative coordinated commissioning, more service users will benefit from accessing the appropriate interventions. As services will be better coordinated the 'patient journey' will become clearer and smoother interface between organisations and services will develop. This should result in a better service user experience.

INITIATIVES TO DELIVER THE NEW MODEL #2

Initiative Title **Develop a performance management process which is robust, equitable, and consistent across Halton & St. Helens footprint**
Rationale (including evidence base) The development of core key performance indicators and outcome measures applicable to all providers. This will enable commissioners to actively compare providers and ensure delivery of outcomes commissioned. – This is a value for money issue alongside promoting improvement and innovation.
Current position There would appear to be a lack of coordinated KPI and outcome measures across the locality therefore no base line
Commissioner Issues Development of core KPI and outcome measures applicable to all services This links to the new contract development. This is core data for the contract. The core KPI and Outcome measures will need to be implemented and enacted.
Provider Issues Ability to provide data on request Development of data improvement plan Development of quality improvement plan Development of data sets, performance management as set by commissioners. This is part of the new contract development and key to its success.
Financial impact The development will necessitate commissioners and providers both statutory and non-statutory devoting time to undertake the development work Cost will be in terms of organisational / individual time. Costs in developing framework and agreeing implementation Time of individuals to agree and implement a reporting framework. Cost of any IT solutions to implementing reporting framework

Timescale

Development of project group - September 09
Identify Core KPI and Outcome measure - January 2010
Develop reporting mechanism - February 2010
Go live - April 2010
This links to new contract development

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
6. Prioritise Investment according to local need and service requirement
8. Promote and specify continuous improvement
   Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality outcomes
11. Make sound financial investments

Links to other local strategies and initiatives

This links to the all the Primary Care Trusts key activities – primarily contracting and performance management

Expected Outcomes

Agreed joint key performance indicators and outcomes for dual diagnosis service users, their carers and families.
Integrated performance management of services for people with dual diagnosis
Robust data collection
Improved service user and carer outcomes

How this will benefit service users and their carers

It ensures quality care and outcomes, best value process will enable more service users to benefit from appropriate and timely interventions. It will also hold services to account. One of the measures will be the data received from the Patient Survey so the service user's voice will be clearly captured and reflected in the performance management of services.
The data will enable service users to make informed choices where there are comparable services and interventions suited to their needs

INITIATIVES TO DELIVER THE NEW MODEL #3

Initiative Title **Establish the model of care and care pathway including the single point of access.**
Rationale (including evidence base) This would facilitate better access to services and interventions, avoid duplication. This would give clarity to commissioners, providers and most importantly service users and their carers as to the expected 'patient journey' Each organisation and discipline would understand their role and function and that of others Deliver a better service user experience
Current position There would appear to be an unclear alcohol pathway. There are identified barriers to accessing mental health services There is a lack of capacity and capability at some levels of service
Commissioner Issues Develop a project group Develop project plan Develop an implementation plan
Provider Issues Providers statutory and non statutory will be required to engage with commissioners to ensure best outcomes are delivered to service users. Providers will be required to engage in service redesign and modernisation processes.
Financial impact Commissioners and providers will need to ensure sufficient time and appropriate staff are enabled to undertake this work. Therefore, initial costs will be in terms of organisational and individual time. Implementing the model and care pathway will necessitate a review of commissioned services and reviews of individual contracts. Service redesign and modernisation process are likely to have financial implications It may be that providers are required to extend their current service delivery across both Halton and St Helens.

Further capacity may also be required at tiers 2 and 3
The implementation of the Advanced Practitioner role will incur significant costs. Funding for these roles have been allocated within Mental Health Development Funding

Timescale

Development of Project Group - September 09
Development of Project Plan - December 09
Development of Implementation Plan - February 10
Pilot Model and Care Pathway - April – June 10
Implementation of Model and Care Pathway - September 10

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
7. Stimulate the market
8. Promote Improvement and Innovation
10. Manage the local health system
3. Engage with public and patients

Links to other local strategies and initiatives

This Model of Care will primarily link to the following strategies and services:
Public Health, Alcohol, Mental Health, Substance Misuse

Expected Outcomes

Clear and accessible care pathways that make sense to referrers and service users and carers.
Early interventions in primary care that are coordinated and integrated which will offer help and support at the earliest opportunity to those experiencing both mental health and substance misuse problems.
Agreed protocols between mental health and substance misuse services that eliminate the blockages to people receiving integrated care.
A holistic assessment that focuses on the needs of the individual rather than just the diagnosis and facilitates help for identified health and social care problems.

How this will benefit service users and their carers

The proposed new model of care and care pathway will facilitate easier access and integration of service. This will ensure a better service user experience. Service users in future will experience one comprehensive assessment of their needs. This will facilitate an integrated care package from the start of their treatment. This avoids silo service delivery and will shorten the overall duration of interventions for many people.

INITIATIVES TO DELIVER THE NEW MODEL #4

Initiative Title

Development of Workforce Plan

Rationale (including evidence base)

Explain the need and the objective of change

Ensure a staff compliment that is equipped and supported to deliver high quality care.

Ensure that all staff across both health and social care are equipped to deliver; advice and brief interventions at first point of contact.

Ensure key staff are qualified and meet the minimum standards required to be commissioned to undertake 'shared care' responsibilities.

Ensure sufficient capacity and capability are employed to deliver high quality care

Develop new role of Advanced Practitioner within Primary Care

Develop role of STaR workers in primary care

Review role and function of Dual Diagnosis Workers

Ensure a robust recruitment and retention plan is in place

Current position

Inequalities in service provision exist across the two localities

Capacity gaps exist at Tiers 2 and 3

After care services are required.

Access to Mental Health Services are an area for development particularly in regard to Common Mental Health Problems

Improved access to Crisis Services is required.

Commissioner Issues

Commissioners will need to be assured that appropriate governance, capacity and systems are in place to support

staff
Commissioners will need to be assured that appropriate protocols and interface between providers is robust.
Commissioners will require evidence that where appropriate providers comply to NHSLA standards
Commissioners will require assurance that all staff are appropriately qualified to deliver the care and treatment required.
Commissioners will need to assure themselves that an appropriate whole systems model of care is delivered giving attention to social as well as health issues

Provider Issues

To work with commissioners to facilitate the above
Work force issues are predominantly the ultimate responsibility of the provider of service, therefore a close working relationship with all providers will be necessary to ensure the above assurances to commissioners are achieved
Ensuring staff are aware of other organisations and individuals roles.

Financial impact

The development of the workforce plan will be the single most revenue intensive development
The development of Advanced Practitioner role A4C band 7
Development of Star role in Primary Care A4C band 3
Training of all Primary Care, Social Care, Police, Probation and other front line staff in advice and brief interventions.

Timescale

Development of Project Group - September 10
Development of Project Plan - November 10
Implementation of Plan and recruitment process - January 10
Implementation of training package - January 10
Review of Recruitment and training progress - June 10
The training of staff will be an ongoing

Links to WCC

1. Locally lead the NHS
2. Work with community partners
4. Collaborate with Clinicians
   Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
6. Priorities investment
7. Stimulate the market
   Effectively stimulate the market to meet demand and secure required clinical and health and well being outcomes
8. Promote improvement and innovation
   Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
10. Manage the local health system
11. Make sound financial investments
    Make sound financial investments to ensure sustainable developments and value for money.

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse

Expected Outcomes

Increased communication and shared training between services.
Increased knowledge and skills in primary care to work with people with dual diagnosis problems.
Access to dual diagnosis advice and support for primary care staff
Close Primary / secondary mental health care interface working
A network of practitioners who can successfully work together for the benefit of the service user, their carers / family when required.

How this will benefit service users and their carer

This initiative will enable more frontline staff provide advice and brief interventions so impacting on the demand of related services. Service users will therefore access advice and brief interventions quicker. There will be increased capacity and expertise within the care pathway and so will have a positive impact on waiting times and an improved service user experience.

A 'whole systems' workforce plan will ensure that the right staff in the right numbers are available in the right places to deliver the appropriate interventions. This should result in shorter waiting times, duration of intervention may be less as the principle of early intervention is that if treated early this will prevent the individual's problems becoming longterm.

INITIATIVES TO DELIVER THE NEW MODEL #5

Initiative Title **The development of service specifications in line with the new NHS standard contract will be developed as part of this process attention will be given to eligibility criteria and interface issues between services, Tiers of service delivery, between organisations and between primary and secondary care. The principle adopted will be 'criteria for inclusion'**
Rationale (including evidence base) Explain the need and the objective of change Develop clear KPI and outcome measures for each service Develop clear kpi and outcome measures for each TIER of Service delivery and mechanism for data capture and measurement Ensure all service users have access to a crisis service when they need it Address new contract issues **Links to Initiative 1** **Links to initiative 2**
Current position Primary Care Trust commissioners are preparing new contracts DAAT Commissioners will have a review programme for contracts Local Authority will have a review programme for contract The processes are not coordinated and have different performance management structures.
Commissioner Issues Develop project group Develop project plan Identification of contracts, and service specification to review. Prioritise review process Develop Implementation plan Impact assessment and sustainability of changes to service specifications. **Links to Initiative 1** **Links to initiative 2**

Coordination of contracting and service specification development.

Provider Issues

Engage with commissioners to facilitate best outcomes
Providers will need to undertake impact assessment of changes to service specifications.
Development of data quality improvement plan
Development of quality improvement plan

Financial impact

The review of service specifications may impact upon:
Eligibility criteria; leading to more people accessing services leading to impact on capacity of services.
Ways of working; changes in interface with other organisations, job descriptions, new posts

Timescale

Development of project group - September 09
Development of Project Plan - October 09
Commencement of implementation of Plan - November 09
Review of progress - January 2010
Complete review and all service specifications in place - February 2010
Sign off for new contracts - February 2010

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services t hat optimise health gains and reductions in health inequalities
4. Collaborate with Clinicians
   Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
8. Promote Improvement and Innovation
   Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
10. Manage the local health system
11 Make sound financial investments

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse

Expected Outcomes Clear, specific and robust service specifications for all services working with people with dual diagnosis problems People are not excluded from services, based on particular diagnoses and that care pathways are developed for all those requiring services. Local services are flexible, coordinated and responsive to identified dual diagnosis issues.
How this will benefit service users and their carers This initiative will improve access, improve quality so improving the service user experience. Service specifications will be developed on the principle of 'criteria for inclusion' this will result in more people being able to access services and so reducing barriers to access. This should also have an impact on waiting times and service users remaining in inappropriate services due to inaccessible interventions. This will impact on the service delivery in terms of organisations and services working together more so delivering an integrated service.

INITIATIVES TO DELIVER THE NEW MODEL #6

Initiative Title **The development of a specific Dual Diagnosis service user peer group support forum in Halton.**
Rationale (including evidence base) Meaningful engagement with service users and their carers, Development of mutual support and self help.
Current position Currently no service
Commissioner Issues Facilitate Providers develop forum
Provider Issues Develop service and support
Financial impact Finances will be required to cover cost of venue, refreshments, any literature and publicity materials, time of staff to support the group.
Timescale Identify staff to facilitate set up and initial organisation - October 09 Identification of Venue - November 09 Identification of Service Users and Carers - December 09 Start Group - January 10
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 10. Manage the local health system

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse plus Management of Long Term Condition

Expected Outcomes

An opportunity for peer support groups across both Halton and St Helens.
Increase service user and carer involvement mechanisms across Halton and St Helens.
Increase equity across the PCT footprint

How this will benefit service users and their carers

Facilitate engagement and give a voice and support to service users and their carers. It will assist in the shaping and development of new services.
Service users engaging in this forum will benefit from informal peer support, being able to discuss their difficulties with people who have experienced similar problems in a non-threatening environment.

INITIATIVES TO DELIVER THE NEW MODEL #7

Initiative Title **The development of a Dual Diagnosis Provider forum**
Rationale (including evidence base) To promote integrated working between providers, to assist identify blockages and barriers to service delivery. Provide commissioners with the opportunity to discuss gaps in service and identify ways in which these may be filled
Current position Currently Local Authority manage a broad provider forum not dual diagnosis specific
Commissioner Issues Develop Forum Engage with providers
Provider Issues Engage with the process
Financial impact The financial impact will be on the time of commissioners from Primary Care Trust, Local Authorities, and DAATs to organise and run forum. Some costs may be incurred in providing venue and refreshments
Timescale Identification of lead commissioner - October 09 Identification and invitations to providers - November 09 Identification of agenda and 1st meeting January 10
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 5. Manage knowledge and undertake robust and regular needs assessment that establish a full understanding of current and future health needs and requirements 6. Prioritise investments according to local needs and service requirements

7. Effectively stimulate the market to meet demand and secure required clinical and health and well being outcomes 10. Manage the local health system
Links to other local strategies and initiatives This will primarily link to the following strategies and services: Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse, Management of Long Term Conditions
Expected Outcomes Regular meetings of service providers to discuss any blockages and delays between services and identify which systems are working well. An opportunity for providers to hear the views and experiences of service users. A forum where commissioners can work with providers to continuously improve services across the care pathway
How this will benefit service users and their carers Ensure continuous improvement in service development. Providers should be supported at the forum by elected service user representatives. The provider forum will assist in the smooth working between organisations and services reducing blockages and barriers and identifying problem areas sooner and bringing a collective approach to problem solving and meeting service user needs.

INITIATIVES TO DELIVER THE NEW MODEL #8

Initiative Title **Mental Health Strategy to be reviewed**
Rationale (including evidence base) The aim of this will be to ensure that an up to date Mental Health Strategy is a 'Strategic Fit' with all other related Strategies and plans
Current position Current Mental Health Strategy is now out of date
Commissioner Issues Develop a Project Group Develop Project Plan Develop Implementation Plan
Provider Issues Engage with the process
Financial impact Organisational and individual time will be required to complete the review and update the strategy
Timescale Develop project group - October 09 Develop Project Plan - November 09 Develop Implementation Plan - December 09
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 5. Manage knowledge and undertake robust and regular needs assessment that establish a full understanding of current and future health needs and requirements 6. Priorities investments according to local needs and service requirements

7. Effectively stimulate the market to meet demand and secure required clinical health and well being outcomes 10. Manage the local health system
Links to other local strategies and initiatives This will primarily link to the following strategies and services: Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse, Management of Long Term Conditions
Expected Outcomes Increased understanding of mental health commissioning plans across primary, secondary and tertiary care and the context for delivering services to people with dual diagnosis. Ensuring a closer 'fit' between any mental health commissioning strategy, substance misuse strategy and alcohol strategy for people with dual diagnosis problems
How this will benefit service users and their carers The development of an up to date Mental Health Strategy will facilitate the progress of a 'whole systems approach to commissioning and the provision of services. So leading, to a better service user experience, and patient journey. An up to date Mental Health Strategy will take account of New Ways of working, and recent policy and guidance. This will impact on; how services are managed, and delivered. The outcome of which, will improve access, reduce waiting times and provide a vehicle for partnership working. Service Users and their Carers will be critical informants to the development of the strategy.

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RESOURCES

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http://www.southeast.csip.org.uk/our-work/mental-health/mental-health-programme/dual-diagnosis/dual-diagnosis-key-resources.html

http://www.londondevelopmentcentre.org/mental-health/dual-diagnosis/dual-diagnosis-news.aspx

http://www.pcc.nhs.uk/204.php

REPORT TO: Executive Board

DATE: 3 December 2009

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Corporate Equalities Scheme

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To bring to the attention of the Executive Board the development of a new updated Corporate Equalities Scheme and provide the opportunity for its content to be considered.

2.0 **RECOMMENDATION: That:**

i) **Executive Board endorse the new Corporate Equalities Scheme.**

3.0 **SUPPORTING INFORMATION**

3.1 The revised Single Equality Scheme, attached at Appendix 1, has been developed following a review of the existing scheme as is required every three years. Appendix 2 identifies a number of achievements since the last Scheme was devised.

3.2 As was the case previously the scheme extends beyond existing statutory requirements relating to race, gender and disability to encompass equality in a wider sense and includes aspects of socio-economic deprivation and other equality dimensions that are relevant to our particular local context. This approach takes full account of the impending changes in statutory responsibilities that are likely to arise in 2011 as result of the introduction of the current Equality Bill which will distil nine pieces of legislation into a single Act.

3.3 The Single Equality Scheme has been structured around the performance principles established within the Equality Framework for Local Government (EFLG), which was introduced earlier this year. Developed by the Improvement and Development Agency (IDeA) the EFLG provides a competency framework against which we can measure our achievements and develop future actions that will focus on what needs to be done in delivering positive equality outcomes for our community.

3.4 The Scheme comprises of three discrete but interrelated documents

that are integral to the ongoing delivery and future design of services which take account of the needs of individuals and groups within the community regardless of their personal circumstance or socio-economic status. It provides a single source of information in relation to:-

i) Section One - The Council's Single Equality Scheme 2009-2012.

ii) Section Two - Guidance relating to Community Impact Review and Assessments.

iii) Section Three - Guidance relating to Equality Mapping

3.5 The scheme contains a detailed action plan which encompasses those areas of focus that are considered relevant to driving the equality agenda within the Borough.

3.6 The structure of the document will facilitate to compilation of an annual report to both capture the extent of our progress and to facilitate the development of future activity in relation to the achievement of our equality goals.

3.7 The draft scheme has been widely circulated for consultation to various audiences including:-

- The all party Elected Members Equality Group.
- All Strategic and Operational Directors.
- The Corporate Equality, Diversity and Cohesion Group and Directorate Working Groups.
- The four Staff Representative Groups.
- The Local Strategic Partnership (LSP) and the LSP Community Cohesion and Equalities Group.

3.8 In addition, the draft Scheme has been promoted in our local newspapers and on the Council's Intranet.

4.0 **Community Impact Review and Assessment (CIRA)**

4.1 The existing approach to Equality Impact Assessment, and the associated guidance notes for Officers, has been reviewed and refreshed in light of the emerging circumstances referred to in 3.4 above.

4.2 The Community Impact Review and Assessment (CIRA) Guidance contained within the toolkit provides those who are involved in, or who support, the organisations decision-making processes with a framework in which to give full and due regard to the potential impact upon the community of any proposals in relation to the design, re-design, or cessation of services. A risk based programme

of Impact Review and Assessments for existing services is currently being finalised and will be included within the Corporate Equality Scheme.

4.3 In addition to supporting transparency and accountability the approach and the consistent use of CIRA's will provide a demonstrable means by which the Council is delivering its commitment to ensuring that equality of opportunity and access remains an integral element of our current and future business practices.

5.0 Equality Mapping

5.1 Equality data, both demographic information about the local community and information about different experiences and outcomes within the community, are needed to:

- address local government priorities set out in Local Area Agreements (LAAs) and wider central government priorities
- contribute to Comprehensive Area Assessments (CAAs)
- meet statutory equality duties through the mechanism of Equality Impact Assessment (EIA)
- progress through the Equality Framework for Local Government.

5.2 The guidance notes contained within the toolkit provides a source of reference from which we can continue to develop our intelligence in relation to changing local demographics and the extent to which services are being used by discrete equality groups.

5.3 This approach will ensure that future actions to deliver and enhance service delivery arrangements which are founded upon equality principles remain evidenced based and consistent with the social and environmental contexts in which the organisation operates.

6.0 FINANCIAL IMPLICATIONS

6.1 The Council continues to be able to deliver the main strategic and policy direction within existing staff resources.

7.0 POLICY IMPLICATIONS

7.1 The Equality Action Plan has been developed to ensure synergy with existing policies and strategies of the Council and its partners, for example the Community Strategy and Local Area Agreement and the Councils Corporate Objectives. Such synergy will need to be a consideration at the time at which existing policies may be reviewed and refreshed.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 The delivery of the Equality Action plan has relevance to, and supports the delivery of all of the Council's Corporate Priorities.

9.0 RISK ANALYSIS

9.1 A failure to adopt the Corporate Equality Scheme and associated elements of the toolkit would result in the risk that:

- The Council will fail to meet its statutory responsibilities in relation to existing race, disability and gender legislation.
- That our arrangements to ensure that equality principles remain a foundation of service provision would be insufficiently robust and systemic with the resulting loss of reputation and credibility.
- That our ambition to achieve the excellent level of the Equality Framework for Local Government would be adversely affected.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 The adoption of the toolkit will provide an organisational focus for the further enhancement of our business processes and a foundation from which the achievement of equality based community outcomes can be monitored and reviewed.

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

Document	Place of Inspection	Contact Officer
Corporate Equality Plan Executive Board 30/03/06	Municipal Building	Strategic Director, Health & Community
Corporate Equality Plan (update) Executive Board 07/12/06	Municipal Building	Strategic Director, Health & Community

HALTON
BOROUGH COUNCIL

SECTION ONE

SINGLE EQUALITY SCHEME

2009 – 2012

Embracing diversity, ensuring equality and supporting cohesion

Version control record

Version	Date	Status	Circulation / publication
v1.0	23.11.09	Final draft	
Nature of Revision(s)			
Page	**Amendment(s)**		
n/a	**n/a**		

Version	Date	Status	Circulation / publication
Nature of Revision(s)			
Page	**Amendment(s)**		

Document Contact(s)

Mike Foy
Corporate Performance Management Team,
Municipal Building, Kingsway, Widnes Cheshire
Tel: 0151 471 7390 or Internal Ext: 1177 / Fax: 0151 471 7301
E-mail: mike.foy@halton.gov.uk

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Section 1

Foreword

"Welcome to Halton Borough Council's Single Equality Scheme for 2009 - 12. It outlines the action that the Council will be taking to ensure equality of opportunity for all who may use and wish to use the extensive range of services that it provides, including residents of Halton, businesses based and operating in Halton, visitors to the area, and to the existing and potential employees of Halton Borough Council.

For some time all public bodies have had a general duties towards the elimination of discrimination and the promotion of equality of opportunity in relation to race, gender and disability. However, as we identified within our 2006 Corporate Equality Plan, it is our stated intention in Halton to ensure that in providing services to the community no individual or group of individuals will be treated any less favourably as a result of their personal circumstances and status.

