Public Document Pack

# Health Policy and Performance Board

**Tuesday, 9 September 2014 at 6.30 p.m.**
**Council Chamber, Runcorn Town Hall**

**Chief Executive**

**BOARD MEMBERSHIP**

| | |
|---|---|
| **Councillor Ellen Cargill (Chairman)** | Labour |
| **Councillor Joan Lowe (Vice-Chairman)** | Labour |
| **Councillor Sandra Baker** | Labour |
| **Councillor Marjorie Bradshaw** | Conservative |
| **Councillor Mark Dennett** | Labour |
| **Councillor John Gerrard** | Labour |
| **Councillor Margaret Horabin** | Labour |
| **Councillor Martha Lloyd Jones** | Labour |
| **Councillor Chris Loftus** | Labour |
| **Councillor Pauline Sinnott** | Labour |
| **Councillor Pamela Wallace** | Labour |
| **Mr T Baker** | Co-optee |

***Please contact Lynn Derbyshire on 0151 511 7975 or e-mail lynn.derbyshire@halton.gov.uk for further information.***
***The next meeting of the Board is on Tuesday, 4 November 2014***

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

**Part I**

**6. PERFORMANCE MONITORING**

| | |
|---|---|
| **(A) PRIORITY BASED REPORT 2014/15 (QUARTER 1)** | **281 - 313** |

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

Agenda Item 3

**REPORT TO:** Health Policy & Performance Board

**DATE:** 9th September 2014

**REPORTING OFFICER:** Strategic Director, Policy & Resources

**SUBJECT:** Public Question Time

**WARD(s):** Borough-wide

## 1.0 PURPOSE OF REPORT

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

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

## 2.0 RECOMMENDED: That any questions received be dealt with.

## 3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

**4.0 POLICY IMPLICATIONS**

None.

**5.0 OTHER IMPLICATIONS**

None.

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

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

**7.0 EQUALITY AND DIVERSITY ISSUES**

7.1 None.

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

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

**REPORT TO:** Health Policy and Performance Board

**DATE:** 9th September 2014

**REPORTING OFFICER:** Chief Executive

**SUBJECT:** Health and Wellbeing minutes

**WARD(s):** Boroughwide

## 1.0 PURPOSE OF REPORT

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

## 2.0 RECOMMENDATION: That the Minutes be noted.

## 3.0 POLICY IMPLICATIONS

3.1 None.

## 4.0 OTHER IMPLICATIONS

4.1 None.

## 5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

## 6.0 RISK ANALYSIS

6.1 None.

## 7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

# HEALTH AND WELLBEING BOARD

*At a meeting of the Health and Wellbeing Board on Wednesday, 7 May 2014 at Karalius Suite, Halton Stadium, Widnes*

Present: Councillors Polhill (Chairman), Morley and Wright and S. Banks, M. Cleworth, P. Cooke, K. Fallon, G. Ferguson, D. Johnson, T. Knight, G Lovatt, D. Lyon, A. McIntyre, E. O'Meara, I. Onyia, D. Parr, M. Pickup, R. Strachan, N. Sharpe, I. Stewardson, D. Sweeney and J. Wilson,

Apologies for Absence: N. Rowe and S. Yeoman

Absence declared on Council business: None

**ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD**

*Action*

HWB66 MINUTES OF LAST MEETING

The minutes of the meeting held on the 12th March 2014 were taken as read as a correct record.

HWB67 PRESENTATION - ARE YOU DIFFERENT?

The Board received a presentation on behalf of R U Different from Gary Lovatt, who outlined to Members details of:

- the aims of the project, how they engaged with young people in a positive way;
- how young peoples' attitudes and perceptions could be identified and be positively changed;
- the range of risk taking behaviours in young people covered;
- how surveys were used to assess young peoples' current attitudes and perceptions;
- examples from recent surveys with young people which highlighted their perception on a number of issues such as percentage of young people who had smoked tobacco, used alcohol and drugs compared

with actual percentages of those who had;

- initiatives previously adopted in secondary schools in the Manchester area such as poster campaigns designed by young people, electronic quizzes, enterprise days, barcodes which could be scanned with mobile phones and an app which could be used by parents; and

- how changing a young person's perception had changed risk taking behaviour.

RESOLVED: That the presentation be received.

HWB68 PRESENTATION - HEALTH AND WELLBEING PRIORITIES UPDATE

The Board received a presentation from Eileen O'Meara, Director of Public Health which provided details on the recent Health and Wellbeing Shape the Future Event. The purpose of the day was to:

- provide progress on the health and wellbeing priorities;

- agree new actions against the priorities;

- provide information on the integration of health and social care; and

- launch the Community Health Champions awards.

Members of the Board were also provided with details on the five presentations around the health and wellbeing priorities which were delivered at the event and the new actions against the priorities which were agreed. It was noted that feedback had been received from those who attended and a high level of satisfaction with the event was noted.

RESOLVED: That the presentation be noted.

HWB69 PERFORMANCE OF WARRINGTON, HALTON, ST HELENS AND KNOWSLEY BREAST SCREENING PROGRAMME

The Board considered a report which outlined details of performance issues identified at the Warrington, Halton, St. Helens and Knowsley Breast Screening Programme. National guidelines stated that 90% of women invited should

be offered an appointment within 36 months of their previous screening, 90% of women should receive their appointment within two weeks and a minimum of 90% of women must (if required) be assessed within three weeks. At present, the programme was currently under-performing in all three of these areas and it was recognised that unless this situation was quickly addressed performance would continue to show a deteriorating picture.

The Cheshire, Warrington and Wirral Local Area Team of NHS England (CWW) Screening Lead had given assurances that the programme performance issues had been identified early, a recovery plan was in place and would be achieved by October 2014. It was noted that:

- the service ensured that all women that had results most suggestive of malignancy were expediated into assessment to minimise the risk of clinical impact from delay;

- Warrington/St. Helens Breast Screening Service had historically experienced robust performance results and had consistently achieved above the 90% minimum target;

- the recent slippage in performance was the result of a combination of radiographic staffing issues that had impacted upon radiographic capacity;

- breast screening performance recovery had been prioritised within the Trust and resources were being made fully available; and

- a sustainable workforce plan to minimise the risk of similar repeat had been developed.

RESOLVED: That

(1) the content of the report be noted; and

(2) the Board note a recovery plan was under way and there was judged to be minimal clinical impact.

HWB70 HEALTH PROTECTION AND PUBLIC HEALTH GOVERNANCE FUNCTIONS

The Board considered a report which outlined the role of the Director of Public Health in providing oversight of local Health protection arrangements and the development of the Health Protection Forum to support this. Under the

Local Authorities Regulations 2013 unitary and upper tier local authorities had a new statutory duty to carry out certain aspects of the Secretary of State's duty to take steps to protect the health of the people of England from all hazards, ranging from relatively minor outbreaks and contaminations, to full scale emergencies, and to as far as possible prevent those threats emerging. Directors of Public Health were responsible for the exercise of local authorities' new public health functions.

Members were advised that Halton Health Protection Forum was created to improve integration and partnership working on health protection between the Local Authority, NHS, Public Health England and other local services and to provide assurance to the Health and Wellbeing Board on behalf of the population of Halton, that there were safe, effective and locally sensitive arrangements and plans in place to protect the health of the population. The Executive Board Portfolio for Health and Wellbeing and a representative from Healthwatch were also invited to the Forum.

It was proposed that the Halton Health Protection Forum would produce quarterly reports to the Health and Wellbeing Board.

RESOLVED: That

(1) the contents of the report be noted;

(2) the development of a Health Protection Forum be supported; and

(3) the systematic approach to the overview of public health governance in Halton be supported.

