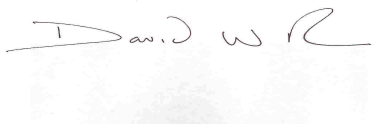
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 12 January 2010 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	**Labour**
Councillor Joan Lowe (Vice-Chairman)	**Labour**
Councillor Dave Austin	**Liberal Democrat**
Councillor Robert Gilligan	**Labour**
Councillor Trevor Higginson	**Liberal Democrat**
Councillor Margaret Horabin	**Labour**
Councillor Martha Lloyd Jones	**Labour**
Councillor Ged Philbin	**Labour**
Councillor Ernest Ratcliffe	**Liberal Democrat**
Councillor Geoffrey Swift	**Conservative**
Councillor Pamela Wallace	**Labour**
Mr Paul Cooke	**LINk Co-optee**

Please contact Lynn Derbyshire on 0151 471 7389 or e-mail michelle.simpson@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 9 March 2010

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

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

Agenda Item 3

REPORT TO: Healthy Halton Services Policy & Performance Board

DATE: 6 January 2010

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

- Requires the disclosure of confidential or exempt information.

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Healthy Halton Services Policy and Performance Board

DATE: 6 January 2010

REPORTING OFFICER: Chief Executive

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Executive Board and Executive Board Sub are attached at Appendix 1 for information.

1.2 The Minutes are submitted to inform the Policy and Performance Board of decisions taken in their area.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

APPENDIX 1

Extract of Executive Board and Executive Board Sub Committee Minutes Relevant to the Healthy Halton Policy and Performance Board

EXECUTIVE BOARD MEETING HELD ON 15 OCTOBER 2009

EXB46 OLDER PEOPLE'S JOINT COMMISSIONING STRATEGY - KEY DECISION

The Board received a report from the Strategic Director, Health and Community, which set out the draft Joint Commissioning Strategy for Older People for 2009-2014.

The new strategy updated the plans for Older People's Services and identified the commissioning priorities and key actions for the next five years. The main themes of the strategy reflected the various consultation exercises which had been undertaken with a range of commissioning staff, voluntary sector representatives, independent providers and service users and carers and one to one meetings, together with the outcome of scrutiny by the Council's Health Policy and Performance Board.

In the local context, a thorough analysis had been undertaken as part of the Commissioning Strategy and strategies identified to address a range of mental health, major illness and quality of life issues. The Council had already considered a range of strategies that would address some of these issues, including Extra Care Housing and Reablement Services. The Commissioning Strategy would now bring together the different strands into one coherent document.

The Board were advised that this was a joint Commissioning Strategy with NHS Halton and St Helens, with funding supported for the main major illnesses through the Primary Care Trust (PCT); the remaining areas would be contained within existing budget allocations set by the Council and the PCT.

RESOLVED: That the Board approve the Older People's Commissioning Strategy 2009-2014

EXECUTIVE BOARD MEETING HELD ON 5 NOVEMBER 2009

EXB53 JOINT CARERS COMMISSIONING STRATEGY 2009-12

The Board received a report of the Strategic Director, Health and Community, on the Joint Carers Commissioning Strategy 2009/12.

The Strategy built upon the aims, objectives and activities outlined in the 2008/9 Carers Strategy, including an action plan, to support services in Halton move toward a more focused way of commissioning services for Carers over the next three years. It had been developed as a result of research carried out in terms of other local authority plans and ongoing consultations and contributions from stakeholders.

The Board were advised that the format of the commissioning strategy followed a similar one adopted with other Joint Commissioning Strategies within the Directorate and took account of the contents of the National Carers Strategy which had been published in June 2008.

The objectives of the Commissioning Strategy were to move towards a process for the commissioning of services, to continue to assist in the identification of hidden carers and improve information and access to support services. The Board were advised that the Care Quality Commission closely monitors the Council's performance on carer's services and had judged that Halton delivered a good service. The introduction of the Strategy would assist in maintaining that judgement.

RESOLVED: That the Board approve the Joint Carers Commissioning Strategy 2009/12 and associated action plan.

EXECUTIVE BOARD MEETING HELD ON 3 DECEMBER 2009

EXB69 DUAL DIAGNOSIS STRATEGY

The Board considered a report of the Strategic Director, Health and Community on the development of a Joint Dual Diagnosis Commissioning Strategy 2009-2012 for Halton and St Helens.

The Strategy documented 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.

The Board was advised that a number of consultation meetings with all stakeholders in both mental health and substance misuse services had been undertaken early in 2009. In addition, a number of one to one interviews with key stakeholders were undertaken to gain views on current services and how services could be improved.

The Strategy recommended more integrated working, earlier identification and treatment in primary care and an increase in skills and knowledge for staff to enable them to provide care to people with dual diagnosis problems. It was designed to improve the care experience and reduce waiting times between services.

RESOLVED: That the Joint Dual Diagnosis Commissioning Strategy be endorsed.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 6 January 2010

REPORTING OFFICER: Chief Executive

SUBJECT: Specialist Strategic Partnership minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Health Specialist Strategic Partnership are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

Halton Strategic PARTNERSHIP

APPENDIX 1

HALTON HEALTH PARTNERSHIP BOARD

MINUTES OF THE MEETING held on

17 September 2009

Present : Fiona Johnstone (Chair)
John Bentley
Glenda Cave
Melissa Critchley
Dwayne Johnson
Diane Lloyd
Eugene Lavan
Karen Tonge
Jim Wilson

Observer: Keeley Harrison

In Support: Elaine Skelland

		ACTION
1.	**Apologies** Stuart Baxter, Cllr McInerney, Eileen O'Meara, Jane Trevor, Ian Stewardson, Sue Wallace-Bonner, Dave Sweeney	
2./3.	**Minutes of the previous meeting/Matters Arising** 4. Petitions regarding saving the NHS - only one family undertaking this and it has been dealt with by Warrington and Halton Foundation Trust. It is not an issue to be discussed at this venue. 7. Fiona Johnstone reported that no commissioning report had been included on this agenda as the draft report from Tribal is to be finalised on Friday afternoon 18 September. A commissioning update will be given at the next meeting. Fiona Johnstone reported that a significant piece of work is being undertaken to target vulnerable people over the winter period and to develop a health gain schedule. 9. Provisional dates for next year's meetings were distributed. Fiona Johnstone asked the group to diarise these dates. Diane Lloyd explained that four meetings have been planned where quarterly data will be available, one date has been reserved for a health summit and remaining date to be used for a review of the Partnership. Elaine Skelland to capture actions onto action summary.	**ES**
4.	**Community Feedback:** Karen Tonge reported upon the following:	

Halton Strategic PARTNERSHIP

	▪ Meeting held with Laura Neilson and updates given on what is happening, training programme to be developed through PQASSO system. ▪ Women's day at Norton Priory. ▪ HVA - Laura Neilson and Debbie Dalby developing a guide for commissioning for the third sector. ▪ A day to be agreed for the third sector to come together to discuss issues. This to be a bi-annual event and the first to take place on 28 January 2010. Fiona Johnstone thanked Karen Tonge for her report.	
5,	**Health Summit:** Fiona Johnstone advised the group that a conclusion upon the Health Summit might not be reached as a number of key members of the group had sent apologies. She asked the group to consider what shape they felt the Health Summit should take. The proposed date for the summit is 14 January 2010. Jim Wilson felt a big element of the summit must be a review of the previous twelve months and proposed an invitation be sent to the Secretary of State. Eugene Lavan referred to a WCC launch that he had attended where the request had been made to refresh strategies by looking at particular scenario planning around the changing financial outlook for public services and how this might affect the ability to deliver. Melissa Critchley felt that it was important that the health summit did not become hijacked with discussions about public service cuts. She also asked that the summit should not focus upon young people. Diane Lloyd proposed the use of this meeting as a review and have a separate conference for the public. Glenda Cave referred to the presentation given by Warrington PCT at the last Board meeting and the use of school teachers and members of the general public to facilitate sessions. Karen Tonge referred to some difficulties experienced at the last joint (with St Helens) summit. John Bentley felt there is a need to have a thematic approach to enable the sharing of good practice. It was agreed that Fiona Johnstone and Diane Lloyd would work together on this and report back to the next meeting.	**FJ/DL**
6.	**Scheme of Delegation:** The Section 75 Agreement from Knowsley had been distributed and Fiona Johnstone advised that mention had been made at an away day for something to enable the partnership to operate as a group within the scope of delegation. Fiona Johnstone asked the group if they felt it would be valuable to have something similar to this agreement. Fiona Johnstone referred to the discussion held on the authority of the partnership to make decisions. Eugene Lavan referred to discussions around where accountability lies and felt that Section 75 would make clear accountability. Dwayne Johnson felt that this was about the deliverability of the groups and asked if having this agreement would change anything. He further added that the group already had a written agreement in the Terms of Reference and that the LIT groups were aware of their accountability. It was felt there was possibly a need for Fiona Johnstone and Eugene Lavan to visit the LIT groups. Fiona Johnstone proposed awaiting feedback from the Tribal work at the next meeting and then some reflection on whether to include some of these outcomes into the Terms of Reference. Fiona Johnstone proposed the use of the spare meeting date in 2010 for presentations from the LIT groups.	**FJ/EL**
7.	**Health Partnership Performance Group Feedback:** Jim Wilson reported that	

	this is work in progress. He advised the group that two meetings had been held which had been well attended and that the group was very enthusiastic. A review of all the targets was undertaken at the first meeting. A great deal of time was spent at the second meeting looking at data against each of the targets and checking on the interventions. He felt that some help was needed and Keeley Harrison had been invited to this meeting as an observer. He reported good news in terms of obesity and work being undertaken to encourage the weighing of children yearly rather than just in reception and year 6. He advised the group that one of the performance managed WNF service level agreements is being investigated as there is possible duplication. This will be brought back to the group. In response to a query raised by Fiona Johnstone, Glenda Cave advised the group that with some of the interventions being introduced there would be an impact on the amber and red areas but it was unclear on the timescale. Jim Wilson reported that St Helens were performing better than Halton on the breast feeding target but was unsure why. Fiona Johnstone reminded the group that action plans had been requested some time ago. Jim Wilson felt that these need to be structured and there is a need to ask the leads for performance reports. Eugene Lavan felt there is a need to get stronger accountability from the project leads. Dwayne Johnson felt that alcohol and drugs were areas of concern and that there could be significant problems in changing the colour status on these areas. Jim Wilson referred to the difficulty of acquiring information due to hospital coding. Fiona Johnstone confirmed that the areas of alcohol, drugs and breastfeeding had arisen at the LSP meeting on Wednesday as issues. Finance: Glenda Cave advised the group that the report circulated was the one which had been circulated at the last meeting. She agreed to request and circulate the more up to date report. She reported that Quarter 1 WNF monitoring visits were being undertaken and Quarter 2 visits would commence shortly. She confirmed that there were no issues around finance. Fiona Johnstone queried some of the unallocated funding and Glenda Cave advised that SLAs had been drawn up for teenage pregnancy and dementia. Work is ongoing to mainstream the Diet and Exercise, Reach for the Stars, Complementary Therapies and the Voluntary Sector Counselling Partnership activities, which are currently funded via WNF, into streams of the CSP which would release c.£140,000 of WNF funding for other priorities for 2010/11. Reference was made to the appointment of Collette Walsh to work upon the priorities for alcohol. Eugene Lavan felt that the money allocated to alcohol would not be spent and that contact needed to be made with those working upon service improvements given that the Strategic Development Directorate of the PCT is currently working up their investment plan for next year which would look at proposals of business cases and priority setting. Fiona Johnstone advised the group that the Commissioning Sub Group had been set up to gauge priorities. Eugene Lavan to discuss this with Dave Sweeney, chair of commissioning sub group.	**GC** **EL**
8.	**CAA**: Fiona Johnstone reported that at the CAA meeting on Wednesday 16 September a presentation was given by Peter Forrester, one of the leads for the Audit Commission, giving headlines on what the key findings would be of the rolling programme review. In June a number of areas were red flagged but this has now been reduced to three: health inequalities, teenage pregnancy and skills and post16 education and worklessness. A meeting was held after the LSP when more feedback was given which included some positive statements but also the message that, although there are some improvements in health inequalities, these are not happening fast enough. Fiona Johnstone	

Halton Strategic PARTNERSHIP

	felt that although no argument could be made against the red flags there was perhaps a lack of recognition for the potential for improvement. She reported upon the plans in progress for rapid improvement which will be rolled out on 1 October as a response to the NST visit. Peter Forrester advised that they are looking for data coming through and Fiona Johnstone has undertaken to obtain QOF data from last year to this year and reference to be made to the improvements in cancer data. Additional information to be submitted by 25 September. A draft report will be circulated on 19 October with a further opportunity to comment and to ask for a review. Final information date is 10 December and a 'one place' web site established. She emphasised the need to be prepared with suitable messages for red flagged areas once the report is published with clear expectations of delivery. Reassurance needs to be given that things are happening for the local population. Diane Lloyd emphasised the need to have all action plans in place for next year. Eugene Lavan felt that the plans should demonstrate that what is being put in place will have the correct impact. It was agreed that the group need to recognise that this will reflect upon them and will also have an impact upon the Council.	
9.	**AOB** ▪ Jim Wilson informed the group that an appointment had been made to the CEO post of the PCT - Andrew Burgess from Warrington PCT. ▪ Diane Lloyd reported that there may be a need to change the meeting date for May next year - elections. ▪ Karen Tonge advised the group of the production of the 'Health Times'.	
10.	**Date and time of next meeting: 10 am 17 September Conference Room 2 Municipal Building**	

Action Summary – previous meetings

Reference	On Whom	Action	Status / Update
17/09/09 1	Elaine Skelland	Action summary to be completed	Immediate
17/09/09 2	Fiona Johnstone/Diane Lloyd	Discussions on Health Summit	
17/09/09 3	Fiona Johnstone/Eugene Lavan	To visit LIT groups	
17/09/09 4	Glenda Cave	To circulate updated finance report & amended Q1 performance report	
17/09/09 5	Eugene Lavan	To discuss priorities with Dave Sweeney	

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 January 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Joint Strategic Needs Assessment (JSNA) – Health & Wellbeing

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the updated JSNA summary of findings document (Attached at Appendix 1).

2. RECOMMENDATION: That the Board: -

(1) Note the contents of the report
(2) Comment as necessary on the JSNA summary of findings document.

3 SUPPORTING INFORMATION

3.1 The Director of Adult Social Services, Public Health and Children and Young People's (CYP) Services in every Local Authority and Primary Care Trust (PCT) had a statutory duty from April 2008 to work together to develop a JSNA for their area.

3.2 The first JSNA (full data document and summary of findings) was produced at the end of 2008 and at that point it was agreed that during 2009 the data included in the first documents would be reviewed to examine if there had been any new data available which would lead to a significant variance or change in the key messages identified in the 2008 JSNA or any new emerging issues identified.

3.3 Over the past few months, work has taken place with colleagues in NHS Halton & St Helens, Commissioning Managers, colleagues within the Children & Young People's Directorate and the Resources Directorate to undertake this task.

4. POLICY IMPLICATIONS

4.1 The JSNA pulls together information about the current and future health and well being needs of the local population. It provides an opportunity to look into the future so that we can plan now for likely changes in needs, so it is therefore one of the major influences in directing commissioning priorities and planning service development.

5. FINANCIAL/RESOURCE IMPLICATIONS

5.1 The production of the updated document has been borne from within existing resources.

6. IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
The JSNA will inform all future commissioning decisions targeted at improving the health and well-being of Children and Young People and in particular the interventions commissioned for children with the poorest health outcomes.

6.2 **Employment, Learning and Skills in Halton**
Improving the education, skills and employment prospects of Halton's residents and workforce is a key driver for reducing health inequalities and hence the relevant data comprises a significant part of the JSNA.

6.3 **A Healthy Halton**
The JSNA will inform all future commissioning decisions targeted at improving health and well-being across Halton and in particular the interventions commissioned for areas with the poorest health outcomes.

6.4 **A Safer Halton**
There is evidence to support the relationship between people's perceptions of their local are and how safe they feel with their health and well-being. As a result improvements to health and well-being are dependent on the successful implementation of this corporate priority.

6.5 **Halton's Urban Renewal**
Regeneration initiatives have a significant beneficial impact on health inequalities. As a consequence, a key aspect of the ongoing development of the JSNA will be to ensure the process informs and is informed by interventions to reverse physical, economic and social decline in a given locality/neighbourhood.

7. RISK ANALYSIS

7.1 The duty placed on LA's, in conjunction with partners in Health, is ongoing. There is an expectation that the summary of findings document will be refreshed on an annual basis and that the full document will be reviewed in line with the 3yr LAA cycle. Work has already started on the review of the full data document and attached at Appendix 2 are details of the timeline for completion of this project.

8. EQUALITY AND DIVERSITY ISSUES

8.1 No specific issues identified.

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

Document	Place of Inspection	Contact Officer
JSNA (Full document)	Runcorn Town Hall	Angela McNamara

HALTON BOROUGH COUNCIL

Health and Wellbeing in Halton

Halton's Joint Strategic Needs Assessment (JSNA)

Updated Position Autumn 2009

NHS Halton and St Helens

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For further information on the Joint Strategic Needs Assessment, or to obtain a full copy, please contact:

Service Development Officer for Health at Halton Borough Council on 01928 704546

Public Health Development Manager at Halton & St Helens NHS Trust on 01928 593021

Introduction

The JSNA has been used to inform a range of local strategic and commissioning plans including Halton's Local Area Agreement, Halton's Community Strategy, PCT Commissioning Plan, Housing/Supporting People Strategy, Children & Young People's Plan and client group commissioning plans (i.e. mental health, older people, obesity strategy)

Halton has undertaken a review of data included in the 2008 'Health & Wellbeing in Halton' Joint Strategic Needs Assessment (JSNA) during the summer of 2009, to examine if there has been any significant new data available. **This document summerises the key findings where there has been a significant variance or change in key message from the 2008 JSNA, or new emerging issues have been identified.**

How has the JSNA been used so far?

Both Halton Borough Council and Halton & St Helens NHS Trust have utilised the 2008 JSNA in identifying where services need to be developed and commissioned to address some of the borough's most significant health and wellbeing issues and inequalities. Just some of the examples where the JSNA has been instrumental include:

Halton Borough Council's Carer's Commissioning Strategy
The JSNA demographic profile of Carers within the borough was used to identify geographical areas where a high proportion of the population are know Carers. This then focused commissioning intentions as it highlighted areas within the Borough where commissioned services need to be focused upon and where and how services are delivered.

Department of Health Funding
The presence of health inequalities and factors affecting health inequality identified by the JSNA has lead to Halton Borough Council being able to secure Communities for Health funding from the Department of Health. The JSNA has directed where initiatives should be focused to address a range of health inequalities.

Local Government Agency/IdEA Funding
The JSNA has been used to identify focus for addressing health inequalities through tobacco control, which has lead to the development of specific initiatives tackling the supply of illicit tobacco and smoking cessation during pregnancy in Halton.

Halton & St Helens NHS Trust Children and Young People's Plan
It has helped to decide the priorities by mapping where the children who are most overweight are and to make sure new weight management services are targeted at these areas.

Cancer Screening
Widnes GPs were given information about the number of people on their patient lists who had not benefited from cancer screening.

They have responded to this by seeking out those people and encouraging them to go for screening. The PCT is now developing a special contract to offer to all general practices in the PCT to help them do the same.

Older People's Needs Assessment
The 2008 JSNA highlighted a number of key health and social care needs of older people, from which, it was felt a more detailed analysis was required to understand the depth and breadth of issues identified. As a result the Public Health & Intelligence Team have been developing an Older People's Health Needs Assessment, due for publication in November 2009, to cover both Halton & St Helens.

Dual Diagnosis Strategy
It was recognized that the needs of people suffering with a co-morbidity of mental health and substance misuse problems were not being sufficiently addressed locally. It is estimated that approximately 75% of users of drug services and 85%

How has the JSNA been used so far? (cont.)

of users of alcohol services also experience mental health problems, whilst 44% of mental health service users report drug use or use of alcohol at hazardous and harmful levels. In response, a joint Dual Diagnosis Commissioning strategy has been developed across Halton and St Helens to improve access to services and the co-ordination of care within them.

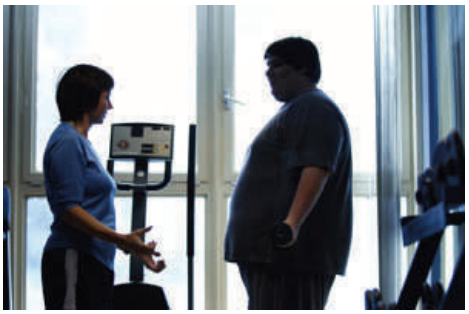
Single Point of Access (SPA) to Mental Health services

A single point of access to mental health services has been developed across Halton and St Helens to improve equality of access and improve the client pathway into services. The SPA will integrate health and social care assessment, ensuring that people receive a holistic assessment that responds to all their health and social care needs. Particular emphasis has been placed both on access to services for all adults, regardless of the severity of their condition, and the early detection of ill health as outlined in the NHS Halton & St Helens Commissioning Strategic Plan (CSP). The aim is to ensure that by identifying ill health sooner and streamlining access to treatment options, we will reduce the likelihood of illness becoming severe and significantly affecting a person's quality of life.

Summary of Halton's updated position

Coronary Heart Disease
The number of people on GP registers has increased, this may be due to more proactive case finding.

All ages mortality rate for males has increased but has decreased for females.



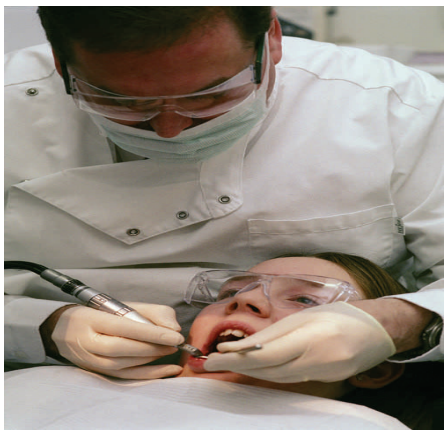
Under 75 mortality has decreased as has admissions from myocardial infarction (heart attack).

Cancers
There has been an increase in the number of new cases of cancer detected (incidence). This could be due to the introduction of the early detection initiative which has highlighted the symptoms of the top three types of cancer across the area and encouraged people to seek early treatment. Deaths (mortality) from cancer have decreased overall and for all major types of cancer.

Whilst these are not statistically significant they do show a trend in the right direction.

Accidents has decreased from 6.8 to 6.1 per 1000 of population.

Access to NHS dentist
The data is reported at PCT level only at present. At 59.2% the PCT rate has increased slightly 2007-8 to 2008-9, a trend not seen across England as a whole where the percentage of the adult population accessing NHS dentist has decreased. The PCT rate is above the England rate.



Sexual Health
Both the total number and numbers for 4 out of the top 5 sexually transmitted infections have reduced since last year.

The percentage of people seen within 48 hours at GUM has also improved from 86% to 95%.

Chlamydia screening coverage for under 25s has improved. Amongst those screening the rate of positive infections has decreased.

More women have been able to access a termination of pregnancy under 10 weeks through the NHS

The number of low birth weight babies has decreased. The Halton's Infant Mortality figures have improved. There has been a drop from 7.1 in 2005/07 to 6.3. in 2006/08 per 1,000 live births

Breastfeeding initiation rates continue to rise. New for 2008-9 has been the monitoring of breastfeeding at the 6-8 week check. There is a significant drop off from initiation to continuation of breastfeeding even within this short space of time. This pattern is reflected across the country; however, the rates in Halton are especially poor and are lower than the North West rate.

smoking during pregnancy
continues to be resistant to change. Slightly more women across the PCT continued to smoke throughout pregnancy than last year. In 2008-9 we were able to break the figures down to borough level. Halton rates, at 31.7%, were significantly higher than the PCT rate of 25.6% which itself was a rise from previous figure of 24.1%. A number of initiatives have been put in place to support the whole family to go smoke-free. These have resulted in an increase in the number of pregnant women quitting, compared to figures from the same time last year.

The number of under 18 conceptions has increased but the rate of under 16 conceptions has fallen slightly (this is based on a three-year rolling average as numbers are small)

Mortality from Road Traffic

Child Health

Summary of Halton's updated position

Overall child obesity levels have improved. The only increase was in reception year overweight and obese category. This needs to be monitored closely through Early Years avenues in order that overweight at this young age does not translate into an upward trend in overweight and obesity levels for children generally.

Work undertaken by Halton's Children and Young People's Directorate since the last JSNA has identified that dental health in Halton is poor. Using data from epidemiological studies of child dental health we know that in 16 of the 21 electoral wards that comprise Halton Local Authority, dental health of 5-year-olds is worse than the national average.

In England, 34% of children aged 5 years have experienced tooth decay, the figure in Halton is 51%, with each Halton 5-year-old having, on average 2 decayed, missing or filled teeth.

There are only 4 Halton electoral wards in which the proportion of 5-year-olds with tooth decay is lower than the national average (Beechwood, Birchfield, Daresbury, Farnworth). The position is similar amongst the 12-year-old population.

Thirty per cent of children in Halton do not attend a dentist regularly and often these children come from communities that have the poorest dental health

Measles Mumps Rubella (MMR) vaccination rates continue to improve.

However, the initial dose by age 2 rate has declined with vaccination rates catching up by the 5th birthday.

Older People

Influenza vaccination rates have improved and continue to be above the 70% coverage target.

Hospital Admissions

There has been an overall increase in the number of admissions to hospital. It is not possible to say at present if this is a good thing or bad. Interestingly, in last year's JSNA there were more non-elective, or emergency, admissions than elective but this pattern reversed when analysis of the latest year's data was done (2007-8). The reasons for this are being further investigated.

Employment

Latest figures show that in 2008 the Halton unemployment rate was 6.8% (equating to 3,900 working age residents), higher than the overall North West Rate of 6.5% and the national average of 6%, but slightly lower than the 2007 figure of 6.9%.

The number of working age people on out of work benefits has increased from 18% in 2007.

In quarter 1 of 2009 Halton had the 4th highest percentage in the North West of working age people claiming out of work benefits at 20%. This equates to 15,000 people from Halton. Halton has the 13th highest rate nationally, from a position of 21st highest in 2007.

Further information and key reports about health and well being in Halton can be found at the Primary Care Trust's 'Your Health' web pages:
http://www.haltonandsthelenspct.nhs.uk/pages/YourHealth.aspx?iPageId=4554

Including:

- Health Inequalities National Support Team report
- 2008/9 Public Health Annual Report
- Cancer Health Equity Audit
- Diabetes Health Needs Assessment
- Older People's Health Needs Assessment
- Child Weight reports
- A range of short topic reports
- Health Impact Assessments

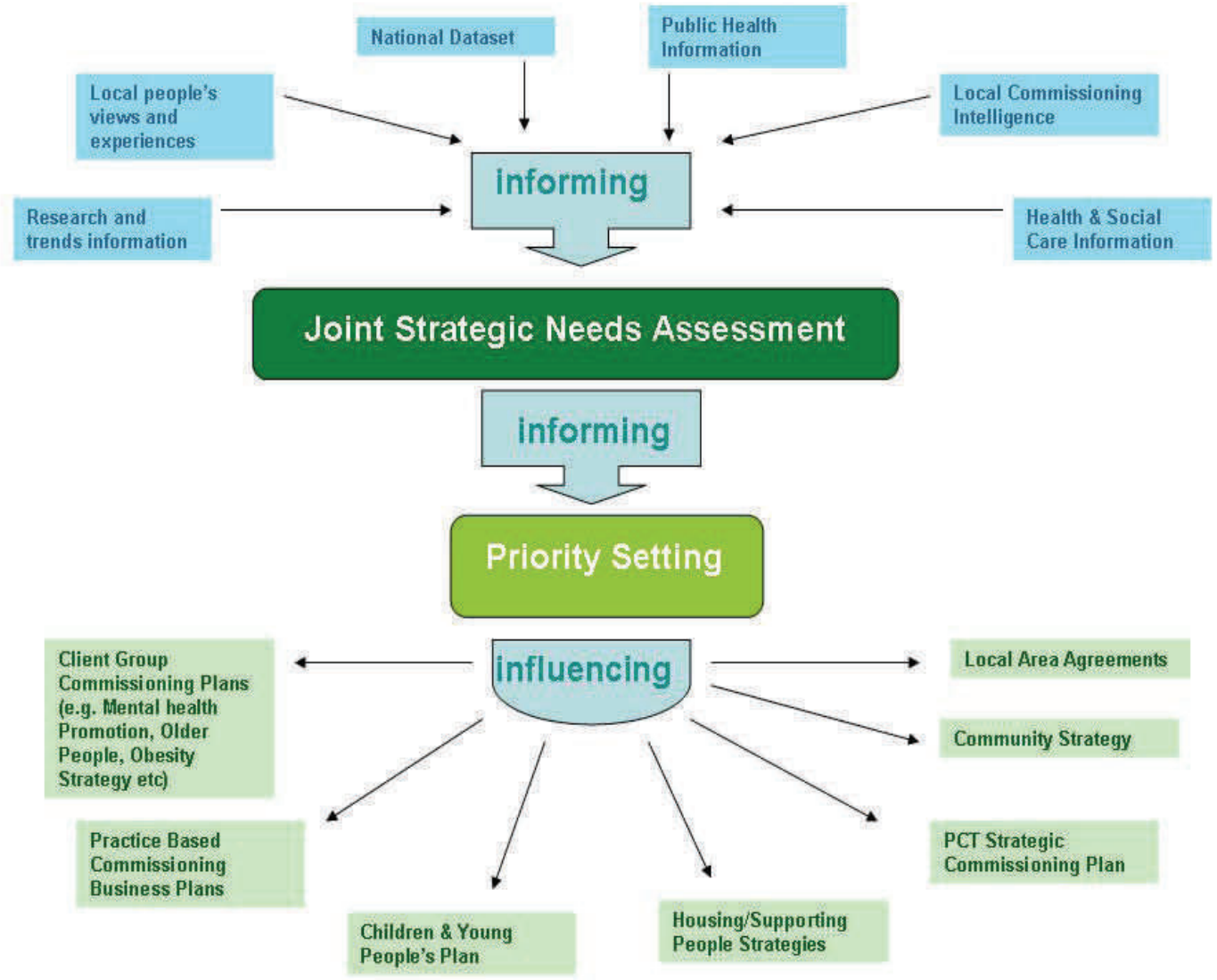
The Primary Care Trust's Commissioning Strategic Plan is also available from the website ' Publications and Freedom of Information' pages

http://www.haltonandsthelenspct.nhs.uk/pages/publications.aspx?iPageId=395

Summary of Halton's updated position

Next Steps

Between September 2009 and September 2010 work is underway to add to this intelligence. The information and analysis produced as result will be used to further direct commissioning priorities and input into future key strategic documents. The following diagram summarises the inputs and potential outputs from the JSNA work.



A range of community engagement and consultation activities and will take place during this period to enhance the data collected and gain an insight from Halton residents on how key health and wellbeing services could be developed to meet future needs.

Information on engagement and consultation activity in relation to the JSNA can be found at halton.gov.uk

Appendix 2

Full JSNA 2010/11: Time scale and Framework for Review/Update

Activity	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	March 10	April 10	May 10	June 10	July 10	Aug 10	Sept 10	Oct 10
Discuss & agree process and timescales with stakeholders and gain agreement on inputs (staff time and data)															
Create project infrastructure (Steps C1-C2 overleaf), develop project documentation and identify strategic and operational leads															
Undertake audit and preparation phase (Steps B1-B6)															
Begin formal project work, including kick off meeting (Steps D1-D3) • Continue monthly project meetings during the lifecycle of the project															
Develop and agree Requirements Document (Steps E1-E4)															
Collect data															
Conduct analysis (Steps F1-F6) and review • Review and refine Requirements Document as appropriate • Recollect and reanalyse data															
Develop and refine JSNA document (Steps F7-F9)															
Community engagement, consult on and develop commissioning priorities															
Update Commissioning & Strategic Plans as required															

ACTIVITIES	TIME ELAPSED
Timing of next JSNA A1. Identify timetable for production of Sustainable Communities Strategies, Local Area Agreements and links to World Class Commissioning. A2. Set timing for JSNA kick off	**0 months**
Preparation B1. Audit of existing JSNA, focusing upon: • Usefulness to commissioners / decision makers • Future themes / groups to consider • Key questions left unanswered • Need for future community engagement to enhance JSNA B2. Audit of data, focusing upon: • What was not included that would have been useful • What additional information is required B3. Identify potential sources for information currently unavailable B4. Update resident / user surveys and systems to collect any additional information B5. Identify community engagement research required B6. Undertake community engagement research	**0-1 month**
Prior to kick off C1. Construct JSNA teams – project steering group and project team(s) C2. Provide a timetable of monthly meetings	**0-1 month**
Kick off meeting D1. Identify Project Manager resource D2. Review Audits (B1 & B2) and confirm focus D3. Inform commissioners / managers and analysts of need for support JSNA process	**1 month**

Developing Requirements Document E1. Project Manager to lead interviews with JSNA team & Commissioners to gain understanding of their requirements E2. Confirm with analysts availability of data and validity of approach E3. Share requirements and approaches with all JSNA team to review and consider additional requirements / joint requirements / sharing of information E4. Formal sign off of requirements document	**1-2 months**
Writing the JSNA F1. Project Manager to propose structure of report to JSNA team F2. JSNA team to sign off proposed structure F3. Project Manager to lead / undertake data analysis F4. Project Manager to report back to JSNA team / commissioners for review F5. Formal change control process if Requirement Document is changed F6. Undertake additional analysis after feedback F7. Write up of Analysis F8. Review process of write up by JSNA Team / Commissioners F9. Formal Sign off by JSNA Team	**2-5 months** **5-6 months**
Update Commissioning & Strategic Plans	**6 months +**

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 January 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Progress in responding to the Ombudsman report "Six Lives: the provision of public services to people with learning disabilities"

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report is presented to Healthy Halton Policy & Performance Board in response to the recommendation made in the joint Health Service and Local Government Ombudsman report regarding complaints made by Mencap on behalf of families of six people with learning disabilities who died between 2003-5 whilst in NHS or local authority care.

1.2 The Ombudsman concluded that the findings from their investigations pose serious questions about how well equipped NHS and Councils are to plan for and provide services tailored to the needs of people with Learning disabilities. They went on to make three recommendations, the first of these is targeted at all NHS and Social care organisations who:

"should review urgently

- The effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disability in their area.
- The capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities."

and should report accordingly to those responsible for the governance of those organisations within 12 months of the publication of the Ombudsman's report."

2.0 RECOMMENDATION:

That the Healthy Halton Policy & Performance Board:

i) Note the contents of this report;
ii) Considers what, if any, further action is needed.

3.0 SUPPORTING INFORMATION

3.1 Overview of the report

In March this year the Health Service Ombudsman and Local Government Ombudsman published a joint report Six Lives: the provision of public services to people with learning disabilities, based on findings from their investigations in response to complaints brought by Mencap following publication of their report Death by Indifference (2007). This report outlined case studies of six people with learning disabilities who Mencap believed died unnecessarily as a result of receiving a lower standard of healthcare than afforded to the general public and prompted the independent inquiry, chaired by Sir Jonathon Michael, into access to healthcare for people with learning disabilities. These findings were reported in Healthcare for All (DH 2008).

3.2 In total the Ombudsman investigated 20 complaints against public bodies including PCT's, NHS acute sector providers, GP's and local authorities. These investigations found maladministration, service failure across the whole system of health and social care and unremedied injustice. In some cases these failures were attributed to disability related reasons stemming from poor leadership and understanding of disability legislation and guidance and the need to make reasonable adjustments. The Ombudsman also found some failures to observe the principles of human rights in particular dignity and equality.

3.3 The investigation found that during the lives of the people concerned basic policy, practice guidance and procedures were not followed, adjustments not made and the co-ordination of services was found to be absent.

3.4 There were a number of complex factors that led to failure to offer good care to individuals in vulnerable situations. The following areas of concern were highlighted not just for people with learning disabilities but also for other vulnerable groups who may be similarly affected and would also benefit from a change in culture:

- Communication
- Partnership Working and co-ordination
- Relationships with families and carers
- Failure to follow routine procedures
- Quality of management
- Advocacy

3.5 Appendix 1 sets out the complaints upheld by the Ombudsman and the systems/practices in place or being progressed by the Council and its partners to guard against such occurrences. Appendix 2 gives similar consideration to the further issues highlighted in the

report, which impacted upon the care given to individuals.

3.6 **Healthcare for All**

The Ombudsman supported the detailed findings of the independent inquiry into access to healthcare for people with learning disabilities, Healthcare for All, and action to improve access to and quality of healthcare has been embedded into the Valuing People Now Delivery Plan (DH 2009).

