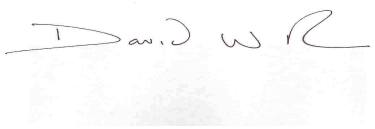
Public Document Pack

Health and Wellbeing Board

Wednesday, 18 September 2013 2.00 p.m.
Karalius Suite, Stobart Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 13 November 2013

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

Part I

Agenda Item 2

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 17 July 2013 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Morley and Polhill and S. Boycott, S. Banks, D. Parr, D. Johnson, D. Sweeney, J. Wilson, E. O'Meara, D. Lyon, N. Sharpe, G. Ferguson, A. McIntyre, K. Fallon, N. Rowe, J. Rule, S Yeoman.

Apologies for Absence: Councillors Philbin, A. Williamson and Wright and S. Baker, J. Dwyer, G. Hayles, A. Marr, M Pickup and A Williamson

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB9 MINUTES OF LAST MEETING

The Minutes of the meeting held on 22 May 2013 were taken as read and signed as a correct record.

HWB10 LONGER LIVES - PRESENTATION

The Board received a presentation from Eileen O'Meara, Director of Public Health, which demonstrated the Longer Lives website. The Public Health England website highlighted premature mortality in the categories of cancer, heart disease and stroke, lung disease and liver disease, across every local authority in England, providing information to help them improve their community's health in these areas. In addition the website could compare Halton with local authorities who have similar levels of deprivation.

The presentation also highlighted to Members a series of graphs which compared Halton to its industrial hinterland statistical neighbours for cancer, heart disease and stroke, lung disease and liver disease.

RESOLVED: That the presentation be noted.

HWB11 BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST - PRESENTATION ON APPLICATION FOR FOUNDATION TRUST STATUS

The Board received a presentation from Kate Fallon, Chief Executive, Bridgewater Community Healthcare NHS Trust which provided an update on the progress of the Foundation Trust application. The application was in the final stage with an inspection on 16th July, an on-site assessment by a Monitor – the independent regulator of Foundation Trusts in November and a stakeholder day in the autumn. It was anticipated that the process would take four months and a Foundation Trust licence would be received in December 2014.

It was noted that a key element of the process was the election of the Trust's Council of Governors and nominations for applications for Governors had been advertised.

RESOLVED: That the presentation be received.

HWB12 WIDNES VIKINGS - HEALTH & WELLBEING PRESENTATION

The Board was advised that Widnes Vikings Rugby League Club had been commissioned by Public Health to work on Health and Wellbeing as part of their contract. On behalf of Widnes Vikings, James Rule, Chief Executive Officer attended the meeting and gave a verbal presentation which highlighted the Clubs community programme involving local schools and community clubs. The programme involved Widnes Viking players working with local youngsters to encourage them to learn new sports and lead a healthy active lifestyle.

As part of the presentation Members viewed a DVD which showed local school children and Widnes Vikings players working together to learn new sports skills.

RESOLVED: That the presentation be received.

HWB13 SUPPORT FOR PATIENTS IDENTIFIED WITH IMPAIRED GLUCOSE REGULATION (IGR)

The Board considered a report of the Director of Public Health, which outlined a proposed Merseyside-wide project to support patients identified as having Impaired Glucose Regulation (IGR) and thereby prevent or delay the progression to type 2 diabetes. It was noted that in

September 2012 a business case was developed for a standardised diabetes prevention pathway to identify and manage patients with IGR across the Mersey Cluster. The proposed pathway was based around a five step process as follows:-

- Step 1 – Identification of high risk patients;
- Step 2 – Offer blood test;
- Step 3 – Patient invited for clinical/lifestyle review;
- Step 4 – Patient offered IGR education and lifestyle intervention; and
- Step 5 – Patients thereafter invited for annual review.

It was proposed that a range of IGR educational material be developed for those patients who chose not to participate in a lifestyle intervention but who wished to manage their condition themselves and to support those that do participate in interventions. Funding for this element had been provided through the Quality, Innovation, Productivity and Prevention (QIPP) Programme. Subsequently, Directors of Public Health across the Mersey cluster had been requested to set aside £20,000 to support the commissioning of an IGR training package.

It was noted that Halton's CCG Governing Body had confirmed its support for the pathway at its meeting on 20th September 2012 and agreed to fund annual reviews for patients known to have IGR and those identified as having IGR through health checks. It was anticipated that, subject to the delivery of the training element, the pathway would be formally launched and rolled out to GP practices in September 2013. It was noted that Directors of Public Health from all local authorities involved had given their in principle support for the new pathway. Subsequently, Directors of Public Health across the Mersey cluster had been requested to set aside £20,000 to support the commissioning of an IGR training package.

RESOLVED: That the report be noted.

HWB14 HEALTH AND WELLBEING ACTION PLANS

The Board received an update report on the progress of the development of the Health and Wellbeing Action Plans. Since the launch of the joint Health and Wellbeing Strategy for Halton 2013/16 in January 2013, work had taken place to develop Actions Plans for each of the priority areas contained within the report. A copy of the draft Action Plans for each of the following five areas was circulated to Members of the Board:-

i) Prevention and Early Detection of Cancer;
ii) Improved Child Development;
iii) Reduction in the number of falls in Adults;
iv) Reduction in the Harm from Alcohol; and
v) Prevention and early detection of mental health conditions.

RESOLVED: That

1) the contents of the report and the appendices be noted; and

2) comments be fed back to the Director of Public Health.

HWB15 CHILDREN IN CARE OF OTHER LOCAL AUTHORITIES

The Board considered a report of the Strategic Director, Children and Enterprise which:-

1. Presented an update report regarding the current numbers of Children in Care of Other Local Authorities (CICOLA's) and the possible impact on services within Halton;

2. Assessed within the context of neighbouring local authorities the numbers of Residential Children's Homes operating within Halton, the types of these services and the potential financial impact on the Borough; and

3. Offered an update regarding on-going works development in this area.

The Board was advised that Halton currently had 138 children on the CICOLA's list (11 of these had an unknown address). The main referer into the Borough was Liverpool followed by Knowsley. It was noted that there had been a significant reduction of CICOLA's moving into Halton from Boroughs many miles away. Within Halton currently there were 12 external agency children's homes operating in the Borough, this represented a reduction of three homes within the last 18 months. In total, this was 22 placements (beds) which represented a reduction of 11 beds in the last 18 months. This reduction represented a home reduction of 20% and a bed reduction of just over 33% in the last 18 months, this was primarily being due to the Commissioning Manager working with colleagues from the Planning Section to confirm providers had appropriate permissions.

In addition, Halton had also been in direct discussions with OFSTED Inspectors for the local homes and shared some of the consistent practice issues. It was noted that the market reduction was highly favourable given that during this same time period there was a 10% increase in both the numbers of Children's Homes nationally and in the North West located homes as well as in the numbers of beds.

Members were also provided with feedback on the Placement Provide Forum meetings which covered Halton, St. Helens and Warrington areas and were held on a quarterly basis. Feedback from the providers had been positive in terms of the usefulness of the forum and also the networking opportunities that it provided.

RESOLVED: That further work is undertaken to get a more accurate picture on how many CICOLA's reside in Halton, ensuring that the procedures around notifications of CICOLA's were appropriately utilised.

Strategic Director Children and Enterprise

HWB16 DOMESTIC ABUSE SERVICES FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

The Board considered a report which advised on the commissioning process, timeline and main elements that would encompass the new Domestic Abuse Services in Halton for children, young people and families.

As part of the proposals for the new Children's Domestic Abuse Service the following steps had taken place over the last few months:-

- Halton Domestic Abuse Forum carried out work during Autumn of 2012 to examine the impact of domestic abuse on children and young people. A draft plan was produced which was due to be refreshed alongside the Borough's Domestic Abuse Strategy later this year;

- The Domestic Abuse and Sexual Violence Co-ordinator had undertaken work to map the impact of domestic abuse across the Borough;

- In January 2013, the Forum asked the Council's Adults and Commissioning Teams to meet and look at future plans for commissioning services, particularly around a perpetrator programme and services for children and young people;

- In March 2013 funding was sourced from Children's specialist budget and a lead commissioner from the Children's Commissioning Team was identified to undertake research and draw together the details required for a service specification to support children, young people and families;

- During April 2013, a benchmarking exercise was carried out with other local authorities;

- Throughout May 2013, there were some initial consultations with service providers and practitioners around their views of the current demand and need of families around domestic abuse services; and

- The procurement process had been drawn up and the main elements of a timeline established.

It was proposed that the four main elements to the new service were:

- Support to parents that were victims of domestic abuse which would enable parents to understand the impact of domestic abuse on how they parent and how domestic abuse had impacted on the children and young people's behaviour;

- Direct work around children/young people's safety planning where the young person was still in the situation;

- Longer term recovery work, therapeutic approach where the perpetrator was no longer within the family; and

- Support social care with the pre-court proceedings process and provide information and assessments were required.

RESOLVED: That

1) the report be noted;

2) the service delivery approach outlined within the attached draft service specification be agreed;

3) children's services support Communities Directorate in the re-commission of Halton's Domestic Abuse Services; and

Strategic Director Children and Enterprise

4) the approach that other services supporting the hidden harm and domestic abuse agenda adopt were viable the main elements required around child safety planning be endorsed.

HWB17 PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided an overview of the background to the Pharmaceutical Needs Assessment,(PNA) changes which were effective from 1st April 2013, the duties of the Health and Wellbeing Board, commissioning arrangements and proposed arrangements for producing Halton's PNA. The PNA was the statutory document that stated the pharmacy needs of the local population. This included dispensing services as well as public health and other services that pharmacies may provide. It was used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacies services. Since 1st April 2013, the Health and Wellbeing Board was responsible for producing Halton's PNA.

The Board was advised that work had been undertaken in Cheshire prior to the closure of PCTs, whereby Health and Wellbeing Boards across Cheshire, agreed a common framework for producing their PNAs. This would ensure that although each PNA would be developed locally and differ according to the local population and area, it would be in the same format and order which would make it easier to use and review. The work had recently been shared with Merseyside Public Health intelligence leads. Subsequently a Merseyside Group of public health representation from each Local Authority and the NHS England had started to meet and progress this area to develop a strategic plan for developing PNAs for each area, maximising the economies of scale, where possible, by working together in the planning, consultation and design stages, which would support at a local level to produce individual PNAs.

Each Health and Wellbeing Board was required to nominate a board-level sponsor with responsibility for the PNA, but the management of the PNA could be passed over to a Steering Group led by public health. The group would oversee the operational development and consultation for the PNA, reporting back to the Health and Wellbeing Board for approval stages of the process.

It was important to ensure that all information within

the PNA was accurate and up to date, and this could be achieved by ensuring that all relevant stakeholders were represented on the steering group. The following next steps were proposed:

- Nominate board level to sponsor for PNA;
- Nominate chairperson of Steering Group from Public Health Team;
- Recruit Steering Group who should then:
- Start to populate the PNA with information already available such as JSNA, gather information to update current PNA, ask the local community for feedback on current pharmacy services and aspirations for future pharmacy services, contact local authority planners and healthcare commissioners to determine future planning of housing, industry and healthcare.

RESOLVED: That

1) the Director of Public Health be nominated as the Board level sponsor for the Pharmaceutical Needs Assessment (PNA); — Director of Public Health

2) the financial risks associated with the PNA be logged through Halton Borough Council's risk assessment and register process; and

3) a local Steering Group be established to develop the PNA and oversee the statutory consultation.

HWB18 SUICIDE PREVENTION STRATEGY

The Board considered a report of the Director of Public Health, which provided an update on the development of a Suicide Prevention Strategy for Halton. At a local level, a recent suicide audit for Halton and St. Helens, completed in April 2013, demonstrated that the number of completed suicides for Halton remained relatively low. However, the existing Suicide Prevention Strategy needed to be updated in line with the National Strategy, published in September 2012. A Suicide Audit would provide some of the evidence to support the development of the Strategy.

It was proposed that the local Strategy follow the same format as the National Strategy by following six key areas for action:

- reduce the risk in key high risk groups;
- tailor approaches to improve mental health in specific

groups;
- reduce access to the means of suicide;
- provide better information and support to those bereaved or affected by suicide;
- support the media in delivering sensitive approaches to suicide and suicidal behaviour; and
- support research, data collection and monitoring.

In order to progress the development of a local strategy, it was proposed that a Suicide Prevention Task Group be established and a workshop be organised for September to provide wider engagement with key stakeholders from across Halton.

RESOLVED: That

1) the report be noted; and

2) the development of a Suicide Prevention Strategy for Halton be supported.

Director of Public Health

HWB19 WINTERBOURNE VIEW UPDATE

The Board was advised that the Transforming Care: A national response to Winterbourne View Hospital (Department of Health Review final report) was produced in December 2012 and included an Action Plan, a copy of the Plan had been circulated to Members of the Board. The majority of areas within the Action Plan were focused at a national level with guidance disseminated to Clinical Commissioning Groups (CCGs) and the Local Authority for implementation. Areas that required CCG and Local Authority input were highlighted in the report together with an implementation date and a progress update.

RESOLVED: That

1) the report be noted; and

2) the Winterbourne View Action plan be noted.

HWB20 HEALTH AND WELLBEING BOARD REVISED TERMS OF REFERENCE

The Board was advised that the Health and Wellbeing Board had been operating in shadow form since December 2011. However, as from 1st April 2013 the Board became a statutory board of the Local Authority. As a result of this change the original Terms of Reference have been updated. The revised document removed reference to a “Shadow”

Board and actions relating to the transitional period. Membership had also been updated to reflect changes. A copy of the revised Terms of Reference had previously been circulated to Members of the Board.

RESOLVED: That

1) the contents of the report and appendices be noted; and

2) a representative from Cheshire Police be added to the Board Membership;

3) any further comments be forwarded to the Strategic Director Communities; and — Strategic Director Communities

4) an updated version of the revised Terms of Reference highlighting the proposed amendments be circulated.

HWB21 URGENT CARE - PROGRESS

The Board considered an update report in relation to the current project/areas of work associated with improvements in urgent care as referenced in Halton's Accident and Emergency Recovery and Improvement Plan. During 2012 Halton Borough Council and NHS Halton Clinical Commissioning Group (HCCG) developed the Urgent Care Partnership Board to lead on the development and management of the Urgent Care system used by the Borough's population. Delivering on this agenda would provide the health and social care economy with sustainable improvements in performance and quality.

With regard to Primary Care Quality and access, the accountability for Primary Care remained with NHS England, and NHS England oversaw the quality elements of Primary Care within Halton. Evidence suggested that access remained an issue for Halton residents and as a result a Primary Care Quality Group, consisting of representatives from the Council and HCCG would be established, with a role to improve the quality and support to local practices in order for them to be able to effectively respond to the growing need for quicker and more effective access.

Members of the Board were advised that a local Recovery and Improvement Plan centred on each A and E Department also needed to be developed. The local plans had to be submitted to Regional Directors by 31st May 2013. Within Halton, the development of the local Plan was co-

ordinated via the Halton Urgent Care Partnership Board and in addition to being formally signed off by Halton CCG, had been agreed by all partners of the Board. In addition, it was noted that prior to submission to the Regional Director, each local plan had to go through the NHS England's North Region assurance process, this exercise had been completed.

RESOLVED: That

1) the report be noted; and

2) the Recovery and Improvement Plan be noted.

HWB22 HEALTH AND ADULT SOCIAL CARE SETTLEMENT 2015/16

The Board considered a report of the Strategic Director, Communities, which provided Members with a summary of the Government's Health and Adult Social Care settlement 2015/16 and put forward recommendations to ensure the conditions attached to funding and integration were progressed.

In order to have the necessary plans in place to comply with the integration, it was proposed that a short, time limited Task and Finish Group, chaired by the Director of Communities, to develop the plan in conjunction with guidance from the Department of Health and Department for Communities and Local Government be established. The Group would conclude its work by 30th September 2013.

In addition, a Task and Finish Finance Group was proposed to ensure that the financial elements of the settlement were considered and management of the financial components were dealt with accordingly. Both groups would report progress to the Board and the plan would also require approval through the NHS, Halton CCG Governing Body as funding would transfer from NHS Halton CCG to the Council.

The LGA had outlined an approach regarding the completion of a Sense check. It was proposed that a brief questionnaire would be circulated to all Members, Chief Executive and Leader of Halton Borough Council, Chief Officer and Chair of NHS Halton CCG, and Operational Director for Commissioning to gain commissioning understanding, direction for integration and key leadership issues that would feed into the plan as it was developed. Thereafter a number of follow-up interviews would also be

required with key members of the Board.

RESOLVED: That

1) the contents of the report be noted;

2) the establishment of a Task and Finish Group to be chaired by the Strategic Director Communities to progress the development of a plan and completion of a Sense check to gain commissioning understanding and direction be approved;

3) the establishment of a Task and Finish Finance Group chaired jointly by the Operational Director for Finance and Chief Officer for Halton CCG, be approved; and

4) the delivery of a workshop in October/November to agree the plan be approved.

Strategic Director Communities

Meeting ended at 4.15 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 18th September 2013

REPORTING OFFICER: Simon Banks, Chief Officer

PORTFOLIO: NHS Halton Clinical Commissioning Group

SUBJECT: The NHS belongs to the people: a call to action

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 The purpose of the report is to inform the Health and Well Being Board of the publication of *The NHS belongs to the people: a call to action* and invite discussion in regard to a local response to this programme of engagement.

2.0 **RECOMMENDATION**

RECOMMENDED: That

1. **the Health and Wellbeing Board notes this report and the publication of The NHS belongs to the people: a call to action;**

2. **notes the work already facilitated by NHS Halton CCG in partnership with Halton Borough Council to commence a public narrative about the future of health in Halton; and**

3. **supports the continuation of this public narrative with local people, NHS staff and politicians.**

3.0 **SUPPORTING INFORMATION**

3.1 *The NHS belongs to the people: a call to action*, calls for the public, NHS staff and politicians to engage in an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of patients. This is set against a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a national funding gap which could to £30bn between 2013/14 and 2020/21.

3.2 *The NHS belongs to the people: a call to action* sets out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat

and rising expectations of the quality of care. The document says clearly that the NHS must change to meet these demands and make the most of new medicines and technology and that it will not contemplate reducing or charging for core services.

3.3 *The NHS belongs to the people: a call to action* highlights that the success of the NHS in extending life means that people are living longer, but with more conditions and illnesses such as dementia that were not common even twenty years ago. New technology has led to earlier diagnosis and better treatment, but this has also increased cost and the NHS is still not reaching everyone that it needs to do.

3.4 *The NHS belongs to the people: a call to action* states that the new independence of NHS England and the establishment of Clinical Commissioning Groups (CCGs) create an opportunity to have a debate about how the public, doctors and politicians want their local NHS to be shaped. NHS England is supporting a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient – and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

3.5 *The NHS belongs to the people: a call to action* aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

3.6 *The NHS belongs to the people: a call to action* sets no predetermined solutions or options for consultation. The document does suggest that bold, new thinking is needed and that NHS England and CCGs will consider a wide range of potential options. However, there are three options that will not be considered:

- ***Do nothing.*** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with the duties of the NHS. The NHS cannot meet future challenges, seize potential opportunities and keep on a sustainable path without change.

- ***Assume increased NHS funding.*** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. NHS England and NHS Halton CCG do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

- **Cut or charge for fundamental services, or 'privatise' the NHS.** NHS England and NHS Halton CCG firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

3.7 NHS Halton CCG has already facilitated an event on 26th June 2013 at which themes similar to those raised by *The NHS belongs to the people: a call to action* were discussed with Halton Borough Council and NHS England colleagues. NHS Halton CCG, working with NHS England and Halton Borough Council, proposes to utilise the outcomes of this event, which are being shared with the Health and Well Being on 18th September 2013, to continue a dialogue with local people about the future shape of the NHS.

4.0 POLICY IMPLICATIONS

4.1 There are significant policy implications for all partners in Halton as a result of the issues raised in *The NHS belongs to the people: a call to action*. There is an opportunity, through dialogue with our local community, to understand the potential outcomes and impact of the strategies and plans of the NHS Halton CCG, Halton Borough Council and NHS England as the key commissioners of health and care services within the borough and how far this contributes to addressing the challenge set by this document.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no financial implications as a direct result of this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None as a result of this report.

6.2 Employment, Learning & Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

NHS Halton CCG is a key partner in this agenda.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

7.1 There are potential reputational and political risks from engaging in a public debate about the future shape of the NHS. These are partially mitigated by clear statements that this debate is open, honest and is about sustaining the NHS for the next 65 years and beyond.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None as a result of this report.

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

NHS England, *The NHS belongs to the people: a call to action*, NHS England, 11th July 2013, http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf

NHS England

HOW CAN WE IMPROVE THE QUALITY OF NHS CARE?

HOW CAN WE MEET EVERYONE'S HEALTHCARE NEEDS?

HOW CAN WE MAINTAIN FINANCIAL SUSTAINABILITY?

WHAT MUST WE DO TO BUILD AN EXCELLENT NHS NOW & FOR FUTURE GENERATIONS?

The NHS belongs to the people

A CALL TO ACTION

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NHS England

Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

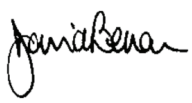
If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

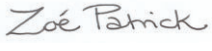
We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.



David Behan,
Chief Executive
Care Quality Commission

Alan Perkins,
Chief Executive
Health and Social Care Information Centre

Ian Cumming,
Chief Executive
Health Education England



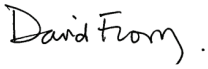
Zoe Patrick,
Chair of the LGA Community Wellbeing Board
Local Government Association

David Bennett,
Chief Executive
Monitor

Andrew Dillon,
Chief Executive
National Institute for Health and Care Excellence

Peter Melton,
Chief Clinical Officer, North East Lincolnshire CCG, Co-chair of NHS Commissioning Assembly steering group

David Nicholson,
Chief Executive
NHS England



David Flory,
Chief Executive
NHS Trust Development Authority

Duncan Selbie,
Chief Executive
Public Health England

NHS England

The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.

[2] For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.

"DOING NOTHING IS NOT AN OPTION – THE NHS CANNOT MEET FUTURE CHALLENGES WITHOUT CHANGE."

How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics (2011) http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587
[4] World Health Organisation (2013) http://data.euro.who.int/hfadb/
[5] World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.[6] People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

"BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

[6] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).
[7] The Marmot Review (2010), "Fair Society Healthy Lives".
[8] Royal College of Physicians (2012), "Hospitals on the edge? The time for action".
[9] Health and Social Care Information Centre
http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

> "Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS."

[10] Commonwealth Fund (2011), "International Health Policy Survey".

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

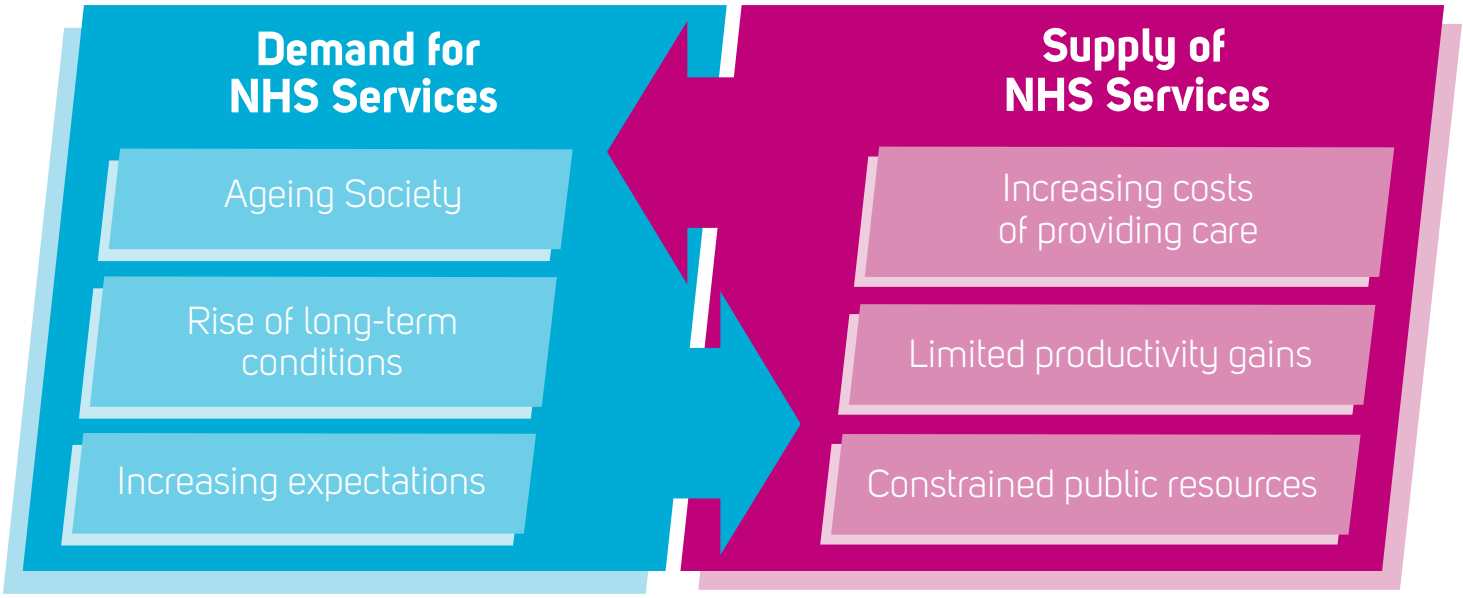
The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.
[12] National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook" http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153
[13] The Marmot Review (2010), "Fair Society Healthy Lives"
[14] The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.[18]

"STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE."

Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.[19]

[15] Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.
[16] Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.
[17] Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".
[18] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[19] A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

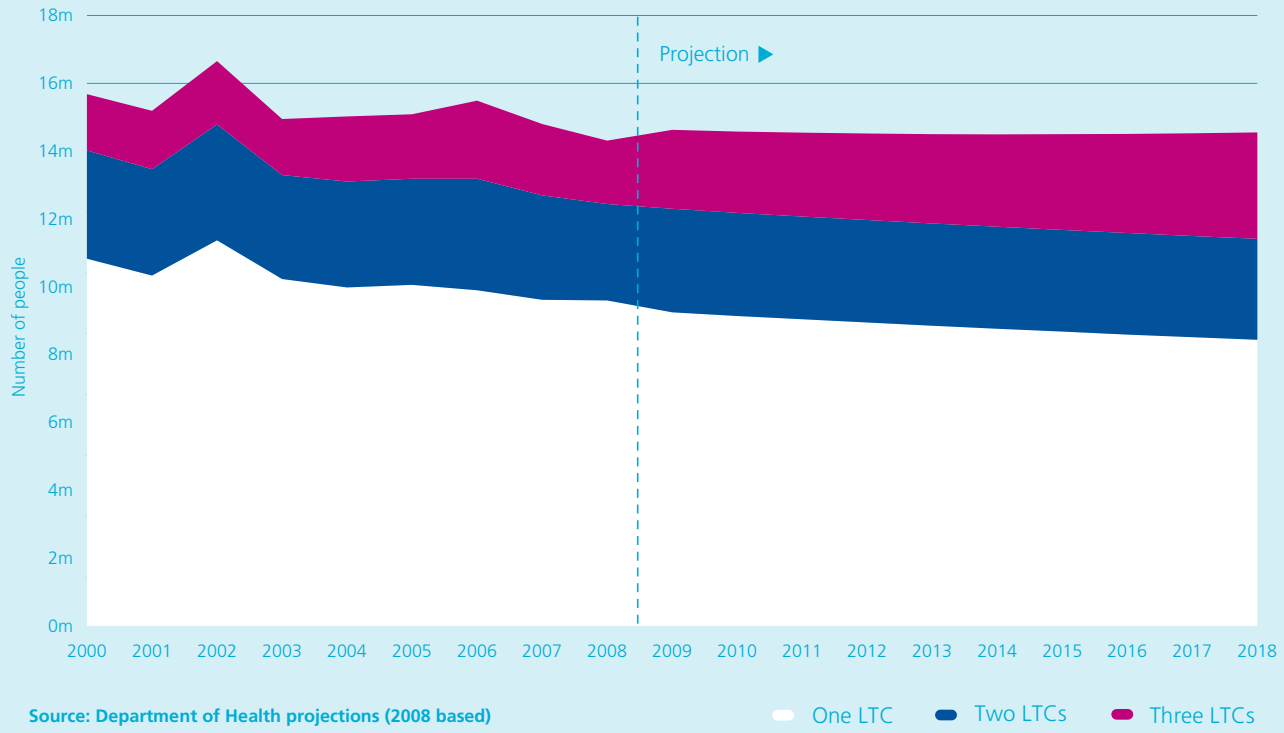
Changing burden of disease

People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[20]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

> "THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

[20] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[21]

Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease.[22] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.[23] If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

[21] Alzheimer's Society (2012), "Dementia 2012".
[22] Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.
[23] See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[24] - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[26] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

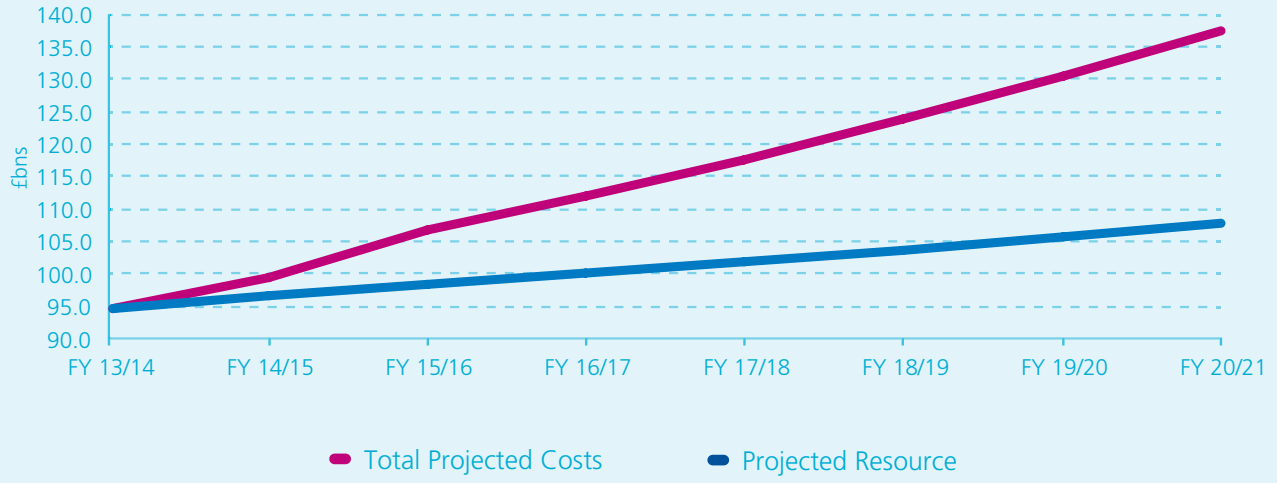
In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[25]

[24] Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", The Lancet Oncology.

[25] NHS England analysis.

[26] Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?," King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.

Projected resource vs. Projected spending requirements



Source: NHS England

Limited productivity improvements

Measuring the productivity[27] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[28] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[29] This suggests that the NHS may not be using its capacity as efficiently as it could.

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.[30] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

"THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14."

[27] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[28] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[29] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[30] This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,[31] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

[31] Department of Health (2009), "Public Health and Prevention Expenditure in England".

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[32] follow appropriate drug treatments[33] and avoid over-treatment.[34] Personalised care planning is also highly effective.[35] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[36]

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.[37]

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[38] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[39] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[32] JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.

[33] Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".

[34] D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

[35] "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".

[36] https://www.phbe.org.uk/

[37] NHS England (2013), "Catalogue of Potential Innovation".

[38] Office for National Statistics (2009), "e-society" (Social Trends 41).

[39] For example Kaiser Permanente and the Veterans Administration, both in the USA

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[40]

"THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013"

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

[40] Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.[41] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[42] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[43]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[44] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[41] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[42] Office of National Statistics (2012), "Sickness absence in the labour market".
[43] Department of Health (2011), "Innovation, Health and Wealth".
[44] Department of Health (2011), "Innovation, Health and Wealth"

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association,the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to cction engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.

REPORT TO:	Health and Wellbeing Board
DATE:	18th September 2013
REPORTING OFFICER:	Strategic Director Children and Enterprise
PORTFOLIO:	Children, Young People and Families
SUBJECT:	Joint Protocol between Halton Children's Trust, Halton Safeguarding Children Board and Halton Health & Wellbeing Board
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to discuss with Halton Health & Wellbeing Board a draft protocol/memorandum of understanding that has been developed to define the role of the Board and relationship with Halton Children's Trust and Halton Safeguarding Children Board. There is close and developing inter-working across each Board and this Protocol is intended to clarify and define the role of each to avoid both gaps in service and duplication.

RECOMMENDATION: That

1. **the Board note the contents of the report;**

2. **agree to sign up to the Protocol (attached as Appendix 1 to this report); and**

3. **discuss the possibility of initiating 6-monthly meetings of the Chief Executive of Halton Borough Council and respective Board chairs as described in Paragraph 36 of the Protocol.**

2.0 SUPPORTING INFORMATION

2.1 The Children Act 2004 established the framework that led to the development of the multi-agency partnership arrangements that are now known as Halton Children's Trust and Halton Safeguarding Children Board. These arrangements are now well embedded and although the Trust is no longer statutory, the partnership remains in place as before the statutory duty was removed in 2010.