This scheme provides a commitment that both Elected Members and Council Officers will work together and with our partners to ensure that equality, diversity, and the cohesion of our community remain at the heart of everything that we do.

Our focus remains not upon the delivery of services that assumes a 'one size fits all' approach, but upon the provision and future development of services that are consistent with the actual and potential needs of all service users.

We will ensure that equality issues will remain an integral element in the way we deliver services, how we review and redesign existing services and in developing new approaches, both as an organisation and with our partners.

We will also continue to gather and use social and demographic information to ensure that our decision making processes remain intelligence led and that across Halton people are provided with equal life chances and that our communities remain free from discrimination, enjoy shared values and offer mutual respect."

David Parr
Chief Executive

Cllr Tony McDermott
Council Leader

Section 2

Introduction

The development of this single equality scheme is a demonstration of the Council's ongoing commitment, as both a provider of services and as a community leader, and as a partner of other local agencies such as the Police and the Primary Care Trust, that we will do all that we can to ensure that equity and fairness remain the cornerstones of our action planning and decision making processes.

This Single Equality Scheme contains information about the work of the Council in relation to equality issues and the action that we have taken, and will be taking, to ensure equality of opportunity for both employees and service users.

The Council intends, through its ongoing work on equality issues that this document will become the focus for promoting equality across the Council. This will mean integrating equality into all aspects of our functions, policies and services. This Scheme sets out a process for long-term and sustainable improvements as to how the Council promotes equality through the progressive adoption of the Equality Framework for Local Government[1]. This framework is based upon the understanding that '*equality is about increasing the life chances of all citizens; it recognises the needs of groups protected by anti-discrimination legislation and others who experience 'significant equality gaps*''[2].

The Council has undertaken a wide consultation of the Scheme including key partner agencies, Elected Members and Council staff. In addition, the Scheme has been publicised in the local press and a draft added to the Council's Internet.

[1] The Equality framework for Local Government can be accessed via http://www.idea.gov.uk/idk/core/page.do?pageId=9491107

[2] Lucy de Groot Executive Director Improvement and Development Agency.

Section 2

Policy Statement

The Council seeks to create a culture where people of all backgrounds and experience feel appreciated and valued. It is committed to achieving equality of opportunity in both it's service delivery mechanisms and employment practices. Service users, job seekers and employees will be treated fairly and without discrimination. Discrimination on the grounds of race, nationality, ethnic or national origin, religion or belief, gender (including gender reassignment), marital status, sexuality, disability, age or any other unjustifiable reason will not be tolerated.

The Council is opposed to unlawful and unfair discrimination (including harassment of any kind). The Council will take appropriate action wherever instances of discrimination and harassment occur, in the delivery of services and in the course of employment. It will work with its partners to develop effective procedures and policies to combat all forms of discrimination and to share good practice.

Section 3

Vision and Purpose

The Council's vision is simply to do all within our power to create, promote and sustain an equal society and an environment that fosters positive interactive relationships where people are treated with respect, dignity and fairness.

In pursuit of this vision we have adopted the following aspirational definition of equality based upon the idea of equal life chances[3]

'*An equal society protects and promotes equal, real freedom and opportunity to live in the way people value and would choose, so that everyone can flourish. It recognises people's different needs, situations and goals and removes the barriers that limit what people can do and can be'.*

In order to realise this vision we have to take practical steps to promote diversity and equality of opportunity and this scheme has been produced primarily to:-

- Provide leadership, accountability and direction in promoting equality and diversity and eliminating discrimination in service delivery and employment practices to all staff and Elected Members of the Council, its partner organisations and the community.

- Make clear the Council's commitments in fulfilling its legal obligations[4] and organisational aspirations to achieve equality of opportunity in the areas of race, gender (including gender reassignment), disability, sexuality, religion of belief, age and other socio-economic disadvantage.

- Draw together the different strands of equality work into one comprehensive scheme that identifies our equality priorities over the next 3 years and ensure that these are widely understood and consistently applied through regular and periodic monitoring, review and evaluations processes.

- Facilitate the mainstreaming of equal opportunities into our business decisions by further developing systems and processes that are accessible and transparent and involve meaningful engagement with minority groups to ensure that our policies remain intelligence led needs driven and effective.

[3] Adapted from the Equality Framework for Local Government
[4] Current legislative requirements are detailed within Appendix 2.

Section 4

Background and Context

In July 2002 the Council adopted its first Race Equality Scheme which was later revised in 2004 to broaden the concept of quality to other groups that may face disadvantage.

Since then the Council has made significant progress in taking forward equality issues and in 2008, following a self-assessment and peer review, was accredited with reaching level 3 of the Equality Standard for Local Government (ESLG)[5].

In March 2009 this standard has now been refined and superseded by the Equality Framework for Local Government (EFLG) which is based upon three levels of achievement: '**developing**', '**achieving**', and '**excellent**'.

In developing this Single Equality Scheme we have adopted the following five performance areas identified within the new framework as this allows us to continually review and assess our areas of strength and identify and exploit opportunities for improvement in a way that is proportionate and appropriate to our own local context.

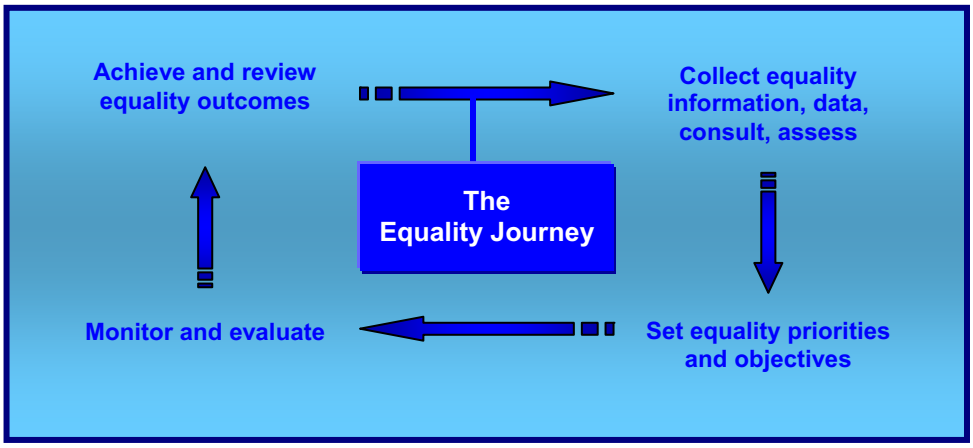
Five areas of Organisational Performance

- **Knowing your communities and equality mapping**
- **Place shaping, leadership, partnership and organisational commitment**
- **Community Engagement and Satisfaction**
- **Responsive Services and Customer Care**
- **A modern and diverse workforce**

In adopting this framework we recognise that to achieve our goal of attaining excellent status within the lifetime of this Scheme it will be necessary to take an holistic view of our performance from all five dimensions and that the achievement of equality outcomes are best understood as a journey of continual improvement as illustrated overleaf.

[5] The ESLG had five levels that could be achieved by public bodies. Further information can be found at http://www.idea.gov.uk/idk/aio/6531086

Section 4



The delivery of appropriate and responsive services has to take account of the existing and future context in which the Council and its partners operate. It is therefore not the intention of this Single Equality Scheme to encourage the routine replication of the activities that may be undertaken by our neighbours, for example the cities if Liverpool and Manchester, who have a much greater depth and breadth of diversity within their communities.

However we do recognise that isolation from peer minority groups can exacerbate the difficulties that individuals may face in terms of the accessibility of services and in achieving their potential. We therefore remain mindful of the fact that the accessibility of information, transportation, and support, as well as direct local service provision, can play an important part in the delivery of our equality agenda.

Along with those nationally recognised equality groups there is also a need, given our local context, to consider the needs of carers and other groups who may be disadvantaged and whose circumstances may make them vulnerable. The table below identifies each of the primary equality groups relevant to the borough.

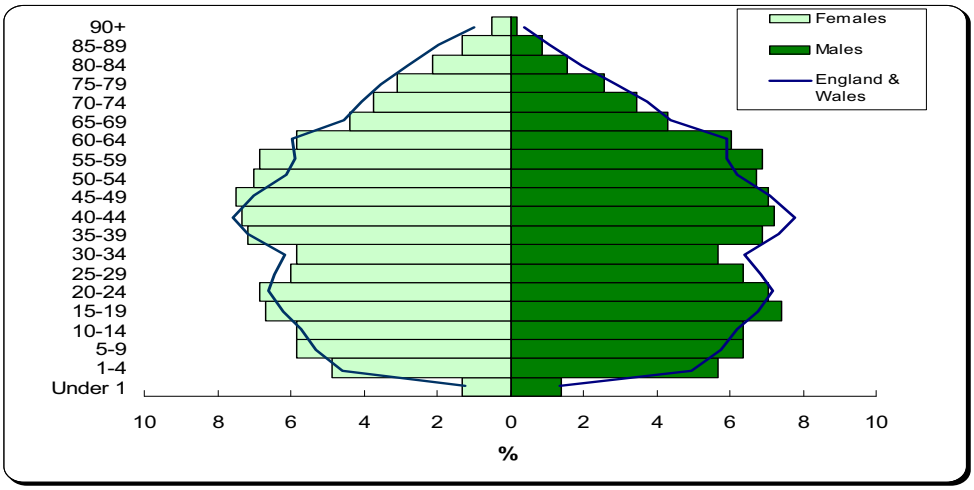
Age	Carers	Disability
Sexual Orientation	Socio-economic disadvantage	
Gender	Race	Religion / belief

Halton profile

The Council presently uses a range of sources to gather statistical information concerning its community profile. The most recent picture of Halton's composition, in terms of identified equality groups, is illustrated below.

Age

Halton currently has a population of 119,800 (mid year 2008) made up of 58,200 males and 61,600 females. The chart below compares the current age structure with England & Wales.



Following national and regional trends, Halton's population continues to age with older people making up an increasing proportion of the population. The growth in older people will increase the demands for both formal and informal support.

Ethnicity

Halton has a relatively small Black and Minority Ethnic (BME) population. The latest ethnicity estimates are for 2007, which show that Halton has a BME population of 2.3%, compared to 7.9% for the North West and 11.8% nationally. Although difficult to obtain reliable official statistics there has been the influx of migrant workers from the accession countries and although numbers are relatively small non-UK National Insurance Number registrations in Halton has been from a range of countries including: Poland, Slovak Republic, Australia, France, China, Latvia, USA, Republic of Ireland, Philippines and Thailand.

Since 1973, Halton has provided a permanent residential site for the Gypsy and Irish Traveller community, with space for 23 pitches. In February 2009, a transit site with 14 pitches and a live-in warden of Irish Traveller background was opened. Within Halton there are two privately-run sites with 13 pitches and there is a housed population of Gypsies and Irish Travellers (10 households). Exact numbers are not known, but a 2007 Needs Assessment found that the average size for a Traveller family was 3.5 persons and population figures for the Gypsy and Irish Traveller community will be collected as part of the 2011 Census.

Religion/Belief

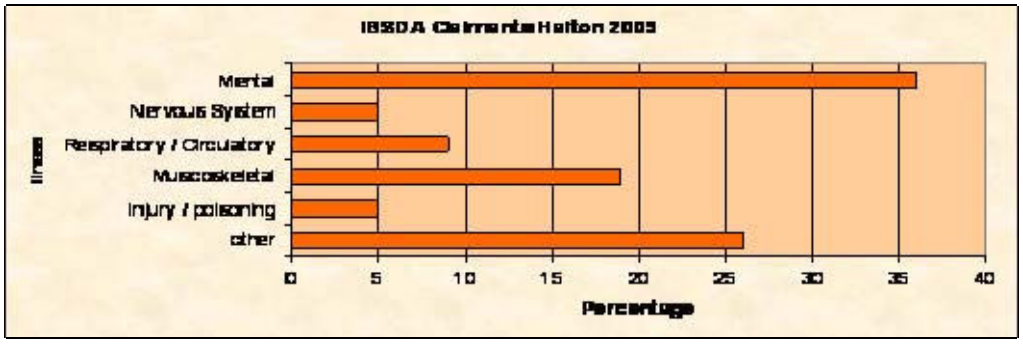
From the 2001 Census, Halton has a higher proportion of people who state their religion to be Christian (84%) than in the North West (78%) or nationally (72%), although there is a need to be aware of other religions listed in the 2001 Census, which included Muslim, Buddhist, Hindu, Jewish and Sikh.

Disability

In the 2001 Census, 22% of Halton's residents stated that they had a limiting long term illness. This compared to 21% for the North West and 18% nationally. From the recent 2008 place survey 72.8% of respondent's stated that their health is 'good' or 'very good' (NI 119) compared to 73.4% for the North West and 75.8% nationally.

However 33% of Halton's population are placed in the worst 4% for health deprivation in England. The cancer rates and life expectancy figures, particularly for women, are among the worst in the country. Although life expectancy has improved in the past decade Standardised all-age all-cause Mortality Rates Rank Halton as second highest, i.e. worse, out of 354 English Local Authorities from 2006.

The chart below shows that at February 2009 mental illness makes up the largest proportion of Incapacity Benefit/Severe Disablement Allowance (IBSDA) claimants in Halton.



At February 2009 2,870 IBSDA claimants in Halton were due to mental illness reasons. Additionally around 1 in 6 adults in Halton suffer from depression at any one time. This rises to 1 in 4 older people having symptoms of depression that are severe enough to warrant intervention. Of other mental health problems, anxiety and phobias are the most common.

Carers

A carer is anyone, irrespective of age, whose life is in some way affected because of the need to take responsibility for the care of a person who has a mental health problem, a learning disability, is physically disabled, is elderly or frail or whose health is impaired (definition taken from Action for Carers 2005 - 2008).

Expected changes in the population over the coming years will mean that people who are cared for will live longer and carers will have to care for much longer periods than in previous years, often experiencing health and other problems as they get older themselves. To alleviate these potential pressures the level of support provided to carers needs to be enhanced and improved, and greater recognition should be given to the pressures they face.

Data from the latest Census shows that 13,531 people provide formal or informal care, which is over 11% of the population, and 14% of these carers consider themselves to be in 'poor health'.

There are an estimated 1,265 young carers within Halton, with a number of these children and young people living with a parent(s) with a drug or alcohol addiction.

Sexual orientation

There are no official statistics on the numbers of Halton residents who are lesbian, gay, bisexual or transsexual (LGBT). However figures, based on estimates produced by the Department for Work and Pensions, suggest that 6% of the population fall into this category. Stonewall, the lobbying and support organisation for lesbians, gay men and bisexuals, agree with the Government's estimate, putting the figure at somewhere between 5% and 7%. Sexual orientation will be included as a question in the 2011 Census.

Lesbian, gay, bisexual and trans people experience a number of health inequalities, and research suggests that discrimination has a negative effect on the health of LGBT people in terms of lifestyles, mental health and other risks.

Many people are reluctant to disclose their sexual orientation because they fear discrimination or poor treatment.

It is commonly assumed that LGBT people's needs are the same as those of heterosexual people, unless these needs are related to their sexual health. It is important to understand that LGBT people can be younger, older, from BME communities, from any faith group and/or disabled and we must not assume that they form one homogenous group with common needs.

Socio-economic deprivation

Halton shares many of the social and economic problems which are experienced by its urban neighbours on Merseyside. The Index of Multiple deprivation shows that Halton is ranked as the 30th most deprived boroughs nationally.

This is the third highest on Merseyside, behind Liverpool and Knowsley, and 10th highest in North West although this is an improvement on the 2004 position in which Halton was 5th highest. Some neighbouring authorities are much better placed in terms of deprivation including St Helens (47th), Wirral (60th) and Sefton (63rd).

Haltons concentration of deprivation has improved form 20th worst in England in 2004 to 27th in 2007 although eight of the boroughs Super Output Areas[6] are in the top 8% of the most deprived areas in the country.

Council and its partners recognise that socio-economic disadvantage cuts across all of the equality domains and continue to develop and use disaggregated data and information to develop appropriate responses and service delivery mechanisms to close the gap between the life opportunities, experiences and outcomes enjoyed between those communities whose circumstances make them most vulnerable and the rest of the borough.

To date the Council has undertaken a significant number of initiatives to further enhance the quality of life experienced by all of those within the community. Whilst it is not possible to document every action that has been taken in this regard during the preceding three years a summary of key activities has been included within Appendix 1.

[6] Additional Information concerning Super Output Areas can be found at http://www.idea.gov.uk/idk/core/page.do?pageId=7175806

Section 5

Our Priorities

The Council's Vision

Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and a safer, stronger and more attractive neighbourhood.

In order to deliver this vision the Council has identified the following 6 strategic priorities[7] that will improve the lives of those within the community, regardless of their individual status, in the medium and longer-term.

A SAFER HALTON

To ensure pleasant, safe and secure neighbourhood environments with attractive, safe surroundings, good quality local amenities and the ability of people to enjoy life where they live.

A HEALTHY HALTON

To create a healthier community and work to promote well-being, a positive experience of life with good health (not simply an absence of disease), and offer opportunities for people to take responsibility for their health with the necessary support available.

HALTON'S URBAN RENEWAL

To transform the urban fabric and infrastructure, to develop exciting places and spaces and to create a vibrant and accessible Borough that makes Halton a place where people are proud to live and see a promising future for themselves and their families.

CHILDREN AND YOUNG PEOPLE IN HALTON

To ensure that in Halton children and young people are safeguarded, healthy and happy, and receive their entitlement of high quality services that are sensitive to need, inclusive and accessible to all.

[7] With the organisational specific priority of Corporate Effectiveness these priorities area also shared with the Councils partners within a Community Strategy for a Sustainable Halton

Section 5

EMPLOYMENT LEARNING AND SKILLS IN HALTON

To create an economically prosperous borough that encourages investment, entrepreneurship, enterprise and business growth, and improves the education, skills and employment prospects of our residents and workforce so they can share in all the opportunities Halton affords.

CORPORATE EFFECTIVENESS AND EFFICIENT SERVICE DELIVERY

To create the maximum effect on the quality of life in the communities of Halton through the efficient use of the Council's resources.

As described previously this Single Equality Scheme has been structured around the performance principles established within the Equality Framework for Local Government. Developed by the IDeA[8] the EFLG provides a competency framework against which we can measure our achievements and develop future actions that will focus on what needs to be done in delivering positive equality outcomes for our community.

The five dimensions of management activity are:-

- ☑ Equality mapping – knowing our communities
- ☑ Place shaping, leadership and commitment
- ☑ Community engagement and satisfaction
- ☑ Responsive services and customer care
- ☑ A modern and diverse workforce

Equality Mapping

Equality mapping is about knowing your community. It is the term used for collecting information about communities and individuals. It can be collected not only on the basis of race, gender, disability, religion/faith, sexual orientation and age, but increasingly other relevant equality demographics such as socio-economic circumstances, health and educational achievement.

[8] The Improvement and Development Agency supports improvement in local government. For more information please visit http://www.idea.gov.uk/idk/core/page.do?pageId=1

Section 5

Data will need to be understood, not just collected, and used as an important baseline for plans such as the Sustainable Community Strategy, Local Development Framework and the LAA.

The profile of the community has been established by using research from census and other data and where appropriate data extracted from various sources such as The Halton Data Observatory, NOMIS, ONS, Paycheck and Acorn. The Place Survey results can also be mapped to give more detailed understanding of small areas[9].

To ascertain the scale of irregularities in outcomes between communities the Council has regularly taken an economic, social and environmental audit since 2000. The most recent 'State of the Borough in Halton' report was published in January 2009 and provides an economic, social and environmental audit of the locality[10].

Identification of gaps was part of the development of the Sustainable Community Strategy. In line with tension monitoring requirements a Tactical Group has been formed for cohesion, which is multi agency and provides live intelligence on community tension indicators which are used to develop proactive and practical solutions.

The Council is currently further exploring and developing mapping systems for equality related measures, in particular those relating to Community Cohesion. As example of this approach is the use of Hotspot Mapping which allows Place Survey data to be analysed at a small area level and compared to local, regional and national data to determine any correlation between personal circumstances or commonality of status and outcomes. This will allow the Council to monitor and develop its policies and services to ensure that they remain accessible and needs driven.

An example of this approach is illustrated within the following section relating to community engagement and satisfaction.

Place shaping, leadership and commitment.

Place shaping may be summarised as a 'creating places where people can thrive', or as highlighted in the 2007 Lyon Enquiry into Local Government, 'the creative use of powers and influence to promote the general well-being of a community and its citizens'.

[9] For further information visit www.halton.gov.uk or contact research@halton.gov.uk

[10] To access the report please visit www.halton.gov.uk or contact research@halton.gov.uk

Section 5

In fulfilling this role the Council will continue to develop arrangements for:

- Building and shaping the local identity;
- Representing the community;
- Maintaining community cohesiveness;
- Helping resolve disagreements;
- Working to make the local economy more successful;
- Understanding local needs in order to provide the right services
- Working with other bodies;
- Working with partners to set equality and cohesion priorities

The Council has a well established and effective Local Strategic Partnership, including the Equality, Diversity and Community Cohesion Partnership, and is in the process of refreshing the Sustainable Community Strategy, which will be subject to an Equality Impact Assessment.

At an organisational level the Equality and Diversity agenda is led by a Strategic Director (Health and Community) who is supported by a Corporate Equality and Diversity Group with Officer representation from each of the four Directorates of the Council. Whilst this group has proved valuable in providing a strategic focus to equality issues it has been recognised that as membership has been drawn from primarily non-specialist staff and therefore further training would be beneficial.

At the operational level there are four Directorate Equality Groups each of which are led by the relevant Strategic Director. These groups provide both a feed up role into the development of strategy and a feed down role to staff who are involved in the implementation of policies and practices.

The Council works in partnership with Cheshire, Halton and Warrington Race Equality Council (CHAWREC) and provides funding and other resources towards establishing a BME and Faith Network.

An example of leadership and place shaping is Halton's BME Floating Support Service funded by Supporting People with a working capacity of fifteen units. There are currently 11 BME households engaged, the majority being families with children.