3.7 Across the Halton and St Helens PCT footprint responsibility for implementing these elements of the delivery plan rests with a multi-agency steering group with representation from Health and Social Care commissioners, acute sector and specialist health providers, GP's, Mencap and care coordinators/managers. Healthcare for All is a standing item on the agenda of the Halton Adult Learning Disability Partnership Board and the People's Cabinet.

3.8 **PCT Governance**

Earlier this year PCT Management Executive Team (MET) considered a report on responses to Government policy and strategy relating to adults with learning disabilities including Healthcare for All. A further report will be taken to MET and also the Clinical Excellence Committee in response to the Ombudsman report.

3.9 **Complaints procedures from 1st April 2009**

Poor complaint handling was also highlighted within the report as compounding the distress experienced by families. From April this year changes in the complaint system established the Ombudsman as the second and final tier across the health and social care system.

3.10 These national changes have given us the opportunity to review procedures and build on processes to further improve people's experience of the complaints system in Halton. Initiatives developed include:

- The introduction of a triage system to assess timely and proportionate action in response to complaints
- Early personal contact to clarify the complaint, desired outcomes and to agree timescales for the investigation
- Cross organisational cooperation to provide a coordinated response where appropriate
- Development of best practice for investigations and resulting reports
- Scrutiny of responses to complaints to assure quality

- Monitoring of any resulting actions, to ensure compliance with recommended actions
- Feedback system to measure satisfaction with how complaint was handled
- Reporting mechanisms to ensure learning from complaints is shared and used to develop improvements in services

Halton is also involved in developing ongoing improvements in complaints handling, including:

- The Development of National Complaint Standards by the National Complaints Managers Group, commissioned by the Association of Adult Directors of Social Services (ADSS)
- Exploration, within the North West Complaints Managers Group, of alternative methods of complaint resolution (eg mediation).
- Training programmes through these groups to improve the skills of those handling and investigating complaints.

4.0 POLICY IMPLICATIONS

4.1 As the Ombudsman suggested there is a plethora of Council policies and procedures that social care staff and service providers must comply with. The challenge is to ensure that these policies are relevant and effective and being consistently applied. This will be achieved through continued engagement with people who access services and their carers to monitor implementation and develop policy, alongside strong leadership from the Council and its partners, to build organisational cultures that value the human rights of individuals.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

Halton's Multi-agency Transition Strategy and Protocol ensures that information, guidance and support is available to young people with complex needs and their families. This helps to disperse any anxiety and uncertainty about what happens next and offers reassurance that Children's and Adults services are working together to make this a positive experience.

5.2 Employment, Learning & Skills in Halton

A successful Transition process for young people with complex needs supports improved outcomes in relation to their future employment and ability to access training opportunities.

5.3 A Healthy Halton

The actions outlined in the appendices to this report, many of which will be progressed through working in Partnership with NHS Halton and St Helens, will improve access for people with learning disabilities to generic health services offering an appropriate level of care to aid recovery and return to their home and precent admission to residential care.

5.4 **A Safer Halton**

None identified.

5.5 **Halton's Urban Renewal**

None identified.

6.0 **RISK ANALYSIS**

6.1 There is potential for legal challenge under the Disability Discrimination Act or Disability Equality Duty around inequitable access to services provided or commissioned by the Council.

6.2 There is a risk of an adverse report by CQC if inspectors are not satisfied with local authority progress on the recommendation in Six Lives for local authorities to review systems and services provided or commissioned (see 1.2).

7.0 **EQUALITY AND DIVERSITY ISSUES**

7.1 The Ombudsman view equality as finding alternative methods to make services available to people with disabilities in order to achieve equality in outcomes rather than treating everybody in the same way. The focus for services needs to be on the outcomes for the individual and this requires flexibility within working practices and procedures to enable reasonable adjustments to be made whilst adhering to policy.

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

Document	**Place of Inspection**	**Contact Officer**
Six Lives: the provision of public services to people with learning disabilities 2009 Local Government Ombudsman and Health Service Ombudsman	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Investigation into the service for people with Learning Disabilities provided by Sutton and Merton Primary Care Trust 2007 Healthcare Commission	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age

Joint investigation into services fro people with Learning Disability at Cornwall Partnership NHS Trust 2006 CSCI/Healthcare commission	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Death by Indifference 2007 MENCAP	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Valuing People Now Delivery Plan 2009 DH	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Healthcare For All 2008 DH	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age

APPENDIX 1

Halton's progress

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
Arrangements for transition from residential school to adult care fell significantly below a reasonable standard.	Halton Borough Council – Adult Social Care	• Dedicated Transition Co-coordinator post jointly employed by Children & Young People and Health & Community. • Multi-agency Transition Protocol in place supported by Operational Managers Group meeting regularly to track individual cases/needs. Protocol under review to extend age range to 14-25 • Health Action Plans for age <18 and health professionals linking in to Transition reviews being explored. • "Change It" project exploring what support is needed locally to avoid placements in residential schools/colleges. • Development of Challenging Behaviour Service underway to prevent people being sent to distant specialist placements • Self-assessment questionnaire by 1/12/2009
Maladministration/less favourable treatment for reasons related to disability	All Health and Social care agencies need to take responsibility for this and	• Action plan agreed by multi agency

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
	Healthcare for All group will progress this across agencies. These areas of progress relate to Halton Borough Council.	HealthCare for All steering Group • Equality impact assessments undertaken on new policies • All procured social care services are subject to providers complying with policies to ensure equal access to and conduct within services. • Adult Safeguarding Board raises awareness of institutional abuse. • No Secrets re-launch will follow publication of DH Guidance on Safeguarding, which will include concerns raised by learning disabled people.
Council failed to live up to human rights principles of dignity, equality and autonomy	Halton Borough Council	• Halton Dignity Champions Network established. Champions from Adult Social Care, Elected members, 5BP, local hospitals, voluntary sector and independent sector providers. • Dignity Charter developed and all providers are expected to work to this. • Dignity in care co-ordinator post (2 years) to working across Health and Social Care. Liverpool John Moores University evaluating post – baseline,

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
		progress review and future options for post.
Poor complaint handling	Halton Borough Council	• See section 3.9 of report
Local authority contributed to public service failure, which resulted in an avoidable death. Failure to provide and/or secure an acceptable standard of care and consequently the care home residents safety was put at risk.	Halton Borough Council	• All residential and domiciliary care providers within Halton supporting learning disabled adults are rated Excellent or Good by CQC. • Independent sector contracts are subject to robust monitoring by Contracts and Supporting People team. • In house supported living services funded by supporting people are also subject to monitoring. • Quality of in house day services is monitored through independent inspection by a group of self-advocates and family carers.
Short comings in fulfilling of responsibilities with regard to planning for the health needs of people with profound and multiple learning disabilities (PMLD)	Halton Borough Council/Halton & St Helens PCT	• Joint Commissioning Strategy has identified number of younger people with profound and multiple learning disabilities and Transition Operational Group will plan for move into adult services • Proposed extension of Health Action Plans for under 18's will highlight specific individual health need for

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
		people with profound and multiple learning disabilities and wider learning disabilities population. • In 2009/10 all adults with a moderate or severe learning disability who are known to social care will be offered an annual health check through their GP • The Warrington and Halton Hospitals NHS Foundation Trust has re-launched its hospital passport, which captures an individual's salient information that will help nursing staff provide appropriate care and support.
Service failure in care and treatment including nursing care and arrangements for discharge to an adult care home	Halton & St Helens PCT	• Dedicated Community Matron for people with learning disabilities in Halton tracks admissions to and discharge from hospital and liaises with community support services/social care as appropriate. • Link between Community Matron/LD Nurses within Adult Social Care and Hospital Discharge Team will be reviewed to streamline discharge process. • Within the Acute Sector, Warrington and Whiston Hospitals have each

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
		appointed a Community Matron to advise staff and improve the hospital experience for patients with learning disabilities.

APPENDIX 2

Halton Progress – Other areas of concern highlighted by the Ombudsman

Note many of the actions in Appendix 1 will also address these concerns but have not been repeated below.

Concern	Progress to date
Communication	• Partnership Board developing a Communication Strategy to promote its work and ensure people have access to appropriate information • Successful communication pilot project recently completed with people with PMLD in day services leading to improved working practices and support. This work is now being extended to independent sector providers. • Information sharing protocols in place between Social Care, PCT and Specialist health service provider (5BP) • Health passports being launched at Warrington Hospital detailing persons needs and preferred method of communication
Partnership Working and co-ordination	• Integrated health and social care Community Learning Disability Team offering a single point of access and referral into intensive support services • People's Cabinet acts as a conduit between professionals and learning disabled adults in Halton to influence strategy and decisions making and ensure improved outcomes for people. Chair of cabinet is co-chair of Partnership Board. • CQ requires local NHS bodies to refer their "annual health check" to Partnership Board for comment providing an opportunity to ensure that people with learning disabilities are getting good, fair and safe treatment and support from Health services.
Relationships with families and carers	• Regional family forum event held in July and three priorities identified for Partnership Board to work on. • Follow up event planned for 2010 to consider annual report on Partnership Board progress. • Person centred reviews and support planning include family members as

	they know an individual best and are part of a person's circle of support.
Advocacy	• Support in Halton is available through Council funded generic advocacy service – Advocates. People with learning disabilities or their families are main users of this service. Capacity is monitored to ensure waiting times are minimised. • Learning Disability Development Fund has been invested for a number of years in developing support for self-advocates. Halton now has a pro-active self-advocacy support group which hosts the People's Cabinet. To provide a period of stability for the group funding has been agreed to March 2011.
Quality of management	• In response to previous reports into support for people with learning disabilities (Sutton & Merton and Cornwall) an action plan was developed. This is now overseen by the Quality sub-group of the Adult Safeguarding Board. The Safeguarding Board reports into the Safer Halton Partnership and annual reports are taken to Healthy Halton and Safer Halton Policy and Performance Boards.
Failure to follow routine procedures	See Section 4.1 Policy implications • The Halton Multi-Agency Adult Safeguarding Board supports the development of and keeps under review local policies relating to Vulnerable Adults sharing learning from national and local experience and research with relevant Teams/Agencies.

REPORT: Healthy Halton Policy and Performance Board

DATE: 12th January 2010

REPORTING OFFICER: Strategic Director Health and Community

SUBJECT: Healthy Halton Policy and Performance Board Work Programme 2010/11

WARDS: Boroughwide

1.0 PURPOSE AND CONTENT OF REPORT

1.1 This report is the first step in developing a work programme of Topics for the Board to examine in 2010/11. While the Board ultimately determines its own Topics, suggestions for Topics to be considered may also come from a variety of other sources in addition to Members of the Board themselves, including members of the Council's Executive, other non-Executive Members, officers, the public, partner and other organisations, performance data and inspections.

1.2 The key tasks for Board Members are:

- to suggest and gather Topic ideas on issues relevant to the Board's remit:
- to develop and prioritise a shortlist of possible Topics for examination in 2010/11, bearing in mind the Council's agreed selection criteria (Annex 1)
- to decide on a work programme of Topics to be undertaken in the next municipal year.

2.0 RECOMMENDED: that the Policy and Performance Board

(1) Put forward and debate its initial suggestions for Topics to be included in the Board's 2010/11 work programme

(2) Develop and informally consult on a shortlist of its own and others' 2010/11 Topic suggestions ahead of the Board's meeting on 9th March 2010 bearing in mind the Council's Topic selection criteria

(3) Decide at its meeting of 9th March 2010 on a work programme of Topics to be examined in 2010/11.

3.0 SUPPORTING INFORMATION

Annex 1 – Topic selection checklist

3.1 Prior to determining their preferred Topics, the PPB may wish to take soundings from relevant Executive Board portfolio holders, the SSP and other key partners.

Annex 1

OVERVIEW AND SCRUTINY WORK PROGRAMME

Topic Selection Checklist

This checklist leads the user through a reasoning process to identify a) why a topic should be explored and b) whether it makes sense to examine it through the overview and scrutiny process. More "yeses" indicate a stronger case for selecting the Topic.

#	CRITERION	Yes/No
Why? Evidence for why a topic should be explored and included in the work programme		
1	Is the Topic **directly aligned with and have significant implications for at least 1 of Halton's 5 strategic priorities & related objectives/PIs, and/or a key central government priority?**	
2	Does the Topic **address an identified need** or issue?	
3	Is there a **high level of public interest or concern about the Topic** e.g. apparent from consultation, complaints or the local press	
4	Has the Topic been **identified through performance monitoring** e.g. PIs indicating an area of poor performance with scope for improvement?	
5	Has the Topic been **raised as an issue requiring further examination through a review, inspection or assessment, or by the auditor?**	
6	Is the Topic area likely to have a **major impact on resources or be significantly affected by financial or other resource problems** e.g. a pattern of major overspending or persisting staffing difficulties that could undermine performance?	
7	Has some **recent development or change** created a need to look at the Topic e.g. new government guidance/legislation, or new research findings?	
8	Would there be **significant risks** to the organisation and the community **as a result of not examining this topic**?	
Whether? Reasons affecting whether it makes sense to examine an identified topic		
9	**Scope for impact** - Is the Topic something the Council can actually influence, directly or via its partners? Can we make a difference?	
10	**Outcomes –** Are there clear improvement outcomes (not specific answers) in mind from examining the Topic and are they likely to be achievable?	
11	**Cost: benefit** - are the benefits of working on the Topic likely to outweigh the costs, making investment of time & effort worthwhile?	
12	**Are PPBs the best way to add value** in this Topic area? Can they make a distinctive contribution?	
13	Does the organisation have the **capacity** to progress this Topic? (e.g. is it related to other review or work peaks that would place an unacceptable load on a particular officer or team?)	
14	Can PPBs contribute meaningfully given the **time** available?	

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 January 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Local Dementia Strategy & Dementia Business Case

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the local dementia strategy and business case, and clearly define the key priorities within the local dementia strategy.

2.0 **RECOMMENDATION:**

That Members of the Healthy Halton Policy & Performance Board:

i) Comment on the overall strategy;

3.0 **SUPPORTING INFORMATION**

3.1 The National Dementia strategy – Living Well with dementia was published in February 2009 and outlined 17 objectives designed to deliver on the three overarching aims:

- Improved public and professional awareness of dementia;
- Early diagnosis and intervention; and
- High quality care and support

3.2 The joint commissioning strategy for dementia was developed across Halton & St Helens to outline the current service position and identify gaps in provision that would be central to commissioning plans in the future.

3.3 The dementia business case outlines the clear shift from long-term care, residential and acute care to low-level community support. By changing the focus of our service provision our main objective is to reduce the need for continuing health care beds, residential beds and nursing care. If we do not effect this change then there is an increasing risk of more high cost residential care required in the borough.

3.4 By improving the efficiency as described in the business case we will see a more planned approach to service delivery, which should result in a reduction in the financial resources required. This will be further

enhanced by completion of a service review and redesign of the current Community Mental Health Team.

3.5 The dementia strategy and business case clearly demonstrate the direction of travel that will result in a planned shift from expensive, high-level packages of care to low-level preventive services based in the community. This investment in low-level services will offer savings to allow for the future increase in the older population and increased prevalence of dementia, as illustrated in the table below.

3.6 The table below outlines the current level of people diagnosed with dementia in Halton and the projected number for 2025.

2008	**2025**

3.7 The implementation plan will be owned by the Older People's Commissioning Manager and will be performance managed through the Older People's Local Implementation Team. In addition a time-limited steering group will be developed to support the completion of the project plan.

4.0 POLICY IMPLICATIONS

4.1 There are three National documents and one local document that will further support the development of the dementia strategy and business case. **Living well with Dementia: A National Dementia Strategy (Feb 2009)** clearly identifies the direction of travel and the commissioning priorities, the key points are covered earlier in this report at 3.1. The **Government White Paper; Our Health, Our Care, Our Say (January 2006)** outlines the overall shift from complex care to prevention. Although this document does not discuss dementia it does demonstrate the importance of prevention and how an agreed model of early intervention could work across a number of service areas.

On 17th January 2008, the **Department of Health issued a Local Authority Circular entitled 'Transforming Social Care'.** The circular sets out information to support transformation of social care and at the heart of this change is the personalisation agenda. As we develop community provision within dementia services we will need to consider the implications of personalisation for people diagnosed with dementia to maintain their independence.

Locally, to support these three National documents, the **Older People's Commissioning Strategy** identifies Mental Health in Older People and particularly dementia as one of it's main priorities. In addition quality of life is a major theme of the document and by moving to more community-based provision we will look to achieve an improved quality of life for people diagnosed with dementia and their carers.

5.0 FINANCIAL IMPLICATIONS

5.1 The business case is asking for support from Halton Borough Council, St Helens Metropolitan Council and NHS Halton & St Helens of £125,000 each on a recurring basis to support the development of low-level dementia services. The contribution from HBC will be met from the re-design of existing services.

5.2 The shift in investment from high cost crisis intervention to community led preventive services will be the most efficient system by ensuring that we get the right people, at the right time into the right part of the system to support people diagnosed with dementia and their carers. The Local Authority will continue to be faced with the challenges of making best use of resources and evidencing value for money. In undertaking this redesign in dementia services we will continually monitor and evaluate the effectiveness of the services to support value for money and improved outcomes for service users.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

It is important that we acknowledge through carer's services how this might impact on young families. In Halton we do have a number of younger people who have been affected by a parent diagnosed with dementia.

6.2 Employment, Learning & Skills in Halton

Dementia does affect people of working age and this needs to be factored into service provision. We need to ensure that there are still opportunities for people with dementia and their carers to realise their potential through employment and volunteering. This has been identified as a Local Area Agreement target (NI150) within Mental Health.

6.3 A Healthy Halton

As we continue to increase life expectancy the numbers of people with dementia increase. It is clear that everybody has the right to enjoy the best quality of life they can and this should be no different for people diagnosed with dementia. This includes performance towards healthier lifestyles, better access to mainstream services, improved accommodation, dignity and improved mental health outcomes.

6.4 A Safer Halton

Contracts within this report will be able to support specific Local Area Agreement targets linked to information provision, satisfaction with

services and overall perception of the area that they reside. These targets will be agreed as part of any revised contract and will be monitored through the relevant Commissioning Manager.

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 This strategy outlines the key risks and issues that commissioning faces in relation to ensuring that people diagnosed with dementia have the same opportunities to access services and support that helps them to remain independent. If these areas are not addressed then the risk to health inequalities, economic burden, strain on frontline health and social care services would continue to grow in the coming years.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Dementia will play an important role within the emerging dignity agenda as well as cutting across a number of service areas including adults of working age. This is due to an increase in the number of people under 60 who have been diagnosed with dementia.

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

Document	**Place of Inspection**	**Contact Officer**
None identified		

Objectives	Priority	Actions	Outcomes	Lead	Progress and Timescales
Theme: Raising Awareness and Understanding					
Objective1: Improving public and professional awareness and understanding of dementia	Medium (Year 1 / 2)	The newly formed project board will agree the following in year 1: • Scope of training defined • Agree specification • Commission year 2 training	Training outcomes will relate to and commission the following • Basic awareness training • Specialist training	Project steering group	Programme will be developed through the project steering group that will be set up from February 2010. Basic awareness training in place by August 2010 Specialist training plan developed by January 2011
Theme: Early Diagnosis and Support					
Objective 2: Good-quality early diagnosis and intervention for all	High (Year 1)	• Employ Project Manager • Establish steering group • Redesign existing services to support the implementation of ACTs • Completion of an implementation plan led by the project manager	• Investment to be agreed from each partner organisation • Redesign of existing service will be agreed • Improved pathway for dementia services agreed.	Project Manager Overseen by the steering group	• Job description and person specification is being developed for project manager Person in post by April 2010
Objective 3: Good-quality information for those with diagnosed dementia and their carers	High (Year 1)	• Protocol developed for high quality information provision for people diagnosed with dementia and their carers. • All dementia services offering consistent information	• ACTs operating high quality information • Peer group support established • Dementia Care Advisors commissioned and employed	Project Manager Overseen by the steering group	• Beginning the process of developing Job descriptions, service specifications and person specifications Peer Support Group in Halton already established, St Helens planned for April 2010 Dementia Care Advisors in place by June 2010
Objective 4: Enabling easy access to care,	High	• Appoint Dementia Care Advisors (Year 1)	• Advisors in post • Improved community	HBC & St H	• Beginning the process of developing job description

support and advice following diagnosis		• Advanced Practitioners qualifications gained by three staff within 5BP (year 2 June 2011)	support for people diagnosed with dementia and their carers • Additional support to ACT service.	Commissioners	Dementia Care Advisors in place by June 2010
Objective 5: Development of structured peer support and learning networks	High	• Ensure both Halton and St Helens have commissioned and established a dementia peer support network	• Peer support will improve the networks available for people diagnosed with dementia and their carers throughout their experience of living with dementia.	Age Concern Mid Mersey Support offered through Partnership Commissioning	The funding has been agreed in Halton and the service has been established. This includes the appointment of a co-ordinator. St Helens is still awaiting a funding decision to move this work forward. Peer Support Group in Halton already established, St Helens planned for April 2010
Theme: Living Well with Dementia					
Objective 6: Improved community personal support services *An additional mapping and gap analysis of the needs of younger adults with dementia, and their carers, will be completed.*	Medium	• A skills audit will be carried out in year 1 of the project to understand the level of knowledge in services including, Domiciliary Care, Intermediate Care, 5 Boroughs Partnership, residential and nursing homes. • Year 2 will see the completion of the Advanced Practitioners training through 5 Boroughs Partnership	• Consistant training being offered across all providers • Improved access to quality services	Training leads for Local Authority, 5 Boroughs Partnership and NHS Halton & St Helens	Programme will be developed through the project steering group that will be set up from February 2010. Basic awareness training in place by August 2010 Specialist training plan developed by January 2011 Advanced practitioners will be qualified by June 2011
Objective 7: Implementing the Carers' Strategy	Medium	The specific needs of carers of people diagnosed with dementia are addressed in the Carers	Ensure dementia is covered in carers commissioning strategy	Carers - service developme	This Objective has been addressed in the current Carers Commissioning Strategy

		Commissioning Strategy		nt officers	
Objective 8: Improved quality of care for people with dementia in general hospitals	High	• Establish named dementia lead in hospital settings • Ensure effective monitoring of the extended psychiatric liaison nurse role • Monitor the impact of the integrated discharge team in Halton	• Improved dignity for people in hospital • Improved effectiveness of hospital discharge • Improved community support on discharge	Dignity Co-ordinator Warrington and Halton Hospital foundation trust	Dignity action plan has been successfully signed off. Dementia lead for Hospital in place by February 2010
Objective 9: Improved intermediate care for people with dementia	High	• Recruit to CPN role (Halton) to sit within RARS • St Helens to explore existing provision for Intermediate Care for dementia	• Improved access to community services	Training leads and Intermediate care leads for Local Authority and NHS Halton & St Helens	• CPN post in Halton to begin in January 2010
Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers	Medium	• Complete development of the Joint telecare / telehealth strategy • Review provision of Seddon Court • Continue to develop plans in relation to Extra Care Housing	• Clear strategic direction in relation to Telecare and Telehealth	HBC / NHS H&StH	• Telecare / Telehealth strategy has begun completion date to be confirmed
Objective 11: Living well with dementia in Care Homes	Medium	ACTS will provide an in-reach support service for people with dementia in care homes and contribute to the training of staff	ACTS provider's operational policy will include details of the in-reach service	ACTS provider	Redesign of Older People's Community Mental Health Team will begin early 2010 and will form a part of the development of the

		A new service specification for residential and nursing homes will be developed that includes the dignity charter The action plan for the dignity coordinator will be implemented A lead for dementia in the hospital will be identified	arrangements Commissioners will assess outcomes through the performance monitoring process		Assessment, Care and Treatment service.
Objective 12: Improved end of life care for people with dementia	High (Delivered through other services)	• To link in with existing work taking place in this area	• Improved dignity for people diagnosed with dementia and their carers	NHS Halton & St Helens	Part of commissioning plan for NHS Halton & St Helens
Theme: Delivering the Strategy					
Objective 13: An informed and effective workforce for people with dementia	Medium	Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education	Agree training programme Commission training	Training leads for Local Authority and NHS Halton & St Helens	On going Basic awareness training in place by August 2010 Specialist training plan developed by January 2011
Objective 14: A joint commissioning strategy for dementia	Medium	This document sets out the overarching strategy for Halton B.C., St Helens B.C. and NHS Halton and St Helens	Clear strategic aims to deliver local dementia strategy	Commissioning	Strategy complete
Objective 15: Improved assessment and regulation of health and care services		The Department of Health is progressing this Objective			On going

Objective 16: A clear picture of research evidence and needs		The Department of Health is progressing this Objective			On going
Objective 17: Effective national and regional support for implementation of the Strategy		The Department of Health is progressing this Objective			On going

NHS
Halton and St Helens

Business Case

Halton and St Helens 'Living Well with Dementia'

(Incorporating Stage 1 and Stage 2 of PCT Commissioning Cycle)

Executive Summary

Objectives

This business case sets out to ensure that services for people with Dementia and their carers in Halton and St Helens help those individuals to live well with dementia and to do this they need to be stretched beyond their current standards and boundaries.

The objectives of this business case resonate entirely with the 4 key principles underpinning the recently published Mental Health Commission report *A Better Future in Mind - Mental Health Services in the North West, 2008.* John Boyington led the Commission that published the report and he leads the Mental Health Improvement Programme for NHS Northwest. His 4 key principles are:

- Making service users and carers more powerful
- Enhancing Commissioning to deliver services that are valued by users and carers
- Shifting the balance of investment towards prevention and early intervention
- Helping staff to provide services people want in a way that they want to receive them

The key local priorities, borne out of the national priorities for health and social care are as follows:

- Early intervention and diagnosis for all
- Improved community and personal support services
- Implementing the new deal for carers
- **Improved quality of care for people with dementia in general hospitals**
- Living well with dementia in care homes
- Considering the potential for housing support, housing related services and telecare to support people with dementia and their carers
- Improved end of life care for people with dementia
- An informed and effective workforce for people with dementia
- **A joint commissioning strategy for dementia**

Improving the quality of care for people with dementia in general hospitals has already been subject to a PCT business case approved in 2008. As a result of

	this a new service was commissioned for the provision of an acute hospital older person's mental health liaison team. A Joint Commissioning Strategy for Dementia has been developed and is currently awaiting full approval by Halton and St Helens Councils. The Joint Commissioning Strategy illustrates the importance of working across Health and Social Care to ensure that we are able to address the challenges that we face in the future. Positive partnership working will be integral to delivering quality service provision throughout community, hospital, social care and residential settings. This business case is **seeking recurrent funding of £125 K from the PCT.** St Helens Council has secured matched recurrent funds to help to deliver this business case in a joined up way and similarly Halton Council has given an in principle agreement to match fund based on redesign and invest to save and an absolute agreement to provide immediately an equal share of the cost of the Dementia Redesign Manager post.
Deliverables	• A service defined by need and not age • A direct, rapid and simple referral process for primary care services, social care, voluntary sector and community services. • Rapid access to the service for patients/service users and carers • Community based assessment - in people's homes wherever possible • A comprehensive specialist assessment and treatment service that will give service users and carers access to all the key services and professionals through one access point • Access to a range of services not currently generally available to patients/service users with organic mental health needs, such as psychology, counseling, physiotherapy, dietetic advice, speech and language therapy and dedicated carer assessment and support • A service that can respond to the needs of people with young onset dementia including people with learning difficulties and alcohol related dementia • Early detection, diagnosis, support and intervention for dementia enabling people to stay at home and be supported effectively in the community • Continuing periodic review of memory and management of medicines in accordance with NICE Guidance for patients / service users in receipt of the specified treatments • Closer and more integrated work with social care services will assist them to reduce the level of admission to long term care homes and enable people to remain longer in the community living more fulfilling lives • Improved community support that should result in fewer and shorter hospital admissions allowing a reduction in the number of high cost in-

	patient beds with commensurate savings • Access to specialist older persons mental health assessment and support for older people with depression or anxiety that hasn't responded to primary care mental health interventions and/ or is co morbid with dementia • Dedicated assessment and support for carers improving carer assessment performance and providing an important source of advice and information • Continuity of access to information and advice through the Dementia Care Advisor • Improved care for people in residential and nursing home care through in-reach, particularly linking into the Dignity in Care agenda • Improvement in awareness, knowledge and skills in other local services through ACTS training input, this will include Sport, leisure, Arts and Cultural services that will enable people with dementia to maintain the lifestyle and activities that they want. • A service that will actively promote patient and carer involvement and peer support to directly support the role of the newly established Dementia Care Advisors in the community • Creation of a balanced and comprehensive older person's mental health service in which the specialist OPCMHT can focus more effectively on people with more complex needs. • Essential and timely capacity development that will enable Halton and St Helens to be better prepared to respond effectively to the forecast growth in demand • The development of a cohesive Multi-disciplinary team across Health and Social Care that can train and develop together establishing appropriate conditions for the ACTS function to develop into a centre of excellence
Needs, Objectives and Current Service	
Strategic Context	• **Our Health, Our Care, Our Say DH 2006.** The 4 main aims promoted in this policy are: - better prevention services with early intervention

	- giving more choice and a stronger voice to service users - more activity on tackling inequalities and improving access to community services - high quality and sufficient support for people with long term needs • **Improving services and support for people with dementia, National Audit Office 2007.** In this report the NAO likened dementia care in the UK as poor as cancer care was in the 1950's. The NAO found that significant sums of money are being wasted on bad care and through its fieldwork the NAO found evidence on how a better community service response can shift care out of acute hospitals. • **Putting People First: Transforming Social Care DH 2008**. This has brought change funding to local councils a 3 year grant to support the shift to prevention; enablement and personalization in adult social care. • **Living well with dementia**: **DH A National Dementia Strategy February 2009.** This strategy sets out 17 key objectives. The local Joint Commissioning Strategy for Dementia includes the local response to meeting these 17 objectives. In view of the specific needs of people with dementia and their level of vulnerability particularly in the later stages of the condition the following policies are also highly applicable: • The Mental Capacity Act 2005 • No Secrets: The Safeguarding of vulnerable adults and compliance with local multi-agency policy and procedures. • Dignity in care DH 2006
Pressure for change	QOF data for 2008/09 indicates that 1369 patients across Halton and St Helens PCT are registered as having dementia (0.42%). The Alzheimer's Society, in a national report published this year, state that the numbers on the QOF register will **only represent 45% of the total number of people** with dementia in Halton and St Helens. So the real number of adults with dementia locally is likely to be closer to **2021 showing prevalence closer to 0.7%.** Figures from POPPI estimate that numbers of dementia sufferers **over 65 years old could increase by 155% by 2025, with over 4,000 patients in Halton and St Helens**. Estimates of dementia shown in Table 1 suggest a prevalence of over 30% in the over 95 population.

The consensus estimates of the population prevalence of late-onset dementia

Age (years)	*F (%)*	*M (%)*	*Total (%)*
65–69	1.0	1.5	1.3
70–74	2.4	3.1	2.9
75–79	6.5	5.1	5.9
80–84	13.3	10.2	12.2
85–89	22.2	16.7	20.3
90–94	29.6	27.5	28.6
95+	34.4	30.0	32.5

Table 1: Estimates of the prevalence of dementia in the general population, 2007 (Source: King's Fund)

(Taken from: Alzheimer's Society, et al. Dementia UK: a report into the prevalence and cost of dementia. London: Alzheimer's Society, 2007)

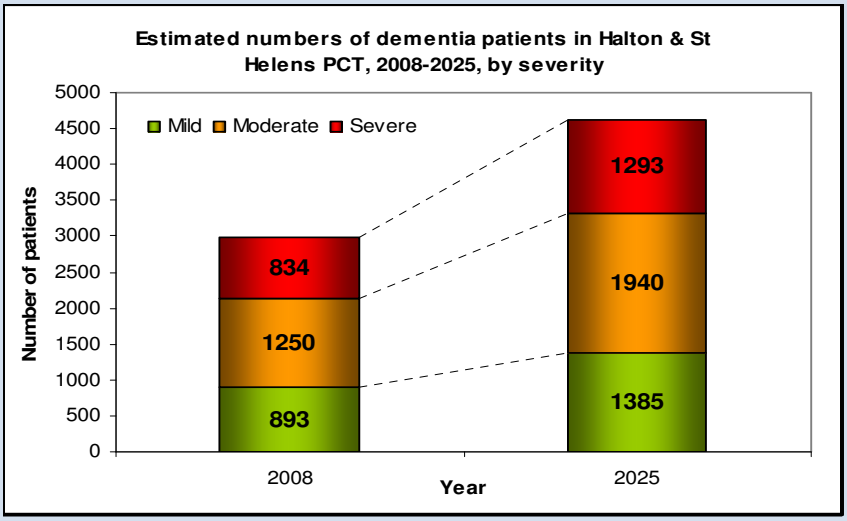
The following table shows the predicted increase in the numbers of men and women with dementia in Halton and St Helens compared to the England average. The table shows the predicted increase in dementia cases from 2008 to 2025 as a percentage difference. Although there are predicted to be more numbers of female patients than male, the increase between these years is greater in the male population. Overall for the PCT, numbers of males over 65 years old presenting with dementia is expected to increase by 105% compared to 43% in females. This is also much higher than the national figure of 73%.

	ENGLAND	HALTON	ST HELENS	HSTH PCT
Predicted Percentage Increase: Males 65+	73.0%	81.6%	77.4%	105.0%
Predicted Percentage Increase:Females 65+	39.6%	45.5%	41.7%	43.0%
Predicted Percentage Increase: Total Population 65+	51.1%	58.6%	53.2%	55.1%

Table 2: Projected growth in dementia cases (%) between 2008 and 2025 (Source: POPPI)

The diagram below shows the estimated numbers of dementia by severity 2008-2025

(Public Health Intelligence Team, NHS Halton & St Helens)



It is estimated that 30% of people with dementia have mild dementia, 42% moderate and 28% severe dementia.[i]

If we apply these estimates to the Halton & St Helens dementia burden, we can forecast numbers of dementia by severity, as shown above.

Key findings from the National Audit Office's publication "Improving Services and Support for people with Dementia" (2007) indicate that almost two thirds of patients live in the community and one third are in care homes. Applying this data to Halton & St Helens we can estimate that by **2025 over 3,000 dementia patients will live in the community and over 1,500 will require a care home**.

	The local mapping and needs analysis already undertaken in preparing the Joint Commissioning Strategy for Dementia strongly suggests that the current numbers are not manageable and that the balance of care is weighted towards high dependency and long term care. **Given the predicted increase in prevalence shown above there is no 'do nothing' option with dementia care.** The Joint Commissioning Strategy for Dementia, the Assessment, Care and Treatment Service and this business case all clearly outline the need to shift to early intervention and prevention. By supporting people diagnosed with dementia at an earlier stage and helping them to remain in the community there will be a positive impact on Hospital admissions, residential placements, nursing provision and Continuing Health Care. This will need to be balanced with the increase in support required across some parts of Social Care, Intermediate Care, Domiciliary Care, Voluntary sector, community services and other mainstream services (e.g. Sports and leisure, Arts etc.)
Current Pathway	The current pathway is heavily reliant on the specialist older person's mental health services to accept all referrals, screen, assess and refer on to other services. The lower level community services do support people with dementia but they lack the confidence and skills to retain people in their services when the condition starts to markedly progress. All services work hard, are fully committed and are in the main highly valued by service users and carers. But given the current service model there is little or no community based multidisciplinary service available to people with dementia regardless of age that can provide the early support package designed with the specific needs of dementia in mind. Our view is that currently there is an over reliance on residential and nursing home care for people with dementia locally and an over reliance on out of area residential placement for younger adults with dementia. In order to transform the pathway and adjust the balance towards early detection and support , using specialist and high dependency care an

	absolute necessity once individuals have reached this stage the development of the Assessment, Care and Treatment Service (ACTS) is required. This is a direction supported by patients, carers and professionals. ACTS would bring together existing services in order to combine skill mix and a central place for all referrals with the ability to respond quickly (within 48 hours following receipt of referral) and ensure that requests for help are screened and acted on according to priority and level of need. ACTS will also be commissioned to provide new and additional services : • Dementia Care Advisor role • Awareness raising and training for all local services including specific in reach support packages for care homes staff To make ACTS work effectively other services will be asked to work differently in order to ensure that people with dementia and their carers gain optimum benefits from the new dementia pathway. (See new Dementia Pathway attached). A number of other commissioned services and pathways will also need to work together more closely with the ACTS service, for example Health Checks +, Alcohol harm reduction; Learning Disabilities; Healthy Living Services; Social Care teams; community and voluntary sector; to ensure that risk factors leading to dementia are picked up and minimized and that people with dementia benefit from physical health checks and good management of their physical health.
Current Activity	
Project Management	
Project Owner	Director of Strategic Planning and Service Development
Project Lead	Head of Partnership Commissioning
Clinical Lead	Dr Lindon and Dr Watson (5BPT) ; Dr Frith and Dr Pogue (GPs)
Project Structure	The governance is provided through the Halton and St Helens Older People's Partnership Boards and use of short lived task and finish groups. In January 2010 a Halton and St Helens Dementia Strategy Implementation group will be established and this will provide the Project Board function required to deliver the service transformation requirements.
Stakeholders	The following teams/groups and individuals have been involved in and asked to comment on the ACTS specification and the Joint Commissioning Strategy for Dementia: • Halton and St Helens Older People's Community Mental Health Teams • Local Alzheimer's Society

	• PCT PBC Strategy Group • CEC • PCT Management Executive • St Helens Council Adult Social Care Senior Management Team • Halton Council Adult Social Care Senior Management Team • The 4 Borough Mental Health Commissioning Alliance • Service user and carer members of the St Helens Alzheimer's Disease Society • Service user and carer members of the Halton Dementia Pathways and Dementia Reading groups • The elderly care team at SHKHT **Regular reports have been presented to the following:** • Halton and St Helens Older People's Local Implementation Team/Partnership Boards
Stakeholder Involvement	See above. The 5 Boroughs Partnership Trust has been fully involved throughout the process and is in full support to the proposed redesign and developments. St Helens and Halton Council Adult Social Care have been fully involved and are in support of the proposed redesign and service developments.
Procurement Process	Working with the established providers with an enhanced and expanded role for the third sector.
How will project be evaluated	The Dementia Project Steering Group will receive performance reports from all services and will consider commissioning external evaluation at the end of Year 1 of the redesign process. The following performance measures will be used to assess the outcomes as the project is progressed: • The impact of the service on hospital and residential / nursing home admissions • The responsiveness of the service including measures of the time taken from referral to initial contact with the service user / patient, and the

time to the communication of the outcome of the assessment to the service user and carers.