HWB71 CHILD DEVELOPMENT UPDATE

The Board considered a report of the Director of Public Health which provided an update on the progress with the Health and Wellbeing Child Development Action Plan. Improving levels of child development was one of the five key priority areas covered by Halton's Health and Wellbeing Strategy. The overall target set for the action plan was a 2% year on year increase in children achieving a good level of development at age 5 (Baseline 2011 – 49.9%). Unfortunately, due to changes in the Early Foundation Stage curriculum and assessment, the measure of child development in 2013 was not comparable to previous years, and therefore a year on year increase could not be

identified.

However, as the Action Plans had now been in place for over 12 months, a recent review took place to gauge progress on each of the outcomes covered. In order to do this, action plan leads were asked to rate each outcome using the Red, Amber, Green system. The results of the exercise were included within the report and a summary of progress on key developments was as follows:-

- 100% of families had access to antenatal sessions;
- 92% of women booked in to see a midwife by 12 weeks and 6 days;
- 100% of women were screened for mental health issues after birth, and vulnerable women were targeted through the offer of home visits;
- targeted work was underway for vulnerable women, through specialised midwives and development health visitor pathways for specific groups;
- an increase in Health Visitor numbers was on target;
- breast feeding rates had increased to 21.2% and Bridgewater Community Health Care Trust had achieved UNICEF'S Baby Friendly initiative stage 2.
- improvements had been seen in infant mortality, the rate was now similar to the England average; and
- improvements had been achieved in the number of babies born with a low birth weight, the rate was now similar to the England average.

In addition, a new Family Nurse Partnership service was being commissioned and would start in Halton in October 2014. It was a targeted programme that built a strong relationship between the nurse and the family and included regular home visits.

RESOLVED: That the contents of the report and the action plan be noted.

HWB72 ADVANCING QUALITY ALLIANCE (AQUA) – QUALITY AND EFFICIENCY SCORECARD FOR FRAIL ELDERLY

The Board considered a report of the Strategic Director, Communities, which presented the latest AQuA

North West (NW) benchmarking data and associated comparisons. The latest data provided by AQuA demonstrated excellent performance in the following areas:-

- Permanent admissions to residential/nursing care (although it should be noted that there had been an increase in permanent admissions to long term care since September 2014); and

- the proportion of Local Authority Adult Social Care spend on residential/nursing care (Halton had previously been ranked the best in the North West in relation to this area. However, according to March 2014 information, Halton had now been ranked 2nd, this linked to the increase in permanent admissions outlined above).

Due to the increase in these areas over the past few months, work was currently taking place to investigate the reasons why. Halton Urgent Care Working Group (UCWG) had established a short term task and finish group to review and develop further the frailty pathways out of acute care. The task and finish group would consist of representation from across the Urgent Care system to explore where improvements could be made and make recommendations to the UCWG.

The report also provided information on areas that were improving but still presented significant challenges, areas that remained as significant challenges and also those areas that remained static.

RESOLVED: That the report and associated appendices be noted.

HWB73 HALTON CHILDREN & YOUNG PEOPLE'S PLAN 2014 -17

The Board considered a report of the Strategic Director, Children and Enterprise, which outlined the progress so far on the new Halton Children and Young People's Plan (CYPP) 2014 – 17.

It was reported that CYPP was a joint strategy of the partners within Halton Children's Trust, which detailed how they would co-operate to improve children's wellbeing. It represented Halton's local vision and aspirations for children and young people in the Borough, provided strategic direction and determined how the Children's Trust Board would work together to commission services to address locally identified needs and better integrate provision.

Members were advised that Halton's first CYPP had been published in June 2006. Although it was no longer statutory as of June 2010, the need for a CYPP to remain in place was universally agreed locally in Halton to provide the strategic direction for the continuing Children's Trust arrangements. Following extensive consultation, the priorities for Halton Children's Trust for the period 2011-14 were agreed and were set out in the report for further information.

It was noted that in Autumn 2013, it had been agreed to develop a new CYPP to frame the work of the Trust from 2014. On this basis, a working group was established from November 2013 to develop the plan based around the agreed priorities which detailed in the report for consideration. The Task and Finish Working Group met bi-weekly and following the development of a short project brief, a number of agreements were made around the approach to take for the new CYPP, including:-

- primarily web-based but with a limited number of copies produced for stakeholders and inspection purposes;
- shorter chapters and simplified language;
- chapters should be different in their approach to that found in other documents;
- the advantages of having a web-based document would be explored, for example being able to link other documents; and
- the involvement of young people.

RESOLVED: That

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

(2) the Board supports the roll out of the CYPP and work in order to meet its priorities over the next three years.

*Meeting ended at 3.40 p.m.*

**REPORT TO:** Health Policy & Performance Board

**DATE:** 9 September 2014

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Critical Review of Integrated Working in Halton

**WARD(S):** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Board with details of the on-going evaluation of Halton's integrated approach to Health and Social Care.

2.0 **RECOMMENDATION: That the Board**

1. **note the contents of the report and associated appendix; and**

2. **support Halton's integrated approach to the delivery of local Health and Social Care Services.**

3.0 **SUPPORTING INFORMATION**

3.1 Aligned with the 2014/15 NHS Halton Clinical Commissioning Group (CCG) and Halton Borough Council's plans are a number of integrated/aligned schemes all aimed at reducing the need for hospital admission; the overall outcome of which is to improve community services and support people to stay well at home, for longer.

3.2 NHS Halton CCG 5 year strategic plan has been through a number of high level reviews and been closely scrutinised by NHS England (NHSE). The draft plan has recently received support from NHSE and is due for final submission in September 2014.

Outlined within the plan are a number of milestones/targets to reduce non elective activity, reduce A&E activity and reduce the time people stay in hospital. In order to achieve these targets, Halton needs to have an effective integrated approach in place in order to achieve our goals which are supported by a commitment from all partners to align plans, innovation, and resources which are all underpinned by a level of overall trust.

3.3 The key component of this integrated approach is the development

of two Urgent Care Centres in Halton, one in Runcorn and one in Widnes. In addition to being able to assess/treat minor illnesses and injuries, the Centres will be able to provide care to those presenting at the Centres will a range of other conditions, through the development of the necessary competencies of staff teams; the Centres will be staffed by a multidisciplinary, multiagency team of professionals. The centres aim to bring a true alternative to the people of Halton to travelling to attend A&E at Whiston and Warrington Hospitals, therefore reducing the need for expensive out of borough hospital care.

3.4 To ensure this approach was credible and achievable we asked Warwick University to undertake a critical review of our approach. Attached at Appendix 1 is a copy of this review. As outlined within the review, the feedback is very clear in that we are way ahead of other areas in our thinking and approach and if we maintain our current direction of travel we are set to deliver everything we have set out in our commissioning intentions.

## 4.0 POLICY IMPLICATIONS

4.1 None associated with this report.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Financial efficiencies will be achieved by implementing the schemes set out in the aligned plans, failure to do so will result in an escalation of current financial pressures.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

Extended paediatric services will be available within the new Urgent Care Centres offering greater choice and local availability to children and young people.

### 6.2 Employment, Learning & Skills in Halton

Local jobs and improved health education will run alongside the two new Centres.

### 6.3 A Healthy Halton

The above offers a host of opportunities of improving health and wellbeing in Halton.

### 6.4 A Safer Halton

None identified.

6.5 **Halton's Urban Renewal**

Utilising existing asset and regenerating a modern and sustainable, local alternative to A&E.