2.2 The Halton Health & Wellbeing Board was established to meet the requirements of the Health & Social Care Act 2012, initially in shadow form before being formally in place from April 2013.

2.3 Halton Children's Trust and Halton Safeguarding Children Board has long had a joint protocol in place that defines the expectations of each and the working relationship between the two. This is in need of updating in light of the new Working Together to Safeguard Children 2013 Guidance. This guidance places a Duty on the Director of Public Health to ensure that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment that is developed by the Health and Wellbeing Board.

2.4 Given the need for all three boards to conform to Working Together, in addition to the natural overlap between each, it was felt appropriate to extend the revised Protocol to cover the interrelationship between the three partnerships.

3.0 POLICY IMPLICATIONS

3.1 This Protocol sets out the expectations of the relationship and working arrangements between Halton Children's Trust, Halton Safeguarding Children Board and Halton Health and Wellbeing Board. It covers the respective roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny, and performance management.

3.2 By signing up to the Protocol on behalf of their Board, the chairs would agree to the arrangements set out in the document. These will be subject to review annually as a minimum to reflect recent developments or immediately following legislative change.

4.0 OTHER/FINANCIAL IMPLICATIONS

4.1 None identified at this time.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children and Young People in Halton

All of the considerations outlined within this report directly contribute to improving outcomes for Children and Young People.

5.2 Employment, Learning and Skills in Halton

Work of all three boards will contribute towards improving educational attainment, skills and maximising employment opportunities.

5.3 A Healthy Halton

All of the areas outlined within this report focus on the linkages to improve the health and wellbeing of children and young people.

5.4 A Safer Halton

There are close links between partnerships on areas such as alcohol and domestic violence. It therefore remains a key consideration for the Health and Wellbeing Board.

5.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. It should therefore be a key consideration when developing strategies to address health and wellbeing.

6.0 RISK ANALYSIS

Without the agreement of a Joint Protocol between Halton Health & Wellbeing Board, Halton Children's Trust and Halton Safeguarding Children Board, there are risks of duplication, overlap and/or issues disappear through 'gaps' between the partnerships. The agreement of a Joint Protocol should significantly reduce these risks.

7.0 EQUALITY AND DIVERSITY ISSUES

This is in line with all equality and diversity issues in Halton.

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

Document	Place of Inspection	Contact Officer
Halton Children's Trust/Halton Safeguarding Children Board Joint Protocol	2nd Floor, Rutland House, Runcorn	Mark Grady

APPENDIX A – JOINT PROTOCOL BETWEEN HALTON CHILDREN'S TRUST, HALTON SAFEGUARDING CHILDREN BOARD AND HALTON HEALTH WELLBEING BOARD

Joint Protocol

Between

Halton Children's Trust,

Halton Safeguarding Children Board,

&

Halton Health & Wellbeing Board

Signed: Chair of Halton Children's Trust _____

Signed: Chair of Halton Safeguarding Children Board _____

Signed: Chair of Halton Health & Wellbeing Board _____

Introduction

1. This document sets out the expectations of the relationship and working arrangements between Halton Council, Halton Children's Trust (HCT), Halton Safeguarding Children Board (HSCB) and Halton Health and Wellbeing Board (HHWB). It covers their respective roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny, and performance management.

2. The chairs of HCT, HSCB and HHWB and Halton Council have formally agreed to the arrangements set out in this document, which will be subject to review annually (from the date of initial agreement) or immediately following legislative change.

Background

3. The statutory duty to have a Children's Trust and for Local Authorities to develop and produce a Children and Young People's Plan has been removed from statute. Partners in Halton have however agreed to continue with the existing Children's Trust arrangements.

4. Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The HSCB ensures that this duty is carried out.

5. The Health and Social Care Act 2012 establishes Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The new Working Together to Safeguard Children: March 2013 places a responsibility on the Director of Public Health to ensure that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment that is developed by the Health and Wellbeing Board.

6. Working Together to Safeguard Children: March 2013 provides guidance on inter-agency working to safeguard and promote the welfare of children.

Halton Children's Trust Arrangements & Responsibilities

7. Halton Children's Trust (HCT) has a clear and separate identity within the wider co-operation arrangements.

8. The purpose of HCT is to consult with and bring all partners with a role in improving outcomes for children together to agree a common strategy on how they will co-operate to improve children's wellbeing and to help embed partnership working in the partners' routine delivery of their own functions. It

also provides a strategic framework within which partners can commission services together. Delivering the strategy, the Halton Children & Young People's Plan, is the responsibility of the partners, both individually and together. This means each partner's existing lines of accountability are unchanged, i.e. each partner of Halton Children's Trust retains its existing formal lines of accountability for delivering its own functions. This avoids any confusion or blurring of lines of accountability.

9. HCT will take forward the priorities for children and young people within the Health and Wellbeing Strategy (priorities agreed following the Joint Strategic Needs Assessment). HHWB will provide constructive challenge and support to the HCT.

10. HCT will include an assessment of the effectiveness of all partners, including local government, and partnership arrangements in supporting the best possible standards for safeguarding children within its annual review of the Halton Children & Young People's Plan. In addition, as part of this review, HCT will advise on workforce development, in particular the safeguarding activity in the delivery of all frontline services.

11. The HSCB will be formally consulted by the HCT when the Children & Young People's Plan is being drafted. The consultation phase will be sufficiently long to allow a thorough debate to support the HSCB response to the consultation. The Children & Young People's Plan will draw on the support and challenge from the HSCB.

12. HCT will consult with HSCB and relevant partners regarding any proposed commissioning arrangements which are linked to the factors which impact on safeguarding children. These will include issues concerning compromised care, including domestic abuse, parental mental health, alcohol and substance misuse and adult criminality.

13. HCT has responsibility for performance information concerning early help, commissioning and vulnerable groups, covering Universal Services, Universal Plus and Multi-Agency Planning within the Levels of Need Framework. This information will be shared with HSCB and HHWB as appropriate. The Children's Trust will also provide challenge to HSCB and HHWB as necessary when scrutinising its performance information.

14. HCT has responsibility for the delivery and effectiveness of Early Help & Support within Halton. HCT will report on the effectiveness of Early Help and Support within Halton to HSCB on a quarterly basis.

Halton Safeguarding Children Board Arrangements & Responsibilities

15. The role of Halton Safeguarding Children Board (HSCB) as set out in Section 14 of the Children Act 2004 is to:

    - Co-ordinate what is done by each agency/partner to safeguard and promote the welfare of children and young people in the area.

- Ensure the effectiveness of that work.

16. HSCB is the decision making body for multi-agency safeguarding issues within Halton. It is a statutory partnership and its work is directed by statutory guidance. This guidance dictates the functions to be undertaken by Local Safeguarding Children Boards and the criteria/functions against which they are inspected.

17. The Director of Children's Services (DCS) has a statutory responsibility for ensuring that an effective LSCB is in place. It is the responsibility of the Chief Executive (Head of Paid Service) to appoint or remove the HSCB chair with the agreement of a panel including HSCB partners and lay members. The Chief Executive, drawing on other HSCB partners and, where appropriate, the Lead Member for Children's Services will hold the Chair to account for the effective working of the HSCB

18. HSCB has an Independent Chair. The Board is supported in discharging its functions through its governance arrangements.

19. HSCB will inform and, when necessary, challenge commissioning arrangements where issues are identified through the various quality assurance processes such as learning from Serious Case Reviews, the Child Death Overview Panel and multi-agency auditing of practice.

20. HSCB will publish an Annual Report on the effectiveness of safeguarding locally. This will include an analysis of the contribution and activities of each partner, for keeping children safe, and the robustness and sufficiency of early help provision for children, young people and their families in Halton. This report will provide robust challenge to the work of HCT and HHWB.

21. HSCB has responsibility for safeguarding performance information, at the Multi-Agency Plan to Protect from Harm level of the Halton Levels of Need Framework and will share this information as appropriate. HSCB will also provide challenge to the Children's Trust as necessary when scrutinising its performance information.

Halton Health & Wellbeing Board Arrangements & Responsibilities

22. Each top tier and unitary authority has its own health and Wellbeing board. Board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

23. The boards will help give communities a greater say in understanding and addressing their local health and social care needs. The boards will be expected to ensure that the needs of local people as a whole are taken into account in their work

24. Halton Health & Wellbeing Board (HHWB) has strategic influence over commissioning decisions across health, public health and social care.

25. HHWB strengthens democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. HHWB provides a forum for challenge, discussion, and the involvement of local people.

26. HHWB brings together Halton Clinical Commissioning Group, Halton Council, health care providers and other interested parties to develop a shared understanding of the health and wellbeing needs of the community. The HHWB takes overall responsibility for assessing local need through the undertaking and maintenance of the Joint Strategic Needs Assessment (JSNA) and for the development and implementation of a Joint Health and Wellbeing Strategy that reflects priorities identified within the JSNA and from local consultation.

27. Through undertaking the JSNA, the HHWB will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

Shared Responsibilities

28. HSCB will provide constructive challenge to HHWB and HCT to ensure that the commissioning of services is in line with safeguarding practices and is reflected in service level agreements with providers. The HHWB and HCT will work together to develop effective commissioning and will provide constructive challenge.

29. HSCB, HHWB and HCT must have separate identities to ensure there is clarity and transparency within the child protection system. In order to provide effective scrutiny, HSCB should be independent. It should not be subordinate to, nor subsumed within, other local structures.

30. At the same time, the HSCB must be held accountable for its work, and be subject to effective scrutiny. This need to balance the responsibility of the HSCB to challenge HCT and HHWB and its duty to speak independently, with the need for appropriate scrutiny and accountability, is addressed in this Protocol.

31. In order to achieve a co-ordinated and coherent planning and performance management process, the HSCB will receive and consider relevant data quarterly and be fully involved in the development of the Joint Strategic Needs Assessment. HHWB will ensure that the Joint Strategic Needs Assessment takes account of children's safeguarding issues, including the priorities set out in the HSCB Business Plan.

32. HHWB may request the HCT and/or the HSCB to consider issues for development, action or scrutiny.

33. The HSCB will present its Annual Report to both the HHWB and HCT. The purpose of the report is to provide a rigorous and transparent assessment of the performance and effectiveness of local services. The report will contribute to the development and annual review of both the Children & Young People's Plan and Joint Health and Wellbeing Strategy. The HHWB and HCT will review the HSCB Strategic Plan, and receive key reports on aspects of safeguarding on a quarterly basis. In return the HHWB and HCT will report on a quarterly basis the priorities of the Joint Strategic Needs Assessment relating to the safeguarding and welfare of children and young people.

Relationship between the chairs of HSCB, HCT and HHWB and with the Director of Children's Services (DCS), the Lead Member for Children and the Chief Executive

34. In Working Together to Safeguard Children: March 2013 there is a clear role for the Chief Executive and Lead Member (as identified in the Children Act 2004), in satisfying themselves that the DCS is fulfilling their managerial responsibility for safeguarding and promoting the welfare of children. This relationship and working arrangements are governed by agreements and processes within the local authority and among partners for improving services and outcomes; and that targets for improving safeguarding and progress against them are reported to the Children's Trust Board and Health and Wellbeing Board. Every year, as part of the HSCB Annual Report and reporting against the Joint Strategic Needs Assessment, the Chief Executive and the Leader of the Council should make an assessment of the effectiveness of local governance and partnership arrangements for improving outcomes for children and supporting the best possible standards for safeguarding children.

35. In Halton the chairs of the Children's Trust Board and Health and Wellbeing Board will receive the annual report of the HSCB. This will set out the achievements of the HSCB against its agreed business plan and work programme priorities and targets, highlighting particular areas of improvement, and particular areas of concern and challenge. This report will be presented to the Chief Executive who will hold the Independent Chair to account.

36. In addition, meetings between the Chief Executive, the DCS, the chair of the Health and Wellbeing Board, chair of the Children's Trust Board and the Independent Chair of HSCB will take place not less than on a 6 monthly basis to ensure co-ordination of work and priorities. There will be an expectation of mutual challenge and accountability. The agenda will cover:

    - Progress against priorities;

- Any issues of concern in relation to the HSCB, including attendance of members, contribution to work plan and priorities;
- Any issues of concern about safeguarding arrangements which should be reported to HHWB or HCT, including the contribution of individual agencies;
- LSCB chair accountabilities for the effectiveness of the LSCB and its delivery of the work programme.

37. The Director of Children's Services (DCS) has the responsibility within the local authority, under section 18 of the Children Act 2004, for improving outcomes for children, local authority children's social care functions and local cooperation arrangements for children's services.

38. The Department for Education Statutory Guidance on the Roles and Responsibilities of the DCS and the Lead Member for Children's Services states that the DCS will make a key contribution to ensuring effective working relationships between HHWB and HSCB. The DCS sits on the HHWBB as a statutory member.

39. The independent chair of HSCB is responsible for the effective delivery of specific priorities as agreed within the Business Plan, as well as challenging the HHWB and HCT if agencies are not delivering on their safeguarding responsibilities.

Membership of HSCB, HCT and HHWB

40. Many organisations will be members of HSCB, HCT and HHWB. However, representation will not necessarily be by the same person. In order to ensure good communication and co-ordinated development, some individual members of HSCB will also be members of the HHWB and HCT. These include:

    - The Strategic Director, Children & Enterprise or representative attends each as representative of children and young people services, and also due to their overall responsibility for ensuring the efficient and effective operation of children and young people partnership working;

    - The Chair of HSCB will also be a member of HCT and will receive regular minutes of meetings and pertinent papers from the HHWB for comment. They are responsible for attending HCT/HHWB meetings to report on key issues arising from HSCB and providing progress reports on key aspects of safeguarding and the delivery of the annual report. They will also be responsible for challenging the HCT and HHWB on issues of safeguarding, as set out in Working Together to Safeguard Children: March 2013;

    - The Lead Member will be an elected representative of the HHWB, will chair HCT, and continue as a participating observer of the HSCB as set out in Working Together to Safeguard Children: March 2013.

41. Each will ensure clear lines of communication and will represent the interests of each board at all meetings.

42. Other individual members will take part in working groups across the boards as required and agreed between the HCT, HHWB and HSCB chairs, and will ensure safeguarding is securely embedded in all developments, as well as other priority issues such as commissioning and early help as appropriate.

43. Working Together to Safeguard Children: March 2013 states that: members (of Local Safeguarding Children Boards) need to be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. For each board, (HSCB, HCT and HHWB) all representatives of organisations should be able to:

    - Speak for their organisation with authority;
    - Commit their organisation to partnership policy and practice matters as appropriate; and
    - Hold their own organisation to account and hold others to account.

Resolution Process

44. Each board will request evidence if any issues arise from any aspects of its work. For example, the HCSB will monitor HCT as to its rigour in commissioning or developing safeguarding services, and will call HCT to account should it have evidence that children are not being adequately safeguarded by one or more partners. The resolution would require a formal response/action. Similarly, HCT will hold HSCB to account if necessary over aspects of safeguarding that go beyond early help if it feels HSCB is not providing sufficient support or resource to the issue. This again would require a formal response from the HSCB in order to ensure a resolution.

45. Boards will be open to mutual challenge and will share any unresolved issues with the Strategic Director Children & Enterprise and ultimately with the Chief Executive if not resolved.

REPORT TO: Health & Wellbeing Board

DATE: 18th September 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: End of Life Services

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide an overview of current End of Life services available in Halton including future priorities.

2.0 RECOMMENDATION: That the Board note and comment on the content of the report and the attached Appendix.

3.0 SUPPORTING INFORMATION

3.1 **National Context**

The End of Life Care Strategy: Promoting High Quality Care for all Adults at the End of Life was produced by the Department of Health in 2008. The strategy outlines the 6 key elements of the end of life pathway:

- Step 1 Discussions as the end of life approaches;
- Step 2 Assessment, care planning and review;
- Step 3 Coordination of care for individual patients;
- Step 4 Delivery of high quality services in different settings;
- Step 5 Care in the last days of life; and
- Step 6 Care after death.

In addition the pathway should be supported by the use of well-established end of life tools and a robust clinical support network, comprising of GP's, District Nurses, Consultants in Palliative Care, Speciality Doctors, Macmillan Nurses and Macmillan services and care, support and bereavement services.

4.0 Local Approach

The Model of support in Halton consists of a range of services and systems of support to ensure that the requirements of the patient pathway are met along with the support networks within the community (Appendix 1 Model of provision).

4.1 **Identifying a Patient Approaching End of Life**

Identifying when a patient is approaching the end stages of life is inherently difficult. As such, within primary care it is necessary to

ensure that there is guidance in place to assist in identifying those patients and ensure they are recorded and monitored so that their care can be effectively coordinated.

The Gold Standard Framework (GSF) is a system designed to support this process supported by GSF Prognostic Indicator Guidance. This guidance is to assist GP's in identifying symptoms that would indicate a patient is approaching the last 12 months of life. Once this identification has been made they should then be added to an End of Life register within their GP Practice.

By adding a patient to an End of Life register, this will allow regular multi-disciplinary discussions to take place to discuss that patients care. These discussions will ensure clarification of patient needs, the ability to provide pro-active support and act as a mechanism to prompt advanced care planning discussions.

The aim in Halton is for all GP's to adopt GSF principles in order to provide seamless care at end of life. To facilitate this, a Cancer and End of Life forum with a representative from each GP practice in Halton has been established to identify any gaps and provide an opportunity to share best practice.

4.2 **Advanced Care Planning**

Evidence suggests that most people, if given the choice would prefer to die at home. If a patient has been identified as approaching the end of life it is necessary for the team caring for the patient to initiate discussions to establish what the patient wishes are in relation to their care.

In order for this to happen, we need to ensure that staff and healthcare professionals feel comfortable in initiating these conversations with patients and families and feel confident in explaining the decisions that can be put in place to ensure patient wishes are adhered to.

To facilitate this, an Advanced Care Planning Team has been established within Halton, which includes an End of Life Care Facilitator and a Project Support Officer who are supported by the wider Palliative care network. The role of the Advanced Care Planning team is to provide staff within both health and social care settings with the skills and training to be able to initiate discussions and effectively communicate with patients and families.

To date, a number of initiatives have taken place to improve end of life skills across health and social care including;

- Bespoke training with GP Practices including all staff.
- Half day training events on end of life tools
- Commencement of the Six Steps training programme in 11 Care Homes

- A two day training Course across care management and assessment services with the aim of increasing knowledge of end of life care issues, which was attended by 74 staff including managers, Social workers, Occupational Therapists and Community Care Workers.
- A number of end of life champions identified across social care teams who will attend a Multi-Agency End of Life Champions Forum.

4.3 24/7 Palliative Care Advice Line

Following a recommendation in Dying Well at Home: The Case for Integrated Working and to further support staff in feeling confident to make decisions regarding end of life care, a 24-hour Palliative Care Advice Line Service was implemented in Halton in October 2012, open to all health and social care professionals across Halton. It is staffed by experienced Palliative Care health professionals working in community, hospice and hospital environments who are able to assist staff in making appropriate decisions at the end of life.

To date, the advice line has provided guidance to GP's, District Nurses, Hospital staff and nursing home staff and will continue to act as a palliative care resource. Evaluation and feedback of the service is carried out monthly and the feedback suggests that this is a valuable service in providing confidence to health professionals in making the right decisions at the end of life. One comment stated:

'Particularly at weekends and evenings you can feel isolated when it comes to being unsure of the course of action to take. I felt very relieved that I had an expert to discuss the situation with so I was able to give the correct care / medication with confidence.'

4.4 <u>Choices Available to Patients at End of Life</u>

Once discussions have been initiated with a patient it may become clear that a patient has specific wishes regarding their treatment at the end of life. For example, this could be to remain at home or be cared for within a hospice environment or they may wish to avoid certain interventions if their condition worsens.

As such there are services and documentation that can be put in place to alert all staff involved in their care to these decisions and preferences and ensure that their patient's wishes are clear.

4.5 <u>Supporting patients in the community</u>

There are a range of services available in the community if a patient wishes to be cared for within their home

End of Life Care Service

This service is provided by Halton Borough Council and supports the work of the District Nurses in the community. The service is available 24 hours a day. The service cared for a total of 143 patients in 2011/2012.

Palliative Care Sitting Service
To support carers who may be in the position in which they are the main carer for a relative there is also a palliative care sitting service available.

Macmillan Nursing Team
This is a team of Clinical Nurse Specialists, which operates 7 days a week providing specialist advice, support and education.

Halton Haven Hospice
Halton Haven Hospice provides 12 inpatient beds along with day hospice and outpatient services. The hospice is staffed by Specialists in Palliative Care including a Consultant in Palliative Care Medicine therefore providing expert medical care for those with complex symptoms and for those patients who may prefer to be within a hospice environment. Admissions are generally for people who require further medical care to manage complex symptoms.

Halton Haven Hospice also provides a Family Support Service which is available to both patients and families within the service and can also be accessed following bereavement. The service provided support to approx. 400 individuals in 2011/12, and it is estimated that this service also indirectly benefits many more family members.

2013/14 will see the expansion of the Family Support Service into a new purpose-built facility providing extra capacity along with dedicated 'Men's Shed' area to provide support for the male population in an environment that is tailored to their needs.

Nursing Homes
There are a number of patients who are cared for in nursing homes at the end of their lives. It is important for nursing home staff to be provided with the necessary skills to have end of life discussions and to document patient's wishes which is a key priority for Halton over the next 12 months. To date, a total of 11 care homes have begun a Six Steps training programme which covers the six key elements of the patients' pathway and also provides training on communication skills.

Hospital Palliative Care Services
Avoiding unnecessary hospital admissions is a priority for the CCG and a hospital admission is something which evidence suggests patients would also like to avoid where possible however if necessary both St Helens and Knowsley Trust and Warrington and Halton Hospital Foundation Trust provide a Specialist Palliative Care Service with Consultants in Palliative Care and supporting doctors, nurses and health care assistants should hospital care be needed.

4.6 <u>Decisions Regarding Treatment</u>
In addition to the services and facilities available, there are a number

of decisions that can be made regarding treatment and supporting documentation put in place to record those decisions. These decisions would be made through open discussions and clear communication with patients and families by health professionals who feel confident in their use via the training provided through the Advanced Care Planning Team and the End of Life Facilitator. All decisions would be signed by the most Senior health care professional either the GP or a hospital consultant. The appropriate use of these tools is reliant on open and honest conversations with patients and families.

These could include:

Preferred Priorities of Care This document is produced by the National End of Life Care Programme and is designed to help people prepare for the future, giving them the opportunity to talk about and write down their preferences and priorities for their care, for example their preferred place of care. This was implemented via the Advanced Care Planning Team in 2010 and will continue to be part of the training programmes offered to health and social care staff.

Advance Decisions to Refuse Treatment (ADRT)
An ADRT is a legally binding document that can be put in place to document treatment which the patient does not wish to receive in advance. For example if a patient, due to their illness was likely to lose capacity at a later stage, they may wish to specify the treatment they do not wish to receive, for example they may not wish to have invasive surgery. This was made legal in October 2007 and is discussed as part of the end of life tools training provided by the Advanced Care Planning Team

Do not attempt Cardio Pulmonary Resuscitation (DNACPR)
A DNACPR order is used when a patient does not wish to be resuscitated should their heart stop. Unlike an ADRT this is not a legally binding document and this decision may also be made based on a person's likelihood of survival following a resuscitation attempt.

Within Halton, along with the rest of the North West, there is now a regional DNACPR document being implemented this will ensure that wherever a patient is being treated within the healthcare system, the form is recognised and resuscitation is only carried out for those patients who wish to receive it or for whom it is clinically beneficial

Best Interest Decisions It may be necessary in certain circumstances, for example if a patient lacks capacity, following a review by the healthcare team, that decisions need to be made in the best interest of patients. These decisions would be made by senior healthcare professionals, in collaboration with families or named advocates where possible based on the patient's condition and the likely outcome of any interventions.

For example, resuscitation attempts have a poor success rate and can often leave patients with severe injuries therefore it may not be appropriate in every circumstance to attempt resuscitation, although a patient may not be in a position to make this decision themselves.

Liverpool Care Pathway The LCP was designed to act as a single, structured record for healthcare professionals when patients were thought to be approaching the last few days or hours of their life. Its aim was to provide guidance to ensure that patients remained comfortable and were only receiving treatment that would be of benefit to them.

A review of the Liverpool Care Pathway was requested in 2012 by Care Minister Norman Lamb following intense media scrutiny into its use. Although upon review of secondary care complaints, specifically related to the use of the pathway were limited, it was felt that the use of the word 'pathway' creates confusion and can be misleading for patients, relatives and carers along with confusion in what the pathway means in relation to treatment. The media scrutiny was particularly related to the perceived withdrawal of food and fluids along with treatment, compounded by a lack of communication between healthcare professionals and families.

The subsequent report, led by Baroness Julia Neuberger was released on the 15th July 2013. The report recommended a phasing out of the LCP within the next 6-12 months. The use of a care plan at the end of life is necessary however it requires effective communication with all parties as to why decisions have been made and why this will benefit the patient. Ensuring that this is in place is a priority over the next 12 months.

5.0 Future Priorities

5.1 Training Priorities – Nursing Homes and Social Care Teams

A 2 year strategy has been put in place to deliver end of life tools training to all care homes in Halton, which will also be monitored via the Care Home contracts, managed by Halton Borough Council. It is anticipated that by 2015 all care homes within Halton will have been part of the Six Steps Training Programme

In addition, key champions who have been identified within Social Care teams will be integrated into the existing key champion's network established across care homes. This will allow the transfer of knowledge across settings and the potential for shadowing across health and social care to ensure that best practice and knowledge is shared.

5.2 Coordination of Care

A priority for 2013/14 is the implementation of an Electronic Palliative Care Coordination System (EPACC's) recommended in Dying Well at Home: The Case for Integrated Working. This system is an electronic information system which will operate across primary, community and secondary care to ensure that all health professionals involved in a patients care are aware of what care plans and decisions have been put in place for that patient.

Halton CCG are currently working with the North West EPACC's project lead to design an implementation plan to ensure that the system is able to operate effectively alongside the current systems. This will include pulling together a steering group within Halton so that we are able to deliver this work by 2015.

5.3 Care in the Last few Days/Hours

As highlighted, a key priority is to ensure that the Liverpool Care Pathway (LCP) is replaced with a care plan that is reflective of individual patients' circumstances in the last few days/hours of their life. This replacement care plan will be coordinated by the Integrated Care Network (ICN) (See Appendix 1) which is represented by stakeholders from primary, community and secondary care and will be implemented via the Advanced Care Planning Team across Halton.

5.4 Bereavement Support

2013 will see the commencement of the build of a new Family Support Centre with "Men's Shed" facility incorporated. In 2012 the Department of Health identified £60 million of funding to support hospices across England to implement projects that would improve the physical environment of hospices (Help the Hospices, 2013). Applications were assessed in collaboration with Help the Hospices and following a bid, Halton Haven Hospice was successful in securing funding. The facility aims to deliver:

- Dedicated, purpose designed space to support families.
- Dignified, unobtrusive access to the service without the potential trauma of people having to access support through the In-patient Unit or Day Hospice.
- An innovative approach to meeting the particular needs of bereaved men through integrating a "Men's Shed" space into the new building.

6.0 POLICY IMPLICATIONS

6.1 This report is in line with national policy guidelines.

7.0 OTHER/FINANCIAL IMPLICATIONS

7.1 As outlined funding for the building of the new family support service was secured via Halton Haven Hospice from the Department of Health Grant Funding. Halton CCG is supporting this work by providing

funding for a coordinator post to ensure the service is delivering its intended outcomes.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children & Young People in Halton
Aspects of the service will meet the needs of children and young people requiring End of Life support and care.

8.2 Employment, Learning & Skills in Halton
None identified.

8.3 A Healthy Halton
The "End of Life' service promotes high quality care for all Adults at the End of Life in different settings including, discussions as the end of life approaches; assessment, care planning and review; co-ordination of care for individual patients; and care after death.

8.4 A Safer Halton
None identified.

8.5 Halton's Urban Renewal
None identified.

9.0 RISK ANALYSIS

9.1 A key risk is the need to ensure that the LCP is replaced within the next 12 months. It is necessary for close working arrangements across agencies continue overseen by the ICN Board to deliver this.

10.0 EQUALITY AND DIVERSITY ISSUES

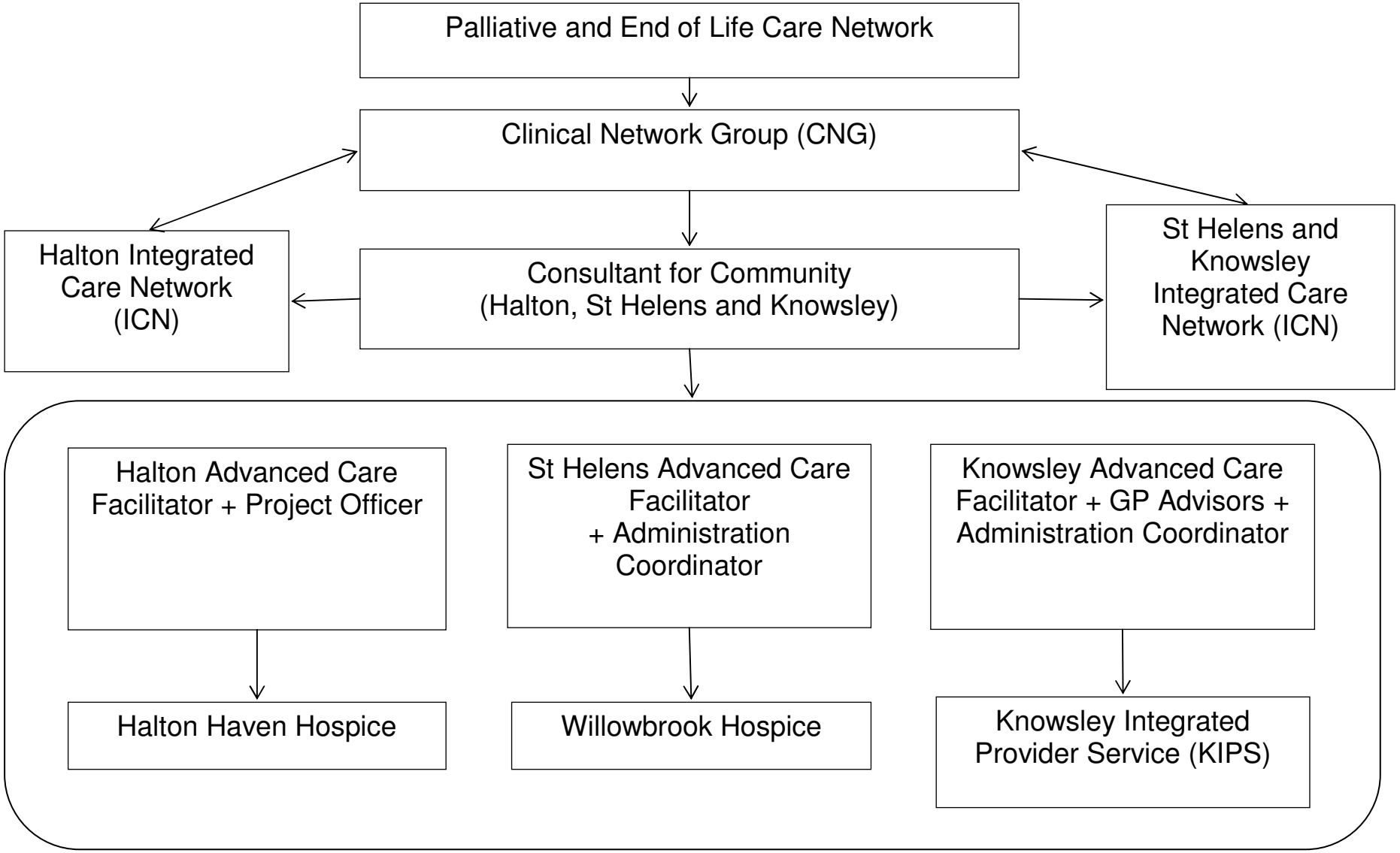
10.1 The service aims to meet the end of life needs of vulnerable people and will therefore have positive impacts for these groups.

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

Document	Place of Inspection	Contact Officer
End of Life Care Strategy: Promoting High Quality Care for all adults at the End of Life, 2008	Department of Health (DH)	Department of Health (DH)
Dying Well at Home: the Case for Integrated Working, London: SCIE, 2013	Social Care Institute for Excellence (SCIE)	Social Care Institute for Excellence (SCIE)
Committed to carers Supporting carers of people at the end of life, 2012	Marie Curie	Marie Curie
National End of Life Care Programme (NEoLCP), 2010, The Route to Success in end of life care – achieving quality in	National End of Life Care Programme (NEoLCP)	National End of Life Care Programme (NEoLCP)

care homes.		
Six Steps, 2011	End of Life Care Network	End of Life Care Network
End of Life Facilitator Report, October 2010-June 2013	Halton Haven Hospice	Averil Fountain

Appendix 1; *Current Model of Clinical Support at End of Life*



REPORT TO: Health and Wellbeing Board

DATE: 18 September 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Adults

SUBJECT: Joint Strategic Needs Assessment Summary update

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with an update on the Joint Strategic Needs Assessment.