- Outcomes for service user and carer, measuring their satisfaction with the service and the impact on their quality of life, health and well-being
- Process measures recording the activity of the service in relation to such areas as in-reach into care homes, training sessions provided, and service user and carer group sessions, for example.
- The number of older people supported to remain independent in their own homes
- Measuring the quality of services for those people with dementia in a residential or nursing setting, particularly ensuring that the Dignity in Care agenda is being addressed.

It will be important to measure the impact ACTS has on earlier detection and intervention. Individuals who had previously not been helped to access low level support services such as respite care; personal assistance in the home and peer support will need to be identified. The overall number of people with a care plan will increase and the % of those with a care plan who fall into the lower and medium dependency bands should also increase and this will be monitored. Some measure of change is included in the following table:

Performance targets relating to the number of people with Dementia living in Halton and St Helens in receipt of a health and social care information and support plan.

	2008/9 Baseline year	2009/10	2010/11ACTS to commence June 2010 **(in development phase)**	2011/12 YEAR 1	2012/13 YEAR 2
Number of people with Dementia	2977	3000	3051	3132	3213

	(based on POPPI data for people aged 65+)					
	Number of people with Dementia in receipt of health and social care information and support plan (estimated based on current team caseloads)	780	800	1000	1500	2000
	Of those in receipt, the percentage that are in the low and medium dependency categories	30%	30%	40%	60%	70%

NB: Target achievement level will be assessed based on the end of year final outturn 2011/12

Options	
Proposed Pathway	(please see proposed pathway attached)
Alternative 1	Do Nothing
Benefits Evaluation	
"Do Nothing" threat	(see Risk Analysis)
Anticipated	By the end of the first Year new pathway implementation, the anticipated

Benefits	benefits are: • 20% increase in the number of people with dementia who have an integrated care plan • 10% increase in the number of people at the lower and medium dependency bands in receipt of an integrated care plan • A dementia care redesign plan for Halton and St Helens that identifies how commissioners will transfer funding from high dependency care services to support individuals and carers in the community and closer to home • Dementia Care Advisers commissioned and in post • Consistent training programme designed with input from current providers and ready to be commissioned across the two boroughs • An outcome based performance management framework for dementia
Investment Appraisal	The **total current spend in Halton and St Helens on older people's mental health** services, of which a high percentage is on dementia, **is £11,267,285** • **Residential / Nursing care £4,756,724** • **Continuing Health Care £3,570,000** • **Out of Borough Placements £1,300,053** • **Community Mental Health Teams £ 779,000** • **Kershaw Day Centre (St Helens) £ 562,744** • **Oak Meadow (short stay) £ 145,600** • **Low-Level Services (Halton) £ 77,500** • **Community Services (Halton) £ 75,664** **<u>Only 8%</u> of this spend is invested in low level community based support the remainder is invested in specialist and high dependency care. (This excludes the investment tied up in the older people's in-patient services).** The Financial Plan in the strategy does assume the majority of the actions can be realised through the re-design of existing services, either the specialist dementia services or generic

services. However some additional resource will be required to deliver ACTS and other elements of the strategy

The highest priority action contained in the strategy is the development of early diagnosis, treatment and care. A specification has already been prepared to enable a specifically commissioned part of the current system to deliver this and to that end the councils and PCT have agreed to frame the pending business case around this action.

St Helens Council has made provision of £125k p.a in its 2010/11 budget for recurrent funding based on a share of the predicted cost of delivering this development in St Helens. Halton Council has given an in principle agreement of £125k p.a from 2010/11for the Halton development but it has made provision in 09/10 for 50% share of a Service re-design Manager post (£40-£45k) to be dedicated to the implementation of the dementia strategy. St Helens Council also supports the appointment of a Service re-design Manager.

The business case outlines the benefits to be gained from a small matched investment by the PCT of 125K (currently in Table A in the PCT Financial plan) toward early diagnosis, treatment and care and will serve to maintain a strong partnership focus in this important area.

The summary financial plan is a follows:

Costs	£k	Funding	£k
Halton	388	Halton	188
St Helens	687	St Helens	888
Total	**1,075**	**Total**	**1,075**

Halton funding = £125k (HBC) + 50% of £125k (PCT)

St Helens funding = £700k (Seddon Court) + £125k (St Helens MBC) + £50% of £125k (PCT)

It should be noted that total funding = total costs and that outside of the £125k referred to above, there are no additional costs for the PCT. The £700k referred to in Seddon Court is PCT funding which will be reviewed and used to the St Helens aspect of the ACTS elements within the dementia strategy.

The borough based Service re-design manager will be a key resource for the respective Older People's Partnership Boards in developing dementia specific (all ages) delivery programmes. The local dementia programme boards will take forward reviews of local OP MH CMHTs and other services that need to be reviewed with a view to de-commissioning or re-designing as appropriate. The dementia project steering group will be looking at all the current investment in dementia and seeking opportunities for strategy implementation within this whole resource over the next 5 years.

A joint agreement has been reached with St Helens Council to ensure that the financial package tied up in the re-design of Seddon Court will play a significant part in achieving ACTS in St Helens. Therefore it is estimated that the financial input into St Helens will be minimal or cost neutral (detail in business case to follow). By expanding the service redesign across the whole pathway key service and financial investments like Seddon Court will hold the key to innovation, value for money and more importantly improvement patient outcomes.

Working with our existing provider (5BP) will ensure not only net but service redesign savings across the two borough footprint. As stated by the current Health Secretary this approach will ensure "*higher performance and value for*

	money". Locally this means our incumbent provider can shift resources to meet the inequity between Halton and St Helens.	
Best /Worse/Likely Analysis	See sensitivity analysis for important co-dependencies and Savings plan below	
Sensitivity Analysis	The business case is dependent on another of associated actions: • Health Checks plus • Social marketing to raise awareness and reduce the stigma and fear associated with dementia • Personal health and social care budgets • A comprehensive staff training programme in acute hospitals, in primary, community and social care • The development of a thriving third sector provision • Implementation of the Carers Strategy	
Financial Data		
One Off (Non recurrent)	Capital Costs	IT to support performance management requirements Cost to be finalized with provider
	Set Up	
	Total	
Recurrent Costs	Staffing - Administration	**10K A&C** **52K Service redesign manager** (both for initial 2 year period to complete the redesign project)
	Staffing -Clinical	**2 full time Dementia Care Advisers** Banding to be determined – to be employed in the third sector **Estimated costs are 45K each post** **The remaining clinical posts are either already employed in existing services and will be redeployed to ACTS or the costs will be covered from the balance of the initial growth funding and future year's savings.**
	Training	To be determined

	Total Year 1	**152K plus training costs**
Phasing	**(see attached the implementation action plan)**	
Source of Funding	125K new funding from PCT, 125K new funding from St Helens Council, 15 K from HBC for its share of re-design posts and admin.	
Financial Template	**NB : Meeting in diary with Martin McDowell – 2nd December to obtain financial approval.**	
Savings	**Until the redesign plan has been developed and agreed it is not possible to identify savings above those to be available to pay for the ACTS developments.**	
Risks & Risk Management		
Summary of Risks	1. Risk of not achieving national and local policies resulting in poor CQC ratings. 2. Cost implications for PCT if not invested in as dementia prevalence already predicted to rise at a higher rate than the average for England. 3. If we do not implement the new proposed pathway we are at risk of not addressing our key strategic objectives – Early detection and prevention as part of CSP objectives. 4. We will fail to meet the high patient and carer expectations arising from the publication of the National Dementia Strategy 5. Failure to help to reduce the burden of CHC escalating costs 6. Increased risk of no appropriate bed availability, major impact on Intermediate Care sub-acute unit, community and domiciliary care. 7. In the absence of a small amount of new investment the proposed redesign of the dementia care pathway will face significant delays 8. More people diagnosed with dementia supported within the community without any additional resource, this will create capacity issues on a range of health and social care services 9. Potential impact on Local Authority priorities in relation to prevention, individualized budgets and direct payment.	

Risk Mitigation	• **PCT pump prime a loan amount of 125K to realize the benefits of the new dementia pathway and ACTS developments. This will result in immediate actions to redesign the dementia care pathway.** • Ensure continued collaboration and engagement with multi-disciplinary teams to ensure that we are able to deliver against a better dementia pathway. • Ensure that the commissioners and providers maximize opportunities provided through the 4 borough commissioner's alliance. • Ensuring that all providers of both specialist dementia and generic health and support services are supported and that there is clear evidence of links with other relevant services and teams • Ensure that local developments in improving care of adults and older people with Long Term Conditions (e.g. Widnes Virtual Ward) give weighted priority to people with dementia and their carers • Ensure that patients with dementia and set to benefit from the Health Checks plus service are given priority in relation to reducing risk of failing health • Continue to work with PCT Performance Team, local acute trusts, and 2 council performance leads to implement the whole system dementia performance framework • Continue to build on the already good partnership working in health and local authority commissioning to keep dementia as a high priority within existing programmes.

Timescales and Next Steps in Commissioning Cycle		
Key Milestones	1	(see attached implementation plan)
	2	
	3	
	4	

Approval by Business Case Panel/PBC Strategic Group			
Project Lead	**Print Name**	**Date**	
Executive Director Sign Off	**Print Name**	**Date**	
Director of Financial Strategy	**Print Name**	**Date**	

St.Helens Council

HALTON BOROUGH COUNCIL

NHS Halton and St Helens

Halton and St Helens Joint Commissioning Strategy for Dementia

October 2009

Contents

Executive Summary

Halton and St Helens Boroughs and NHS Halton and St Helens have drawn up this Joint Commissioning Strategy to address the objectives of the National Dementia Strategy (NDS) with a view to achieving the best possible local health and social care services for people with dementia and their carers.

The commissioning strategy is structured around the four thematic areas of the NDS: 'Raising Awareness', 'Early Diagnosis and Support', 'Living Well with Dementia' and 'Delivering the NDS'. In addition, it addresses key issues raised in a review in 2009 by the Halton Scrutiny Committee of services for younger adults with dementia.

There is currently a 'Cycle of Stigma' that prevents people seeking help and services from offering help. The strategy proposes a number of commissioning actions that are intended to break this cycle through a public health programme, a public information programme, and the provision of information to relevant groups of employers. This will be assisted by joint work with Children's Services to ensure that non-stigmatising information is included in school curricula and through community engagement activities.

Currently only a small percentage of people with dementia ever receive a diagnosis and when they do it is usually in the latter stages of the illness. The commissioning of an Assessment Care and Treatment Services (ACTS) is proposed for each of the boroughs which will ensure that early and high quality assessment and support is available to all. This will include access to counselling and to a Dementia Care Advisor who will provide an enduring point of contact through time.

The 'Living Well with Dementia' set of objectives is focussed on improving current services such as home care, carer support, intermediate care, residential care and end of life care to ensure that they meet the needs of people with dementia and the needs of their carers. Current services have been mapped and evaluated against these six objectives and actions that will help to guide commissioning developments for each area of service have been defined.

National and regional structures are being established by the Department of Health to oversee and support the Delivery of the NDS objectives Local action to ensure the effective delivery of the NDS objectives will be focused on the effective performance management of this strategy. To assist this process the actions identified to support the delivery have been set out in separate Implementations Plans for Halton and St Helens.

Summary of the Key Actions Identified to Address the Objectives of the National Dementia Strategy

- A Public Health programme will be established to support the prevention of dementia in general, and specifically amongst the younger population
- A strategy for community engagement will be drawn up
- A local public information programme will be developed drawing on, and aligned with the national campaign
- Information will be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately
- Information will be made available to local employers' personnel/human resources departments so that they can appropriately recognise and respond to the needs of carers within their workforces
- Joint work will be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy, and are provided with suitable information for inclusion in PSHE and Citizenship Education
- Early Assessment, Care and Treatment Services (ACTS) for people with dementia and their carers will be commissioned for Halton and for St Helens.
- The ACTS service will be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' that are available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers.
- A Dementia Care Adviser will be commissioned as part of the development of an Early Assessment, Care and Treatment Service
- The development of peer support and learning networks will be progressed through specific focused projects in Halton and St Helens
- Service Commissioners will develop and promote a clear care pathway for younger adults with dementias, and will ensure that service developments reflect the additional needs of this group of people
- Objectives 6-12 of the NDS will be met through actions identified through the mapping and gap analysis exercise as detailed in the Implementation Plans

- A full and detailed analysis of the population and care needs of younger adults with dementia, and their carers, will be undertaken, to ensure that services are appropriately targeted at this group of people, with consideration given to developing a daytime resource that specifically reflects their needs
- As a part of the analysis of the population of younger adults with dementia, service providers will be asked to assess their own provision and processes, to evidence their suitability for younger adults
- Health and social care services will be restructured according to need rather than age
- Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education, and including staff who may deal with younger adults with dementia

Halton and St Helens Joint Commissioning Strategy for Dementia

1. Introduction

Halton and St Helens Joint Commissioning Strategy for Dementia has been drawn up with a view to achieving the best possible local health and social care services for people with dementia and their carers, by ensuring that they are consistent with, and help to deliver the key objectives of the National Dementia Strategy 2009[1] (NDS). It has also been developed with reference to the *Strategic Framework for Older People's Mental Health Services in Halton* (2004 / updated in February 2009) and the Commissioning Strategy for Older Peoples Mental Health *Securing Better Mental Health for Older Adults* (2006 / refreshed in April 2009), developed jointly by the 4 Borough Alliance. The strategy is intended to be consistent with and promote the objectives of 'Our health, our care, our say' (2006), Putting People First (2007) and 'High quality care for all' (the Darzi report, 2008.)

It is a 5 year broadly based joint health and social care strategy that sets out a framework for future service development in the context of a defined vision for services for people with dementia, irrespective of age. In addition the strategy contains borough specific implementation plans that set out the main work streams and the more detailed actions required to achieve real improvements in outcomes for service users and carers.

Current provision for people with dementia and their carers in Halton and St Helens has been considered in relation to the guidance on high-quality health and social care services set out in the National Dementia Strategy, to enable gaps to be identified, and priorities for development determined.

The strategy addresses the need to raise awareness and understanding of dementia and to ensure that everyone with dementia and their carers has access to early assessment, care and treatment services.

Particular attention has been given to the needs of carers, the majority of care for people with dementia being provided by family members who are often old and frail themselves, and who, as a consequence of the heavy burden of care often experience high levels of depression and physical illness.

[1] *Living well with dementia: A National Dementia Strategy' DH 2009*

2. The National Dementia Strategy

Dementia has been recognised as a national priority by the government and it is in this context that the National Dementia Strategy has been developed to help to ensure progress in the development of health and social care services for dementia that are 'fit for the 21st Century'. The Strategy provides guidance on local service development based on sound research evidence and acknowledged best practice, informed by a major programme of consultation.

The NDS sets out 17 key objectives (full descriptions can be found in Appendix 1) most of which are to be addressed at local level. The objectives are grouped thematically:

Raising awareness and understanding:

Objective 1: Improving public and professional awareness and understanding of dementia

Early diagnosis and support:

Objective 2: Good-quality early diagnosis and intervention for all

Objective 3: Good-quality information for those with diagnosed dementia and their carers

Objective 4: Enabling easy access to care, support and advice following diagnosis

Objective 5: Development of structured peer support and learning networks

Living well with dementia:

Objective 6: Improved community personal support services

Objective 7: Implementing the Carers' Strategy

Objective 8: Improved quality of care for people with dementia in general hospitals

Objective 9: Improved intermediate care for people with dementia

Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers

Objective 11: Living well with dementia in care homes

Objective 12: Improved end of life care for people with dementia

Delivering the National Dementia Strategy:

Objective 13: An informed and effective workforce for people with dementia

Objective 14: A joint commissioning strategy for dementia

Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers

Objective 16: A clear picture of research evidence and needs

Objective 17: Effective national and regional support for implementation of the Strategy

Seven key priority outcomes have been identified for early delivery (NDS Implementation Plan[2]):

- Early intervention and diagnosis for all
- Improved community personal support services
- Implementing the New Deal for Carers
- Improved quality of care for people with dementia in general hospitals
- Living well with dementia in care homes
- An informed and effective workforce for people with dementia
- A Joint Commissioning strategy for dementia.

In order to secure and monitor the delivery of "Living well with dementia", the Department of Health has established a National Programme Board for older people and dementia. With cross Government representation and involvement from people with dementia and their carers, it will monitor progress, highlight best practice and work to remove barriers to successful implementation.

The Programme Board will link to the regional tier through the Deputy Regional Directors for Social Care (DRDs), who progress the Department's business in the Regions, and with the Strategic Health Authorities (SHAs). The DRDs have close links to SHAs and will support the necessary linkages between Health, Social Care and other local stakeholders.

The Department of Health is establishing a core team to help deliver the national dementia strategy. The team will support the delivery programme regionally and co-ordinate the production of materials to support the implementation, using web based materials and networks. It will also run workshops and conferences at the national level. Whilst much of this will be developed and provided in the regions according to local needs, there will also be some core support materials that will be needed everywhere and these will be produced nationally to avoid duplication and make best use of resources.

The core team is overseeing, through a steering group, the development of a national framework for the delivery of demonstration sites for particular themes in the strategy, such as peer support and dementia care advisers.

[2] *Living well with dementia: The National Dementia Strategy Implementation Plan DH 2009*

3. What is dementia?

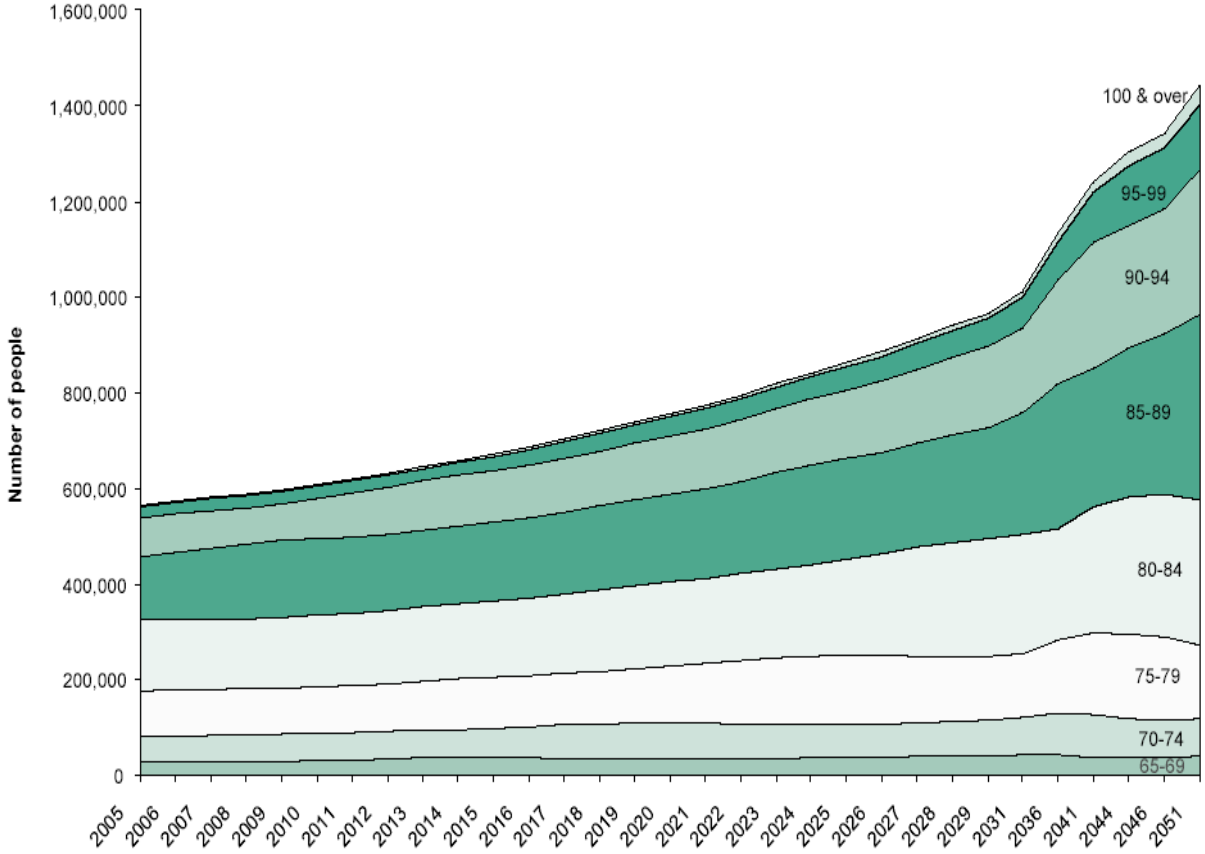
The National Dementia Strategy defines dementia as 'a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills, and the ability to carry out daily activities. Alongside this decline individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression, and wandering, which cause problems in themselves, which complicate care, and which can occur at any stage of the illness.' The causes of dementia are not well understood but the illnesses all result in structural and chemical changes in the brain leading to the death of brain tissue. It is a terminal disorder but people may live with their dementia for 7-12 years after diagnosis.

Dementia affects all groups in society regardless of gender, ethnicity and class. It is predominantly a disorder of later life but there are significant numbers of people under the age of 65 who have the illness.

The proportion of the population that is over 65 is increasing, and this is a trend that will continue for several decades. As there is a higher incidence of dementia in older adults the number of people in the UK with dementia is forecast to grow from 700,000 today to 1.4 million in 30 years time. In Halton the number of people with dementia is forecast to increase by 55% between 2010 and 2025 rising from 1085 to 1683 while in St Helens the forecast increase in the same period is 53% rising from 1,916 people with dementia to 2,935[3].

[3] Data Source: DH 'Projecting Older People Population Information System' Website: www.poppi.org.uk

Figure 1: The number of people with dementia in England is increasing and is forecast to reach 1 million by 2031 and 1.4 million by 2051



There is a great deal of fear and stigma associated with dementia and a common misconception that it is a normal part of ageing and that nothing can be done to help people that have the illness. However it is now increasingly understood that there is a great deal that can be done to help people with dementia and to support their carers. Where people receive an early diagnosis, together with access to effective care and treatment it has been shown that this can improve people's quality of life, and the quality of life of their carers, and enable them to 'live as well as possible with dementia'[1].

Younger Adults with dementia

Dementia is a destructive and incurable condition which, at its worst, leaves people unable to manage even the simplest aspects of their care. It is commonly associated with old age (but is certainly not an inevitable consequence of ageing), and this is in itself one of the difficulties. Evidence suggests that younger people are unaware of the possibility of dementia and are reluctant to refer themselves. Even if they do refer themselves, they are even less likely than older people to be diagnosed quickly, because professionals can be more reluctant to attach this diagnosis to a younger person. In consequence, they are more likely to come to services at a late stage in their condition, and to have more complex and challenging needs as a result.

It is important to stress that younger people with dementia have many needs which **can** be met from a general service for people with dementia. However, they may also have additional issues to consider, and dementia services need to be structured to take these into account. In particular:

- There is greater likelihood that the person with the condition is a parent of younger children, and therefore there are significant impacts on family life

- There is also a potential economic impact on both the person with the condition and their family, as people may still be in employment and, without the condition, could reasonably have expected to be economically productive for some years to come

- Finally – and importantly – most services for people with dementia are set up for an older age group. Younger adults can be one, even two, generations younger than those receiving help and support around them. As a consequence they may have little in common with the other people. This is particularly important when considering residential or nursing placements for people in the later stages of their condition.

The number of younger adults with dementia in Halton is estimated by the Department of Health's PANSI tool to be 33, which is backed up by local research on cases known to professionals which puts the figure at between 30 and 35[4], while in St Helens the PANSI estimate is that the population would be expected to have 48 people with young onset dementia. This is likely to be a substantial underestimate and further work needs to be done across the two Boroughs to fully assess the population and needs of this group of people.

In general, there are no additional risk factors for developing dementia at a younger age, although it is known that people with some forms of learning disability are at particular risk of developing dementia. However there is a greater lack of awareness amongst the general public that other risk factors – obesity, smoking, alcohol and drug use – can affect younger people.

[4] Scrutiny Review of Services in Halton for Younger Adults with Dementia: 2009

4 The vision for services for dementia

This strategy endorses the goal of the National Dementia Strategy to help people with dementia and their carers to live well with dementia, and the vision that it sets out to achieve this, which is to:

- encourage help-seeking and help-offering (referral for diagnosis) by changing public and professional attitudes, understanding and behaviour

- make early diagnosis and treatment the rule rather than the exception; and achieve this by locating the responsibility for the diagnosis of mild and moderate dementia in a specifically commissioned part of the system that can, first, make the diagnoses well, second, break those diagnoses sensitively and well to those affected, and third, provide individuals with immediate treatment, care and peer and professional support as needed

- enable people with dementia and their carers to live well with dementia by the provision of good-quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals and in care homes

5. Raising Awareness and Understanding

A key element of the strategy is to address the need for both public and professional awareness to be raised and to take action to address the stigma that is often associated with dementia

5.1 The Cycle of Stigma

The National Dementia Strategy describes a cycle of stigma and false beliefs that currently tends to lead to inactivity. The elements of the cycle are:

Stigma

- Stigma creates a background where public and non-specialist professionals find it hard to talk about dementia
- Stigma within professional groups results in work associated with dementia - and the acquisition of the skills to identify and work with people with dementia - being accorded low priority

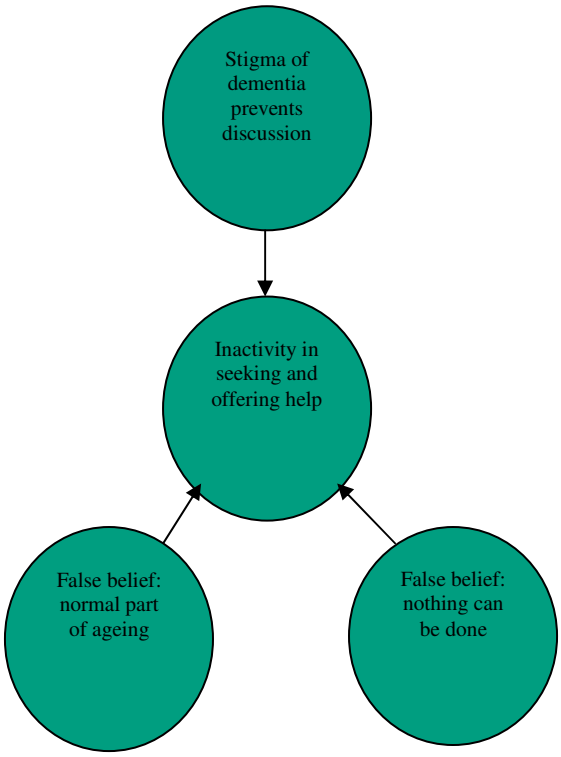
False belief: 1

- Dementia is a normal part of ‘old age’ and therefore there is unwillingness to seek or offer help

False belief: 2

- Nothing can be done to help people with dementia and their carers

Figure 2: The Cycle of Stigma and False Beliefs (National Dementia Strategy: 2009)



Together these factors combine to delay diagnosis and prevent access to good-quality care, and this is particularly significant for younger adults. People over 65 have been found to be much more worried about developing dementia than they are about cancer, heart disease or stroke, and yet they currently wait up to three years before reporting their symptoms to their doctor. At the same time 70% of their carers report being unaware of the symptoms of dementia before diagnosis while 58% of carers believe that the symptoms are just part of ageing. Of equal concern, 69% of GPs believe that they haven't had sufficient training to diagnose and manage dementia.

5.2 Prevention

Current evidence suggests that up to 50% of dementia cases may have a vascular component, and that it may therefore be possible to prevent or minimise dementia by promoting better cerebrovascular health. This may be done through actions such as health promotion in relation to diet and lifestyle, and encouraging health checks with additional focus on the potential for reducing the likelihood of developing dementia. There is real scope for developing a public health programme which alerts people to the risks of developing dementia at a younger age if they adopt unhealthy lifestyles.

ACTION: A Public Health programme will be established to support the prevention of dementia

5.3 A Local Strategy for Raising Awareness and Understanding

The NDS proposes that public information campaigns are needed at both national and local levels and it sets out the key messages for the national campaign. (See Appendix 2)

At the local level it suggests the development of strategies for community engagement to increase levels of understanding and to build supportive social networks.

An effective approach may be to target major employers and bodies with workforces that interact with the public, providing them with information about the symptoms and special needs of people with dementia and giving advice on what action to take if they are concerned about someone they are providing a service to. The campaign could also target the personnel / human resources and occupational health departments of employers so that they are aware of the early signs of dementia and its impact on carers.

Another key target group should be children, young people and younger adults. If Halton is to achieve significant change in awareness and understanding then the campaign materials should be made available to schools for inclusion in Personal, Social and Health Education and Citizenship Education.

ACTIONS:

- *A strategy for community engagement will be drawn up*
- *A local public information programme will be developed drawing on, and aligned with the national campaign, and will include awareness of the risks of developing dementia at a younger age*
- *Information will be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately*
- *Information will be made available to local employers' personnel/human resources departments so that they can appropriately recognise and respond to the needs of carers within their workforces*
- *Joint work will be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy, and are provided with suitable information for inclusion in PSHE and Citizenship Education*

6. Early Diagnosis and Support

One of the priorities of the National Dementia Strategy is to ensure that there is 'good-quality early diagnosis and intervention for all' (NDS Objective 2.) At present only about one-third of people with dementia receive a formal diagnosis at any time in their illness. Even in the minority of cases where a diagnosis is made, it is often too late for the person with the illness to make choices, and often takes place at a time of crisis which might have been avoided if proper assessment and support had taken place earlier. This can be particularly notable for younger adults who develop dementia, who (as seen in Section 4) may be more likely to get a late diagnosis of the condition.

Early diagnosis and intervention has been shown to improve the quality of life of service users and carers, reducing levels of anxiety and depression, and allowing them to plan for the future, at the same time as accessing help, support and treatments. Such services have also been shown to be cost effective, significantly reducing the level of care home and acute hospital admissions.

The NDS proposes that new specialist services should be commissioned that:

- can deliver good quality early diagnosis and intervention
- provide a simple single focus for referrals from primary care
- work locally to stimulate understanding of dementia and referrals
- are available to people of all ages

and that can focus on:

- making the diagnosis well
- breaking the diagnosis well to the person with dementia and their family
- providing directly appropriate treatment, information, care and support after diagnosis

The new services are intended to sit alongside and complement the work currently undertaken by old age psychiatry, geriatrics, neurology and primary care and are considered likely to benefit from the core involvement of third sector organisations. With the new early diagnosis and support service in place, the role of primary care should then be to identify people with suspected dementia and then after excluding other possible explanatory disorders to refer them on to the specialist service to receive a definitive diagnosis. Following diagnosis the primary care role will then be helped by the specialist's assessment of whether the person has dementia, and of what sub-type together with advice on the appropriate treatment regime

Halton and St Helens' older persons' mental health services currently have only very limited capacity for early diagnosis and support for people with dementia and their

carers. The services have not been structured or resourced to provide an early assessment service and as a result tend, in the main, to respond to referrals for people in the later stages of dementia, often at a time of crisis. Following a review of those services in 2008 specifications for Assessment, Care and Treatment Services for Halton and for St Helens were commissioned and business case reports have been completed and are currently progressing through the relevant local commissioning bodies.

The commissioning of multidisciplinary and interagency early assessment, care and treatment services is consistent with recommendations of the recently updated *Strategic Framework for Older People's Mental Health Services in Halton* and the 2009 'refresh' of the 4 Borough Alliance's Commissioning Strategy for Older Peoples Mental Health.

ACTION: Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers will be commissioned for Halton and for St Helens.

A key objective within the development of effective early diagnosis and support services is the provision of 'good quality information for those with diagnosed dementia and their carers' (NDS Objective 3.)

The NDS proposes the national development of a comprehensive package of high-quality information on the nature of dementia which should then be adapted locally to describe the treatment and support available. There should also be information on what options there are for planning ahead for people diagnosed with dementia, to ensure that their desires and wishes are properly considered should they lose mental capacity, such as advice on how to make a Lasting Power of Attorney.

ACTION: The ACTS service will be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' that are available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers.

The NDS recommends the development of a new role of 'Dementia Care Adviser' to achieve its fourth objective of 'enabling easy access to care, support and advice following diagnosis'. In the consultation programme during the development of the national strategy, one of the most consistent concerns expressed was that social and health care involvement was episodic and that they 'normally discharge individuals

once the case is stable and the care package is being delivered.' However people with dementia and their carers, faced with a serious illness with inevitable long-term decline and increase in dependency were clear that they need to be able to have continuing support available – someone that they can approach for help and advice – at any stage of the illness, and whenever they need it. It is felt that the role Dementia Care Adviser should not be case management but rather, to provide an identifiable point of contact for everyone in an area diagnosed with dementia, and their carers, with knowledge of and direct access to the whole range of local services available. When contacted they would identify the problem and signpost and facilitate engagement with the appropriate services.

ACTION: A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service

The ACTS service will play a major role in helping Halton and St Helens to deliver a number of the Key Objectives of the NDS:

NDS Objectives supported by the Assessment, Care and Treatment Service

Objective 1: Improving public and professional awareness and understanding

Objective 2: Early assessment and intervention services that can respond to the needs of all people in an area with dementia

Objective 3: Provide good quality information for those diagnosed and their carers

Objective 4: Enable easy access to care, support and advice following diagnosis

Objective 6: Improved community personal support services

Objective 7: ACTS will contribute to 'Implementing the Carers Strategy' in a number of ways including: - information to carers, support provided by the Dementia Care Advisor role, and providing carers with access to a counselling service.

Objective 11: ACTS will significantly help to ensure: 'Improving care for people with dementia in care homes' through its in-reach function:

Objective 13: ACTS will contribute to the development of an 'Informed and effective workforce for people with dementia' through its training function and by providing a reference point for advice and information

The final objective within the theme of 'early diagnosis and support' is 'The development of structured peer support and learning networks' (Objective 5). The NDS proposes that this can be delivered through:

- Demonstrator sites and evaluation to determine current activity and models of good practice to inform commissioning decisions

- Development of local peer support and learning networks for people with dementia and their carers that provide practical and emotional support, reduce social isolation and promote self-care, while providing a source of information about local needs to inform commissioning decisions

- Support to third sector services commissioned by health and social care

The development of early assessment services is expected to lead to a significant increase in the number of people that are diagnosed as having dementia during the early stages of the illness. Currently there are few services that are specifically focused on meeting the needs of people in the early stages of the illness or on meeting the needs of their carers. Peer support arrangements, and relatively low level community supports many of which will more appropriately be provided by voluntary and community organisations will need to be developed to meet these needs. This will also go some way towards meeting the needs of people who contract the condition at a younger age.