7.0 **RISK ANALYSIS**

7.1 None associated with this report. NB. As part of the governance arrangements in place connected to the Urgent Care Centre development a full risk register has been developed and is monitored via the Urgent Care Centre Development Project Board.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

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

9.1 None identified.

# Improving the critical review capacity of commissioning networks to reduce needless admissions of older people into acute hospitals

## Report to NHS Halton Clinical Commissioning Group – Executive Summary

## April 2014

***Overview of Research***

- We explored the critical review capacity of your CCG, examining the commissioning process for services aimed at reducing needless admissions of older people into acute hospitals

- 10 semi-structured interviews were conducted with individuals within the general commissioning structure, or from a provider related to urgent care, and lasted between 45 minutes and 1 hour

- We asked respondents to describe the commissioning process, specifically focusing on Urgent Care Centres (UCCs)

- Our analysis was guided by the concept of Absorptive Capacity (ACAP). This is a concept developed through academic studies conducted in the private sector, derived from study of how R&D departments acquired and actioned knowledge to inform organisational innovation. We have applied this model to an exploration of critical review capacity in a healthcare setting.

- It is not our intention to 'blind you' with organisation science. We aim to give you concepts and a model to examine a strategic issue, and allow you to take a helicopter view of developing service interventions to reduce needless elderly care admissions of older people into acute hospital.

- Analysis following the ACAP model was divided into four areas: acquisition – obtaining information; assimilation - analysing information; transformation – turning new information into commissioning decisions by combining it with existing knowledge; exploitation – changing or developing organisational behaviour or routines in response to the new information.

- In addition, we considered antecedents to ACAP, also known as combinative capabilities. This refers to the knowledge processing activities of an organisation to generate, synthesise and apply new knowledge to enhance critical review capacity. There are three types of combinative capabilities: socialisation capabilities (which may be fragmented due to diverse professional and organisational cultures); systems capabilities (top-down guidelines or incentives from above); and coordination capabilities (social and structural mechanisms supporting information and knowledge exchange). A full theoretical explanation of combinative capabilities can be found in Appendix 1.

***Overall Findings***

- Notable at Halton CCG was the integration between the CCG and local authority which enhanced coordination capabilities

- Public engagement also enhanced your coordination capabilities, and there were indications that Patient and Public Involvement (PPI) was integrated at all stages of commissioning

- Acquisition of information was relatively straightforward, although there were concerns about the quality of the information acquired due to a perceived distance between the CSU and CCG

- The problems with acquisition of information from the CSU impacted the ease with which the CCG could assimilate data. However, coordination capabilities

(such as PPI and joint working between health and local authorities) mediated these problems

- Transforming information into service design of UCCs was complicated by the large number of stakeholders involved in service provision (i.e. primary care, secondary care, ambulance service, out of hours, voluntary sector etc.). Aligning these multiple organisations was once again facilitated by the coordination capabilities of the CCG. However, as the UCCs were not operational at the time of our first visit, it is not possible to comment fully on transformation (or exploitation), or on the way coordination capabilities facilitate the process. This may be something the CCG wishes to focus on in the second round of data collection

- It is also hard to comment on the exploitation of information fed back from UCCs, as the centres were not operational. However, initial findings suggest coordination capabilities will be central in aligning multiple stakeholders to enhance the way information is used to develop or scale up the centres as appropriate. Patient involvement will also be key in enhancing these coordination capabilities. More research is needed into the most effective way to enhance coordination capabilities with a view to improving exploitation of information and knowledge, and subsequent improvement of critical review capacity.

***Implications and recommendations***

- All interview respondents were clear that, in their opinion, the partnership between the local authority and health enhanced their ability to commission services for UCCs. In addition, this was complemented by comprehensive PPI, enhancing the coordination capabilities of the CCG. However, our analysis of the way this is transformed into practice is limited as the UCCs were not operational at the time of our visit.

- There is a need for a more in-depth exploration of how the information is transformed into service delivery within the UCCs, and the way in which the coordination capabilities of the CCG can be enhanced to facilitate the alignment of multiple stakeholders, exploiting the potential of the UCCs. This could cover one of the following areas:

    - The use of PPI to exploit information fed back from UCCs
    - The way in which primary and secondary care providers transform information to design UCC services
    - The relationships between multiple stakeholders and the challenges of aligning them in complex service design
    - The way the CCG harnesses and exploits information fed back from UCCs to continually develop services

- If you chose to continue to explore your critical review capacity in relation to UCCs, we recommend returning when they are operational. In the next (and final) report, we will be able to consider the way the CCG manages the transformation and exploitation of information, and consider the antecedents to enhancing your critical review capacity. This will offer opportunities for you to develop an action plan to maximise your organisational capacity for commissioning services to reduce needless elderly care admissions into hospital.

***Contact Details***

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WARWICK BUSINESS SCHOOL

# Improving the critical review capacity of commissioning networks to reduce needless admissions of older people into acute hospitals

## Report to Halton Clinical Commissioning Group

## April 2014

## Study Overview

CCGs do not operate in isolation, but exist within a wider network of stakeholders inclusive of primary care, secondary care, the national NHS Commissioning Board, Local Area Teams, Commissioning Support Units, tertiary care services, and local government agencies commissioning and providing health and social care. Given the complex nature of the network in which they are operating, and the boundaries across which they have to communicate information, CCGs will need to enhance their critical review capacity to be successful. To explore how CCGs can achieve this, we consider commissioning interventions to reduce needless admissions of older people into acute hospitals. The results from this study are not limited to care of older people, as they can be generalised to other commissioning domains.

To explore commissioning in your CCG, we conducted semi-structured interviews with 10 individuals from within your commissioning network. These individuals were stakeholders, from within and outside the organisation, which were involved at some stage of the commissioning process. Interviews focussed on the commissioning cycle, and respondents were asked about where they felt they were positioned within it; i.e. the acquisition of information, the analysis of information, service design and commissioning, or in the implementation and assessment of front line services. Once their position within the process was established, issues around the flow or translation of information, and the ability to link up front line services with data feedback systems, were explored. Specifically, we focused on the design and implementation of the Urgent

Care Centres (UCCs) within Halton CCG. Interviews lasted between 45 minutes and 1 hour and were audio recorded and transcribed.

To analyse the interviews, the research team used the concept of Absorptive Capacity (ACAP). ACAP is a model developed in the private sector, derived from study of how R&D departments acquired and actioned knowledge to inform organisational innovation. We recognise that healthcare represents a distinctive environment compared to private sector R&D contexts in which much of the empirical work around ACAP has taken place. This renders some of the dimensions of the ACAP literature less relevant to healthcare, but at the same time, brings others to the forefront. We are applying this model to the healthcare sector to enhance commissioning networks (for a thorough theoretical explanation, please see Appendix 1). The four areas of ACAP, guiding our analysis, are: acquisition of information; assimilation or analysis of information; transformation into commissioning decisions; and exploitation of those services by continuous development and dissemination. To improve critical review capacity, the literature suggests the need to consider antecedents to ACAP, otherwise known as combinative capabilities (a full theoretical explanation of combinative capabilities can be found in Appendix 1).

There are three types of combinative capabilities: socialisation capabilities (which may be fragmented due to diverse professional and organisational cultures); systems capabilities (top-down guidelines or incentives from above); and coordination capabilities (social and structural mechanisms supporting information and knowledge exchange). ACAP literature emphasises that enhancing coordination capabilities is key for organisations, as systems and socialisation capabilities are relatively fixed and can be negative influences on critical review capacity. Enhancement of coordination capabilities enables organisations to mitigate these potential problems.