2.0 RECOMMENDATION: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 Background to the JSNA summary document

Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA underpins the health and well-being strategy and commissioning plans. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.

The Health and Social Care Act 2012 outlines the continuing role for JSNAs to bring together partners from across the NHS, local government and the voluntary sector to analyse current and future health needs of populations.

At the April 2012 Health & Wellbeing Board, the first executive summary of the JSNA mapped across the life course (the approach advocated by the Marmot Review on tackle health inequalities) was presented.

This approach met with a favourable response from the Board and has continued to do so from various partnerships and stakeholders. As a consequence the revised annual summary has used broadly the same approach, updating data and information since the previous version.

3.2 **Local development of the JSNA**

Since the transfer of the public health responsibility and team to the local authority a public health page has been set up on the Halton Borough Council website and all JSNA chapters, data updates and other products are now located there.

A series of other products have fed into the continuous update process such as detailed health needs assessments and local health profiles.

The JSNA summary document outlines the data across five key life stages:

- Pregnancy and infancy (under 1 year)
- Children (1-15)
- Young adulthood (16- 24)
- Healthy adulthood (25-64)
- Older People

It also includes a set of data on wider determinants of health:

- Economic
- Community safety
- Housing
- Transport
- Social care & vulnerable people

To reflect the need to have a view of the health and wider priorities at a ward level as well as borough level the key findings of each Area Forum Profile are also summarised.

This document is attached as Appendix 1.

3.3 **In depth needs assessments**

Updating a core dataset only gives a brief overview of the main health and social outcomes of the borough. To aid commissioning decisions it is sometimes necessary to explore an issue in more depth. The summary document presents a number of in depth health needs assessments that have been completed February 2012 to March 2013.

- Assessing the impact of the economic downturn on health & wellbeing (February 2012)
- Child EHW
- Adult offenders
- Young offenders
- Ex-armed forces

3.4 **Developments for the JSNA during 2013-2014**

It is important to recognise that the JSNA is an on-going, continuous process, refreshing data to ensure its timeliness, and producing 'deep dive' needs assessments to assist commissioning decisions. The final elements of the summary document detail plans for major refresh elements of the JSNA:

- Children: following discussions with the Children's Trust Executive and Commissioning Partnership, a refresh of all elements of the children's JSNA using a life course approach has begun. This also includes vulnerable children & young people such as Looked After Children and those with disabilities
- Disabilities: following requests for information to support the annual Self-Assessment Framework submission, Liverpool Public Health Observatory were commissioned to undertake a detailed needs assessment for Learning Disabilities and Autism. This covers children and adults and has had input from both adults and children's commissioners from HBC and CCG. This has been led by Halton public health team.
- Environmental Health: this issue is not currently covered within the JSNA. Work will start on developing this section during quarter 2, 2013-14.
- An in depth needs assessment has been jointly commissioned from Liverpool Public Health Observatory on the health needs of homeless people. This will be led by Liverpool public health with input from Halton staff.
- Halton is also participating in a research project on the impacts of fixed point gambling terminals. This is scheduled to report April 2014.

3.5 **Changes since the February 2012 summary**

Despite the continuing challenges the borough faces many of the health indicators show year on year improvements. So whilst the borough's health continues to be, generally, worse than the England average, these improvements show that we are moving in the right direction – we are doing the right things for the right people, who are then able to engage with services, making the most of them to bring about positive changes for themselves, their families and their communities.

Some highlights include:

- Average life expectancy for both men and women has improved. Internal differences in life expectancy for men have reduced.
- Breastfeeding initiation has improved but continues to be below the England average
- Reduced levels of child obesity (now similar to England

levels)

- Improved levels of children achieving a good level of development by age 5.
- Increased levels child immunisations and flu vaccination uptake.
- Reductions in teenage pregnancy rates
- Reduction in the rate of hospital admissions due to self-harm amongst under 18 year olds
- Increased case finding of people with long-term conditions had reduced the gap between estimated (true) prevalence and diagnosed levels of disease.
- Substantial improvements in the uptake of all 3 cancer screening programmes (cervical, breast and bowel).
- Reduction in overall reduction emergency hospital admission rates.
- Unemployment rates have fallen slightly although they remain at significant levels for some parts of the borough.
- Level of qualifications and educational attainment continue to rise. The Borough now performs at the same level as the England average.
- Halton has good outcomes for Looked After Children compared to England and its comparator boroughs.
- Rates of statutory homeless and households in temporary accommodation continue to be lower than England.
- There have seen a fall in the percentage of households in fuel poverty.
- The number of mortgage possession claims and orders has fallen.
- A greater proportion of older people discharged from hospital to intermediate care/ rehabilitation/ re-ablement remain in their own homes.

However, some areas do remain difficult to improve and others have worsened since the previous reporting period:

- Internal differences in life expectancy for women have widened.
- Infant mortality remains at similar levels (low numbers)
- Smoking at time of delivery has only improved fractionally (21.1% smoking at time of delivery 2011/12 compared to 21.7% 2010/11)
- Hospital admissions due to accidental injury for children and older people remain high.
- Hospital admissions due to alcohol remain high and for both under 18s and all ages. However, they have reduced for those under aged 18.
- Smoking levels amongst routine & manual workers remain high and have altered little 2011/12 compared to 2010/11. Overall smoking prevalence has reduced which is good but this does mean the gap has widened.

- Premature mortality (death rates) have improved but remain some of the poorest in the country. However, compared to local authorities in the same socio-economic grouping as Halton, borough death rates are about average (apart from Cancers were the borough performs worst).

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA have been used to develop the Health & Wellbeing Strategy.

The JSNA provides a robust and detailed assessment of need and priorities across Halton borough. As such is should continue to be used in the development of other policies, strategies and commissioning plans and reviews such as those of Halton Clinical Commissioning Group.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and this is reflected in the JSNA, taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication.

6.2 **Employment, Learning & Skills in Halton**
The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents and is reflected in the JSNA.

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
Reducing the incidence of crime, improving community safety and reducing the fear of crime have an impact on health outcomes, particularly on mental health. Community safety is part of the JSNA.

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and will therefore need to be addressed within the JSNA and Health and Wellbeing Strategy. Health Impact Assessments of the Local Development Plan, the Local Transport Plan and the HBC Field development as part of 3MG have taken place. Evidence reviews on the health impacts of housing and ways of addressing these have

been undertaken and an assessment of the health and healthcare costs of fuel poverty presented to the housing partnership.

7.0 RISK ANALYSIS

7.1 Developing the JSNA does not in itself present any obvious risk. However, there may be risks associated with the resultant commissioning/action plans developed based upon it and these will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The JSNA seeks to provide intelligence on which to base decisions on action to tackle health inequalities. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

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

None within the meaning of the Act.

Report Prepared by: Sharon McAteer, Public Health Evidence & Intelligence Team
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HALTON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

PURPOSE:
This document is an annual summary - a supplementary document to support the updating of the JSNA. It reflects work undertaken during 2012 and developments that are taking place during 2013-14.

Updating the JSNA:
This document is the second to use the '*Life course'* approach to summarise data and priorities from the suite of JSNA documents.

Since the commissioning priorities across the JSNA were last reviewed, the Health & Wellbeing Board has agreed its first Health & Wellbeing Strategy, 2013-2016. Based on the JSNA and wide ranging consultation, 5 priorities have been chosen. The board used a prioritisation process and the reasons for choosing the 5 priorities are summarised in this document. Halton Clinical Commissioning Group (CCG) has produced its first overarching commissioning strategy and Halton Borough Council has also updated several of its commissioning plans and strategies.

Each of the health issues and social determinants identified in the 2011 JSNA continue to present challenges locally, although there has been much progress.

The full 2011 JSNA, together with the annual data updates spread sheet, can be found on Halton Borough Council's website at
http://www3.halton.gov.uk/councilanddemocracy/statisticsandcensusinformation/318888/

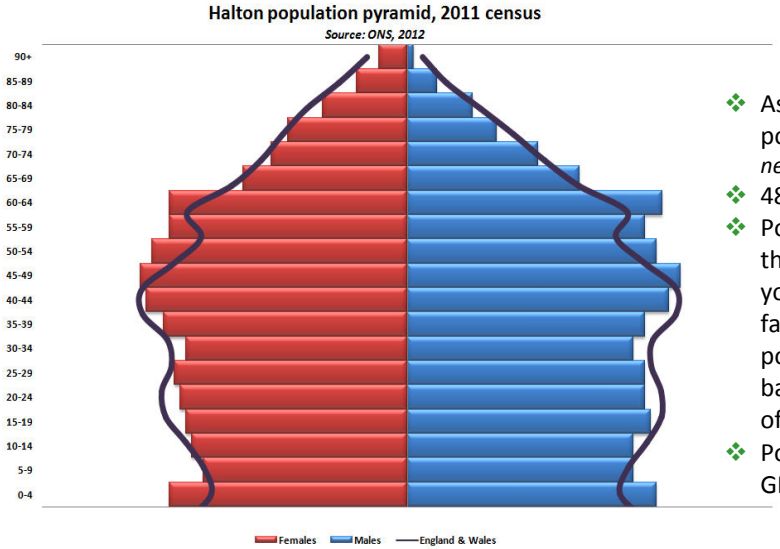
In depth needs assessments and other reports are also available at
http://www3.halton.gov.uk/healthandsocialcare/318895/318899/

If you require any further information about the Halton JSNA please contact Sharon McAteer at: sharon.mcateer@halton.gov.uk or a member of the Public Health Evidence & Intelligence Team at: health.intelligence@halton.gov.uk

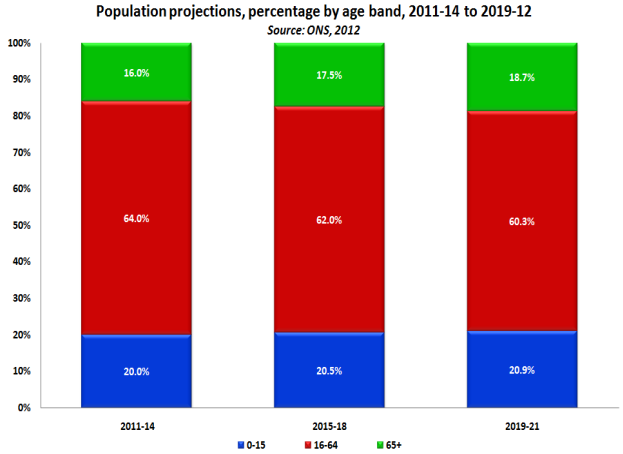
myhalton
living life well

Produced by Sharon McAteer, Public Health Development Manager, Halton Borough Council, August 2013

HALTON JSNA: POPULATION & DEPRIVATION



- As at the 2011 Census, Halton's population was 125,700 *rounded to nearest 100)*
- 48.8% male to 51.2% female
- Population projections based on the 2011 census suggest the younger age band will remain fairly static, with the working age population to shrink and older age band will increase as a proportion of total population
- Population registered with Halton GPs is 128,446 (July 2012).



Index of Multiple Deprivation (IMD) 2010

- Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities). This is the 3rd worst out of the six local authorities which make up the Liverpool City Region, behind Liverpool and Knowsley.
- The ward with the highest average IMD score in 2010 and therefore the most deprived ward in Halton is Windmill Hill. The least deprived ward in Halton is Birchfield.
- The overall IMD is made up of seven domain measures. Daresbury ward does well across all of these whilst Windmill Hill has some of the highest scores.
- Deprivation scores at small area geography (known as Lower Super Output Areas) shows that the area with the highest deprivation is located in Kingsway ward.
- There are 21 LSOAs in Halton that fall in the top 10% most deprived nationally. Of these 10 fall in the top 3% most deprived nationally and 2 fall in the top 1%.

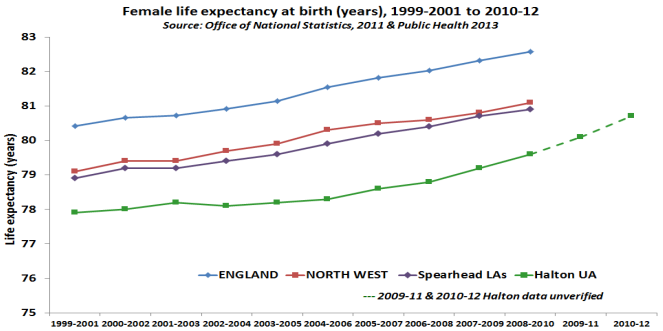
Just a few success stories from across the borough

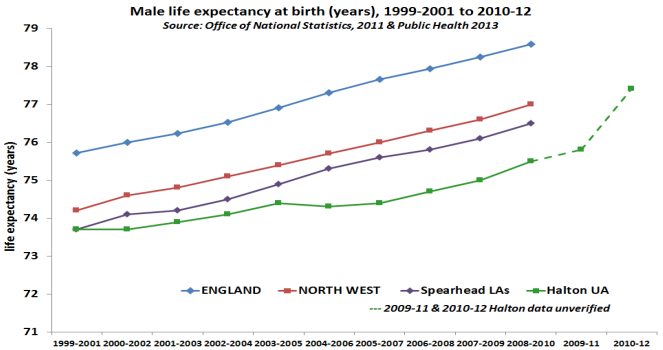
- Halton has been successful in attracting new jobs in to the borough.
- Employment rates as at February 2013 were slightly lower than those seen in February 2012.
- The number of young people not engaged in education and training (NEET) has decreased from 10.3% in 2011 to 8.9% in 2012.
- Attainment of 5 or more A*-C including English and Maths again improved in 2012 and was the Halton's best ever result. Overall, 87% achieved 5 A*-C's, with 59% achieving 5 A*-C's including English and Maths.
- The level of excess winter deaths is lower than England average
- The Infant mortality rate has fallen and is now similar to the national average.
- The rate of statutory homelessness is lower than England average.
- Immunisation rates are similar to the England average.
- There were 125 children in care at 31 March 2012 which gives a lower rate when compared to the England average. A higher percentage of children in care are up-to-date with their immunisations compared to the England average.
- The ASB (Anti Social Behaviour) Victim and Witness Service Impact Report showed a positive impact, providing accessible supportive service to vulnerable hard to reach groups and individuals in Halton. The service has also shown caseload and cost benefits for the police. The service has had positive feedback from users.

…… and lots of others.

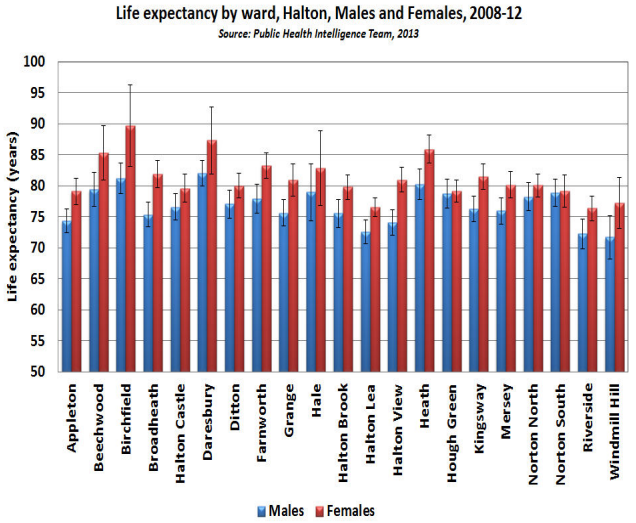
HALTON JSNA: OVERALL HEALTH STATUS

Life expectancy

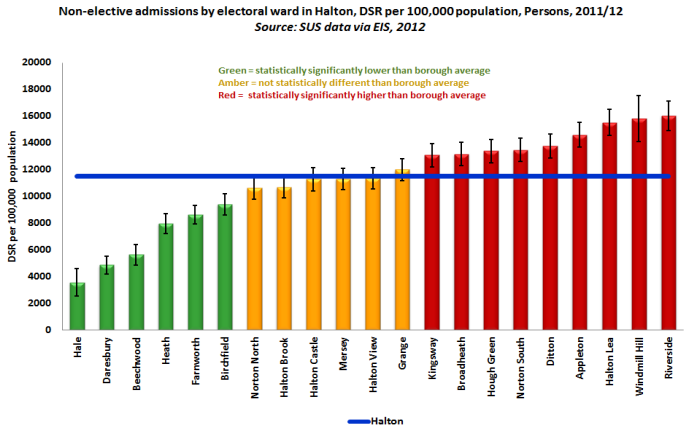




- Life expectancy has risen steadily over time. In 2010-12 average life expectancy in the borough was 77.4 years for men and 80.7 years for women. However, the borough is consistently lower than its comparators (about 3 years lower than the England figures).
- Internal differences in life expectancy range from 71.1 years for males in Windmill Hill to 82.1 years in Daresbury. For females the differences range from 76.4 years in Riverside to 89.7 years in Birchfield ward: a difference of 10.4 years for males and 13.3 years for females
- This is a slight narrowing of internal inequalities for men from 11.4 years and widening for women from 9.4 years during the previous reporting period 2008-10.

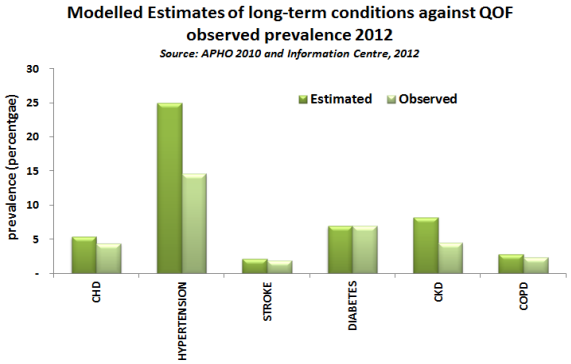


Hospital admissions



- There were 15,035 15,779 emergency admissions, a slight decrease on the previous years figure of 15,779. Injuries accounting for 14.6%, respiratory for 12.1%, digestive 10.3% and circulatory 9.3%. Riverside ward remains the ward with the highest admissions rate (compared to 2010/11) and Hale is now the lowest (in 2010/11 Daresbury was lowest).
- There have been year on year improvements in the number of people identified with long term conditions (CHD slight decrease in number in 2011/12 compared to 2010/11, prevalence rate remained the same). This has further closed the gap between the numbers identified and the estimated levels.

Disease prevalence: expected against observed rates



LONG TERM CONDITION	MODELLED		OBSERVED	
	Number	Prevalence (%)	Number	Prevalence (%)
CHD	6933	5.41	5,651	4.41
HYPERTENSION	32141	25.00	18,760	14.64
STROKE	2868	2.20	2,405	1.9
DIABETES	7072	6.94	7,108	6.97
CKD	7,474	8.2	4,544	4.5
COPD	3635	2.84	3,106	2.42

HALTON JSNA: DATA ON HEALTH & WELLBEING ACROSS THE LIFECOURSE -4-

Pregnancy & 1st year of life

1661 live births (1% pop)

- Smoking at time of delivery ***21.1%,*** higher than comparators
- Low birth weight ***8.5% (2011),*** higher than England rate
- Breastfeeding initiation 51.1% and breastfeeding at 6-8 weeks 22% (2011-12). An improvement on the previous year but remaining lower than comparators
- Access to antenatal care within 12 weeks of pregnancy ***85.5%*** *(Q1-Q3 2010-11)*
- Infant mortality ***4.8 per 1,000 live births*** (2009-11) which is slightly higher than comparators

Childhood (1-15)

23,200 children (19% pop)

- Child Poverty **27.3%**
- Hospital admissions due to asthma (0-18 years), crude rate ***367.9 per 100,000 population (crude rate)***
- Hospital admissions due to accidental injury, 2011-12, ***3010.9 per 100,000 population.*** *An increase from 2010-11*
- Children in Need ***959*** (as at 31 March 2012)(higher rate than NW and England)
- Looked After Children ***125*** (as at 31 March 2012)
- Obesity : ***Reception 9.6%,*** a reduction on previous year.
- Obesity: ***Year 6 19.5%,*** a reduction on previous year
- Immunisation : MMR 1st & 2nd dose by 5years **85.2%** (2011-12), an increase on the 2010-11 figure
- Children achieving a good level of development at age 5, ***55.2%.*** This is an improvement on the previous year but remains lower than comparators and one of the lowest in the country.

Young adulthood (16-24)

14,500 people (12% pop)

- NEETs 2012 **400** people aged 16-18 (8.93%, higher than comparators). An decrease on the 2011 figures.
- Teenage pregnancy: ***41.5 per 1,000 females aged 15-17*** (2011), a reduction on the 2010 rate.
- Hospital admissions due to alcohol: ***122.9 per 100,000 population*** (2008-11), a reduction on previous period.
- Sexually Transmitted infections 2008-10: ***Chlamydia 1851 cases; genital warts 1483 cases***
- Chlamydia screening (2010-11) ***34.4%*** 15-24 year population tested
- Hospital admissions due to self harm, aged under 18, ***204.2 per 100,000*** (crude rate), a reduction on the previous year.

Healthy adulthood (25-64)

67,800 people (54% pop)

Lifestyle choices:
- Smoking prevalence ***23.1%***; prevalence for manual workers ***30.7%***
- Binge drinking ***23.9%***
- Obese ***25.9%***

Number of people with long term conditions (All ages) (QOF 2011-12):
- Hypertension ***18,760***
- CHD ***5,651***
- Diabetes ***7,108***
- COPD ***3,106***
- Stroke ***2,405***
- Depression ***12,471*** (12.4% GP pop aged 18+)

Coverage/uptake of cancer screening (average for CCG, range across GP practices):
- Breast: average ***73.5%***, range ***60.8% to 78.4%***
- Cervical average: ***76.2%***, range ***73.4% to 85.64%***
- Bowel: average ***51.22%***, range ***34.29% to 68.87%***

Hospital admissions (all ages, rate per 100,000 population, 2011-12):
- Emergency admissions ***11,490***
- Alcohol specific ***1017.7***
- Alcohol related ***3,027***
- Cancers ***1,349.55***
- Heart Disease ***514.57***
- Stroke ***163.39***
- Digestive ***1,300.5***

Older people (65+)

18,500 people (15% pop)

Life expectancy (2009-11)
- Males ***76.5 (England 78.91)***
- Females ***80.7 (England 82.89)***

Life expectancy at 65 (2009-11)
- Males ***16.7*** (England 18.40)
- Females ***19.5*** (England 21.05)

Inequalities in life expectancy (by ward 2008-12)
- Males ***10.4 years*** (71.7 in Windmill Hill, Daresbury 82.1) (a decrease in inequality)
- Females ***13.3 years*** (Riverside 76.4, Daresbury 89.7) (an increase in inequality)

All age all cause mortality:
- Males ***843.14 per 100,000*** population (2008-10)
- Females ***610.85 per 100,000*** population (2008-10)

- Hospital admissions (2011-12) due to falls ***, aged 50+, 2768.7 per 100,000 population***
- Dementia: estimated ***1,143 people aged 65+:*** **QOF register (2011-12) 690** people diagnosed (better diagnosed to expected ratio that NW & England)

- Flu vaccination uptake 65+ CCG average ***73.6%*** (2012-13), range ***56.9%-83.1%.*** 9 out of 17 achieved 75% target.

Populations all based on 2011 census rounded to nearest 100 (ONS 2012) except live births which is actual numbers for 2012.
Population percentages rounded to nearest whole number (based on population of 125,700)

HALTON JSNA: DATA ON WIDER DETERMINANTS OF HEALTH

Economic

- Unemployment (Job Seekers Allowance) rate ***4.8% = 3927*** adults (May 2013)
- ***11.4%*** working age adults in Windmill Hill unemployed (Job Seekers Allowance)
- Working age adults claiming out of work benefits ***13,650*** (February 2013) or ***16.6%.***
- Windmill Hill ***37.6%*** working age adults claiming out of work benefits (February 2013) is the highest in the borough. (range 4.7% to 37.6%)
- Youth unemployment rate (18-24years) ***10.5% = 1,170*** people (May 2013)
- Business survival rate (after 1 year) similar to England average at ***90.8%*** (Eng 90.9%).
- Average weekly earnings for full-time workers lower than England and North West averages, ***£452.2*** in 2012 (NW £472.5, GB £508)
- Gap between Halton adult qualifications & GCSEs compared to England has narrowed since 2010 across all levels.
- Proportion of working-aged adults with no qualifications slightly higher than England average, ***11.5%*** (Jan 2011-Dec 2011).
- ***75.9%*** working aged adults economically active (Oct 2011-Sept 2012) (NW 75.2%, GB 76.7%)

Community Safety

- Anti-social behaviour incidents ***83.5, per 1,000*** residents
- Hate crimes ***0.4, per 1,000*** residents
- Domestic incidents ***116, per 1,000*** residents
- Domestic violence ***46, per 1,000*** residents
- Levels of crime were seen as important indicators for making an area a good place to live (2011 Residents survey)
- Overall crime rate ***42.8 per 1,000*** residents

(all data is for 2011)

Housing

- At 31st March 2013 there were ***54,833*** dwellings in Halton.
- ***25%*** housing in Halton is social rented accommodation (higher than the England level of 10%)
- There were ***86*** Statutory Homeless Households and ***15*** households in temporary accommodation (2012/13). This means rates per 1,000 households are much lower in Halton than in England.
- Homelessness was prevented for a further 431 households during the year.
- In 2011 ***14.9%*** of households were in fuel poverty. This is a fall on the previous 2 years (18.1% for 2010 and 19.3% for 2009). Previous to this rates had been rising.
- During the first three quarters of 2012/13 ***165*** mortgage possession claims were issued, of which ***120*** resulted in a repossession order being made.
- Over the same period ***275*** Landlord Possession claims were issued, resulting in ***185*** orders being made.

Transport

- The number of cars licensed in Halton between 2002 and 2009 increased by ***22%***
- Since 2001, Halton has experienced an ***increase in traffic growth***. This increase is greater than the increase experienced by Great Britain as a whole.
- ***27%*** of households are without private transport (no car/van), compared to 25.8% across England (Census 2011)
- ***40.4%*** use their car/van to get to work, ***5.6%*** travel on foot, ***1.3%*** use a bicycle, ***4.1%*** bus, ***4.3%*** car passenger (Census 2011).
- The rate of all persons and children killed or seriously injured on the roads is higher than comparators. Steady reductions since 2000, but static for last 4 years. Number children seriously injured has more than doubled over the same four. There were ***40*** people killed or seriously injured 2012 with ***337*** slightly injured (a reduction on the previous year)
- The number of people working from home increased from 3.6% (2001 census) to ***4.2%*** (England 6.9%) (Census 2011).

Social care & vulnerable people

- Proportion older people discharged from hospital to intermediate care/ rehabilitation/ re-ablement who are still living 'at home' 91 days after discharge: ***74.1%. This is an increase on previous figures*** but lower than NW and England. Higher for females (72.5%) than males (61.5%) and for those aged 65-74 (82.4%) than total 65+ population
- Clients and carers receiving self directed support as percentage of all receiving community based support ***49.5% = 2785*** out of total of 5620, a significant rise on previous reported figure of 27.5%.
- Adults with learning disabilities in settled accommodation ***77.2%,*** higher than NW & England (2011-12)
- Proportion of adults on CPA receiving secondary mental health services in settled accommodation ***80%*** (2011-12).
- Rate of Disability Living Allowance claimants ***8.53%*** (England 5%) (August 2012)

In developing our first joint Health & Wellbeing Strategy the wide social influences on health and the need to work on prevention & early intervention across the life course have been at the centre of priority setting

Using the JSNA to understand need

Early discussions about the Health and Wellbeing Board produced a consensus on the need to focus on prevention and early detection and the value of using the Marmot Review life course approach.
The February 2012 JSNA summary document pulled data and commissioning priorities from all the JSNA chapters in to 5 broad life stages.
This enabled Health & Wellbeing Board members to see what the issues were overall but also to clearly identify health and wellbeing needs for particular sections of the population. This helped identify key priority groups to target, for example, for hospital admissions due to injuries, young children and older adults were the groups most at risk of accidental injury.
The summary document also looked at the wider determinants of health, detailing the levels of need and commissioning priorities.

Information on these life stages and wider determinates are updated in this summary.

Prioritisation process

The Health Strategy sub-group sifted the issues and identified a list of potential priorities across all life stages and wider determinants where performance was poorer than comparators and/or where it had worsened or had been resistant to change over recent years.

A further sifting produced a shorter list of issues, all of who merited further investigation and discussion. This list was used for a wide ranging community consultation and also with the Health & Wellbeing Board.

A prioritisation framework was developed and agreed with the Health & Wellbeing Board. Information on all the 'shortlisted' issues was provided across the prioritisation framework categories.

Chosen Priorities

The Health & Wellbeing Board considered the feedback from the community consultation events and information provided from the JSNA to agree a small number of priorities were they felt significant action needed to be taken.

The priorities chosen were:

- **Prevention and early detection of cancer**
- **Improved child development**
- **Reduction in the number of falls in adults**
- **Reduction in the harm from alcohol**
- **Prevention and early detection of mental health conditions**

Making it happen.
The Health & Wellbeing Strategy:

- Does not replace existing strategies, commissioning plans and programmes, but influences them.
- Agreed that integration is a key strategic approach with all partners working together to deliver joint commissioning, bring about a culture change and joint advocacy and policy work.
- Has a set of Action Plans to meet the key priorities.
- The Wellbeing Areas will be utilised, based on the existing Area Forum boundaries, to deliver the Board's vision at a community level.
- The Well Being Practice model commissioned jointly by the council and Halton Clinical Commissioning Group underlines their commissioning intentions to focus provision around local communities.

Ultimate responsibility for the monitoring of the implementation of the Strategy and Action Plans against set outcomes and key performance indicators lies with the Health and Wellbeing Board who are accountable to the public.

HALTON JSNA 2012: HEALTH & WELLBEING PRIORITIES

Early Child Development

- **Strategic Fit:** relevant to public health outcomes framework and identified as key action in Marmot Review on health inequalities
- **Health Inequalities:** significant impact on outcomes in later life
- **Strength of Evidence:** some
- **Value for Money:** likely to be cost saving
- **Magnitude of benefit:** significant
- **Number of people benefiting:** whole population
- **Public acceptability:** highly desirable
- **Risk of not investing:** high impact

Cancer

- **Strategic Fit:** relevant to public health outcomes framework and identified as high priority in the JSNA due to high death rates .
- **Health Inequalities:** major cause of continuing health inequalities. Highest death rates in England for women and one of highest for men.
- **Strength of Evidence:** strong
- **Value for Money:** clear cost benefit, especially screening and behaviour change
- **Magnitude of benefit:** significant benefit on life expectancy and quality of life
- **Number of people benefiting:** over 5,000 people screened each year; over 3,000 accessing health improvement services
- **Public acceptability:** very high
- **Risk of not investing:** significant as major cause of death and disability

Mental Health

- **Strategic Fit:** relevant to all three national outcomes frameworks. Government strategy. High level of mental ill health, self harm and unemployment identified in JSNA.
- **Health Inequalities**: largest single cause of healthy life years lost
- **Strength of Evidence:** some interventions have sound evidence e.g. NICE guidance; Foresight report
- **Value for Money:** cost benefit analysis of NICE guidance; other areas less clear although likely to be cost saving; Foresight Report and national strategy provide for evidence.
- **Magnitude of benefit:** substantial impact on levels of ill health and costs to health and care budgets as well as wider economy.
- **Number of people benefiting:** over 5000 e.g. 1 in 4 attendances as GP mental health related
- **Public acceptability:** highest priority from public consultations
- **Risk of not investing:** high impact

Alcohol

- **Strategic Fit:** relevant to public health outcomes framework; new national strategy. High levels of alcohol related harm - hospital admissions and community safety
- **Health Inequalities:** current limited capacity for Tier 1 (prevention) and Tier 4 (treatment for highly dependent drinkers); rates of admissions higher than national average. High rates of undewr-18 admissions
- **Strength of Evidence**: NICE guidance for schools-based prevention and treatment; national strategy
- **Value for Money:** sound cost benefit analysis – NICE and cost saving - National Audit Office £1 investment saves £4.
- **Magnitude of benefit:** minimum pricing can bring about large improvements, including life expectancy and reduce social burden
- **Number of people benefiting:** large numbers drinking above recommended levels, 5000+
- **Public acceptability:** public priority
- **Risk of not investing:** high impact

Falls amongst older people

- **Strategic Fit:** relevant to public health outcomes framework; high levels of falls identified in JSNA. Impact on other outcomes frameworks re independent living
- **Health Inequalities:** significant impact on outcomes for older people; one of highest rates of hospital admissions due to falls in England.
- **Strength of Evidence:** NICE guidance on falls prevention.
- **Value for Money:** cost benefit analysis within NICE guidance **Magnitude of benefit:** impact on disability, mobility, social isolation and loss in independence
- **Number of people benefiting:** over 4000 falls amongst 65+ per year and predicted to rise due to aging population
- **Public acceptability:** likely to have high level of acceptability
- **Risk of not investing:** to date lack of strategic approach

HALTON JSNA: AREA FORUM (AF) HEALTH & WELLBEING PRIORITIES

AF1
Broadheath
Ditton
Hale
Hough Green

Similar to the Halton averages across all academic, environmental and crime indicators.

Similar to the Halton figures for unemployment – however this is still worse than the England figures.

Overall, Broadheath, Ditton and Hough Green similar to the Halton average for the majority of the health indicators.

However, Hale tends than the Halton and England average.

Alcohol-specific hospital admissions for males are significantly higher than the Halton average for Broadheath and Hough Green.