Although there has been some important early developmental work, in this regard in both Halton and St Helens, such as the Dementia Café and Dementia Reading Group projects (further details can be found in the section on Mapping of Services), there is a need to undertake focused work to achieve significant progress in this area. Accordingly the Halton Health Partnership has commissioned Age Concern Mid Mersey, through the Vulnerable Adults Task Force (VATF), to lead on developing a Dementia Network in Halton. The Dementia Network will involve the development of a peer support network and a community training, awareness and development programme.

ACTION: The development of peer support and learning networks will be progressed through specific focused projects in Halton and St Helens, with one project focusing specifically on the needs of younger people who develop dementia.

7. Living well with dementia: Local Mapping and Gap Analysis

While Objectives 1-5 of the NDS represent major new areas of development for most local authorities and PCTs the services that are particularly relevant to Objectives 6 - 12 on 'Living well with dementia' are for the most part services that may need further development, but that are nonetheless significant elements within current local provision. These are services such as intermediate care, carers support, and residential care homes. Consideration of these NDS Objectives has therefore been approached through an exercise in which current services have been evaluated and gaps analysed in relation to each of the relevant NDS Objectives.

The results of the service mapping and gap analysis exercise are set out in Appendices 3a and 3b with separate analyses for the services in Halton and in St Helens. An additional mapping and gap analysis will need to be done for younger adults with dementia, to include the registration of local care homes to meet the needs of this group of people, and an analysis of the use of high cost out of area placements for younger adults who also present with more challenging behaviours.

The services considered include generic services for older people or older people's mental health, that are accessed by people with dementia and their carers, as well as services that are specifically targeted at people with dementia. The gap analysis points up areas where services are missing or insufficient to meet needs. Where development plans are proposed to meet the needs that have been identified in the gap analysis these are specified and linked to actions in the implementation plan.

The exercise has involved two parallel analyses. In the first, current services that are accessed by people with dementia have been set out in a table. The table lists services by name and category and gives details of the specific service provided followed by a description of the identified gaps. The second analysis has looked at each of the NDS Objectives 6-12 in turn, and has evaluated current services against the Objective, identified gaps, and set out under a 'Future Plans' heading the work that is required to develop services in relation to the relevant Objective.

As would be expected the boroughs have different service configurations and this is reflected in the differing gaps and service development requirements that have been identified. As there are separate borough-specific actions required to support NDS Objectives 6-12 these have been extracted from the gap analysis and set out in the separate Implementation Plans in Appendices 4a and 4b

ACTION: Objectives 6-12 of the NDS will be met through actions identified through the mapping and gap analysis exercise and are detailed against each of the NDS Objectives in the Implementation Plans in Appendices 4a and 4b An additional mapping and gap analysis of the needs of younger adults with dementia, and their carers, will be completed.

8. Delivering the Strategy - Overview

NDS Objectives 13 to 17 are intended to ensure that the national strategy is delivered:

Objective 13: 'An informed and effective workforce for people with dementia'

Objective 14: 'A joint commissioning strategy for dementia'

Objective 15: 'Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers'

Objective 16: 'A clear picture of research evidence and needs'

Objective 17: 'Effective national and regional support for implementation of the Strategy'

Objectives 15, 16, and 17 are to be achieved, in the main, through nationally determined programmes of action. Objective 14 the development of a joint commissioning strategy for dementia requires local action which is being realised in Halton and St Helens through this document. Objective 13 is considered in the following section.

9. Workforce Development

In order to achieve 'an informed and effective workforce for people with dementia' (NDS Objective 13) professionals providing services need to have received appropriate basic training and access to continuous professional and vocational development in the principles of the Mental Capacity Act 2005, to ensure that all decisions made on behalf of dementia sufferers, where they lack capacity, are in their best interests and take their wishes and desires into account.

The national strategy says that in the medium and longer-term there needs to be curricula development for professional qualifications and continuing professional development programmes for relevant health and social care staff to ensure that they include relevant modules on dementia care. In the short term however PCTs and local authorities need to commission a trained and competent workforce using regional and local workforce development resources. The best arrangements it suggests are where health and social care system work together to develop their workforce.

The development of the local social care workforce will need to take account of 'Working to Put People First: The Strategy for the Adult Social Care Workforce in England' (2009)

ACTION: Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education

10. Implementation Plans

Separate implementations plans have been drawn up for Halton and St Helens reflecting the fact that the two boroughs have different service configurations. The Implementation Plans, which are attached as Appendices 4a and 4b address in turn each of the NDS Objectives and are intended to ensure that the boroughs and NHS Halton and St Helens can fulfil the Objectives and deliver high quality services for people with dementia and their carers

Appendix 1 Dementia Financial Plan

The financial plan linked to this dementia strategy is clear that it needs a certain level of investment to deliver the changes that are outlined in the document. It is accepted that we are in a position to offer some redesign of service, however this will only scratch the surface and in no way will it be able to deliver the major shift in service delivery that this document describes. In Halton there is very limited investment in community services and the majority of investment is still channeled to bed based accommodation. However even this gives us limited opportunity to reinvest as the majority of people in residential or nursing accommodation already have complex needs that could not be managed in the community.

The development of the Assessment, Care and Treatment Service aims to deliver an improved level of early diagnosis, early intervention and community support to help both people diagnosed with dementia and their carers to gain the highest quality of support possible. There will be opportunities to carry out some of this work via redesign of existing services, however to have the major impact that the strategy is hoping to achieve then investment would be required. This investment requirement will form the basis of the business case.

Section 5.2 PREVENTION				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
A public health programmme will be established to support the prevention of dementia	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without additional resource and training.	Generic dementia information could be offered through existing public health programmes including Healthy lifestyle services, Cardiovascular disease and prevention services. However, the provision will be low-level and will only meet the needs of some people diagnosed with dementia.	There will only be limited success for people diagnosed with dementia within the existing programmes and with no additional investment. The respective Older People's boards will be required to clearly monitor the activity to ensure links to prevention of dementia.	If existing measures are not supporting the agreed action then the programme could be picked up through the Older people's prevention strategy that is currently under development. However once again this would require additional funding to support an increase in specialist dementia support.

Section 5.3 A LOCAL STRATEGY FOR RAISING AWARENESS AND UNDERSTANDING				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
A strategy for community engagement will be drawn up	Unknown at present	£45,000 2009/10 £46,000 2010/11 Funding for the Dementia Peer Support through the Halton Health Partnership	The Dementia Peer Support project will be responsible for this action; however the project currently only has short-term funding until 31st March 2011.	Evaluation of the Dementia Peer Support project is to commence in January 2010 with a view to building a future business case as necessary.
A local public information programme will be developed drawing on, and aligned with the national campaign, and will include awareness of the risks of developing dementia at a younger age.	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without additional resource and training.	It is clear that more investment will be required to deliver the local public information programme. Although there are existing work streams that are able to link into existing low-level networks we would still need far more to deliver in line with the National Dementia strategy	Any local campaigns need to be aligned to National campaigns to ensure maximum effectiveness. The present position would only allow us to deliver a low key generic dementia campaign and is likely to completely miss the strength and depth of any National campaign.	The Dementia Peer Support project will be tasked to support the local implementation of the dementia awareness raising campaign in the long term.
Information will be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy,	The information available through existing public health programmes will not be able to deliver anything other than low-level generic services for people diagnosed with dementia.	All employers need to be confident in the level of support available to ensure quality and consistent information is provided. Without additional investment the support for employers will be limited and is unlikely	The long-term implementation of this will be through the dementia strategy this will become a core part of business for a range of identified providers.

Section 5.3 A LOCAL STRATEGY FOR RAISING AWARENESS AND UNDERSTANDING				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
	however it is unlikely to be fully successful without additional resource and training.		to deliver appropriate signposting.	
Information will be made available to local employers' personnel/human resources departments so that they can appropriately recognize and respond to the needs of carers within their workforces	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without additional resource and training.	The information available through existing public health programmes will not be able to deliver anything other than low-level generic services for people diagnosed with dementia.	All employers need to be confident in the level of support available to ensure quality and consistent information is provided. Without additional investment the support for employers will be limited and is unlikely to deliver appropriate signposting.	The long-term implementation of this will be through the dementia strategy this will become a core part of business for a range of identified providers.
Joint work will be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy, and are provided with suitable information for inclusion in PSHE and Citizenship Education	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without	Need to review current links between adult, children and older people's services. This link will allow access to education and awareness raising across all ages. However, this currently receives no funding and there will need to be investment in place to	This would require joint ownership and funding between children's and adults services to ensure clear and successful implementation.	Separate piece of work will need to be undertaken with children's services to establish the scope of the work and the investment required.

Section 5.3 A LOCAL STRATEGY FOR RAISING AWARENESS AND UNDERSTANDING				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
	additional resource and training.	deliver specialist dementia information and training.		

Section 6 EARLY DIAGNOSIS AND SUPPORT				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers will be commissioned for Halton and for St Helens.	This is a new and emerging development. There is currently no investment agreed for this service.	The source of funding will be primarily NHS Halton & St Helens as the lead organisation for dementia. The Department of Health has allocated specific funding to each Primary Care Trust to deliver and implement local dementia strategies. Although there is an in principle agreement from Halton Borough Council and St Helens Council, this is dependent on the finances being available through NHS Halton & St Helens and ensuring invest to save / redesign options are explored.	There will be opportunities to deliver some redesign of existing services, however if there is no additional investment on top of existing service provision then the ACT Service will be very limited in what it can deliver. There would be some small improvements in the efficiency of existing pathways and referral processes, but it would not be in a position to deliver fully on the ACTS business case.	If additional investment is required then there will be a clear improvement in the diagnosis, early intervention and overall support for people diagnosed with dementia. This should significantly impact on the timeliness of referral into long-term care, (including Continuing Health Care) and reduce overall bed days in hospital, residential and nursing accommodations. This fits with the overall aims and objectives as outlined in this document.

Section 6 EARLY DIAGNOSIS AND SUPPORT				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
The ACTS service will be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' that are available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers.	This is a new and emerging development. There is currently no investment agreed for this service.	The source of funding will be primarily NHS Halton & St Helens as the lead organisation for dementia, also the Department of Health has allocated specific funding to each Primary Care Trust to deliver and implement local dementia strategies. Although there is an in principle agreement from Halton Borough Council and St Helens Council, this is dependent on the finances being available through NHS Halton & St Helens and ensuring invest to save / redesign options are explored.	By increasing the success of early diagnosis we would need to ensure that support services, both generic and specialist are in place and prepared for an increase in earlier detection of dementia. This will need investment that is currently only available in some low-level amounts.	This will need to be continually reviewed through the Older people's Boards, but only if additional investment is identified and utilised in the right areas as outlined in this document and the ACTS business case. The main priority would be the development of Dementia Care Advisers and the continued support for the Dementia Peer Support Network.
A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service	No investment in this area at present	No investment at present	The Dementia Care Adviser is a vital part of the overall delivery of improved dementia services. A business case will be submitted in December, but it is clear that this is a major risk in the development of services.	Redesign of existing generic roles will be explored, but this is more likely to yield results in later years as ACTS becomes established

Section 6 EARLY DIAGNOSIS AND SUPPORT				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
The development of peer support and learning networks will be progressed through specific focused projects in Halton and St Helens, with one project focusing specifically on the needs of younger people who develop dementia	£45,000 2009/10 £46,000 2010/11 Funding for the Dementia Peer Support (Halton Only)	Halton Health Partnership	It needs to be clear that the dementia peer support network that is delivered through Age Concern will be in a position to support younger people who develop dementia. It is clear that we do not want to duplicate this service.	Evaluation of the Dementia Peer Support project is to commence in January 2010 with a view to building a future business case as necessary.

Section 9 WORKFORCE DEVELOPMENT				
ACTION	**CURRENT INVESTMENT**	**SOURCE OF FUNDING**	**IMPLICATIONS**	**EXIT STRATEGY**
Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia and training and education	Not Applicable	Not applicable as there is currently no funding, however there is much work required in the area of training and this will need joint investment from NHS St Helens, each Local Authority and Warrington and Halton Foundation Trust.	Halton and St Helens can ensure improved efficiencies by jointly implementing the local dementia strategies	Need to ensure that the Older People's Boards play an active role in performance managing the implementation of the dementia strategies.

Appendix 2 The Key Objectives of the National Dementia Strategy

The key objectives of the National Dementia Strategy are:

- **Objective 1: Improving public and professional awareness and understanding of dementia.** Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.
- **Objective 2: Good-quality early diagnosis and intervention for all.** All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.
- **Objective 3: Good-quality information for those with diagnosed dementia and their carers.** Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.
- **Objective 4: Enabling easy access to care, support and advice following diagnosis.** A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.
- **Objective 5: Development of structured peer support and learning networks.** The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.
- **Objective 6: Improved community personal support services.** Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.
- **Objective 7: Implementing the Carers' Strategy.** Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

- **Objective 8: Improved quality of care for people with dementia in general hospitals.** Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.
- **Objective 9: Improved intermediate care for people with dementia.** Intermediate care which is accessible to people with dementia and which meets their needs.
- **Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.** The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.
- **Objective 11: Living well with dementia in care homes.** Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services
- **Objective 12: Improved end of life care for people with dementia.** People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.
- **Objective 13: An informed and effective workforce for people with dementia.** Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia
- **Objective 14: A joint commissioning strategy for dementia.** Local commissioning and planning mechanisms to be established to determine the services needed for people with dementia and their carers, and how best to meet these needs. These commissioning plans should be informed by the World Class Commissioning guidance for dementia developed to support this Strategy and set out in Annex 1.
- **Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.** Inspection regimes for care homes and other services that better assure the quality of dementia care
- **Objective 16: A clear picture of research evidence and needs.** Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.
- **Objective 17: Effective national and regional support for implementation of the Strategy.** Appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

Appendix 3: National Dementia Strategy - Key Messages for a Public Information Campaign

Emerging key messages for a national public information campaign

- Dementia is a disease.
- Dementia is common.
- Dementia is not an inevitable consequence of ageing.
- The social environment is important, and quality of life is as related to the richness of interactions and relationships as it is to the extent of brain disease.
- Dementia is not an immediate death sentence; there is life to be lived with dementia and it can be of good quality.
- There is an immense number of positive things that we can do – as family members, friends and professionals – to improve the quality of life of people with dementia.
- People with dementia make, and can continue to make, a positive contribution to their communities.
- Most of us will experience some form of dementia either ourselves or through someone we care about.
- We can all play a part in protecting and supporting people with dementia and their carers.
- Our risk of dementia may be reduced if we protect our general health, e.g. by eating a healthy diet, stopping smoking, exercising regularly, drinking less alcohol and generally protecting the brain from injury.

Source: *Living Well with Dementia* - National Dementia Strategy DH 2009

Appendix 4: Service Mapping and Gap Analysis – Halton

The service mapping and gap analysis is in two parts. Part 1 is an evaluation of the performance of current services in relation to Objectives 6-12 of the National Dementia Strategy that points up actions that will be needed (see under 'future plans') to enable the Objectives to be met. Part 2 is a more detailed and service specific analysis. It provides details of the broad range of current services accessed by people with dementia and their carers, and gives details of the services provision and identifies gaps that are specific to each service category.

1) Evaluation of current services, gaps and future plans in relation to NDS Objectives 1-12

Objective 1: *Improving public and professional awareness and understanding of dementia.* Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help seeking and help provision.

Current Provision: Public and professional awareness is limited, information is provided through the Alzheimer's Society on a National and local basis, however there are still major concerns on the amount of timely information and knowledge available to people.

Gaps in Service: Gaps include the quantity, quality and frequency of information that is available. There are also possible gaps within information that would support early diagnosis and access to improved community services. In relation to community services there is a gap in specialist knowledge that often leads to people with dementia being unable to access some generic community services and facilities.

Future Plans: in line with National plans to offer additional support to GPs and other professionals we aim to commission training that will range from basic awareness skills up to specialist accredited training. In addition developments within existing voluntary and community service providers will allow us to improve skills across the whole sector. This will include engaging with a wider range of providers e.g. Sport, leisure, culture, arts, retail etc.

Objective 2: *Good-quality early diagnosis and intervention for all.* All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

Current Provision: In Halton the provision of early diagnosis and intervention is poor. It is not unusual for people to wait for a period of some years before receiving a definitive diagnosis. There is a Community Mental Health Team, however due to capacity issues the service often spends time dealing with complex cases and does not have the time to deal with earlier interventions.

Gaps in Service: No designated team specifically designed to address early diagnosis and intervention.
Future Plans: The Assessment, Care and Treatment Service are specifically designed to address early diagnosis and intervention. It is planned that the service will be operational from April 2010.

Objective 3: *Good-quality information for those with diagnosed dementia and their carers.* Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.
Current Provision: As in objective 1, information provision is limited, mainly through the Alzheimer's Society.

Gaps in Service: Consistent, timely and widely available information available for people with dementia and their carers.
Future Plans: dementia will be included in the overall marketing strategy for older people's services in Halton. This will include a range of communication methods that will help to inform the population on activities, support, opportunities and where to get help.

Objective 4: *Enabling easy access to care, support and advice following diagnosis.* A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.
Current Provision: Community family support is available through The Alzheimer's Society, however capacity is limited.

Gaps in Service: Capacity is only available to offer support to a maximum of 30 people with dementia in Halton.
Future Plans: The Dementia Care Advisors role will be a key element of the Assessment, Care and Treatment service that is planned to begin operating from April 2010.

Objective 5: *Development of structured peer support and learning networks.* The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

Current Provision: A newly formed dementia peer support network delivered through Age Concern Mid Mersey has been established and will begin to facilitate a range of peer support groups and opportunities for people diagnosed with dementia and their carers.

Gaps in Service: None identified at present, see future plans.
Future Plans: Over the next two years capacity for the above service will need to be monitored to ensure that there is enough service provision. In addition an exit strategy will need to be developed as the service is only grant funded for the next two years.

Objective 6: *Improved community personal support services. Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services*

Current Provision: Oak meadow, day care offers 13 people 2 days a week. 5 Short stay dementia beds are offered on a short-term basis as part of the intermediate care service as part of the rapid rehabilitation service.

Gaps in Service: Specialist training at a higher level is required. Increased capacity in relation to day care or alternative social activities to support people with dementia to remain independent in their own homes and communities.
Future Plans: Need to develop professional and vocational training to support continuing professional development. Ensure that dementia is included in the plans to develop the personalisation agenda in both health and social care. Further analysis to be done on the needs of younger adults with dementia.

Objective 7: *Implementing the Carers' Strategy. Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected*

Current Provision: The specific needs of carers of people diagnosed with dementia are addressed in the carers commissioning strategy. However, the additional support needs of carers of younger adults with dementia require further consideration.

Objective 8: *Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals*

Current Provision: A psychiatric liaison service has been operating in Halton since 2006. Initially set up as a pilot the service was mainstreamed and expanded in 2008 and now operates in Warrington and Whiston Hospital. Evaluation of the service clearly demonstrated the positive impact for individuals accessing the service, clinicians and from a financial point of view. In addition the Local Authority has recently recruited a dignity co-ordinator who will be responsible for ensuring that dignity standards are raised across a range of disciplines including general hospital settings.

Gaps in Service: Plans are being developed to identify a specific lead for dementia in general hospital.
Future Plans: Implement action plan for dignity co-ordinator and identify lead for dementia within the hospital.

Objective 9: *Improved intermediate care for people with dementia. Intermediate care which is accessible to people with dementia and which meets their needs*
Current Provision: Intermediate Care in Halton offers inclusive access to all parts of their service. However, it is important to clearly identify that intermediate care services are generic and not specialised.
Gaps in Service: Access to specialist training for dementia and to the specific issues facing younger adults.
Future Plans: Need to develop professional and vocational training to support continuing professional development. This needs to be tailored to the needs of individuals linked to the capacity and specialisms within each specific team.

Objective 10: *Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers. The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and Telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services*

Current Provision:

Telecare: Telecare services in Halton are provided on 3 levels with a range of manually or automatic operated telecare sensors. Installation of which is dependant on need, currently very much focused on risk management and intervention to potential crisis.
Ongoing awareness sessions re the availability of Telecare and assistive technology and the potential benefit its use can have to both service users and their carers is delivered to colleagues in health/social care private and voluntary sectors.

Technical support and advice is available in relation to standalone assistive technology.

Gaps in Service:

Better communication is needed across all services involved as lack of this can impact on the effectiveness of the service

Need to increase public awareness of assistive technology and Telecare Service.

Future Plans:

Progressing towards using virtual sensor technology and lifestyle monitoring technology to enable us to identify changes in individual circumstances, and therefore deliver early intervention to changing needs and potential crisis to maintain independence.

Consideration is being given to joint work between the Borough and PCT/Practice based commissioner in the use of telehealth applications to monitor and manage long term conditions.

Objective 11: *Living well with dementia in care homes. Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes*

Current Provision: Halton offers 330 registered beds in Halton and has 15 people placed outside of the borough. Regular monitoring visits are conducted; however there are clear indications that there is a lack of parity in the level of care and support that a resident might receive. This is particularly acute when looking at the ability for providers to deal with challenging behaviour.

Gaps in Service: Improved professional training relating to dementia.

Future Plans: Develop new service specification for residential and nursing homes to include the dignity charter. Implement action plan for dignity co-ordinator and identify lead for dementia within the hospital. Registration requirements to be addressed to ensure that younger adults with dementia do not have to change placements as they get older. Commissioners to consider cross-boundary commissioning for younger people with more complex needs, to avoid high cost out-of-area placements.

Objective 12: *Improved end of life care for people with dementia. People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.*

Current Provision: A multi-professional group of specialists in Palliative Care, Older People's Mental Health services, the Alzheimer's Society, General Practice, Dietetics, Speech Therapy and Care of the Elderly met to formulate symptom control

guidelines for health care professionals caring for patients with end stage dementia. These focus on symptoms, which are common or troublesome in this patient group. The Care Pathway, symptom control guidelines developed will be followed up by a series of educational events for health care professionals. The Care Pathway aims to help provide continuity of care for this patient group, whose care needs are often provided by a range of carers.

Gaps in Service: Clarity around direction of service provision and multi-agency working.

Future Plans: There is a clear need to develop a multi-agency end of life strategy relating to people who have dementia and including support for their families and carers. NHS Halton & St Helens is beginning this work and the details outlined above in the current position show progress made to date, however more detailed work is required.

Appendix 4a. Halton: Current Service Analysis

The mapping of current services in Halton has been split into two distinct categories:

- Specialist dementia services
- Generic services that support people diagnosed with dementia.

The strategy has also produced a financial summary of the specialist services, breaking them down in the following areas, low-level community services, domiciliary care services and residential or accommodation based services.
It is important to acknowledge that although the second table begins the process of mapping some of the generic services that provide support for people diagnosed with dementia; this is by no means an exhaustive list. It is also clear that by classing services as generic as opposed to specialist dementia services do not assume that they are in any way unable to meet the needs of service users with dementia. The generic services do have high levels of knowledge and training in relation to dementia and also allow access to their service for a range of service users across the population. An example of this would be Adult Placement that is equipped to support people diagnosed with dementia and currently supports a total of twenty-one, however also supports a number of service users with different conditions.

Financial breakdown of Specialist dementia services

Category	Service Name	Investment
Community Services	**Oak Meadow: day-care and carers break day-care**	**£25,686 p.a.**
	Older Peoples Community Mental health Team	Investment £120,000* - Halton Borough Council £259,000 – NHS Halton and St Helens
	Intermediate Care – current provision	£49,978
Total		**£454,664**
Low-level services	**PSS**	£40,000
	Dementia reading group	£7,500

	Alzheimers Society	£30,000 p.a.
Total		**£77,5000**
Accommodation based	**Long stay dementia care residential/nursing homes** **Continuing Health Care**	**£1.49 million (Local Authority)** **£3.57 million (NHS Halton & St Helens)**
	Out of Borough Placements (Residential)	£251,719.
	Oak Meadow: short stay dementia beds	**£145,600 p.a. (£560.00 per bed per week)**
Total		**£5,457,319**

Mapping of Current Services and Gaps - Halton: Specialist dementia services

Service Name / Description	Service Provided	Gaps	Development Plans
Oak Meadow: day-care and carers break day-care	Oak Meadow provides day care for up to 13 people 2 days a week. Capacity for 26 carers to receive 1352 breaks per year **Investment £25,686 p.a.**	Quality specialist service provision Specialist training Staffing cover	
Oak Meadow: short stay dementia beds	Oak Meadow has a 5 bedded dementia unit for short-term care including respite, transitional, shared care and support for carers in crisis. The unit provides care for people whose needs relate primarily to their mental health. Currently operating on a 1-5 staffing level with dedicated specially trained staff for dementia. **Investment: £145,600 p.a. (£560.00 per bed per week)**	Specialist support activity Enhanced training Support for younger adults	Ensure working locally within DoH workforce strategy DOH working with professional and vocational bodies to support continuing professional development Develop pre and post qualification and occupational training. Commissioners to specify necessary dementia training for

Service Name / Description	Service Provided	Gaps	Development Plans
			service providers
Long stay dementia care residential/nursing homes	See summary details at end of table Halton has a total of 330 beds registered for people with dementia, it is important to note the vacancy rates on these beds are regularly high. If we operated at 100% occupancy then the total cost would be in excess of £7 million and the premium payment on top of the standard residential rate would be £1.1million (if all funded through Local Authority or NHS Halton & St Helens) **Actual Investment for 2008/09 for the local authority on dementia beds: £1.49 million** **Continuing Health Care: £3.57 million** **This does not include any self funders, out of area placements.**	Specialist support activity Enhanced training Specialist local unit for younger people	Ensure working locally within DoH workforce strategy DOH working with professional and vocational bodies to support continuing professional development Develop pre and post qualification and occupational training. Commissioners to specify necessary dementia training for service providers
Out of Borough Placements (Residential)	Investment: Dementia specific financial information for placements is only available for Frodsham Christian NH which is 100% dementia care the total for 08/09 was £251,719. This supports 15 people out of the borough.	Capacity issue in Runcorn due to shortage of EMI nursing provision Specialist Training to support quality of service	2 existing providers changed registration in Widnes (Ferndale and Millbrow) Ensure working locally within DoH workforce strategy DOH working with professional and vocational bodies to support continuing professional

Service Name / Description	Service Provided	Gaps	Development Plans
			development Develop pre and post qualification and occupational training. Commissioners to specify necessary dementia training for service providers
PSS	PSS provide a sitting service for people with dementia. Currently the service supports 28 service users *(June 2009)* Investment: £40,000	Capacity – no weekend or evening cover currently being offered	Recommission service – develop new service specification to include higher level of flexibility.
Dementia reading group	Two sessions operating on one day a week reading with people diagnosed with dementia Currently 14 people access the service, however there is capacity for 16 people Investment £7,500	Capacity issues in both residential and community settings	Identify funding to increase the service provision.
Older Peoples Community Mental health Team (100 per cent)	Assessment and care management for older people with mental health needs Investment £120,000* - Halton Borough Council	Capacity – managed through accepting a narrow band of referrals Access for people in the early stages of dementia is inconsistent No crisis response capacity	The gaps identified are currently being addressed in the proposals to develop the Assessment, Care and Treatment Service (ACTS) Continued developments to support the improved integration of the existing team
Alzheimers Society	Monthly educational groups, luncheon club (dementia café), Activities group – memory clinic, home visits, social	Peer networks	Currently developing a Dementia peer support service funded

Service Name / Description	Service Provided	Gaps	Development Plans
	events, information and signposting service. 700 breaks to 120 individuals carers (The carers will relate to the service users with dementia) £ Investment 30,000 p.a.	Capacity for dementia café	through Working Neighbourhood Fund and delivered through Age Concern Mid Mersey
Intermediate Care – current provision	Specialist provision within Intermediate Care in the form of 1.0 Whole Time Equivalent Community Psychiatric Nurse (CPN) Investment: £49,978 approx	Input from specialist mental health teams needs to be increased.	

** Finance figures are indicative – pending completion of PSSEX1*

Summary of expenditure on residential care for dementia 2008/9

External provision within Halton	Total for 08/09
Widnes Hall and Lodge (Orchard Care Homes)	6,870.34
Trewan House	140,200.34
Simonsfield Residential Home	391,744.18
Norton Lodge Care Home	87,105.68
Hannah & Olivia Court Nur/Res	143,793.33
Ferndale Court & Mews	504,477.59
Croftwood	103,859.31
Cartref Residential Home	78,374.66
Beechcroft Nursing Home	41,665.16
Sub-total external provision	**1,498,090.60**

Mapping of Current Services and Gaps - Halton: Generic services for people diagnosed with dementia

Service Name / Description	Service Provided	Gaps	Developments
Oak Meadow: day-care and carers break day-care	Social day-care is held on 3 days a week providing up to 20 places on each day and can accommodate people with low to moderate diagnosis level of dementia	People with dementia often attend the venue on days when no sessions are planned. Therefore it is clear that there is a capacity issue for this service. This service would need an increase in specialist support to increase quality.	
Older Peoples Teams – safeguarding (About 1/3 of the service is provided to people with dementia of all social care staff community and hospital)	Assessment and care management for older people including older people with dementia. Investment £558.282*	Continue to build on existing specialist knowledge through training to support the highest quality of service provision	Ensure working locally within DoH workforce strategy DOH working with professional and vocational bodies to support continuing professional development Develop pre and post qualification and occupational training. Commissioners to specify necessary dementia training for service providers
Adult Teams (About 5 per cent of the service is provided to people	Assessment and care management for adults including adults with young onset dementia.	Continue to build on existing specialist knowledge through training to support the highest	Ensure working locally within DoH workforce strategy

Service Name / Description	Service Provided	Gaps	Developments
with dementia)	£154,595 Investment *	quality of service provision	DOH working with professional and vocational bodies to support continuing professional development Develop pre and post qualification and occupational training. Commissioners to specify necessary dementia training for service providers
Younger adults with dementia	Investment £300,000 22 people between 45 – 64 diagnosed with dementia requiring out of area support.	Of the 22 service users receiving a service 12 of them are aged between 60 – 64 and the implication of transition would need to be considered in relation to these people	The element of transition will be considered in the development of the Assessment, Care and Treatment Service
Domiciliary care	It is estimated that a third of the budget is for dementia care. Investment :The overall annual budget is made up of £4,500,748 (HBC) and £51,543 (Grant) 1/3 = £1,517,430		
Adult placement	119 day care places per week. 21 of 31 carers currently provide care to people suffering from dementia.	Continued specialist training for staff to support people diagnosed with dementia.	Ensure working locally within DoH workforce strategy DOH working with professional and vocational bodies to support continuing professional development Develop pre and post

Service Name / Description	Service Provided	Gaps	Developments
			qualification and occupational training. Commissioners to specify necessary dementia training for service providers
Intermediate Care – current provision	14 Intermediate Care beds with registration for one dementia bed Intermediate care services in Halton do support access to their services for people diagnosed with dementia, however they are generic and not specialist	Clear pathways from Intermediate Care services to local Mental Health services provision Better communication needed across all services & need to increase public awareness of the service	Ensure working locally within DoH workforce strategy DOH working with professional and vocational bodies to support continuing professional development Develop pre and post qualification and occupational training. Commissioners to specify necessary dementia training for service providers

Appendix 4b: Service Mapping and Gap Analysis – St Helens

The service mapping and gap analysis is in two parts. Part 1 is an evaluation of the performance of current services in relation to Objectives of the National Dementia Strategy that points up actions that will be needed (see under 'future plans') to enable the Objectives to be met. Part 2 is a more detailed and service specific analysis. It provides details of the broad range of current services accessed by people with dementia and their carers, and gives details of the services provision and identifies gaps that are specific to each service category.

1) Evaluation of current services, gaps and future plans in relation to NDS Objectives

Objective1*: Improving public and professional awareness and understanding of dementia.*

Current Provision: St Helens, Adult Social Care offers training in dementia awareness and the Alzheimer's Certificate programme to a variety of service providers. These include the voluntary and independent sectors as well as to their own staff. Within the Reablement Team, the psychiatric nurse provides additional training, advice and support to staff on working with people living with dementia. Adult Social Care has also worked with Bradford University on a 4 day intensive programme on dementia care.

Gaps in Service: There is no coherent or co-ordinated public or professional awareness raising programmes for dementia across Health and Social Care. There are limited services and information available to people with dementia. Moreover, these services are targeted at older people and consequently younger people are often unaware of the possibility of dementia and are reluctant to self refer. There is an inconsistency in professional knowledge and skills and professionals are often reluctant to diagnose dementia in younger people.

Future Plans: There is a need to engage with Public Health and professionals to raise awareness and understanding of dementia. Therefore a public health programme to support the prevention of dementia will be developed. Local dementia awareness campaigns to coincide with national campaigns will be planned. A skills audit will be conducted across a range of professionals who are already involved in caring and supporting people with dementia. The results from the audit will inform training needs and a programme of training will be planned and rolled out to professionals.

Objective 2: *Good quality early diagnosis and intervention for all*

Current Provision: Early diagnosis is variable across the borough. This is compounded by the stigma attached to dementia and the difficulty in making the diagnosis. The Cognitive Function Clinic (memory clinic) undertakes specialist assessment and monitoring of cognitive impairment as well as the effects of pharmacological interventions that are designed to delay cognitive impairment.

Gaps in Service: Services are not currently well resourced to provide a good quality early diagnosis. Consequently the effects of early interventions that will delay or reduce cognitive impairment may be implemented at a later stage with reduce efficacy.
Future Plans: The commissioning and implementation of the planned Assessment Care and Treatment Service (ACTS) will provide for good quality early diagnosis and intervention for all people with dementia irrespective of age. The ACTS is currently awaiting final sign off from the PCT.

Objective 3: *Good quality information for those with diagnosed dementia and their carers*

Current Provision: Information is available from the local Alzheimer's Society, the 5 Borough Trust and the Carers' Centre. People living with dementia and their carers will need to be in contact with these services in order to access these services.

Gaps in service: Good quality information is not easily accessible locally for those with diagnosed dementia. There is no locally recognisable main place to obtain information on Dementia in the Borough. This can result in a number of people not having access to information on dementia.

Future Plans. The planned ACTS will improve the dissemination of information and will be a focal point for people to obtain information on dementia. The dementia advisor, attached to the ACTS will also help to enable people to access the necessary information

Objective 4: *Enabling easy access to care, support and advise following diagnosis*

Current Provision: Some support and advise are available from Adult Social Care , Primary Care, GPs, the Carers Centre , the Alzheimer's Society, the 5 Borough Trust and some voluntary groups. This support and advise is not uniformed and access is inconsistent and variable.

Gaps in service: Access to care and support is not uniform and consistent. The support may not be timely and easily accessible to the individual.

Future Plans: The Acts service will be designed to enable people with dementia and their carers to access the care and support they need. The role of the dementia advisors will be vital to delivering this objective of the NDS.

Objective 5: *Development of structured peer support and learning networks.*

Current Provision: There is very limited structured peer support and learning networks for people with dementia in St Helens. The Carers Centre runs a dementia support group for carers of people living with dementia and the Alzheimer's Society provides some support.
Gaps in Service: There is insufficient peer support within the borough for people with dementia and their carers.
Future Plans: St Helens will be developing Peer Support networks which will be hosted within the voluntary sector. Knowledge gained from the Peer Support Pilots in the Department of Health programme will be used to inform the further development of the local peer support Groups.

Objective 6: *Improved community personal support services. Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services*

Current Provision:
St Helens Council's Domiciliary Care Team provides general domiciliary care for people with dementia.
There is also a Specialist domiciliary service, commissioned from the independent sector which provides specialist domiciliary care for people with dementia**.**
Gaps in Service:
The demand for specialist domiciliary care hours is greater than what has been commissioned by Adult Health & Social Care Services.

Future Plans
The service is currently being reviewed. The Council will be increasing the number of specialist domiciliary care support for people living with dementia.

Objective 7: *Implementing the Carers' Strategy. Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected*

Current Provision:

Carers are given a Carers assessment irrespective of their diagnosis. Joint Carers' assessments are undertaken with the Carers' Centre

The carers Centre also runs a Carer Dementia support group.

Gaps in Service:
Development of personalised breaks for carers. Support for children who are in a caring role needs to be strengthened.
Future Plans:

Work is in hand to develop personalised breaks for carers

Work with Young Carers to ensure that their needs as children are protected.

Further work needs to be done to implement the Carers Strategy

Objective 8: *Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals*

Current Provision:

A nurse consultant and a hospital consultant provide leadership for dementia in the local general hospital.

A Psychiatric liaison service has recently been established at the local hospital.