## Acquisition

Acquisition refers to the process of gathering information from a wide variety of sources, beginning the commissioning cycle. Within Halton CCG, acquiring data was not seen as a significant problem, with some even reporting a sense there was too much data available:

*When we have a problem it's not information. We have information overload. It's analysis that's our problem. (Halton 7)*

Analysis, or assimilation, of information is discussed below. However, the problems related to analysis stem from concerns about the quality of the information acquired from the CSU, who were seen as detached from the CCG:

*I think the commissioning support units are too distant from the CCGs and the work that's going on in the locality (Halton 8)*

*The best data we ever had was when we had a local team. They were destroyed and put into a more central group. They've been destroyed and put into another group which covers a much wider area. The data they produce is rubbish… because they don't have our local feel at all. They don't know what we need. I mean they're techie people who are used to numbers. The numbers are only going to make sense presentationally as well as meaningfully operationally if you've got clinical input. They don't seem to have any clinical input. (Halton 6)*

As a result, the extent to which the data acquired could be used appropriately by the CCG was sometimes questioned:

*My biggest challenge is the fact that I don't always have access to the data that I think I need to do my job and that data when it is being used and discussed isn't necessarily being used in the appropriate way… I almost feel like there's sort of a mass of data that's floating around in the system but it's not always being necessarily used in the appropriate manner. I don't think some of the people who are perhaps collecting that are using it or deriving from that the correct answers. They're not asking the right questions so they're not therefore deriving the right answers from that data that they have (Halton 5)*

However, despite these problems, when discussing the data acquired in relation to the Urgent Care Centres (UCCs), it was clear that information was acquired from a wide range of sources to supplement the information from the CSU:

> *So we got lots of information together. We collated information and we looked at… There was already a walk-in centre in Widnes and there was a minor injuries unit in Holton General Hospital in Runcorn, so we asked for figures of attendances and outcomes from both of those units. We had a questionnaire that went into GPs to ask them about their throughput in terms of urgent care. We had a questionnaire that went into local A&Es for both patients and staff asking basically why the patient was there, whether that was the best place for them and if it wasn't why didn't they go to the place they should have gone and what were the barriers to that. So we got that kind of information as well. So once we got all that information we kind of collated it all and came up with three kind of possible models of care and those models went to the board. We had a preferred model and the board agreed with the preferred model which is what we're just starting to implement. (Halton 10)*

In conclusion, despite some minor difficulties associated with the acquisition of relevant data, due to a perceived disconnect between the CSU and the CCG, commissioners were able to acquire information to guide the set up of UCCs. As we explore in the following sections, this ability is due to their coordination capabilities, enhanced by joint working between social care and health care, and a focus on patient involvement during the commissioning cycle.

## Assimilation

Assimilation refers to the process by which the information acquired is turned into a form which be analysed and used by commissioners. As acknowledged above, there were concerns that the information acquired was not always useful or relevant to the CCG.

> *I think where we are a bit weak as a system is some of the performance information that comes through from all of our provider organisations in the main. "Are we asking the right questions around the information we need?" and I don't believe that it's as robust as it could be in relation to making commissioning decisions. Emergency readmissions for example, we've got a high number of people who go back into hospital after they've been discharged. We've got some information here, some soft information here around some of the follow-up that happens, I've got some soft information here around some of the community teams that have to pick up a mess because somebody's been discharged inappropriately and then they go back into hospital. Those two lots of information don't tend to come together so it's quite anecdotal really as to who's got that info… And it's that level of intelligent data that we need and then we need that analysed so that that makes it more useful… We're trying to build that up, but I think it's still quite ad hoc really. (Halton 8)*

Being able to bring together the 'soft' data with the data acquired from providers and the CSU was reported as underdeveloped. Having access to assimilated information was felt to be particularly important for a detailed understanding of local needs, in order to commission responsive services:

> *It's the deep dive stuff. So we've got the kind of overview and we can understand the kind of top level stuff. Actually it's delving into that, using information from other sources… So I think what I'm saying is from an integrated performance point of view you get a richer picture in terms of what's happening. (Halton 7)*

Considering the assimilation of information with regard to UCCs, the importance of an integrated approach to data acquisition and assimilation was acknowledged as particularly important for developing joined up healthcare for patients:

*What we needed to do was re-establish, go back and revisit some of the business plans that had been in play, revisit some of the evidence – so using the cluster PCT to draw out some evidence about pathways and flow; so ambulance utilisation, admits and readmits, attendances, use of walk-in centre, use of minor injuries and a raft of data really to understand what we might need on any given day and time of day to help think about what is it that we need to develop… it was suddenly clear that again there was this piecemeal approach and actually if we move forward and look at urgent care in the round and use the data and information about what we currently do and how we do it, we could potentially build quite a case for looking at managing those issues in the borough. And so we did some of that work and then kind of entered into public consultation about those really (Halton 3)*

The use of information 'in the round', and the involvement of multiple organisational information, indicates how the assimilation of data concerning UCCs was enhanced by CCG coordination capabilities. In particular, public consultation was noted as a key mechanism for framing the assimilation process:

*So we've done a kind of string of events that we'll go and ask the public "What do you think? What is it you think? What is your opinion on health services? What do you think should change and how should you do that?"… We do that across the local authority, we use all our media in an innovative way… We've just signed a deal now with the local radio… it goes out to usually about 10,000 to 12,000 people a day and further afield. It's got a website as well. So it's got quite a decent following… So as we're commissioning these things we're going to be actively linking in live with the public to say "Well this is what we're doing guys. What do you think? How can you help shape that?". (Halton 7)*

For example, the enhancement of coordination capabilities through comprehensive PPI enabled the CCG to analyse information about A&E attendances from a different perspective, leading to an understanding about the need for X-Ray diagnostics in UCCs:

*And so one of the things we did running up to this was an audit of people who attended A&E over a two week period and looked at had they approached primary care, what was available in primary care, had they been to a walk-in centre, asked them questions about what alternatives they'd explored, would they consider alternatives? And that information also helped shaped some of the areas of service that we wanted to pick up on. Diagnostics x-ray was a big one. We found something like 25% to 30% of people who attended A&E actually just needed an x-ray and because we didn't have x-ray facilities available all the time and we've only got them in one part of the borough then we were pushing people to go to A&E and people themselves were able to identify that "I just need an x-ray. I know I don't need … I've broken my arm. I know it's not badly broken, but I just need an x-ray to confirm it and a plaster" (Halton 3)*

Assimilating the information acquired, generating in-depth, locally applicable analysis and understandings of the data sets was not a service provided by the CSU, and was a minor area of concern. However, the coordination capabilities of the CCG, enhanced by patient involvement and the use of information from multiple, external partners, were able to overcome these problems.

## Transformation

Once different types of information have been assimilated into locally responsive knowledge, it needs to be transformed into a design for a service to be commissioned. As mentioned above, this was facilitated by enhanced coordination capabilities relating to PPI:

*You talk to local people here and they will say "What we want is local services. What we want is to be able to go to one place where we can have our x-ray done, where we can have our whatever. That's what we want," which is why the feedback from the public engagement and from the engagement with the*

*local authority, particularly elected members, was "We've been asking you for this for ten years. If you can do that we'll be made up." So I do think it's the right model. (Halton 2)*

Information acquired from public consultation was transformed into service design which was responsive to their needs. For example, the acknowledgement that a UCC needs to provide a 'one stop' service for the public if it is to be successful at reducing A&E attendances:

*What this community is saying to us is "I don't want to start something to then have to go somewhere else because I may as well have just gone somewhere else," and anecdotally that's a function that A&E fulfils for people. You turn up, okay you might have to wait, but somebody sees you, somebody gives you some tests, somebody gives you a diagnosis and they give you treatment and they send you away including the medication that you might need. So you're done and dusted in the time that you spend in A&E. We need to replicate that for these pathways as much as possible in the borough or else people won't use them. Our population are not stupid. You know, they'll go and search out and find the best possible service that they can get. And so the population are clear about that (Halton 3)*