Smoking quitter rates are significantly higher for Broadheath and Hough Green, but are significantly lower for Hale.

AF2
Appleton
Kingsway
Riverside

Higher than average levels of 16-18's Not in Education, Employment or Training (NEET) and higher than average levels of children claiming free school meals.

High levels of anti-social behaviour, burglary, criminal damage to dwellings and deliberate fires.

Higher rates of unemployment, people on out-of-work benefits and youth unemployment than the Halton average. The area also has low average house prices.

Generally worse than the Halton average for the majority of the health indicators, particularly in terms of alcohol hospital admissions and life expectancy.

Smoking quitter rates significantly better for all wards in the Area Forum compared to the borough average.

AF3
Birchfield
Farnworth
Halton View

Lower than average levels of children claiming free school meals.

Crime is comparatively low.

Relatively low levels of unemployment, worklessness, youth unemployment and 16-18's Not in Education, Employment or Training (NEET). High levels of GCSE attainment (5+ A*-C inc. English and Maths).

Health generally better than the borough average.

Levels of overweight and obese children are around the same or lower than the Halton and England averages.

Admissions to hospital due to alcohol-related and alcohol-specific conditions are lower than the borough average.

Smoking quitters rate significantly worse than the borough average.

AF4
Grange
Halton Brook
Heath
Mersey

Has the largest population out of the 7 area forums in Halton.

Quite poorly performing economy (when compared with Halton's average) and quite poor crime rates.

However, Heath ward is an exception, as this area generally performs better than the Halton average across most indicators.

Grange, Halton Brook and Mersey generally perform similar to or below the borough average for the health indicators. However, Heath tends to perform better.

The percentage of overweight or obese children in Reception and Year 6 is higher than the Halton average, (except for Year 6 in Halton Brook).

Percentage of low birth weight babies is higher than the borough average.

AF5
Halton Castle
Norton North
Norton South
Windmill Hill

Higher than average levels of NEET and lower GCSE pass rates than borough average.

Contains some of the most deprived areas in Halton. Norton North is an exception to this.

Very high levels of unemployment, youth unemployment and worklessness. Very low average house prices.

Deaths under 75 years of age due to cancer higher than the Halton and England averages (except Norton North).

Alcohol-attributable and specific hospital admissions are higher than the Halton and England averages (except Norton North).

The percentage of overweight or obese children in Reception is higher than the borough average.

Smoking quitter rate is higher than the borough average, except for Halton Castle which is slightly lower

AF6
Beechwood
Halton Lea

Consists of two differing areas, the ward of Beechwood is one of the most affluent in Halton, with low levels of unemployment and crime.

Halton Lea is quite deprived, with high levels of unemployment and worklessness and low house prices.

Crime also remains an issue in Halton Lea But is lower than Halton average in Beechwood.

Beechwood better than the borough average for all but two of the health indicators (cancer incidence is slightly higher and the smoking quitter rate is lower).

Halton Lea worse than the Halton and England averages for the majority of health indicators.

AF7
Daresbury

Has the smallest population out of the 7 area forums in Halton .

NEETs: lower than borough average.

All crime indicators are better than borough average.

Area one of the most affluent in Halton, with low levels of unemployment, and higher than average house prices.

Better than the borough average for the majority of health indicators.

Highest male life expectancy in Halton.

The percentage of overweight and obese children in Reception and Year 6 is slightly higher than the England and Halton averages.

Assessing the Impact of the Economic Downturn on Health and Wellbeing (February 2012)

Key Findings

This recession is different than others:

- Diminished safety net for the unemployed
- New unemployment along side structural worklessness
- Changing nature of work environment – less secure employment
- Areas hard hit already have low resilience
- Reduced welfare support plus public sector cuts in services

Some groups are especially vulnerable

- Those already disadvantaged
- Ethnic minorities and women – disproportionately employed in public sector
- Disabled and older people – heavier reliance on public sector services
- Children living in poverty – low income and workless families

Health impacts: adults

- Mental health & wellbeing of adults –job insecurity and unemployment leading to increased use of mental health services and welfare advice
- Food poverty – increased reliance in cheap high fat, energy dense 'junk food' and use of food banks
- Increases in alcohol consumption (young men especially)
- Cuts in legal aid and welfare may leave women and children more at risk of domestic violence (economic dependence)
- Possible affect on mortality rates
- Fuel poverty has increased by 31% to 50% across Merseyside between 2006 to 2009

Health Impacts: children & young people

- Mental health & wellbeing of children
- School staffing reductions could affect educational development
- Increasing child poverty can affect child development in to adulthood
- High youth unemployment – attempted suicides up to 25 times more likely for unemployed young men than those in employment

Child emotional health and wellbeing (October 2012)

Key Findings

- Across Merseyside, there are likely to be between 1,804 to 2,706 new mothers with a mental health problem
- Good level of development at age 5:
- Having GCSEs reduces the risk of depression at the age of 42 by five percentage points : GCSE attainment has been improving
- Analysis at small area level shows many areas across Merseyside where school absence rates are between 11.3% to 22.5%.
- Research suggests that almost 1 in 4 children (24%) who are in receipt of disability benefit have an emotional disorder (ONS, 2005).
- In Merseyside, for under 18's admitted to hospital with alcohol specific conditions, levels are more than twice as high as the national rate
- Being in education, employment and training between the ages of 16-18 increases a young person's resilience. In 2011 across Merseyside, levels of young people who were 'NEET' were higher than the average
- Conception rates amongst those aged under 18 are higher than the national average in each Merseyside area except Sefton
- In Merseyside in 2010, each local authority (with the exception of Sefton) had levels of child poverty significantly worse than the national average
- Looked after Children across Merseyside all had lower levels of emotional wellbeing than the national average (2011), apart from in Sefton which was higher.
- Across Merseyside, estimated to be significant numbers of children living with a parent with mental health problems, included those who live with a problem drinker and/or drug user who also has mental health problems.
- For those children and young people with mental health conditions severe enough to be admitted to hospital, rates of admission were higher than national and North West averages in each local authority in Merseyside.
- Children and young people from more deprived areas are significantly more likely to be admitted to hospital for self-harm. In Merseyside rates were worse than the national average.

Both reports included a set of recommendations for local commissioners and policy makers

Full needs assessments detailed on pages 9 and 10 can be found at http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

Adult offenders (June 2012)

Prisons

❖Offenders and staff were generally satisfied with prison health care.
❖Areas for improvement included the need to submit 'applications' for health care at most prisons, which could deter prisoners with low literacy levels from seeking help.
❖Offering the option of health care on prison wings would increase uptake.
❖Prisoners reported that questions about accommodation, employment, benefits etc, were sometimes only raised shortly before discharge, which did not give sufficient time to plan.
❖Prisoners and health care staff also mentioned that it was easy to access drugs in prison. However, being sent to prison provided an opportunity for offenders to withdraw from drugs, with excellent support services.
❖ Other areas of concern for prisoners and prison health care staff included security procedures delaying transfer to hospital.
❖Female prisoners reported losing residency of their children whilst in prison. Women lost accommodation whilst in prison, and because they served relatively short sentences, it was difficult to get appropriate accommodation in place prior to discharge: the same was true of issues such as employment, benefits etc.

Probation/other

❖Wider health needs such as accommodation, employment and benefits advice were key concerns. Accommodation immediately following discharge was not always conducive to preventing re-offending. Female offenders did not always feel safe using accommodation/services that were used by male offenders.
❖Employment and training needs were of priority health concern. Although provision for some groups of offenders was excellent, more comprehensive 'signposting' for offenders was necessary.
❖Services that were specifically targeted at female offenders, were highly valued by both offenders, and staff. This included being able to access a range of services under one roof. Women were also able to get basic needs met, e.g. food, and access to a washing machine.
❖Offenders and health care staff expressed the view that services were in place, should offenders be willing/able to use them. Offenders were more likely to use services where they could access several services under 'one roof', or drop-in services that they were able to access immediately.

Young Offenders (March 2013)

Interviews were conducted, with young offenders at HMOI Hindley, and Red Bank Community Home, and with young offenders being managed in the community by Merseyside YOSs. Interviews were also conducted with members of staff.

Accessibility was key in terms of ensuring that young people engaged with services in the community, and staff were very flexible about where and when they saw young people. Key areas for improvement identified include gaps in services for those aged 16-18, and in provision for wider health needs, such as accommodation and education, training and employment needs. Earlier identification of health problems, and increasing the confidence of front-line staff to identify these problems, particularly ADHD and mental health problems, was a further recommendation.

Health needs assessment for ex-Armed Forces personnel (March 2013)

❖Estimated 42,659 ex-Service personnel in Merseyside, aged under 65.
❖ A high proportion of UK recruits come from more deprived
❖Service in the armed Forces may have a positive impact on the health of individuals who might otherwise have had a poorer diet, limited exercise, and been at risk of unemployment and criminality.
❖However, a study conducted by the Royal College of GPs found that the risk of death for those in the Army was 1 in 1000, 150 times higher than for the population as a whole (rate is lower for those in the Navy and the RAF).
❖Conflicts in Iraq and Afghanistan have increased the risk of injury that results in amputation.
❖Some evidence, that ex-Armed Forces personnel aged under 65 were more likely to report long term health problems than their peers in the general population.
❖Some evidence that alcohol misuse is a problem.
❖Stress and common mental health problems may also be a feature, although many personal do not ask for help.
❖younger members of the armed Forces returning from duty were more likely to commit violent offences than the rest of the population. 20% of males aged under 30 had been convicted with violence, compared with 6.7% of civilians. King's College London has recently begun a large scale study, looking at the impact of military Service upon families.

Full needs assessments detailed on pages 9 and 10 can be found at http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

National Institute of Health & Clinical Evidence (NICE) guidance

NICE are global leaders in the production of gold-standard guidance, based on bespoke evidence reviews into the cost effective and efficient interventions across clinical and public health priorities. These are supplemented by commissioning guides and care pathways within and across individual pieces of guidance to support commissioners and providers in ensuring robust care management. NICE is also involved in the development of the Quality Outcomes Frameworks for GPs and will soon be tasked with producing guidance on key areas of social care. Currently housed on the NICE website are:

- **41** Quality standards
- **46** Public health guidance
- **176** Clinical guidelines – primary and community care
- **294** Technology appraisals e.g. drugs
- **395** Interventional procedures – secondary care

NHS Evidence

It is not possible to find ready-made systematic reviews of evidence on every subject. It is sometimes necessary to supplement evidence from NICE guidance and/or national policy with bespoke reviews of evidence. NHS Evidence provides a portal through which to search multiple databases of primary research papers, policy documents, NICE guidance, Social Care Institute of Excellence (SCIE) guidance and so on.

Local Insight work

Intelligence reports and data tell us what is happening but often stop short of telling us why. For example we know that cancer deaths in Halton are amongst the highest in the country. We know some of the risk factors that lead to this such as smoking rates, screening uptake and to some extent deprivation. Once we know what is happening we need to understand why in order to put in place appropriate services and advice that connect people people's attitudes, motivations, barriers, aspirations and so on. Locally, a range of research techniques are used to discover these insights, such as.

- Lifestyle Survey amongst residents aged 18+
- Social marketing, for example, on Impaired Glucose Regulation (IRG)
- Schools survey

Needs assessments, equity audits, health impact assessments

The Public Health Evidence & Intelligence team carry out are range of topic based health needs assessments and health equity audits. These use a wide range of local and national data, policy, evidence reviews and details about local services and local consultations (where available) to describe the current and future health needs of our local communities. They also assess where gaps in service provision and/or improvements in service delivery mechanisms or performance are needed to reduce inequities. Needs assessments are also carried out by other teams/staff, of major policy areas such as Housing, Child Poverty and Substance Misuse. Recently, some of the larger scale polices and developments in the area have been subject to health impact assessments to determine likely impacts of the developments at various stages and remedial action to ensure potential negative impacts are not realised.

In-depth needs assessments:

Diabetes	Cancer	Alcohol	Older People
Maternity	Cardiovascular Disease	Chronic Obstructive Pulmonary Disease	Young People's Sexual Health
Pharmaceutical Needs Assessment	Adult Mental Health	Children & Young People's emotional health & wellbeing	
Children in Care	Housing	Child Poverty	Sexual Violence
Adult Drug Misuse	Young People's Drug Misuse	Adult Offenders	Young Offenders
Military Veterans	Learning Disability & Autism	Child & Adolescent Mental Health	

In development

Child Speech, Language and Communication Needs Assessment

Homelessness (due April 2014)

Research: Health & Wellbeing Impacts of Fixed Odds Betting Terminals (due April 2014)

Health Impact Assessments:

Core Strategy Local Transport Plan Castlefields Health Centre development

Assessing Impact of the economic downturn(February 2012) HBC Field development

Profiles:

National : general health profile; child health profile; CVD; Diabetes; GP practice

Local: Area Forum profiles; dementia; COPD; set of cancer profiles

It is not the intension of JSNA to update every element on an annual basis. The full refresh will fall in line with the Health & Wellbeing Strategy timeline i.e. it will be a three-year rolling programme of work. In addition to in-depth needs assessments, research and analysis, the core dataset for the overall JSNA and the Area Forum profiles will be updated on an annual basis.

The following information details key developments and issues for 2013.

Focus on: children

Children's Trust Executive Group requested a review of the children's element of the JSNA. Using the lifecourse approach, a template has been agreed by public health intelligence and key stakeholders through the Children's Trust Commissioning Partnership. A task & finish group has been established to oversee the review and rewriting of this work. Focus on:

- Early years
- School age
- Transition to adult services
- Vulnerable groups e.g. children in care, children with complex needs
- Wider social and economic issues as they affect families and children

It is envisaged this review and rewrite will take the whole of 2013/14.

Focus on: Disabilities

The current JSNA includes a chapter on physical, sensory and learning disabilities. However, this generic consideration of disabilities has not given scope to explore issues about specific types of disability in any detail. A piece of work has been commissioned across Merseyside, Halton and Warrington to assess the needs of people with learning disabilities and autism. ***Completion is due August 2013.***

The RNIB has recently published a toolkit for assessing need to people with eye health problems. The need to a work on sensory disabilities and physical disabilities will be explored towards the end of 2013/14.

Focus on: Environmental Health

The JSNA currently does not include any reference to environmental health issues. Given the history of and continuing concern about such issues it has been agreed to write a new chapter detailing the level of environmental health issues, best practice and current provision. This can then be used for onward planning of preventative and remedial activity needed.

It will link closely to the Local Development Plan which details spatial usage and developments over the next 15 years.

The *scope* and datasets needed will be agreed in the autumn of *2013, with the* ***chapter being completed during 2014*** *(schedule to be agreed)*.

Outcomes Frameworks: Role of JSNA in base lining and target setting

Data contained in the JSNA will be used to establish the baseline position and looking at trends will assist in setting targets that are realistic yet challenging.

Staff leading on each priority have been working with public health intelligence staff. Additional work by the public health intelligence staff looking at each of the national outcomes is ongoing. Close links are being made across the local authority intelligence and performance teams as well as CCG. Information sharing agreements with Commissioning Support Unit and data from NHS Commissioning Board, Local Area Teams and Public Health England are also needed.

Collaborative working to assess need

It is important to continue to work on a bigger footprint where with delivers economies of scale and enables scarce skills to be utilised locally.

- Cheshire & Merseyside Public Health Intelligence are currently reviewing their collaboratively commissioned research & intelligence.
- Needs assessments continue to be generated for Liverpool Pubic Health Observatory
- Explore possibility of undertaking Secondary Care Demand modelling .
- ChaMPs (public health network) collaborative service work plan is being developed
- Working within the new NHS commissioning arrangements, for example, on the Pharmaceutical Needs Assessment

REPORT TO: Health and Wellbeing Board

DATE: 18th September 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Adults

SUBJECT: NHS Health Check Programme

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform members of Halton's Health and Wellbeing Board of the NHS Health Check Programme and to make recommendations on how health checks should be implemented in Halton.

2.0 RECOMMENDATION: That

1. the report be noted; and

2. Members comment on the recommendations for local implementation contained in section 7 of this report.

3.0 SUPPORTING INFORMATION

3.1 From 1 April 2013, local authorities took over responsibility for the NHS Health Check programme, previously the responsibility of Primary Care Trusts (PCTs). The provision of NHS Health Check risk assessments is a mandatory requirement for local authorities. The Department of Health and Public Health England issued joint draft guidance in May 2013 to support local authorities to fufil their statutory duty to offer health checks to the local eligible population and advise on where there is scope to tailor programmes to local needs.

3.2 The NHS Health Check programme is a public health programme for people aged 40-74 which aims to keep people well for longer. It is a risk assessment and management programme to prevent or delay the onset of diabetes, heart and kidney disease and stroke. Together these conditions account for a third of the difference in life expectancy between the most deprived areas and the rest of the country.

3.3 The programme also aims to reduce levels of alcohol related harm and raise awareness of the signs of dementia and where people can go for help. Everyone attending a NHS Health Check will have their

alcohol consumption risk assessed. In addition, people aged 65-74 will be informed of the signs and symptoms of dementia and sign posted to memory clinics if needed.

3.4 As Health Checks is a public health programme aimed at preventing disease, people who have been previously diagnosed with the following are excluded as they should already be being managed and monitored through existing care pathways:

- Cardiovascular disease;
- Coronary heart disease;
- Chronic kidney disease (CKD);
- Diabetes;
- Hypertension;
- Atrial fibrillation;
- Transient ischaemic attack;
- Hypercholesterolaemia;
- Heart failure;
- Peripheral heart disease;
- Stroke.

Also excluded are people:

- Being prescribed statins;
- Who have previously had an NHS Health Check or any other check undertaken through the health service in England and found to have a 20% or higher risk of developing cardiovascular disease over the next 10 years.

3.5 Local authorities have the flexibility to cover a wider age range or include everyone aged 40 to 74 years but they are advised to consider the cost and benefits of doing so.

4.0 **Local authority responsibilities**

4.1 From 1 April 2013, local authorities are responsible for:

- Commissioning the risk assessment element of the programme (mandatory);
- Monitoring of offers made to complete a NHS Health Check (mandatory);
- Monitoring and seeking continuous improvement in take up of the programme (mandatory);
- Promotion/branding of the programme;
- Risk management and reduction (lifestyle interventions).

4.2 Commissioning and monitoring of the risk assessment element of the NHS Health Check is a mandatory public health function in the Health and Social Care Act 2012 and requirements upon councils

are set out in The Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013. The programme is to be funded from the local authority ring fenced Public Health budget.

4.3 Specifically, local authorities must make arrangements:

- for each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible;
- so that risk assessments include specific tests and measurements;
- to ensure that the person having their health check is told their cardiovascular risk score and other results are communicated to them;
- for specific information and data to be recorded and, where the risk assessment is conducted outside the GP's practice, for that information to be forwarded to the person's GP.

4.4 Local authorities are also required to seek continuous improvement in the percentage of eligible individuals taking up their offer of a NHS Health Check. It is for each authority to determine how best to do this and to make their own decisions about continuous improvement bearing in mind that take up rates for Health Checks is one of the indicators in the Public Health Outcomes Framework. Whilst draft government guidance acknowledges that 100% take up is unlikely to be achieved and does not set targets, it suggests that over time authorities may wish to aspire to take up rates comparable with screening programmes (in the region of 75%). Local authorities will be required to provide data returns which will be published allowing national and local comparisons of achievement.

4.5 The risk reduction elements of the NHS Health Check are the shared responsibility of both councils (lifestyle interventions) and Clinical Commissioning Groups (clinical interventions). Where additional follow up and testing is required, for example, where someone is identified as being at high risk of having or developing vascular disease this remains the responsibility of primary care and is to be funded through NHS England.

5.0 **The risk assessment**

5.1 The risk assessment requires a number of tests and measures to be carried out, as set out below:

- Age
- Gender

- Smoking status
- Family history of coronary heart disease
- Ethnicity
- Body mass index (BMI)
- Cholesterol level
- Blood pressure
- Physical activity level
- Cardiovascular risk score
- Alcohol Use Disorders Identification Test (AUDIT) score.

In addition those aged 65-74 should be made aware of the signs and symptoms of dementia and signposted to memory services if appropriate.

The tests and measurements to be used as set out in the draft Best Practice guidance are detailed in Appendix A.

5.2 The use of a risk engine to calculate the individuals' risk of cardiovascular disease in the next ten years is required, and everyone who undergoes a NHS Health Check must have their cardiovascular risk score communicated to them as well as their BMI, cholesterol level, blood pressure and AUDIT score.

5.3 Local authorities are free to decide where Health Checks are carried out and who conducts them but must ensure that staff who carry them out are appropriately trained and are advised to ensure quality assurance systems are in place e.g. ensuring that actions taken at certain thresholds are consistent with national guidelines. Where the assessment has taken place outside of the GP practice (e.g. in a pharmacy or community setting) there is a legal requirement for the above information to be forwarded to the individual's GP.

6. Guidance on risk management and lifestyle interventions

6.1 Although not a statutory requirement, the risk management element of the programme, provided through lifestyle interventions, is important to ensure that the programme has long term benefits for public health. The guidance recommends that everyone receiving a health check is given individually tailored advice to help motivate them to make appropriate lifestyle changes to manage their risk (unless clinically unsafe to do so). Such advice may include referrals to:

- Local stop smoking services;
- Physical activity interventions;
- Weight management programmes;
- Alcohol use interventions.

6.2 The guidance recognises that those providing this advice may not

be the same as those who have undertaken the risk assessment element of the health check and, there is a need, therefore, to ensure that relevant information from the health check e.g. smoking status, blood pressure, activity levels is relayed to the lifestyle intervention provider.

6.3 The Department of Health has published a ready reckoner for Health Checks which estimates the local outputs from the Health Check programme. It estimates that in each of the first five years of implementing the NHS Health Check programme:

- 330 additional people will complete a weight loss programme
- 180 additional people will be taking statins
- 85 additional people will be compliant with an Impaired Glucose Regulation lifestyle
- 46 additional people will be diagnosed with diabetes
- 138 additional people will be taking anti-hypertensive drugs
- 113 additional people will be diagnosed with chronic kidney disease
- 84 additional people will increase physical activity
- 6 additional people will quit smoking (the low number of people quitting smoking is due to the low compliance rate with smoking cessation interventions – 5%)

The ready reckoner also provides a cost benefit analysis of providing NHS Health Checks in Halton based on national cost estimates of delivering the programme and a total health gain of 627 QALY per annum at a cost of £1,905 per QALY. This estimates that the programme will deliver net savings of £31,895 after 20 years after the HC is completed.

7.0 Proposals for delivering NHS Health Checks in Halton

7.1 Currently the Council has an agreement with GP practices to deliver "Health Checks Plus" to local residents as a local enhanced service. Health Checks Plus include most of the minimum requirements of NHS Health Checks in addition to some locally developed questions around housing and fuel poverty and some medical questions which are not necessary to carry out the risk assessments.

7.2 Feedback from GP practices reveals that in its current form the Health Checks Plus assessment takes on average around 45 minutes per patient, far longer than the 20 minutes expected. It is likely that this is one reason why Halton consistently does not reach the required targets for invitations and for take up of Health Checks.

7.3 It is proposed that Health Checks are streamlined so that they include only the required information to carry out the mandatory risk assessments and including the new areas of alcohol screening and dementia awareness raising for patients aged 65 to 74.

7.4 Currently GP practices are paid £1 for each eligible patient invited for a Health Check, £18 for each Health Check completed and £1 for each HC recorded on the GP system. Despite the proposed reduction in the time needed to complete a HC, the authority does not propose to reduce this fee schedule. This is due to the fact that the fee per HC is already slightly higher in other areas. However the time reduction will enable more HCs to be completed increasing the potential income generation for GPs.

7.5 The review of existing HealthChecks also looked at the commissioned pharmacy based programmes and found that while four pharmacy based providers had signed up to deliver HealthChecks Plus not one had over a two year period. The existing SLA would require that they are paid a fee per client and an additional full HealthCheck fee also be paid to individual practices in order to send out invitations, complete CVD risk assessment and input data onto systems in order to complete returns- which are taken wholly from GP practice systems. This makes pharmacy based provision more expensive currently.

7.6 The Council proposes that HC will continue to be delivered by GP practices under existing contractual arrangements and will seek to identify community based provision that is cost effective. A pilot will be run by the Public Health Team working with occupational health and human resources will seek to offer HealthChecks and lifestyle advice to eligible staff of the Council as part of a healthy workplace based initiative. This will be funded from the Public Health Budget

7.7 Currently Halton's Health Improvement Team carries out an opportunistic assessment with their clients which includes many of the questions undertaken as part of the Health Check. To prevent duplication and to ensure that an appropriate cardiovascular risk assessment and recording on GP systems takes place an agreement to share the information has been reached which will still allow primary care to claim a full Health Checks payment.

7.8 A range of well-established and successful lifestyle interventions are available for HC patients who are identified as being at risk of CVD, diabetes and other conditions. These include free weight management courses such as Fresh Start, Stop Smoking Services including the provision of free vouchers for nicotine replacement products and alcohol reduction services such as Brief Interventions. The Council is working with Halton's Health and Well Being Service and Halton Clinical Commissioning Group to ensure that GP practices can advise patients of the full range of available services and make appropriate referrals into the services on behalf of the patient and for outcomes resulting from lifestyle interventions to be monitored.

7.9 A new Service Level Agreement has been drafted for GP practices setting out the requirements of the revised NHS Health Checks. This is attached as Appendix B.

8.0 POLICY IMPLICATIONS

The Health and Social Care Act 2012 placed a statutory duty on local authorities to make arrangements for the delivery of NHS Health Checks in their area.

9.0 OTHER/FINANCIAL IMPLICATIONS

Halton has a budget of £160,000 per annum for the delivery of Health Checks. This sits within the ring fenced Public Health budget.

10.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

10.1 Children and Young People in Halton

While HCs are specifically for people aged 40 to 74, it is anticipated that there will be indirect benefits to children and young people as a result of their parents and other family members being supported to lead a healthier lifestyle and/or prevent or delay the onset of ill health.

10.2 Employment, Learning & Skills in Halton

Improving the health of individuals can have a positive impact on their long term employability.

10.3 A Healthy Halton

HCs are a key tool in the identification, early detection and prevention of a range of health issues and can help to promote healthier lifestyles, thereby contributing to the aims and objectives of Halton's Health and Well Being Strategy.

10.4 A Safer Halton

None directly

10.5 Halton's Urban Renewal

None directly

11.0 RISK ANALYSIS

11.1 NHS Health Checks are a statutory requirement for local authorities. Failure to offer Health Checks in a locality could result in damage to the authority's reputation and impact on future funding levels.

11.2 A risk register has been developed by champs the public health commissioning service on behalf the Cheshire and Merseyside authorities for the transition to the newly branded NHS Health Checks. Mitigating factors have been identified and are being put in

place.

12.0 EQUALITY AND DIVERSITY

An Equality Impact Assessment has been completed for the delivery of NHS Health Checks. The assessment revealed two potential negative impacts.

The first relates to the fact that GPs are unlikely to invite pregnant women for Health Checks due to the high probability of temporarily misleading results. However provided they remain eligible pregnant women can be invited once the baby is born. In any case pregnant women are in regular contact with their GP so that any potential health issues are likely to be picked up.

The second relates to the fact that traditionally a disproportionately high proportion of Gypsies and Travellers do not register with GPs. To mitigate this impact it is proposed that proactive engagement is carried out with the Gypsy and Travelling community through the Council's Gypsy and Traveller Co-ordinator and site wardens with a view to the Halton Health and Well Being service offering health screenings on site. The service already carries out health screenings for people who participate in its weight management programmes. While the screenings do not constitute a full health check (as blood tests are not carried out) they will indicate whether there is an increased risk of certain conditions sufficient for advice to be given and for the patient to be signposted to relevant services or health establishments.

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

Department of Health/Public Health England draft Guidance on NHS Health Checks.

NHS Health Checks – Best Practice on the Risk Assessment

1. Cardiovascular risk assessment				
Tool/engine	**Data required**	**Thresholds**	**Key points**	**References**
Either QRISK2 or Framingham depending on local needs	Age (in years)	40 – 74 (inclusive)		
	Gender	Male or Female		
	Smoking status	QRISK2: Current smoker Non smoker (including ex-smoker) Framingham: Cigarette smoking or quit within past year Otherwise (i.e. not smoking and/or quit over a year ago)		
	Physical activity levels	UK Chief Medical Officer recommends that all adults shall be physically active daily and activity over a week should add up to 150 minutes.	A validated tool such as the Department of Health's General Practitioner Physical Activity Questionnaire (GPPAQ) is recommended to measure activity levels	http://publications.nice.org.uk/four-commonly-used-methods-to-increase-physical-activity-ph2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152108/dh_128210.pdf.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152000/dh_133101.pdf.pdf
	Family history of coronary heart disease	In first degree relative under 60 years (required for QRISK2 but not Framingham)	First degree relative means father, mother, brother or sister	
	Ethnicity	White/not recorded Indian Pakistani Bangladeshi Other Asian Black African Black Caribbean Chinese Other (including mixed)	Ethnicity is needed for diabetes risk assessment Ethnicity should be recorded using the codes used for Office for National Statistics	
	Body Mass Index	Blood sugar tests required when	Required for CVD and	

		individual is in obese category: BMI is 27.5 or over in Indian, Pakistani, Bangaldeshi, Other Asian and Chinese ethnicity categories BMI over 30 for other ethnicity categories	Diabetes risk assessment	
	Cholesterol test	Framingham model: cholesterol measured as total serum cholesterol and high density lipid cholesterol QRISK2: cholesterol measured as ratio of total serum cholesterol to high density lipoprotein cholesterol	Cholesterol is a major modifiable risk factor of vascular disease and can be reduced by dietary change, physical activity and drugs A random (not fasting) cholesterol test can be used to ensure maximum take up	http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf http://publications.nice.org.uk/statins-for-the-prevention-of-cardiovascular-events-ta94
	Systolic (SBP) and diastolic (DBP) blood pressure	If the individual has a blood pressure at, or above, 140/90mmHg or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires: A fasting plasma glucose (FPG) or HbA1c test An assessment for hypertension An assessment for chronic kidney disease	Required for the diabetes filter and for assessment for chronic kidney disease and hypertension within primary care Local authorities will need to consider the provision of these tests and work closely with partners to ensure people are clinically followed up appropriately Recommended that 2011 NICE clinical guidance 127 on management of hypertension is followed	http://publications.nice.org.uk/hypertension-cg127 http://www.nice.org.uk/nicemedia/live/13561/56008/56008.pdf http://www.nice.org.uk/nicemedia/live/13561/56015/56015.pdf

2. Diabetes risk assessment					
Data required	**Thresholds for blood glucose test**	**Type of tests**	**Thresholds for lifestyle intervention**	**Key points**	**References**
Ethnicity BMI Blood pressure	BMI is in the obese range (30 or over, or 27.5 or over in individuals from the Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnic groups) Or Blood pressure is at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHG or 90mmHg respectively Some people who do not fall into the above categories will also be at significant risk: People with first degree relatives with type 2 diabetes or heart disease; People with tissue damage known to be associated with diabetes, such as retinopathy, kidney disease or neuropathy Women with past gestational diabetes; People with conditions or illnesses known to be associated with diabetes (e.g. polycystic ovarian syndrome or severe mental health disorders); People on current medication known to be associated with diabetes (e.g. oral corticosteroids)	Fasting plasma glucose	FPG greater than or equal to 7mmol/l (with symptoms) = diabetes diagnosis FPG greater than or equal to 7mmol/l (no symptoms) = repeat FPG – if same = diabetes diagnoses, if less than 7mmol/l = Non diabetic hyperglycaemia – intensive lifestyle advice FPG between 6 to 6.9 mmol/l = non diabetic hyperglycaemia – intensive lifestyle advice FPG less than 6mmol/l = healthy lifestyle advice	Recognised as an acceptable first test to identify those at high risk of diabetes. Person tested should be informed of fasting requirement and if possible appointment scheduled for 11am or earlier to make fasting easier.	www.screening.nhs.uk/vascular/VascularRiskAssessment.pdf http://publications.nice.org.uk/preventing-type-2-diabetes-risk-identification-and-interventions-for-individuals-at-high-risk-ph38 http://www.who.int/diabetes/publications/report-hba1c_2011.pdf
		HbA1c (glycated haemoglobin)	HbA1c greater than or equal to 6.5%/48mmol/mol (with symptoms) = diabetes diagnosis HbA1c greater than or equal to 6.5%/48mmol/mol (no symptoms) = repeat HbA1c – if same = diabetes diagnosis, if less than 6.5%/48mmol/mol = non diabetic hyperglycaemia –intensive lifestyle advice	More convenient than FPG as individual doesn't need to fast. Recognised by World Health Organisation as an alternative method of diagnosis provided: Stringent quality assurance methods are in place; Measurements are standardised; No conditions exist that would affect its accuracy	

			HbA1c between 6 to 6.5%/42 to 48mmol/mol = non diabetic hyperglycaemia – intensive lifestyle advice HbA1c less than 6%/42mmol/mol = healthy lifestyle advice	(e.g. anaemia and some variant haemoglobins) The test is not recommended for pregnant women or where in situations where the blood glucose levels can rise rapidly	

3. Alcohol risk assessment			
Data required	**Key points**	**Thresholds**	**References**
AUDIT score	The AUDIT questionnaire is 10 questions long (not everyone will need to answer all 10 questionnaires) and takes approximately 3 minutes to complete The assessment can be split into 2 phases: 1. An initial screen to identify those at risk; 2. A second phase to identify the level of risk There are two initial screening questionnaires bot are sub sets of the full audit and can be self completed by the user or as verbal questions: AUDIT-C (first 3 questions of full audit); Fast Alcohol Screening Test (FAST) (four of ten questions from full AUDIT).	Initial screening: AUDIT-C Above or equal to 5 FAST Above or equal to 3 If patient scores above threshold the second phase is to complete the full AUDIT AUDIT threshold – a score of 8 or above indicates that the person's alcohol consumption could put their health at risk and they should be offered brief alcohol advice. A referral to alcohol services should be considered for those scoring 20 or more.	http://publications.nice.org.uk/alcohol-use-disorders-preventing-harmful-drinking-ph24

REPORT TO: Health and Wellbeing Board

DATE: 18th September 2013

REPORTING OFFICER: Strategic Director Children and Enterprise

PORTFOLIO: Children, Young People and Families

SUBJECT: Troubled Families / Inspiring Families Update

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To provide an update to the group on the development of Inspiring Families programme.