Gaps in Service:
Future Plans. Ensure that there is sufficient capacity to provide the service to mange demand

Objective 9: *Improved intermediate care for people with dementia. Intermediate care which is accessible to people with dementia and which meets their needs*
Current Provision: The Intermediate care service is inclusive of people with mild to moderate dementia. Referrals are accepted based on whether the service is able to meet the individual needs. A Community Psychiatric Nurse is based within the service to provide support and advice to team members as well as therapeutic interventions to people with mental health issues.
Gaps in Service:
There is no intermediate care service available to meet the needs of people with severe dementia.
Future Plans:
Explore the feasibility of developing intermediate care for people with severe dementia

Objective 10: *Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers. The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and Telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services*

Current Provision:
Housing:
The St. Helens Housing Strategy for Older people has actively encouraged the development of a range of housing options for people living with dementia both from a specialist and a non-specialist perspective.
Portland House 1, is a specialist extra care facility providing 8 rented flats for people with dementia. Flexible support is provided by a domiciliary care agency.
Helena Housing has established 30 flats at Parr Mount Court, which are available for rent to people with dementia. An independent provider will provide domiciliary care support to these tenants. Other housing developments include Heyeswood, a 92 unit facility

and Heald Farm Court which provide 89 units of general housing for people including those living with dementia. Reeve Court, a 206 unit will provide support for residents who develop dementia.

The introduction of a specialist domiciliary care service has provided people who have mild to moderate dementia with home care support. This home care support has made it possible for people to remain in their own homes for as long as possible. Consequently, a number of Residential and Nursing Homes are experiencing voids in their facilities. This has led some Homes to consider diversification into the provision of day care and respite care.

Telecare: St Helens provides a Careline service as well as a range of manually or automatic operated telecare sensors. The provision of this service is based on need and the recipient and carer's acceptance of the service. This service is very much focused on risk management and intervention to prevent crisis.

Ongoing awareness sessions re the availability of Telecare and assistive technology and the potential benefit its use can have to both service users and their carers is delivered to colleagues in health/social care.

Gaps in Service:

Better communication is needed across all services to ensure the effectiveness of the service

Need to increase public awareness of assistive technology and Telecare Service.

Future Plans:

Housing : A Portland House 2 consisting of 15 mixed tenure flats is currently being planned for the future.

The Local Authority is currently reviewing the usage of a residential facility to provide a service for young people with early onset dementia, older people who challenge and short breaks to benefit both carers and people with dementia.

Telecare : Progress needs to be made in implementing further sensor and lifestyle monitoring technology. This will enable clinicians and professionals to identify changes in individual circumstances, and therefore deliver early intervention to changing needs and avert possible crisis in order to maintain the independence of people with dementia.

Future Plans:

Consideration needs to be given to joint work between the Borough and PCT/Practice based commissioner in the use of telehealth applications to monitor and manage long term conditions.

Objective 11: *Living well with dementia in care homes. Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes*

Current Provision:

A Nurse Specialist for Older People provides education and training in dementia care to the local nursing homes.

Gaps in Service:
There needs to be a specialist in reach service from the community mental health team into nursing homes.
Future Plans:
The planned Dementia support care worker will be required to establish links with care homes. The work of the Older People Mental Health Team needs to be reviewed in light of the future establishment of the Assessment Care and Treatment Service.

Objective 12: *Improved end of life care for people with dementia. People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.*

Current Provision:
There is no specific end of life care for people with dementia. The PCT is currently piloting a Gold Standard Framework in a nursing home in St Helens for all patients, irrespective of diagnosis and whose needs require end of life care. On the successful completion of the pilot, it is anticipated that this provision will be made available in all care homes. The implementation of is Framework will benefit people with dementia.

Gaps in Service:
People with severe dementia have difficulties in communicating their needs and wishes. There is no end of life care pathway which is specific to people with dementia**.**
Future Plans:
Work needs to commence on an end of life care pathway for people who have dementia to include support for their families and carers. Halton & St Helens NHS is piloting a Gold Standard Framework (GSF) in a nursing home in St. Helens.

Although this GSF is not specific to people with dementia much of this work can be applied to this group of people.

Mapping of Current Services and Gaps –St Helens

Service Name / Description	Service Provision	Gaps in Service
Intermediate Care Service	**St Helens Intermediate Care Services - Newton Community Hospital Inpatient Unit, Reablement and Rapid Response Team and Seddon Suite Intermediate Care Unit.** This service is inclusive of people with mild to moderate dementia. Referrals are accepted based on whether the service is able to meet the individual need. A Community Psychiatric Nurse post is based within the service to provide support and advice to team members as well as therapeutic interventions to people with mental health issues.	Service to meet the needs of people with severe dementia and those with Alzheimer's disease both within their own home and also unit based. There is currently limited resource to provide a crisis response for older people with mental health needs within the community (e.g. a rapid response within 2 hours of referral).
St Helens Access and Advice Team	**St Helens Access and Advice Team** This service provides a single point of referral for primary and secondary mental health services. Provides advice and/or signposting to PCMHT and local non-statutory services. Provides specialist assessments for access into secondary mental health services.	
5 Borough Mental Health Trust **Inpatient Care - Older Adult**	**Stewart Assessment Ward** Provides inpatient care and treatment to older people having mental health problems of a degree and	There is currently no service available for early diagnosis of dementia. A business case has been put forward to the PCT for

Service Name / Description	Service Provision	Gaps in Service
Acute Assessment –	nature which require services beyond those which can be provided within a community setting Referral is via the Care Co-ordinator; Specialist Mental Health Service; Consultant.	the development of an Access Care and Treatment Service which will include a dementia care worker
Memory Assessment service	**The Cognitive Function Clinic (memory clinic)** Undertakes specialist assessment and monitoring of cognitive impairment and the monitoring of the effects of prescribed anti dementia drugs	
Out Patients	**Psychiatric Outpatients** Appointment for first and follow up appointment. Appointments can take place in service users usual place of residence Referral: Primary Care Mental health Team, Specialist mental Health Service	
Primary and Community Care - Day Services	**Stewart Day Hospital** The Stewart Day Hospital provides time limited support to people with moderate dementia via an assessment group. This is an eight week programme which provides a safe and supportive environment in which patients are able to demonstrate and practise their functional and motor skills, ability to follow instruction and the use of long and short term memory. The hospital also provides one to one care and support and education as and when required for Carers A range of therapeutic interventions are available.	Stewart Day hospital will be reconfigured and instead of offering traditional hospital based services only, will also provide outreach services to older people and support for people with memory problems in the community
Psychiatric Liaison Service	**Psychiatric Liaison Service** This nurse-led psychiatric liaison service provides	This service may need to be enhanced due to the large numbers of older people with a

Service Name / Description	Service Provision	Gaps in Service
	specialist knowledge to staff on the management of depression, dementia and delirium in older people. The service is provided by the 5 Boroughs Partnership Trust with performance oversight provided by St. Helens & Knowsley Hospital Trusts	mental health need, who require psychiatric care input, and who are occupying an acute general hospital bed
Integrated Community Mental Health Team	**Older People Mental Health Team** A multi-disciplinary team providing assessment care and treatment to older people with mental health problems. Care is provided in various community based settings including the service user's residence. Referral; Primary Care Mental Health Team; Specialist Mental Health Service	
Advocacy Services	**Advocacy Services** These services are currently provided under the 'Mental Capacity Act 2007. The services are provided by independent mental health advocates working in the independent sector. The advocates act on behalf of the person only if there are no relatives available to do so.	Improvements in the availability of advocacy services for all older people living with dementia was one of the recommendations included in the Older Peoples CSCI Inspection 2006. Currently Mental Health Commissioners in the Primary Care Trust are working with Commissioners in Adult Social Care & Health Older Peoples services on how to identify and implement extra capacity in this service area.
Primary Care Mental Health	**PCMHT**	This service, although available to older

Service Name / Description	Service Provision	Gaps in Service
Team (PCMHT)	The primary care mental health team offers brief evidence based (generally CBT type)interventions to people presenting with mild to moderate mental health problems with manageable risk	people, receive very few referrals for older people with dementia. Consideration needs to be given as to how these services can be accessed by people living with dementia
Specialist Day/Resource Centres	**Kershaw Day Centre** This Centre provides traditional day care for people with dementia. It is run by the Local Authority. Customers are usually provided with transported to the Centre by the Council. The service operates Monday to Friday. It can accommodate up to a maximum of 60 places. It offers various activities for people with dementia. Referral is via: Specialist Mental Health Service; customer services	
Primary and Community Care **- Homecare** **- Crisis Intervention**	**Home Care** - Specialist Domiciliary care is provided by an independent agency to people with dementia in their own homes. It provides a minimum of 750 hours Co-ordinator; Specialist Mental Health Service **Crisis Intervention** A service level Agreement has been agreed with the Crisis Resolution Team to provide a service for older people who qualify and are aged 65 years and over. This includes people with dementia	This service is currently under review. The number of care hours needs to be increased to cope with the demand for the service
Emergency Duty Team	**EDT** This service provides an emergency social care assessment service, including ASW, outside normal working hours	

Service Name / Description	Service Provision	Gaps in Service
Primary and Community Care - Residential	**Seddon Court** This local Authority facility is a 30 bedded unit offering care for people with dementia. It has 3 respite places for service users who have a confirmed diagnosis of dementia and are over 65 years age. As all other service areas Seddon Court will be reviewed and redesigned to meet a large part of the missing gaps in the St Helens provision. It has been agreed that the PCT allocation within Seddon Court will remain to support this new development. This alongside large scale redesign will meet a significant part of St Helens contribution to the strategy. **Brookfield & Mossbank** These 2 facilities, although not specialist dementia residential homes will accept people with a mild form of dementia.	
Primary and Community Care Specialist Housing – Extra Care Housing	**Portland House** This is an extra care facility providing 8 rented flats for people with dementia. Flexible support, is provided by a domiciliary care agency	This service has been very successful and there is a demand for further provision. A Portland House 2 consisting of 15 mixed tenure flats is currently being planned for the future.
Voluntary Sector Services **-Carers Centre** **-Alzheimer's Society**	**Carers** The Carers Centre provides advice, information and emotional support for anyone visiting the centre or contacting them by telephone. Most specifically, the	Action plan for the promotion of ways for Carers of Older People with Mental Health problems to access advice and support.

Service Name / Description	Service Provision	Gaps in Service
	Centre provides training on dementia via a 6 week dementia awareness course. It also produces a dementia guidelines leaflet. It also loans Carers a DVD 'How to care for someone with dementia. It also runs a dementia support group **Alzheimer's Society** The St Helens Alzheimer's Society meets on a monthly basis and provides support to people with dementia and their carers.	
Registered Social Landlords (RSLs)	**Helena Housing** This RSL has established 30 flats at Parr Mount Court which are available for rental to people with dementia. An independent provider will provide domiciliary care support to these tenants.	Another 180, 1 and 2 bedroom flats will be available at Heald Farm Court and Heyeswood will become available in September and October 09. People with dementia will be enable to become tenants
Mental Health Promotion	**Mental Health Promotion** This generic service is provided by the PCT. The Mental health Directory has been reviewed to include older people	There needs to be targeted structured campaigns to raise awareness of dementia. There is also a need for a peer support network

Appendix 4c. Financial breakdown of Dementia Services – St Helens

The strategy has also produced a financial summary on dementia services, breaking them down in the following areas, Community services and residential or accommodation based services.
It is important to note that there may be other services e.g. domiciliary care, Careline etc that are not included in the financial mapping as it is difficult to break down the spend across dementia services.

Category	Service Name	Investment
Community Services	Kershaw Day Centre 50 places per day	£ 562,744 p.a.
	Older Peoples Community Mental Health Team	£ 400
Total		**£ 962,744**
Accommodation based	Long stay dementia care residential/nursing homes (in borough) Long stay dementia (in house)	£2,149.601 £1,087.145
	Out of Borough Placements (but within a 2 miles of the Borough)	£1,048,334.
Total		**£5,247.824**

Summary of expenditure on residential and Nursing care for dementia 2008/9

Out of Borough Approved Providers - St Helens	**Total for 08/09**
Ashton View	128,263
Callands	23,422
Green Park	65, 895
Hillside	65,574
Knowsley Manor	21,429
Rosevilla	407,524
Shawcross	218,581
Stocks Hall	78,374.66
Beechcroft Nursing Home	117,646
Sub-total of out of borough provision	**1,048,334**
In Borough Approved Providers	Total for 08-09
Broad Oak Manor	399.000
Cedric House	284,155
Eccleston Court	110,000
Elizabeth Court	408,000
Elm Tree House	281,000
Prospect House	393,446
Tree Tops	164,000
Victoria	110,000
Grand Total	**2,149,601**

Appendix 5

Halton and St Helens Joint Commissioning Strategy for Dementia

Implementation Plan

Halton

NDS Objectives	National NDS Implementation Plan: Key Priorities
1: Improving public and professional awareness and understanding of dementia 2: Good-quality early diagnosis and intervention for all 3: Good-quality information for those with diagnosed dementia and their carers 4: Enabling easy access to care, support and advice following diagnosis 5: Development of structured peer support and learning networks 6: Improved community personal support services 7: Implementing the Carers' Strategy 8: Improved quality of care for people with dementia in general hospitals 9: Improved intermediate care for people with dementia 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers 11: Living well with dementia in care homes 12: Improved end of life care for people with dementia 13: An informed and effective workforce for people with dementia 14: A joint commissioning strategy for dementia 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers 16: A clear picture of research evidence and needs 17: Effective national and regional support for implementation of the Strategy	• Early intervention and diagnosis for all • Improved community personal support services • Implementing the New Deal for Carers • Improved quality of care for people with dementia in general hospitals • Living well with dementia in care homes • An informed and effective workforce for people with dementia • A Joint Commissioning strategy for dementia

Halton and St Helens Joint Commissioning Strategy for Dementia

Implementation Plan - Halton

Objectives	Actions	Tasks	Lead	Progress to date	Expected outputs / outcomes
Theme: Raising Awareness and Understanding					
Objective1: Improving public and professional awareness and understanding of dementia	1. A Public Health programme to support the prevention of dementia should be developed and progressed 2. A strategy for community engagement should be drawn up 3. A local public information programme should be developed drawing on, and aligned with the national campaign and will include awareness of the risks of developing dementia at a younger age 4. Information should be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately 5. Joint work should be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy and are provided with suitable information for inclusion in PSHE and Citizenship Education	• Agree key messages for publication • Identify funding • Agree distribution • Evaluate impact of campaign • Establish community engagement steering group	NHS HStH - Public Health		• Increase in the number of people presenting at primary care • Major increase in the number of people receiving a timely diagnosis • Increase in support for people diagnosed with dementia to access community services • Reduction in the cycle of stigma and discrimination associated with dementia.

Theme: Early Diagnosis and Support					
Objective 2: Good-quality early diagnosis and intervention for all	Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers should be commissioned for Halton and for St Helens	• Investment to be approved • Tender exercise – NHS H&StH • Approve provider • Implementation plan led by a Project Manager overseen by a Steering Group	HBC, St H C, and NHS HStH	Specifications for ACTS completed & business cases progressing through commissioner approval processes. It will then be subject to a tendering exercise	• Increase in the number of people presenting at primary care • Major increase in the number of people receiving a timely and early diagnosis • Increase in support for people diagnosed with dementia to access specialised services • Improved quality of life for patient and carer • Reduction in high-end, high-cost support
Objective 3: Good-quality information for those with diagnosed dementia and their carers	ACTS should be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers	ACTS service provider to produce appropriate information Commissioners should assess outcomes through the performance monitoring process	ACTS service provider NHS HStH	See 2 above	See 2 above
Objective 4: Enabling easy access to care, support and advice following diagnosis	A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service		HBC & St H Commissioners	See 2 above. The development of the DCA post will need to be timed to fit with the ACTS implementation time-table	• Increase in support for people diagnosed with dementia to access specialised services • Increase in support for people diagnosed with dementia and their carers to access community services • Increased access to information • Improved quality of life for patient and carer •

Continued: Theme: **Early Diagnosis and Support**

Objective 5: Development of structured peer support and learning networks	A Dementia Network Project will be commissioned through Age Concern Mid Mersey to develop Peer Support and Learning Networks with one project focusing specifically on the needs of younger people who develop dementia	Applications will be made to Halton Health Partnership for funding for the Project Age Concern will establish a project framework, establish a Task Group, Stakeholder Group and enlist consultancy support ACMM will recruit a part time project lead An Action Plan will be drawn up and implemented	Age Concern Mid Mersey Support offered through Partnership Commissioning	Funding has been agreed Project lead has been recruited Steering group has been established Dementia event has taken place	• Increase in support for people diagnosed with dementia to access specialised services • Increase in support for people diagnosed with dementia and their carers to access community services • Increased access to information • Improved quality of life for patient and carer • The project will also undertake an analysis of what training is required for both Professionals and carers in relation to dementia
Theme: Living Well with Dementia					
Objective 6: Improved community personal support services *An additional mapping and gap analysis of the needs of younger adults with dementia, and their carers, will be completed.*	Professional and vocational training will be developed to support continuing professional development. People with dementia will be supported to remain independent in their own homes through inclusion in the health and social care personalisation developments	Training needs analysis completed through the dementia peer network Agree training programme Commission training Establish links to personalisation to ensure people diagnosed with dementia have opportunities to access direct payments and individualised budgets	Training leads for Local Authority and NHS Halton & St Helens	On going	• Improved awareness for professionals • Improved awareness for the public • Improved choice, quality and independence for people diagnosed with dementia and their carers.

Continued: Theme: **Living Well with Dementia**

Objective 7: Implementing the Carers' Strategy	The specific needs of carers of people diagnosed with dementia are addressed in the Carers Commissioning Strategy	Ensure dementia is covered in carers commissioning strategy	Carers - service development officers	This Objective has been addressed in the current Carers Commissioning Strategy	• Improved access to carers support • Greater choice and quality of service for carers • Increased opportunity for carers to maintain some level of independence and quality of life
Objective 8: Improved quality of care for people with dementia in general hospitals	The action plan for the Dignity Coordinator will be implemented A specific lead will be identified for dementia in the general hospital	Dignity action plan agreed through the Older People's Local Implementation Team Invite Hospital lead to attend dignity group	Dignity Co-ordinator Warrington and Halton Hospital foundation trust	Action plan currently in draft – awaiting sign off	• Framework established to identify poor quality • Improved access to information for hospital patients whilst in hospital and on discharge
Objective 9: Improved intermediate care for people with dementia	Professional and vocational training will be developed to support continuing professional development, linked to the capacity and specialisms in each team	Agree training programme Commission training	Training leads for Local Authority and NHS Halton & St Helens	On going	• Improved awareness for professionals • Improved awareness for the public • Improved choice, quality and independence for people diagnosed with dementia and their carers.
Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers	Use of virtual sensor and lifestyle monitoring technology will be progressed Joint HBC / NHS H&StH action on telehealth will be considered	Develop and implement joint telecare and telehealth strategy	HBC / NHS H&StH	On going	• Increase in number of people supported to remain independent in their own homes • Increased support for carers • Reduction in bed based provision

Continued: Theme: **Living Well with Dementia**

Objective 11: Living well with dementia in Care Homes	ACTS will provide an in-reach support service for people with dementia in care homes and contribute to the training of staff A new service specification for residential and nursing homes will be developed that includes the dignity charter The action plan for the dignity coordinator will be implemented A lead for dementia in the hospital will be identified	ACTS provider's operational policy will include details of the in-reach service arrangements Commissioners will assess outcomes through the performance monitoring process	ACTS provider	See 2 above	• Increase in the number of people presenting at primary care • Major increase in the number of people receiving a timely and early diagnosis • Increase in support for people diagnosed with dementia to access specialised services • Improved quality of life for patient and carer • Reduction in high-end, high-cost support
Objective 12: Improved end of life care for people with dementia	To ensure people with dementia and their carers receive the best quality end of life care.	A multi-agency end of life strategy for people who have dementia including support for their families/carers will be developed. Implement Gold standard	NHS Halton & St Helens	Part of commissioning plan for NHS Halton & St Helens	• Reduce acute care admissions • Improve choice, quality and independence for people with dementia at any stage of their life.
Theme: Delivering the Strategy					
Objective 13: An informed and effective workforce for people with dementia	Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education	Agree training programme Commission training	Training leads for Local Authority and NHS Halton & St Helens	On going	• Improved awareness for professionals • Improved awareness for the public • Improved choice, quality and independence for people diagnosed with dementia and their carers.
Objective 14: A joint commissioning strategy for dementia	This document sets out the overarching strategy for Halton B.C., St Helens B.C. and NHS Halton and St Helens		Sue Wallace-Bonner HBC, Rob Vickers StHBC and	Document to be agreed through Management Executive Team,	• The strategy aims to deliver more capacity and higher quality of service provision

Continued: Theme: **Delivering the Strategy**

			Janet Dunn NHS H&StH	Senior Management Team and Executive Members by the end of November	
Objective 15: Improved assessment and regulation of health and care services	The Department of Health is progressing this Objective			On going	
Objective 16: A clear picture of research evidence and needs	The Department of Health is progressing this Objective			On going	
Objective 17: Effective national and regional support for implementation of the Strategy	The Department of Health is progressing this Objective			On going	

Appendix 6

St.Helens Council

NHS
Halton and St Helens

Implementation Plan

St Helens

Halton and St Helens Joint Commissioning Strategy for Dementia

Implementation Plan – St Helens

Objectives	Implementation Plan Priority	Actions	Tasks	Lead	Progress to date
Theme: Raising Awareness and Understanding					
Objective1: Improving public and professional awareness and understanding of dementia		1. A Public Health programme to support the prevention of dementia should be developed and progressed 2. A strategy for community engagement should be drawn up 3. A local public information programme should be developed drawing on, and aligned with the national campaign and will include awareness of the risks of developing dementia at a younger age 4. Information should be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately 5. Joint work should be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy and are provided with suitable information for inclusion in PSHE and Citizenship Education		NHS HStH - Public Health	

Theme: Early Diagnosis and Support					
Objective 2: Good-quality early diagnosis and intervention for all	Yes	Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers should be commissioned for Halton and for St Helens	• Investment to be approved • Tender exercise – NHS H&StH • Approve provider • Implementation plan led by a Project Manager overseen by a Steering Group	HBC, St H C, and NHS HStH	Specifications for ACTS completed & business cases progressing through commissioner approval processes. It will then be subject to a tendering exercise
Objective 3: Good-quality information for those with diagnosed dementia and their carers		ACTS should be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers	ACTS service provider to produce appropriate information Commissioners should assess outcomes through the performance monitoring process	ACTS service provider NHS HStH	See 2 above
Objective 4: Enabling easy access to care, support and advice following diagnosis		A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service		HBC & St H C commissioners	See 2 above. The development of the DCA post will need to be timed to fit with the ACTS implementation time-table
Objective 5: Development of structured peer support and learning networks		A Dementia Network Project will be commissioned through Age Concern Mid Mersey and the Local Alzheimer's Society to develop Peer Support and Learning Networks.	Applications will be made to St Helens Adult Social Care & Health for funding for the Project	St HBC	
Theme: Living Well with Dementia					
Objective 6: Improved community personal support services *An additional mapping and*	Yes	Professional and vocational training will be developed to support continuing professional development. People with dementia will be		5 BP Trust, St.HBC, NHS H& St.Helens	

gap analysis of the needs of younger adults with dementia, and their carers, will be completed.		supported to remain independent in their own homes through inclusion in the health and social care personalisation developments			
Objective 7: Implementing the Carers' Strategy	Yes	The specific needs of carers of people diagnosed with dementia are addressed in the Carers Commissioning Strategy		NHS H& St. H, St.HBC	This Objective has been addressed in the current Carers Commissioning Strategy
Objective 8: Improved quality of care for people with dementia in general hospitals	Yes	A specific lead will be identified for dementia in the general hospital		StH&K	A specific lead has already been identified in StH&K Trust
Objective 9: Improved intermediate care for people with dementia		Professional and vocational training will be developed to support continuing professional development, linked to the capacity and specialisms in each team			
Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers		Use of virtual sensor and lifestyle monitoring technology will be progressed Joint HBC / NHS H&StH action on telehealth will be considered			
Theme: Living Well with Dementia					

Objective 11: Living well with dementia in care homes	Yes	ACTS will provide an in-reach support service for people with dementia in care homes and contribute to the training of staff A new service specification for residential and nursing homes will be developed that includes the dignity charter The action plan for the dignity coordinator will be implemented A lead for dementia in the hospital will be identified	ACTS provider's operational policy will include details of the in-reach service arrangements Commissioners will assess outcomes through the performance monitoring process	ACTS provider	See 2 above
Objective 12: Improved end of life care for people with dementia		A multi-agency end of life strategy for people who have dementia including support for their families/carers will be developed.			
Theme: Delivering the Strategy					
Objective 13: An informed and effective workforce for people with dementia	Yes	Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education			
Objective 14: A joint commissioning strategy for dementia	Yes	This document sets out the overarching strategy for Halton B.C., St Helens B.C. and NHS Halton and St Helens		Sue Wallace-Bonner HBC, Rob Vickers StHBC and Janet Dunn NHS H&StH	
Objective 15: Improved assessment and regulation of health and care services		The Department of Health is progressing this Objective			
Objective 16: A clear picture of research evidence and needs		The Department of Health is progressing this Objective			
Objective 17: Effective national and regional support for implementation of the Strategy		The Department of Health is progressing this Objective			

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 12th January 2010

REPORTING OFFICER: Strategic Director Corporate and Policy

SUBJECT: Local Area Agreement Performance Report

WARDS: Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide information on the progress towards meeting Halton's Local Area Agreement (LAA) targets to September 2009.

2.0 RECOMMENDED THAT:

i. The report is noted

ii. The Board considers whether it requires any further information concerning the actions being taken to achieve Halton's LAA targets.

3.0 SUPPORTING INFORMATION

3.1 The revised LAA was signed off by the Secretary of State in June 2008. The LAA contains a set of measures and targets agreed between the Council, local partner agencies (who have a duty of co-operation in achieving targets) and government. There are 32 indicators within the LAA along with statutory and education and early years targets. The current agreement covers the period April 2008 to March 2011.

3.2 The Agreement was refreshed in March 2009 following a review with Government Office North West. It is not expected that there will be many significant changes to the agreement excepting those areas affected by the downturn in the national economy, such as measures relating the local economy and house-building. As a consequence of this government has identified a list of indicators for which targets will be reviewed before the end of March 2010.

3.3 Attached as Appendix 1 is a report on progress to the 2009 – 10 mid-year which includes those indicators and targets that fall within the remit of this Policy and Performance Board.

3.4 In considering this report Members should be aware that:-

a) All of the measures within the National Indicator Set are monitored through Quarterly Departmental Service Plan Monitoring Reports. The purpose of thus report is to consolidate information on all measures and targets relevant to this PPB in order to provide a clear picture of progress.

b) In some cases outturn data cannot be made available at the mid-year point and there are also some Place Survey based indicators for which information will not become available until 2010 i.e. the next date the survey is due to be undertaken.

4.0 CONCLUSION

4.1 The Sustainable Community Strategy for Halton, and the Local Area Agreement contained within it, is the main mechanism through which government will performance manage local areas. It is therefore important that we monitor progress and that Members are satisfied that adequate plans are in place to ensure that the Council and its partners achieve the improvement targets that have been agreed.

5.0 POLICY IMPLICATIONS

5.1 The Local Area Agreement acts as the delivery plan for the Sustainable Community Strategy for Halton and is therefore central to our policy framework.

6.0 OTHER IMPLICATIONS

6.1 The achievement of Local Area Agreement targets has direct implications for the outcomes in relation to Comprehensive Area Assessment judgements.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 This report deals directly with the delivery of the relevant strategic priority of the Council.

8.0 RISK ANALYSIS

8.1 The key risk is a failure to improve the quality of life for Halton's residents in accordance with the objectives of the Sustainable Community Strategy. This risk can be mitigated thorough the regular reporting and review of progress and the development of appropriate actions where under-performance may occur.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 One of the guiding principles of the Local Area Agreement is to reduce inequalities in Halton.

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

Document	Local Area Agreement 2008 – 11
Place of Inspection	2nd Floor, Municipal Building, Kingsway, Widnes
Contact Officer	Rob MacKenzie (0151 471 7416)

APPENDIX 1

A Local Area Agreement For Halton

June 2008 – April 2011

Healthy Halton

Mid-Year Progress Report

01st April – 30th September 2009

Halton Strategic PARTNERSHIP

Performance Overview

This report provides a summary of progress in relation to the achievement of targets for Halton Local Area Agreement.

It provides both a snapshot of performance for the period 01st April to 30th September 2009 and a projection of expected levels of performance to the period 2011.

The following symbols have been used to illustrate current performance against 2009 and 2011 target levels.

✓	Target is likely to be achieved or exceeded.
?	The achievement of the target is uncertain at this stage
✗	Target is highly unlikely to be / will not be achieved.

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Additional Contact	Mark Grady Tel 0151 471 7390 / Internal extension 1023 mark.grady@halton.gov.uk

Performance Overview

HEALTHY HALTON

NI	Descriptor	09/10 Target	2011 Target
8	Adult participation in sport	?	?
53	Prevalence of breastfeeding at 6 – 8 weeks from birth	?	?
120	All-age all-cause mortality	✗	?
123	16+ Smoking rate prevalence	✓	✓
139	People > 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently		
142	Number of vulnerable people supported to maintain independent living	✓	?

HEALTHY HALTON

NI 8 Adult participation in sport

Baseline (2006)	2009 - 10			2011	
	Target	Mid-year Actual	Progress	Target	Projected
20.13%	22.13%	**19.33**	?	24.13%	?

Data Commentary

Although this report covers 1st April – 30th September 2009, the survey covers 15th October 2008 – 14th October 2009.

We do not expect another outturn until full results are released Jan 2010. As the sample size increases we anticipate the participation rate to increase.

Data interpretation
Based on 94,310 adult 16+ population in Halton participation targets are as follows:
22.13% is the LAA target thus 20870 actual target for participation
18.5% 2007/08 outturn result; (number of people surveyed 493);
Baseline number of people participating 17,447

Latest interim results (18.06.09) based on 501 people surveyed puts us now at 19.33% so progress is being made as the sample size increases.
18,230 figure thus further 2,640 required

General Performance Commentary

The Active People Survey from which the data is sourced is issued annually which means that quarterly reporting is not possible.

For this reason proxy indicators have been introduced to gauge progress:
*Leisure Centre usage can be monitored on a monthly basis. Adult participation is being monitored and contractor has been set a 1% increase target for adult participation at the Council's 3 Leisure Facilities.

*Free swim campaign for those aged 60 years and over can be monitored monthly

Sports Participation Project is targeted at increasing participation this is a multi agency project with targeted interventions to get more people active.

All of the above are reported Quarterly through Health SSP quarterly LAA reporting.

HEALTHY HALTON

Summary of key activities undertaken / planned during the year

Sports Participation project, is a multi agency resourced project, which through targeted work seeks to actively engage approx 1000 new participants per year. See Sports participation WNF quarterly reporting to Health SSP. Annual Action Plan produced

Monthly meetings with Leisure Centre Manager reviews usage and centre programming, to ensure on track to achieve 1% participation target and progress of free swim initiative. Quarterly progress is reported into Health SSP.

NI 53 Prevalence of breastfeeding at 6 – 8 weeks from birth

Baseline (Q.2 2008)	2009 - 10			2011	
	Target	Mid-year Actual	Progress	Target	Projected
12.1%	21% (indicative, will be refreshed 09/10)	**18.58%**	?	23% (indicative, will be refreshed 09/10)	?

Data Commentary

General Performance Commentary

The number of infants being breastfed at 6-8 weeks is 18.58% which is below target for this period but has seen a 4.5% increase since the last reporting period.

Summary of key activities undertaken / planned during the year

The Maternity Support Worker service has been developed and is now becoming established in the Borough providing breastfeeding support. Breastfeeding group support is being accessed with group support available in all areas of the Borough. Further developments include the joint partnership working between Maternity Support workers and the Le Leche Peer Support service. The Peer Support service is provided by the Kings Cross Parents Project and provides a complete service for breastfeeding mothers within Halton. The Get Closer 2 Social Marketing campaign was presented to the Breastfeeding steering group and will be going to staff, mothers and maternity community groups for consultation.

HEALTHY HALTON

All health visiting teams have been asked to review the support they offer to breast feeding mothers and to consider a range of evidence based interventions they may be able to implement in terms of increasing the number of mothers who continue to breast feed at 6-8 weeks. All teams have an action plan in place which will be reviewed quarterly. Breast feeding status at 6-8 weeks is being collected by all health visiting teams. A recent event facilitated by the SHA recognised the quality of the data provided by Halton and St Helens health visiting teams.

NI 120 All-age all cause mortality

Baseline (2007/08)	2009 - 10			2011	
	Target	Mid-year Actual	Progress	Target	Projected
Male - 906	780	**769.5**	✗	755	?
Fem - 673	590	**607.9**		574	

Data Commentary

Data provided is provisional and relates to the period September 2008-August 2009. The next official data update will be available in December 2009 with 2008 data.

General Performance Commentary

Life expectancy has increased overall and deaths from CVD and cancer have fallen but at a slower rate than England as a whole so the gap has widened.

Halton and St Helens have worked with the Health Inequalities National Support Team (NST) to identify the key areas we need to make progress on if we are to reduce the gap for life expectancy by the government target of 2010.

Summary of key activities undertaken / planned during the year

Life expectancy has now become a Commissioning Strategic Plan (CSP) priority.

Analysis has been undertaken to understand the major causes of deaths for males and females between the years 2005-07 to understand if there are any causes of deaths that could merit further investigation. For both genders circulatory and cancer are still major factors with respiratory also being a major cause (either COPD, pneumonia or other respiratory conditions).

HEALTHY HALTON

Chronic liver disease also figured within males deaths. Vascular and unspecified dementia and senility also figured within females deaths.

The Commissioning Strategic Plan interventions will address these conditions partly through early detection and prevention of chronic diseases as outlined in alcohol, tobacco and obesity plans.

Areas identified for focus from the NST Health Inequalities visit are CVD (secondary prevention), CVD (acute management), alcohol, seasonal excess deaths, COPD and cancer. An additional visit in April 2009 by the Health Inequalities team also identified infant mortality and diabetes as areas for focus.

A programme of accelerated action is being implemented from the recommendations of the National Support Team visit for Health Inequalities and whilst this is being led by the PCT, the Borough Council are fully engaged in this process especially linking to actions around vulnerable people. The PCT and LA has established a Health Inequalities Oversight Group and has identified a lead for each of these 8 areas who is accountable for implementing the recommendations made following the visit from the NST. An example to address the CVD element is that the PCT and LA has agreed to support an industrial scale "case finding" project that will identify all patients at risk of developing CVD over the next 10 years. This is a systematic approach that will be delivered through Primary Care. A more opportunistic scheme will be launched across the Halton and St Helens population within 2009/10. The PCT is developing a Quality Outcomes Framework (QOF) system via a local enhanced scheme across high priority disease areas such as CVD, diabetes and stroke.

In addition, the following initiatives should have an impact on all age, all cause mortality: Health Checks Plus, QOF Plus, Workwell health checks, GO Men's Health Programme health checks, early presentation of cancer programme and working with vulnerable adults and GPs to prevent excess winter deaths through enhanced services. There is an ongoing programme around tobacco control and we are making good progress with stop smoking results.

HEALTHY HALTON

NI 123 16+ current smoking rate prevalence

Baseline (2007/08)	2009 - 10			2011	
	Target	Mid-year Actual	Progress	Target	Projected
914	1082	**351**	✓	1128	✓

Data Commentary

Data is incomplete for Q2, 2009/10 as it is still awaited from a number of GPs, pharmacies and the smoking cessation service (SUPPORT) need to carry out follow ups.

General Performance Commentary

In terms of stop smoking services, tobacco control is making good progress. A comprehensive approach to tobacco control including illegal and counterfeit tobacco prevention, normalising smoke free lifestyles and communications is making progress and this will be enhanced with the implementation of the actions associated with the Tobacco Control Strategy and Action Plan.

Halton and St Helens have received the 2009 Merseyside and Cheshire Charter award for smoke free workplaces.

Summary of key activities undertaken / planned during the year

The Commissioning Strategic Plan has put considerable funding in place to reduce smoking levels. Smoking initiatives will have considerable impact on cancer. The tobacco control initiatives will target six key areas including prevention, illegal and counterfeit tobacco, pregnant smokers, stopping smoking, social marketing and normalising smoke free lifestyles. We are currently conducting research into how our marketing programme can take these areas forward. A reduction in exposure to a smoking environment and in smoking rates will reduce levels of smoking related cancers.

A smoking in pregnancy pathway has been developed and implemented and training is ongoing with midwives and health visitors. All smoking cessation staff working with pregnant women are now using baby monitors to ascertain the level of carbon monoxide in babies at the first ante-natal appointment. The pregnant woman and her partner are offered smoking cessation support and advice on how to keep the home smoke free.

HEALTHY HALTON

NI 139 People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently

Baseline (2008 survey)	2009 - 10			2011	
	Target	Mid-year Actual	Progress	Target	Projected
30.4%	N/A	N/A	N/A	32.8%	N/A

Data Commentary

This is collected through the Place Survey carried out every 2 years. The next planned Place Survey is during the Autumn of 2010.