The BME Support Service has established a Client Involvement Forum at which service users are encouraged to discuss equal opportunity/anti-discriminatory practice, harassment, supporting victims of abuse, service user involvement, and employment issues within the BME community.

A Service Management Steering Group has also been established which meets every two months with a membership from a range of partners including Cheshire Police, CHAWREC, HBC Gypsy Liaison, Making Space, and Citizens Advice Bureau.

An LGBT Youth Group is facilitated by the Youth Service to support young gay, lesbian, bisexual and transgender individuals in the area. An event recently took place led by CHAWREC and supported by the Council to launch a BME Network in the borough and CHAREC is also being supported in capacity building.

It has been recognised however that there are currently a considerable number of groups within the local area that have some equality dimension to their work. In order to ensure that efforts are being effectively co-ordinated and channels of communication maximised it is considered opportune that a review of such groups and their structures be undertaken in order that resources are being utilised to their best effect.

Community engagement and satisfaction.

The Council has developed an audit and analysis framework to capture community engagement activity on four levels, information giving, consultation, deciding together and acting together.

The council recently undertook the audit and the framework is being shared with partner agencies. The audit provides a baseline from which a review of the Halton Partnership Community Engagement Strategy will commence in 2010 ensuring we better understand how we engage with Halton's residents and use our resources effectively.

The Council has used the audit process to strengthen links on engagement activity to business planning and supporting our Members in their pivotal role in the communities they serve.

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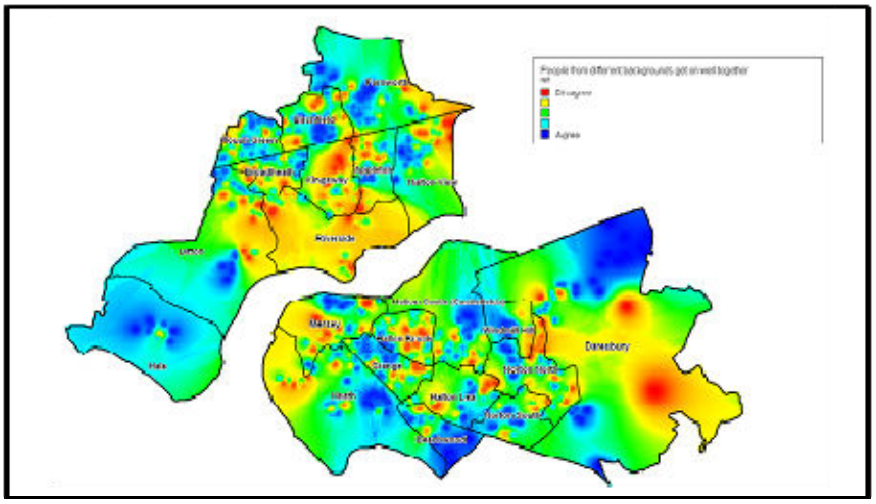
Work is currently being undertaken to make use of disaggregated perception data to better understand the cause and effect relationships between organisational and partnership outputs and community outcomes.

This approach allows us and our partners to use detailed intelligence to target our energies and resources more effectively upon those areas and for those groups who are most in need.

The following example is the use of a hotspot map in relation to the % of people who feel that they belong to their area.

Halton's figure for this measure, of 54.8%, is the 5th lowest out of the 23 Unitary and Metropolitan authorities in the Northwest. Manchester City Council, with 47.6%, has the lowest figure with Cumbria, at 69.7% having the highest.



Generally speaking people in rural areas feel that they belong to their neighbourhood more than people in urban areas. In addition areas with high levels of deprivation have a lesser feeling of belonging than areas with low levels of deprivation. It is therefore unsurprising that given the levels of deprivation that exist within the borough Halton's figure is below that of it's nearest neighbours family group which averages 58.7%.

In analysing results in this way it allows us to determine whether there are any inconsistencies in the level of belonging across the borough and develop interventions for specific areas where positive responses are unusually low.

This level of disaggregation / analysis has been used to develop differential targets to narrow the gap between specific areas / groups and the borough average to ensure that personal circumstance does not remain a barrier to life opportunities.

Responsive Services and Customer Care

The Council aims to: -

- Be able to demonstrate greater cultural understanding on behalf of service users;

- Use Community Impact Review and Assessments (CIRA's) and other assessment methods to ensure that the impact of service provision on different communities is understood.

The practice of undertaking regular Community Impact Review and Assessments by all Council services has been variable although steps are being taken to improve on this to ensure that our decisions in relation to service provision remain customer centric.

To ensure that CIRA's are integrated in to all aspects of service planning and delivery the Council has:-

- Revised the guidance and procedures for undertaking CIRA's;
- Formulated a timetable following a process of Relevance Assessments (appendix refers). Directorate E&D Groups to draw up a timetable;
- In accordance with the revised CIRA process guidance, equality actions will be regularly monitored by Officers and Elected Members through both the Corporate Performance Management Framework and relevant Directorate Equality Groups;
- EIA summaries will be published on the Council's website

During 2009 a relevance assessment of all Council services was undertaken in order that a rolling programme of review will continue to determine the nature and extent of the impact that existing services have upon the community. Details of this programme of reviews are included as Appendix ii.

In the methods described above equality issues and objectives will be clearly integrated into service planning and performance management frameworks and encourage proactive policy making.

Section 5

In order to ensure that the services the Council provides meet the needs of people from different backgrounds (including personalisation of services where appropriate) there will be regular Equality and Diversity Monitoring (see Section Three of this Toolkit). There are regular resident satisfaction surveys which can be disaggregated by equalities groups and the information from these will be monitored to identify areas for improvements and inform service development. The 2008 Place Survey indicated that 74.5% of residents agreed that their local area is a place where people from different areas get on well together and a target of 80% has been set for 2010. Overall satisfaction with the area was 70.4% with a 2010 target of 74.6%.

Place Survey data can be disaggregated further to highlight the satisfaction levels of equality groups. The Halton Local Strategic Partnership plans to conduct some focused consultation work to underpin the main findings of the Place Survey.

A multi-agency Cohesion Officers Group has been established to interpret national performance indicators and provide front line responses to any community tensions and to support cohesive communities in Halton.

Further examples of tangible outcomes, where a real difference is being made include, resulting from consultation at strategic level, the establishment of a Faith Room, improvements to HDL front office to take into account age and disability and an agreement to changes to measures of achievement in the Children's Plan which more fairly reflect achievements than government guidelines.

Section 5

A Modern and Diverse Workforce

The Council aims to be an employer which ensures:-

- Fair employment practices that comply with the legislation
- Training on equality issues including CIRA's
- That the workforce profile reflects the diversity of the community and that measures are in place to monitor diversity and promote equality of opportunity
- It has established targets against objectives

The Council's current workforce profile (excluding school based employees) is as follows: -

Ethnicity

Ethnic Origin	%
White – British	***69.91***
Other	***14.97***
Not Declared	***13.42***
White Irish	***0.60***
Other White Background	***0.33***
Mixed – White & Black Caribbean	***0.21***
Chinese	***0.12***

Ethnic Origin	%
Asian or Asian British (Indian)	***0.09***
Any other mixed background	***0.09***
Black or Black British (Caribbean)	***0.06***
Black or Black British (African)	***0.06***
Mixed – White & Black African	***0.06***
Any other Asian Background	***0.06***
Asian or Asian British (Pakistani)	***0.03***

Gender

Female	***71.76***
Male	***28.15***

Transgender	***unknown***
Not declared	***0.09***

Disability (Self perception based upon DDA Definition)

Yes	***16.91***
Not declared	***1.33***

No	***81.76***

% Of top 5% of earners who are

Women	***45.58***
From BME Communities	***0.83***

Disabled	***2.87***

Section 5

At the present time there is little information available concerning sexual orientation, faith and caring responsibilities and as a result the Council will seek to redesign its existing process so that such data can be captured to inform future actions.

This workforce profile will be updated regularly so that adverse trends, for example in relation to resignations, disciplinary action, grievances etc can be identified. The Council's overall aim is to have a workforce which closely represents the demographic make up of the Borough

At the core of the Council's people Strategy is a commitment to value the diversity of the workforce. The purpose of the strategy is to bring together in one place a strategy for how people will be deployed, managed and developed within the organisation and to communicate expected standards of behaviour. This strategy will ensure that:

The Council is a first class employer that engages a well-trained, motivated and committed workforce in a working environment of trust, co-operation and respect.

At the time of developing this scheme the Council are awaiting detailed results and analysis of a comprehensive staff survey that was undertaken earlier in 2009.

This survey included specific questions concerning the extent to which people from different equality groups considered that they were treated with fairness and respect. Although the full results have yet to be analysed early indications are extremely positive with high levels of satisfaction across all groups and an action plan will be developed to address any areas where further improvement could be secured.

Measures to be put in place to reverse measured adverse trends and to increase workforce satisfaction include: -

- A tailored mentoring scheme
- Introduction of Positive Action Statements, leading to;
- Targeted recruitment advertising
- Encouragement of and support for Worker Representative Groups

Section 5

A number of Equality and Diversity Worker Representative Groups have been established. These include: -

- Women's Group
- Disability Group
- BME Group
- LGBT Group

The remit of the Representative Groups is, broadly, to promote equality and diversity in employment, training and service delivery, to support potentially disadvantaged sectors of the workforce and act as a point of consultation for the Council.

It has been acknowledged that the provision of additional training in relation to the use of Community Impact Reviews and Assessments will be required to ensure a common clarity of purpose and consistent application.

Suitable training will ensure that: -

- Staff managing and delivering services are trained to provide an appropriate and informed response to all service users without unlawful discrimination by raising awareness of training in the community;
- Staff managing and delivering services are clear about their responsibilities to promote equal opportunities and good relations in accordance with Council policy;
- Managers have the knowledge and capacity to discharge the Council's duties around equalities specifically the requirements to monitor service provision and take up, carry out impact assessments and report the outcomes of this work to be able to make appropriate changes to service provision;
- Managers are equipped to manage a diverse workforce and implement the Council's Equality Policy;
- Staff have a clear understanding of the relationship between the various items of equal opportunities legislation and associated schemes and standards;
- Equalities issues are fully understood and taken account of in the Council's HR Policies in particular recruitment and selection practices and procedures and bullying and harassment policies;

- All new staff joining the Council are provided with an understanding of the Council's policies and understand how these are translated into procedures and codes of practice.

Directorates will determine specific training requirements to ensure training is relevant to the requirements of each service.

Medium-Term Equality Action Plan

The following plan identifies those key areas of focus and performance measures that will enable the Council and its partners to take forward the equality agenda within Halton. These key objectives and outcomes will help to ensure that life chances are not determined by social status or personal circumstance but through equality of access and service provision.

Within this document it is not practicable to identify all of those actions that the Council and its partners will undertake in pursuit of these outcomes. However the Council's organisational and partnership planning frameworks will facilitate the ongoing monitoring and reporting of progress through the Local Strategic Partnership and Senior Officer and Elected Member Policy & Performance Boards.

Corporate Objective	To create a healthier community and work to promote well being – a positive experience of life with good health (not simply an absence of disease) and offer opportunities for people to take responsibility for their health with the necessary support available.
Priority Outcome	Reduce health inequalities in the Borough

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 1	Narrow the gap so that the overall death rate in any ward is no more than 25% above the Halton average	Local Strategic Partnership	2008 - 2011	All	Responsive Services & Customer Care
ECA 2	Reduce the conception rate of women under the age of 18 by 55%	Local Strategic Partnership	2008 - 2011	Gender / SE[11]	Place shaping, Leadership & Commitment
ECA 3	Increase adult participation in sport from 20.13% (2006) to 24.73% (NI 8)	Culture & Leisure Services	2008 - 2011	All	
ECA 4	Increase the number of drug users in effective treatment from 513 to 544 (NI 40)	Culture & Leisure Services	2008 - 2011	SE	

[11] SE = Socio-economic disadvantage

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 5	Improve the number of people over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently from 30.4% to 32.8%	Older People's Services Department	2008 - 2011	Age / Gender	Responsive Services & Customer Care
ECA 6	Improve the number of vulnerable people supported to maintain independent living from a baseline in 2007/08 of 98.17% to a target of 99.04% in 2011 (NI 142)	Health & Partnerships Department	2008 - 2011	Disability	Responsive Services & Customer Care
ECA 7	Number of adults in contact with secondary mental health services in employment, target to be set by March 2010 (NI 150)	Adult Services Department	2008 - 2011	Disability	Place shaping, Leadership & Commitment
ECA 8	Increase the percentage of older people from BME groups receiving a social care assessment (OPLI 4)	Older People's Services Department	2009 - 2012	Race	Responsive Services & Customer Care
ECA 9	% of adults assessed in the year where ethnicity is not stated (target: reduction in %) (OPLI 6)	Adult Services Department	2009 - 2012	Race	
ECA 10	Increase in the number of carers receiving an assessment or review and a specific carer's service, or advice and information (NI 135)	Adult & Community Directorate	2009 - 2012	Carers	

Corporate Objective	To transform the urban fabric and infrastructure. To develop exciting places and spaces and to create a vibrant and accessible Halton – a place where people are proud to live and see a promising future for themselves and their families
Priority Outcome	To ensure Halton designs in and maintains high levels of accessibility to places and spaces so that opportunity and need are matched

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 11	Increase residents' overall satisfaction with their local area from 70.4% in 2008 to 75% in 2010.	Local Strategic Partnership	2008 - 2010	All	Community Engagement & Satisfaction
ECA 12	Improve access to services and facilities by public transport, walking and cycling.	Highways & Transportation Department	2009 - 2011	All	Place shaping, Leadership & Commitment
ECA 13	Build additional homes in Halton in line with LAA target between 2008/09 and 2010/11 (NI 154)	Environment and Regulatory Department	2008 - 2011	All	
ECA 14	To reduce the number of households in temporary accommodation from 32 to 16 (NI 156) by Dec. 2010	Health and partnerships Directorate	2009 - 2010	SE	Responsive Services & Customer Care
ECA 15	To increase the number of people known to secondary mental health services and those with learning disabilities in settled accommodation (NI 149)	Adult & Community Directorate	2009-2012	Disability	

Corporate Objective	To ensure that in Halton, children and young people are safe, healthy and happy, and receive their entitlement of high quality services that are sensitive to their needs, inclusive and accessible to all
Priority Outcome	Children and young people do well wherever they live and whatever their needs

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 16	Reduce the gap of attainment of 5 A* - C GCSEs (including English and Maths) by 25% between those living in the worst 10% Lower Super Output Areas nationally and the Halton average	Children and Young People's Directorate	2009 - 2011	SE	Responsive Services & Customer Care
ECA 17	To improve the educational attainment of those pupils whose socio-economic circumstances may make them vulnerable (as expressed through eligibility for free school meals).				
ECA 18	Reduce the number of 16 – 18 year olds not in education, employment or training from 11.5% in 2008 to 7.7% by 2011	Local Strategic partnership	2009 - 2011	Age / SE	Place shaping, Leadership & Commitment
ECA 19	Achieve a year or year reduction in numbers of people accepted as statutorily homeless	Health and Community Directorate	2009 - 2012	SE	Responsive Services & Customer Care
ECA 20	Increase by 15% per year the number of agencies including schools that work with children and young people who are signatories to Halton's Anti-Bullying Charter which identifies the link between equality issues and bullying.	Children and Young People's Directorate	2009 and on-going till 100%	All	Place shaping, Leadership & Commitment
ECA 21	Increase the stability of placements for Looked After Children from 69% in 2008 to 81.5% in 2011.	Children and Young People's Directorate	2008 - 2011	LAC Children	
ECA 22	100% of Commissioned services will be informed and underpinned by proportionate equality and diversity targets and will at a minimum, be annually monitored against targets.	Children and Young People's Directorate	2010	Age / Children	
ECA 23	Schools to analyse and if required, action how the school compares with national/local data across the three strands: ethnicity, culture, social economic and religion/belief	Children and Young People's Directorate	2009 - 2010	Race/ SE religion/belief	

ECA 24	All schools to promote equal opportunities and tackling discrimination as identified in the school's Equality Scheme including policy statement and a 3 year plan	Children and Young People's Directorate	2009 - 2010	All equality strands	

Corporate Objective	To ensure that in Halton, children and young people are safe, healthy and happy, and receive their entitlement of high quality services that are sensitive to their needs, inclusive and accessible to all
Priority Outcome	To support the physical, emotional and sexual health of children and young people

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 25	Reduce number of children killed or seriously injured in road traffic accidents by 29.6% of 2008 figure by 2011	Children and Young People's Directorate	2008 - 2011	Age	Responsive Services & Customer Care
ECA 26	Reduce obesity amongst primary school Year 6 from 22.4% 2008 to 21.3% 2011.	Children and Young People's Directorate	2008 - 2011	Age Age	Place shaping, Leadership & Commitment
ECA 27	Reduce the number of young people who misuse substances from 12.6% 2008 to 9.8% in 2011	Children and Young People's Directorate	2009 - 2011	Age	Place shaping, Leadership & Commitment
ECA 28	Increase the number of children who have Carer Needs Assessment which is evoked by the adult in the household receiving services from adult social services.	Children and Young People's Directorate/Health and Community	2010	Young Carers	Responsive Services & Customer Care
ECA 29	To increase the number of disabled children accessing a short break through HBC funding from 162 in 2008 / 09 to 360 in 2010 / 2011	Children and Young People's Directorate	2009 - 2011	Disability / Age	Responsive Services & Customer Care

Corporate Objective	To create an economically prosperous Borough that encourages investment, entrepreneurship, enterprise and business growth, and improves the education, skills and employment prospects of our residents and workforce so they can share in all the opportunities Halton affords.
Priority Outcome	To develop a strong, diverse, competitive and sustainable knowledge-based local economy.

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 30	To reduce the proportion of working age people claiming out of work benefits in the worst performing neighbourhoods from 31.5% in 2007/08 to 28.5% by 2010/11		2008 - 2011	SE	Place shaping, Leadership & Commitment
ECA 31	Increase the number of adults that are in secondary mental health services who are in employment (target to be established, NI 150)	Adult Services Department	2009-2012	Disability	
ECA 32	To increase the number of adults with learning disabilities who are in employment (NI 146)	Adult Services Department	2009-2012	Disability	Place shaping, Leadership & Commitment
ECA 33	Number of learning disabled / physically disabled adults and those with mental health problems helped into voluntary work (AWALI 5, 6 & 7)	Adult Services Department	2009-2012	Disability	Place shaping, Leadership & Commitment

Corporate Objective	To ensure pleasant, safe and secure neighbourhood environments with attractive, safe surroundings, good quality local amenities and the ability of people to enjoy where they live.
Priority Outcome	To create and sustain better neighbourhoods that are well designed, well built, well maintained, safe and valued by the people who live in them, reflecting the priorities of residents.

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 34	Reduce the number of incidents of anti-social behaviour in the worst five Lower Super Output Areas compared with the rest of the Borough (11% reduction)	Local Strategic Partnership	2009-2012	All	Community Engagement & Satisfaction
ECA 35	To develop a partnership Hate Crime Action Plan	Crime Disorder Reduction Partnership	2011	All	Place shaping, Leadership & Commitment
ECA 36	Increase residents' overall satisfaction with their local areas from 70.4% in 2008 to 75% in 2010 (NI 5)	Crime Disorder Reduction Partnership	2011	All	Community Engagement & Satisfaction
ECA 37	Increase voluntary and community sector satisfaction from 22.2% in 2007/08 to 29.7% by 2010/11 by creating a strong environment in which it can thrive (NI 7)	Culture & Leisure Services	2010-2011	All	Community Engagement & Satisfaction
ECA 38	Reduce the repeat incidents of domestic violence from 28% in 2008/09 to 27% by 2010/11 (NI 32)	Culture & Leisure Services	2008 - 2011	Gender	Place shaping, Leadership & Commitment
ECA 39	Increase the number of drug users in effective treatment from 513 in 2007/08 to 544 by 2010/11 (NI 40)	Culture & Leisure Services	2008 - 2011	SE	Place shaping, Leadership & Commitment
ECA 40	An improvement in the satisfaction of people over 65 with both home and neighbourhood (NI 138)	Corporate	2009-2012	Age	Community Engagement & Satisfaction
ECA 41	User reported measure of respect and dignity in their treatment (NI 128)	Adult & Community Directorate	200-2012	Age / Disability	Community Engagement & Satisfaction

Corporate Objective	To create the maximum effect on the quality of life in the communities of Halton through the efficient and effective use of the Council's resources.
Priority Outcome	To work towards ensuring a modern and diverse workforce (of both internal employees and independent contractors) this adequately reflects the local community.

Ref	Equality Actions	Delivery Lead	Timeframe	Equality Strand	Performance Dimension
ECA 42	Provide specific training to all appropriate staff, including Senior Management, in relation to the purpose and process of COMMINITY Impact Review and Assessment.	Corporate Lead (Equality, Diversity and Cohesion)	2009 - 10	All	A modern and Diverse Workforce
ECA 43	No of relevant staff in adult social care who have received training addressing work with adults whose circumstances make them vulnerable (HPLI 2)	Human Resources Department	2010-2012	Age / Disability / Socio-economic	
ECA 44	% of relevant adult social care staff in post who have had training to identify and assess risks to adults whose circumstances make them vulnerable	Human Resources Department	2010-2012		
ECA 45	Establishing robust and detailed baseline data for future use in targeted initiatives	Organisational Development	2009 – 12	Gender / Race / Disability	
ECA 46	Revise employee questionnaire to include details of disability type and devise pamphlet to encourage responses to enhance our equality mapping arrangements and improve organisational intelligence	Human Resources Department	2009 – 2010	Disability	
ECA 47	Ensure that all new jobs are subject to evaluation process to ensure pay parity.	Human Resources Department	Ongoing	Gender	

Section 7

Key Performance Measures

A number of performance measures have been identified that will be used to determine our progress in an equalities context. It should be noted however that in some instances because of the very small numbers involved % variations may appear inordinately high and would require further clarification for the purposes of reporting.