2.0 RECOMMENDATION: That

1. **To support the Inspiring Families approach in Halton;**
2. **To ensure that partners were viable adopt a 'Think Family' approach in the planning and implementation of their service delivery;**
3. **To progress the development of family assessment that can be used across all organisations;**
4. **Partners consult with the Troubled Families co-ordinator when commissioning services for children, young people and families; and**
5. **To explore with partners the options of reinvesting cost savings to add investment to areas of agreed work.**

3.0 SUPPORTING INFORMATION

3.1 The Troubled Families Unit provided national criteria for identifying 'troubled families' in addition local authorities could identify local measures. In Halton for 12/13 these were domestic abuse and alcohol for 13/14 we have increased these measures to include drug misuse, NEET and a child under the age of 5.

3.2 In Halton the Local Strategic Partnership is the overarching responsible board for the programme. Following the last report to the LSP it was agreed that the Chair of the board Councillor Polhill issue a letter to all partners seeking their support for the borough wide implementation of the Inspiring Families programme.

3.3 There is a strategic group in place chaired by the Operational Director Children's Organisation and Provision. The membership, terms and reference of this group have recently been reviewed and revised. In addition the task and

finish groups established to progress the programme have now been replaced by an operational group. This group will meet bi-monthly and will report into the strategic group

Delivery

3.4 145 families were identified for the first year. We are working with partners and agencies to identify where families are with regard to interventions, engagement and assessing are all the whole family's needs being met. We have confirmed our numbers for year 2 and 3 with the Families Team – year 2 195 families of which 163 are PBR. For year 3, 35 families of which 30 are PBR.

3.5 When scoping out delivery options it was agreed that the most viable option was to 'scale' up existing services and this existing service would be the Team around the Family (TAF). The Team around the Family model includes family support and an intensive family work service that also supports young people on the edge of care. This system / service are embedded within the council and the teams work to a key worker model based on the nationally recognised Family Intervention Projects model. This consisted of a 'Lead Professional/key worker' that was allocated to each family who used a variety of methods to engage the family and was persistent in undoing any blockages that were presented in order to gain the family's engagement; used sanctions and rewards to gain trust and progress; undertook holistic whole family assessments; provided interventions; and led on multi -agency tailored care packages for the whole family in a timely manner to suit their needs and capabilities.

3.6 Halton has strong partnership links and partners are supporting the implementation and development of the programme. Within IFWS partners have put in dedicated resources these have come from Police, Youth Offending Service, Education Welfare and Halton Housing Trust. We have also including the Intervention team as a commissioned service and we are pursuing other avenues with other partners to how they can support the programme.

3.7 The expectation is that agencies across the borough will contribute to support the development of the concept of the Inspiring Families programme. At this stage it shows that Halton will have a mixture of families that will require different levels of intervention and support which will be scaled high, medium, low.

High	Very difficult / high demand families. With complex needs requiring frequent / daily contact and support from multiple services.
Medium	Difficult families. With multiple needs requiring weekly contact and support from several services.
Low	Less difficult families. With a small number of needs requiring less frequent practical support over a shorter period of time.

3.8 The Intensive Family work service has been scaled up to deal with some of the demand of some of the most 'complex/ high demand' families and the dedicated resources from partners will support and co-ordinate activity across families with medium and low need but this will only be a percentage of the total families . Across the partnership there is an expectation that with 'Inspiring families' that services were viable will support the whole family approach to achieve outcomes for families as well as for individuals.

3.9 We have issued two Inspiring Families newsletter and these will continue throughout the life of the programme across partners for them to cascade to staff so individuals can understand the scheme, what it means for them and progress made.

Performance

3.10 The following table summarise the number of families issued to leads from Year 1, their status in relation to PBR claims in January and July 2013 and those estimated for January 2014 with percentage of those families achieving targets. Approximately 70% (102 out of 145) of all families from year 1 are likely to achieve targets and a claim made for PBR to the DCLG by the end of July 2013. Performance review meetings have been put in place through September and October to review progress of families.

Year 1 Families Allocated to for intervention / monitoring	Claimed PBR Jan 2013	Confirmed Claim PBR July 2013	[1]Estimated PBR submissions January 2014	*Total Estimated* PBR achieved by end of July 2013	Number of families not achieved PBR - performance progress meeting required	Total Number of families allocated	Estimated % of families where PBR achieved @ July 2013
Intensive	10	19	14	43	17	60	72%
Education Welfare	4	8	9	21	8	29	72%
Social Care	2	5	6	13	9	22	59%
YOS	4	0	1	5	4	9	56%
Intervention	7	1	1	9	0	9	100%
Police	0	3	1	4	0	4	100%
Family Support	0	0	1	1	2	3	33%
YPT	0	2	0	2	1	3	67%
IOM	0	1	0	1	1	2	50%
Adult Mental Health 5 Boroughs	1	0	0	1	0	1	100%
Adult Social Care	0	0	1	1	0	1	100%
School (Heath)	0	0	0	0	1	1	0%
monitor only	1	0	0	1	0	1	100%
Total	29	39	34	102	43	145	70%

3.11 60 families have been allocated to the intensive team, 37 of these families have been allocated as a low / medium resourcing where predominately monitoring has taken place and therefore less resource intensive.

[1]This includes all PBRs claimed during January 2013 and July 2013. Those to be claimed in July 2013 are those families who have already achieved YOS and ASB targets and are highly likely to achieve the education target too, however full term data is not available until Sept 2013 - claims for these families cannot be made until Jan 14 during the next submissions to the DCLG

3.12 Performance results to date are extremely encouraging, however it is important to note that the performance is against National criteria only. Whilst the Inspiring Families monitoring and PBR may have been claimed, the family may still remain open to services. Other strategic / structural / organisational / process changes have not been assessed locally. During March and April 2013 the first review sessions were undertaken to be begin this process this will assist to ensure the wider ethos of Inspiring Families are considered and driven forward.

3.13 From the 29 families in January where PBR has already been claimed we have 12 adults on the work programme, there was a 75% reduction in calls to the police. This resulted in 139 less calls for service over a 6 month period. 11 young people successfully completed their YOT order and have not reoffended over a 6 month period.

3.14 Whilst these families have been claimed for in relation to the PBR, interventions continue to address those local measures that are still relevant and central measures around worklessness. Referrals for either the work programme or ESF and claims for relating to worklessness will be made where appropriate; generally after all other issues have been resolved within the family.

3.15 In addition it has been agreed that the programme will use The Short Warwick-Edinburgh Mental Well-being scale (SWEMWBS). SWEMWBS is a nationally recognised tool for measuring well-being. This tool consists of a questionnaire about thoughts and feelings and is completed both pre and post intervention by all family members over the age of thirteen. The details will then be analysed by the Performance Management Officer to monitor family wellbeing, highlight the journey travelled and whether the Inspiring families cohort has low, average or high mental wellbeing compared with local / national population.

Cost Benefit Analysis

3.16 Development of the Inspiring Families cost savings tool continues. Nationally there is an array of research papers suggesting the positive financial and service demand savings of the Inspiring families approach, however a great number of these relate to those savings achieved over a long period of time and are often quite generic. For this reason the Performance Management Officer is collating local costs incurred in relation to 'staffing' the process. This will enable strategic leaders to see real costs and savings in staff time and money in addition to the longer term savings.

3.17 The below table highlights the early work around cost avoidance/ cost savings on the families where PBR was claimed in July. The **Police service** demand reductions (for 15 families) show 182 less calls for service over a 6 month period (almost 70% reduction). The reductions translated into cost savings (based on staff costs to deal with the call and allocate and arrests where they have taken place) equate to almost £15,000.00 over a six month period. **There is the potential for the Police Service to benefit by £2000 per family per year in reduced calls / arrests**. This is before the national costs for each offence has been considered, £1.9 million a year for 15 families.

3.18 The **YOS service** demand reductions (for 15 families) show that 12 young people did not reoffend 6 months after their last offence. There is the potential for the YOS service to benefit by reduced demand 49 young people reoffending from year 1 cohort. Costs for all YOS order types are currently being gathered, therefore financial benefits cannot portrayed at this stage.

3.19 For the 15 families chosen from July 2013 PBR claim there was a 69% reduction in Police calls for service and 75% of young people did not reoffend in 6 months,

Detail of POLICE **COSTS**	**Pre engagement** Aril 2011 - Sept 2011	**Pre engagement** Oct 2011 - Mar 2012	**engagement commenced** April 2012 - Sept 2012	**during engagement and year of closure** October 2012 - March 2013	% reductions	cost savings over 6 months for 15 families	estimated Police savings if all **145** families achieve similar results **over 1 year**
Sum of local / national costs	£128,293.19	£119,889.06	£189,224.84	£90,550.74	52.15%	£98,674.10	£1,907,699.27
Sum of police calls for service costs (including cost of arrest if one made)			£70,825.50	£56,126.33	20.75%	£14,699.17	£284,183.95
Police Total			£260,050.34	£146,677.07	43.60%	£113,373.27	£2,191,883.22

		Detail of POLICE and YOS **DEMAND**	**engagement commenced** April 2012 - Sept 2012	**during engagement and year of closure** October 2012 - March 2013	% reduction	Demand avoided 6 months for 15 families	estimated demand savings if all **145** families achieve similar results **over 1 year**
		police calls for service	264	82	68.94%	182	3519
							estimated demand savings if same **% reductions** across 65 young people identifed as having a YOS issue **over 1 year**
		YOS Demand - offences	69	15	78.26%	54	210
		YOS individuals	16	4	75.00%	12	49

3.20 During the autumn there will be further work undertaken and performance updates will show impact on the families' outcomes and will incorporate the cost avoidance and reduced / increased service demand against the partnership.

Year 2 / 3 allocation

3.21 During March and April 2013 review session's practitioners and lead managers raised concerns at the number of families allocated at one time. They suggested that instead, the Inspiring Families team should 'drip feed' families on a smaller scale. This would enable teams to manage the work load / demands more effectively.

3.22 The identification of Year 2 families has been undertaken based on the Local and Governmental measures using numerous datasets and practitioner experience / suggestions. As suggested families where allocated over a two month period, 109 out of 195 families have been allocated the remaining families will follow during October and November.

4.0 POLICY IMPLICATIONS

4.1 The implementation of the inspiring families programme will have policy implications for the future implementation and delivery of services. These implications will need to be evidenced within individual action plans.

4.2 The sustainability of programme will have some policy implications as we agree an invest to save model for the future.

5.0 OTHER IMPLICATIONS

5.1 There is the continued work that needs to take place to co-ordinate the DWP ESF and work programmes to ensure that clear process are in place for both practitioners and families.

5.2 The current ISA for been signed by Halton Council, Cheshire Constabulary, Youth Offending Team, 5 boroughs, Catch 22, Halton Housing Trust, Liverpool Housing Trust, Riverside, Arena Housing, young addaction, Plus Dane, Cosmopolitan Housing, CRI, Barnardo's and Public Health. We are still in a dialogue with Probation, NHS Halton and St. Helens and the Clinical Commissioning Group. The ISA was reviewed in July 2013 and additional partners will be added as required by the programme.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

The Troubled Families' initiative is intended to address the crucial factors for children in disadvantaged settings not meeting their potential.

6.2 Employment, Learning and Skills in Halton

The programme will be integrated with other employment/learning based initiatives such as the Work Programme and the ESF/DWP Programme.

6.3 A Healthy Halton

A range of health partners are committed to contributing to the programme including case analysis and service delivery.

6.4 A Safer Halton

Troubled Families make a significant impact on public resources; a more targeted approach offers economic advantage.

7.0 RISK ANALYSIS

7.1 The quality of data information means that we have reviewed the local criteria for year 2 and 3. This information will be reviewed as where families choose not to engage with the programme other families will need to be identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment will be undertaken on the Business Plan. The aim of the programme is to try and work with disadvantaged families supporting them to overcome many of the barriers they face.

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

Document	Place of Inspection	Contact Officer
The Troubled Families Programme Financial Framework for Troubled Families March 2012	***2nd Floor Rutland House***	***Lorraine Crane Divisional Manager IYSS***
The Cost of Troubled Families January 2013	***2nd Floor Rutland House***	***Lorraine Crane Divisional Manager IYSS***

REPORT TO: Health and Wellbeing Board

DATE: 17th July 2013

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Autism Self-Assessment Framework update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of the report will be to provide members of the Health and Wellbeing Board with an update of the Autism Self-Assessment Framework.

2.0 **RECOMMENDATION: That the Board:**

1) Note the contents of the report

3.0 **SUPPORTING INFORMATION**

3.1 Autism Self-Assessment Framework Government passed the Autism Act (2009) with an accompanying Autism Strategy, *Fulfilling and Rewarding Lives* (2010), with publication of statutory guidance for health and social care and full delivery plan in December 2010. Fulfilling and Rewarding Lives, the Government's vision is that "All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them".

Department of Health – local self-assessment for adults with autism for Local Authority's and Clinical Commissioning Groups – for commissioners to plan how they are going to respond to the statutory guidance.

Events at Winterbourne have highlighted the vulnerability of those with Autism who challenge services. The inappropriate use of restrictive practices, the insufficient skills of staff teams that support individual with Autism.

The purpose of the SAF is to:

- Assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy
- See how much progress has been made since the baseline survey, as at February 2012
- Provide Evidence of examples of good progress made that can be shared and of remaining challenges.

Health Inequalities have been highlighted as a key area that needs to be targeted this includes access to mainstream NHS services:

- Prevention of diseases
- Screening
- Health promoting activities
- Knowing the local Autistic population
- Services available for individuals who are described as having behaviours that challenge services.

3.2 The Autism SAF will be submitted on the 30th September 2013 as part of the validation process the submission will be presented to the Autism Strategy Group on the 23rd September 2013 and the Learning Disability Partnership Board.

The submission will be joint owned by both the Local Authority and Clinical Commissioning Group and is monitored via the Winterbourne, LDSAF, Autism SAF strategy Group chaired by Paul McWade.

A Joint Strategic Needs Assessment is underway by Public Health colleagues across the Merseyside Region.

3.3 The Autism SAF has 42 questions based on the below themes. (Appendix A)

The questions focus on specific themes to enable with a comparison to the base line submission in February 2012.

The Red, Amber, Green rating will enable the LA and CCG to focus resources to improve outcomes for individuals.

Key themes Autism SAF 2013

1. Initial questions on local authority area
2. Planning
3. Training
4. Diagnosis
5. Care and Support
6. Housing and Accommodation
7. Employment
8. Criminal Justice Service
9. Optional Self Advocate story - To be completed by individuals with Autism that work with Halton Speak Out.

3.4 The final submission of the Autism SAF will be presented to the Health and Wellbeing Board no later than the end of January 2014.

4.0 **POLICY IMPLICATIONS**

4.1 None

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None

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

6.1 **Children & Young People in Halton**
Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will captured through the Autism SAF, and support future developments and service planning.

6.2 **Employment, Learning & Skills in Halton**
Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing and implementing the Autism SAF

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
The environment in which we live and the physical infrastructure of our communities has a direct impact on health and wellbeing of individuals.

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on health and wellbeing.

7.0 **RISK ANALYSIS**

7.1
- Services not meeting the needs of those individuals with Autism.
- Reputation damage for both the Council and CCG if score is poor.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 This is in line with all equality and diversity issues in Halton

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

Document	Place of Inspection	Contact Officer
n/a		

DRAFT

The 2010 Adult Autism Strategy : Evaluating Progress in Local Authority areas

Note comments may
be positive or negative

The second national self assessment exercise

Initial questions on features of the local authority area								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
1	How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?	Number	Yes					
2	Are you working with other local authorities to implement part or all of the priorities of the strategy?	Yes/No	If yes, how are you doing this?					

Planning								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
3	Do you have a named joint commissioner/senior manager responsible for services for adults with autism?	Yes/No	If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.					
4	Is Autism included in the local JSNA?	RAG	Comment	No.		Steps are in place to include in the next JSNA.		Yes.
5	Have you started to collect data on people with a diagnosis of autism?	RAG	Comment	Data recorded on adults with autism is sparse and collected in an ad hoc way.		Current data recorded annually but there are gaps identified in statutory health and/or social care services data. Some data sharing exists between services.		Have you an established data collection sharing policy inclusive of primary care, health provision and adult social care.
6	Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any) If so, what is 1. the total number of these people? 2. the number who are also identified as having a learning disability, and 3. the number who are identified as also having mental health problems?	Yes/No 3 Numbers	Comment					
7	Does your commissioning plan reflect local data and needs of people with autism?	Yes/No	If yes, how is this demonstrated?					

Note - Comments may be positive or negative

8	What data collection sources do you use?	RAG	Comment	No work underway.	Collection of limited data sources.	Have made a start in collecting data and plan to progress.	Have started to collect data and while not comp-rehensive, feel that it is an accurate reflection.	Information from GPs, Schools or Local Education Authority, voluntary sector, providers, assessments and diagnosis are all collected and compared against the local population prevalence rate.

Note - Comments may be positive or negative

Planning (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
9	Is your local CCG or CCGs (including the Support Service) engaged in the planning and implementation of the strategy in your local area?	RAG	Comment	None or Minimal engagement with the LA in planning and implementation.		Representative from CCG and / or the Support Service sits on autism partnership board or alternative and are in regular liaison with the LA about planning and implementation.		CCG are fully engaged and work collaboratively to implement the NHS responsibilities of the strategy and are equal partners in the implementation of the strategy at a local level.
10	How have you and your partners engaged people with autism and their carers in planning?	RAG	Please give an example to demonstrate your score.	Minimal autism engagement work has taken place.		Some autism specific consultation work has taken place. Autism Partnership Group is regularly attended by one person with autism and one parent/carer who are meaningfully involved.		A variety of mechanisms are being used so a cross section of people on the autistic spectrum are meaningfully engaged in the planning and implementation of the Adult Autism Strategy. People with autism are thoroughly involved in the Autism Partnership Group.
11	Have reasonable adjustments been made to everyday services to improve access and support for people with autism?	RAG	Please give an example.	Only anecdotal examples.		Clear council policy covering statutory and other wider public services.		Clear council policy and evidence of widespread implementation.
12	Do you have a Transition process in place from Children's social services to Adult social services?	Yes/No	If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.					

Note - Comments may be positive or negative

Planning (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
13	Does your planning consider the particular needs of older people with Autism?	RAG	Comment	No consideration of the needs of older people with autism: no data collection; no analysis of need; no training in older people's services.		Training in some but not all services designed for use by older people, and data collection on people over-65 with autism.		Training inclusive of older people's services. Analysis of the needs of population of older people inclusive of autism and specialist commissioning where necessary and the appropriate reasonable adjustments made.

Note - Comments may be positive or negative

Training								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
14	Have you got a multi-agency autism training plan?	Yes/No	No Comment option					
15	Is autism awareness training being/been made available to all staff working in health and social care?	RAG	Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.	Historical workforce training data available from statutory organisations on request. Not yet devised an autism training plan/strategy.		Good range of local autism training that meets NICE guidelines - and some data on take up. Workforce training data available from statutory organisations on request. Autism training plan/strategy near completion.		Comprehensive range of local autism training that meets NICE guidelines and data on take up. Workforce training data collected from all statutory organisations and collated annually, gaps identified and plans developed to address. Autism training plan/strategy published.
16	Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?	RAG	Comment	No specific training is being offered		At least 50% of assessors have attended specialist autism training.		More than 75% of assessors have attended specialist autism training specifically aimed at applying the knowledge in their undertaking of a statutory assessment, ie applying FACs, NHS Community Care Act.
17	Have CCGs been involved in the development of workforce planning and are GPs and primary care practitioners engaged included in the training agenda?	Yes/No	Please comment further on any developments and challenges.					

Note - Comments may be positive or negative

Training (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
18	Have local Criminal Justice services engaged in the training agenda?	Yes/No	Please comment further on any developments and challenges.					

Note - Comments may be positive or negative

Diagnosis led by the local NHS Commissioner								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
19	Have you got an established local diagnostic pathway?	RAG	Please provide further comment.	No local diagnosis service planned or established. No clear transparent pathway to obtaining a diagnosis for Adults identified and only ad-hoc spot purchasing of out of area services. NICE guidelines are not being followed.		Local diagnosis pathway established or in process of implementation / sign off but unclear referral route. A transparent but out of locality diagnostic pathway is in place. Some NICE guidelines are being applied.		A local diagnostic pathway is in place and accessible, GPs are aware and involved in the process. Wait for referral to diagnostic service is within 6 months. NICE guidelines are considered within the model
20	When was the pathway put in place?	Year Month	Comment					
21	How long is the average wait for referral to diagnostic services?	Number (Weeks)	Comment					
22	How many people have completed the pathway in the last year?	Number	Comment					
23	Has the local CCG/support services taken the lead in developing the pathway?	Yes/No	Comment					

Note - Comments may be positive or negative

Diagnosis led by the local NHS Commissioner (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
24	How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?	Radio button: 1. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis 2. Specialist autism specific service?	Please comment further.					
25	In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?	Yes/No	Please comment, ie if not who receives notification from diagnosticians when someone has received a diagnosis?					
26	What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?	Comment question						

Note - Comments may be positive or negative

Care and support								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
27	Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?	Question requires three numbers: 1. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget 2. Number of those reported in 1 who have a diagnosis of Autism but not learning disability 3. Number of those reported in 1 who have both a diagnosis of Autism AND Learning Disability	Comment					
28	Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?	Yes/No	Comment: if yes, please give details					

Note - Comments may be positive or negative

29	Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?	Yes/No	Comment: if yes, please give details					
30	Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?	RAG	Comment	No programme in place.		Programme in place, not all advocates are covered.		Programme in place, all advocates are covered.
31	Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?	RAG		No.		Yes. Local advocacy services are also developing training in autism.		Yes. There are mechanisms in place to ensure that all advocates working with adults with autism have received specialist autism training.
32	Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?	Yes/No	Provide an example of the type of low key support that is available in your area.					

Note - Comments may be positive or negative

Care and support								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
33	How would you assess the level of information about local support in your area being accessible to people with autism?	RAG	Comment	Minimal choice of appropriate local provision and where required local care and support services. Database of universal and autism specific services is out of date.		Some existence of low level, preventative services such as befriending/mentoring, advocacy, social groups, outreach, activity groups, and access to therapies and counselling (ie IAPT primary care mental health services). Database of universal and autism specific services has known gaps.		Accessible information available on the range of autism accessible support services such as befriending/mentoring, advocacy, social groups, outreach, activity groups, and carer's support. There is a progressive level of support dependant of the needs of the individual who happens to have autism. More specialist services accessible to meet their needs with autism for those who needs it from advocacy to high level services Housing & Accommodation

Note - Comments may be positive or negative

Housing & Accommodation								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
34	Does your local housing strategy specifically identify Autism?	RAG	Comment	No mention of Autism within the local housing strategy. No range of options available to meet the broad needs of someone with a diagnosis of Autism. No data available on individual housing needs and usage of different housing services.		Universal housing strategy details needs of people with disabilities, autism not specifically referenced.Minimal current and historic data availability on individual housing needs and usage of different housing services.		Autism accessible housing detailed in universal housing strategy. A range of housing and accommodation options available to meet the broad needs of people with autism including universal housing supported living, residential care, etc. Using data to inform future planning, of accommodation and housing needs.

Note - Comments may be positive or negative

	Employment							
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/Amber	Amber	Amber/Green	Green
35	How have you promoted in your area the employment of people on the Autistic Spectrum?	RAG	Comment	No work in this area has been provided or minimal information not applied to the local area specific to Autism. Local employment support services are not trained in autism or consider the support needs of the individual taking into account their autism. Local job centres are not engaged.		Autism awareness is delivered to employers on an individual basis.Local employment support services include Autism.Some contact made with local job centres.		Autism is included within the Employment or wordlessness Strategy for the Council / or included In a disability employment strategy. Focused Autism trained Employment support. Proactive engagement with local employers specifically about employment people with autism including retaining work. Engagement of the local job centre in supporting reasonable adjustments in the workplace via Access to work.
36	Do transition processes to adult services have an employment focus?	RAG	Comment	Transition plans do not include specific reference to employment or continued learning.		Transition plans include reference to employment/activity opportunities.		Transition plans include detailed reference to employment, accesses to further development in relation to individual's future aspirations, choice and opportunities available.

Note - Comments may be positive or negative

Criminal Justice System (CJS)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
37	Are the CJS engaging with you as a key partner in your planning for adults with autism?	RAG	Comment	Minimal or no engagement with the CJS.		Discussions with the CJS are underway, including training of the police and wider CJS and inclusive of the use of alert cards. Representative from CJS sits on autism partnership board or alternative.		People with Autism are included in the local work of local diversion team's from CJS. Representative from CJS regularly attends meetings of autism partnership board or alternative. Alert card or similar scheme in operation. Police training in place.

Note - Comments may be positive or negative

Optional Self-advocate story								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
38	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					
39	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					

Note - Comments may be positive or negative

Optional Self-advocate story								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
40	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					
41	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					
42	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					

Note - Comments may be positive or negative

REPORT TO: Health and Wellbeing Board

DATE: 18th September 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Children, Young People and Families

SUBJECT: School Nursing Service

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Health and Wellbeing Board with an update on the progress of the procurement of a School Nursing Service for Halton.

2.0 RECOMMENDATION: That

1. **the Board note the contents of the report and appendices; and**
2. **feedback comments to the Director of Public Health; and**
3. **Support the recommendation to commence with consultation on the procurement of a service to be in place no later than September 2014.**

3.0 SUPPORTING INFORMATION

3.1 From April 2013, Local Authorities assumed the accountability for the commissioning of School Nursing services. This therefore, has provided a timely opportunity to review the existing commissioning arrangements to shape and design future provision with input from stakeholder engagement, in line with the ongoing review of all public health contracts.

3.2 The School Nursing Service sits within the statutory responsibility of the Director of Public Health for public health protection and health improvement.

3.3 The contract for the existing School Nursing Service has been extended to March 2014, with the option to extend for a further one year period. Due to the financial value of the contract (over £1million per year), and in line with Council policy, the service will need to go through an open procurement process.

3.4 A new specification is being developed as part of a collaborative piece of work with commissioners across the Cheshire and Merseyside footprint and the core elements of the proposed service are listed below. A further briefing on the School Nursing service is included as **Appendix A**.

3.5 The service to be procured will:

- Work in partnership with schools, health services, social care and other partners to understand local health needs and support the development of local provision.
- Undertake a school health entry assessment for all reception age children.
- Provide public health advice, health assessments, health screening, immunisations, brief intervention, guidance and support to those of school age, involving their families, carers and education staff where appropriate.
- Routinely offer height and weight screening as part of the National Childhood Measurement Programme (NCMP) in reception and year 6.
- Undertake a health and well-being assessment to facilitate the transition into year 7.
- Work within the scope of the Working Together to Safeguard Children document and local protocols and guidance around the safeguarding children agenda. It will provide professional reports to conference as appropriate, attend safeguarding conferences and take an active part in safeguarding activity where appropriate.
- Initiate the Common Assessment Framework (CAF) and act as lead professional where appropriate and where a health need has been clearly identified.
- Initiate or attend meetings when a health need has been clearly identified (including long term conditions).
- Recognise the significant impact that domestic violence can have on children and young people and act in accordance with national and local guidance.
- Offer screening to any child moving into a Halton school from out of area as appropriate.
- Provide further screening, health assessment and advice at the request of parents at any stage of a child or young person's time at school.
- Offer support to individual children, young people, parents and families and make referrals to a wide range of other professionals when specific needs are identified, as appropriate.

3.6 Public Health Teams and partners across Cheshire and Merseyside have reviewed the current service specification to ensure that it is in line with the Healthy Child Programme and National Guidance in relation to the School Nursing Charter and have developed the enclosed draft specification to begin the process of engagement (**Appendix B**). There is a requirement to reinforce the need for an effective universal, preventative, collaborative and early intervening service that has a crucial role in identifying 'at risk' children and young people. The specification will also need to clarify that the aim of the service is to reduce the risk of this client group becoming the most vulnerable adults in the future.

3.7 In order to ensure that all stakeholders can inform and influence the development of the service, it is intended that a period of engagement will

begin in September and last for two months. During this time, Head Teachers, school staff, School Nurses, youth workers, and other partners will be encouraged to provide their opinions on how the service can be improved to better meet the needs of children, young people and their families. More importantly, children and young people will also be encouraged to provide feedback on the service and identify ways in which it can be improved. Such engagement will ensure that local people can influence the future direction of this vital service.

3.8 The process of engagement will particularly seek the views of elected members, as well as the Children's Trust, the Health and Wellbeing Board, the local Healthwatch and other interested partners who will inform the final specification before it is subjected to procurement.

3.9 It is intended that the procurement process will commence in early 2014 with a view to ensuring that the successful provider is mobilised to begin operation no later than September 2014, in line with the beginning of the new school year.

4.0 POLICY IMPLICATIONS

4.1 The delivery of an effective School Nursing Service compliments the overarching framework set out in both the Halton Health and Wellbeing Strategy and the Children and Young Peoples Plan. It is informed by the commissioning plans for the NHS, Social Care, Public Health and other services through which the Health and Wellbeing Board has agreed are relevant. The service contributes to a number of key national indicators, as identified through the NHS Outcomes Framework, the Public Health Outcomes Framework and the Adult Social Care Framework and also supports the delivery of the Children and Young Peoples Plan.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 As part of the procurement process, potential bidders will be encouraged to look at efficiency and innovative practice to provide the best possible value for money. Whilst the quality of a proposed service will be the most important factor in any final decision, the proposed cost of any application will also be a factor in the final decision and award of contract.

5.2 Any successful bidder may be subject to TUPE regulations with regards to staff. Currently 28.5 WTE staff are employed by the service.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will continue to be addressed through the delivery of an effective and efficient School Nursing Service that supports the delivery of

both national and local strategies and action plans whilst at the same time meeting the needs of children, young people and their families.

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

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to address health inequalities. An effective service will support children and young people in reducing the impact of ill health and risk taking behaviour on their life chances.

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health. There are also close links between the service and on areas such as mental health, alcohol and domestic violence.

6.5 **Halton's Urban Renewal**

By providing, education, information and support to children, young people and their families the service can contribute to the wider urban renewal of Halton.

7.0 RISK ANALYSIS

Halton Borough Council may be at risk of not meeting national targets if recommendations outlined in the report are not met. The current contract is due to expire in March 2014, which is the end of a one year contract extension. There are no financial risks. The recommendations are not so significant they require a full risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

This is in line with all equality and diversity issues in Halton.

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

Document	Place of Inspection	Contact Officer
APPENDIX A DH Briefing for Elected Members 2013	Runcorn Town Hall	Simon Bell
APPENDIX B DRAFT Specification and Questionnaire	Runcorn Town Hall	Simon Bell

APPENDIX A – Briefing for elected members

A new role for local authorities

From April 2013, local authorities are statutorily responsible for delivering and commissioning public health services for children and young people aged 5-19. This will include providing prevention and early intervention services, delivering the Healthy Child Programme and addressing key public health issues such as sexual health, emotional health and wellbeing issues, obesity, drug, alcohol and tobacco misuse.

What is the Healthy Child Programme 5-19?

- A national public health programme for children and young people from 5-19
- Provides a robust evidence based framework and sets out good practice for prevention and early intervention services
- Identifies the school nursing service as crucial to the effective delivery of the Healthy Child Programme
- Assists local areas to ensure services:
  - are based on a robust needs assessment
  - utilise effective practice and prioritise evidence based programmes
  - make best use of their workforce

What are the key public health issues for children?

- Bullying
- Emotional health and wellbeing
- Dental decay
- Obesity and weight management
- Teenage pregnancy
- Sexually Transmitted Infections
- Smoking
- Drug and alcohol misuse

Who are school nurses?

- Qualified nurses with specialist training in the public health needs of school aged children including sign posting and referring to other services where appropriate
- Lead and deliver the Healthy Child Programme (5-19)
- Equipped to work at community, family and individual levels
- Skilled in identifying issues and risks early, providing early intervention
- Work in a range of settings including mainstream education, faith schools, specialist services for looked after children, special schools and alternative education provision
- Support children with illness and disability to enable them to access education and recreation

Elected members play a key role in ensuring the health and social care needs of local school aged children and young people are met through services that are commissioned appropriately. School health services play a vital role in supporting children and young people. School nurses lead and deliver the Healthy Child Programme and work in partnership with other agencies to deliver school health locally. The school nursing offer provides Elected Members with a benchmark to assess and review the local services being provided by school nurses and to decide if they meet local children's and young people's health needs including those who are looked after.