General Performance Commentary

Not applicable

Summary of key activities undertaken / planned during the year

Plans are being developed to carry out a brief survey of older people using existing networks to assess direction of travel. This survey will be carried out initially through Halton Older People's Empowerment Network (OPEN) and the five local participation groups. The next stage will be to get the question incorporated into existing service feedback forms. The first phase of this will be through Halton Borough Council's existing Lifeline service.

NI 142 Number of vulnerable people supported to maintain independent living

Baseline (2007/08)	2009 - 10			2011	
	Target	Mid-year Actual	Progress	Target	Projected
98.17%	98.69%	98.7%	✓	99.04%	?

Data Commentary

This report covers the periods 6th April to 5th July and 06th July to 4th of October 2009 and has been calculated as accumulated half year total. Data is actual with one service failing to submit for the 2nd quarter.

HEALTHY HALTON

General Performance Commentary

Whilst the individual target for older people's services has been reached there are a small number of clients who have moved into residential care services' as they have been unable to maintain their independence without more intensive support. The service for Teenage parents has not been consistent over the 6 month period measured. An action plan and meeting has been arranged to review performance of this service.

Summary of key activities undertaken / planned during the year

REPORT TO: Healthy Halton PPB

DATE: 12th January 2010

REPORTING OFFICER: Chief Executive

SUBJECT: Performance Management Reports for 2009/10

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To consider and raise any questions or points of clarification in respect of the 2nd quarter performance management reports on progress against service plan objectives and performance targets, performance trends/comparisons, factors affecting the services etc. for;

- Adults of Working Age
- Older People's and Independent Living Services
- Health & Partnerships

2.0 RECOMMENDATION: That the Policy & Performance Board;

1) Receive the 2nd quarter year-end performance management reports;

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

3) Highlight any areas of interest and/or concern where further information is to be reported at a future meeting of the Policy and Performance Board.

3.0 SUPPORTING INFORMATION

3.1 The departmental service plans provide a clear statement on what the services are planning to achieve and to show how they contribute to the Council's strategic priorities. The service plans are central to the Council's performance management arrangements and the Policy and Performance Board has a key role in monitoring performance and strengthening accountability.

3.2 The quarterly reports are on the Information Bulletin to reduce the amount of paperwork sent out with the agendas and to allow Members access to the reports as soon as they have become available. It also provides Members with an opportunity to give advance notice of any questions, points or requests for further information that will be raised to ensure the appropriate Officers are available at the PPB meeting.

4.0 POLICY IMPLICATIONS

There are no policy implications associated with this report.

5.0 OTHER IMPLICATIONS

There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

The quarterly performance monitoring reports demonstrate how services are delivering against the objectives set out in the relevant service plan. Although some objectives link specifically to one priority area, the nature of the cross-cutting activities being reported means that to a greater or lesser extent a contribution is made to one or more of the priorities listed below;

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**

6.6 **Corporate Effectiveness and Efficient Service Delivery**

7.0 RISK ANALYSIS

N/A

8.0 EQUALITY AND DIVERSITY ISSUES

N/A

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

Document	Place of Inspection	Contact Officer
N/A		

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Adults of Working Age**

PERIOD: **Quarter 2 to period end 30th September 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Adults of Working Age Department second quarter period up to 30 September 2009 It describes key developments and progress against all objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 6

2.0 KEY DEVELOPMENTS

Mental Health
Employment: the employment worker continues in post and has had some early success in finding employment placements for people with mental health problems. Richmond Fellowship have advertised for staff to support this process but have yet to appoint. Access to Work have been contacted and are interested in developing a project to develop support workers for people in employment with mental health needs.

Personalisation: an event has been arranged for senior managers in the 5BoroughsPartnership, along with commissioners and social care leads from St Helens, Knowsley and Warrington. This will take place in November 2009. The Planning Live process is taking place in mental health services which will take place shortly. With the aim of supporting 6 people with mental health needs to manage their own care and support. The Mental Health Outreach Team will be looking to train all its staff as Support Planners.

Mental Health Single Point of Access: some delays in delivery of this service by the PCT have occurred but a process is now in place. A Steering Group has been set up and it is planned that the service should be delivered by January 2010.

Care Programme Approach: this important policy and procedure – which applies across health and social care services, and which describes the process of care management in mental health services - was due for implementation by October 2008. The lead responsibility for delivering this policy rests with the 5BoroughsPartnership, and the Council continues to work closely with the 5Boroughs and other Local Authorities to deliver this.

Approved Mental Health Professionals: the 5Boroughs have now agreed that NHS staff should be put forward for AMHP training as appropriate. The details and processes of this are yet to be established.

Personalisation
A Transformation Team now lead and progress the personalisation agenda. The planning live programme has enabled 7 individuals across Adults with Learning Disabilities and Physical and Sensory Disabilities services (ALD & PSD) to receive an indicative allocation and support plan and this programme is about to be rolled out to mental health services. Physical and Sensory Disabilities are currently implementing the conversion of current direct payment recipients to an individual budget service.

ALD & PSD
We are currently working with out local GP's, Practice Nurses and Community Matron to establish a comprehensive and central register of all the people within the Borough who are identified as learning disabled and will require health screening and health action plans completing with the overall aim of improving the health and well-being of people locally.

We are currently reviewing and reassessing all people who have been placed out of area. The overall aim is to look at the qualitative aspects of service provision. This piece of work will enable us to quantify service deficits and proactively plan for the service and the individuals involved.

Transition co-ordinator has successfully secured funding to initiate a project which will allow young people to learn skills which are imperative in the work place which can be accredited and will result in increasing participation and sustainable employment.

3.0 EMERGING ISSUES

Mental Health
A project has been set up by the Commissioners of Mental Health Services across Halton, St Helens, Warrington and Knowsley, to review the purpose, functioning and operation of Community Mental Health Teams within the 5BoroughsPartnership. As Local Authority staff are fully involved in these teams through the integrated partnership, the Borough Council will be fully involved in this review.

In addition, a programme is being developed to review the service provided by the mental health outreach team. This is in the light of the changes to delivery of local mental health services, the developing personalisation agenda and the transfer of the Physical and Sensory Disabilities outreach service to the team. A review specification is being developed and this will be completed by March 2010.

PSD & ALD
PSD & ALD are currently piloting a joint integrated assessment team based within the Contact Centre. A Social Worker and a Community Care Worker on a rota basis daily resource the team. All workers have been trained on Carefirst six. This pilot will enable the teams to identify issues and contribute to the development of the programme prior to its rollout across other service areas.

A tri partite collaboration between Halton Borough Council, Halton and St Helens PCT and St Helens Metropolitan Borough Council have successfully become a demonstration site for a Housing and Social Inclusion project. The partners believe that local arrangements can be developed to meet the needs of many people currently placed out of area and are keen to facilitate repatriation including pathways to more specialist support and to promote independence and social integration.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**16**		**16**		**0**		**0**

All milestones are making satisfactory progress

5.0 SERVICE REVIEW

Nothing to report in this quarter

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**9**		**8**		**0**		**1**

In most cases most PIs are meeting target although one is expected not to unless further progress is made before year end

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**7**		**6**		**1**		**0**

In most cases most PIs are meeting target although and one is expected make further progress is made before year end

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.
There were no risk control measures identified

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4. Please refer to Appendix 4

9.0 DATA QUALITY

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress Against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4- Progress against High Priority Equality Actions
Appendix 5- Financial Statement
Appendix 6- Explanation of traffic light symbols

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
AWA 1	**Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for Adults of Working Age**	• *Contribute to the safeguarding of vulnerable adults and children in need, by ensuring that staff are familiar with and follow safeguarding processes* ***Mar 2010.*** *(AOF6)*		Joint training day for managers of Mental Health services and Childrens services planned. Action plan making good progress
		• *Person Centred reviews for adults with PMLD, to be implemented in ALD Care Management and influencing strategic commissioning to enhance service delivery* ***Mar 2010.*** *(AOF7)*		There is an identified Social Worker leading on Person Centred Reviews for people attending day services at Pingot with Profound Multiple Learning Disabilities in conjunction with 5BP and a Speech And Language Therapist in order to achieve better outcomes for people who historically have challenged services.
		• *Redesign the Supported Housing Network to meet the needs of those with the most complex needs* ***Mar 2010.*** *(AOF6 & 7)*		With the implementation of 'active support' a system devised by Dr Sandy Too good a behavioural analyst, the service continues to improve tenants' lives developing a wider range of activities and an increase in social inclusion. Staff complete weekly records of participation for indoor/outdoor activities and community presence. Each tenant has his or her own activity

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
				support plan. Tenants are able to participate with activities in their own home i.e. laundry, preparing meals, weekly tasks etc. We continue to use the person centred approach offering choice and empowering tenants. The interactive training being completed with Esther Gibbons the Network and Day Services has given the staff more insight to what those with complex needs are trying to communicate. When this work is complete, all tenants will have care plan to show how people communicate at the very least their likes and dislikes.
		• Analyse the impact of Valuing People Now on service delivery to ensure that services met the needs and improve outcomes for people with LD **Mar 2010** (AOF 6 & 7)		Peoples Cabinet established, increasing participation of people with learning disabilities. Annual report of Partnership Board due to be submitted March 2010.
		• Implement strategy to deliver improved services to younger adults with dementias **Mar 2010** (AOF 6)		The dementia strategy has been developed and has incorporated all the recommendations arising from the review of services for younger adults with dementia earlier this year. An action plan will be developed to implement this.
		• *Fully implement the Volunteer Strategy to ensure appropriate volunteering opportunities are available **Mar 2010** (AOF6)*		Executive Board to consider strategy for approval November 2009. Halton Voluntary Action to appoint coordinator.

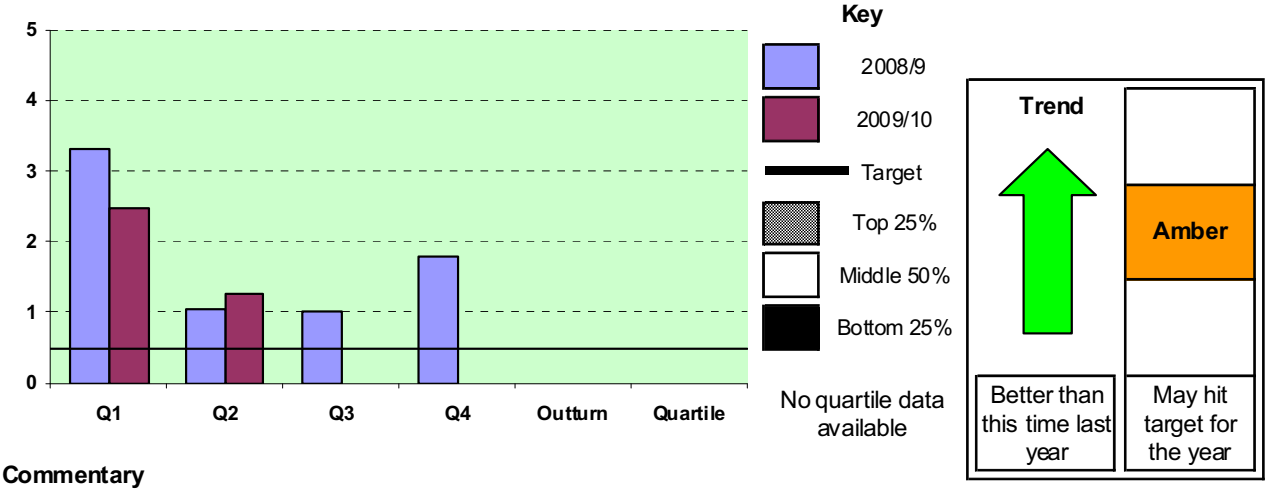
Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		• Review implementation of Mental Health Act 2007 to ensure all policies, procedures and processes are fit for purpose **Oct 2009** (AOF 6)		All comments and proposals for amendments to the Mental health Act policies and procedures have now been received. Policies are currently being amended.
		• *Review key partnership working arrangements and associated structures to ensure that they are fulfilling service delivery requirements **Mar 2010** (AOF 7)*		Mental Health Partnership has undergone extensive revision and a new draft will be taken to the executive Board for consideration and approval.
		• Implement agreed recommendations of review of services and supports to children and adults with Autistic Spectrum Disorder **Mar 2010** (AOF 6)		Draft Training strategy drawn up to provide training on a multi agency basis.
		*Continue to implement a behaviour solutions approach to develop quality services for adults with challenging behaviour - Models of good practice to be developed **Mar 2010.** (AOF7)*		A business case to secure three year funding for a specialist challenging behaviour support service has been completed and is due for submission December 2009. The proposed service will be available to support mainstream services in working with people with learning disability and/or autism whose behaviour is a significant challenge for services.
AWA 2	**Effectively consult and engage with Adults of Working Age to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required**	• *Review key partnership working arrangements and associated structures to ensure that they are fulfilling service delivery requirements **Mar 2010** (AOF 7)*		Review continues, Healthy Halton PPB received report in Sept. 2009 showing good performance in Emergency Duty Team.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		• Review implementation of Mental Health Act 2007 to ensure all policies, procedures and processes are fit for purpose **Oct 2009** (AOF 6)		See above.
		• Implement agreed recommendations of review of services and supports to children and adults with Autistic Spectrum Disorder **Mar 2010** (AOF 6)		See above, good progress is being made
		Continue to implement a behaviour solutions approach to develop quality services for adults with challenging behaviour - Models of good practice to be developed ***Mar 2010.*** *(AOF7)*		A business case to secure three year funding for a specialist challenging behaviour support service has been completed and is due for submission December 2009. The proposed service will be available to support mainstream services in working with people with learning disability and/or autism whose behaviour is a significant challenge for services.
AWA 3	**Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs**	*Review key partnership working arrangements and associated structures to ensure that they are fulfilling service delivery requirements and are being managed in a cost effective way* ***Mar 2010.***		See above, good progress is being made

AWA LI4

Percentage of adults assessed in year where ethnicity is not stated

Lower figures represent better performance



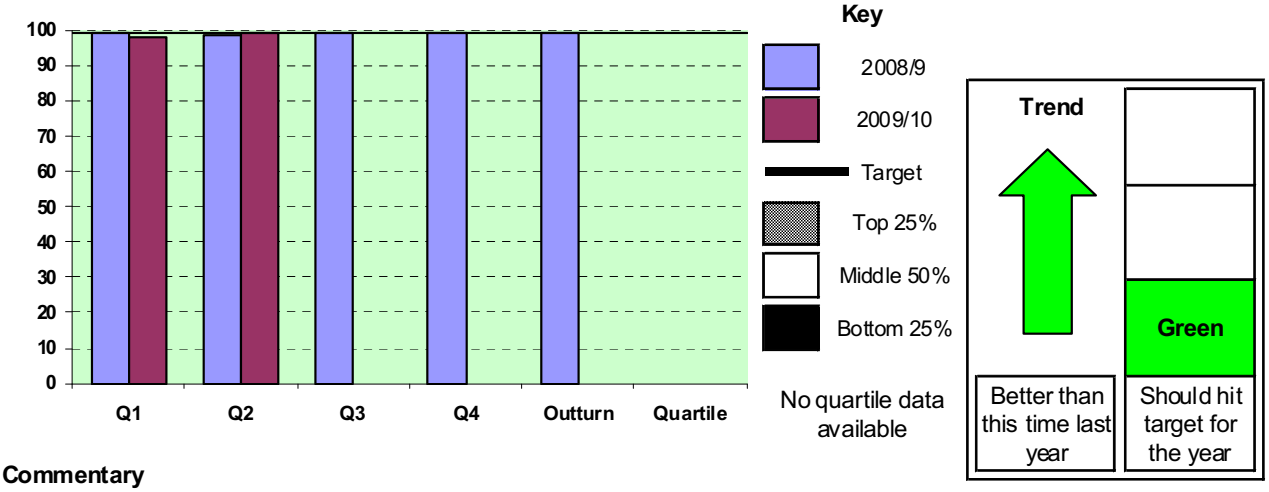
Commentary

Out of 722 assessments this year 9 clients do not have an ethnicity recorded. In order to ensure the target will be met at year end monthly exception reports of unknown ethnicity ate sent to operational teams to action.

AWA LI8

Percentage of people receiving a statement of their needs and how they will be met.

Higher figures represent better performance



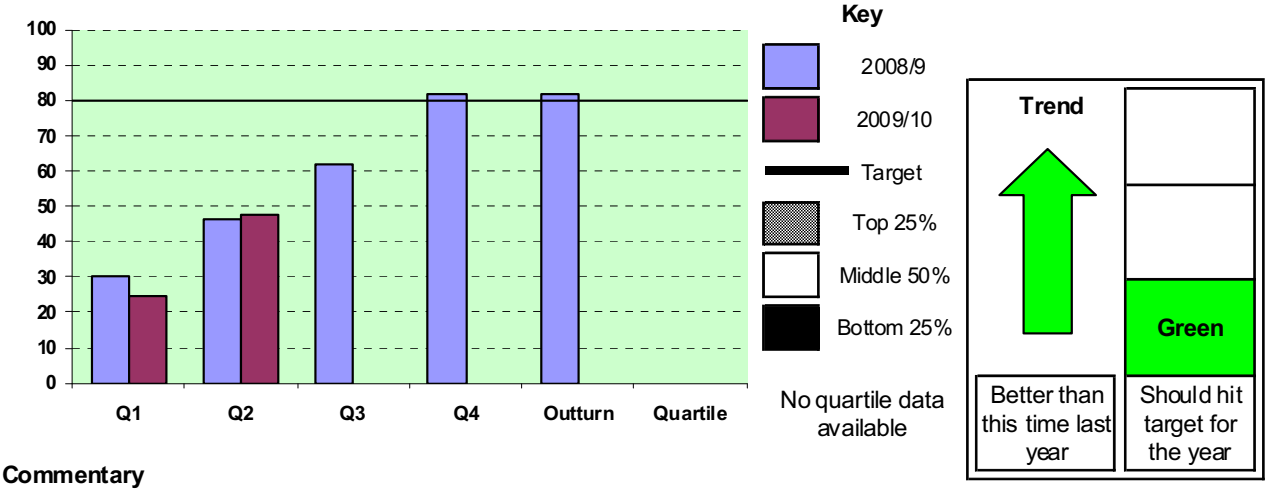
Commentary

99.23% of people in receipt of repairs of services have been given a statement of their needs and how they will be met. Target already acheived, however monthly exception reports are still produced for operational teams to action of those clients who are not in receiept of a statement of their needs.

AWA LI9

Clients receiving a review as a % of adult clients receiv)ng a service (cost effectiveness PSA Target)

Higher figures represent better performance



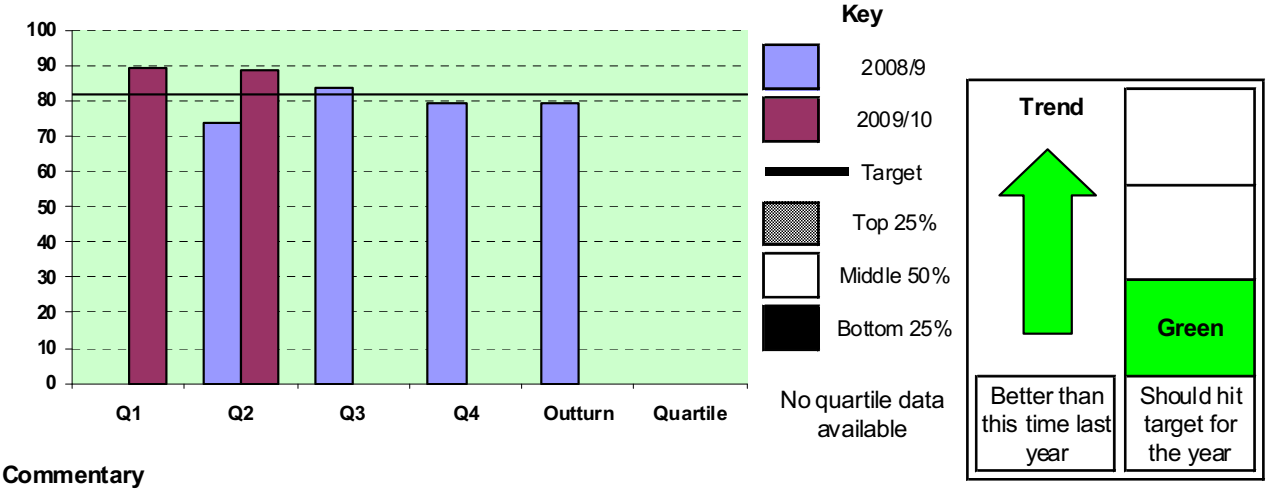
Commentary

47.93% of clients receiving services have been reviewed so far. In order to ensure the target will be met at year end, monthly exception reports of outstanding reviews are sent to operational teams to action.

AWA NI 132

Timeliness of social care assessment DH DSO

Higher figures represent better performance



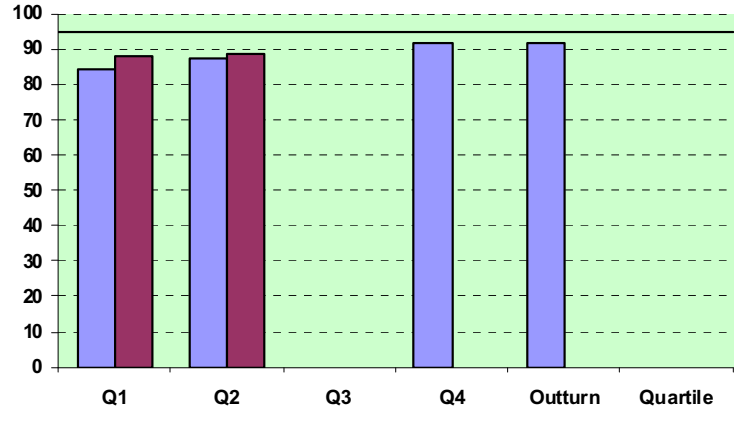
Commentary

Target exceeded. Final year end figure is determined by a file check which is ongoing.

AWA NI 133

Timeliness of social care packages DH DSO

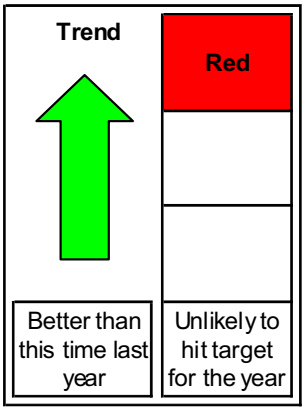
Higher figures represent better performance



Key

- 2008/9
- 2009/10
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available



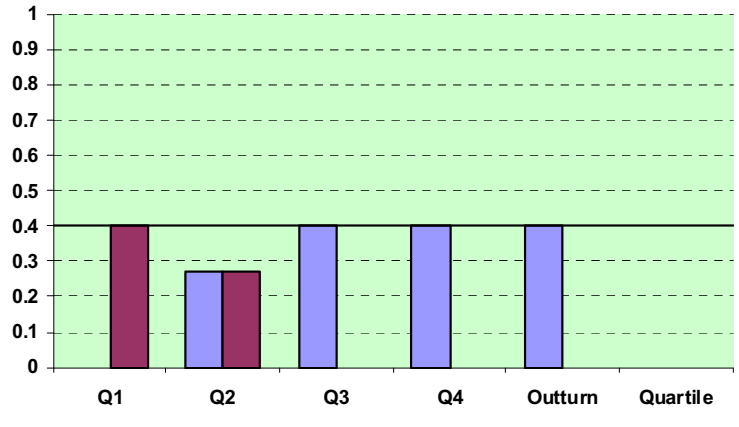
Commentary

Final year end figure is determined is determined by a file check which is ongoing

AWA LI10

Admissions of Supported Residents aged 18-64 into residential/nursing care

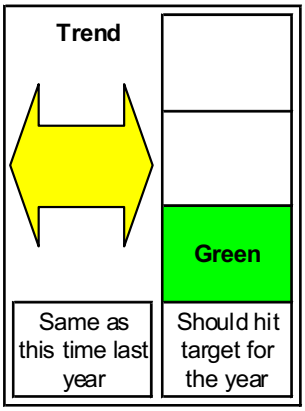
Lower figures represent better performance



Key

- 2008/9
- 2009/10
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available



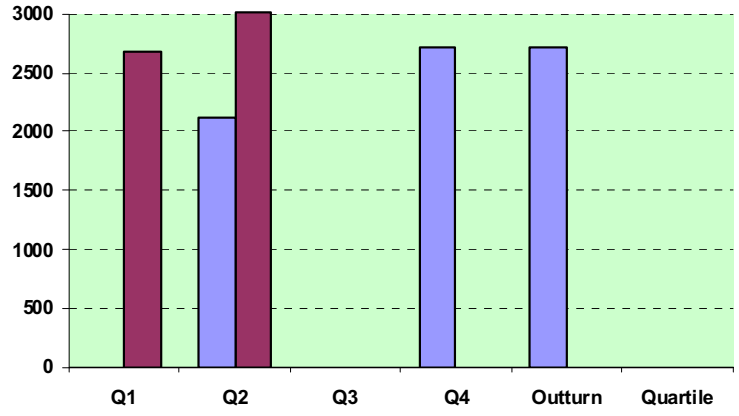
Commentary

1 person admitted to permanent residential/nursing care this year. Target equates to 3 people.

AWA NI 136

People supported to live independently through social services (all ages) PSA 18

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Better than this time last year

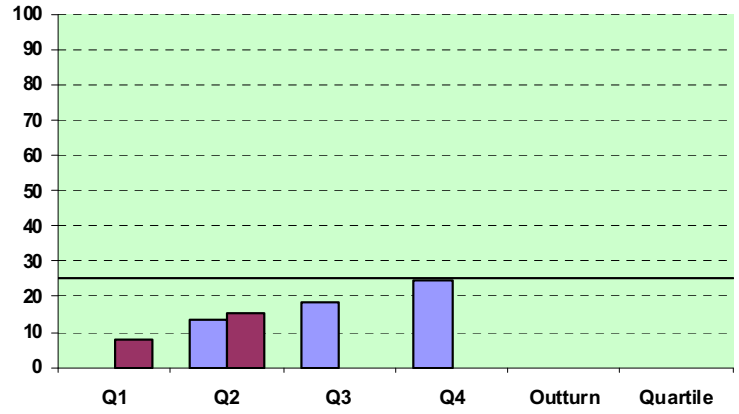
Commentary

Q2 performance has increased from Q1 performance. Helped to live at home continues to to be good. No target has been set for 2009/10 therefore ca traffic light indicator cannot be allocated.

AWA NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

Same as this time last year

Should hit target for the year

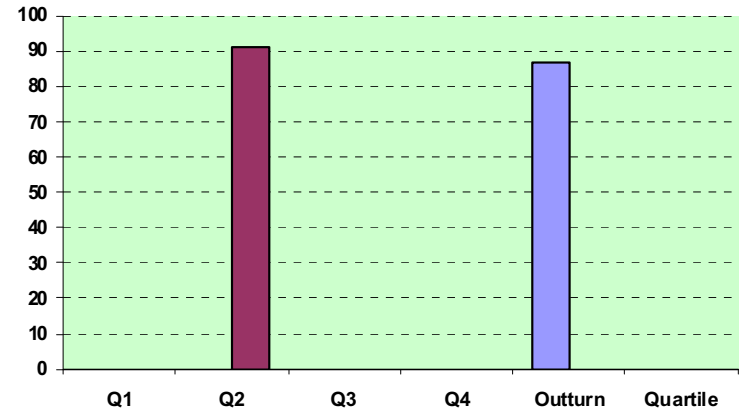
Commentary

To date 611 carers have received an assessment/review and a specific carers service, or advice and information. Exception reports are produced on a monthly basis of carers who have not yet received an assessment/review but have had a service for operational teams to action.

NI 145

Adults with learning disabilities in settled accommodation PSA 16

Higher figures represent better performance



Key

- 2008/9
- 2009/10
- Target
- Top 25%
- Middle 50%
- Bottom 25%

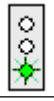
No quartile data available

Trend

No data for same Qtr last year	Should hit target for the year
	Green

Commentary

We continue to map current activity and analyse performance, barriers and progress in order to improve this target

Ref.	Description	Actual 2008/09	Target 20091/0	Quarter 2	Progress	Commentary
Cost & Efficiency						
AWA LI 1	% of client group expenditure (MH) spent on domiciliary care services	16		25	N/A	All invoices relating to creditors have been received; the % split should increase slightly each quarter. The realisation of Continuing Health Care & Homecare retender is still distorting figures and will be monitored.
AWA LI 2	% of client group expenditure (ALD) spent on domiciliary care services	38		33	N/A	All invoices relating to creditors have been received; the % split should increase slightly each quarter. The realisation of Continuing Health Care & Homecare retender is still distorting figures and will be monitored.
AWA LI 3	% of client group expenditure (PSD) spent on domiciliary care services	34		24	N/A	All invoices relating to creditors have been received; the % split should increase slightly each quarter. The realisation of Continuing Health Care & Homecare retender is still distorting figures and will be monitored.
Fair Access						
AWA LI 4	Percentage of adults assessed in year where ethnicity is not stated Key threshold < 10%	1.8	0.5	1.25		Out of 722 assessments this year 9 clients do not have ethnicity recorded. In order to ensure the target will be met at year end monthly exception reports of unknown ethnicity are sent to operational teams to action.
AWA LI 5	Number of learning disabled people helped into voluntary work in the year	56	43	30		30 learning disabled people have been helped into voluntary work in the year. In order to achieve the target at year end, a further 13 clients are required.
AWA LI 6	Number of physically disabled people helped into voluntary work in the year	14	5	2		2 physically disabled people have been helped into voluntary work in the year. In order to achieve the target at year end, a further 3 clients are required.
AWA LI 7	Number of adults with mental heath problems helped into voluntary work in the year	8	17	3		3 adults with mental health problems have been helped into voluntary work in the year. In order to achieve the target at year end, a further 14 clients are required.
Quality						
AWA LI 8	% of people receiving a statement of needs and how they will be met	99	99	99.28		99.23% of people in receipt of services have been given a statement of their needs and how they will be met. Target already achieved, however monthly exception reports are

Ref.	Description	Actual 2008/09	Target 20091/0	Quarter 2	Progress	Commentary
						still produced for operational teams to action of those clients who are not in receipt of their statement of needs
AWA LI 9	Clients receiving a review as a % of adult clients receiving a service	81.65	80	47.93		47.93% of clients receiving services have been reviewed so far. In order to ensure the target will be met at year end, monthly exception reports of outstanding reviews are sent to operational teams to action.
NI 132	Timeliness of Social Care Assessment	79.2	82	88.78		Target exceeded. Final year end figure is determined by a file check which is ongoing.
NI 133	Timeliness of Social Care packages (Former BVPI 196)	91.7	95	88.75		Final year end figure is determined by a file check which is ongoing. However given present rates of performance it is not expected that the target will be achieved.
Service Delivery						
AWA LI 10	Admissions of Supported Residents aged 18-64 into residential/nursing care	0.4	0.4	0.27		1 person admitted to permanent residential/nursing care this year. Target equates to 3 people.
AWA LI 11	Adults with physical disabilities helped to live at home	8.11	8	7.91		7.91 people per 1000 population helped to live at home. This equates to 595 clients and in order to ensure the target is met at year end a further 10 clients are required.
NI 136	People supported to live through independent care services	2714		3018	N/A	Q2 performance has increased from Q1 performance. Helped to live at home continues to be good. No target has been indicated for 2009/10 therefore a traffic light indicator cannot be allocated.
AWA LI 12	Adults with learning disabilities helped to live at home	4.39	4.3	4.12		4.12 people per 1000 population helped to live at home. This equates to 310 clients and in order to ensure the target is met at year end a further 15 clients are required.

Ref.	Description	Actual 2008/09	Target 20091/0	Quarter 2	Progress	Commentary
AWA LI 13	Adults with mental health problems helped to live at home	3.5	3.75	3.61		3.61 people per 1000 population helped to live at home. This equates to 272 clients and in order to ensure the target is met at year end a further 11 clients are required.
NI 131	Delayed transfers of care		25	NYA	NYA	Data derived from NHS which is not yet available
NI 135	Carers receiving Needs Assessment or Review and a specific Carer's Service, or advice and information	24.95	25	15.22		To date 611 carers have received an assessment/review and a specific carers service, or advice and information. Exception reports are produced on a monthly basis of carers who have not yet received an assessment/review but have had a service for operational teams to action.
NI 145	Adults with Learning Disabilities in Settled accommodation	86.6%	90%	91.3%		We continue to map current activity and analyze performance, barriers and progress in order to improve this target.
Area Partner National Indicators: **Th indicators below form part of the new National Indicator Set introduced on 1st April 2008. Responsibility for setting the target, and reporting performance data, will sit with one or more local partners. As data sharing protocols are developed baseline information and targets will be added to this section**						
NI 129	End of life access to palliative care enabling people to choose to die at home		20.7	25.2		The PCT IS in the process of employing an EOL facilitator to roll out tools such as GSF, PPC and LCP across Halton and St Helens and is also working with our genera. practices in regards to implementation of GSF which would also compliment and address patient preferences, this particular piece of work is being taken through the CSP palliative care working group.
NI 149	Adults in contact with secondary mental health services in settled accommodation					Data derived from health, not yet available.

Policy/Service	HIGH Priority Actions	Target	Progress	Commentary
Housing	Private Sector Housing Conditions survey to be carried out, with resulting data disaggregated and analysed for race and disability	March 2010		Survey fieldwork completed. Final report expected Jan 2010. On target to produce data by financial year end.
Business Support	Collection and analysis of biannual service user survey, disaggregated by equality strand	March 2010		Completed.
Service Planning	Carry out a consultation and scoping project to identify LGBT carers and potential carers to identify any specific needs not currently addressed, ensuring that services are responsive to needs	March 2010		LGBT survey completed no replies received. Survey sent to 130 people in Halton - that were members of an LGBT magazine.
Older People's Services	Appointment of a Dignity Coordinator to drive the agenda forward in relation to older people in health and social care settings	March 2010		Coordinator in post. Action plan completed.
Housing	Private Sector Housing Conditions survey to be carried out, with resulting data disaggregated and analysed for race and disability	March 2010		Survey fieldwork completed. Final report expected Jan 2010. On target to produce data by financial year end.

HEALTH & COMMUNITY – ADULTS OF WORKING AGE (ALD, MH, PSD)

Revenue Budget as at 30th September 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Staffing	3,409	1,638	1,620	18	1,651
Premises	197	97	96	1	96
Other Premises	66	29	28	1	40
Joint Equipment Service	231	93	93	0	0
Supplies & Services	336	140	137	3	137
Food Provisions	9	5	2	3	2
Aid & Adaptations	113	35	59	(24)	81
Transport of Clients	633	236	233	3	316
Departmental Support Services	1,089	0	0	0	0
Central Support Services	412	14	14	0	14
Contract & SLAs	915	434	416	18	483
Emergency Duty Team	95	18	18	0	18
Community Care:					
Residential Care	921	390	408	(18)	408
Home Care	737	312	290	22	290
Direct Payments	659	357	413	(56)	413
Supported Living	60	28	12	16	12
Day Care	26	12	4	8	4
Unallocated Grants	91	0	0	0	0
Asset Charges	203	0	0	0	0
Contribution to ALD Budget	6,961	2,854	2,805	49	2,858
Total Expenditure	**17,163**	**6,692**	**6,648**	**44**	**6,823**
Income					
Residential Fees	-135	-57	-40	(17)	-40
Fees & Charges	-151	-70	-81	11	-81
Preserved Rights Grant	-92	-79	-79	0	-79
Supporting People Grant	-371	-166	-166	0	-166
Mental Health Grant	-500	-250	-250	0	-250
Carer Grant	-517	-259	-259	0	-259
Mental Capacity IMCA Grant	-85	-43	-43	0	-43
Aids Support Grant	-5	-5	-11	6	-11
Local Involvement Network Grant	-110	-55	-55	0	-55
Community Roll Out Funding	-75	-25	-25	0	-25
Tobacco Control Grant	-100	-100	-100	0	-100
PCT Reimbursement	-503	-130	-134	4	-134
Other Income	-7	-3	0	(3)	0
Total Income	**-2,651**	**-1,242**	**-1,243**	**1**	**-1243**
Net Expenditure	**14,512**	**5,450**	**5,405**	**45**	**5,580**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 2 is over budget profile by £4k excluding the ALD pool budget.

Staff costs at the mid point of the financial year are less than expected due to a number of vacancies relating to front line staff within the departments particularly within PSD services. Many of these posts will be appointed to in the coming months so the staffing budget is not expected to under spend significantly at year end.