Further work will be undertaken during 2009 – 10 to develop a suite of indicators that can be monitored with sufficient frequency and the following list identifies those measures that will be given primary consideration.

Ref	Description	Frequency	Equality Strand
LOD 10	% Of BME employees	Quarterly	Race
LOD 17	Electoral turnout	Annual	CC[12]
LOD 4a	Top 5% of earners that are women	Quarterly	Gender
LOD 4b	Top 5% of earners from BME communities	Quarterly	Race
LOD 4c	Top 5% of earners that have a disability	Quarterly	Disability
LOD 5	Racial Incidents per 1000 population[2]	Annual	Race
LOD 8	% Of disabled employees	Quarterly	Disability
NI 1	% of people who believe that people from different backgrounds get on well together	Biennial	CC
NI 140	Fair treatment by local services	Biennial	All
NI 2	% Of people who feel that they belong to their neighbourhood	Biennial	All
TBA	Equality Framework for Local Government	Annual	All
PYSLI 9	% Buildings accessible for disabled people	Quarterly	Disability
CCLI 4	% Overall satisfaction library users		CC
CCLI 5	% Satisfaction sport & leisure		CC
CLLI 3	% of racial incidents with further action	Quarterly	Race
NI 23	Perception that people treat one another with respect	Biennial	CC
NI 26	Specialist support to victims of sexual offence		Gender
NI 32	Repeat incidents of domestic violence		Gender
NI 34	Domestic violence		Gender
NI 42	Perception of drug use / dealing as a problem	Biennial	CC
NI 8	Adult participation in sport and recreation		*Age*
NI 13	Migrants English & Knowledge	Annual	Race

[12] Community Cohesion

Section 7

Ref	Description	Frequency	Equality Strand
NI 126	Early access for women to maternity services		Gender
NI 128	User reported measure of respect and dignity in their treatment		All
HTLI 3	% of pedestrian crossings for disabled		Disability
HTLI 5	% Of footpaths / ROW easy to use		Disability
NI 175	Access to services and facilities by public transport, walking and cycling		*Age* / disability
NI 176	Working age people with access to employment by public transport		*Age* / disability
NI 48	Children KSI	Quarterly	*Age*
NI 125	Achieving independence for older people through rehabilitation /intermediate care		*Age*
NI 129	End of life care		*Age*
NI 130	Social care clients receiving self-directed support per 100,000 pop		*Age* / disability
NI 135	Carers receiving a needs assessment etc		Carers
NI 136	> 65's helped to live at home per 1,000 population		*Age*
NI 137	Healthy life expectancy @ 65		*Age*
NI 138	Satisfaction of people over 65 with both home and neighbourhood	Biennial	*Age*
NI 139	The extent to which older people need support to live independently	Biennial	*Age*
NI 141	% Of vulnerable people achieving independent living		CC / *Age* / disability
NI 142	% Of vulnerable people who are supported to maintain independent living		CC / *Age* / disability
NI 145	Adults LD in suitable accommodation		Disability
NI 146	Adults LD in employment		Disability
OPLI 14	% Of items of equipment delivered < 7 days	Quarterly	Disability
OPLI 16	Intensive home care per 1,000 population		*Age*
NI 109	Delivery of Sure Start Children's centres		*Age*
NI 110	Young people participation in positive activity		CC / *Age*
NI 116	Proportion of children in poverty		*Age*
NI 69	Children who have experienced bullying		CC / *Age*
NI 44	Ethnicity of offenders on YJS disposals		Race
NI 45	Young offenders engagement in ETE		*Age*
NI 46	Y. Off access to accommodation		*Age*
NI 50	Emotional health of children		*Age*

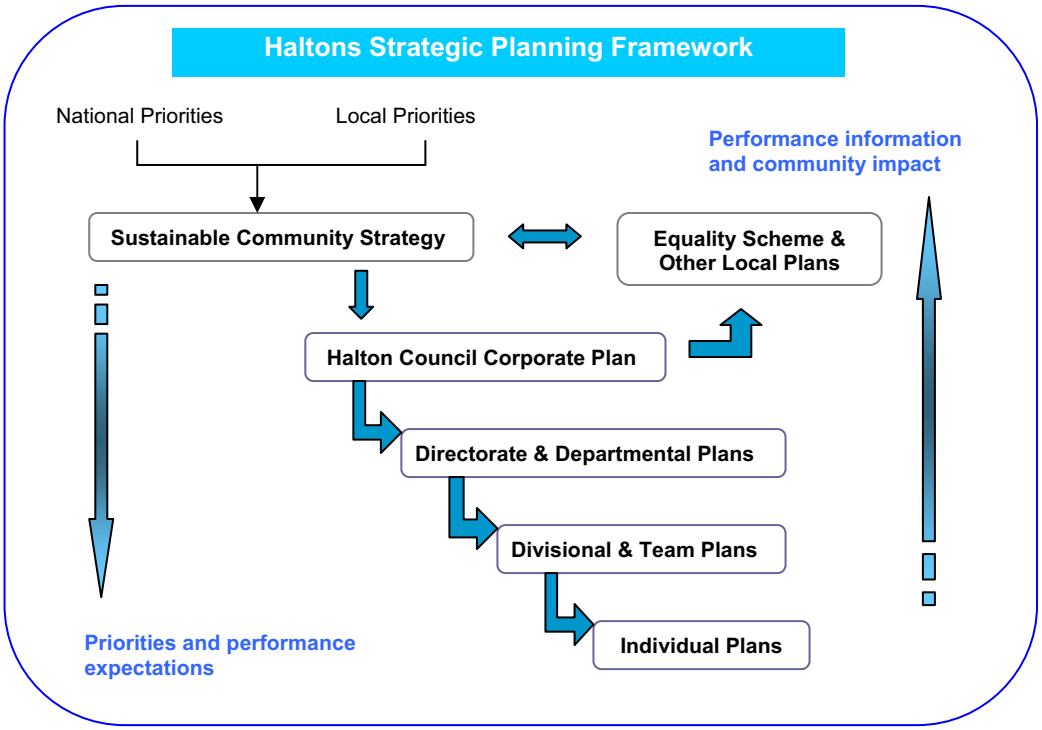
Section 7

Ref	Description	Frequency	Equality Strand
NI 54	Services for disabled children		*Age* / disability
NI 107	KS2 attainment BME	Annual	Race
NI 108	KS4 attainment BME	Annual	Race

Section 8

Management and Monitoring Arrangements

The Council will manage and monitor the delivery of its equality objectives through the existing Corporate Planning framework that is illustrated below. This also shows the strategic linkages between this Equality Scheme and other significant plans within the framework.



This alignment of plans ensures that the strategic priorities of the Council and its partners inform the day to day activities of departments and are informed by the information and intelligence that is acquired through the day to day interaction between individual services and the local community.

The action plan that has been developed as part of this scheme draws from a number of plans within this hierarchy, including the Community Strategy, and the Local Area Agreement contained within it, and will be routinely monitored through:

- ☑ Periodic reports to the Specialist Strategic Partnerships
- ☑ Departmental Quarterly Monitoring Reports to Senior Officers and Elected Members
- ☑ The provision of an annual report to the Corporate Equalities Group.

APPENDIX 1

During the lifetime of the preceding Single Equality Scheme the Council has taken a number of actions to ensure that at both an organisational and partnership service provision has been geared toward inclusivity and participation.

Although it would not be possible to identify all such actions within this scheme the following summary provides an overview of some of the activities and initiatives that have been undertaken.

Initiatives to improve outcomes for disabled people include:

- Establishment of day services centres for adults and older people with Physical and/or Sensory Disabilities (PSD)
- Ensure accessibility all areas where there are Council meetings
- Full accessibility of all polling stations
- HHILS - service established to ensure fewer disabled people are waiting for adaptation's
- Support for the Halton Disability Partnership, whose membership consists of service users and sponsored organisations
- All Council buildings conform to the Disability Standard

Initiatives to improve outcomes for people from different ethnic groups include:

- Partnership working to with CHAWREC establish the BME and Faith Network
- Establishment of the BME Floating Support service (Supporting People) which supports 11 BME families, mainly with children; service users are encouraged to discuss issues that they face of equal opportunity/discrimination
- Production of a Migrant Workers Information Pack
- CYP & Children's Trust Equalities Groups monitors and acts upon reported racist incidents in schools
- Established a senior dialog with the Riverside College to ensure coordination between their overseas student recruitment strategy and the capacity within Halton to meet the needs of those families.
- Increased the number of sites and pitches for Gypsy and Traveller families and established a consultative and support group

- The Health and Community Directorate has an 'Unmet Needs' policy, which provides a mechanism for delivery and assessment staff to record requests for services/equipment which we are unable to meet. This allows us to determine how to prioritise spend (for example by purchasing new equipment if there is sufficient demand) and keeps us up to date on the needs and requirements of our service users.

Initiatives to improve outcomes for people of different ages include:

- The Halton Children's Centre Fishing Club was formed to enable parents and children to use fishing as an activity to help engage young people from disadvantaged backgrounds in combating social exclusion, to help improve young peoples social and interactive skills and help Young People gain confidence with regard to their social abilities and interact and communicate as part of a team through angling. This has also proved to have socio economic benefits
- The Welcome Audit which is carried out annually and has developed practitioners and young peoples understanding of inequality and discrimination and has ensured that these have been addressed to ensure all young people can access the youth provisions. This has been rolled out across Halton Youth Service.
- Establishment of day services centres for adults and older people with Physical and/or Sensory Disabilities (PSD).
- This service also ensures equality of access and service provision for young LGBT people
- Establishment of and support to the Youth Parliament
- CYP has developed information systems enable disaggregation to vulnerable groups and geographically to measure health inequalities
- A Dignity Co-ordinator is in the process of being appointed. Halton BC is the lead partner on the Dignity Champions agenda in the area and has established a network consisting of independent, voluntary and statutory sectors.

Generic Initiatives to improve equality across more than one strand include:

- The Benefits Express service and re-routing of the mobile library service to access hard to reach groups and outlying areas including nursing homes. These services have benefitted the elderly, people with disabilities and benefitted those socio economic groups in need

- The formation of the HSP Equalities and Community Cohesion Group which enable partnership working to deal with issues of equality and diversity
- Inclusion in Housing needs survey of questions about age ethnicity disability, also waiting list and grant applications. User surveys of Adult and Older People's services are disaggregated by ethnicity age gender disability Also all services tracked by same as are complaints.
- .In line with tension monitoring requirements the Council's Cohesion Officers Group has established a Tactical Group which is multi agency and provides live intelligence on community tension indicators which are used to develop proactive solutions.
- The profile of the community has been established by using research from census and other data and where appropriate data extracted from sources such as The Data Observatory, NOMIS, ONS, Paycheck and Acorn.
- To ascertain the scale of irregularities in outcomes between communities the Council has regularly taken an economic, social and environmental audit since 2000. The 2009 State of the Borough report is now published.
- Identification of gaps was part of the development of the Sustainable Communities Strategy
- The Council is currently further developing mapping systems for the National Indicators, particularly Community Cohesion. This is being developed further, for example Hotspot mapping allows the Place Survey data to be shown at small area level. The data extracted can also be compared at local, regional and national level and is currently being analysed further, for example by make up of respondees. This will allow the Council to monitor and, influence and adapt the way its policies and services serve the needs of its community and will facilitate the undertaking of a needs assessment exercise
- The Health and Community Directorate has produced, in partnership with the Health Services, a 'Joint Strategic Needs Assessment' (JSNA) which documents detailed information about the Halton community with a specific focus on health inequalities, including physical and sensory disabilities and mental health issues. There are detailed population statistics, in most cases at ward level, which describe communities within Halton.

- A range pf BVPIs and NIs relating to Equality, Diversity and Community Cohesion have been incorporated into the service planning process and will be monitored at least on a quarterly basis via the quarterly monitoring reports, which are subjedct to scrutiny by PPBs and Chief Officer Management Team.
- A range pf BVPIs and NIs relating to Equality, Diversity and Community Cohesion have been incorporated into the service planning process and will be monitored at least on a quarterly basis via the quarterly monitoring reports, which are subjedct to scrutiny by PPBs and Chief Officer Management Team.

Initiatives to improve equality in the workplace include:

- Introduction of family friendly flexible working practices
- Establishment of worker representative groups to help women, LGBT, disabled and BME staff
- Steps are taking place to improve workforce diversity monitoring, now to include sexual orientation and religious belief. The aim is to have a workforce whose makeup, if possible, mirrors the diverse community that the Council serves
- Equality awareness training for all staff is now included on the induction course. Training for all staff on Equality and Diversity in general and Community Impact review and Assessments in particular is currently being arranged corporately in partnership with external training providers. Training is also being provided for partners within the LSP and to Members who serve on the Partnership Equality, Diversity and Community Cohesion Group.

APPENDIX 2

The Council has adopted a risk-based approach to the Community Impact review and Assessment of existing services to ensure that our response is both proportionate and appropriate. The following table identifies how services will be reviewed during the lifetime of this plan and identifies the extent of relevance to equality issues.

Phase 1 – Highly Relevant Functions

Corporate & Policy Directorate

Department	Division / Function
Exchequer & Customer Services	Customer Services Exchequer Services Revenues & Benefits
Legal, Organisational Development & HR	Personnel Services Committee & Member Services
Policy & Performance	Communication & Marketing

Children & Young People Directorate

Preventative Services	Access Children, Families & Extended Services Integrated Youth Support
Specialist services	Children in Care Children in Need Safeguarding Link to YOT
Universal & Learning Services	14 - 19 Education & Skills Inclusive Learning School Improvement

Environment Directorate

Economic Regeneration	Business Development Enterprise & Employment Adult Learning Skills Development
Environmental & Regulatory	Pest Control Service
Highways & Transportation	Transport Coordination

APPENDIX 2

Health & Community Directorate

Department	Division / Function
Adult Services	ALD - Day Services ALD - Supported Housing Bridge Building ALD - Assessment & Care Management Mental Health - Assessment PSD - Assessment & Care Management
Culture & Leisure Services	Sport & Recreation Community Involvement Community Safety DAT Cultural Services Library Services
Health & Partnerships	Client Finance Gypsies & Travellers Training Customer Care
Older Peoples Services	Care Management Safeguarding Adult Placement Service Community Day Care/Bridgewater HHIILS Community Wardens Homecare Oakmeadow Rapid Access & Rehab Service Dorset Gardens Sure Start to Later Life Community Meals

APPENDIX 2

Phase 2 – Relevant Functions

Corporate & Policy Directorate

Department	Division / Function
Legal, Organisational Development & HR	Legal Services
	Training Services
Policy & Performance	External Funding
	Neighbourhood Management
	Strategic Policy & Partnerships

Children & Young People Directorate

Business Support & Commissioning	Finance & Resources
	Management Info & Communication
	Planning & Performance

Environment Directorate

Environmental & Regulatory	Environmental Health
	Enforcement
	Building Control
Highways & Transportation	Transportation
Major Projects	Castlefields Regeneration
Stadium & Hospitality	Stadium Management

Health & Community Directorate

Culture & Leisure	Parks & Countryside
	Bereavement Services
Health & Partnerships	Finance Services
	Contracts & Supporting People
	Commissioning
	Housing Strategy
	Homelessness Service
	Service Planning
	Personalisation

APPENDIX 2

Phase 3 – Minimally Relevant Functions

Corporate & Policy Directorate

Department	Division / Function
Financial Services	Accountancy Audit
ICT	ICT Services
Legal, Organisational Development & HR	Payroll Services
Policy & Performance	Best Value & Performance Research & Intelligence Risk Management/ Emergency Plan
Property Services	Operations Strategic Asset Management

Environment Directorate

Environmental & Regulatory	Landscape Services Planning & Policy Waste Management
Highways & Transportation	Bridge & Highway Maintenance Highways Maintenance Network Management/Lighting Operational Support Traffic & Road Safety
Major Projects	3MG Management Projects Development Urban Renewal Funding Widnes Waterfront
Stadium Hospitality	School Meals Council Catering

Health & Community Directorate

Health & Partnerships	Management Accountants IT Systems Performance Management

APPENDIX 3

Legislation at a glance

This page provides an overview of the equality and diversity legislation that public bodies must be aware of, plus external links to the full legal texts.

Civil Partnerships Act 2004:
Provides legal recognition and parity of treatment for same-sex couples and married couples, including employment benefits and pension rights. Access the Civil Partnerships Act 2004 at the website of the Office of Public Sector Information. Further information at the Equality and Human Rights Commission (EHRC) website.

Disability Discrimination Act 1995
Outlaws the discrimination of disabled people in employment, the provision of goods, facilities and services or the administration or management of premises. Access the Disability Discrimination Act 1995 at the Office of Public Sector Information (OPSI) website. Further information at the Equality and Human Rights Commission (EHRC) website.

Disability Discrimination Amendment Act 2005
Introduces a positive duty on public bodies to promote equality for disabled people. Access the Disability Discrimination Act 2005 at the OPSI website Further information at the Equality and Human Rights Commission (EHRC) website.

Employment Equality (Age) Regulation 2006
Protects against discrimination on grounds of age in employment and vocational training. Prohibits direct and indirect discrimination, victimisation, harassment and instructions to discriminate. Access the Employment (Age) Regulation 2006 at the OPSI website. Further information at the Acas website and the Local Government Employers website

Employment Equality (Religion or Belief) Regulation 2003
The directive protects against discrimination on the grounds of religion and belief in employment, vocational training, promotion and working conditions. Access the Employment Equality (Religion or Belief) Regulation 2003 at the OPSI website. Further information at the Acas website

The Employment Equality (Sex Discrimination) Regulations 2005
Introduces new definitions of indirect discrimination and harassment, explicitly prohibits discrimination on the grounds of pregnancy or maternity leave, sets out the extent to which it is discriminatory to pay a woman less than she would otherwise have been paid due to pregnancy or maternity issues. Access the Employment Equality (Sex Discrimination) Regulations 2005 at the OPSI website. Further information at the Equality and Human Rights Commission (EHRC) website.

Employment Equality (Sexual Orientation) Regulation 2003
The directive protects against discrimination on the grounds of sexual

orientation in employment, vocational training, promotion, and working conditions. Access the Employment Equality (sexual orientations) Regulation 2003 at the OPSI website. Further information at the Acas website

Equal Pay Act 1970 (Amended)
This gives an individual a right to the same contractual pay and benefits as a person of the opposite sex in the same employment, where the man and the woman are doing: like work; work rated as equivalent under an analytical job evaluation study; or work that is proved to be of equal value. Access the Equal Pay Act (Amendment) 1970 at the OPSI website Further information at the Equality and Human Rights Commission (EHRC) website.

Equality Act 2006
Establishes a single Commission for Equality and Human Rights by 2007 that replaces the three existing commissions. Introduces a positive duty on public sector bodies to promote equality of opportunity between women and men and eliminate sex discrimination. Protects access discrimination on the grounds of religion or belief in terms of access to good facilities and services. Access the Equality Act 2006 at the OPSI website Further information at the Women and Equality Unit website

Gender Recognition Act 2004
The purpose of the Act is to provide transsexual people with legal recognition in their acquired gender. Legal recognition follows from the issue of a full gender recognition certificate by a gender recognition panel. Access the Gender Recognition Act 2004 at the OPSI website. Further information at the Equality and Human Rights Commission (EHRC) website.

Race Relations Act 1976
The Act prohibits discrimination on racial grounds in the areas of employment, education, and the provision of goods, facilities, services and premises. Further information at the Equality and Human Rights Commission (EHRC) website.

Race Relations Amendment Act 2000
Places a statutory duty on all public bodies to promote equal opportunity, eliminate racial discrimination and promote good relations between different racial groups. Access the Race Relations Amendment Act 2000 at the OPSI website. Further information at the Equality and Human Rights Commission (EHRC) website.

Race Relations Act 1976 (Amendment) Regulation 2003
Introduced new definitions of indirect discrimination and harassment, new burden of proof requirements, continuing protection after employment ceases, new exemption for a determinate job requirement and the removal of certain other exemptions.

Access the Race Relations Act 1976 (Amendment) 2003 at the OPSI website. Further information at the Equality and Human Rights Commission (EHRC) website.

Racial and Religious Hatred Act 2006
The Act seeks to stop people from intentionally using threatening words or behaviour to stir up hatred against somebody because of what they believe. Access the Racial and Religious Hatred Act 2006 at the OPSI website Further information at the Equality and Human Rights Commission (EHRC) website.

Sex Discrimination Act 1975
The Act makes it unlawful to discriminate on the grounds of sex. Sex discrimination is unlawful in employment, education, advertising or when providing housing, goods, services or facilities. It is unlawful to discriminate because someone is married, in employment or advertisements for jobs. Access the Sex Discrimination Act 1975 at the Press for Change website. Further information at the Equality and Human Rights Commission (EHRC) website.

The Sex Discrimination (Gender Reassignment) Regulations 1999
The Act seeks to prevent sex discrimination relating to gender reassignment. It clarified the law for transsexual people in relation to equal pay and treatment in employment and training.
Access the Sex Discrimination (Gender Reassignment) Regulations 1999 at the Press for Change website. Further information at the Equality and Human Rights Commission (EHRC) website.

APPENDIX 4

Glossary of commonly used terms

Ageism

This is discrimination against people based on assumptions and stereotypes about their age (both young people and older people in particular)

Anti –Semitism

This refers to unfounded hostility towards the Jewish faith and people. It also refers to the practical consequence of such hostility in unfair discrimination against Jewish individuals and communities and to the exclusion of Jewish people from mainstream political and social affairs.

Community Cohesion

Community Cohesion incorporates and goes beyond the concept of equality and social inclusion. It describes a situation where:

- There is a common vision and a sense of belonging for all communities
- The diversity of people's different backgrounds and circumstances is appreciated and positively valued
- Those from different backgrounds have similar life opportunities
- Strong and positive relationships are being developed between people from different backgrounds in the workplace, in schools and within neighbourhoods

Disability

The loss or limitation of opportunities to take part in society on an equal level with others due to social and/or environmental barriers.