How can the School Nursing Service help?

School nurses are responsible for delivering cost effective public health programmes or interventions to improve health outcomes for school aged children and young people (5-19yrs). This includes reducing childhood obesity, under 18 conception rates, prevalence of chlamydia and management of mental health disorders.

Health Visitors are responsible for input to children 0-5yrs and their family. Health visiting and school nursing services work together to ensure children, young people and families are supported. The school nursing service offers a structured approach to delivering the Healthy Child Programme (5-19), providing public health advice and ensuing the emphasis is on providing early help to children and young people from school nurses.

The school nursing team local service offer:

The 4 tiered service offer helps LMCS to understand what each level of support is.

Community

All communities have a range of health services (including GP and community services) for children and young people and their families. School nurses develop and provide these and make sure children and young people know about them.

Universal services

School nurses and their teams provide the Healthy Child Programme and public health services to ensure a healthy start for every child (e.g. immunisations, advice on healthy eating and weight management, health checks). They support children and parents to ensure access to a range of community services.

Universal plus

Gives children, young people and parents a swift response from your School Health Service when they need additional or specific expert help (e.g. with sexual health, mental health concerns, long-term conditions and additional health needs including asthma, diabetes, learning disabilities).

Universal partnership plus

Provides ongoing support by the school health team from a range of local services working together and with children and young people, to deal with more complex issues over a period of time, for example, support for children who may need specialist services including child and adolescent mental health services, looked after children, and young carers.

Dear Colleague,

The future of School Nursing in Halton

I am writing to you to inform you of developments in relation to the Halton School Nursing service and to invite any comments you may have regarding these developments.

Halton's school nursing team's role is to work in partnership with children, young people and their families to help them to make the best possible start to life by monitoring their health and promoting good health habits from an early age. The school nursing teams see children and young people between 4 to 19 years of age who attend school or reside in Halton.

Halton Borough council assumed responsibility for the school nursing service in April 2013 and is committed to providing a service that is visible, accessible and confidential. The service will identify individuals health needs early, and work collaboratively to put in place extra support as required. They will work with children and young people with illness or disability within the school to put in place a package supporting the family. The service also works to promote positive health and wellbeing, and delivers immunisation and screening programmes for school aged children and young people.

Halton Borough Council is reviewing the existing commissioning arrangements for the school nursing service. This is in response to the Department of Health recommendations made in 'School Nursing - a call to action', and to best meet the needs of children and young people in Halton.

The Local Authority aims to commission a service that is of a high quality, meets the needs of local people and is value for money. The establishment of a new service specification that has been through a robust tendering process will enable Halton Borough Council to be confident that future commissioned services are delivered effectively to meet required standards in a way that is conducive to children and young people and their parents school nursing, schools and other

partner organisations.

This process has been informed by National School Nursing Guidance, the 'Vision and Call for Action' and legislation and include the particular expertise of the Public Health Commissioning Team to build on the current comprehensive specification to ensure that early intervention and long term investment can support children, young people and their families to reach their full potential.

The enclosed draft specification does not propose any significant changes to what the School Nursing service offers, or the way in which it provides key services but rather clarifies the responsibilities of the service and puts in place systems and measures to demonstrate its impact.

I am delighted to include information for you about the proposed specification for the School Nursing service that we would like to procure to provide the best possible outcomes for the children, young people of Halton and their families.

Please consider the enclosed information which makes up the proposed service specification and let me know any suggestions or comments that you may have.

At the end of the document is a brief questionnaire – I would be most grateful if you could complete it with any comments that you may have, or contact Simon Bell on 0151 511 6736 or simon.bell@halton.gov.uk to discuss the service further.

I look forward to hearing from you.

Yours faithfully,

Eileen O'Meara
Director of Public Health

Halton School Nursing Service - Draft Specification 2013

1. Key Service Outcomes

The aim of the specification is to ensure that School Nurses work to an agreed standard by incorporating guidance from the Healthy Child Programme (HCP) whilst providing an evidence-based approach to practice. The direction of service intervention will be determined by local/individual identification of need; focusing on prevention and early intervention in breaking the cycle of health inequalities within families (Marmot, 2009).

This specification sets out the minimum requirement for the school nursing service for Halton, that it is safe, accessible and of a high standard. Focusing on the promotion of health and the prevention of disease from the earliest age. The service will seek out and provide early interventions and continuing support for individual and group health needs on a universal and non-stigmatising basis. The school nursing service will provide signposting and hand-holding into health services for children and young people of school age (4 to 19 years) in order that they are given the very best chance to achieve good health as well as contributing to the ambitions for improving outcomes outlined by Halton Children's Trust.

"Halton's ambition is to build stronger, safer communities which are able to support the development and learning of children and young people so they grow up feeling safe, secure, happy and healthy, and ready to be Halton's present and Halton's future"

In particular it will embrace the content of '*Getting it right for children, young people and families. Maximising the contribution of the school nursing team: vision and call to action'* (DH 2012) which identifies the next steps towards achieving improved services and outcomes. The new service model is set within the Healthy Child Programme which is based on best evidence to promote and protect the health of children in the developing years. It aims to join up best evidence of what should be done with the views of professionals, parents, children and young people on how it should be done. By implementing the model, good health outcomes and a positive experience can be achieved for children, young people and their families.

Summary of National / local context and evidence base

- Getting it right for children, young people and families: Maximising the contribution of the school nursing team: Vision and call to action (DH, 2012);
- Children Act 1989 & 2004;
- Healthy Lives, Brighter Futures (DH, 2009);
- Schools and Families (Department for Children Schools and Families (DCSF) 2009);
- Working together (DfES 2006) – currently under review;
- Healthy Weight, Healthy lives: National child measurement programme, (DH,

DCSF 2010/11);

- The NMC Standards and Codes of Practice;
- Fair Society, Healthy Lives, The Marmot Review, 2010
- Public Health Outcomes Framework (Department of Health, 2011)
- Children and young people's health outcomes strategy: Report of the children and young people health outcomes forum, 2012
- Halton Health & Well Being Strategy 2013
- Halton Children and Young Peoples Plan 2011 – 2014
- Halton Joint Strategic Needs Assessment

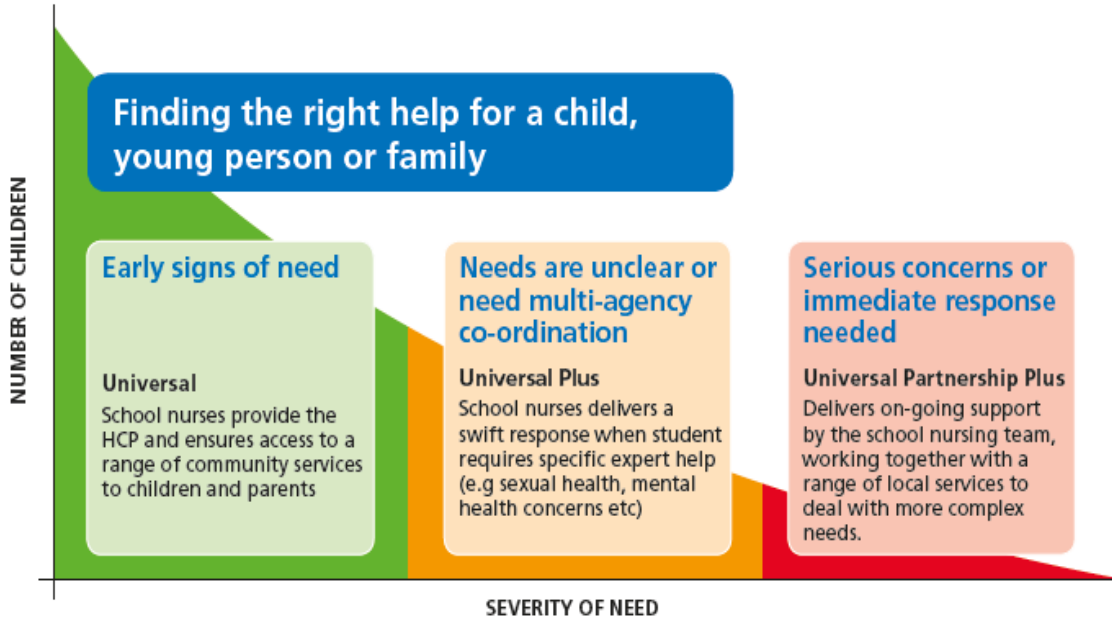
2. Aims and Objectives

The service will work proactively, and provide on-going commitment to an integrated model of service delivery. It will support the development of a School Health Profile and ensure that a robust action plan, developed in partnership with schools and other partners, is in place for every school.

2.1 Early intervention

An effective, universal, preventative, collaborative and early intervening service has a crucial role in identifying 'at risk' children and young people. The service will aim to reduce the risk of this client group becoming the most vulnerable adults in the future. Early intervention and long term investment will support children, young people and their families to reach their full potential.

The school nurse service will need to identify key interventions within a local 'Wedge' model. The 'Wedge' model has been developed by the Department of Education and Association of Directors of Children's Services (ADCS) to inform choices and decisions about investment priorities. An effective model of local working through integrated local children and young people networks will be vital in order to demonstrate an effective and efficient delivery of service.



The 'Wedge' is a model developed by the Department of Education and Association of Directors of Children's Service (ADCS) to inform choices and decisions abc

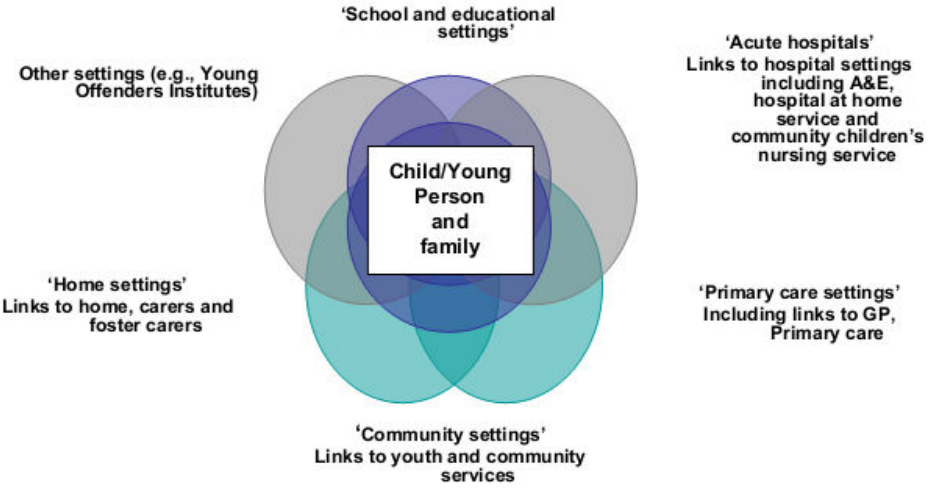
Research into referral patterns indicate that teachers and other education services are best placed to detect the early onset of risky behaviours, but lack of time and conflicting priorities mean that teachers did not always follow through to ensure that young people received the help they needed.

This service will work in partnership with the school to identify young people who are at risk of poor health outcomes. The early indicators (not exhaustive) of needs include:

- truancy or school exclusion
- behavioural problems
- poor emotional, social or coping skills
- poor mental health
- learning difficulties
- specific disabilities
- low aspirations or low self-esteem
- poor family support or problems in the family
- domestic abuse
- friends or family members involved in risky, antisocial or criminal behaviour
- deprivation or poverty
- family instability
- drug or alcohol misuse
- not being in education, employment or training (NEET)
- homelessness
- health protection (infectious disease, emergencies)

The service will also develop health action plans for each young person in need, including children with long term conditions, looked after children, those on a child protection plan and any other child deemed appropriate.

The new school nursing service model maximises the contribution of school nursing teams at a community, family and an individual level. In doing this, existing and new school nursing services will work closely with families, school, health visitors, other public health specialists, GPs, specialist services and, where appropriate, social care services.



2.2 Underpinning activities and approach (including safeguarding)

The service will:

- Undertake a school health entry assessment for all reception age children
- Provide public health advice, health promotion activity, health assessments, health screening, guidance and support to those of school age, involving their families, carers and education staff where appropriate;
- Routinely offer height and weight screening as part of the National Childhood Measurement Programme (NCMP) in reception and year 6;
- Undertake an assessment to facilitate the transition into year 7;
- Work within the scope of the Working Together to Safeguard Children document and local protocols and guidance around the safeguarding children agenda. It will provide professional reports to conference as appropriate, attend safeguarding conferences and take an active part in core group
- Initiate or attend meetings when a health need has been clearly identified (including long term conditions);
- Initiate the Common Assessment Framework (CAF) and act as lead professional where appropriate and where a health need has been clearly identified;

- Demonstrate integrated working and a commitment to the 'Team Around the Family' approach;
- Recognise the significant impact that domestic violence can have on children and young people and act in accordance with national and local guidance;
- Offer screening to any child moving into a Halton school from out of area as appropriate. All children will also receive a health assessment;
- Provide further screening, health assessment and advice at the request of parents at any stage of a child or young person's time at school;
- Offer support to individual children, young people, parents and families and make referrals to a wide range of other professionals when specific needs are identified, as appropriate.

2.3 Signposting and hand-holding into services

The term 'hand-holding' is widely used by Think Family practitioners to describe a helping approach to intervention. The term can be seen to equate with 'going with' or 'going alongside' families, both practically and emotionally, through a process of change.

The school nursing service will:

- Be accessible to school age children and young people and ensure that the service meets their needs by engaging with the local population;
- Provide a minimum of a weekly lunchtime or after school drop in service of a minimum of at least ½ hour at all secondary schools in Halton, offering children and young people the opportunity to discuss any health related issues they might have.
- Provide a minimum of a monthly drop in service for each primary school that lasts at least ½ hour and provides the opportunity for children, parents and carers or staff to seek advice and information and discuss any issues or areas of concern.
- Provide all Halton schools with a named school nurse, who will offer support on the basis of assessed need, taking into account local needs, safeguarding cases, and numbers of pupils on school roll.
- Offer ongoing signposting and hand-holding into services and support to children, young people and families on issues such as parenting, quitting smoking (including nicotine replacement therapy), substance misuse, sexual health, anxiety, depression, eating disorders and deliberate self-harm when health needs have been identified for the child or young person;
- Offer appropriate and ongoing support to children and young people who are looked after, have an identified long term condition or are young carers
- Ensure appropriate referrals to specialist services; and
- Support school staff in the coordination of specific health needs in school. This will includes providing training in the appropriate use of inhalers,

adrenaline auto injectors prescribed for children and young people with diagnosed anaphylaxis and any specialist equipment as appropriate.

- Provide support, advice and guidance and co-ordination of care (where appropriate) for those children and young people with specific health needs or long term conditions.

2.4 Delivering national Public Health Programmes: Immunisations and Child Measurement Programme

The service will be responsible for the following Programmes:

National Child Measurement Programme

National Vaccination and Immunisation Programme – as appropriate to the population (commissioned by NHS National Commissioning Board)

2.5 Standard sexual health components to be included in school nursing service specifications (Cheshire and Merseyside Sexual Health Network, 2013, see Appendix 1)

The service will also offer (regardless of site and time of year) the following:

- Time for young people to talk about issues concerning them including relationships, sexuality, sex and peer pressure
- Provision of 1:1 sexual health service, to include all or some of the following depending on the faith ethos of the school: pregnancy testing, Chlamydia testing, condom demonstrations and provision, provision of emergency hormonal contraception under PGD, referral for first pill prescription. This will be delivered in a healthy lifestyles drop in session.
- Targeted work to support the reduction in teenage pregnancies
- Liaison with school PSHE leads to plan and implement joint activity re SRE curriculum

2.6 Safeguarding

The service will work within the scope of the Working Together to Safeguard Children document and local protocols and guidance around the safeguarding children agenda. It will provide professional reports to conference as appropriate, attend safeguarding conferences and take an active part in core group.

The service will initiate CAFs where appropriate and will take the role of lead professional in cases where a specific health need has been identified. The service will be specifically monitored against the KPIs as identified within Appendix 2.

3 Service Model

This specification does not set out to tell school nurses how to care for young people – it sets out the specification for the school nurse service.

The School Nursing Team will be represented by Specialist Community Public Health Nurses (SCPHN), School Nurses and an appropriate skill mix of support staff. For the purpose of this document, the word School Nurse will be used for both School Nurses and SCPHN.

It is expected that the School Nurse will exercise professional judgement in collaboration with other agencies and using appropriate evidence bases when deciding whether or not a child or young person receives additional support and/or intervention.

The specification should be used in conjunction with agreed service procedures, policies, competences and LSCB policies, whilst adhering to the Nursing and Midwifery Council (NMC) code of professional conduct. The school nurse service will provide interventions targeted at different levels of identified need. The diagram below illustrates a national representation of how the level of targeted intervention will integrate with service delivery.

'The Offer' - Wendy Nicholson, Professional Leadership Team - Department of Health School Nursing Programme of Development - 2011

3.1 Service description

The service will provide a health service for children and young people in Halton of school age (up to 19 years) and will operate 52 weeks a year and will be delivered by suitably qualified nurses and support staff. The service will seek out and provide for individual and group health needs on a universal basis, focusing on the promotion of health and the prevention of disease from the earliest age. Interventions will be based upon up to date evidence based practice and relate to need. This will include (but not limited to) the following services:

- Deliver a Universal, Universal Plus and Universal Partnership Plus Service, working in a range of settings.
- Early identification of health needs through formal partnerships with schools children and young people and their families/carers.
- Working with partners to improve the health outcomes of children and young people.
- Deliver school age immunisation programmes as directed by Public Health England.
- Underpinning activities and approach (including safeguarding);
- Universal advice and support to schools, young people and their families;
- Signposting and hand-holding into services;
- National Child Measurement Programme
- Health protection: rapid response and ongoing participation during outbreaks or other incidents

3.2 Roles and Responsibilities

The School Nurse Team will promote the holistic health of the school aged population, thereby enabling them to realise their potential. They will encourage children and young people to think about their health and support them to become responsible for their own health and wellbeing as they progress through childhood and adolescence.

The role is varied and includes:

- Keeping children and young people safe from harm and protecting them from injury and abuse in accordance with LSCB policies.
- Offering health advice and universal health surveillance, incorporating early intervention and support to children and young people and their families. The school nurse will work in partnership with colleagues in education, allied health professionals and children and young people's services.
- Working with schools and academies to develop health policies, e.g. sexual

health, contributing to the Personal Social Health Economic (PHSE) education Curriculum.

- Reviewing the health status of children and young people and facilitating care plans (e.g. for long term conditions) as required.

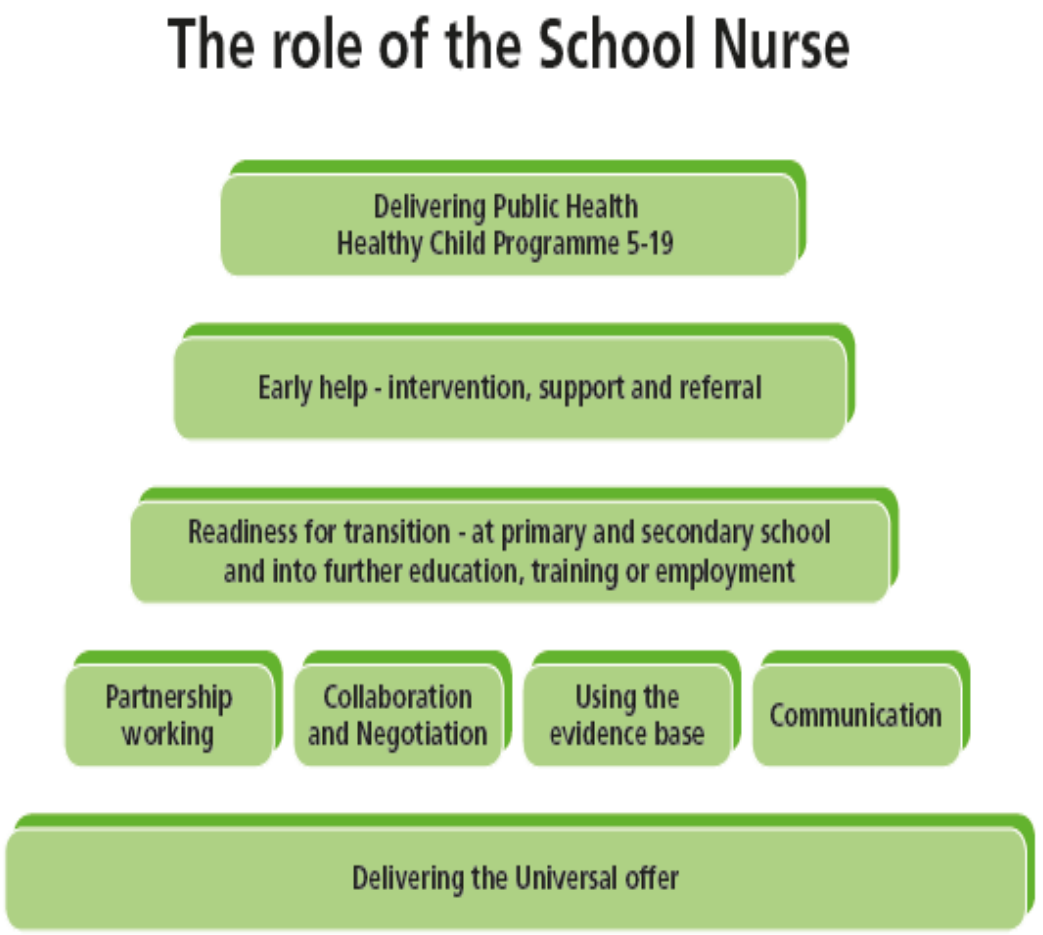
- Offering a choice of services that are accessible and confidential to children, young people and families (e.g. 'drop in' or appointments)

- School nursing teams will promote early intervention to support children, young people and families to reach their full potential

- Health protection of school age population, i.e. provide a trained and proficient immunisation workforce as required by Public Health England and aim to achieve full immunisation uptake

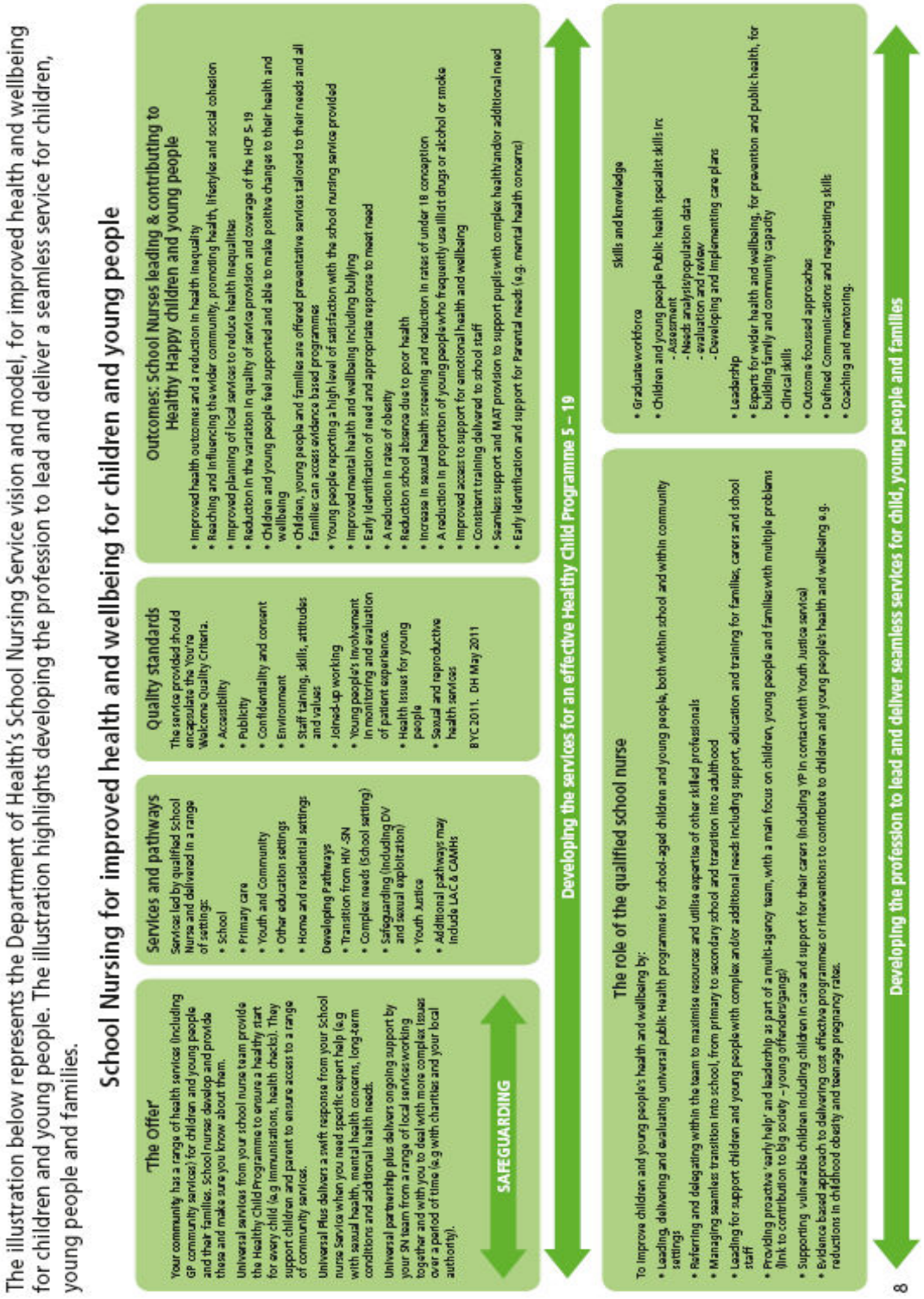
The next 2 graphics summarise the role and scope of the school nurse service.

The illustration below represents the Department of Health's School Nursing Service vision and model:



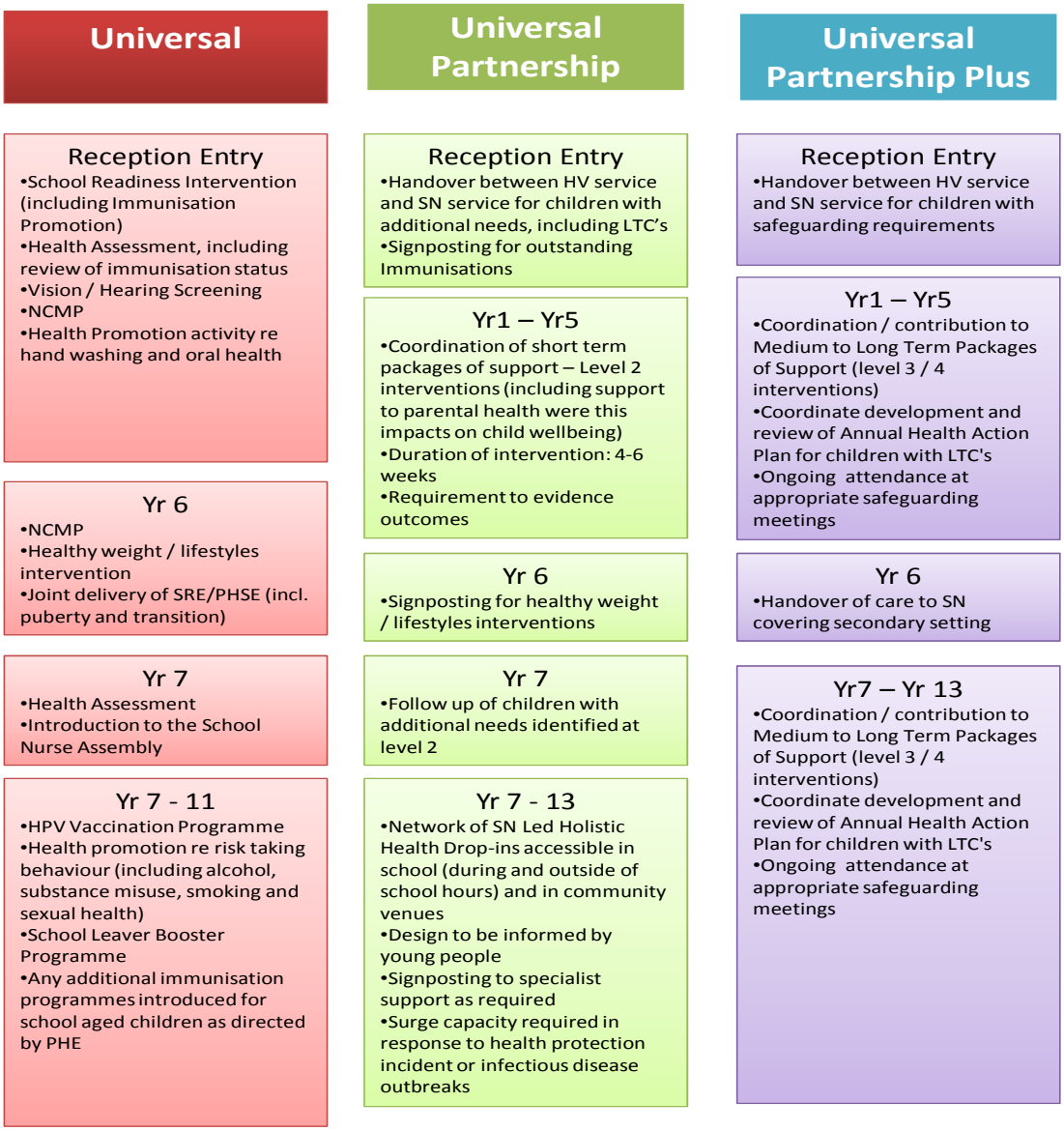
"The Role of the School Nurse" – Wendy Nicholson, Professional Leadership Team – Department of Health School Nursing Programme of Development-2011

The illustration below represents the Department of Health's School Nursing Service vision and model, for improved health and wellbeing for children and young people. The illustration highlights developing the profession to lead and deliver a seamless service for children, young people and families.



3.6 Care Pathway

The school nursing service will follow a care pathway similar to that below. The care pathway will be further developed in line with government and local guidance.



Children, young people and their families will be provided with up to date information and support to enable them to recognise and manage their own health needs and promote healthy living. Those receiving services will receive regular reviews as appropriate to their situation, to ensure that the service continues to match their needs. This may also be in conjunction with other partners involved in their treatment.

The school will inform the service when the child is registered at the school. The nursing service will work with other professionals on an individual case led basis. Consultations and referrals will involve carers and all related staff when appropriate. Feedback will be sought at each meeting and outcomes acted upon accordingly. Actions will be monitored in family support meetings / conferences / reviews and

annual local education authority (LEA) reviews.

There are several sources of information for the school nursing service to be aware of, and to ensure that all records are kept up to date. All staff must work within the standard information sharing protocols.

4 Who is the service for?

4.1 Geographic coverage / boundaries

The school nursing service will cover all children and young people that attend schools located within Halton. This will include special, independent, academies; primary, secondary, free schools and those not in mainstream settings, e.g. Pupil Referral Units and approved training providers. There will be a clear partnership reciprocal relationship with neighbouring authorities.

The service will ensure that any coverage / boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers, and relevant commissioners as appropriate.

Delivery of a service that meets the needs (including safeguarding) of the child or young person must take precedent over any boundary discrepancies or disagreements.

4.2 Referral criteria and sources

The service will provide a universal service with open access for any child or young person aged 4 to 19 attending education provision within Halton, and for Halton residents either receiving home education or not currently in any educational provision. Core services will be offered to independent education providers. School nurses will be accessible via telephone or face to face either at their office bases, (e.g. health centres) or through the schools or through home visits or meetings at other suitable community venues.

All children and young people who attend Special Schools will have access to the service and fall into the categories stated below:

- Children with a statement of Special Educational Needs (SEN);
- Children with life limiting conditions;
- Children requiring physiotherapy, speech and language therapy and occupational therapy; and
- Looked after children (LAC) attending the special needs schools.

4.3 Referral processes

There will be open access to the service. A child or young person may self-refer, be referred by their family or by teaching / school staff or other partner organisations.

4.4 Days / hours of operation

The service will normally be available between 8.30am and 5.00pm, Monday to Friday. The service will ensure that cover is available outside of this where relevant and appropriate and that there is continuity of service provision, where appropriate, during school holidays.

4.5 Discharge processes

When a child/ young person and their family leave the Halton borough there will be a clear local protocol in place to ensure continuity of services for the family, as appropriate, in the new residing borough. Disadvantaged and socially excluded families will be actively followed up to reduce the incidence of families not being linked up in their new residing area.

For children and young people on the Universal pathway
When the child and/or young person leave their respective schools, they will be discharged to the care of their GP (for referral if necessary).

For children and young people on the Universal Plus, and Universal Partnership Plus Pathways
The Service will retain an oversight and co-ordination role where appropriate. Until the 19th birthday of the young person.

4.6 Response time and prioritisation

Depending upon the individual circumstance of the request, children, young people or families seeking advice and support from the service will usually receive a response within 5 working days.