The community care budget for service users with mental health needs and physical & sensory disabilities as a whole, including associated fees and charges is £34k over budget. There has been a slight increase during the second quarter on related expenditure compared to the first 3 months of the financial year, due to a rising number of referrals with some high cost mental health packages agreed for quarter 3. The budget will continue to be scrutinised throughout the remainder of the year particularly with the introduction of personalised budgets.

Other pressures are noted for the aids and adaptations budget as more service users are supported enabling them to stay in their own homes.

Note: A summary of the H.B.C. Contribution to ALD Pooled Budget can be found on the following page:

HEALTH & COMMUNITY – ADULTS WITH LEARNING DISABILITIES

Contribution to ALD Pooled Budget

Revenue Budget as at 30th September 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Residential Care	1,359	575	436	139	436
Supported Living	2,110	1,015	970	45	1,004
Home Care	1,432	606	596	10	596
Direct Payments	526	263	407	(144)	407
Day Services	1,866	865	846	19	846
Specialist LD Team	553	276	312	(36)	312
Management Costs	1,179	86	84	2	84
Respite	361	136	129	7	148
Other Expenditure	149	47	47	0	47
Total Expenditure	**9,535**	**3,869**	**3,827**	**42**	**3,880**
Income					
Rents & Service Charges	-28	-7	-6	(1)	-6
Community Care Fees	-72	-33	-42	9	-42
Residential Fees	-125	-58	-55	(3)	-55
Direct Payments	-35	-18	-25	7	-25
Supporting People Grant	-1081	-541	-543	2	-543
Preserved Rights Grant	-374	-157	-156	(1)	-156
Campus Closure Grant	-57	-57	-57	0	-57
LDDF	-149	-74	-74	0	-74
CITC – Astmoor	-53	0	0	0	0
PCT Income	-79	0	0	0	0
CHC – PCT Reimbursement	-362	-2	-1	(1)	-1
Other Fees & Charges	-159	-68	-63	(5)	-63
Total Income	**-2,574**	**-1,015**	**-1,022**	**7**	**-1,022**
Net Expenditure	**6,961**	**2,854**	**2,805**	**49**	**2,858**

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 30th September 2009

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Diet & Exercise Programme	23	11	0	11	0
Vulnerable Adults Task Force	100	51	87	(36)	89
Vol. Sector Counseling Proj	41	20	13	(7)	13
Info. Outreach Services	35	18	9	9	9
Reach for the Stars	36	18	8	10	8
Complementary Therapies	21	10	0	10	0
Capacity Building	58	29	14	15	14
Dignity	53	26	0	26	0
Priority 4 Employment Learning & Skills					
Voluntary Sector Sustainability	7	3	0	3	0
LSP TEAM					
Unallocated Funds	59	30	0	30	0
Total Expenditure	**433**	**216**	**131**	**71**	**133**

Adults of Working Age

Capital Budget as at 30th September 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
PODS utilising DFG	17	0	0	17
Mental Health Centre	115	0	112	3
Total Spending	**132**	**0**	**112**	**20**

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage, due to a lack of information or a key milestone date being missed, whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Older People's Services**

PERIOD: **Quarter 2 to period end 30th September 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Older People's Services Department second quarter period up to 30 September 2009 It describes key developments and progress against all objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 6

2.0 KEY DEVELOPMENTS

The early invention and prevention strategy is currently being developed, base line assessment completed and steering group established.

Implementation of the dignity agenda in progress. Dignity in Care Action Plan completed - approved by SMT. The Action Plan will now be presented to the Halton Dignity Champions' Network, Older People's Local Implementation Team, Safeguarding Adults Board and other key stakeholders i.e. PCT, hospitals, 5BPT, care providers. The implementation of the action plan will be across the whole system.

The first draft of the local Dementia strategy has been completed, to be presented to PCT management team and SMT.

The Community Extra Care Evaluation completed, the future service development work plan in relation to this has also been completed.

Both the local authority and PCT have now agreed the Virtual Ward proposal. The PCT has identified the funding required to establish the ward including the funding for the additional staff.

The PBC is now funding the manager of the SCIP service, which places social care staff in the Runcorn primary care practices. A more comprehensive evaluation tool has been developed to determine the range of qualitative and quantitative outcomes for service users. This evaluation will continue until February 2011 and will form the basis of the decision of the longer term future of the service.

Funding for the 50:50 Partnership Agreement with the RSLs, to provide home adaptations, has been agreed for 2009/10 and the Partnership Agreement has been revised to include stair lifts. The number of RSLs participating in the agreement has increased from 7 to 10, and the budget is on target for full spend.

Funding has been secured through the Department of Communities and Local Government to introduce a handyperson service. The model of provision has been developed. The handyperson post has been advertised. Consultation about charging arrangement is to be undertaken.

Ten days input from National Energy Action (NEA) has been secured to enable HBC to develop an Affordable Warmth Strategy. A steering Group has been established and 2 consultation events planned.

3.0 EMERGING ISSUES

The review of Palliative Care and End of Life services within the PCT is still ongoing, in the interim the PCT has agreed to fully fund the domiciliary End of Life service that our in house provider delivers on their behalf. This arrangement will continue until the final outcome of the review, including the future model of care, is determined.

Following the integration of the Assessment Service, the Home Improvement Agency and the Grants Section into the Halton Home Improvement and Independent Living Service a business case for the whole service is being developed to cover the period 2009-12.

Further staff are to be recruited to the Adult Placement Service in order to expand the range of provision.

Contingency plans have been developed for Swine flu in partnership with the PCT.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**15**		**13**		**2**		**0**

The majority of objectives/milestones are on target but where this is not the case this has been caused by unavoidable delays

5.0 SERVICE REVIEW

Environmental improvement work in Oakmeadow continues and is in the 2nd phase, which includes improvements to the internal fabrics of the building. The installation of an integrated electronic Care Monitoring/Call system will be completed by December 2009.

Implementation of the review of the new Reablement service will be completed on target within this financial year.

The review and development of restaurant provision at Dorset Gardens has been completed ahead of schedule and will be fully implemented by October 2009.

An initial review of Older People's Community Mental Health Team (OPCMHT) has been completed and plans are in place to enhance the service in partnership with the 5BP. Additional social work capacity will be in place by March 2010. This review has taken place as part of the overall review of mental health services for older people and ensures that the new Assessment Care and Treatment Service team will has clear pathways into the OPCMHT.

5 Satellite units in the community have been developed to provide a range of day service activities and a programme of consultation has been completed as part of a review of future day service provision.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**8**		**7**		**1**		**0**

The majority of KPIs are on target. Where reported data suggests that this is unclear work is being undertaken in order to report improved performance in Quarter 3.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**5**		**3**		**2**		**0**

In some instances no data was available for Quarter 2.
The majority of indicators which have been reported are on target. Where this is unclear action is being taken to improve performance.

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4. Please refer to Appendix 4.

9.0 DATA QUALITY

The author provides assurances that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

10.0 APPENDICES

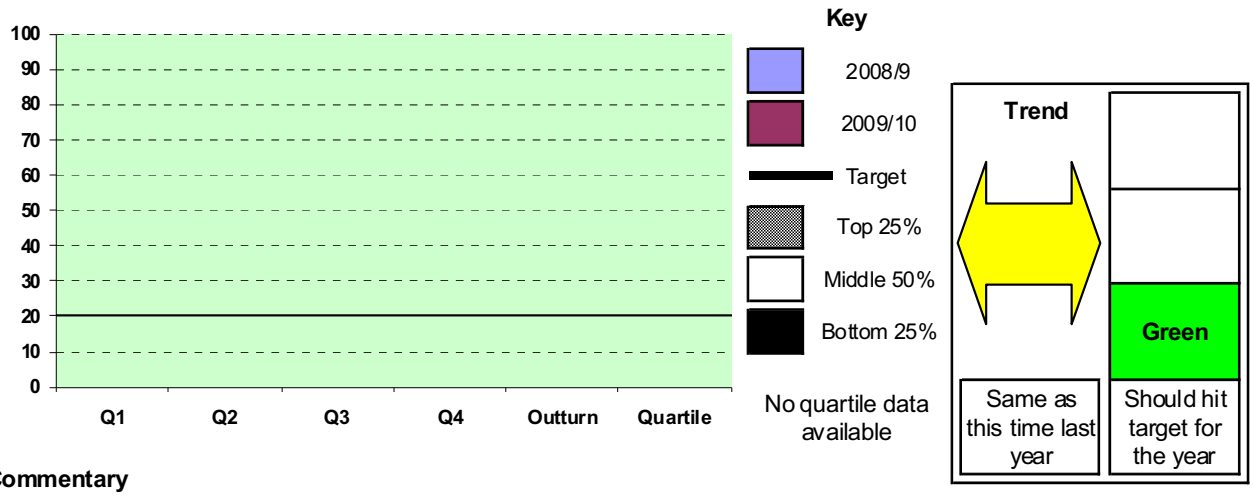
Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4- Progress against High Priority Equality Actions
Appendix 5- Financial Statement
Appendix 6 - Explanation of traffic light symbols

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
OPS 1	Evaluate, plan, commission and redesign services to ensure they meet the need of vulnerable people within the local population, including those from hard to reach group (including the black and minority ethnic community)	Commission specialist housing provision for older people with higher levels of need **Mar 2010.** (AOF6 & 7).		Some delay on extra care decisions, should be resolved in quarter 3
		Implement of the Gold Standard and Performance Management Framework for Intermediate Care **Apr 2009** (AOF 6 &7)		Completed on target
		Increase the numbers of carers provided with assessment leading to the provision of services, to ensure Carers needs are met **Mar 2010.** (AOF7)		On target
		Maintain the number of carers receiving a carers break, to ensure Carers needs are met **Mar 2010.** (AOF7)		On target
		Comprehensive pathways for using transitional care within Halton are in place **Mar 2010** (AOF 6 &7)		Service development officer has been allocated to ensure that pathways are in place within the agreed time scales
		Intergenerational activities project established as part of the review on early intervention and prevention aimed at improving outcomes for Older People **June 2009** (AOF 6 &7)		Wide range of intergenerational activity now taking place in Halton, delivered through Community Development Team. Specific work has taken place in Castlefields and plans are in place for six localities to carry out intergenerational Halloween events.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Review of Long Term Conditions and Therapy services commissioned jointly with NHS Halton and St Helens **Apr 2009** (AOF 6 &7) NB. Deadline dependent on contribution from the Primary Care Trust		Final draft report now available. Business case for future service to be developed by December 2009.
		Agreement with the PCT on the responsibility for Medication Prompts in place **Sept 2009** (AOF 7)		Agreement with the PCT for joint responsibility has been progressed. However implementation of the project is slightly delayed due to pressures within the PCT in relation to Swine Flu. The Northwest Medicines Management Network have been contacted to support this work programme.
OPS 2	Effectively consult and engage with older people to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required	Review local arrangements for continuing health care following National Review **Apr 2009** (AOF 2&7) NB. Dependent on National Review being completed to timescale of Jan 2009		Complete
		Implement revised Joint Commissioning Strategy for Older People **March 2010** (AOF 2&7)		Strategy Complete. Implementation plan on target
		Evaluate joint service developed with Runcorn PBC **Mar 2010** (AOF 2&4)		Evaluation completed, service now extended until 2011. Therefore an additional period of evaluation will be undertaken.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		As part of the review on early intervention and prevention aimed at improving outcomes for Older People, develop a meaning engagement strategy with Service Users **June 2009** (AOF 7)		On Target, however timescale reviewed to Dec 09
		Establish Social Care element of the 'Virtual Ward' established with Widnes PBC **March 2010** (AOF 2)		On target for completion, social care component will be fully operational within the agreed time scales of March 2010
OPS 3	Ensure that there are effective processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet peoples needs	Analyse need and submit bids to DOH, Housing Corporation or other pots for at least one extra care development to provide additional extra care tenancies in Halton **Mar 2010.** AOF 6&7)		Work progressing with RSL's to develop a number of sites across Halton. Potential for two bids to be submitted to the HCA by March 2010.
		Implement new residential and domiciliary care contracts for older peoples services Sept 2009 (AOF 6&7)		Complete.

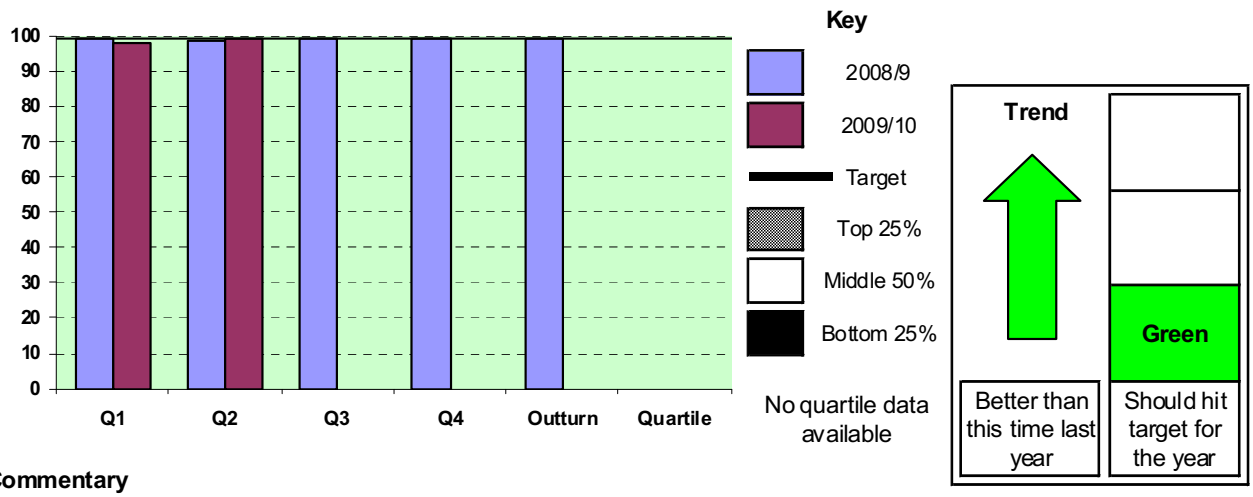
OP LI3 **Unit cost of home care for adults and older people**



Commentary

There have been no re-imbursable delays during this period

OP LI7 **Percentage of people receiving a statement of their needs and how they will be met.**

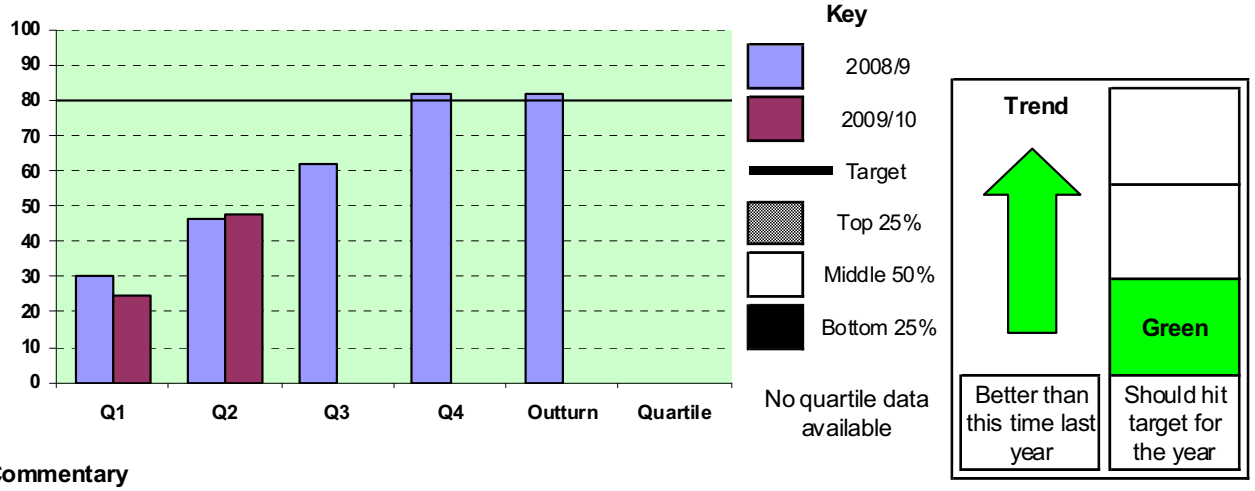


Commentary

99.23% of people in receipt of services have been given a statement of their needs and how they will be met. Target already achieved, however, monthly exception reports are still produced for operational teams to action of those clients who are not in receipt of their statement of needs.

OP LI8

Clients receiving a review as a %age of adult clients receiving a service



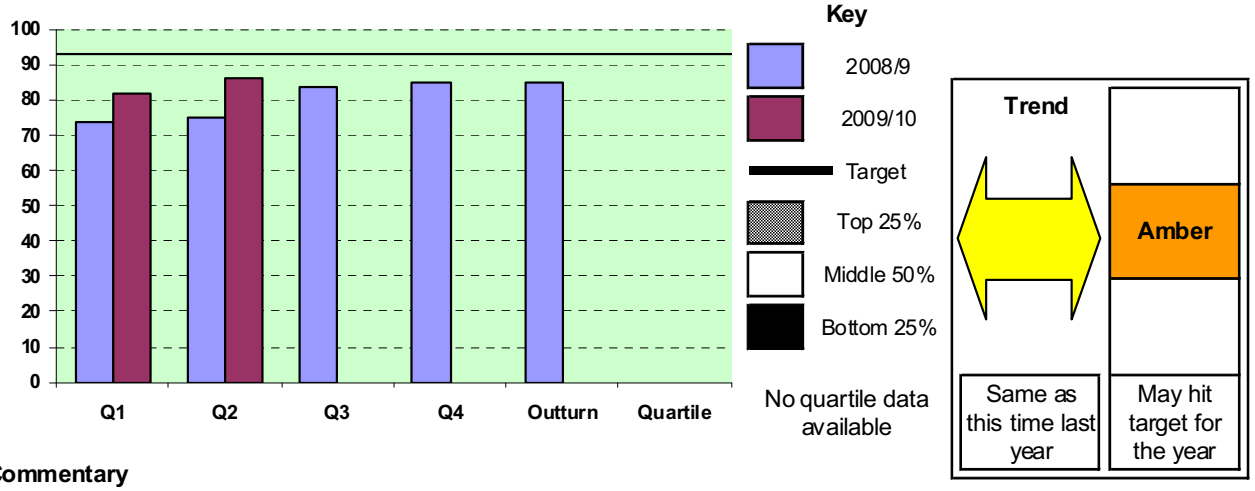
Commentary

47.93% of clients receiving services have been reviewed so far. In order to ensure the target will be met at year end, monthly exception reports of outstanding reviews are sent to operational teams to action.

OP LI9

Percentage of items of equipment delivered within 7 working days

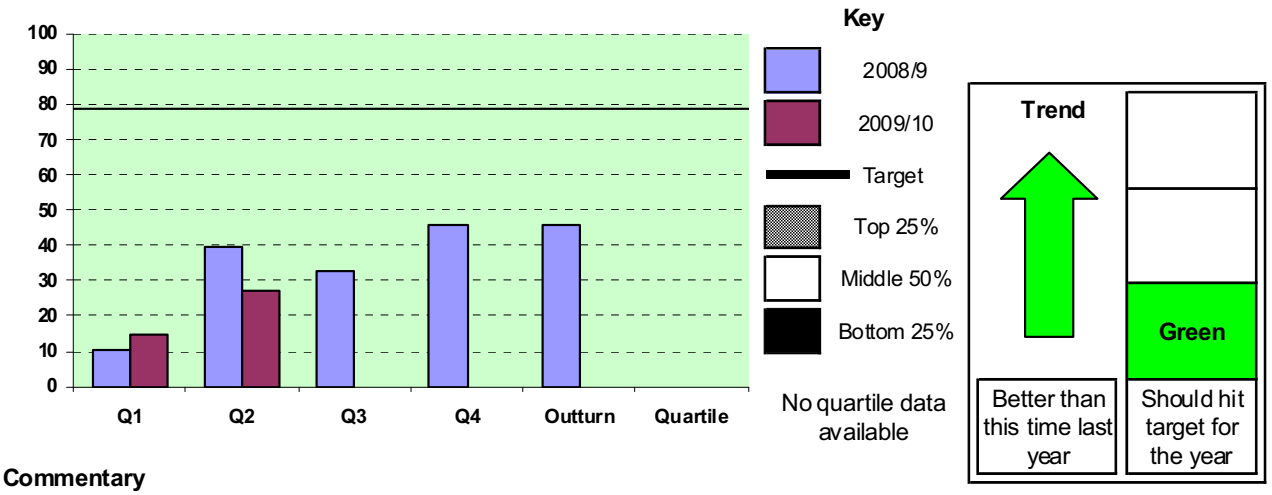
Higher figures represent better performance



Commentary

Work being undertaken with minor adaptations to validate the figures. Indicator value may be subject to change.

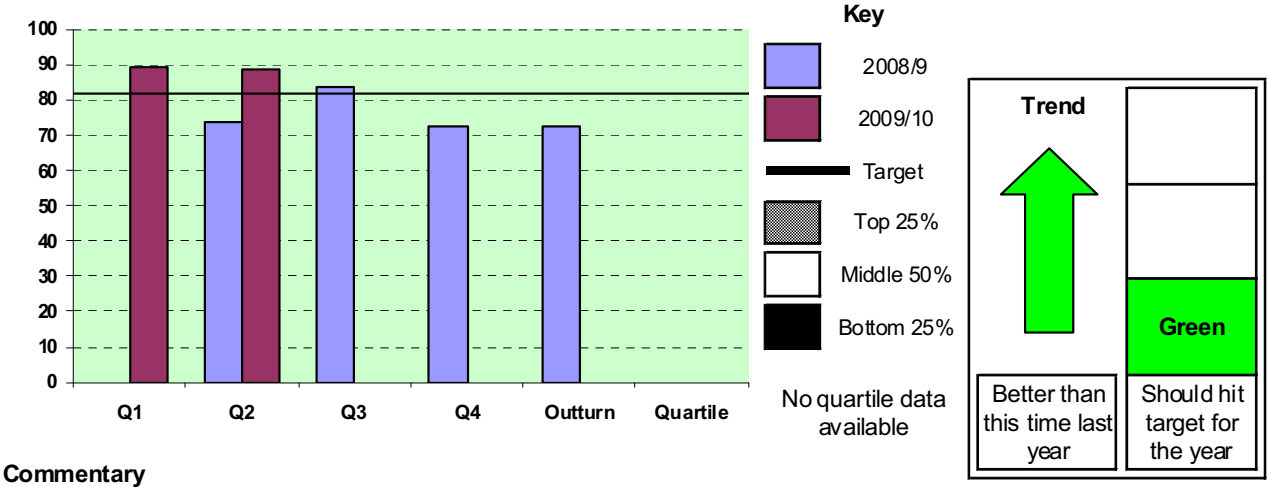
OP LI10 **Admissions of supported residents aged 65+ to permanent residential/nursing care (per 10,000 population)**



Commentary

To date, 45 older people have been admitted to permanent residential and nursing care. All clients are allocated a single room.

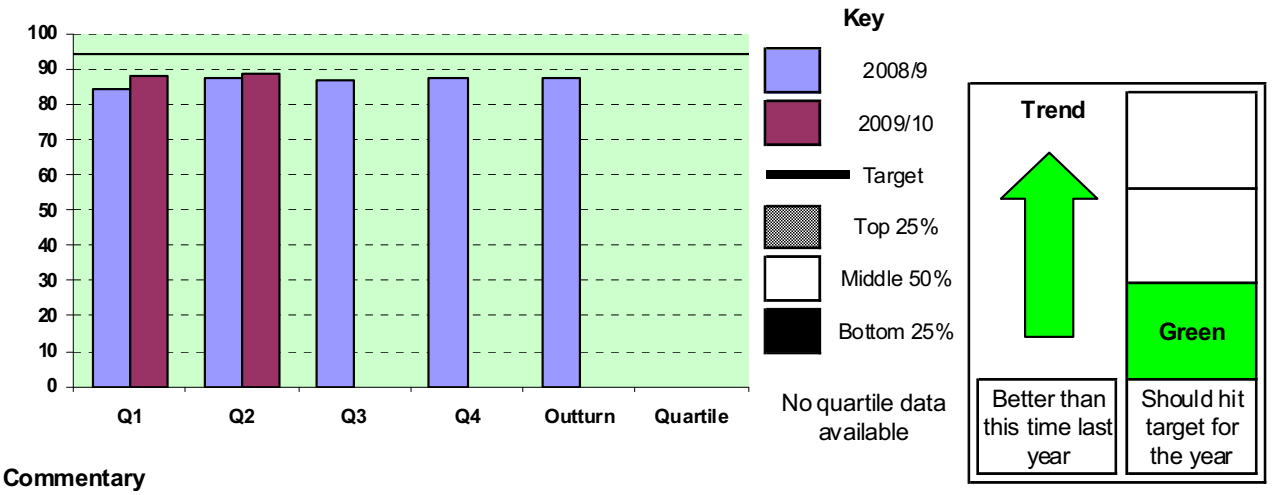
OP NI 132 **Timeliness of social care assessment DH DSO**



Commentary

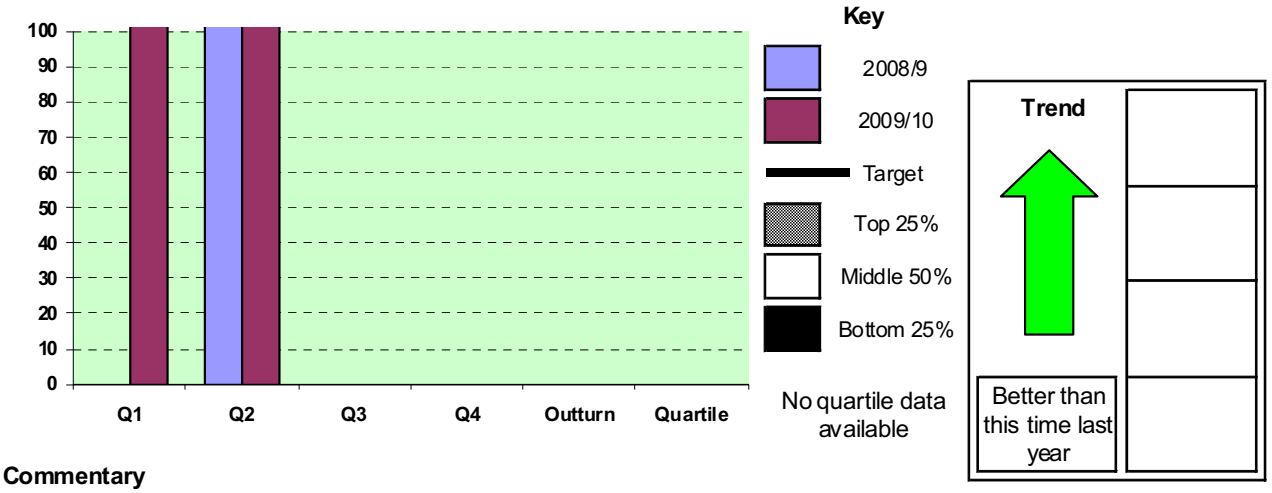
Target exeeded. Final year end figure is determined by a file check which is ongoing.

OP NI 133 **Timeliness of social care packages DH DSO**



Commentary
Final year end figure is determined by a file check which is ongoing.

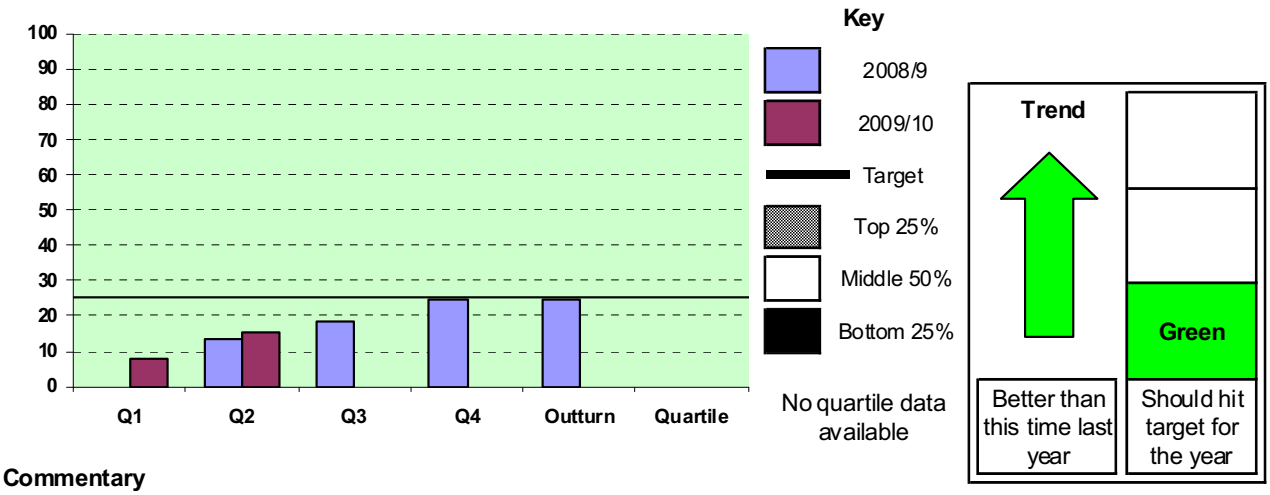
OP NI 136 **People supported to live independently through social services (all ages) PSA 18**



Commentary
Q2 performance has increased from Q1 performance. Helped to live at home continues to be good. No target has been set for 2009/10, therefore a traffic light indicator cannot be allocated.

OP NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO



Commentary

To date 611 carers have received an assessment/review and a specific carers service, or advice and information. Exception reports are produced on a monthly basis of carers who have not yet received an assessment/review but have had a service for operational teams to action.

The following key indicators have not been included in the tables above for the reasons stated: -

NI 131 Delayed Transfers of care;
Data derived from health, which is not yet available

NI 125 Keeping independence for Older People through rehabilitation/intermediate care;

Indicator data derived from a sample which is undertaken in December. Figure will not be known until year end.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
Cost & Efficiency						
OP LI 1	Number of people receiving Intermediate Care per 1,000 population	46.27	53.39	39.27		Target equates to 900 people. Total number of people for Q1 and Q2 is 662.
OP LI 2	% of client group expenditure (OP/ILS) spent on domiciliary services	24		23	n/a	All invoices relating to creditors have been received; the % split should increase slightly each quarter. The realisation of Continuing Health Care & homecare retender is still distorting figures and will be monitored.
OP LI 3	No of days reimbursement as a result of delayed discharge of older people	0	20	0		There have been no re-imbursable delays during this period.
Fair Access						
OP LPI 4	Ethnicity of older people receiving assessment	1.7	1.5	0.73		Out of 532 clients who have received an assessment this year, 2 clients have an ethnic origin other than white. Given the small proportion of ethnic minority clients, this indicator is fluctuation to change.
nOP LI 5	% of older people being supported to live at home intensively, as a proportion of all those supported intensively at home or in residential care	25.53	29	33.7		The HH1 Return from which the intensive homecare element is derived no longer exists. The figure is based on planned activity rather than actual activity as a result. The planned activity is taken from Carefirst and therefore does not reflect variations between planned and actual homecare.
OP LI 6	% of adults assessed in year where ethnicity is not stated Key Threshold< 10%	1.8	0.5	1.25		Out of 722 assessments this year, 9 clients do not have an ethnicity recorded. In order to ensure the target will be met at year end, monthly exception reports of unknown ethnicity are sent to

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
						operational teams to action.
Quality						
OP LPI 7	Percentage of people receiving a statement of their needs and how they will be met	99	99	99.28		99.23% of people in receipt of services have been given a statement of their needs and how they will be met. Target already achieved, however, monthly exception reports are still produced for operational teams to action of those clients who are not in receipt of their statement of needs.
OP LPI 8	Clients receiving a review as a %age of adult clients receiving a service	81.65	80	47.93		47.93% of clients receiving services have been reviewed so far. In order to ensure the target will be met at year end, monthly exception reports of outstanding reviews are sent to operational teams to action.
OP LPI 9	% of items of equipment and adaptations delivered within 7 working days	84.74	93	86.31%		Current performance suggests that the target will not be achieved. Work is being undertaken regarding minor adaptations specifically to check whether data quality issues may be causing a low performance outturn. As a consequence, the indicator value may be subject to change in Q3 or Q4.
NI 131	Delayed Transfers of Care		25	NYA	NYA	Data derived from health, which is not yet available.
NI 132	Timeliness of Social Care Assessments	79.2	82	88.78		Target exceeded. Final year end figure is determined by a file check which is ongoing.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
NI 133	Timeliness of Social Care packages (Former BVPI 196)	91.7	94	88.75		Final year end figure is determined by a file check which is ongoing.
Service Delivery						
OP LI 10	Availability of single rooms for adults & older people entering permanent residential / nursing care (per 10,000 population) key Threshold <140	46	70	27.29		To date, 45 older people have been admitted to permanent residential and nursing care. All clients are allocated a single room.
OP LI 11	Household (all adults) receiving intensive homecare (per 1000 population aged 65 or over) Key Threshold > 8	11.43	13	N/A	N/A	This indicator was derived from the annual HH1 return. This return no longer exists.
NI 136	People Supported to Live independently through Social Care Services	2714		3018	N/A	Q2 performance has increased from Q1 performance. Helped to live at home continues to be good. No target has been set for 2009/10, therefore a traffic light indicator cannot be allocated.
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	24.95	25%	15.22		To date 611 carers have received an assessment/review and a specific carers service, or advice and information. Exception reports are produced on a monthly basis of carers who have not yet received an assessment/review but have had a service for operational teams to action.
NI 125	Achieving independence for	77%		NYA	NYA	Indicator derived from a sample which is not

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
	Older People through rehabilitation/Intermediate Care					being undertaken until December. Figure will not be known until year end.
Area Partner National Indicators: The indicators below form part of the new National Indicator Set introduced on 1st April 2008. Responsibility for setting the target, and reporting performance data, will sit with one or more local partners. As data sharing protocols are developed, baseline information and targets will be added to this section.						
NI 129	End of life access to palliative care enabling people to choose to die at home		20.7	25.2		The PCT IS in the process of employing an EOL facilitator to roll out tools such as GSF, PPC and LCP across Halton and St Helens and is also working with our general practices in regards to implementation of GSF which would also compliment and address patient preferences, this particular piece of work is being taken through the CSP palliative care working group.
NI 134	The number of emergency bed days per head of weighted population		232820	57508.6	-	Data derived from health not yet available.
NI 138	Satisfaction of people over 65 with both home and neighbourhood			NYA	-	Data derived from health not yet available
NI 139	People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently		N/A	N/A	N/A	This is collected through the Place Survey carried out every 2 years. The next planned Place Survey is during the Autumn of 2010. Plans are being developed to carry out a brief survey of older people using existing networks to assess direction of travel. This survey will be

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
						carried out initially through Halton Older People's Empowerment Network (OPEN) and the five local participation groups. The next stage will be to get the question incorporated into existing service feedback forms. The first phase of this will be through Halton Borough Council's existing Lifeline service.

Policy/Service	HIGH Priority Actions	Target	Progress	Commentary

APPENDIX FOUR – PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS
Older People's Services

HEALTH & COMMUNITY – OLDER PEOPLE

Revenue Budget as at 30th September 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Employees	6,148	3,069	2,997	72	3,145
Premises Support	215	107	108	(1)	108
Other Premises	58	20	16	4	16
Food Provisions	255	113	97	16	117
Supplies & Services	450	134	137	(3)	345
Transport	242	68	63	5	63
Departmental Support Services	1,704	0	0	0	0
Central Support Services	639	10	11	(1)	11
Community Care:					
Residential Care	6,987	2,821	2,337	484	2,337
Home Care	2,360	968	802	166	802
Supported Living	355	166	178	(12)	178
Day Care	29	12	18	(6)	18
Direct Payments	352	144	116	28	116
Other Agency	2,581	43	43	0	43
Asset Charges	52	0	0	0	0
Total Expenditure	**22,427**	**7,675**	**6,923**	**752**	**7,299**
Income					
Residential Fees	-2,717	-1,419	-1,194	(225)	-1,194
Fees & Charges	-617	-409	-422	14	-422
Preserved Rights Grant	-91	-45	-43	(2)	-43
Supporting People Grant	-857	-428	-286	(142)	-286
Adult Stroke Services Grant	-170	-85	-85	0	-85
Intermediate Care PCT contribution	-2,961	-1,276	-1,278	2	-1,278
PCT Reimbursement	-221	-8	-9	1	-9
Joint Finance – PCT	-33	-5	-5	0	-5
PCT Contribution to Care	-35	-20	-25	5	-25
Other Income	-169	-85	-89	4	-89
Total Income	**-7,871**	**-3,780**	**-3,436**	**(344)**	**-3,436**
Net Expenditure	**14,556**	**3,895**	**3,487**	**408**	**3,863**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 2 is under budget profile by £408k. This is due to expenditure on the community care budget continuing to be lower than anticipated at the mid point of the financial year as more service users are awarded continuing health care funding when residing in nursing or residential care homes. However this also means that residential and nursing fees are lower than expected as fewer clients are being placed in nursing and residential care.