Similarly, issues such as geographical location of the UCCs were strongly guided by public opinion. Transformation of service design for UCCs was strongly influenced by the need to commission two sites, due to the river crossing cleaving the CCG area in two:

*So we've got this notion of two sites, one either side of the bridge, and that's really important in this borough because although the bridge isn't very long people do not cross the bridge or tend not to cross the bridge, the local community, and moving down the line that's going to become more important because we're having another bridge built which you'll have to pay to go over and so that will even more mean that people are less likely to go over the bridge. So having a two-town solution has been quite important (Halton 3)*

PPI was a strong influence on the transformation of services, enhancing the ability of the CCG to commission responsive services. Alongside this, transformation was also enhanced by the inclusion of a large number of stakeholders in the implementation of UCCs. For example, the involvement of the ambulance service was a critical aspect of 'diverting' patients to UCCs, rather than A&E:

> *Urgent care centres eventually will be kite marked, so the paramedics will be able to divert… If somebody dials 999 and they need to be seen they can divert. They'll have certain algorithms that they'll divert into the urgent care centre. So it could be respiratory. It could be they've had a fall and a suspected fracture, elderly falls, but they could go to the urgent care centre for an x-ray and the falls team could pick them up. So it's just looking at alternatives. They don't have to go to A&E for everything. (Halton 9)*

Whilst the involvement of multiple organisations could complicate the transformation of services (as we have experienced amongst other CCGs), these problems were not markedly notable at Halton. This was attributed to the integration of health and local authority, creating a more joined up approach to service design, and positively impacting the alignment of other stakeholders:

> *I think to actually make all the changes that we're going to make it's required a lot of engagement between clinicians and directors of both CCG and the borough council and secondary care and that's only happened because the CCG and the borough council work very closely together and there's no suspicion anymore, so everyone's pushing in the same direction and because of that I think that secondary care feel that… I mean they're dealing with one unit now instead of two units pulling in different directions; and the community trust's the same so you can actually get people in a room that actually will agree to things more readily. I mean there's always disagreements…. But it's been more of an adversarial kind of tone to meetings in the past where now it's we've got to look forward (Halton 10)*

The coordination capabilities of the CCG were enhanced by their integration with the local authority, facilitating the transformation of services and enabling them to provide joined up, superior care for their local population:

> *I think I'm very, very pleased to have found that Halton CCG is able to work so closely with Halton borough council to the extent that we're actually based in council buildings as you can see. That was never the case in the days of PCTs. There was a lot of suspicion between the two, but now they work hand in hand. That I think facilitates what you're talking about – being able to bring in social care so that we can give people a package of care that's not fragmented. So that will be accessible through the urgent care centres. (Halton 10)*

> *By having that real integrated partnership approach focused on Halton then we can really make a difference to Halton residents (Halton 8)*

The challenge of aligning stakeholders relies on coordination capabilities of the CCG network. This was enhanced by the integration of health and social care, and of patient involvement. However, there are multiple stakeholders involved in the running of these services, and how they will influence the running of services is unclear. As the centres are yet to be set up, there was relatively little commentary about exploitation and transformation (considered further below), compared to areas of acquisition and assimilation. It may be that the CCG wishes to focus further on exploitation and transformation during the second stage of research, exploring more fully how the UCCs are put in place.

## Exploitation

Research on ACAP in the private sector suggests exploitation is related to the ability of organisations to use the information based on small, local pilots or projects, to develop wide scale service change. This is difficult to comment on at this stage, as the centres were not operational at the time of our visit. However, instead we highlight some areas that may be problematic, for future consideration.

One of the main challenges, as mentioned briefly above, will result from the multiple stakeholders involved in the centres, particularly the interactions between primary and secondary care:

> *I think the biggest challenge probably will be we're going to have kind of an internal interface really between secondary and primary care where the urgent care centre and clinical decision unit lie in the hospital because we're basically asking a secondary care provider to provide us with staff to help us stop them admitting patients and we're asking to spend less money on employing those people than we would pay in tariff to admit the patient to hospital or to send them to A&E. So obviously that's a challenge (Halton 10)*

Encouraging secondary care to work in the UCCs may be problematic, complicated by the awareness that the two main providers for Halton CCG were not always amenable to providing services together:

> *In terms of those two acute trusts potentially working together and splitting the business that's more challenging and that's already presented some challenges… what we wanted to do was for them to be able to have discussions facilitated by us to kind of sort that out rather than running through those processes, but we've been unable to do that… I think we could have managed that a little bit better. I think we could have provided a bit more leadership and a bit more kind of assertiveness about our expectations and managed that process a little bit better than we have done (Halton 2)*

Exploitation of UCCs will rely on the enhancement of coordination capabilities to develop relationships between secondary care providers, to facilitate the on-going development of services offered by UCCs:

> *I think it's building that trust and building the foundations of relationships underneath which are key to everything that we were able to do… communication is key to all that (Halton 7)*

Once again, coordination capabilities will be enhanced through PPI, and the ability of the CCG to communicate the nature of the UCCs to the public, to ensure they access the services appropriately:

> *Obviously they're the people we need to communicate with because they're the people we're relying on to go into the urgent care centres rather than the acute trusts or we will be in a pickle. So there have been some issues around communication. I mean some of that is around when you go out and you do your consultation events sometimes the public think that it's just going to happen now because they've just told me about it so there's some challenges there for us. I suppose the other challenges are making sure that it doesn't develop as a silo and it develops as part of the whole system. Unless we tie it into the whole system I don't think it will work as well as we think it's going to (Halton 8)*

In terms of exploitation for the UCCs, this will require the involvement of a wide range of the public in decision-making, ensuring that a representative view of the wider population is used to develop the UCCs further. Whilst this may be challenging, the ability of the CCG to access public opinion from those who may not otherwise engage with health consultations, is enhanced by their integration with the local authority. This enables them to harness the potential of PPI structures they may not otherwise have had access to:

> *And the other thing is we spend a lot of time looking at where do the local authority go to engage with people and can we piggyback onto that which*

*actually has saved us in some ways a lot of work because we've been able to do dual things. So the local authority have local health groups and we go to them, local stuff like ward forums and we will go to the ward forums and have conversations (Halton 2)*

In conclusion, the exploitation aspect of the commissioning process is the most underdeveloped of the four ACAP areas. This is unsurprising as the centres are not yet operational. However, findings suggest that coordination capabilities will be key in aligning multiple stakeholders in order to enhance the way information is used to develop or scale up the centres as appropriate. Patient involvement will also be key in enhancing these coordination capabilities. More research is needed into the most effective way to enhance coordination capabilities with a view to improving exploitation of information and knowledge, and subsequent improvement of critical review capacity.

## Conclusions and Key Messages

- There were clear indications that the critical review capacity of Halton CCG was enhanced by its coordination capabilities in terms of the integration between health and local authority, and comprehensive PPI.

- The coordination capabilities enabled the CCG to overcome some of the problems noted with the acquisition or assimilation of data, stemming from a distant relationship with the CSU. This was particularly clear with the way PPI information was used to triangulate and make sense of data

- Transformation of data into service design holds the potential for difficulty, due to the large number of stakeholders involved in the UCCs. However, the integration of health and the local authority enhanced coordination capabilities, facilitating the alignment of multiple stakeholders, enabling complex service design.

- Conclusions about exploitation are currently limited, but we highlight the importance of developing relational interactions amongst stakeholders to continue to develop UCC services. Continuing development and exploitation will also rely on the integration of PPI structures, and the development of new PPI mechanisms in partnership with the integrated local authority.

## Recommendations

- All interview respondents were clear that, in their opinion, the partnership between the local authority and health enhanced their ability to commission services for UCCs. In addition, this was complemented by comprehensive PPI, enhancing the coordination capabilities of the CCG. However, our analysis of the way this is transformed and exploited in practice is limited, as the UCCs were not operational at the time of our visit.