Each school will have a link to a community clinic and prioritisation will be given dependant on the need at the time. Children and young people who require support of the school nurse will have an individual review, the timing of this will be dependent upon the urgency of the support required.

4.7 Exclusion criteria

The service is a universal provision and will not have any exclusion criteria.

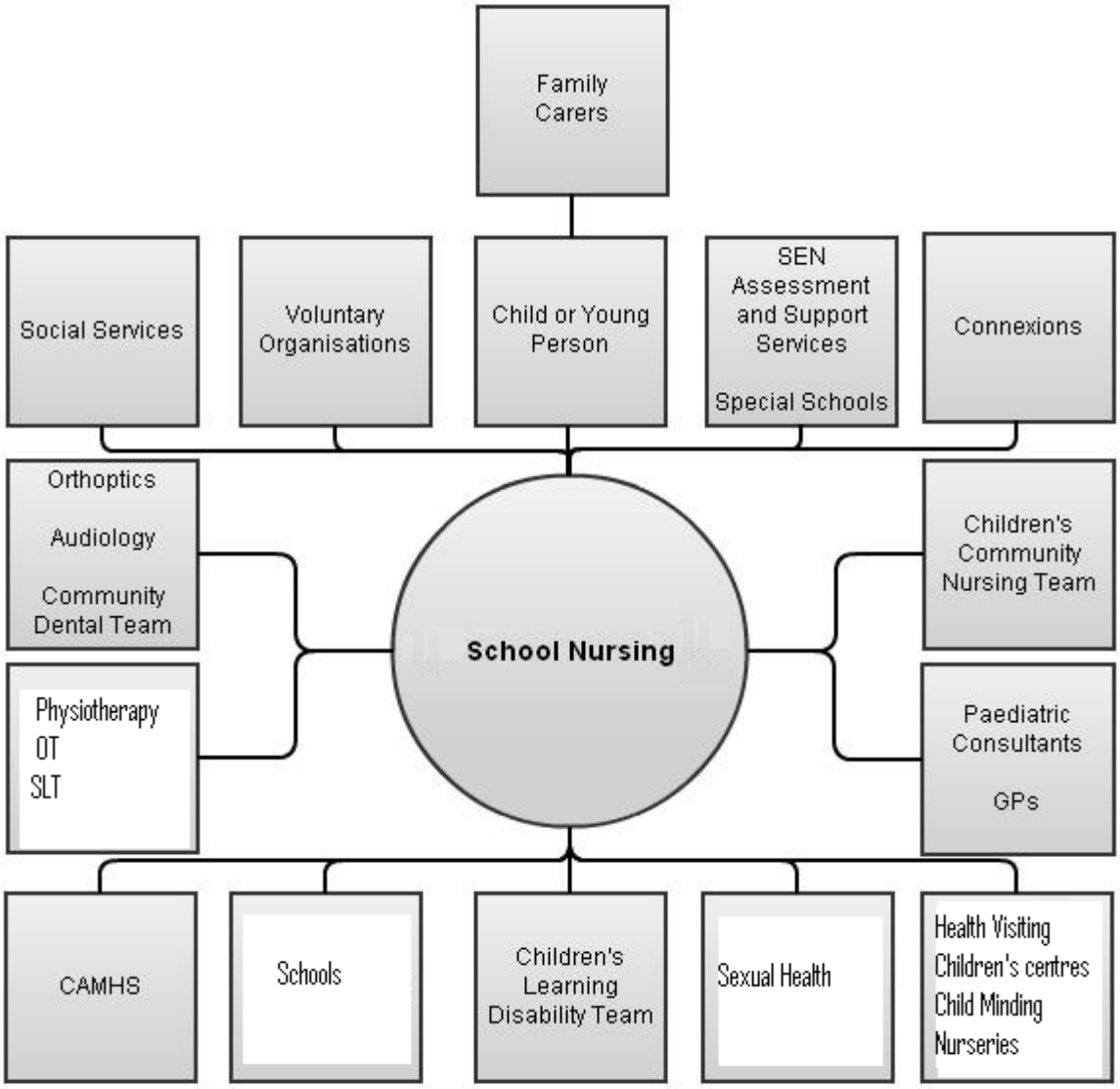
5 Workforce and system relationships

5.1 Whole system relationships

The service and its staff will have a clear understanding of how their service interlinks with other services within Halton and clear referrals pathways for specific needs.

The service will ensure that Halton policies and procedures relating to safeguarding are adhered to and that all staff members have undertaken training appropriate for their professional role. All staff working in this service must have an up to date enhanced Disclosure and Barring Service (DBS) check.

The service will work as part of a wider network of partners and service providers to ensure an integrated approach to service delivery is maintained.



The service will work with interpreter services locally to ensure equality of access and provision for children, young people and their families who do not have English as a first language. These will include providers of interpretation for foreign languages and sign language.

5.2 Interdependencies and other services

The service will maintain close links with a wide variety of stakeholders, children and young people, parents, staff working in schools, general practitioners (GPs), the Health Visiting service, safeguarding leads and specialist health providers.

5.3 Relevant networks and screening programmes

The School Nursing service will be responsible for delivering national screening programmes as those described in the core school health programme. Current programmes include the National Child Measurement Programme and Immunisations. The National Commissioning Board will assume commissioning responsibility for immunisations programmes, whereas the Local Authority will commission child measurement. The Local Authority commissioners will expect the school nursing service to ensure maximum uptake.

The service will be expected to have representatives on local boards, steering groups and working groups as determined flexibly and in line with local needs and priorities.

5.4 Training/ education/ research activities

Staff will be:

- Required to attend all mandatory training;
- Expected to undertake training relevant to their role on an ongoing basis as identified through personal development plans (PDP), including confidentiality as specified in *You're Welcome* and in line with continuing professional development;
- Encouraged to complete relevant training to diploma level;
- Encouraged to undertake specialist practitioner training;
- Required to contribute to the ongoing development of the core school nursing programme using relevant data collection tools.

5.5 Staffing

Each local secondary school will have a dedicated named School Nurse who will also be responsible for the cluster of primary schools to which it is linked. Special schools will also have a named School Nurse.

Service delivery will be provided by the most appropriate member of the team and will be delivered by a skill / grade mix of staff.

In Halton there are a variety of schools:

- **50** primary schools
- **7** secondary schools
- **4** special schools
- **1** all through school (nursery to secondary)
- **3** maintained nursery schools and many primary schools with nursery classes

Staff will be expected to have a wide range of skills and competencies including knowledge of:

- Health promotion, behaviour change and motivational interviewing;

- Safeguarding;
- Health needs of children and young people;
- Sexual health;
- Causes and treatment of health issues;
- Screening skills in hearing, height and weight assessment;
- Emotional health and well being;
- Immunisations; and
- Public health issues.

Staff will have access to training in order to develop these skills. All training will be based upon current evidenced based practice and Nursing and Midwifery Council (NMC) guidelines. Unqualified staff will attain / work towards core competencies to NVQ level 3 standards and be trained in specific areas of care according to the needs of the child or young person.

6 Key Performance Indicators

8 Quality and performance standards

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
Outcomes				
Reduction in Teenage Pregnancy	NI 112(variant) Teenage conception rates		Live births drawn from data systems Terminations gathered through central booking	Quarterly
Reduction in levels of obesity	NI55 – Obesity levels at reception NI56 –Obesity levels in year 6		National Child hood Measurement programme (NCMP) Reception children with height and weight recorded Year 6 children with height and weight recorded	Annually
Immunisation rates	Immunisation take up rates	95% - HPV 80% booster (split these up?)	Cover data from Department of Health Immunisation rates for booster of tetanus, diphtheria and polio (13-18) Immunisation of HPV Vaccination (13)	Quarterly
Screening for Chlamydia	NI113- Chlamydia Screening rates		Screening rates reported through national and local screening programme	Quarterly
Hospital admission rates			Alcohol attributable	Annually

attributable to alcohol			admission data	

9. Activity

9.1 Activity

Activity Performance Indicators	*Method of measurement*	*Baseline Target*	*Threshold*	*Frequency of Monitoring*
School health Profile and Action plan developed for each school and refreshed on a termly basis	Plans shared with the commissioner	All schools to have a plan in place		*Termly*
Demographics of CYP activity: NHS number, Name, Address, postcode, DOB, ethnicity, GP to be recorded	All data will be monitored by monthly activity data submission	TBD		*Quarterly*
Number of interventions detailed into universal, universal plus and universal partnership plus and by setting	Monthly performance reports	N/A		*Quarterly*
Total patient contacts by type (domiciliary/ drop in / telephone)	(number and %)	TBD	TBD	Quarterly
Total onward referrals	(number and type)	TBD	TBD	Quarterly
Number of School entry assessments	(number)	100% of reception aged children		Quarterly
% of reception children receive vision screening (measure in August)	(number, and %screened, onward referral, those reported as requiring additional support and % of false positives)	90%		Annually
% of reception children receive hearing screening (measure in August)	(number, and %screened, onward referral, those reported as requiring additional support and % of false positives)	80%		Annually
% coverage for National Child Measurement Programme for Reception	(number, and %, breakdown of those classed as overweight /obese)	90%		Annually

Number of children referred on to weight management programmes	(number and %)			
% coverage for National Child Measurement Programme for Year 6	(number, type and %)	90%		Annually
Number of children referred on to weight management programmes	(number and %)			
% of year 8 Girls to have received three doses of HPV to be (measured in August)	(number and %)	95%		Quarterly
% of 10-18years olds to have received the school age booster	(number and %)	80%		Quarterly
Number of children with incomplete immunisation status, who are now complete	(number and %)	50% Completed 100% Followed up		Quarterly
% of Children and young people who are transferred into area, to receive a health assessment within 1 month of the School nursing service being informed.	(Number and %)	100%		Quarterly
Number of annual Health Care Assessments undertaken for Looked After Children notified to service	(number, and %)	100%		Quarterly
Total of caseload with active Health Care Plan in place, split into LAC, CP / CIN / CAF, Long term condition and Youth offending#)	(number, type and %)	100%		Quarterly
Number of Year 6 children assessed for transition into year 7 (measured in August)	(number, and %)	100%		Annually
Number of children and young people from age 11 to 19 to have access to a sexual health service (weekly??)delivered locally to the young person	(number of sessions)	100%		Quarterly
Total number of sexual health interventions by type	(number of Chlamydia Tests, Pregnancy Tests, EHC Provided, Pre and Post Termination Support, Condom			Quarterly

	demonstration and provision, and Sexual Health Promotion and onward referrals) (see Appendix A)			
Number of A&E notifications received	(number and number identified as requiring follow up)			Quarterly
Number of children and young people followed up following A&E attendance	(number and outcome)			Quarterly
Actual number of patients/service users completing a feedback/satisfaction questionnaire	(number and %)	TBD	TBD	Quarterly
Actual number of patients/service users reporting that the service met their individual needs	(number and %)	TBD	TBD	Quarterly
Actual number of patients/service users reporting a satisfactory outcome as a result of using the service	(number and %)	TBD	TBD	Quarterly
Number of service users reporting that they would recommend the service to a family member or friend	(number and %)	TBD	TBD	Quarterly
Number of complaints	(number, type and result of complaint)			Quarterly
Number of staff	(number, WTE and grade)			Quarterly
Vacancies	(number WTE and grade)			Quarterly
Relevant staff to receive sexual health training	(number WTE and grade)			Annually
All staff to receive inter-disciplinary training relating to Your Welcome Theme 4 Confidentiality 4.4 and Theme 5 Staff training 5.2 and Working Together safeguarding	(number WTE and grade)			Annually

Please see Appendix 1 and Appendix 2 for specific KPIs relating to sexual health services and safeguarding which are integral parts of this specification.

Additional Key performance indicators will be included to accommodate new immunisations programmes, as required

The Service will also be expected to ensure that the voice of the child / service user is captured at regular intervals to inform service development.

Case studies and additional insight activity will be expected to be shared on a regular basis.

9.2 Activity Plan / Activity Management Plan

Activity Plan

Any Activity Plan required by this Service guidance shall specify a forecast threshold to function as an early warning of where the actual level of demand exceeds the forecast threshold, with the intent that any breach of the forecast threshold will be reviewed by the relevant parties without delay.

The service will need to use an appropriate system to collect:-

- Patient information-age band /ethnicity
- GP
- Care locations
- Activity - Clinical/non clinical
- Health Promotion Activity
- Outcomes
- Individual additional information that may be pertinent to the care of the individual and also support data collection for monitoring purposes e.g. asylum seekers, children staying in women's refuge, etc.

9.3 Capacity Review

A capacity review will be undertaken by the Service in 2013. The findings from this review will inform the development of this specification and future commissioning plans along with the JSNA.

Service capacity will continue to be reviewed through regular monitoring against the Key Performance Indicators contained within this specification.

6 Continual Service Improvement

The service, in liaison with the commissioner where appropriate, will look to continually improve its service offer. It will ensure that it advises the commissioner where there are significant changes to services. Issues will be raised at the regular contract meeting with the commissioner, and in between meetings as required.

APPENDIX 1

Standard Sexual Health Components to be included in School Nursing Service Specifications

N.B. This content is only applicable when included as part of a holistic school nursing specification.

1. Aims and objectives of service

To support the young people to make appropriate, positive and active health choices through access to enhanced advice, information and services which need to be age and gender specific as well as being open to diversity and cultural sensitivity.

To demonstrate commitment across the Partnership to work together to improve the health and well-being of young people by providing young people friendly preventative and clinical services at a time and place convenient to them.

To expand the range of health and well-being services offered to students in secondary schools, co-ordinated through the school nursing service.

Expected Outcomes including improving prevention

- Reducing teenage conceptions and associated negative health and social outcomes
- Reducing the under 18 conception rate
- Reducing the under 16 conception rate
- Ensuring equality and equity of access to sexual health and contraception services for young people
- Increased uptake of Chlamydia screening programme
- Increased uptake of Emergency Hormone Contraception (EHC)
- Increased evidence of condom use

2. Service description/care pathway

The service will offer, (regardless of site and time of year) the following:

- Time for young people to talk about any issues concerning them including relationships, sexuality, sex and peer pressure.
- Provision of 1:1 sexual health service, to include all or some of the following, depending on the faith ethos of the school: pregnancy testing, Chlamydia testing, condom demonstration and provision, provision of emergency hormonal contraception under PGD, referral for first pill prescription
- Targeted work to support the reduction of teenage conceptions
- Provide swift and supportive referral to termination of pregnancy services
- Liaison with school PSHEE leads to plan and implement joint activity re SRE curriculum

Agreed services:

- Chlamydia testing
- Pregnancy testing

- EHC provision
- Pre and post termination support
- Sexual health promotion advice
- Free condom demonstration and provision

3. Applicable Service Standards

3.1 Applicable national standards eg NICE, Royal College

- NICE guidelines – PH3 Prevention of Sexually Transmitted Infections and under-18 conceptions [Feb 2007], PH33 Increase in the Uptake of HIV Testing among Black Africans in England [March 2011], PH34 Increasing the Uptake of HIV Testing to Reduce Undiagnosed Infection and Prevent Transmission among Men who have Sex with Men [March 2011]
- Department of Health (2005) *'Your Welcome quality criteria: Making health services young people friendly'*
- Fraser Guidelines[1]
- Medical Foundation for Sexual Health Standards for sexual health services (Medfash, 2005) – in particular, Standard 1: Delivery networks; Standard 2: Promoting Sexual Health; and Standard 3: Access to services.

4. Key Service Outcomes

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
PH Outcomes Framework 2013-16				**Monthly report /quarterly monitoring**
Domain 2 Health Improvement 2.4	Under 18 conceptions-Teenage Pregnancy		No. of EC prescribed. No. and outcome of pregnancy tests. No. of referrals to contraception provision.	Quarterly
Domain 3 Health Protection 3.2	Chlamydia diagnoses (15-24 year olds)	Diagnostic rate of at least 2.4 per 1000 resident population		

Activity Performance Indicators	**Method of measurement**	**Baseline figures from 2012-2013**	**Target for 2013-14**	**Frequency of Monitoring**
Young people who are sexually active accepting Chlamydia test	Record monthly Number of YP 15-18 accepting the offer of Chlamydia test per school			Quarterly
Young people requesting condoms	Record monthly number distributed			Quarterly
Young women request and prescribed	Record monthly Number of young			Quarterly

[1] General Medical Council. 0-18 years: guidance for all doctors. London: GMC; 2007.

Emergency Hormone Contraception (EHC)	women seen that month from aged 13 to 18 requesting EHC per school			
Young women request and provided with a pregnancy test	Record monthly the number of young women requesting pregnancy test.			Quarterly
Young people request relationships and sexual health advice	Record monthly the number of young people requesting relationships and sexual health advice			Quarterly
Young people requiring onward referral to sexual health services and reason for referral	Record monthly the number of young women signposted to other service and reason for referral.			Quarterly

APPENDIX 2 – To be added

The Halton School Nursing Specification

1. This specification covers the health service provided to children and young people of school age from 4-19. What would be the most appropriate name for this service?

	Please tick
a) School Age Health Service specification	
b) School Nursing specification	
c) Specification for the provision of healthcare to school aged children	
d) Other (Please state)	

2. What do you think is good about the current School Nursing Service?

3. Have you any suggestions as to how the service could be improved?

4. Do you feel there is anything missing from the draft specification? If so, what?

5. Have you any other comments about School Nursing?

6. About you

I am responding as: (please tick)

A child / young person	
A parent / carer	
A School Nurse	
A GP	
Another member of Health Staff	
A Head Teacher	
Another member of education staff	
Other Partner organisation	
A Commissioner	
An elected member of the Council	
Other (Please specify)	

Thank you for taking the time to help us to improve this specification.

Please return this form, along with any other comments before XX XXXX to:

Simon Bell
Public Health Commissioning Manager
Halton Borough Council
Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD

Office: 0151 511 6736
simon.bell@halton.gov.uk

REPORT TO: Health and Wellbeing Board

DATE: 18th September 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Adults

SUBJECT: National Energy Action (NEA) Public Health Work Programme

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To seek approval in principle of an application for free assistance from National Energy Action (NEA) to support the achievement of fuel poverty public health outcomes.

2.0 RECOMMENDATION: That Members of the Health and Wellbeing Board provide support in principle for the application for free NEA support that will be circulated at the meeting.

3.0 SUPPORTING INFORMATION

3.1 National Energy Action (NEA) is the national charity which aims to eradicate fuel poverty and campaigns for greater investment in energy efficiency for vulnerable people.

3.2 The organisation is seeking expressions of interest from Health and Wellbeing Boards (or member agencies) for assistance to:

- Support the development and/or implementation of action plans or other activities which will help achieve local public health outcomes on fuel poverty (and by association excess winter deaths where applicable) in support of Health and Wellbeing Strategy and other aligned policy commitments; or

- To assist Health and Wellbeing Board member agencies (particularly local public health teams) to develop wider sectoral or community engagement on the issue of fuel poverty to inform future refreshes of the JSNA.

3.3 The support offered takes the form of up to 12 days of officer time for development activities in 8 localities across England, which must be utilised by 14th March 2014.

3.4 Examples of potential activities that an NEA officer could support include:

- **Practical assistance to contribute to the development of a local action plan** which provides a planned approach to the achievement of public health outcomes on fuel poverty and excess winter deaths
- **Sectoral partnership development/ engagement activity** to bring health, social care, energy, housing and other agencies together with a view to collaborative action
- **Community development/ engagement activity** including activities that raise awareness of the impact of fuel poverty on communities and help them to participate in priority setting and decision making e.g. focus groups, consultation activity etc
- **Project development support** including advice and guidance on practical project design and delivery which helps households to achieve warmer, healthier homes they can manage to afford to heat
- **Awareness raising activities with the public** including energy advice/ fuel debt surgeries, energy awareness events etc
- **Developing local referral practice or provision** to ensure communities have access to local or nationally available energy efficiency, advice or other services including Green Deal and the Energy Company Obligation, Warm Homes Discount and services for vulnerable households etc
- **Awareness raising and/or training for frontline practitioners** to improve professional practice including better targeting, assessment and referral of individuals into services - including awareness of the health/mental health impacts of fuel poverty etc
- **Information support** – including content for briefings, local promotional or other resources for policy makers, practitioners and/or the public
- **Technical advice** – for home improvement projects with a healthy housing dimension

3.5 It is important to note that NEA officers are not health/public health professionals but have an awareness of the health impacts of cold homes associated with fuel poverty and can offer a wealth of experience in the areas of domestic energy efficiency, fuel poverty, income maximisation, energy advice and fuel debt. If the application is successful NEA staff will require the support of an appointed local contact(s) with high level support to lead any agreed local activity, facilitate local introductions and assist with the development and delivery of agreed actions.

3.6 Applications for assistance must be submitted by Friday 20th September 2013 by either a Director of Public Health or the Chair of the Health and Wellbeing Board (or an appointed representative). NEA expects that all applications must

be supported in principal by individual Health and Wellbeing Boards.

3.7 Unfortunately due to the tight timescale it is not possible to undertake a full consultation on potential projects with all member agencies. However, officers from a range of disciplines are working together to develop an application which supports the aims of Halton's Health and Wellbeing Strategy, Affordable Warmth Strategy and Home Energy Conservation report.

3.8 The completed draft of the application will be circulated for comment and endorsement in principle at the September meeting of the Health and Wellbeing Board. Should the application be successful there will be an opportunity for Board members and partner organisations to influence the delivery of the project as appropriate.

3.9 Should the application be successful an NEA officer will attend an initial meeting with a representative of the Health and Wellbeing Board to discuss local priorities, determine support activities and agree an outline work plan and delivery timescale. Time associated with this initial meeting is additional to the development support time available from NEA.

8.0 POLICY IMPLICATIONS

If successful the application for NEA Officer support will support the delivery of the Health and Wellbeing Strategy and associated action plans and the delivery of the Affordable Warmth Strategy and Home Energy Conservation report.

Fuel Poverty is also an indicator in the Public Health Outcomes Framework.

9.0 OTHER/FINANCIAL IMPLICATIONS

The application relates to up to 12 free days of NEA officer time. This includes desk preparation work and delivery activity within the locality as well as travel time. NEA will cover all NEA staff costs, travel, accommodation and subsistence costs associated with delivery activity.

All other costs associated with agreed delivery activities must be covered by the local partner(s) e.g. meeting, event, resource, printing or other activity costs.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children and Young People in Halton

Research shows that living in a cold home can have an adverse impact on child development in terms of their health and emotional wellbeing and educational attainment.

7.2 Employment, Learning & Skills in Halton

None directly

7.3 A Healthy Halton

Research shows that fuel poverty contributes to excess winter deaths, cardio

vascular disease, respiratory disorders, mental health issues and reduced resistance to cold and flu.

7.4 A Safer Halton

None directly

7.5 Halton's Urban Renewal

Action to improve the energy efficiency of housing can help to reduce carbon emissions and have a positive impact on climate change.

8.0 RISK ANALYSIS

None identified at this stage. However, should the outline application be successful a full risk assessment will be undertaken prior to the commencement of the project and mitigating factors identified and actioned.

9.0 EQUALITY AND DIVERSITY

Should the application be successful an Equality Impact Assessment will be undertaken with regard to the detailed delivery plan.

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

None

REPORT TO: Health and Wellbeing Board

DATE: 18th September 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: St Helens and Knowsley Teaching Hospitals NHS Trust - Proposed 5 year Clinical and Financial Plan

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide the Board with an initial assessment of St Helens and Knowsley (STH&K) Teaching Hospitals NHS Trust proposed 5 year Clinical and Financial Plan and outline areas that require close scrutiny.

2.0 RECOMMENDATION : That Board Members note the contents of the report and associated appendices.

3.0 SUPPORTING INFORMATION

3.1 On 2nd August 2013 Ann Marr, Chief Executive of STH&K Teaching Hospitals NHS Trust wrote to the Chief Officers of Halton, Knowsley and St Helen's Clinical Commissioning Groups (CCGs) outlining details of the Trust's draft 5 year Clinical and Financial Plan ***(Appendix 1 and 2 attached).***

3.2 The bulk of the Trust's income comes from contracts with English CCGs, NHS England and Local Authorities. The table below shows the breakdown of this funding[1].

	Local CCGs	NHS England	Local Auth's	Total Eng Contracts
	£m	£m	£m	£m
Payment By Results (PbR)	162.0	6.9	0.9	169.8
Non-PbR	43.0	7.1	1.6	51.7
	205.0	14.0	2.5	221.5

The bulk of this money is paid on a cost and volume basis – actual activity multiplied by a national NHS "PbR" tariff which varies according to the specialty, procedure and category of the patient. The tariff is set on a full cost recovery basis so that Trust's will gain on the margin between the marginal cost for doing an extra unit of activity and the full cost price they receive under tariff. The bulk of the non-PbR income also varies on levels of activity but uses local full cost tariffs. As at month 3 (2013/14), STH&K was

[1] (Total Trust income will be around £270m after allowing for PFI support (£2m from local CCGs, £13m from DH), clinical income from Wales, out of area CCGs and private patients (£5m) and non-clinical income (£29m) for services such as payroll, catering and money received for education and research.

over performing on its English Contracts by £1.3m - £1.0m on PbR and £0.3m on non-PbR.

3.3 The Department of Health (DH) introduced rules to limit the amount of income growth Hospital Trust's would receive from non-elective admissions whereby activity above their 2008/9 base level would only be reimbursed at 30% of the national tariff. However the 70% was still a cost in that it was paid by Primary Care Trusts to the Strategic Health Authorities. This was intended to discourage supply led growth in emergency admissions and encourage Trusts and commissioners to work together to reduce such activity. From April 2013, CCGs will pay over the 70% to NHS England (NHSE) Area Teams. The Mersey Area Team have said that the money will be recycled back to CCGs to put in place plans to reduce emergency admissions. The Trust's view is that the application of the national policy whereby additional non-elective activity is only remunerated at 30% of the tariff (NB. 70% funding from excess urgent care tariff is retained by CCGs at the discretion of the NHSE Area Team) coupled with the rise in attendances and increase in admissions is putting significant financial strain on them and therefore on their ability to continue to provide appropriate care to those admitted and in meeting the A&E operational standard (i.e. 95% of patients admitted, transferred or discharged within 4 hours) on an on-going basis and especially into the winter period. As at month 3 (2013/14), the 70% adjustment across all commissioners is £1.8m, Halton's share is £0.4m.

3.4 The Trust is therefore proposing that contracted levels for non-elective activity should be rebased, releasing the 70% tariff for investment within the Trust to maintain safety, patient experience and levels of performance. The associated Clinical and Financial Plan outlines how this investment would be utilised. It is recognised that the 2008/9 baseline calculation using current year tariffs used by the Trust was set too low and that some re-basing of the contract should be undertaken worth roughly £3m for Halton, Knowsley and St Helens CCGs. This is however considerably below the £8.1m referred to the Trust's Plan and it is still likely that there would still be non-elective activity which the Trust would only be paid at 30% of tariff.

3.5 The Clinical and Financial Plan outline a number of developments intended to improve performance, maintain patient safety and improve patient experience via the introduction of 7 day working etc.; the premise of which is not in dispute and Halton Borough Council would fully support these developments, however it would not be able to support these developments via the release of the 70% tariff.

Issues for Consideration

3.6 Following a review of the Plan, a number of points need to be highlighted, as follows :-

Support to the whole of the Urgent Care Pathway

3.6.1 NHS England document 'Improving Accident & Emergency Performance' states:-

'*Where areas have not already agreed plans and committed funds, we expect Urgent Care Boards to oversee the use of the 70% funding retained from excess care tariff. In particular, the use of money must be clearly identified to support* ***any*** *aspect which will support the urgent care system and acute providers' ability to deliver the operational standard'.*

As outlined in NHS Halton CCG's Integrated Commissioning Strategy 2013-15, it

intends to commission hospital based services only where they are absolutely necessary and sets out intentions to invest in and develop services outside of acute hospital settings to:

- support 7/7 working on a health economy footprint across all providers;
- reduce inappropriate attendances at both of our local A&E providers;
- build upon our work in Halton alongside Halton Borough Council to improve discharge, reduce readmissions and maintain frail and vulnerable people in the local community; and
- offer alternative pathways and services to A&E within Halton.

Plans are already in place for a number of initiatives outlined in Halton's Urgent Care Response Plan, agreed by the Urgent Care Board, intended to make improvements across the urgent care system and funded via the 70% unpaid tariff. Examples of initiatives introduced include:-

- Diversion/escalation processes;
- NWAS Community Care Pathways;
- Walk in Centres and the Urgent Care Centre; and
- Improving access to primary care.

These investments will ultimately impact positively on the A&E standard within both Whiston and Warrington hospitals.

It should be highlighted that for the financial year 2013/14, in addition to spending already being fully committed, NHS Halton CCG has agreed with the Trust a contract that is based on activity, tariff and the application of the nationally set rules for payment to providers. The nationally set rules state that the 30% marginal tariff for non-elective admissions remains in place. It would be difficult to argue a departure from this national requirement. In addition NHS Halton CCG is only guaranteed funding until 2015/16, so it would be difficult to support any financial plans after that date.

It should also be noted that if funding were released to STH&K then why shouldn't funding also be released to Warrington and Halton Hospitals NHS Foundation Trust (WHHFT).

AED Attendances and Non-Elective Admissions

3.6.2 Pressures faced by Accident and Emergency Departments have resulted in a national aggregated rise in attendances of 5.9% over the past three years. Within the Plan the Trust outline that they have experienced an increase of 25% in attendances and admissions over the past three years; approximately 20,000 AED attendances and approximately 8,000 in admissions.

Table 1[2] shows the actual attendances at STH&K and Warrington AED's for which there has been a 20% increase at the former between 2010/11 and 2012/13 and a 3.4% reduction in the latter. The overall effect is 3.4% increase in AED attendances for the Halton population when you examine the **total** attendance figures across the two areas between 2010/11 and 2012/13. This compares favourably with national figures.

Table 1 : AED Attendances

A&E Attendances - St Helens & Knowlsey	QTY
2010/2011	11,738
2011/2012	12,670
2012/2013	14,080
2013/2014 Q1	3,850

A&E Attendances Warrington Trust	QTY
2010/2011	28,615
2011/2012	27,845
2012/2013	27,631
2013/2014 Q1	7,345

Table 2[3] shows the number of non-elective admissions into St Helens and Knowsley and demonstrates an 18% increase between 2010/11 and 2012/13 – the actual figure is 1117, whilst Warrington report a 7.2% reduction (actual figure -648) between 2010/11 and 2012/13. The overall effect is a 3.1% increase in non-elective admissions for the Halton population when you examine the **total** non-elective admissions figures across the two areas between 2010/11 and 2012/13. Like AED attendances this compares favourably with national figures.

Table 2 : Non Elective Admissions

Non Elective St Helens & Knowlsey Trust	QTY
2010/2011	6,242
2011/2012	6,706
2012/2013	7,359
2013/2014 Q1	1,932

Non Elective Warrington Trust	QTY
2010/2011	8,954
2011/2012	8,671
2012/2013	8,306
2013/2014 Q1	1,992

Social and Intermediate Care Activity and 7/7 Working

3.6.3 Intermediate Care activity from STH&K has increased by 28%[4] from 2010/11 – 2012/13 and accounts for approximately 14% of all the intermediate care activity in the Borough.

Community Care Panel data reveals that 6-7%[5]of this type of social care activity comes from STH&K Trust discharges. It would be usual for the on-site team to utilise intermediate care services in the first instance, rather than long term packages, which would explain why this figure is low.

A key issue in the STH&K Plan and for the whole economy is in relation to providing 7 day services. For example, the Trust has outlined their intention to implement full seven day consultant and support staff working (NB. The Trust has already advertised for necessary posts in the 'hope of a successful outcome' to the consultation on the Plan).

In relation to the hospital discharge team, on site this would either require some additional resources and / or a flattening out of the discharges across the 7 day period and therefore a realignment of the existing resources.

HBC currently contribute £114K into the on-site team. In addition, consideration would need to be given as to how we can actually arrange services during weekend hours.

This may require other arrangements with service providers and better use of existing intermediate care services in the Borough which currently operates 7/7. Weekend activity from a Halton perspective is likely to be a fraction of total activity for the Borough. It should be noted that packages can be restarted at weekends and new services commissioned to start at the weekend however, for the latter these would need to be arranged during office hours. To enable new packages to be arranged at the weekend would require the authority to review service provision with Domiciliary and Residential Care Providers. This doesn't apply to Intermediate Care and Reablement services which can be accessed 7 days per week

It should be highlighted that WHHFT have been working closely with commissioners for a number of years to increase 7 day services across their hospitals, a full service description of what 7 day cover will require is being produced and the Trust will then work with commissioners to find sustainable solutions with support from any DH funding streams to deliver this change.

Every provider is under pressure to deliver 7/7 working; delivery of 7/7 working is about a system wide approach, not one provider. If investment was limited to just one provider then this would not deliver full benefits across the health and social care system.

Moving forward, NHS Halton CCG will be working with co-commissioners within Halton Borough Council and NHS England to focus investment within primary, community and social care, which ultimately should enable acute trusts to reconfigure their business models.

Estate Costs

3.6.4 It would appear from the Plan that the majority of the additional contribution would be used on closing the Private Finance Initiative (PFI) gap rather than on emergency pathway resilience or nursing costs i.e. £6.7 m during 2013/14. Whilst £1.9m would go on delivering the 4 hour target this winter and £3.5m to increase staffing levels on wards.