APPENDIX FIVE – FINANCIAL STATEMENT
Older People's Services

The continued success in gaining continuing health care (CHC) funding, investment in re-enablement services and a reduction in high cost packages during quarter 2 means expenditure on the community care budget is significantly less than otherwise expected. A changing focus by the Primary Care Trust to offer more intermediate care and transitional arrangements to enable people to recover from illness is reducing the number of people who are eligible for fully funded healthcare. This is likely to holt the rapid rise in service users receiving CHC funding and may lead to increased demands for funding by the Local Authority. Thus, expenditure on community care will be closely monitored throughout the year to enable the community care budget to be realigned for 2010/11.

Employee costs to date include £160k for agency staff used within Older People's Services to fill essential social worker posts in both Older People's team Widnes & Runcorn, the Hospital Discharge team and additional care staff in the Rapid Access Rehabilitation Service.
Additional funding from the PCT has been agreed for a number of posts to support continuing healthcare, the discharge process within Warrington Hospital and Social Care in Practice in Runcorn, which will alleviate some of these pressures.
Expenditure on staffing will continue to be closely monitored throughout the year and a balanced budget is expected to be achieved at year end.

Supporting People funding for the Lifeline service will be reviewed during the year to ensure it is contained within the departments' budget.

Older People

Capital Budget as at 30th September 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Redesign Oakmeadow Phase 2	60	3	3	57
Major Adaptations for Equity release/Loan Schemes	100	0	0	100
ILC market garden canopy	16	0	0	16
Bridgewater	2	0	0	2
Total Spending	**178**	**3**	**3**	**175**

APPENDIX FIVE – FINANCIAL STATEMENT
Older People's Services

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Health & Partnerships**

PERIOD: **Quarter 2 to period end 30th September 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Health & Partnerships Department second quarter period up to 30 September 2009 It describes key developments and progress against all objectives and performance indicators for the service.

It should be noted that this report is presented to a number of Policy and Performance Boards. As such those objectives and indicators that are not directly relevant to this Board have been shaded grey.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 7

2.0 KEY DEVELOPMENTS

Housing

The refreshed Homelessness Strategy was approved by Exec Board on the 24/9/09 and the action plan within it will guide future developments of the service over the next few years.

Following Executive Board approval on the 24th September 2009 the Council's temporary accommodation for homeless households at Grangeway Court is being re-designated as supported housing which, accompanied by a minor change to the Council's allocations policy, should enable the Council to reduce its homelessness acceptance rate and assist its homelessness prevention plans.

Commissioning

Joint report with PCT is being prepared in response to the Ombudsman Report "Six lives: the provision of public services to people with learning disabilities" which recommended all NHS and social care organisations should review effectiveness of systems and capability and capacity of services to meet additional and often complex needs of people with learning disabilities.

Quality Assurance

The team have completed tenders for the following:

1. Community Enablement service – this service provides floating support to people with learning & physical disabilities. The organisation that was successful in winning the tender was Glenelg who specialise in

providing support to children & adults with complex needs.

2. Domestic Abuse tender – Halton has brought together 3 Domestic abuse services and combined them to make one co-ordinated wrap around service. Halton Womens Aid has won this tender. The new service will comprise of the following:
   IDVA – Independent Domestic Violence Advisor – who provides Independent support for high-risk individuals.
   Floating support – to provide support to women who are deemed lower risk.
   Sanctuary scheme – to provide security measures to enable people to stay in their own homes. This will assist in homeless prevention. This service will incorporate a 24-hour helpline.

Other tenders that have recently started are :
Meals on wheels. Stair lifts, and the Minor adaptations contract.

In addition a consultant is currently reviewing the current and future housing needs of adults with enduring mental health problems.

Service Planning & Training

A comprehensive training programme commenced in April 2009 to support the implementation of Self Directed Support and Personal Budgets. The training programme aims to provide managers and staff with the appropriate skills they require in order to implement self-directed support effectively. We have also commissioned training for contracted providers, which will help them make the changes that are required to deliver personalised services and Individualised Service Funds. The attendance and feedback from the training to date has been positive. The training programme will be evaluated in Jan 2009 with consideration of a second phase.

The Draft Joint Carers Commissioning Strategy 2009 - 2012 was presented to Healthy Halton Policy & Performance Board on 15.9.09 and is due to be presented to the Executive Board on 5.11.09

Halton Disability Partnership (HDP) formerly Halton Disability Alliance has been in existence for around 2 years. The organisation has found it difficult to sustain membership and develop aims, objectives or a business plan, therefore the Directorate will be working with an external provider to explore the options for HDP's development in more detail and following the outcome of this project, manage the transition of HDP to a user led organisation with the capability to manage services, effect change etc.

The Training Section, supported by a Business Process Analyst from ICT Services, have been investigating the potential benefits of implementing an e-learning package aimed at social care staff within the Directorate and offering the resource to contracted provider and partners. The project is currently at the stage of seeking expressions of interests from external providers to introduce and implement the E-Learning package.

3.0 EMERGING ISSUES

Commissioning
Halton in collaboration with the PCT and St Helens MBC has been selected by the NDTi to be the North West demonstration site for its Housing and Social Inclusion project. The project is part funded by DH and will run for two years See Quarter 1 for more details.

Quality Assurance
Work on the Business Contingency Plans for all independent Providers of support & care is underway. The QA team are co-ordinating the plans, training and responses in order to ensure to provide effective services in the event of an emergency.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**23**		**21**		**2**		**0**

Satisfactory progress has been made for the majority of milestones/objectives. Where one objective has been given an amber traffic light this was due to an agreed revised completion date for a project being undertaken in partnership with the NHS. For further details please refer to Appendix 1.

5.0 SERVICE REVIEW

No issues to report in this quarter

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**4**		**2**		**2**		**0**

One KPI cannot be reported on as survey data will not be available until next year, and another has a changed definition hence it was considered appropriate to give an amber traffic light. The other amber refers to an indicator currently not achieving target but performance is expected to rise in the next quarter following staff training. For further details please refer to Appendix 2.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**12**		**8**		**3**		**1**

One indicator, which measures staff turnover, is currently unlikely to meet target due to an increased number of staff leaving. This is being addressed by the introduction of exit interviews.
Where it is currently unclear the causes include the speculative data by partners and situations where timescales have been changes and I one instant the failure to meet some aspects of the targets.

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4. Please refer to Appendix 4

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4. Please refer to Appendix 5

9.0 DATA QUALITY

The author provides assurances that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress Against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4 – Progress against Risk Control Measures
Appendix 5- Progress against High Priority Equality Actions
Appendix 6- Financial Statement
Appendix 7- Explanation of traffic light symbols

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
HP 1	**Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for the community of Halton**	Develop commissioning strategy for challenging behaviour/Autism Spectrum Disorder **Mar 2010** (AOF 6 & 30)		Business case prepared and to be presented to NHS Halton & St Helens in Dec. 2009
		Commission combined advice, support and sanctuary service for people experiencing domestic violence **Mar 2010** (AOF 6, 30 and 31)		Completed The new wrap around Co-Coordinated service will commence December 1st 2009
		Commission feasibility study for Supporting People 'Gateway' or single point of access service **Mar 2010** (AOF 6, 30 and 31)		Feasibility study complete- work ongoing to progress to implementation.
		Establish effective arrangements across the whole of adult social care to deliver self directed support and personal budgets **Mar 2010** (AOF6)		Transformation Team now established. Good progress being made. A comprehensive training programme underway.
		Commission supported living services for Adults with Learning Disabilities and People with Mental Health issues **Mar 2010** (AOF 6, 30 and 31)		Work is in progress but report being taken to Exec sub to extend contract for further 12 months as completion date has been revised to 31/03/2011.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Redesign the housing solutions service to ensure the continued effective delivery of services **Mar 2010** (AOF6 &)		Plans to integrate the homeless prevention and homeless assessment teams have been approved and are being implemented. Work to examine options to relocate the service from Catalyst House has been suspended pending the corporate accommodation review
		Deliver against the government target to reduce by half (by 2010) the use of temporary accommodation to house homeless households **Mar 2010** (AOF 6, 30 and 31)		A range of measures are being developed to ensure achievement of the target, including the re-designation of Grangeway Court as supported housing and negotiations with RSLs to provide a smaller number of units for use as furnished temporary accommodation.
		Introduce a Choice Based Lettings System to improve choice for those on Housing Register seeking accommodation **Dec2010** (AOF 11&30)		It is anticipated that a report will be presented to Exec Board in the Autumn seeking key decisions to endorse a common sub regional allocations policy, the ICT supplier, and cost sharing details. The project is still on track to be implemented in 2010.
		Commission floating services for vulnerable groups **Mar**		Timeline for tender of floating support services to be aligned

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		2011 (AOF 6,30,31)		with introduction of Gateway service.
		Work with the Council's Planning Department to introduce an affordable housing policy within the Local Development Framework **Mar 2011** (AOF 11)		Draft LDF currently out for consultation- Affordable housing policy to be developed following outcome of consultation.
HP2	**Effectively consult and engage with the community of Halton to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required**	*Introduce new advocacy and service user involvement service **Mar 2010** (AOF 6 and 30)*		A Tender process complete - contract awarded to SHAP. Aim to have service up and running August 2009.
		*Update JSNA summary following community consultation **Mar 2010** (AOF 6)*		Draft refresh of JSNA complete- currently out for comment from key stakeholders.
		Continue to survey and quality test service user and carers experience of services to evaluate service delivery to ensure that they are receiving the appropriate outcomes **Mar 2010** (AOF 32)		Quality of life service questions have been created and are now used at every review by care staff. This should enable us to gauge the overall well being of the people that we come into contact with and take steps to deliver more positive outcomes.

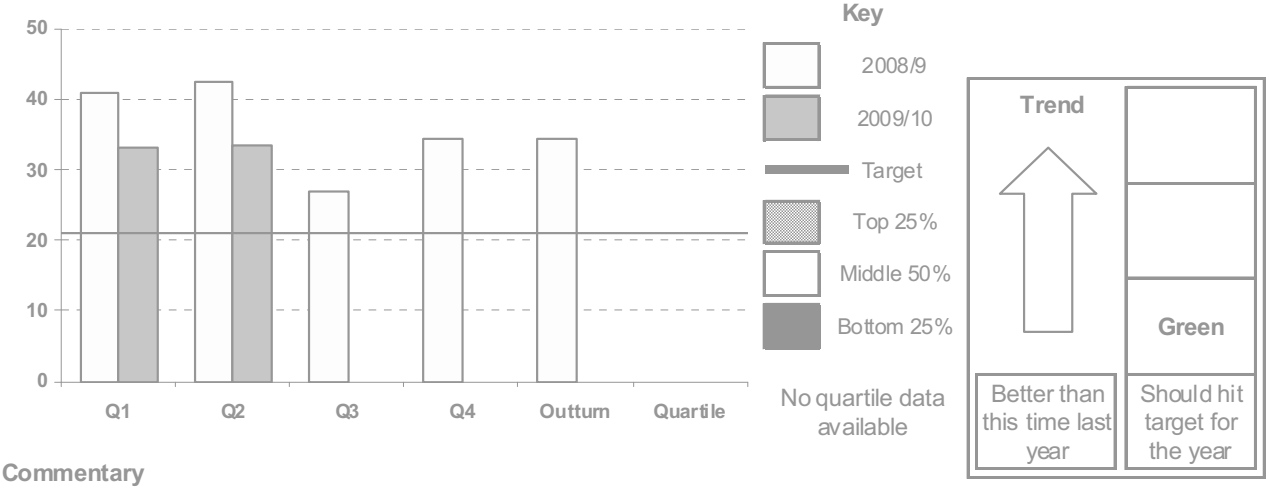
Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
HP3	**Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs**	*Agree with our PCT partners the operational framework to deliver Halton's section 75 agreement **Mar 2010** (AOF 33,34 and 35)*		Final report by Tribal completed and ongoing discussion to progress action plan.
		*Review commissioning framework for Supporting People to ensure links to LSP **Mar 2010** (AOF 33 and 34)*		Report re the direction of SP programme to be presented to Urban Renewal PPB in November. Report includes recommendation re changes to the governance of the SP programme.
		Assess, on a quarterly basis, the impact of the Fairer Charging Policy strategy to ensure that the charging policy is fair and operates consistently with the overall social care objectives **Dec 2009** (AOF34)		Revised policy presented to Exec. Board Sub Committee on 10/0910
		Following the publication of the new national guidance on complaints, review, develop, agree and implement a joint complaints policy and procedure to ensure a		Current policy reviewed and amended as appropriate.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		*consistent and holistic approach **Nov 09** (AOF 33)*		
		*Review and revise the performance monitoring framework according to changing service needs to ensure that any changing performance measure requirement are reflected in the framework and the performance monitoring cycle **Sep 2009** (AOF33)*		A new outcome focussed review from has been agreed and a person centred assessment from is being developed. When these are finished we will liaise with Helen Sanderson to produce an outcomes performance framework for the Directorate.
		*Develop and implement appropriate workforce strategies and plans to ensure that the Directorate has the required staff resources, skills and competencies to deliver effective services **Mar 2010** (AOF 39)*		Workforce strategy updated for 2009/10. New strategy considers workforce implications of personalisation agenda.
		Develop a preliminary RAS model and explore impact on related systems **Apr 2010 (AOF 34)**		RAS model developed and will now be tested. National work on RAS to be incorporated.
		Review existing Direct Payment arrangements to ensure alignment with the personalisation agenda **May 2010** (AOF 34)		Arrangements reviewed and additional capacity created to meet personalisation agenda.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Review & update, on a quarterly basis, the 3 year financial strategy **Mar 2010** (AOF 34)		Interim work underway.
		Review and deliver SP/Contracts procurement targets for 2009/10, to enhance service delivery and cost effectiveness **Mar 2010**. (AOF35)		Annual work plan completed and incorporated into divisional workplan. Progress to be reviewed on a quarterly basis at DMT.

NI 156

Number of households living in Temporary Accommodation



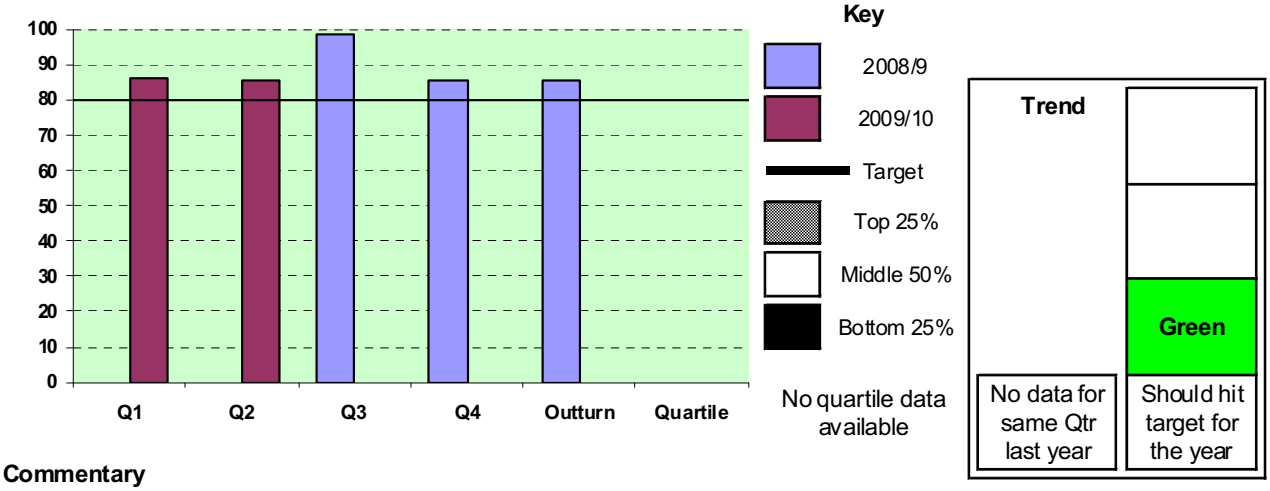
Commentary

There were 33 households in temporary accommodation in Q1, and 34 in Q2, producing an average of 33.5 for the first half year. Recently agreed changes to the designation of the Council's temporary accommodation at Grangeway Court and to the Council's allocations policy should ensure that the year end cumulative average is close to the target of 21.

HP NI 141

Number of vulnerable people achieving independent living CLG DSO

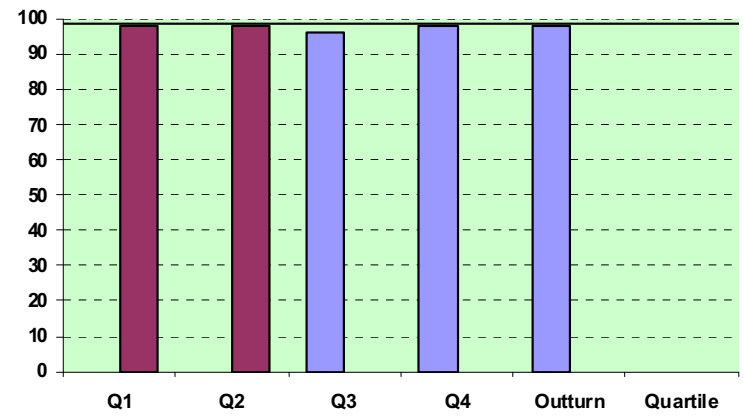
Higher figures represent better performance



Commentary

The services within this indicator are showing continuous improvement with Quarter 2 - 6th July to 4th October reaching a figure of 86.2%

HP NI 142 **Number of vulnerable people who are supported to maintain independent living CLG DSO**



Higher figures represent better performance

Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Amber

No data for same Qtr last year

May hit target for the year

Commentary

CLG data collection period for Qtr 1 is from Apr-Jul 2009.

Improved performance from providers who have action plans in place. Traning completed in July and improvement expected in next quarter.

The following indicator has not been shown as a table, for the reason stated: -

NI 127 self reported experience of Social Care Users: -
Indicator is derived from the Equipment Survey. Value will be reported either at year end if value known or in Quarter 1 2010.

NI 130 Social Care Clients and carers receiving self directed support (DPs/Individualised Budgets)
Indicator now monitored against the new definition, which is clients and carers in receipt of self directed support as a percentage of clients and carers in receipt of services, as opposed to the old definition of clients and carers in receipt of self directed support per 100000 population. Target and out-turn figure have been adjusted to reflect the change in definition.
It has therefore not been practical to show this indicator in tabular format

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
Cost & Efficiency						
HP LI 1	% of SSD directly employed posts vacant on 30 September	7.9	8	7.9		This figure remains the same as the previous year and will change after September 2009. Currently it is on track for remaining within the target set for the year.
Quality						
Service Delivery						
HP LI 2	No of relevant staff in adult SC who have received training (as at 31 March addressing work with adults whose circumstances make them vulnerable	450	475	460		Printed out relevant staff list from SSDS001 (30.9.08) and obtained all Safeguarding Adults Training registers for 2005-06, 2006-07, 2007-08, 2008-09 & 2009-10 to date. Mapped signatures against staff list and calculated attendance. Working closely with the Safeguarding Vulnerable Adults Co-ordinator and operational services, staff will be allocated specific training dates to ensure meeting target.
HP LI 3	% of relevant social care staff in post who have had training (as at 31 March) to identify and assess risks to adults whose circumstances make them more vulnerable	71%	81%	77%		Printed out relevant staff list from SSDS001 (30.9.08) and obtained all Risk Assessment Training Registers for 2005-06,2006-07, 2007-08, 2008-09 & 2009-10 to date. Mapped signatures against staff list and calculated attendance. Working closely with operational services staff will be allocated specific training dates to ensure meeting target.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
HP LI 4	Estimate % of relevant staff employed by independent sector registered care services that have had training on protection of adults whose circumstances make them vulnerable.	82%	82%	82%		Obtained all Safeguarding Vulnerable Adults Registers, then identified Independent Sector attendees that had attended the Facilitators, Train the Trainer, Basic Awareness and Referrers Training and obtained the Ind. Sector Staffing numbers from Contracts Section. **636** Ind. Sector Staff attended training and **133** attended Facilitators/Train the Trainer Training, therefore, assuming that each facilitator trained **3** members of their team that gives a total of **1002** from a grand staffing total of **1035. Assuming a 15% turnover on the staff trained (852) the calculated percentage is 82%**
HP LI 5	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough).	5.4	4.0	2.7		There were 147 successful prevention outcomes in the first half year (2.7 preventions per thousand households). If this trend continues in the second half year the target of 4.0 preventions per thousand households will be exceeded.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
H LI 6	The proportion of households accepted as statutorily homeless who were accepted as statutorily homeless by the same LA within the last 2 years	1.2	1.2	0		There were no cases of repeat homelessness in Q1 or Q2. (The P1E definition of repeat homelessness has now changed to the proportion of households accepted as statutorily homeless who have previously been accepted by the same LA where a main duty was ended within the past 2 years.)
P LI 7	Percentage of SSD directly employed staff that left during the year.	7.58	8	10.32		The Exit Interview Policy is due for review over the next couple of months and as part of this review the exit interview questionnaire will be revised. The KPMG Efficiency Review is currently underway, as well as the results of the job evaluation appeals for the Directorate being announced earlier this year, both of which may have a negative impact on the leavers figure throughout the remainder of this year.
HP LI 8	Percentage of Social Services working days/shifts lost to sickness absence during the financial year.	8.03	8	6.72		
HP LI 9	The percentage of undisputed invoices, which were paid in 30 days	99	97	NYA	NYA	Indicator value not yet available.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
Area Partner National Indicators: The indicators below form part of the new National Indicator Set introduced on 1st April 2008. Responsibility for setting the target, and reporting performance data will sit with one or more local partners. As data sharing protocols are developed, baseline information and targets will be added to this section.						
NI 39	Hospital Admissions for Alcohol related harm	2354.8	2137.9	637.5	NYA	An 'Alcohol Partnership Commissioning Group' has been formed with the main aim of reducing alcohol related harm throughout Halton and St Helens. With support from St Helens Council, Halton Borough Council, the police, the probation service, the voluntary sector and other partners, the group will devise an ambitious, overarching alcohol harm reduction programme as well as overseeing the alcohol work streams of the Commissioning Strategic Plan. The PCT has secured the support of the Regional Alcohol Improvement Programme who have now re-branded as 'Drink Wise North West' and who are funded by the Department of Health. They have agreed to An 'Alcohol Partnership Commissioning Group' has been formed with the main aim of reducing alcohol related harm throughout Halton and St Helens. With support from St Helens Council, Halton Borough Council, the police, the probation service, the voluntary sector and other partners, the group will devise an ambitious, overarching alcohol harm reduction

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
						programme as well as overseeing the alcohol work streams of the Commissioning Strategic Plan. □ The PCT has secured the support of the Regional Alcohol Improvement Programme who have now re-branded as 'Drink Wise North West' and who are funded by the Department of Health. They have agreed to
NI 119	Self-reported measure of people's overall health and well-being					Data derived from health not yet available.
NI 120	All-age all cause mortality rate	Male 851.9 Female 690.3	Male 780 Female 590	Male 844.5 Female 624.6		Provisional figures based on mortality from Jun 08-May 09 suggests that both male and female all age all cause mortality is higher than we would expect if the Borough was on target to meet year end LAA targets. A programme of accelerated action is being implemented from the recommendations of the National Support Team visit for Health Inequalities and whilst this is being led by the PCT, the Borough Council are fully engaged in this process especially linking to actions around vulnerable people.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
NI 121	Mortality rate from all circulatory diseases at ages under 75	64.3	83.21	80.6		Current initiatives in progress include Health Checks Plus to be delivered by all key front line health workers; an initiative that measures key health influences on CVD eg. cholesterol, blood pressure, pulse, BMI, blood glucose levels and smoking status. QOF Plus - health checks in GP practices to identify all patients at risk of CVD and monitor those with CVD problems. NHS Halton & St Helens staff are working with Council staff to identify cohorts of vulnerable people in the local population and prevent excess winter deaths. The GO men's health programme is working with men over 40 in NMT areas and identifying people with heart disease and signposting them to appropriate services. The staff Work Well programme is now established and running across the PCT and as a pilot in the Local Authority. This programme identifies staff at risk of CVD and signposts them if necessary. It also offers lifestyle advice. Obesity services have now been commissioned and will be in place by January 2010. These should have a significant impact on CVD. Given smoking targets were exceeded in 2008/09 and we are on target to achieve the 09/10 target this also will have a significant impact on CVD rates.
NI 122	Mortality from all cancers at ages under 75	161.7	128.9	157.9		The current data is speculative and robust data will be available in December 2009. The early detection for cancer pilot has been developed as a

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
						business plan and approved. It has now started to rollout across Halton and St Helens. Good progress has been made with smoking cessation. Halton and St Helens had the 4th highest quit rate across the North West for 2008/09 and it is anticipated this progress will continue for 2009/10. Bowel screening continues with Halton and St Helens progressing favourably against other spearhead PCTs. A business plan has been developed to put in place a screening lead to work with GP practices that are under performing regarding bowel, breast and cervical screening.
NI 123	16+ current smoking rate prevalence – rate of quitters per 1000 population	687	961	351		Halton has met the proposed target for September. Halton and St Helens continue to make good progress with smoking cessation exceeding set targets. The latest analysis of stop smoking results across the North West indicate that Halton and St Helens had the fourth best result in the area.
NI 124	People with a long tern condition supported to be independent and in control of their treatment		NYA	NYA	NYA	The PCT's Commissioning Strategic Plan (2009-2014) places a strong emphasis on early diagnosis and detection of disease and ill health prevention. This will result in an increase in the number of people supported to manage their own condition through risk management plans and personalised health and social care plans. Although we presently cannot measure the performance routinely, we are confident that the

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 2	Progress	Commentary
						2010 survey will reflect this new and stronger emphasis on self care.
NI 126	Early access for women to maternity services		3002	342	NYA	This information is collected quarterly as part of the Vital Signs Monitoring Return and this data is from July 09 - September 09 from Halton and St Helens PCT.
NI 128	User reported treatment of respect and dignity in their treatment					Data derived from health not yet available
NI 137	Healthy life expectancy at age of 65			12.3		A measure of the number of years that a person can expect to live in good or fairly good health after the age of 65 .To obtain healthy life expectancy, a standard survey question on self-reported health is asked of those over 65. Results from this are then applied to life expectancy projections at 65 to show how many of the years to be expected will be spent in good health. Data sourced from the 2001 ONS Census data.

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
HP2 Milestone: Update JSNA summary following community consultation	Failure to identify resources/skills required to refresh data and summary on an annual basis and produce full JSNA on 3yr basis	Work with colleagues in Public Health, Corporate Intelligence Unit and CYP to identify staff with appropriate skills/knowledge to undertake work Ensure that work on JSNA is built into identified staffs work programmes Establish formal reporting mechanism for progress with JSNA to Health PPB	March 2010		JSNA Working Group comprising of reps from HBC Research & Intelligence, Policy and Partnerships, Health & Community and Children & Young Peoples Directorates and PCT Public Health colleagues set up. Meeting in October will confirm Terms of Ref./membership etc Work on JSNA to be built into work programmes – Framework agreed. Fu refresh Sept'09-Sept'10 Service Development Officer (Healtl attends the Health PPB and will provid updates on JSNA as required.
	Failure to implement comprehensive community consultation	Work with colleagues in Public health, corporate communications and CYP to identify staff with appropriate skills/knowledge to carry out annual consultation. Ensure that work on JSNA consultation is built into identified staffs work programmes	March 2010		JSNA Communication, Engagement & Consultation plan under development and will form part of the Service Development Officer (Health) work plan. Community consultation/communication activity planned to date: JSNA Road Shows & Street Survey on health/lifestyle factors. Survey will also be available on line form HBC website

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
					(Sept/Oct 09), Halton Citizens 2000 Panel Survey on barriers to healthy lifestyles/wellbeing. The Health & Wellbeing section of this survey will also be available on line form HBC website (Oct 09 – LINk assisting with the development of survey). MORI/Place Survey update (Sept 09) Cross Directorate analysis of what existing/scheduled consultation activity could feed into the JSNA. Article in Halton's Health 'e' Newsletter to raise awareness of forthcoming JSNA – can have a regular slot to promote planned consultation activity (Oct 09)
HP 2 Milestone: Continue to survey and quality test service user and carers experience of services to evaluate service delivery to ensure that they are receiving the appropriate outcomes	Failure to demonstrate outcomes and work with service users to improve them could mean that poor services are provided to the people that need them and ultimately reduce the Directorate's performance rating	Contact Centre Surveys undertaken on new service users to test service experience Surveys undertaken on specific topics through the year so that outcomes are tested and views on service improvements are sought.	Nov 2010		A new quality of life survey is now undertaken at review and the results are being collated. The intention is t extend this to a similar survey to be used by the lifeline service with people who are only in receipt of lifeline in the meantime the contact centre continues to test service users experiences of the lifeline service. The statutory service user survey was undertaken in April 2009 and this has been followed up in

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
					December 2009 to make sure that people receive quality care services that meet their needs.
HP 3 Milestone: Following the publication of the new national guidance on complaints, review, develop, agree and implement a joint complaints policy and procedure to ensure a consistent and holistic approach	Failure to respond to the statutory performance agenda and care frameworks could impact on the people the Directorate provides services to and the performance rating of the Directorate.	An annual performance strategy is created that details all the checks and balances in place so that performance is monitored appropriately. This includes a timetable of the reporting and testing mechanisms that are used to monitor performance.	Septe mber 2009		The performance strategy has been developed and a divisional business plan outlines all tasks to be accomplished in the year ahead.
HP3 Milestone: Develop a preliminary RAS model and explore impact on related systems	Failure to follow a staged approach to developing the preliminary RAS model will not highlight areas of concern and meet NI 130 targets.	A ongoing monitoring of performance development, highlighting findings and taking appropriate action to amend the RAS	March 2010		The Personalisation team is evaluating Halton's bespoke questionnaire. Points allocated will feed into the developing Desktop RAS which will be available at the end of January 2010 to test a further 20 physical and sensory disability service users, with a working model rolled out in April 2010. The Personalisation team has also evaluated the National RAS and questionnaire and has decided to continue with the development of the

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
					existing model given current ownership from staff and recognition of informal care in Halton's model.
	Failure to review on going performance development to ensure RAS is continually updated	Regularly review RAS with appropriate managers, and provide progress reports on a monthly basis	March 2010		The performance strategy has been developed and a divisional business plan outlines all tasks to be accomplished in the year ahead.
	Failure to explore areas of concern on related systems and flag issues with manager	Regularly review RAS with appropriate managers, and provide progress reports on a monthly basis	March 2010		The Personalisation team is evaluating Halton's bespoke questionnaire. Points allocated will feed into the developing Desktop RAS which will be available at the end of January 2010 to test a furthe 20 physical and sensory disability service users, with a working model rolled out in April 2010. The Personalisation team has also evaluated the National RAS and questionnaire and has decided to continue with the development of the existing model given current ownership from staff and recognition of informal care in Halton's model.
HP3 Milestone: Review existing	Not consulting with all relevant parties throughout the process	Regular meetings of the Self Directed Support Groups will ensure all	May 2010		Various consultation events have been held this quarter by the Direct Payments/ Individualised Budgets

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
Direct Payment arrangements to ensure alignment with the personalisation agenda	may delay the alignment of the agenda	parties are informed and any areas of concern highlighted and considered. Consultation with service users arranged.			team e.g. Meeting with Carers forums, Social Work Teams to promote the use of Direct payments and IB's. A support group for service users and their carers receiving a DP has also re-commenced which will be held every two months to update and engage service users on the progress of the personalisation agenda. Quarterly Newsletters also provide useful feedback.
HP3 Milestone: Review and deliver SP/Contracts procurement targets for 2009/10, to enhance service delivery and cost effectiveness	Failure to secure/retain adequate staffing resources within team to project manage tender process	Secure support from SMT to resource team at level needed to complete 2009/10 work programme Limit opportunities for secondment to reduce loss of skills/knowledge within the team Agree priority work areas (based on risk) and offer advice and guidance only in respect to projects/tenders deemed low risk	March 2010		The Seconded staff member returns in time to assist with the high-risk tenders This will strengthen the team in the necessary skills and knowledge for the high-risk tenders. All the tenders within the work plan are recorded against the level of risk they pose to the Council

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
	Unable to award contract due to lack of or poor quality of tender submissions	• Maximise opportunities for providers to submit comprehensive tenders by building in sufficient time for returns at each stage of the tender process. • Advertise tenders on a national basis. • Develop contingency plans for the extension of existing services subject to tender.	March 2010		The tenders will be advertised Nationally in trade journals (Community Care magazine) In addition " Open days have been integrated into the Project Plan. The Contingency plan will ensure that Contracts will agree formal extensions to all Providers.

Strategy/Policy/Service	HIGH Priority Actions	Target	Progress	Commentary
Housing	Private Sector Housing Conditions survey to be carried out, with resulting data disaggregated and analysed for race and disability	March 2010		Survey fieldwork completed. Final report expected Jan 2010. On target to produce data by financial year end.
Business Support	Collection and analysis of biannual service user survey, disaggregated by equality strand	March 2010		Completed.
Service Planning	Carry out a consultation and scoping project to identify LGBT carers and potential carers to identify any specific needs not currently addressed, ensuring that services are responsive to needs	March 2010		LGBT survey completed no replies received. Survey sent to 130 people in Halton - that were members of an LGBT magazine.
Older People's Services	Appointment of a Dignity Coordinator to drive the agenda forward in relation to older people in health and social care settings	March 2010		Coordinator in post. Action plan completed.

HEALTH & COMMUNITY - HEALTH AND PARTNERSHIP

Revenue Budget as at 30th September 2009

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000	Actual Including Committed Items £'000
Expenditure					
Employees	4,062	2,067	2,065	2	2,174
Premises Support	121	52	50	2	50
Other Premises	33	17	15	2	15
Supplies & Services	427	245	257	(12)	305
Training	131	18	12	6	12
Transport	19	9	14	(5)	14
Departmental Support Services	174	0	0	0	0
Central Support Services	731	15	15	0	15
Agency Related	259	91	68	23	84
Supporting People Payments to Providers	7,222	3,358	3,355	3	3,355
Unallocated Grants	366	0	0	0	0
Asset Charges	963	0	0	0	0
Total Expenditure	**14,508**	**5,872**	**5,851**	**21**	**6,024**
Income					
Sales	-13	-6	-5	(1)	-5
Receivership Income	-19	-10	-15	5	-15
Rents	-142	-115	-133	18	-133
Departmental Support Services Recharges	-3,687	0	0	0	0
Supporting People Main Grant	-7,411	-3,718	-3,719	1	-3,719
Social Care Reform Grant	-559	-559	-559	0	-559
Adult Social Care Workforce Grant	-364	-182	-182	0	-182
Supporting People Admin Grant	-112	-56	-56	0	-56
Training Support Implementation Fund	-95	-95	-95	0	-95
Homelessness Grant	-65	-43	-46	3	-46
Disabled Facilities Grant	-40	-40	-38	(2)	-38
Mortgage Rescue Scheme	-38	-38	-38	0	-38
Other Grants	-92	-90	-90	0	-90
Re-imbursements	-95	-84	-86	2	-86
Other Income	-84	0	0	0	0
Total Income	**-12,816**	**-5,036**	**-5,062**	**26**	**-5,062**

Net Expenditure	**1,692**	**836**	**789**	**47**	**962**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 2 is £47k under budget profile, due in the main to the overachievement of income targets and reduced expenditure on bed and breakfast accommodation for the homeless.

Receivership income has continued to overachieve against budget profile despite lower interest rates reducing income received from fees. The trend of service users changing from appointee to receivership status in line with the Mental Capacity Act continues and there are an increased number of appointee service users being managed by the Appointee & Receivership team having transferred from Halton Supported Housing Network. The additional income generated is being used to fund a post in order to meet current demand.

Rents received during the period are continuing to be higher than anticipated at budget setting time.

Health & Partnership

Capital Budget as at 30th September 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
IT	28	0	0	28
Total Spending	**28**	**0**	**0**	**28**

Housing Strategy & Support Services

Capital Projects as at 30th September 2009

	2009/10 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Private Sector Housing				
Housing Grants/Loans	354	107	77	277
Disabled Facilities Grants	686	295	291	395
Adaptations – Joint Funding RSLs	650	168	165	485
Stair Lifts	120	67	67	53
Energy Promotion	100	0	0	100
Choice Based Lettings & Communications Technology	50	0	0	50
Modular Building	45	0	0	45
Home Link	10	0	0	10
Contingency	50	0	0	50
Total Spending	**2,065**	**637**	**600**	**1,465**

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage whether the objective will be achieved within the appropriate	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.