- Impairment – an injury, illness or congenital condition that causes or is likely to cause a long-term effect on physical appearance and/or limitation of function within the individual that differs from the commonplace. The DDA 2005 defines a disabled person as someone with "a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day to day activities".

- The Medical Model of Disability believes that disabled people's inability to join in society is seen as a direct result of having impairment and not as the result of features of society that can be changed.

- The Social model of Disability postulates that disability is not caused by an individual impairment but by the way society fails to meet their needs.

- Disablism refers to the attitudinal, organisational and environmental discrimination faced by disabled people.

- Inclusion is the full integration of disabled people into mainstream activities and services with adequate supports and resources.

Discrimination

Is to treat an individual or group differently and less favourably than others under the same or similar circumstances. The result of discrimination is that it has an unfavourable impact on a specific group.

Discrimination can be direct or indirect

- Direct discrimination means treating one person less favourably than another on the grounds of a personal characteristic such as gender, race or sexuality.

- Indirect discrimination happens where a rule or condition, which is applied equally by everyone:
    - Can be met by a considerably smaller proportion of people from a particular group
    - Is to the disadvantage of that group
    - Cannot be justified by the aims and importance of the rule or condition

Discrimination in the workplace can be experienced as Harassment. This can be defined as unwanted conduct affecting the dignity of people at work. It can include unwelcome verbal, non-verbal and physical conduct (including 'jokes' etc) intimidation or inappropriate personal attention.

Positive discrimination means treating one person more favourably than another on the grounds of a personal characteristic, for example sexuality, gender or race. Positive discrimination is not to be confused with Positive Action

APPENDIX 4

Diversity

The concept of diversity encompasses acceptance and respect. It means acknowledging and understanding that each individual is unique, and recognising and respecting our individual differences. These differences can be with regard to race, ethnicity, gender, sexuality, socio-economic status, age, disability, religion or belief, martial status or physical appearance.

Equality (of Opportunity)

No individual or group receives less favourable treatment on the grounds that are not justifiable, for example, race, disability or gender.

Ethnicity

A group of people that share ethnicity share a common identity, which can be culture, values, language, ancestry, social norms.

- Ethnic Majority – The ethnic group that is the dominant group in the society
- Ethnic minorities – Ethnic groups that are smaller than the dominant group in their society
- Black and Minority Ethnic (BME) – the term used to identify minority ethnic groups in the UK. These groups include bi-racial/mixed heritage people, Asian, Chinese, Black, Gypsy/traveller and other ethnicities

Genuine Occupational Qualifications (GOQs)

Some jobs are likely to restrict certain people from applying because they require GOQs. People who apply for such jobs must possess the personal characteristics that are necessary for the job, for example female care worker proving personal care.

Hate Crime

Any incident which is perceived by the victim or any other person to be motivated by the offenders prejudice against any person because of their actual or perceived sexuality, race etc.

APPENDIX 4

Heterosexism

This is when a person or persons believes that heterosexuals are naturally superior to gay men, lesbians, and bi-sexuals or make the assumption that everybody is heterosexual. It equally applies to men or women who believe they have the right to dominate the smaller minority.

Homophobia

Is an irrational fear and dislike for individuals who identify as gay men, lesbian or bi-sexual. This fear usually results in judgemental, discriminatory or even violent aggressive behaviour.

Islamophobia

This refers to unfounded hostility towards Islam. It also refers to the practical consequences of such hostility in unfair discrimination against Muslim individuals or communities and to the exclusion of Muslims from mainstream political and social affairs.

Transgender

This is a blanket term for any person whose internal gender identity differs from their physiological gender.

Transsexual

A transsexual person is a person who is proposing to undergo, is undergoing, or has undergone a process (or a part of a process) for the purpose of reassigning their sex by changing their physiological or other attributes of sex.

HALTON
BOROUGH COUNCIL

SECTION TWO

COMMUNITY IMPACT REVIEW AND ASSESSMENT

Corporate Guidance Notes and Templates

Embracing diversity, ensuring equality and supporting cohesion

Version control record

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Page	**Amendment(s)**		
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Nature of Revision(s)			
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Document Contact(s)

Mike Foy

Corporate Performance Management Team,
Municipal Building, Kingsway, Widnes Cheshire
Tel: 0151 471 7390 or Internal Ext: 1177 / Fax: 0151 471 7301
E-mail: mike.foy@halton.gov.uk

Section 1

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Section 1

Introduction

The primary purpose of this guidance is to provide practical assistance and guidance in relation to the purpose and completion of Equality Impact Review and Assessments (EIRA's) in terms of:

WHAT Community Impact Review and Assessments are;

WHY they should be undertaken;

WHEN they should be undertaken;

WHO should be involved in their completion;

HOW they should be undertaken and how they should be monitored.

These guidance notes form one element of the management arrangement's that the authority has in place to support the delivery of the Council's diversity agenda. For further information or additional copies of this document please contact your relevant Directorate Equality Representative as detailed below:-

Children & Young People Directorate	Sue Branch	Ext.
		Ext.
Corporate & Policy Directorate	Shelah Semoff	Ext.
	Les Unsworth	Ext.
Environment Directorate		Ext.
		Ext.
Health & Community Directorate		Ext.
	Jo Burrows	Ext.

Section 2

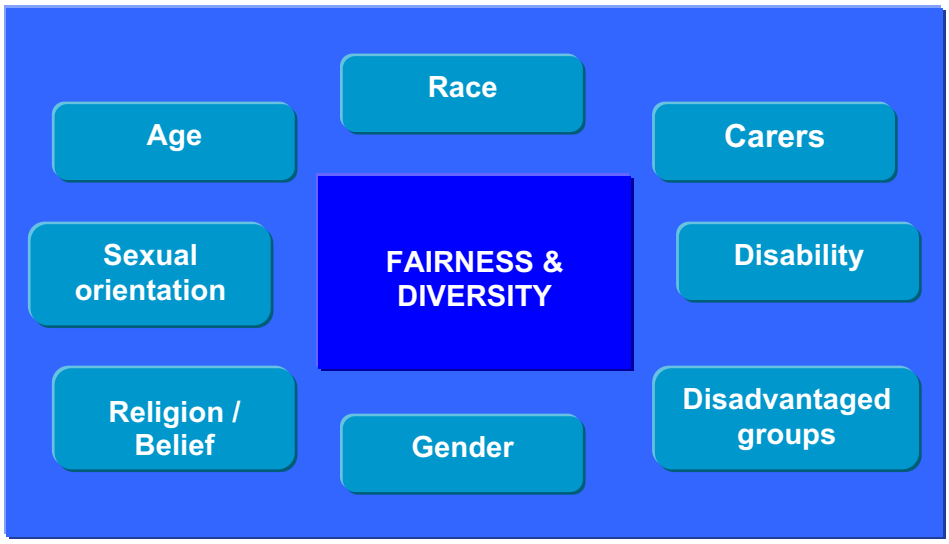
Background and Context

In providing and designing inclusive services that are responsive to the needs of all of the community every officer of the Council has a part to play in considering equality, diversity and cohesion as an integral element of our normal business processes.

Aside from the moral and business case (*as discussed in section 3*) all local authorities have legal responsibilities under the Race Relations Act (2001) and the Gender and Disability Equality Duties to asses both their existing and new policies and functions and to set out how they will monitor any impact on disability/ gender and race equality.

In addition to these requirements the authority will be working towards achieving 'excellent' status within the new Equality Framework for Local Government[1]. As a result we will have to demonstrate that the needs of the following diversity groups[2] have been given consideration in the planning and redesign of new or existing policies and practices.

Along with those nationally recognised equality groups there is also a need, given our local context, to consider the needs of carers and other groups who may be disadvantaged and whose circumstances may make them vulnerable. The table below identifies each of the equality groups relevant to the borough.



[1] Available at http://www.idea.gov.uk/idk/core/page.do?pageId=9491107
[2] For additional information concerning diversity classification please refer to section 1 of this toolkit 'Halton Corporate Equality Scheme'

Section 3

What is a Community Impact Review and Assessment?

Community Impact Reviews and Assessments are a methodology by which the organisation can give structured consideration to issues of equality, social inclusion, and cohesion when reviewing existing or developing new policies, projects, services or functions as described below[3]. For simplicity within this document the term policies / practices will be used to capture all of these issues.

A policy can be written or unwritten, formal or informal. This will include strategies, guides, manuals and common practice. It outlines an approved decision, plan or set of procedures that influence, direct and determine the way that business is carried out both internally and externally.

A project is a temporary structure or scheme created to achieve a specified business benefit or goal. This includes functions and events that are carried out either annually, regularly or on an ad-hoc basis.

A service usually refers to facilities, resources or provisions made by the Council for its residents. This is made either directly or indirectly through partnership with the public or through financing the provision of services with third sector agencies and other organisations.

A function usually refers to actions assigned to, required by or expected of the Council e.g. a waste disposal facility.

If managed effectively the process of undertaking an assessment represents a systematic approach to assessing and recording the actual or potential impact that the Councils activities may have upon different groups of people. It also provides the opportunity to analyse the potential consequences upon any particular group in order that they can, as far as possible, be eliminated or minimised and that opportunities for ensuring equality can be maximised.

Community Impact Reviews and Assessments are intended to ensure that the organisation has fully considered the needs of the whole of the community when developing and reviewing its activities and that it is able to demonstrate transparency and accountability in relation to the outcomes being sought and achieved.

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[3] For the purposes of consistency of understanding and application these definitions have been derived from the Improvement and Development Agency's online learning resource which can be accessed via http://www.idea.gov.uk/idk/core/page.do?pageId=8017247

Section 3

What is an impact?

An impact is defined as the intentional or unintentional affect that the actions of the Council has upon the communities of Halton.

The primary purpose of the CIRA process is to understand how our polices and procedures may affect different groups of people in different ways.

Differential impact suggests that a particular group has been affected differently by the policy (either favourably or unfavourably).

A negative or adverse impact occurs when one or more equality target group could be disadvantaged by the policy / practice in question and may be unlawful. This impact could be differential where the negative impact upon one particular group may be greater than on another.

For example an employment policy may have an adverse impact upon all those with child care responsibilities but may have a greater impact upon women than men given that they are disproportionately represented within the group.

A positive impact occurs whereby equal opportunities and / or relationships between groups are improved. This impact could also be differential in that the positive impact upon one particular group of individuals or equality group may be greater than on another.

For example an activity aimed at women from one particular racial / religious group may have a positive differential impact than on other equality groups such as other women or other racial / religious groups. In such circumstances the policy / procedure may be justifiable and lawful on the grounds of improving equality of opportunity or improving relations between groups.

They will also allow the organisation to determine whether there is likelihood, or that the possibility exists, that either direct or indirect discrimination could occur and to act appropriately to develop mitigating or neutralising actions.

Direct discrimination occurs whereby a person or group is treated less favourably upon the grounds of race, gender disability, sexual orientation, religion, faith, belief or age e.g.

- A policy that charges only specific groups a deposit for use of a facility to cover damages

Indirect discrimination occurs where an apparently neutral provision, criteria or practice disadvantages the members of one group or community e.g.

- A residency requirement, e.g. proof of address being required to access a service, which would discriminate against homeless people.

The CIRA process is a systematic approach to establishing the extent to which peoples needs are being met and identifying the impact of the Council's policies and procedures and involves taking the following steps.

Community Impact Review & Assessment – A two stage approach

REVIEW

Step 1 Identify the aims and purpose of the policy or practice

Step 2 Gather and analysing relevant data and intelligence

Step 3 Make an assessment of the impact that the policy / practice may have upon different equality groups.

Step 4 If no adverse impact can be determined complete Community Impact Review Template and sign off (including any relevant actions in Directorate Action Plans / Departmental Service Plans)

ASSESSMENT

Step 5 Gather further relevant data / consult and give consideration to whether anything could be done to mitigate against any negative impact or to further promote equality, inclusion and cohesion

Step 6 Identify any changes / actions required or whether to proceed with the actual or proposed policy / procedure

Step 7 Complete Community Impact Assessment Template and sign off (including any relevant actions in Directorate Action Plans / Departmental Service Plans)

Step 8 Make arrangements to publish findings of the Equality Impact Assessment

Section 4

Why should a Community Impact Review / Assessment be undertaken?

The following section summarises the moral, business and legal case for undertaking Community Impact Reviews and Assessments. When undertaken effectively they will help to:-

- ☑ Determine the actual or potential impact of our policies and practices upon different sections of the community including those relating to health;
- ☑ Better inform and improve decision making processes by having a fuller understanding of the needs and expectations of discrete community groups and as far as possible configure our service delivery mechanisms to meet those needs and to improve the appropriateness and accessibility of services;
- ☑ Develop ways of monitoring and reviewing the effects of our new or existing polices and procedures to ensure that we take steps to eliminate or deal with any unintended consequences and;
- ☑ Maximise the opportunities for embracing diversity, ensuring equality and supporting cohesion.

The moral and business case

As a democratically elected provider of local public services the Council has a moral and ethical duty to act in a manner that does not marginalise any sector(s) of the community and that supports social inclusivity and cohesion. In addition we have a responsibility to ensure that every individual has equal access to the services that we provide and that we support an environment where groups and individuals can make the most of the opportunities and life chances that are on offer.

Undertaking impact reviews and assessments will allow the authority to ensure that through its business intelligence and planning processes it provides fair treatment for all within the wider community of the borough.

'The added value is created not simply by the act itself but more often by the quality of thought that preceded it'

Furthermore a systematic review of existing policies and functions will provide the opportunity to ensure that any actual or potential barriers to fair treatment that may exist can be identified and removed.

In order for any organisation to flourish and succeed it requires a sufficient base of knowledge and understanding of the needs, perceptions, expectations and aspirations of those who use, or may need or wish to use, its services.

As the Council is an organisation which is driven by social profit it is particularly important that it has the means by which such information can be captured, understood and used in all aspects of its policy making, service delivery arrangements and employment practices.

Whilst historically equality issues have generally been inwardly focussed, i.e. concerned primarily with employment practices, the CIRA methodology provides a more outwardly focussed and outcome based approach to managing our business. As social expectations continue to rise, and the benefits that valuing diversity can bring become more commonly recognised and understood, the EIRA process can be used effectively to facilitate the shift in public services away from traditional service 'delivery' to service 'provision' through the development of user focussed services which are delivered to an increasingly diverse range of users and through an increasingly diverse range of channels.

Tackling inequality, disadvantage and discrimination and supporting people whose circumstances make them vulnerable form two of the four key themes within the national Comprehensive Area Assessment framework. In forming a judgement inspectors will look at how effectively the authority engages with communities and how well they understand the needs of vulnerable and marginalised groups. In this respect the CIRA process will provide useful evidence that we have analysed, understood and acted upon the needs of all citizens in the development and redesign of our policies and practices.

Notwithstanding those legal obligations referred to below these are compelling reasons for adopting the CIRA process as a transparent and effective means of securing equality of access, engagement, service design and inclusive delivery options.

Statutory and Legal responsibilities

The Council has a range of statutory and legislative responsibilities and general duties to promote equality of opportunity and relations between groups and to eliminate unlawful discrimination.

At present such responsibilities require public bodies to demonstrate they are taking action on race, disability and gender equality in policy making, the delivery of services and in employment practices.

These duties, within the forthcoming Equality Bill (what is the status of the Bill at present – ask Rob Barnet) will be harmonised into a single duty that will cover seven equality strands:- age, disability, gender and gender identity, race, religion or belief and sexual orientation.

Although it is likely that these changes will only become effective from the end of 2011 it is important that we continue to meet our existing responsibilities and that we begin to gather and use information and intelligence across all seven equality strands.

In addition it has to be remembered that within the local context there may be other groups, such as carers and those whose socio-economic circumstances may make them vulnerable, that also need to be considered when developing or revising policy and service delivery approaches.

The above provides an overview of the various and extensive legislative and statutory requirements for which the authority has a responsibility.

Additional details and links to external texts are provided within Appendix 1 – 'Legislation: at a glance'[4]

'Community Impact Reviews and Assessments are not merely concerned with mitigating against any identifiable adverse impact but provide the opportunity for the organisation to focus upon service improvement and the delivery of better outcomes for disadvantaged equality groups.'

[4] Derived from IDEA website at http://www.idea.gov.uk/idk/core/page.do?pageId=5145524

When should a Community Impact Review / Assessment be undertaken?

Not all circumstances or proposals will necessarily warrant a Community Impact Review and Assessment and it is a matter of judgement as to the approach that is taken.

For example as a result of highway maintenance works the decision to temporarily relocate a bus stop 20 feet away from the original site for a short period of time may not necessarily require a review or assessment. However moving a disabled parking bay 20 yards may have serious consequences for disabled drivers and therefore and CIRA would be relevant.

New or proposed policies / practices.

In relation to new policies and practices the CIRA should form an integral element of the development process and should be completed in advance of any policy / practice being formally considered for approval or endorsement.

It is therefore important that the findings of any review / assessment are included within any proposal that is being made.

Those responsible for undertaking CIRA's must make a judgement as to whether there is a differential impact arising from the proposed policy / practice and then determine if that impact is adverse based upon a systematic assessment of the accumulated information.

If the impact is adverse decision makers will need to consider whether it is, or is not, unlawfully discriminatory and as a result give consideration to appropriate mitigation measures or alternative policies / practices.

It should be remembered that, by definition, any policy / practice that is targeted at particular groups will have a differential impact. The assessment of this impact must take into account whether it is unlawful and unjustifiable or whether it is intended and justified to address the needs of a particular group.

If the first stage Community Impact Review reveals that a policy / practice is likely to be unlawfully discriminatory then there is no requirement to proceed to the second stage Assessment and the policy / practice should be abandoned. Any new policies / practices that are then proposed should be subject to a further CIRA.

Existing policies / practices

Departments need to have in place arrangements for the proportionate and risk based review of existing policies and practices. The purpose of this approach is to ensure that existing practices, which may have been in place for some time, do not have unintended consequences in relation to fair treatment across each of the quality strands.

Such arrangements should be developed alongside the Council's annual business planning cycle and would compliment existing arrangements for the development of Departmental Service Plans and the CIRA of service policies / practices.

Who needs to be involved in the process?

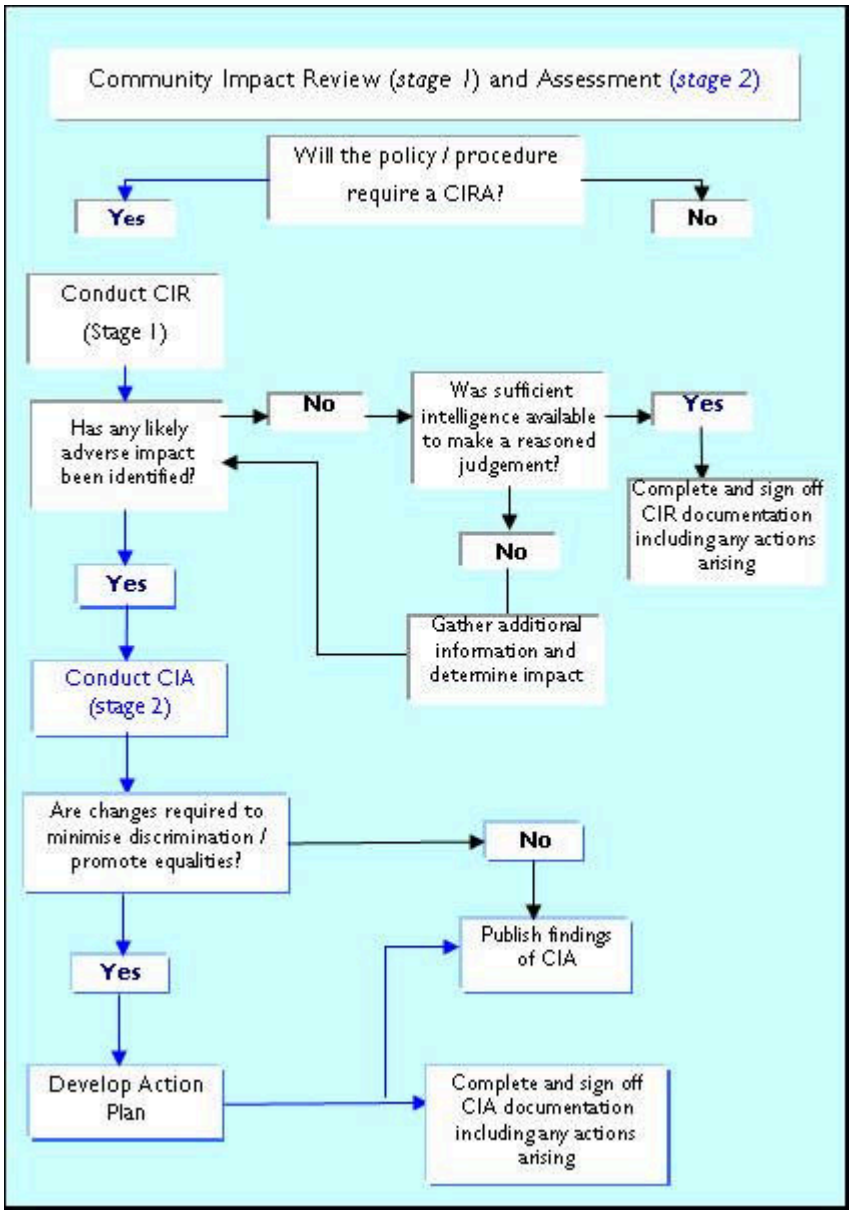
Ownership of and responsibility for undertaking CIRA's lies at the service level and rests with those who are delivering the policy, project, practice or procedure. As such each EIRA should have a named Lead Officer who will act as the primary point of contact both during and after the process is complete. This would normally be the senior manager responsible for the implementation of the policy / practice.

Given that undertaking CIRA will involve predicting and assessing what the implications of the policy / practice will be for a range of people from diverse groups it is advisable that review teams be formed that would include front-line staff and other relevant service managers. It may also be helpful to use a directorate equalities representative as a critical friend at both the outset of the process and during key stages of its implementation.