It should be noted that NHS Halton CCG have provided for the payment of their proportional share of the final year of PFI in 2013/14 but thereafter have not set aside further provision for excess PFI costs as they are not the responsibility of NHS Halton CCG.

Nurse Staffing Levels

3.6.5 The Plan states that the Trust is in the lower half in terms of nurses per bed compared to other Trust in the NW. WHHFT are actually lower.

A review of nursing staffing levels has been undertaken resulting in a business case to employ 95 additional staff; some of which have already been recruited to.

The increase in staffing numbers is across all wards and it is anticipated that the 70% of unpaid tariff would be used to fund these posts. This places the Trust under significant financial risk.

Medium Term Growth

3.6.6 The plan references that '*the Trust should work with commissioners and community partners to reduce non-elective activity and use the released capacity to increase electives, thereby increasing income and delivering financial sustainability. For many, complex reasons, this has not been successful and non-elective activity has continued to grow'*.

There have been many examples of initiatives introduced to support the urgent care system and based on latest AQuA information, this is starting to have a positive impact on emergency admissions and readmissions etc. and the direction of travel within Halton is promising.

The Trust's plan outlines its intention to increase its share of the elective activity market but concerns exist as to the feasibility of this considering the fact that nationally this market is contracting. Non-elective activity is increasing however investing in different community services should begin to slow and reverse this trend. It would be difficult to support a financial plan that assumes an increase in the level of elective admissions, even though the market is contracting and an increase in the level of AED attendances and non-elective admissions over the next 5 years.

£500 million to relieve pressures on A&E

3.6.7 There has been a recent announcement that A&E will benefit from an additional £500 million over the next 2 years to ensure they are fully prepared for winter.

The intention is that this funding is not only used to make improvement to A&E but to other services away from A&E as well so there are less unnecessary visits or longer stays in urgent and emergency wards.

However it is anticipated that the new funding will go to areas that are identified as being the most under pressure. This may exclude both STH&K and WHHFT who both achieved their 4 hour A&E targets.

It should also be highlighted that when the announcement was made in terms of the winter pressures funding, reference was also made to the £3.8 billion pooled health and social care funding for integration (the Integration Transformation Fund) to be held by Local Authorities. There will be an expectation that this fund is also used to support pressures across the urgent care system.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 As at month 3 (2013/14), the 70% adjustment across all commissioners is £1.8m, Halton's share is £0.4m.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified.

6.2 **Employment, Learning & Skills in Halton**
None identified

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 There are a number of risks to STH&K as outlined in their 5 year Clinical & Financial Plan if additional funding was not forthcoming. However in terms of Halton, the main risks would be associated with our inability to effectively implement Halton's Urgent Care Strategy and associated Response Plan.

8.0 **EQUALITY & DIVERSITY ISSUES**

8.1 An Equality Impact Assessment is not required for this report.

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

9.1 None identified.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Steve Cox, Clinical Accountable Officer, St Helens CCG
Dianne Johnson, Chief Officer, Knowsley CCG
Simon Banks, Chief Officer, Halton CCG

02 August 2013
by email

Dear Simon

The Trust Board has recently approved a draft five year clinical and financial strategy for consultation with partner organisations and stakeholders.

The essence of the strategy is the recognition that the increase in activity at the Trust has now reached such a level that bed and A&E capacity is consistently being exceeded and safety and good patient experience will only be maintained through transformational change. The major issue is the application of the policy whereby additional non-elective activity is only remunerated at 30% of the tariff. The thinking behind this policy was to deter providers from taking steps to inflate activity. This theory has now been comprehensively discredited, and it is generally accepted that this has not been the driver behind increasing levels of non-elective activity. The effect of the policy is only to fund the direct costs of treatment (e.g. drugs and dressings), and therefore provides no funding towards nursing and other staffing costs, nor a contribution to overheads (e.g. estate costs). This is clearly inappropriate in cases where activity has increased by almost 25%, as is the case here. The recent NHS England document: "Improving Accident & Emergency Performance" (Gateway Reference 00062), talks about major pressures facing Accident & Emergency departments, resulting from the national aggregate rise in attendances of 5.9% over the past five years. By comparison, this Trust has experienced an increase of 25% over three years, which equates to a rise in attendances of almost 20,000 and an increase in admissions of almost 8,000. Many of these admissions are frail, elderly, sick patients with multiple co-morbidities, who have long lengths of stay, are difficult to discharge, and are very dependent upon the care of nurses. It is unreasonable to expect that this can be managed through existing capacity and with existing staffing levels. Despite this, the Trust has worked extremely hard to maintain the four hour Accident & Emergency performance through investing in staff at financial risk, and by reviewing all pathways and working practices (with the assistance of Emergency Care Intensive Support Team). It is a credit to the hard work and commitment of the Trust's staff that in spite of the pressures, the four hour target was achieved last year, and stands at over 97% so far this year. However, this cannot be maintained into the winter. Without transformational change, the Trust will not be able to cope with a further increase in demand this winter. It is concerning that numbers of Accident & Emergency attendances broke all previous record levels during the (summer) month of July – for the first time ever almost hitting 9,000 attendances (8,944).

To address these challenges, the Trust is proposing that contracted levels for non-elective activity should be rebased, releasing the 70% unpaid tariff for investment to maintain safety, patient experience and levels of performance. These resources are already in the system anyway. The Trust would invest these funds into transforming the way in which non-elective activity is managed through implementing full seven day Consultant (and support staff)

working, which will improve the quality of care, reduce mortality and morbidity, reduce length of stay releasing capacity, deliver best practice, evidence based care for ambulatory patients and reduce multiple transfers and handovers of care for patients. The anticipated quality improvements are substantial and significant, and this is also the only proposal currently available, which will enable delivery of the four hour target this winter.

The other Trust priority for investment is to improve nurse staffing levels. The increased levels of activity and acuity prompted the Trust to undertake a review of nurse staffing levels, resulting in the production of a business case to employ 95 additional staff. Some of these nurses have already been recruited at financial risk to the Trust, so that safety and quality have been maintained.

The Trust's proposal is that receiving full payment for non-elective activity would enable investment in nurse staffing and service transformation, but would also make a contribution to the Trust's overhead costs (in particular the PFI estate). Full payment of the tariff would actually allow the remaining PFI gap (£6.7m) to be closed. A copy of the proposal is attached for your consideration.

As winter is approaching, it is hoped that agreement can be reached, so that safe, high quality services can continue to be delivered. The benefits to our community would be substantial, as follows:-

- Improve safety and quality
- Reduce mortality and morbidity
- Achieve the four hour Accident & Emergency target.
- Deliver 7 day consultant cover
- Reduce length of stay
- Reduce occupancy
- Improve nurse staffing ratios
- Implement more appropriate pathways of care and reduce admissions
- Reduce transfers and handovers of care
- Reduce the numbers of medical outliers in surgical beds and therefore disruption to the elective surgical programme resulting in cancellations
- Close the PFI funding gap

I look forward to receiving your comments, and would be happy to provide any additional information as required.

Yours sincerely

Ann Marr
Chief Executive

Cc: Clare Duggan, Area Director, NHS England (Merseyside)
Carole Hudson, Chief Executive, St Helens Council
Paul Brickwood, Chief Finance Officer, Halton, Knowsley and St Helens CCGs

Proposed 5 year clinical and financial plan

Introduction

The Trust's financial problems stem from the major investment into the estate, to replace inadequate and inappropriate Victorian workhouse buildings with a purpose built hospital facility. The business case was approved by the Trust's Commissioners, the Strategic Health Authority, the Department of Health and the Treasury. After identifying all possible savings, additional revenue consequences of around £20m were recognised, and the three local PCTs signed side letters to the contract agreeing to contribute their proportionate share towards meeting these additional costs.

The delivery of this business plan has been compromised since these decisions were taken by the many changes that have taken place since then. Funding the outstanding additional estate costs of £20m (at 2006/07 prices) have remained a challenge for the Trust. This was recognised when McKinsey's undertook their review of PFI sites which required national support, and resulted in a planning assumption that the Trust should receive £13m per year to contribute towards the excess costs. The Trust has been working with commissioners to find ways to close the remaining £7m gap (obviously now higher than this due to inflation), and has been generously supported non-recurrently since the new hospital opened in 2010. Going forward, this is not an arrangement that commissioners are prepared to continue, and so a new solution is needed. This will also support the Trust's intention to achieve financial sustainability.

Over the course of building, commissioning and operating the new estate, there has been a constant tension between the Trust and its commissioners about supporting the excess PFI costs (albeit non-recurrently), whilst at the same time also being expected to pay for the full PbR effect of extra activity. This has been particularly pertinent because both elective and non-elective demand has increased significantly at the Trust since the new buildings opened. This has led to a number of difficult, year-end compromise agreements being reached, with neither party really satisfied, with unhelpful repercussions for future working relationships.

The point has now been reached when it may be better to put aside these sorts of arrangements and normalise transactions based upon tariff rules. This would enable financial sustainability to be achieved if the 30% marginal rate paid for increases in non-elective activity could be re-based to recognise the impact of opening the new hospital. There is a powerful and effective argument that can be presented to support this.

The case for not applying the 30% marginal rate

It is understood that the rationale behind the 30% marginal rate policy was to deter provider organisations from attempting to inflate activity and therefore

maximise income. This theory has now been widely discredited, and it is generally accepted that this has not been the driver behind increasing levels of non-elective activity. The impact of this policy has been most challenging for any trusts which have seen non-elective activity increase significantly, but has been most difficult for trusts which have experienced increases well outside the normative range. The recent document "NHS England: Improving Accident and Emergency Performance (Gateway reference 00062)", described the massive pressures facing Accident and Emergency departments resulting from the national, aggregate rise in attendances of 5.9% over the past five years. By comparison, this Trust has experienced an increase of 25% over three years, which equates to a rise of attendances from 85,000 to well over 100,000 in 2013/14, and has resulted in an increase in admissions from 49,000 to a projected 57,000. It might be argued that the 30% marginal rate policy is not applicable in situations like this anyway. From a business case and sustainability point of view, it means that the contribution to overheads and semi-fixed costs that this activity should be making is lost. In the Trust's case, 70% of a substantial income figure has not been available, which would have made significant contribution to closing the funding shortfall against the estates overhead cost ("the PFI gap"). Nor have these sums been made available to the Trust's commissioners to help with the non-recurrent support previously provided, as the money was retained by the Strategic Health Authority for other uses.

Much more important than the economic impact of this policy is the potential effect on patient care. This Trust has absorbed over 20,000 additional Accident and Emergency attendances, and 8,000 additional admissions resulting in the need for 30,000 additional bed days equating to around 90 additional beds. However, capacity is largely fixed, so on general and acute wards occupancy levels have increased, and increased to the point where something has to change. The most damaging aspect of this policy has not been that it has suppressed the generation of a contribution to overheads, but that it has resulted in staff on wards and other direct support departments being required to absorb unsustainable increases in workload without any additional workforce capacity. For the most part, the additional non-elective activity compromises frail, elderly, sick patients with multiple co-morbidities, who have long lengths of stay, are difficult to discharge, and are very dependent upon the care of nurses. This policy specifically precludes providing any funding to manage these vulnerable patients and thus places a huge burden on the organisations trying to manage this workload, whilst at the same time also delivering on very challenging savings requirements. Most importantly, it places huge stresses on the staff themselves and creates risks to the quality and safety of services delivered. In the wake of the Francis enquiry, the Keogh review, and clear evidence that staffing levels play such a major part in delivering safe care, it is disappointing that this policy is still retained. The Trust is seeking recognition that in cases of extreme rates of non-elective activity growth, and in the interests of patient safety, the policy is not applied and that activity is remunerated at full tariff. These sums are already in the system and a decision could be taken to deploy them in a different way, if it were considered important.

Delivery of safe services into the winter

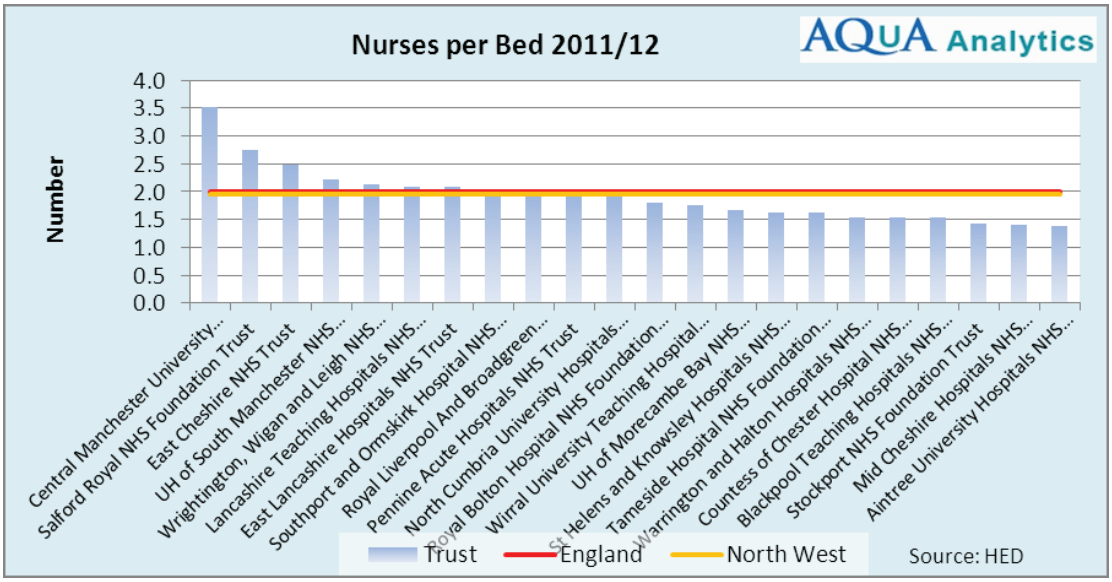
What would the Trust do with this money if made available? The most important challenge facing the Trust is maintaining high quality, safe care and a good patient experience. As mentioned earlier, the Trust has already exceeded reasonable bed occupancy levels and realistically cannot absorb any further activity into the winter. Nurse staffing levels have had to be increased, despite a lack of funding and this has increased financial pressure. The Accident and Emergency department has been overwhelmed at times, and last year's Q3 and Q4 Accident and Emergency performance fell just short of 95% (although achieved for the year over all). The Trust recognised that something major has to change before next winter, as service delivery will become compromised. So, the Trust management invited in the Emergency Care Intensive Support Team and sat down with senior clinicians to devise a plan.

- Seven day working

  The plan that was devised has the support of clinicians across the Trust, and is a radical redesign proposal, which will reduce time patients spend in Accident and Emergency, improve many non-elective pathways, and deliver full on site seven day Consultant presence, with all day time admissions reviewed by a Consultant within four hours. The major benefits of the proposal will be to improve the quality of care, reduce mortality and morbidity, reduce length of stay releasing capacity, deliver best practice evidence based care for ambulatory patients and reduce multiple transfers and handovers of care for patients. The anticipated quality improvements are substantial and significant, and this is also the only proposal currently available which will enable delivery of the four hour target this winter. Some of the proposed changes (particularly to Accident and Emergency) have already been implemented on the basis of goodwill from the staff, and have demonstrated that despite record breaking levels of activity, 97% of patients have spent less than four hours in Accident and Emergency. The proposal has been turned into a business case, and presented to commissioners, seeking their support and investment. Time is running out for a decision to be taken, so the Trust has advertised the necessary posts, in the hope of a successful outcome. A copy of the business case is attached for reference.

- Increasing nurse staffing levels

  The other Trust priority for the investment of any contribution from the 70% unpaid tariff is to invest in improved nurse staffing levels. Comparative data (see below) shows that the Trust is in the lower half in terms of nurses per bed compared to other Trusts in the North West.



However, the Trust has a much greater proportion of non-elective patients than others, has a very deprived population with much co-morbidity, and has very high percentage occupancy and growing demand. For all of these reasons, and in the wake of the lessons learned from the Francis report, a further review has been undertaken of nursing staffing levels across the Trust. The result of this was a recommendation that the Trust should increase staffing by 95 nurses, to ensure that safe, high quality services can be maintained. Once again, this has been submitted to commissioners as a business case for reinvestment of some of the 70% unpaid tariff. In the meantime, increased nurse staffing numbers have been authorised on all wards at financial risk to the Trust.

A short term solution for clinical and financial sustainability

The Trust's proposal for delivering on its short term clinical and financial imperative is to achieve agreement that all activity will be remunerated at full PBR rates, including non-elective activity. The planned surplus would also be reduced to a minimum acceptable level, releasing internally generated savings for reinvestment. Taken together, these sums would release around £12m to invest in the schemes described. This would encompass funding the outstanding PFI debt (£6.7m), redesigning emergency care services to enable the delivery of the four hour target in the winter (£1.9m) and increasing nurse staffing levels on wards (£3.5m). Financial schedules shown later in the document also cover the impact in 2014/15. So, largely through the re-use of resources that should be already somewhere in the system, the Trust could achieve the following improvements:-

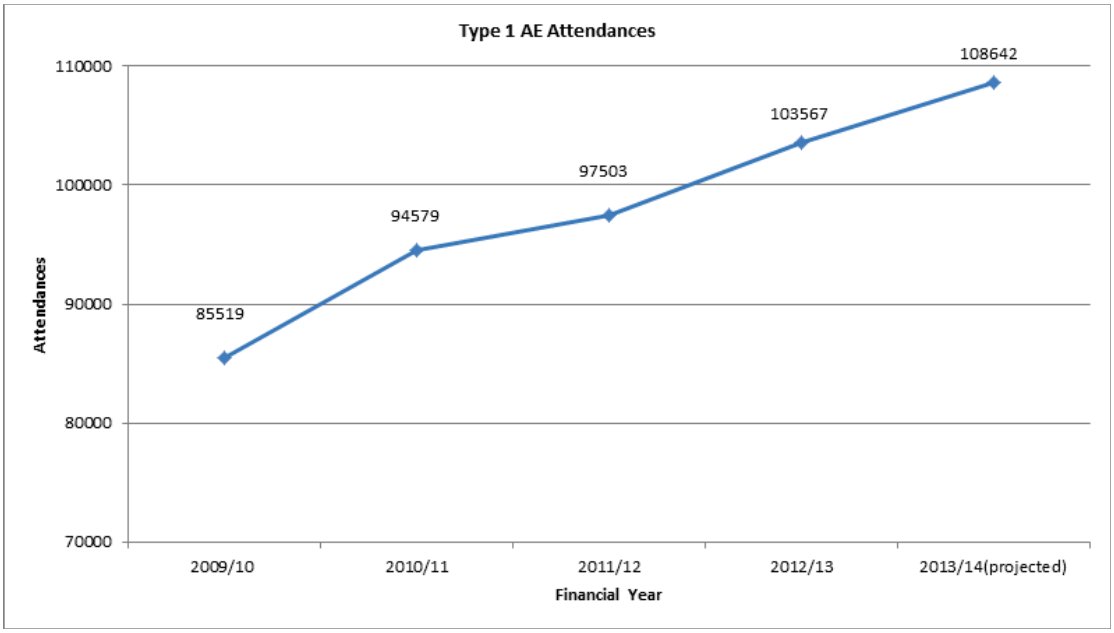
- Improve safety and quality
- Reduce mortality and morbidity
- Achieve the four hour Accident & Emergency target.

- Deliver 7 day consultant cover
- Reduce length of stay
- Reduce occupancy
- Improve nurse staffing ratios
- Implement more appropriate pathways of care and reduce admissions
- Reduce transfers and handovers of care
- Reduce the numbers of medical outliers in surgical beds and therefore disruption to the elective surgical programme resulting in cancellations
- Close the PFI funding gap

This is such a substantial and critically important list of improvements, that the Trust would encourage earnest consideration of this proposal. With the clear evidence of increasing activity pressure, the Trust has carefully devised these plans engaging with staff across the organisation in a genuine attempt to transform service delivery, further improve quality and above all, protect patient safety.

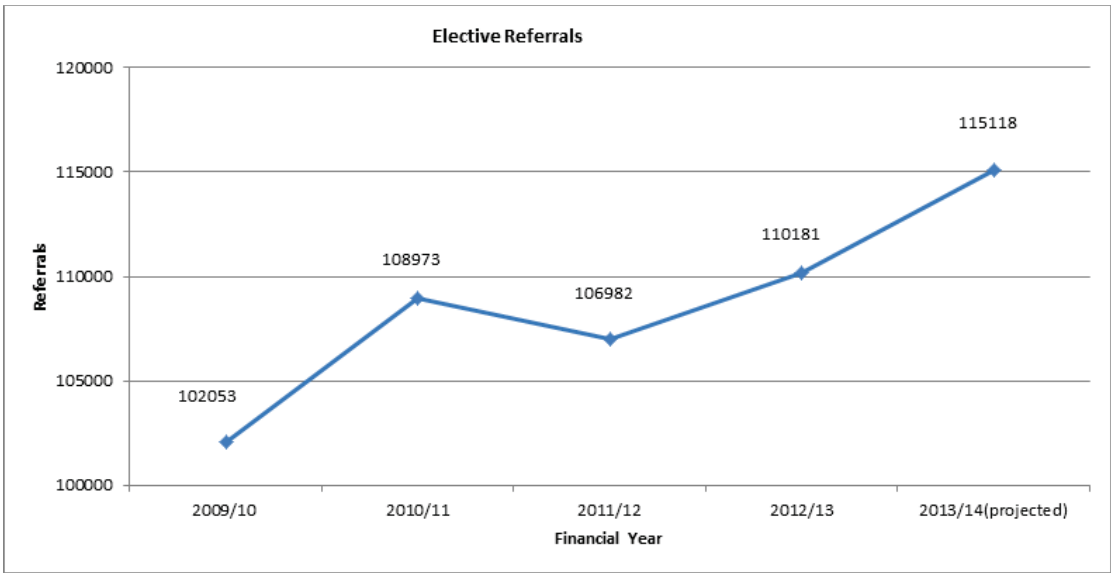
The medium term

From the time that the first Tripartite Formal Agreement was produced, it has always been acknowledged that part of the Trust's underlying structural financial problem was the unusual elective/non-elective split. According to benchmarks, the Trust has the highest percentage of non-elective patients in the country, and this has a major impact on income. Even without the anomaly of the 30% marginal rate on increased non-elective activity, remuneration for the older, more complex, longer length of stay non-elective patients generated smaller margins (contribution to overheads) than elective cases. The plan was that the Trust should work with commissioners and community partners to reduce non-elective activity and use the released capacity to increase electives, thereby increasing income and delivering financial sustainability. For many, complex reasons, this has not been successful and non-elective activity has continued to grow (see below).



NB: Adjusted for change in GPAU pathway

Meanwhile elective referrals have also increased substantially (see below), but pressures on capacity have meant that this work is often not being undertaken in an efficient way.



In the face of unsustainable service delivery pressures, the Trust has had to find a different way to respond to the huge activity demands placed upon it. This was the imperative that brought the Trust's staff together to produce the plan for the complete redesign of non-elective flows, pathways and care delivery, which has proved difficult to achieve in very many other organisations.

A consequence of the service improvements described is that bed capacity is released, which can be used to accommodate alternative activity. This would include the Trust's own elective programme (undertaken in a more cost effective way), developments and repatriation of activity, capacity needed for

collaborative working, private patient facilities, sub-acute beds, and other proposals. This creates the opportunity to generate further income, which together with other initiatives and the Trust's own savings plans provide the basis for the Trust's medium term financial plan. The key steps are as follows:

- Repatriation of local activity

  Generating additional income is crucial to ensure financial stability although the Trust recognises that this will need to be achieved within a commissioning environment of flat or falling activity in the acute sector. Local residents and GPs are generally very loyal to the Trust, evidenced by the fact that approximately 75% of St. Helens patients choose to come here for their routine elective care. In relative terms this is a high figure with a significant proportion of the remaining 25% of patients accessing routine care via neighbouring tertiary providers such as; LHCH or Alder Hey, or via private sector providers through Choose & Book.

  The Trust will continue to grow its "local" elective markets and is particularly focused upon repatriating activity which is directed into the private sector. St. Helens CCG is strongly supportive of this approach and acknowledges that the LTFM assumption of a "general growth" increase of 3% in GP referrals both this year and next year is reasonable given that referrals over the last 3 years have increased by over 8,000 in a diminishing market. Market share has increased by 5% over this time.
  The Trust recently commissioned a detailed market analysis from Deloitte in order to test that the LTFM assumptions are reasonable. This analysis identified:-

  - that there are some referral pattern inconsistencies between specialties at several local GP practices;
  - those practices where patients choose to be treated at the local private provider.

  The analysis confirmed that there are opportunities to expand market share over and above the LTFM assumption despite the expected overall market contraction. It identified C&B private sector leakage as a specific area of focus and in order to enact this change the Trust has:-

  - Developed a clinically led GP engagement plan to improve our understanding of the perception of each individual clinical service at each GP practice.
  - Introduced out-of-hours and weekend "consultant only" clinics to develop a "distinct selling point".
  - Worked to ensure that waiting times are comparable to or better than neighbouring providers, including the private sector.

  The combined impact of this is expected to deliver an additional 1% increase in GP referrals next year over and above the LTFM

assumption. Again St. Helens CCG is supportive of this approach as it expected that this additional growth will be at the expense of other providers. As such it will come from within the existing commissioning expenditure resource.

- Improving efficiency

  The Trust has developed four projects to optimise the efficiency of the service portfolio:

  Advanced Scheduling - This project recently received an award from the British Quality Foundation (BQF) for project excellence, the first time that a healthcare provider has won this award. The project involves the implementation of a hospital resource planning system that schedules and plans the patient journey using demand information. The project uses lean methodologies and includes the planning and scheduling of outpatients, AED, elective and non-elective theatres activity. To date the project has achieved remarkable results, with an 11% improvement in theatre session utilisation across both sites. This equates to an annual cost saving of at least £1.2m by the end of year 3.

  Analysis of Capacity and Utilisation within St Helens Hospital - This analysis has identified capacity increase opportunities via the use of 3 session days and weekend working. Extension to 3 session days could increase day case capacity at St Helens by up 30 sessions with a further 24 day case theatre sessions at the weekend.

  Improving Service Line Efficiency - The Trust has rolled out Service Line Reporting, and the benefits of being able to scrutinise performance at a service and patient level are evident in the reviews currently underway.
  Using SLR and introducing Service Level Management at the Trust will deliver future productivity gains, and will ensure that individual services are appropriately benchmarked against their peers so that each area of the organisation can become best in class both in terms of clinical and financial performance.

  Clinical Director Business Development Programme - Our clinicians are a credit to the organisation and provide excellent care for our patient population, however as a means of ensuring clinical involvement and ownership of business plans being developed, a Clinical Director Business Development Programme is being introduced. This will ensure that our clinical leaders have access to the training and information required to fully understand and influence the financial as well as clinical aspects within their respective specialities. The combined impact of the above will enable a combination of efficiencies and service improvements that will improve the patient experience and lead to a more efficient organisation which maintains the highest standards of care.

- Enhancing Earnings

  Additional income will be generated by maximising other opportunities from our clinical and commercial income streams.

  A significant amount of work has taken place to ensure that these projects take place and it is expected that they will make an annual contribution of c£7m by year 5 of the LTFM. Examples of some of the key projects are provided below.

  Clinical Income Streams

  Collaboration Projects - the Trust has been developing collaborative projects for some time and there are numerous areas where we are working with partners both to improve services now and reduce costs over the next 3-5 years. These include:

  - Warrington & Halton Hospitals NHS Trust

    The two Trust Boards reached a formal agreement to collaborate some 15 months ago and service improvements have been made in Stroke services, Haematology and Cardiology. These have yielded c£500,000 contribution to date. The two Trust Boards have also agreed in principle to develop a shared pathology service. This will produce an annual financial saving in excess of £1.4m annually by year 3. A joint Board to Board meeting has been arranged for October to review other collaboration opportunities between the two Trusts.

  - Royal Liverpool & Broadgreen University Hospitals

    The two Trusts have recently established a joint governance structure led by the two Directors of Finance and agreed to make a joint appointment to take forward the formal collaboration programme. Immediate service improvements are planned in:-

    - Vascular and Interventional Radiology – service changes are planned from this September with a potential £600k impact across partners.
    - Plastic Surgery input to Orthopaedics – Business case recently approved for additional Consultant input to RLUH from STHK.
    - Dental – STHK looking to divest non-profitable orthodontics services to RLUH this year.
    - Renal Services –Hub and spoke model business case agreed using existing RLUH hub.
    - Sleep Laboratory – Hub and spoke business case in the final stages of development using existing RLUH hub.

  With regard to medium –longer term capacity planning, a recent KPMG report identified that short stay elective activity with a value of c£9m

may need to be relocated from RLUH as a result of their move into a smaller site. This equates to some 6,000 cases which can be accommodated at the St. Helens site. This will yield a contribution of up to £2m annually after profit sharing. Moving this activity also offers significant benefits to RLUH.

- Southport & Ormskirk Hospitals

  The two Trusts have recently agreed a joint Consultant Urologist appointment to ensure that patients in need of complex urological surgery can be offered a full MDT service based at STHK with outreach support to Southport. This agreement includes the commencement of a shared on-call service between the two Trusts.

  The Trust has also recently submitted a tender to Southport & Ormskirk Hospitals with regard to pathology services.

- Aintree University Hospital

  Discussions are at an advanced stage to develop joint services in Ophthalmology and Urology.

- Community Service Provision and Service Tender Opportunities.

  The Trust does not currently provide its own therapy services and is about to complete a review of the existing service contract. St. Helens CCG has also recently commissioned a community therapy services review and it is highly likely that this service will put to tender next year. The Trust intends to compete for this tender in order to provide a holistic therapy service across the local health economy. The Trust does not currently provide community services apart from maternity and a small amount of ophthalmology and paediatrics. It views the therapy tender as an opportunity to gain a wider foothold in the provision of community services. This will create opportunities for further collaboration with or competition with existing community providers.

Plastic Surgery - plans to expand plastic surgery services in Wales are at an advanced stage. This will make a c£2.5m annual contribution by year 5.

Radiology - the Trust also has access to world class radiology equipment under the PFI scheme which allows us to offer both hospital based and community diagnostic services. This will enable the early identification of underlying conditions which will benefit both patients and the health economy as a whole. The local CCGs have already commissioned some additional community based diagnostics and commissioning plans indicate that this will be expanded.

Private Patients - The Trust does currently provide services to private patients and generates c£200,000 income. It has recently agreed an expansion plan with a number of clinicians to provide further private/cosmetic services at St. Helens Hospital. Although the local population does not generate a large volume of private practice the Trust does expect to at least double its private patient income over the next 3 years or so.

Other clinical expansion plans are at various stages of development for example:-

- Breast onco-plastics
- T&O clinical specialty developments
- Expansion of Trauma Rehab

- Commercial Income Streams

The Trust currently provides estate facilities for a GP practice on the St. Helens site and is working closely with St. Helens CCG to exploit other estates opportunities by finalising plans to:-

- Co-locate a GP practice onto the Whiston site this year
- Relocate the St. Helens WIC/MIU next year
- Introduce a primary care stream adjacent to/incorporated within the Whiston AED next year.

The Trust will continue to take advantage of any commercial opportunities in areas such as; IT, Procurement, Information Governance and Human Resources.

Financial Summary

The Trust's draft plan can deliver national targets and priorities including the ambition for the NHS to be a genuinely seven day service thereby providing resilience for emergency pathways. It addresses concerns raised from the Francis enquiry and eliminates all residual PFI cost pressures. A financial schedule is shown below demonstrating how this can be achieved through allocation of the unpaid 70% tariff monies, complemented by additional plans for collaborative working, cost improvement and efficiency savings to meet national QIPP expectations.

Financial Schedule

		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Sources of Financial Contribution							
70% NEL Threshold Contribution		8,500	8,100	8,100	8,100	8,100	8,100
Additional Savings identified on 7 day working		700	4,100	4,100	4,100	4,100	4,100
Reduction in Planned Surplus		2,900	2,900	2,900	2,900	2,900	2,900
Repatriation of Local Activity			677	880	1,056	1,268	1,394
Improving Efficiency, incl advanced scheduling, SLR			2,805	3,287	3,920	3,955	3,999
Enhancing Earnings - Clinical Collaborations:	- Pathology		1065	1420	1420	1420	1420
	- Burns and Plastics			517	1,545	2,577	2,577
	- Other (incl Royal Liverpool)			1,455	4,406	4,406	4,406
Commercial Income Streams				425	1,825	1,825	1,825
TOTAL Contribution		**12,100**	**19,647**	**23,084**	**29,272**	**30,551**	**30,721**
Application of Contribution							
Emergency pathyway resiliance, incl A&E and 7 day working		(1,900)	(2,700)	(2,700)	(2,700)	(2,700)	(2,700)
Francis / Nursing		(3,500)	(3,700)	(3,700)	(3,700)	(3,700)	(3,700)
Residual PFI Gap		(6,700)	(8,700)	(8,700)	(8,700)	(8,700)	(8,700)
Total		**(12,100)**	**(15,100)**	**(15,100)**	**(15,100)**	**(15,100)**	**(15,100)**
NET contribution to Future CIP's / Increased Surplus		**0**	**4,547**	**7,984**	**14,172**	**15,451**	**15,621**

More detailed information can be provided if required.