- There is a need for a more in-depth exploration of how the information is transformed into service delivery within the UCCs, and the way in which the coordination capabilities of the CCG can be enhanced to facilitate the alignment of multiple stakeholders, exploiting the potential of the UCCs. This could cover one of the following areas:

    - The use of PPI to exploit information fed back from UCCs
    - The way in which primary and secondary care providers transform information to design UCC services
    - The relationships between multiple stakeholders and the challenges of aligning them in complex service design
    - The way the CCG harnesses and exploits information fed back from UCCs to continually develop services

- If you chose to continue to explore your critical review capacity in relation to UCCCs, we recommend retuning when they are operational. In the next (and final) report, we will be able to consider the way the CCG manages the

transformation and exploitation of information, and consider the antecedents to enhancing your critical review capacity. This will offer opportunities for you to develop an action plan to maximise your organisational capacity for commissioning services to reduce unnecessary elderly care admissions into hospital.

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WARWICK BUSINESS SCHOOL

# Appendix 1

## Theoretical Background

Clinical Commissioning Groups (CCGs) need to develop critical review capacity to intelligently commission healthcare, to increase positive clinical outcomes, financial management and service effectiveness. This requires CCGs, not only to critically review both formal (external) and local knowledge or information, but to subsequently transform and exploit this information to encourage service development throughout their local health and social care economy. Given CCGs are new organisations, extant literature on their critical review capacity is sparse. Nevertheless, early scoping studies highlight the potential for weakness amongst CCGs (Imison, Curry, & McShane, 2011), which was also apparent in their predecessors, Primary Care Trusts (Smith, Regen, Shapiro, & Baines, 2000; Swan et al., 2012).

Our study examines CCG critical review capacity in more detail, exploring commissioning processes related to reducing needless admissions of older people into hospital, a perennial problem in all healthcare systems (Audit Commission, 2002; Keating, Sealy, Dempsey, & Slater, 2008; Lyon, Miller, & Pine, 2006; Point, 2010; Windle et al., 2009). We draw upon the concept of absorptive capacity (ACAP) (Cohen & Levinthal, 1990; Lane et al., 2006; Zahra & George, 2002). Hitherto, ACAP literature has developed in the private sector, but has been applied to provide considerable insight to the case of healthcare (Berta et al., 2010; Ferlie, Crilly, Jashapara, & Peckham, 2012; Harvey, Skelcher, Spencer, Jas, & Walshe, 2009).

The concept 'absorptive capacity' (ACAP) was first coined by Cohen and Levinthal (1989), to describe an organisation's *'ability to identify, assimilate, and exploit knowledge from the environment'* (p.569). Lane et al (2006) hail ACAP as *'one of the most important constructs to emerge in organisational research in recent decades'* (p.833). Since its inception, ACAP has been seen as a core element of increasing critical review capacity, but the dynamics of enhancing ACAP are theoretically under-developed (Hotho, Becker-Ritterspach, & Saka-Helmhout, 2012; Lane et al., 2006). Zahra and George (2002) characterise four aspects of knowledge mobilisation crucial for developing ACAP: identifying and accessing relevant knowledge through acquisition processes; analysing and interpreting this information through assimilation; integrating existing knowledge

with the newly assimilated knowledge through transformation; and finally refining and developing existing organisational routines and behaviours through exploitation of the transformed knowledge. These components can be further considered as two interacting and complementary elements: Potential Absorptive Capacity (PACAP) - the ability to acquire and assimilate knowledge; and Realised Absorptive Capacity (RACAP) - the ability to put newly acquired knowledge into action within the organisation through transformation and exploitation. It is the variance between PACAP and RACAP which accounts for performance differences amongst organisations, with a decrease in variance crucial to enhancing ACAP (Zahra and George, 2002).

## Combinative Capabilities

In this study we are concerned with reducing the variance between PACAP and RACAP to increase the critical review capacity of CCGs. To do this, it is beneficial to consider the antecedents to ACAP, otherwise known as combinative capabilities (Jansen, Van Den Bosch, & Volberda, 2005; Todorova & Durisin, 2007; Van Den Bosch et al., 1999; Volberda, Foss, & Lyles, 2010). Combinative capabilities refer to the knowledge processing activities of an organisation to generate, synthesise and apply new knowledge (Kogut & Zander, 1992; Van Den Bosch et al., 1999). They will influence the ability of organisations to develop the four dimensions of ACAP (acquisition, assimilation, transformation and exploitation), as harnessing and developing them will enhance critical review capacity and strategic innovation through exploratory, shared learning and decision making (Gebauer, Worch, & Truffer, 2012; Lane et al., 2006). Van den Bosch et al (1999) distinguish three types of combinative capabilities which will influence ACAP: systems capabilities, coordination capabilities and socialisation capabilities.

Regarding their effects upon ACAP, combinative capabilities work in different ways. First, socialisation capability refers to an organisation's vision to produce a shared ideology and development of a distinct group identity. The social processes associated with this capability are often seen as most influential in the development of ACAP within professional organisations (Hotho et al., 2012; Zahra & George, 2002). The shared culture or ideology that socialisation capability represents can transform and exploit new knowledge quickly, but may also represent a 'mental prison' that leaves little room for absorbing outside sources of knowledge that contradict shared beliefs. The absorption of new, external knowledge proves easier where it is linked to that

knowledge already embedded within the organisation, rather than representing a significant departure from pre-existing knowledge. Similarly, knowledge is more likely to be transferred between those within the organisation, where they have common knowledge in terms of expertise, training or other background characteristics (Volberda et al., 2010). Linked to this, powerful groups of actors, within and outside an organisation, may influence knowledge absorption processes to achieve their goals (Easterby-Smith & Prieto, 2008; Todorova & Durisin, 2007). The implication is that employees need to be exposed to diverse knowledge sources, but these need to complement existing knowledge sources (Zahra & George, 2002). Socialisation capabilities may render organisational members unable to 'see' or 'understand' the potential value of new, external knowledge (Todorova & Durisin, 2007). Healthcare is one such distinctly professionalised context, and the communication of knowledge and information between different organisational members is highly complex and iterative, with considerable but variable agency for actors to affect the process (Berta et al., 2010). There exist deeply ingrained organisational structures and social networks, which engender institutionalised epistemic communities of professional practice that exist in silos, relatively decoupled from one another (Ferlie, Fitzgerald, Wood, & Hawkins, 2005). This may impact socialisation capabilities, as professional training and early career experience may engender a custodial role orientation, so that professionals orientate narrowly towards their peers, rather than across the healthcare delivery system (Currie & White, 2012).

Second, system capabilities refer to formal knowledge exchange mechanisms such as written policies, procedures and manuals that are explicitly designed to facilitate the transfer of codified knowledge (Van Den Bosch et al., 1999). Within healthcare contexts this could be in the form of clinical guidelines, such as those set by the UK National Institute for Clinical Excellence (NICE), or mandatory priority setting by top-down Government initiatives, such as the continuing influence of the National Commissioning Board over CCGs. System capabilities such as pre-existing policy in the realm of organisational incentives, legislation and system level dissemination mechanisms or initiatives, which afford access to external resources and influencers, formalise but narrow knowledge acquisition and assimilation, and, at the same time, restrict exploratory learning, innovation and transformation (Berta et al., 2010). The primary virtue of systems capabilities is they provide a memory for staff handling routine situations in an organisation, meaning staff can react quickly. Like socialisation

capabilities, they increase the efficiency of knowledge exploitation, but narrow the search for new external knowledge and scope for information processing.