It should be remembered that a stage 2 Community Impact Review will require consultation with a range of stakeholders who have a legitimate interest in the policy / procedure under consideration particularly representatives from the equality target group(s) who are likely to be affected.

How should a Community Impact Review / Assessment be undertaken?

In order that the process of assessment remains manageable and practical a two-stage process has been developed that comprises of a Community Impact Review (CIR) and Assessment (CIA) as illustrated within the diagram below.



A stage one review is used to determine if there is any possibility that a differential and adverse impact exists and provides an opportunity for such impacts to be removed before any decision is taken to endorse and implement, or continue with the policy or procedure.

A stage two assessment should be undertaken where either:-

I. there remain concerns that there will be a differential or adverse impact upon one or more of the equality strands identified or;

II. there is a statutory requirement for public consultation regarding the policy being developed or reviewed

What is an impact?

An impact is defined as the intentional or unintentional affect that the actions of the Council has upon the communities of Halton.

The primary purpose of the CIRA process is to understand how are polices and procedures may affect different groups of people in different ways.

A differential impact suggests that a particular group is, or could be, affected differently by the policy / practice.

There are 2 possible impacts that need to be considered when undertaking a Review or Assessment:-

A negative or adverse impact, which is potentially unlawful, occurs when one or more equality target groups could be disadvantaged by the policy / practice in question. This impact could also be differential where the negative impact upon one particular group may be greater than on another.

For example an employment policy may have an adverse impact upon all those with child care responsibilities but may have a greater impact upon women than men given that they are disproportionately represented within the group.

A positive impact occurs whereby equal opportunities and / or relationships between groups are improved. This impact could also be differential in that the positive impact upon one particular group of individuals or equality group may be greater than on another.

For example an activity aimed at women from one particular racial / religious group may have a positive differential impact than on other equality groups such as other women or other racial / religious groups. In such circumstances the policy / procedure may be justifiable and lawful on the grounds of improving equality of opportunity or improving relations between groups.

Section 6

General Issues

Consideration should be given, as you review existing or develop new policy / practice proposals, to the impact that they may have upon each of the diversity strands identified below. These are not intended to provide a comprehensive or exhaustive list of issues but should help to give an indication of those aspects of equality and diversity that may need to be taken into account.

Age - Older People: Issues may include

- living in a safe community / own home
- feeling of loneliness / isolation / bereavement / being in control and having choice
- reduced income / access to local facilities / affordable accessible transport / mobility

Age - Younger People: Issues may include

- income and budget management
- access to affordable leisure activities / education / training / employment / housing
- personal development / relationships / peer pressure / bullying

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Disability / Carers: Issues may include

- Social isolation / low income / reduced employment
- Access to transport / buildings / services
- Physical and sensory access and learning difficulties
- Safety & security and participation in public life

Gender Groups (incl. Transgender): Issues may include:

- *Stereotyping / bullying / harassment*
- *Understanding of needs and dress codes*
- *Educational attainment and school exclusion*
- *Access to and take up of health services*
- *Caring responsibilities and flexible working*
- *Access to single sex facilities*
- *Domestic violence / homophobic attitudes*

Race / Ethnicity: Issues may include

- *Awareness of, and access to, appropriate services / jobs / training and isolation from peers*
- *Access to translation and interpretation services*
- *Culture e.g. dietary needs / dress codes*
- *Educational attainment / exclusion rates between different racial groups*
- *Racial harassment and violence*
- *Support for voluntary and community groups and business development*

Religion or Belief: Issues may include

- *Dietary requirements and fasting*
- *Religious calendars / festivals and practices for prayer*
- *Arrangements for birth and bereavement*
- *Religious observance e.g. washing and bathing facilities*

Sexual orientation: Issues may include

- *Isolation / bullying and hate crime*
- *Stereotyping / right to privacy / intrusive questions.*
- *Assumptions concerning partners and family types / invisibility / dignity and inclusion*

Other Disadvantaged Groups: Issues may include:

- *Access to services by those whose socio-economic circumstances may make them vulnerable e.g.*
    - *high levels of deprivation in comparison to other areas of the borough (Index of Multiple Deprivation)*
    - *Homelessness / substance abuse*
    - *Low literacy / numeracy levels*
    - *Lone / young parents*

Section 6

The use of data, information and intelligence

The availability and effective use of information is an intrinsic element of the CIRA process. Whether internally or externally derived both quantitative and qualitative data will be needed to be able to successfully determine the actual or potential impact that policies / procedures may have upon equality groups.

Quantitative data is that which relates to numerical values derived form either a general population or a sample within that population.

Such data may be helpful in ascertaining the extent to which certain equality groups represent users or non-users of a service in the context of the local demographic and social profile or differential satisfaction levels between groups

Qualitative data relates to the experiences of individuals from their perspective, most often with less emphasis upon numerical values or statistical analysis. It is more likely that consultation in its various forms will provide a qualitative dimension to the extent to which groups and individuals feel that they are affected by, or can affect, the activities of the Council.

Each method of data collection has inherent advantages and disadvantages. For example, quantitative procedures allow data to be gathered from a large number of people relatively efficiently, but the information may be less rich than that derived from more intensive qualitative techniques. To overcome problems associated with any one method it is recommended that a range of techniques is used.

The various sources of information, both primary and secondary, may vary and will be dependant in part upon the nature of the policy / procedure being assessed. Such sources may include:-

- Information from the Corporate Research & Intelligence Unit
- Information from partner agencies, such as the PCT / Police
- Service Monitoring Reports
- User and Elected Member feedback / survey data
- Workforce monitoring
- Outcome of specific consultation exercises and feedback from individuals or organisations representing key target groups.

- The knowledge and experience of Council Officers and those people engaged in the completion of Community Impact Reviews and Assessments.
- Research information available through the internet for example through government departments and other agencies such as the Equality and Human Rights Commission etc.

Further guidance in relation to equality monitoring is included within section 3 of the toolkit.

The following sections will provide detailed guidance concerning the completion of a Stage 1, Community Impact Review, and Stage 2 Assessment.

Undertaking and CIRA should be considered an integral element of the Council's effective policy and service development process and not be seen as a discrete activity that is undertaken in isolation or once new policies / procedures have been endorsed or approved.

Completing a Community Impact Review / Assessment

All policies / procedures will have either a positive / negative / neutral impact upon each of the diversity strands referred to earlier in this document. The primary purpose of a stage I review is to determine either the extent to which a reasoned judgement can be made based upon available data and information or to identify where an adverse impact may become evident.

The following provides a step by step guide to undertaking a review and completing the corporate template developed for this purpose, which is included within section 4 of this toolkit.

Please note the CIRA Reference number should comprise of a directorate level identifier, the departmental initials, a number denoting the financial year and the sequential reference denoting a Stage 1 Review (R) or Stage 2 Assesment (A).

For example the refrence CP / PP / 09 / 01(R) would indicate

Corporate & Policy Directorate
Policy and Performance Department
2009 Financial year
Review Number 01

CIRA Ref		
Lead Officer	Name	
	Position	
	Contact details	

SECTION 1 –Context & Background

1.0 What is the title of the policy / practice?

This section should clearly articulate the subject and boundary of the review / assessment

1.1 What is the current status of the policy / practice?

Existing ☐ New ☐

1.2 Who are the main stakeholders and who has primary responsibility for delivering the policy / practice?

This could include specific divisions, groups of staff / teams, customers and partner agencies. In regard to statutory responsibilities central or regional government may be a key stakeholder and any statutory responsibilities may need to be identified / referred to.

For policies / practices developed in a corporate context responsibility for delivery is generally devolved to specific departments or delivery agents such as working groups.

1.3 Are there any other related policies / practices?

This section should identify any policies / practices related to that being reviewed. If a whole service area is under review this information may be included as an appendix.

1.4 Who is the policy / practice intended to affect?

Residents ☐ Staff ☐ Specific Group(s) ☐ (add details below)

1.5 What are the principal aims and the intended outcomes of the policy practice?

This section should identify any policies / practices related to that being reviewed. If a whole service area is under review this information may be included as an appendix.

SECTION 2 – Consideration of Impact

2.1 Is there sufficient evidence to determine, on the balance of probability, that the policy / practice has, or could have, an impact upon each of the equality groups identified below?

Yes ☐ (proceed to question 2.4) No ☐

2.2 Where further data / intelligence / consultation is required please provide details below.

Information Source / Planned Activity	Timeframe	Lead Officer
This section should identify what information is being sought and what activity will be undertaken to acquire it	*Should provide the date(s) by which the activity will be completed*	*Should provide details of individual officers responsible for undertaking / completing the work.*

2.3 What were the principal findings / conclusions of this research / consultation?

2.4 On the basis of evidence has the actual / potential impact of the policy / practice been judged to be positive (+), neutral (=), or negative (-) for each of the equality groups and is the level of impact considered to be high (H), Medium (M) or low (L)?

Policy / practice dimension	Equality Strand	Impact	
		Type	Level
Where a comprehensive policy / relatively broad practice is being considered it may be appropriate to identify each aspect e.g. in considering the provision of a library service issues may arise concerning library membership, access to facilities etc.	Age		
	Carers		
	Disability		
	Gender		
	Race / ethnicity		
	Religion / belief		
	Sexual Orientation		
	Socio-economic Disadvantage		

2.3 Are any of these impacts health related?

Yes ☐ No ☐

Advisory Notes:

Where an actual or potential negative impact has been identified, a Stage 2 Assessment will be required - refer to section 3.

In relation to the level of impact it should be remembered that this relates to the number of people affected as a proportion of the equality group and not as a proportion of the population as a whole. The level of impact should be considered as;-

Low = Marginal short-term impact on small number within the group(s).

Medium = Medium term impact on a moderate number within the group(s).

High = Medium to longer-term impact upon a significant number within the group(s).

Where a positive deferential impact has been identified as a result of activity intended to further equality or community cohesion, e.g. where one equality group may be more positively affected than another, or in relation to the general population as a whole, this will need to be justified within the following section.

2.5 What data and information has been used in determining the positive / neutral impact of the policy / procedure under review in relation to promoting equality or good relations or eliminating discrimination and is this justifiable and lawful in regards to any negative impacts for other groups?

Equality Group(s)	*Section should identify those groups that will be positively affected by the policy / practice* ***e.g.*** *A dedicated 50+ men's health initiative would have a positive impact upon age and gender.*

Baseline data and information
Should provide details of the quantitative and / or qualitative evidence that has been used to support the judgement ***e.g.*** *National Statistics (identify data source) show that males over 50 are less likely to visit GP surgery for advice and treatment.* *Local statistics (as above) confirm low attendance rates particularly in Wards X and Y where disproportionate rates of ill health occur within the cohort group*

Nature of impact and where this is positive justification
e.g. *The intended impact of the Over 55's Men's Health project is to improve the health of the group by facilitating earlier medical intervention and providing focused health advice and education.* *Whilst the initiative will reduce the availability of GP's to other groups this is considered justifiable in that existing opportunities for such groups to access medical advice are comprehensive and levels of ill-health amongst target group are disproportionately high in comparison to other groups.*

Additionally the project will be piloted within the most affected areas of the borough to minimise any negative impact upon other groups and the community as a whole.

2.6 How will the impact of the policy / practice be monitored?

Section should clearly identify the means by which the ongoing impact of the policy / practice will be measured.

e.g. *Number of GP referrals of cohort group i.e.*

Number of males 50+ attending sessions and follow up visits within wards X and Y and in comparison to National and Borough wide attendance rates.

2.7 Who will be responsible for monitoring and how will this be arranged?

Should state what vehicle will be used e.g. periodic monitoring of data by Operational Director / SMT

2.8 What actions, if any, has this review identified (that do not form part of a stage 2 assessment) to promote equality of opportunity or relations between groups and to support community cohesion? If no actions have been identified please insert 'no further action identified' within first column.

Action & purpose / outcome	Priority	Timeframe	Lead Officer
This section should identify any activities that may have been identified to facilitate effective monitoring, further promote equality or social inclusion or relations between different groups. **e.g.** *Robust arrangements, including named data handlers and a data sharing protocol, need to be in place with PCT to capture timely data for referrals / attendances*	*High*	*Sept 2009*	*A.N. Other*

2.9 Summary of stakeholders involved in this review

Job Title or Name	Organisation / representative of

2.10 Stage 1 Review - Completion Statement

As the identified Lead Officer of this review I confirm that:- (Please complete only one of the following sections)	
1. A negative impact has been identified for one or more equality groups and that a Stage 2 Assessment is required	☐
2. There is sufficient information available to provide assurance that there will be a positive differential impact for one or more equality groups, and that this is justifiable and lawful OR a neutral impact has been determined, and that details of the review and the actions arising from it have been provided to the Directorate Equality Lead Officer for inclusion within the Directorate Register.	☐

Signed	
Dated	

SECTION 3

3.1 Is this stage 2 Assessment being undertaken because:-

There is a specific statutory duty to consult upon this policy / practice	☐
A negative impact has been identified and consideration needs to be given to terminating the proposed policy / identifying mitigating actions	☐

3.2 Where consultation is required please provide details of how this will be managed below.

Nature of consultation	Timeframe	Lead Officer
This section should identify how consultation will be undertaken e.g. placed on public deposit, representative focus groups etc	*Should provide the date(s) by which the activity will be completed*	*Should provide details of individual officers responsible for undertaking / completing the work.*

3.3 What were the principal findings / conclusions of this research / consultation?

3.4 Where a negative impact has been identified for one or more groups please provide details below?

Policy / practice dimension	Equality Strand	Impact	
		Type	Level
Where a comprehensive policy / relatively broad practice is being considered it may be appropriate to identify each aspect e.g. in considering the provision of a library service issues may arise concerning library membership, access to facilities etc.	Age		
	Carers		
	Disability		
	Gender		
	Race / ethnicity		
	Religion / belief		
	Sexual Orientation		
	Socio-economic Disadvantage		

3.5 What is the nature of this impact?

Group(s)	Nature of impact

3.6 In light of this impact is it considered appropriate to?

Discontinue the policy / procedure as unlawful or unjustifiable	☐
Revise the policy / procedure and or take the following action(s) to minimise or remove any negative impact	☐

3.7 Details of policy revision / mitigating actions?

Action	Purpose / outcome	Priority	Timeframe	Lead Officer

3.8 How will the impact of the policy / practice be monitored?

Section should clearly identify the means by which the ongoing impact of the policy / practice will be measured.

3.9 Who will be responsible for monitoring and how will this be arranged?

Should state what vehicle will be used e.g. periodic monitoring of data by Operational Director / SMT

3.10 Stage 2 Assessment - Completion Statement

As the identified Lead Officer of this review I confirm that:-
(Please complete only one of the following sections)

1. An unlawful and unjustifiable negative impact has been identified and the policy / practice has been discontinued ☐

2. The policy / practice has been modified / actions identified to mitigate against any negative impact and that details of the assessment and the actions arising from it have been provided to the Directorate Equality Lead Officer for inclusion within the Directorate Register. ☐

Signed	
Dated	

Section 7

How should impact reviews and assessments be monitored?

This section is subject to finalisation as a result of emerging circumstances and resource implications. However the following approach is, at this stage, considered the preferred option.

Actions Arising from CIRA

Actions arising from the CIRA processes will need to be periodically monitored to ensure the progression of identified actions and that any necessary intervention is undertaken in a timely and effective manner.

It is therefore proposed that:

Details of all CIRA's undertaken will be submitted to the Directorate Equality, Diversity and Cohesion Lead Officer (EDCLO) for inclusion within the Directorate Register.

All low, medium and high priority actions arising from the CIRA will then be included within the relevant Directorate Action Plan and monitored by the Directorate Equalities Group bi-annually.

All high priority actions will also be monitored as an element of the Departmental Quarterly Monitoring Report cycle i.e. quarterly.

Where actions have been identified following Departmental Service Plan (DSP) finalisation in a given year actions should be retrospectively added to the relevant plan and associated monitoring report. An appropriate footnote should be included to identify the point I time at which the action was added.

It will be the responsibility EDCLO to advise the appropriate Service Plan and Monitoring Report support officer (*currently within the Corporate Performance Management Team*) of any such high priority actions

Departmental CIRA Registers

As a minimum each departmental CIRA register should contain the following information.

CIRA Ref	Lead Dept	Lead Officer	Contact Details	Date complete	Actions			Added to DSP
					L	M	H	

Appendix 1

Legislation: at a glance

This page provides a round-up of all the equality and diversity legislation that public bodies must be aware of, plus external links to the full legal texts.

Civil Partnerships Act 2004:
Provides legal recognition and parity of treatment for same-sex couples and married couples, including employment benefits and pension rights.
Access the Civil Partnerships Act 2004 at the website of the Office of Public Sector Information
Further information at the Equality and Human Rights Commission (EHRC) website.

Disability Discrimination Act 1995
Outlaws the discrimination of disabled people in employment, the provision of goods, facilities and services or the administration or management of premises.
Access the Disability Discrimination Act 1995 at the Office of Public Sector Information (OPSI) website
Further information at the Equality and Human Rights Commission (EHRC) website.

Disability Discrimination Amendment Act 2005
Introduces a positive duty on public bodies to promote equality for disabled people.
Access the Disability Discrimination Act 2005 at the OPSI website
Further information at the Equality and Human Rights Commission (EHRC) website.

Employment Equality (Age) Regulation 2006
Protects against discrimination on grounds of age in employment and vocational training. Prohibits direct and indirect discrimination, victimisation, harassment and instructions to discriminate.
Access the Employment (Age) Regulation 2006 at the OPSI website
Further information at the Acas website and the Local Government Employers website

Employment Equality (Religion or Belief) Regulation 2003
The directive protects against discrimination on the grounds of religion and belief in employment, vocational training, promotion and working conditions.
Access the Employment Equality (Religion or Belief) Regulation 2003 at the OPSI website
Further information at the Acas website

Appendix 1

The Employment Equality (Sex Discrimination) Regulations 2005
Introduces new definitions of indirect discrimination and harassment, explicitly prohibits discrimination on the grounds of pregnancy or maternity leave, sets out the extent to which it is discriminatory to pay a woman less than she would otherwise have been paid due to pregnancy or maternity issues.
Access the Employment Equality (Sex Discrimination) Regulations 2005 at the OPSI website
Further information at the Equality and Human Rights Commission (EHRC) website.

Employment Equality (Sexual Orientation) Regulation 2003
The directive protects against discrimination on the grounds of sexual orientation in employment, vocational training, promotion, and working conditions.
Access the Employment Equality (sexual orientations) Regulation 2003 at the OPSI website
Further information at the Acas website

Equal Pay Act 1970 (Amended)
This gives an individual a right to the same contractual pay and benefits as a person of the opposite sex in the same employment, where the man and the woman are doing: like work; work rated as equivalent under an analytical job evaluation study; or work that is proved to be of equal value.
Access the Equal Pay Act (Amendment) 1970 at the OPSI website
Further information at the Equality and Human Rights Commission (EHRC) website.

Equality Act 2006
Establishes a single Commission for Equality and Human Rights by 2007 that replaces the three existing commissions. Introduces a positive duty on public sector bodies to promote equality of opportunity between women and men and eliminate sex discrimination. Protects access discrimination on the grounds of religion or belief in terms of access to good facilities and services.
Access the Equality Act 2006 at the OPSI website
Further information at the Women and Equality Unit website

Gender Recognition Act 2004
The purpose of the Act is to provide transsexual people with legal recognition in their acquired gender. Legal recognition follows from the issue of a full gender recognition certificate by a gender recognition panel.
Access the Gender Recognition Act 2004 at the OPSI website
Further information at the Equality and Human Rights Commission (EHRC) website.

Appendix 1

Race Relations Act 1976
The Act prohibits discrimination on racial grounds in the areas of employment, education, and the provision of goods, facilities, services and premises.
Further information at the Equality and Human Rights Commission (EHRC) website.

Race Relations Amendment Act 2000
Places a statutory duty on all public bodies to promote equal opportunity, eliminate racial discrimination and promote good relations between different racial groups.
Access the Race Relations Amendment Act 2000 at the OPSI website
Further information at the Equality and Human Rights Commission (EHRC) website.

Race Relations Act 1976 (Amendment) Regulation 2003
Introduced new definitions of indirect discrimination and harassment, new burden of proof requirements, continuing protection after employment ceases, new exemption for a determinate job requirement and the removal of certain other exemptions.
Access the Race Relations Act 1976 (Amendment) 2003 at the OPSI website
Further information at the Equality and Human Rights Commission (EHRC) website.

Racial and Religious Hatred Act 2006
The Act seeks to stop people from intentionally using threatening words or behaviour to stir up hatred against somebody because of what they believe.
Access the Racial and Religious Hatred Act 2006 at the OPSI website
Further information at the Equality and Human Rights Commission (EHRC) website.

Sex Discrimination Act 1975
The Act makes it unlawful to discriminate on the grounds of sex. Sex discrimination is unlawful in employment, education, advertising or when providing housing, goods, services or facilities. It is unlawful to discriminate because someone is married, in employment or advertisements for jobs.
Access the Sex Discrimination Act 1975 at the Press for Change website
Further information at the Equality and Human Rights Commission (EHRC) website.

The Sex Discrimination (Gender Reassignment) Regulations 1999
The Act seeks to prevent sex discrimination relating to gender reassignment. It clarified the law for transsexual people in relation to equal pay and treatment in employment and training.
Access the Sex Discrimination (Gender Reassignment) Regulations 1999 at the Press for Change website
Further information at the Equality and Human Rights Commission (EHRC) website.

HALTON BOROUGH COUNCIL

SECTION THREE

EQUALITY & DIVERSITY MONITORING

Using it to make a difference

Corporate Guidance Notes

Embracing diversity, ensuring equality and supporting cohesion

Version control record

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Document Contact(s)

Mike Foy

Corporate Performance Management Team,
Municipal Building, Kingsway, Widnes Cheshire
Tel: 0151 471 7390 or Internal Ext: 1177 / Fax: 0151 471 7301
E-mail: mike.foy@halton.gov.uk

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Section 1

Introduction

Diversity monitoring promotes more choice and better value. Halton Council adopted the diversity monitoring categories in 200? to help inform it of the different needs of its diverse communities and therefore improve the way it designs and delivers its services to local residents.

This guidance is designed to assist officers on how to use the diversity monitoring categories when gathering information about service users/residents/non-users and to use that knowledge as evidence to prioritise the delivery of appropriate public services.

Diversity monitoring emerged from the Race Relations Amendment Act 2000 duty placed on public authorities to collect ethnicity data about its workforce. However, Halton Council widened the scope to collect a range of diversity data relating to both employment practice and service delivery.

The categories enable the council to collect information on age, disability, ethnicity, faith/belief, gender and sexual orientation.

Production of a Corporate Diversity Monitoring Form setting out minimum standards of what diversity data is needed at an organisational and partnership level is presently being considered. However service areas may need bespoke monitoring forms which best reflect the most relevant data they need to collect to improve their services. Appendix 1 illustrates the different types of diversity data service areas must consider collecting together with advice on how they can be used.

As the council has a statutory duty to promote race, disability and gender equality, diversity data relating to these categories must be collected as a minimum. The council is keen to collect other diversity data which can be used to inform resource prioritisation, however, it is recognised that improving certain types of service delivery does not need all types of diversity data to be collected.

The guidance focuses on data collection, but also includes advice and information on:

- designing bespoke diversity monitoring forms
- equality targets and objectives
- comparative data

Section 3

What is equality and diversity monitoring?

Equality and diversity monitoring is a process of collecting information about service users and (potentially) non-users as well as information on residents.

Such monitoring is not a bureaucratic data gathering exercise but a tool for the council to analyse the use and experience of service delivery by different groups of people and, where necessary, to take appropriate action to improve those services. It is most useful when it is incorporated as part of a survey or consultation.

Analysing diversity data can reveal:

- Whether the service is being used by a particular group and highlight and over or under use.
- If there are any different needs that are pertinent to a particular demographic group.
- Discriminatory practices or unintended consequences.

It also allows the council to show

- services are delivered in a fair and equal way to all customers
- that customers who the council's services are not further disadvantaged because of the way services are delivered
- how to shape new and existing services around customer needs
- An increased awareness and understanding of non-users and our residents.
- Whether customer satisfaction rates vary between different communities and take appropriate action

Categorisation of Equality Groups

The council should collect information on age, disability, ethnicity, faith/belief, gender and sexual orientation by asking people to answer questions based on individual self-identification **(should carers be included?).**

Section 3

In accepting that sometimes people do not wish to share information about themselves the Council would want to explain to people participating in consultations or surveys that sharing diversity information is as important as finding out people's opinions on the services the council delivers.

Sometimes, it is not relevant to know the full diversity profile of service users because of the type of service being provided. In such cases officers are expected to use their common sense about which diversity information should be collected. Managers will be required to explain the reasons for excluding certain diversity categories.

The questions expected to be the most sensitive to service users are age, disability, faith/belief and sexual orientation and it is therefore important that we can provide assurance as to the confidentially of the information that we receive.

Priority areas for diversity monitoring

Analysing diversity information can be particularly useful in surveys being used in the following priority areas:

- frontline service delivery
- services targeted at vulnerable people
- those services where there is a local or national history of unequal impact
- customer complaints, comments and compliments
- delivering services based on judgement or entitlement
- services where there are nationally established equalities indicators
- cross-cutting services affecting different groups of people
- consultations with residents/service users/non-users

'It should be recognised that equality data will be improved if people responding to requests for data understand the purposes for which it will be used, and those asking for the data understand and value this information as useful for their own purposes'[1]

[1] Cabinet Office The Equalities Review ' Fairness and Freedom' 28th February 2007 http://archive.cabinetoffice.gov.uk/equalitiesreview/

Section 3

How will diversity monitoring data be used?

Diversity monitoring is mainly used in corporate consultations primarily to find out:

- What people think about council services or if they know about a particular service.
- If the experience of a service is different for different communities and if people feel that they are being treated equally.
- If the Council's employment practices take sufficient account of equality issues within the workplace

A number of techniques can be used by the council including:

- Customer satisfaction surveys like the Place Survey which are useful to measure the perceptions of customers with a view to improve service delivery.
- Focus groups to carry out in-depth discussions on a particular issue where members of the groups share some common characteristics such as age and gender which relate to the discussion topic.
- User panels to provide a forum for discussion issues relating to a service they use.
- Questionnaires and surveys which can be carried out by post, telephone, online and face-to-face contact.
- Working with Halton Citizens' Panel, which represents Halton's residents and which regularly participates in postal and online surveys.
- Consulting with community organisations representing the interests of Halton's diverse communities to hear their views and experiences as service users.
- Engagement with equality groups at a service level and feedback from staff delivering services.

The data collected in corporate consultations will be analysed along diversity strands and cross referenced to the activity or perception being measured. In addition to data captured at a service level it will be used to inform the decision making processes, particularly with regards to future resourcing requirements and service improvement initiatives.

Section 4

How should diversity monitoring be questions be included in questionnaires?

Including diversity monitoring questions can seem daunting initially. However, it is not difficult to do. The following steps should be taken:

- one of the data capture methods listed in Appendix Two that most closely matches a particular service delivery style should be chosen
- it should be decided what additional diversity information needs to be collected about service users (particularly relating to age, faith/belief and sexual orientation)
- decide which diversity questions should be asked
- if it is decided not to collect information on age, faith/belief or sexual orientation reasons and justification should be clarified
- the person responsible for analysing the data should be identified
- It should be agreed and understood how the data will be used and any findings fed back into the business planning process

Ensure colleagues understand why the service is including diversity monitoring as part of its service analysis so that queries from users can be answered. Support of diversity monitoring is crucial in making it a meaningful tool to improve council services.

Sometimes, people have never shared this information before and feel a little awkward when answering the questions. Officers collecting data should take the time to explain why the council is collecting this information and how the information will be used to improve services. Respondents should be encouraged to share as much information as possible but remain sensitive to the fact that people may choose not to do so.

The service's decision to include diversity monitoring in its consultation surveys and the contribution of officers in making it a success should be publicised.

As an element of the consultation people should be reminded that the information collected is anonymous.

Section 5

Collecting the Data

Provide an explanation

An explanation of why diversity information is being collected, and what it will be used for should always be included. People should be reminded that the information shared is confidential. An example of a suitable preamble is included within Appendix 1.

It is reassuring to include contact details of an officer based in the service area who can answer further queries.

Questions

Successful diversity monitoring relies on an individual's personal identification as this is a subjectively held conviction. To ensure consistency of data quality, services need to adhere to this principle and not prompt or attempt to classify people themselves.

Storing the information

The Data Protection Act 1998 requires sensitive information to be stored in a secure manner, where access to the information is restricted to named officers in the service area. Further details about the Act can be found in Appendix Three.

Officers must be clear that the information being collected is lawful and for a specified purpose.

Publishing the information

Care must be taken when publishing the data to make sure that it is anonymised and that individuals cannot be identified. For example, it would be improper to publish information on educational attainment within a school by ethnicity, where there is a single pupil in a year group from a particular diversity group.

Confidentiality

In the majority of monitoring exercises, the information collected is anonymous. However, to ensure confidentiality is maintained the monitoring information should be stored in a separate and secure place and be separated from the service-specific information once it is recorded.

Section 6

What do I do with the data I collect?

Once it has been decided what type of diversity information to collect the following should be agreed:

- How will the information be collected
- What comparison will be made
- How will the information be analysed
- Where relevant how will the results be published
- How will the findings of the analysis be incorporated into business planning and improvement
- How will intended outcomes be measured

Once the data is collected, it needs to be analysed both within diversity categories, but also cross-related to the key activities or stages of the service being monitored. A summary of the data analysis and interpretation should be retained either centrally or within the relevant department to ensure it's availability for other purposes.

Ideally a departmental register of consultation activity should be maintained with a named Lead Officer responsible for its maintenance.

Cross-relating measures could include for example:

- take-up of services
- satisfaction levels or number of complaints
- number of people applying for or accessing a service
- number of people receiving positive outcomes
- funding levels

As an example in developing a new customer access point customer data could be used to inform decision making on both design features and the services to be provided. Data could be collected from a number of sources including, compliments, comments and complaints and then analysed to help design a customer access facility that meets the needs of the boroughs residents.

Section 6

The system of recording and collecting diversity information needs to be incorporated into existing service management systems to ensure the information is used effectively. The following section shows how analysing diversity data can be used to measure the impact of services on different groups of people.

Significant difference

Small differences in outcomes for different groups are to be expected as a result of chance. However, where differences are substantial and persist over time investigation is required. Exactly what size of difference should trigger investigation is a matter of judgement. It is helpful to present data for different groups as rates rather than percentages as demonstrated in the following two tables.

Table 1:

Comparing percentages among service users in the population

Ethnic Group	% among service users	% in population
White	68%	70%
Asian	7%	13%
Black	9%	6%
Chinese	5%	2%
Other Group	11%	9%

It can be difficult to judge what a significant difference is when data is presented in this way because of differences in the sizes of the groups. It may be helpful to carry out further investigations where rates vary by 5 percentage points or more. It is often preferable to show the data in the following way, where such differences in size of groups are better taken account of.

Ethnic Group	Service users per 10,000 residents
White	21
Asian	14
Black	40
Chinese	28
Other Group	20

In this case we can see that the rate of usage among Black residents is almost twice that for all groups and a third lower for Asian residents, large differences that might have been missed if the same data were displayed as table 1.

Where base numbers are very small, for example second tier management or for some cohort groups in education, then any comparisons may be of less use and may need to be supplemented with additional contextual data.

There are a wide variety of graphical and numerical methods by which data can be displayed and care should be taken to consider the needs of the audience when choosing an appropriate format. Further advice and guidance can be obtained in relation to statistical analysis and presentation from the central Research and Intelligence Unit.

Target setting and Performance Indicators

Target setting is an important component of measuring performance improvement.

The inclusion of segmented diversity data into the performance target ensures that the impact of the service on different communities can be compared and remedial action can be identified if necessary.

Segmenting targets can also help to legitimise resource allocation, make sure expectations of performance is realistic and agree timescales for improvement.

Performance indicators show what the council is currently delivering. Incorporating diversity data is an explicit way of showing how a service can be discriminatory. For example, if a service shows under-use by a single group then a target can be set measuring how far improvements have resulted in an increase in the range of users.

All services should consider how they will monitor the take-up of their services and the workforce profile of their staff and in the development of Departmental Service Plans should reflect organisational equality and diversity priorities.

Approved Contractors

All suppliers from whom the council procure services must demonstrate how they support the council in meeting its public duties to promote race, disability and gender equality.

In addition to completing the equalities section of the Pre-Qualifying Questionnaire, approved suppliers are encouraged to monitor the diversity profile of their employees. There is currently no obligation upon private sector providers to monitor the diversity of service users.

Section 7

What should happen after data has been collected and analysed?

Once diversity data has been analysed it should be used to:

- inform the service and business planning processes
- inform any judgements that are made in relation to Community Impact Reviews and Assessments
- identify key improvement initiatives
- understand the differential impact of service upon equality groups and the wider community
- define key user and non-user groups and asses their needs
- prioritise and target resources to ensure equality of provision particularly where there is evidence of non-use of services or under achievement
- show how the information has been used to make a difference to the outcomes for the community

Appendix 1

Design of monitoring form for service users

In designing your own diversity monitoring form the following information should be included:

Explanatory Note

The Council is committed to providing equality of access and opportunity to all sections of the residential and business communities in Halton. We monitor the delivery of our services to ensure that they remain accessible and that all our service users are treated fairly. In addition, we have statutory responsibilities in regards to the promotion of equality and good relations between different equality groups.

Whilst some of these questions are very personal the information that you give on this questionnaire will remain strictly confidential, in accordance with the Data Protection Act 19981.

Disability / Carer

The Disability Discrimination Act (DDA) 1995 defines a disability as 'a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'. In this definition, long term is taken to mean more than 12 months and would cover long term illness such as cancer, HIV or mental health problems.

Do you consider that you have a disability under the DDA Definition?	**Yes**	☐	**No**	☐

If you have answered 'yes' please select from the list below the definition that best describes your disability / disabilities			
Hearing (i.e.: deaf / partially deaf / hard of hearing)	☐	**Reduced physical capacity** (such as an inability to lift, carry or otherwise move everyday objects, debilitating pain and lack of strength, breath energy or stamina, asthma, angina or diabetes)	☐
Vision (such as blindness or partial sight that cannot be corrected by glasses / contact lenses)	☐		
Speech (such as impairments that can cause communication problems)	☐	**Severe disfigurement**	☐
Mobility (such as wheelchair user, artificial lower limbs, walking aids, rheumatism or arthritis)	☐	**Learning difficulties** (such as dyslexia)	☐
Physical co-ordination (such as manual dexterity, muscular control, cerebral palsy)	☐	**Mental illness** (substantial and lasting more than a year, such as severe depression or psychoses)	☐
Other disability (please specify)	☐		

Appendix 1

Ethnicity

White	Black / Black British	Asian / Asian British	Mixed	Other
British ☐	Caribbean ☐	Indian ☐	White & Black Caribbean ☐	Chinese ☐
Irish ☐	African ☐	Pakistani ☐	White & Black African ☐	Other ☐
Gypsy or Roma ☐	Other ☐	Bangladeshi ☐	White & Asian ☐	
Irish Traveller ☐		Other ☐	Other ☐	
Other ☐				

If you have selected 'other' please tell us how you would describe your ethnicity

Do not wish to disclose ☐

Gender

Female ☐ Male ☐ Transgender ☐

Post code	

Thank you for taking the time to complete this questionnaire which will provide very useful information to the Council in considering the existing and future provision of services.

If you would like further details as to how this information will be used please contact ……..

Optional questions

Before deciding to exclude the additional diversity information overleaf careful thought would need to be given as to whether your service has the potential to disproportionately affect groups of people in relation to their age, religious belief, sexual orientation or caring responsibilities.

If such information is not presently available then it may be relevant to include such questions in order to establish a baseline position concerning service usage and or to gather intelligence that can be used to determine the ongoing impact of service provision

Appendix 1

Age / Faith & Religion / Sexual Orientation / Caring responsibilities

In addition to disability, race and gender equality the Council is also committed to ensuring that its services are provided and developed to take full account of people's age, religious belief, sexual orientation and caring responsibilities.

Age

Under 18 ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-59 ☐ 60+ ☐

Do not wish to disclose ☐

Faith / religion

No religion ☐ Christian (all denominations) ☐ Buddhist ☐ Jewish ☐ Muslim ☐

Sikh ☐ Other (please write in) ☐

Do not wish to disclose ☐

Sexual Orientation

Heterosexual ☐ Bisexual ☐ Lesbian ☐ Gay ☐

If you prefer to describe your sexuality in terms other than those used above please use the space below

☐

Caring responsibilities

Are you presently acting as a carer Yes ☐ No ☐

If 'yes' how many hours care do you provide each week 0 - 10 ☐ 10 – 20 ☐ 20+ ☐

Appendix 2

Methods of data capture

Ongoing Contact

This measures people's experience of council services over a particular period.

Advantage: it shows how different groups are treated at different stages of a process. An example could be measuring the experience of people applying for housing as they progress or fail in their attempt to be awarded accommodation.

Disadvantage: relies on being able to track responses at different stages of the process

This method can be used this method to find out:

- differences in outcomes of applications for diverse groups
- differences in perception of service delivery for diverse groups
- that all groups are accessing services equally
- that any actions intended to improve services are working

Service usage

Understanding the profile of service users and the particular needs of different groups can help in the way a service is best delivered to meet the needs of its users. For instance, the type of usage of parks and green spaces by different communities

Advantage: it can help in the assessment and allocation of resources for the future delivery of the service

Disadvantage: sometimes, it is possible to be overwhelmed by the amount of information generated and to use it to effectively manage service improvement

You can use this method to find out:

- differences in frequency of service usage by different communities
- differences in the way the service is used by different communities
- whether the service is meeting the needs of the communities they serve
- ways of increasing service usage amongst those communities who under use the service

Appendix 2

Customer satisfaction or complaints

Including an additional section on diversity monitoring to routine customer satisfaction surveys or complaints records is helpful to assess whether satisfaction rates vary between different communities.

You can use this method to find out:

- different satisfaction levels or complaint rates between different communities
- if there are particular areas of a service that are a problem/liked by different communities
- if there are different expectations between different groups of people
- ways of increasing service usage amongst those groups who under-use the service

Appendix 3

Data Protection Act 1988

How will monitoring information be kept and who will have access to it?

The Data Protection Act 1998 requires any information contained on the Diversity Monitoring Form to be processed, accessed and retained as laid out in its Codes of Practice. This means that when people complete the monitoring form they should be aware of the following:

- Can they be identified from the form?
- Where will the information be kept?
- How will the information be used?
- Who will have access to the information?

Access to diversity monitoring information must be restricted to officers who will use it for monitoring purposes and guarantee that the information is subject to strict security procedures.

What does the Data Protection Act 1998 cover?

The Data Protection Act 1998 came into force on 1 March 2000. It regulates the use of personal data and gives effect in UK law to the European Directive on data protection (95/46/EC).

The act covers some manual records, such as those recorded on paper or media such as microfiche, as well as computerised records and is concerned with the way 'personal data' relating to identifiable living individuals is processed.

It works in two ways;

- it gives individuals (data subjects) certain rights

- it requires those deciding how and why personal data is processed data controllers) to be open about how they use the data and comply with data protection principles in their information-handling practices

Appendix 3

Data protection principles

There are eight data protection principles that are central to the act. In brief, they say that personal data must be:

1. processed fairly and lawfully
2. processed for limited purposes and not in any manner incompatible with those purposes
3. adequate, relevant and not excessive
4. accurate
5. not kept for longer than is necessary
6. processed in line with data subjects' rights
7. secure
8. not transferred to countries that don't protect personal data adequately

Responsibilities of data controllers

Most data controllers will need to notify the Information Commissioner of their processing of personal data. Notification is the process by which data controllers inform the Information Commissioner of certain details about the processing of personal data they carry out. These details are then included on a public register. Data controllers or workers can inspect this register at any time by visiting the data protection register website at: www.ico.gov.uk

What are the rights of data subjects under the act?

The act grants people the right to have a copy of the information an organisation holds about them. It allows them to apply to the courts to obtain an order requiring a data controller to correct inaccurate data held about them, and to seek compensation where damage and distress have been caused as a result of any breach of the act. Workers may also object to the processing of personal data about them. In some circumstances they can stop employers keeping information about them or using the information in particular ways.

What can happen if the council doesn't comply with the act?

Enforcement

If the Commissioner considers that breaches of the principles have occurred, enforcement action can be taken against the council. This will require changes to bring about compliance, for example the deletion of records or the redesigning of an application form. The organisation may appeal to the independent Information Tribunal.

Appendix 3

However, if the Tribunal upholds the Commissioner's enforcement action, and the organisation continues to break the principles, this is a criminal offence.

Prosecution

There are also offences of unlawfully obtaining personal data and unlawfully selling the data. If a criminal offence has been committed, the Commissioner can and does prosecute. Company directors or chief executives can be prosecuted where an offence is due to their negligence or connivance.

Compensation

Compensation can be awarded through the courts to an individual if damage has been caused by an organisation not meeting a requirement of the act. If damage is proved, then the court may also order compensation for any associated distress.

If you require more information about the act please visit the Information Commissioner's website at: www.ico.gov.uk

APPENDIX 2

Halton Borough Council has made improvements to the lives of disabled people, for example:

- Establishment of day services centres for adults and older people with Physical and/or Sensory Disabilities (PSD)
- Ensure accessibility all areas where there are Council meetings
- Full accessibility of all polling stations
- HHILS - service established to ensure fewer disable people are waiting for adaptions
- Support for the Halton Disability Partnership, whose membership consists of service users and sponsored organisations
- All Council buildings conform to the Disability Standard

Lives of our minority ethnic communities have been improved by, for example:

- Partnership working to with CHAWREC establish the BME and Faith Network
- Establishment of the BME Floating Support service (Supporting People) which supports 11 BME families, mainly with children; service users are encouraged to discuss issues that they face of equal opportunity/discrimination
- Production of a Migrant Workers Information Pack
- CYP & Children's Trust Equalities Groups monitors and acts upon reported racist incidents in schools
- Established a senior dialog with the Riverside College to ensure coordination between their overseas student recruitment strategy and the capacity within Halton to meet the needs of those families**.**
- Increased the number of sites and pitches for Gypsy and Traveller families and established a consultative and support group
- The Health and Community Directorate has an 'Unmet Needs' policy, which provides a mechanism for delivery and assessment staff to record requests for services/equipment which we are unable to meet. This allows us to determine how to prioritise spend (for example by purchasing new equipment if there is sufficient demand) and keeps us up to date on the needs and requirements of our service users.

People of different ages have benefitted from a number of Council initiatives, such as:

- The Halton Children's Centre Fishing Club was formed to enable parents and children to use fishing as an activity to help engage young people from disadvantaged backgrounds in combating social exclusion, to help improve young peoples social and interactive skills and help Young People gain confidence with regard to their social abilities and interact and communicate as

part of a team through angling. This has also proved to have socio economic benefits

- The Welcome Audit which is carried out annually and has developed practitioners and young peoples understanding of inequality and discrimination and has ensured that these have been addressed to ensure all young people can access the youth provisions. This has been rolled out across Halton Youth Service.
- Establishment of day services centres for adults and older people with Physical and/or Sensory Disabilities (PSD).
- This service also ensures equality of access and service provision for young LGBT people
- Establishment of and support to the Youth Parliament
- CYP has developed information systems enable disaggregation to vulnerable groups and geographically to measure health inequalities
- A Dignity Co-ordinator is in the process of being appointed. Halton BC is the lead partner on the Dignity Champions agenda in the area and has established a network consisting of independent, voluntary and statutory sectors.