Co-ordination capabilities refer to lateral forms of communication such as education and training, job rotation, cross functional interfaces, distinct liaison roles. ICT solutions, social relationships, shared mental models, strategic alignment. In contrast to socialisation and systems capabilities, co-ordination capabilities increase scope of external knowledge acquired and assimilated, and flexibility in knowledge absorption. Hence, to enhance ACAP, managers might attend to organisational mechanisms associated with co-ordination capability (Jansen et al., 2005; Van den Bosch et al., 1999). Co-ordination capabilities might be developed in the domain of 'social integration mechanisms', such as boundary-spanning or liaison mechanisms, communities of practice, and decentralising authority and decision-making (Cohen and Levinthal, 1990; Jansen et al., 2005; Lane et al., 2006; Volberda et al., 2010). The aim for organisational managers, through developing co-ordination capabilities, is to establish ties with external sources of new knowledge and support this through establishing dense networks of ties within the organisation (Jansen et al., 2005). For example, within commissioning networks, such as CCGs, the increased involvement of GPs within the commissioning structures might act as a co-ordination capability as doctors have been noted as holding a mediating role in communication (or lack of) across jurisdictional boundaries (Berta et al, 2010).

From the literature review it is evident that CCGs need to reduce the variance between their PACAP and RACAP by improving their combinative capabilities, and subsequently enhancing their critical review capacity and commissioning processes. However, the influence of intra-organisational dynamics on combinative capabilities has received little attention in the existing literature, both within healthcare and the wider body of organisational research (Volberda et al., 2010). We recognise that healthcare represents a distinctive environment compared to private sector R&D contexts in which much of the empirical work around ACAP has taken place. This renders some of the dimensions of the ACAP literature less relevant to healthcare, but at the same time, brings others to the forefront (Easterby-Smith et al., 2008). As such, our exploration of in-depth CCG cases is timely in two respects: firstly it responds to calls for a deeper consideration of the influence of combinative capabilities on the variance between PACAP and RACAP, an area which has been highlighted for future research (Jansen et al, 2005); and secondly, the application of the ACAP model to CCGs allows exploration of the challenges facing commissioning bodies in healthcare globally.

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# Improving your critical review capacity to reduce needless admissions of older people into acute hospitals

## Report to NHS Halton Clinical Commissioning Group

Dr Charlotte Croft

# Overview

- We explored the critical review capacity of your CCG, examining the commissioning process for services aimed at reducing needless admissions of older people into acute hospitals
- 10 semi-structured interviews were conducted with individuals working within the general commissioning structure, or from a provider related to urgent care, and lasted between 45 minutes and 1 hour
- Analysis following the ACAP model was divided into four areas: acquisition – obtaining information; assimilation - analysing information; transformation – turning new information into commissioning decisions by combining it with existing knowledge; exploitation – changing or developing organisational behaviour or routines in response to the new information.
- We also considered antecedents to ACAP – the ability of an organisation to generate, synthesise and apply new knowledge to enhance critical review capacity.

# Key Message

***"I think I'm very, very pleased to have found that Halton CCG is able to work so closely with Halton borough council to the extent that we're actually based in council buildings as you can see. That was never the case in the days of PCTs. There was a lot of suspicion between the two, but now they work hand in hand. That I think facilitates what you're talking about – being able to bring in social care so that we can give people a package of care that's not fragmented. So that will be accessible through the urgent care centres" (Halton 10)***

***"By having that real integrated partnership approach focused on Halton then we can really make a difference to Halton residents" (Halton 8)***

- The close working partnership between the CCG and local authority acted as a coordination capability, enhancing the commissioning process for the urgent care centres

# Acquisition

***"So we got lots of information together. We collated information and we looked at… There was already a walk-in centre in Widnes and there was a minor injuries unit in Holton General Hospital in Runcorn, so we asked for figures of attendances and outcomes from both of those units. We had a questionnaire that went into GPs to ask them about their throughput in terms of urgent care. We had a questionnaire that went into local A&Es for both patients and staff asking basically why the patient was there, whether that was the best place for them and if it wasn't why didn't they go to the place they should have gone and what were the barriers to that. So we got that kind of information as well. So once we got all that information we kind of collated it all and came up with three kind of possible models of care and those models went to the board. We had a preferred model and the board agreed with the preferred model which is what we're just starting to implement" (Halton 10)***

- There were some minor difficulties associated with the acquisition of relevant data, due to a perceived disconnect between the CSU and the CCG. However, commissioners were able to acquire rich information to guide the set up of UCCs (due to enhanced coordination capabilities)

# Assimiliation

***"And so one of the things we did running up to this was an audit of people who attended A&E over a two week period and looked at had they approached primary care, what was available in primary care, had they been to a walk-in centre, asked them questions about what alternatives they'd explored, would they consider alternatives? And that information also helped shaped some of the areas of service that we wanted to pick up on. Diagnostics x-ray was a big one. We found something like 25% to 30% of people who attended A&E actually just needed an x-ray and because we didn't have x-ray facilities available all the time and we've only got them in one part of the borough then we were pushing people to go to A&E and people themselves were able to identify that "I just need an x-ray. I know I don't need … I've broken my arm. I know it's not badly broken, but I just need an x-ray to confirm it and a plaster" (Halton 3)***

- Assimilating the information acquired, generating in-depth, locally applicable analysis and understandings of the data sets was enhanced by the coordination capabilities of the CCG, particularly PPI

# Transformation

***"So we've got this notion of two sites, one either side of the bridge, and that's really important in this borough because although the bridge isn't very long people do not cross the bridge or tend not to cross the bridge, the local community, and moving down the line that's going to become more important because we're having another bridge built which you'll have to pay to go over and so that will even more mean that people are less likely to go over the bridge. So having a two-town solution has been quite important" (Halton 3)***

⊙A strong focus on PPI was also evident in the transformation of services. The urgent care centres were designed with the needs of the local population as a central priority, even reflected in the geographical positioning of the sites

# Transformation

**"I think to actually make all the changes that we're going to make it's required a lot of engagement between clinicians and directors of both CCG and the borough council and secondary care and that's only happened because the CCG and the borough council work very closely together and there's no suspicion anymore, so everyone's pushing in the same direction and because of that I think that secondary care feel that… I mean they're dealing with one unit now instead of two units pulling in different directions; and the community trust's the same so you can actually get people in a room that actually will agree to things more readily. I mean there's always disagreements…. But it's been more of an adversarial kind of tone to meetings in the past where now it's we've got to look forward" (Halton 10)**

- As mentioned previously, another important element of transformation of knowledge into services was the close working relationships between the CCG and the local authority, acting as a coordination capability

# Exploitation

- Research on ACAP in the private sector suggests exploitation is related to the ability of organisations to use the information based on small, local pilots or projects, to develop wide scale service change. This is difficult to comment on at this stage, as the centres were not operational at the time of our visit. However, instead we highlight some areas that may be problematic, for future consideration.

- Secondary care interface:

***"I think the biggest challenge probably will be we're going to have kind of an internal interface really between secondary and primary care where the urgent care centre and clinical decision unit lie in the hospital because we're basically asking a secondary care provider to provide us with staff to help us stop them admitting patients and we're asking to spend less money on employing those people than we would pay in tariff to admit the patient to hospital or to send them to A&E. So obviously that's a challenge" (Halton 10)***

# Exploitation

- Ongoing communication with the public:

***"Obviously they're the people we need to communicate with because they're the people we're relying on to go into the urgent care centres rather than the acute trusts or we will be in a pickle. So there have been some issues around communication. I mean some of that is around when you go out and you do your consultation events sometimes the public think that it's just going to happen now because they've just told me about it so there's some challenges there for us. I suppose the other challenges are making sure that it doesn't develop as a silo and it develops as part of the whole system. Unless we tie it into the whole system I don't think it will work as well as we think it's going to" (Halton 8)***

- The exploitation aspect of the commissioning process is the most underdeveloped of the four ACAP areas. This is unsurprising as the centres are not yet operational. However, findings suggest that coordination capabilities will be key in aligning multiple stakeholders in order to enhance the way information is used to develop or scale up the centres as appropriate. Patient involvement will also be key in enhancing these coordination capabilities.