A number of Council service improvements have benefitted more than one vulnerable group. These include:

- The Benefits Express service and re-routing of the mobile library service to access hard to reach groups and outlying areas including nursing homes. These services have benefitted the elderly, people with disabilities and benefitted those socio economic groups in need
- The formation of the HSP Equalities and Community Cohesion Group which enable partnership working to deal with issues of equality and diversity
- Inclusion in Housing needs survey of questions about age ethnicity disability, also waiting list and grant applications. User surveys of Adult and Older People's services are disaggregated by ethnicity age gender disability Also all services tracked by same as are complaints.
- .In line with tension monitoring requirements the Council's Cohesion Officers Group has established a Tactical Group which is multi agency and provides live intelligence on community tension indicators which are used to develop proactive solutions.
- The profile of the community has been established by using research from census and other data and where appropriate data extracted from sources such as The Data Observatory, NOMIS, ONS, Paycheck and Acorn.
- To ascertain the scale of irregularities in outcomes between communities the Council has regularly taken an economic, social and environmental audit since 2000. The 2009 State of the Borough report is now published.

- Identification of gaps was part of the development of the Sustainable Communities Strategy
- The Council is currently further developing mapping systems for the National Indicators, particularly Community Cohesion. This is being developed further, for example Hotspot mapping allows the Place Survey data to be shown at small area level. The data extracted can also be compared at local, regional and national level and is currently being analysed further, for example by make up of respondees. This will allow the Council to monitor and, influence and adapt the way its policies and services serve the needs of its community and will facilitate the undertaking of a needs assessment exercise
- The Health and Community Directorate has produced, in partnership with the Health Services, a 'Joint Strategic Needs Assessment' (JSNA) which documents detailed information about the Halton community with a specific focus on health inequalities, including physical and sensory disabilities and mental health issues. There are detailed population statistics, in most cases at ward level, which describe communities within Halton.
- A range pf BVPIs and NIs relating to Equality, Diversity and Community Cohesion have been incorporated into the service planning process and will be monitored at least on a quarterly basis via the quarterly monitoring reports, which are subjedct to scrutiny by PPBs and Chief Officer Management Team.
- A range pf BVPIs and NIs relating to Equality, Diversity and Community Cohesion have been incorporated into the service planning process and will be monitored at least on a quarterly basis via the quarterly monitoring reports, which are subjedct to scrutiny by PPBs and Chief Officer Management Team.

The Council's workforce has also benefitted from a number of initiatives. These include;

- Introduction of family friendly flexible working practices
- Establishment of worker representative groups to help women, LGBT, disabled and BME staff
- Steps are taking place to improve workforce diversity monitoring, now to include sexual orientation and religious belief. The aim is to have a workforce whose makeup, if possible, mirrors the diverse community that the Council serves
- Equality awareness training for all staff is now included on the induction course. Training for all staff on Equality and Diversity in general and EqIAs in particular is currently being arranged corporately in partnership with external training providers. Training is also being provided for partners within the LSP and to Members who serve on the Partnership Equality , Diversity and Community Cohesion Group.

REPORT TO: **Executive Board**

DATE: **3rd December 2009**

REPORTING OFFICER: **Strategic Director – Corporate and Policy**

SUBJECT: **Locality Working**

WARDS: **Borough-wide**

1. PURPOSE OF REPORT:

This report is to enable Executive Board to respond to a recommendation from Corporate Services Policy and Performance Board.

2. RECOMMENDED THAT:

1. Executive Board support the creation of a Working Group to consider how locality working should operate and be funded in Halton when Neighbourhood Management funding ceases to be available from Central Government

2. The Working Group receive evidence from a wide range of partners across Halton and report their findings to the Local Strategic Partnership and Executive Board

3. SUPPORTING INFORMATION

At its meeting on 8th September 2009 the Corporate Services Policy and Performance Board considered a report on the future of locality working. The report offered three options as follows:

Option 1. Disband the Neighbourhood Management Team and the Boards.

Option 2. Transfer the Neighbourhood Management Partnership to a third sector/charitable host/accountable body.

Option 3. The development of wider, more systematic or targeted locality working and community engagement arrangements across the whole borough based on the Area Forum footprint.

The Board resolved “that the Executive Board be recommended to accept Option 1 – complete close down, and a working party be set up with the Business Efficiency Board to consider the future of locality working in Halton”.

4. POLICY IMPLICATIONS

The Council and its partners have made policy commitments to narrow the gap between the more deprived areas and the rest of the Borough. Locality working is one way of addressing this and would be consistent with government policy as set out in the Communities in Control White Paper.

5. OTHER IMPLICATIONS

If there are any additional costs associated with developing locality working, they will be identified by the Working Group.

6. IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 A Healthy Halton

6.2 Halton's Urban Renewal

6.3 Children and Young People in Halton

6.4 Employment Learning and Skills in Halton

6.6 A Safer Halton

Locality Working should aim to support the delivery of our objectives under all of the Council's key priority areas.

7. RISK ANALYSIS

There is a risk that the Council will fail to deliver its objectives under the five priorities, including targets in the Local Area Agreement. This would be reflected in an adverse Comprehensive Area Assessment. The introduction of an appropriate locality working model will mitigate this risk.

8. EQUALITY AND DIVERSITY ISSUES

Locality working should aim to reduce geographical inequalities within the Borough.

9. LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 12972

None

REPORT TO: Executive Board

DATE: 3rd December 2009

REPORTING OFFICER: Strategic Directorate Corporate and Policy

SUBJECT: Land at Houghton Street, Widnes

WARDS: Halton View Ward

1.0 PURPOSE OF THE REPORT

1.1 To seek the Council's approval to dispose of land at Houghton Street, Widnes to Halton Housing Trust.

2.0 RECOMMENDATION: That

(1) the report be noted; and

(2) the land at Houghton Street be sold to Halton Housing Trust on the terms reported.

3.0 SUPPORTING INFORMATION

3.1 Introduction

3.1.1 Halton Housing Trust have approached the Council with a view to purchasing land retained by the Borough Council following the LSVT Transfer in 2005 (plan attached).

3.1.2 Negotiations have taken place and the District Valuer has been consulted and has recommended the land be sold for the sum of £135,000 (one hundred and thirty five thousand pounds) subject to timescales for the development to take place to ensure the land is developed within a given time and not land banked for the future.

3.1.3 Halton Housing Trust have a scheme for building twelve social rent properties in this area, nine of which will be on this site.

3.1.4 The sale will be subject to Planning Consent being granted.

4.0 POLICY IMPLICATIONS

4.1 This development will contribute to the Borough's urban renewal policies by utilising an underused site and securing overall improvement in the environment of the area.

5.0 FINANCIAL IMPLICATIONS

5.1 A capital receipt will be payable to the Council.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton –** N/A.

6.2 **Corporate Effectiveness and Efficient Service Delivery** - N/A.

6.3 **A Healthy Halton –** This development will contribute towards health by providing good quality accommodation for people in need.

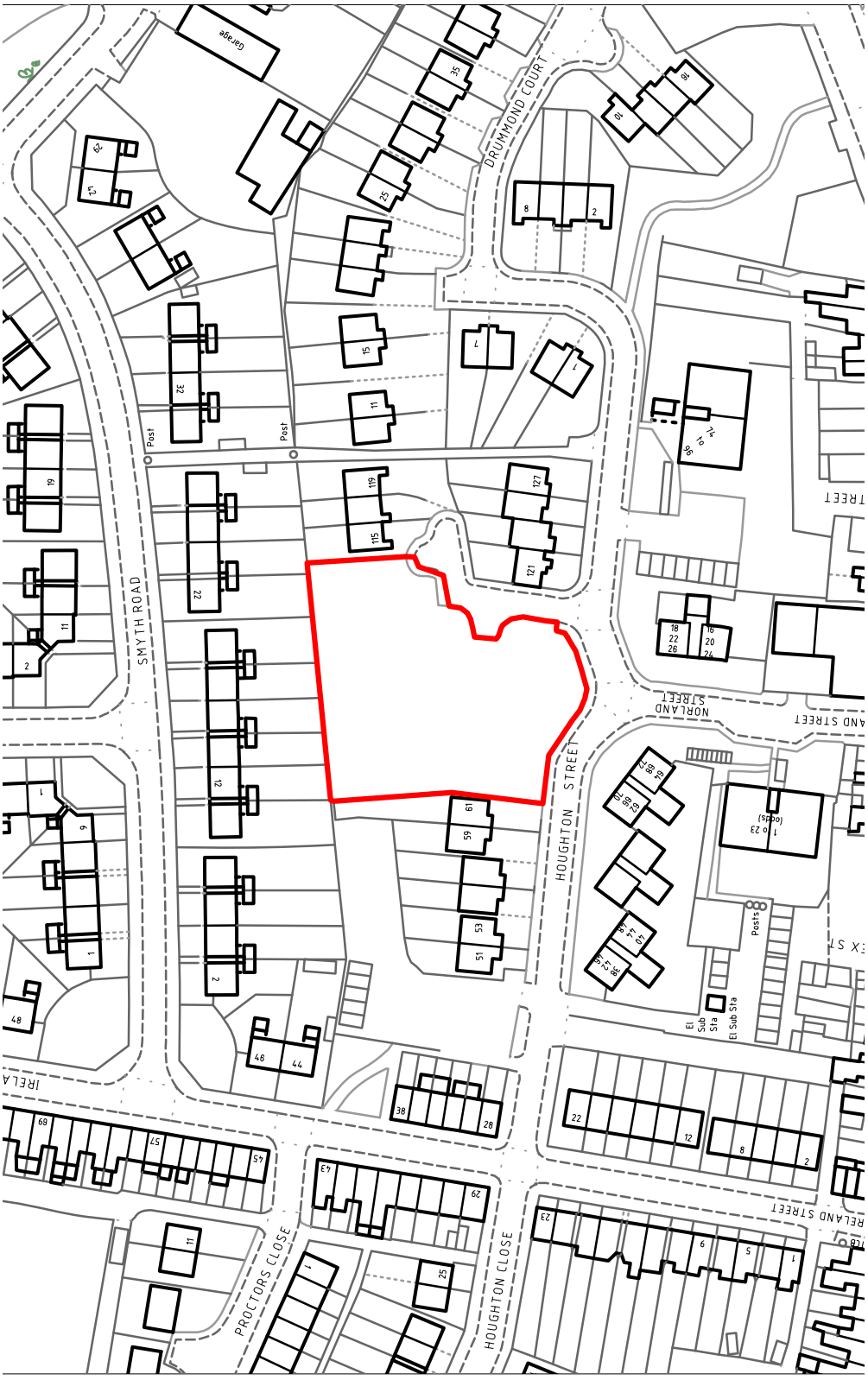
6.4 **A Safer Halton –** The development will be designed with safety in mind thereby satisfying the safer Halton priorities.

7.0 RISK ANALYSIS

7.1 There is no risk to the Council.

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

8.1 Background papers are held within Property Services Department, 5th Floor, Municipal Building, Widnes.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REPORT TO: Executive Board

DATE: 3rd December 2009

REPORTING OFFICER: Strategic Director – Children & Young People

SUBJECT: Pilot Health Visiting Service Partnership Project at Warrington Road Children's Centre

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform Executive Board of the proposed arrangements for a pilot Partnership working project at Warrington Road Children's Centre.

1.2 To seek approval for the pilot to take place.

2.0 **RECOMMENDATION: That:**

i) Executive Board note the information contained within the report

ii) Executive Board supports the pilot Health Visiting Project at Warrington Road Children's Centre

3.0 **SUPPORTING INFORMATION**

3.1 DCSF Children's Trusts guidance (2008) requires Local Partners, through inter-agency arrangements, to integrate frontline delivery organised around the child, young person and family, rather than professional boundaries. Such an inter-agency approach to services improves the prospects of positive outcomes for children and young people.

3.2 The Pilot will be overseen by Halton's Children's Trust. The proposed Pilot Project meets the five essential elements of Children's Trust Arrangements:

- Integrated Front Line delivery
- Integrated processes fostering professional understanding between services and agencies
- Inter-agency governance, leadership and whole system change
- Integrated strategic planning and commissioning
- Children and Young People, parents and family focussed

3.3 The proposed pilot project initially involves a re-design of the PCT's Halton Health Visiting Service to provide a new geographical approach to service delivery. This will be initially tested at Warrington Road Children's Centre as the first phase of a possible

roll out across the Borough.

3.4 The pilot would include the relocation of a Health Visiting Team to Warrington Road Children's Centre. The Team would provide universal, targeted and specialist support to children and families. It would work closely with staff of the Children's Centre and Children's Social Care to join up provision more effectively.

3.5 A Pilot Project Steering Group will be established to agree the principal areas of partnership working; these are:

- Management systems
- Sharing skills
- Integrating key processes for children
- Aiding inter-professional learning

3.6 Subject to Executive Board approval, the Pilot Project will start between January to March 2010 and then formally evaluated in terms of outcomes for children and families.

3.7 The Pilot is intended to inform the place that the PCT's Health Visiting Service will take in relation to the proposed new structure for the Children & Young People's Directorate, and specifically within the Locality Teams for early intervention and prevention proposed for Widnes and Runcorn. (See CYPD Structural consultation document).

3.8 Should the Pilot prove successful, the PCT will consider rolling out the Health Visiting Service in this way across the Borough.

4.0 POLICY IMPLICATIONS

4.1 The Pilot Project is consistent with guidance on Children's Trust Arrangements; Every Child Matters and Halton's Children & Young People's Plan.

5.0 FINANCIAL IMPLICATIONS:

5.1 The cost of facilitating the re-location of the Health Visiting Team to Warrington Road Children's Centre is £49,753.50. The costs will be met equally by PCT and the Council. Funds have been earmarked from the Children's Centre to undertake this work.

5.2 Costs are made up of:

- Establish Health Visitor/Children's Centre Office - £12.5k
- Relocation of IT Room - £10k
- Additional Car Parking (Year 2) - £21k
- Rental fees at £3.5k per year will be met by the PCT thereafter

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The Proposal meets the requirements of the Halton Children & Young People's Plan and the aspirations of Halton's Children's Trust

6.2 **Employment, Learning & Skills in Halton**
The proposal fosters inter-agency working and sharing skills.

6.3 **A Healthy Halton**
The proposal will ensure the PCT's core "Ambition for Health" that all children have a healthy start in life.

6.4 **A Safer Halton**
The Pilot Project will further join up safeguarding practice at the front line.

6.5 **Halton's Urban Renewal**
The Children's Centre function will be enhanced through the Pilot as a focus for services for the Local Community.

7.0 **RISK ANALYSIS**

7.1 The opportunities within the proposal enable better communication and joined up working to promote effective outcomes for Children and Young People.

7.2 The proposed project will see the Health Visiting Team in the Warrington Road locality relocate from a GP attachment. The risk assessment carried out highlights the need for GP practices in the locality to have a named Health Visitor to facilitate communication in relation to the health needs of the families registered with the practice.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The Pilot will improve access to services for a range of vulnerable young people and their families; including those 'hard to reach'.

9.0 **REASON(S) FOR DECISION:**

- The project has the potential to influence the development of integrated services in Halton that offer support and early intervention for families.
- The PCT's aspiration for the future delivery of Universal Health Services is across a children's centre footprint.
- The proposed pilot will test out how we might roll out this way of working across Halton.

10.0 **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

10.1 The alternative is that we remain working as separate organisations. Given the need to constantly improve efficiency and the safety of

children, this needs to change.

11.0 **IMPLEMENTATION DATE**

- January – March 2010

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

Document	**Place of Inspection**	**Contact Officer**
Ambition for Health	PCT	Dympna Edwards
Transforming Community Services Commissioning Strategy	PCT	David Tanner

REPORT TO: Executive Board

DATE: 3 December 2009

PRESENTED BY: Strategic Director – Children and Young People

SUBJECT: Consultation on the Closure of Halton High

WARDS: Wards in Runcorn

1.0 PURPOSE OF REPORT

1.1 To outline the Local Authority proposal to close Halton High. This will allow an Academy to be opened on the same site.

1.2 A further report summarising the outcome of the Consultation will be tabled for consideration by Executive Board.

2.0 RECOMMENDATION:

2.1 (a) Executive Board approves the commencement of the Statutory Consultation to close Halton High school on 31st August 2010 to allow the development of an Academy subject to consideration of any further representations received prior to the end of the consultation period; and

(b) That it be approved that this decision be excluded from call in as immediate action is required so that the Statutory Consultation can commence on 10th December 2009.

3.0 BACKGROUND

3.1 During the consultation on future secondary provision in Halton it was agreed that Halton High be developed as an Academy. In order to open the Academy it is a requirement that Halton High school is discontinued. To ensure that the Academy can be established by 1st September 2010 the school organisation process needs to be complete so that the Funding Agreement can be signed in February 2010.

3.2 The proposal is that Halton High be closed on 31st August 2010 and that an Academy be opened on 1st September 2010. The Ormiston Trust and the University of Chester are the Sponsors of the proposed Academy which would open in Halton High School's buildings.

3.3 The Ormiston Trust is the Lead Sponsor. It has worked to support children and young people for the last 40 years and established its first Academy in 2006. Since 2006, the Trust has opened a number of Academies and by 2010 will have nine with many more in development. The proposed Halton Academy would therefore have the best opportunity to work with other Academies in the Ormiston network and share best practice.

3.4 The co-sponsor, the University of Chester is currently involved in three Academy projects including the recently opened University Church of England Academy in Ellesmere Port. The University has specialist expertise in areas such as school leadership and teacher training including secondary and post-16. It has the potential through its expertise in Continuing Professional Development and Research in Education to provide the Academy with current knowledge on school improvement and thereby enhance the opportunities for Academy staff to be engaged in innovative developments in learning. The University has its strong networks with business and industry which will enhance the quality of the Academy's work based learning curriculum.

3.5 Consultation on the closure of Halton High is the responsibility of the Local Authority, however, as it is linked to the development of the new Academy all consultation has been undertaken in conjunction with representatives from the Ormiston Trust and the University of Chester. The DCSF make the decision on the establishment of the Academy.

3.6 The first phase of the Consultation on the closure of Halton High commenced on 5th November 2009 and finished on 30th November 2009. Consultation meetings were held with Staff, Governors, Parents and other stakeholders on 12th November 2009. A second stakeholders consultation was then held on 24th November 2009. The notes of each of the meetings have been placed on the BSF website and passed to the school. Details of the proposal were also circulated to the local press, all schools, Trade Unions, Children's Centre and the Local Library.

3.7 As the Consultation does not close until 30th November 2009 a summary of the outcome of the Consultation will be presented to Executive Board meeting.
.

3.8 For the Academy to be opened by 1st September 2010 it is necessary for the School Organisation process to be completed by the end of January 2010. To meet this timescale if the outcome of the first phase of consultation supports the proposal to close Halton High, the Statutory Consultation will need to commence on 10th December 2009. The decision to commence Statutory Consultation will therefore need to be excluded from call in to allow for the six weeks representation period and the decision by Executive Board by the end of January 2010.

4.0 FINANCIAL IMPLICATIONS

4.1 Once approved the Academy will benefit from up to £150,000 Environment Grant which can be used to make improvements to the school building. In addition, funding is made available for all pupils to have a new school uniform. The Academy funded comes direct from the DSCF instead of the Authority. The Dedicated Schools Budget is adjusted to remove the Academy funding and a proportion of the centrally managed resources.

4.4 The Academy is part of the BSF Programme and will benefit from both Capital funding to remodel the school buildings and IT funding.

5.0 OTHER IMPLICATIONS

5.1 The Halton Academy will provide 900 11 -16 places and 200 post-16 places. The Sponsors will also support the development of extended school provision, including working more closely with Parents and the wider community.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People

The pupils at the Halton Academy will benefit from the experience and resources of Ormiston Trust and the University of Chester. In addition, the sponsors intend to focus on the specialisms of English and Applied Learning.

6.2 Employment Learning and Skills in Halton

Through access to an excellent Secondary School for all pupils, standards will improve providing greater employment prospects for Halton's Children and Young People. The University of Chester will seek to use its strong networks with business and industry to enhance the quality of the Academy's work based learning curriculum.

6.3 A Healthy Halton

Halton High is part of the BSF Programme, in developing its Secondary Schools for the future the Authority will demonstrate how it will enable schools to meet the School Sport Public Service Agreement through its Capital Investment and achieve high nutritional standards and encourage healthy living and eating.

6.4 A Safer Halton

Schools for the future will be designed to ensure that children, staff and other community users feel safe and secure on schools sites.

6.5 **Halton's Urban**

Through the BSF Halton schools will become a major resource for communities they serve and will be designed to offer shared community facilities, linking to other wider regeneration projects as well as being the focus for the local delivery of children's services.

7.0 RISK ANALYSIS

The Academy is part of the diversity of provision required within Halton. Failure to close Halton High by the end of January 2010 could lead to a delay in the establishing of the Academy by 1st September 2010. This would be disruptive to staff, pupils and parents and impact on the standards and viability of the school.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The proposals for the re-organisation of Halton's Secondary and Secondary Special Provision seek to provide choice and diversity, promote inclusion and access.

9.0 REASON(S) FOR DECISION

9.1 To provide more choice and diversity and retain pupils within the Borough.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10.1 N/A

11.0 IMPLEMENTATION DATE

11.1 The decision needs to be made on 3rd December 2009 so that statutory consultation can commence on 10th December 2009.

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

Documents	Place of Inspection	Contact
Consultation Presentation	3rd Floor Chester Building – Grosvenor House, Runcorn and website www.halton.gov.uk/bsf	Ann McIntyre – Operational Director – Business Support and Commissioning
Notes of Public Meetings	3rd Floor Chester Building – Grosvenor House, Runcorn and website www.halton.gov.uk/bsf	Ann McIntyre – Operational Director – Business Support and Commissioning

All responses to First round of consultation	3rd Floor Chester Building – Grosvenor House, Runcorn and website	Ann McIntyre – Operational Director – Business Support and Commissioning

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