# Conclusions & Implications

- There were clear indications that the critical review capacity of Halton CCG was enhanced by its coordination capabilities in terms of the integration between health and local authority, and comprehensive PPI.
- The coordination capabilities enabled the CCG to overcome some of the problems noted with the acquisition or assimilation of data, stemming from a distant relationship with the CSU. This was particularly clear with the way PPI information was used to triangulate and make sense of data
- Transformation of data into service design holds the potential for difficulty, due to the large number of stakeholders involved in the UCCs. However, the integration of health and the local authority enhanced coordination capabilities, facilitating the alignment of multiple stakeholders, enabling complex service design.
- Conclusions about exploitation are currently limited, but we highlight the importance of developing relational interactions amongst stakeholders to continue to develop UCC services. Continuing development and exploitation will also rely on the integration of PPI structures, and the development of new PPI mechanisms in partnership with the integrated local authority.

# Next Steps

- There is a need for a more in-depth exploration of how the information is transformed into service delivery within the UCCs, and the way in which the coordination capabilities of the CCG can be enhanced to facilitate the alignment of multiple stakeholders, exploiting the potential of the UCCs. This could cover one of the following areas:

  - The use of PPI to exploit information fed back from UCCs
  - The way in which primary and secondary care providers transform information to design UCC services
  - The relationships between multiple stakeholders and the challenges of aligning them in complex service design
  - The way the CCG harnesses and exploits information fed back from UCCs to continually develop services

| | |
|---|---|
| **REPORT TO:** | Health Policy & Performance Board |
| **DATE:** | 9 September 2014 |
| **REPORTING OFFICER:** | Strategic Director, Communities |
| **PORTFOLIO:** | Health & Wellbeing |
| **SUBJECT:** | North West Specialised Commissioning Planning and Engagement |
| **WARD(S)** | Borough-wide |

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a presentation from Gaynor Hales, from NHS England, in relation to specialised commissioning in the North West.

**2.0 RECOMMENDATION: That the Board**

1) **Receive the presentation; and**
2) **Agree how Members would like to be kept informed of progress in respect of specialised commissioning in the future.**

3.0 **SUPPORTING INFORMATION**

3.1 NHSE are responsible for the commissioning of specialised services. The presentation aims to provide the Board with an overview of specialised commissioning and an understanding of the 2 year operational plans for the North West as a whole and provide an opportunity to clarify how the Board would like to be kept informed with the progress of the operational plans and any changes to services across the North West.

4.0 **POLICY IMPLICATIONS**

4.1 None identified

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified

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

6.1 **Children & Young People in Halton**
None identified.

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

None identified.

6.3 **A Healthy Halton**

All issues outlined in this report/presentation 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 None identified.

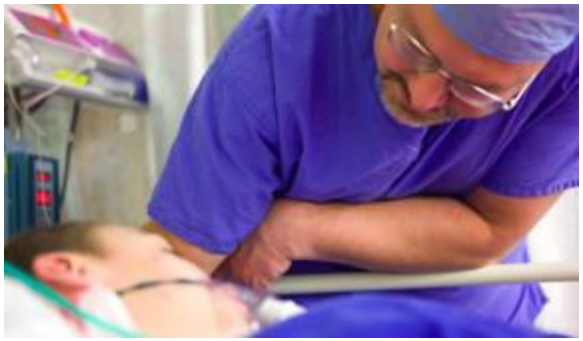
8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

9.1 None identified.

# North West Specialised Commissioning Planning and Engagement



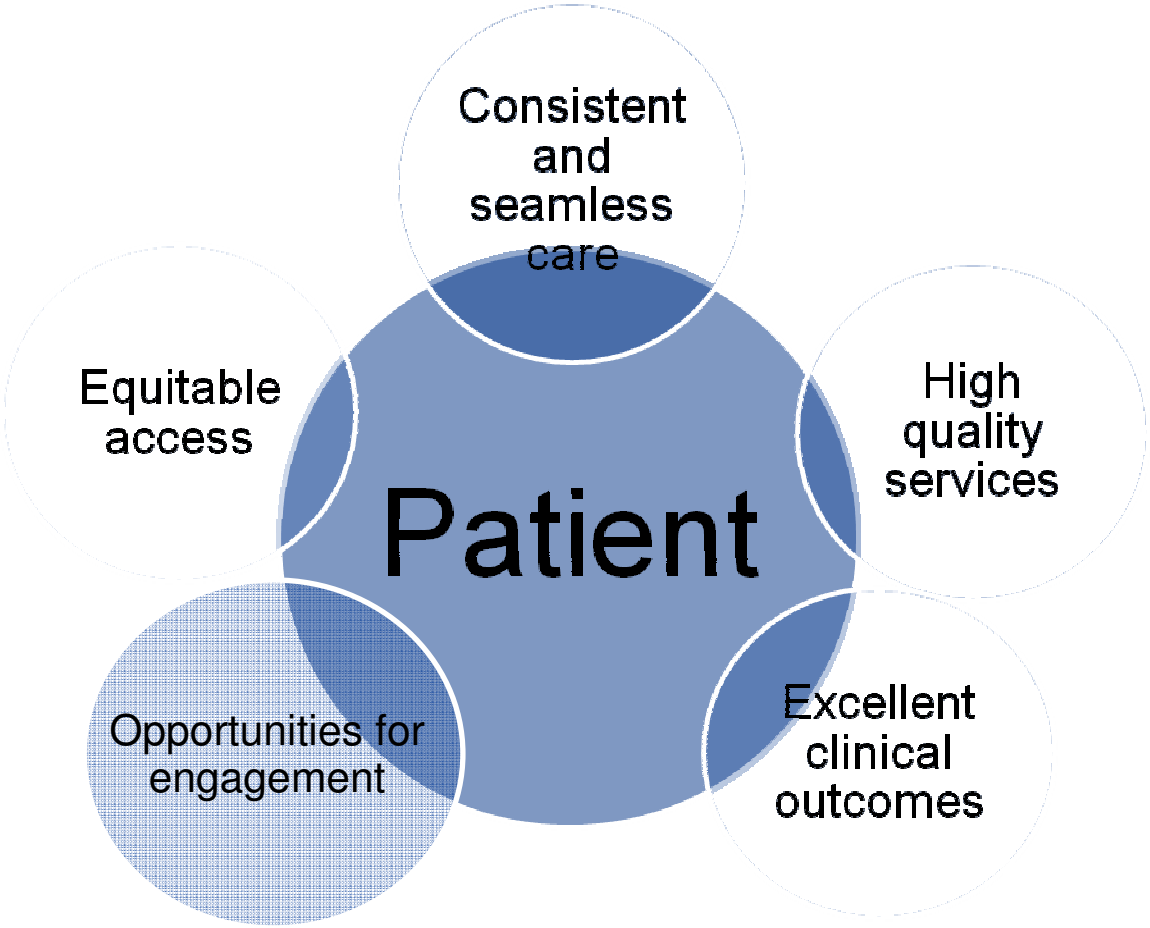
Dr Alison Rylands

July 2014

# Principles of Commissioning

- Deliver service improvement
- Clinically driven and informed
- A commitment to working in partnership across organisational boundaries
- A focus on outcomes, quality and patient experience rather than outputs
- Decision making based on evidence and best practice
- A strong and empowered patient voice

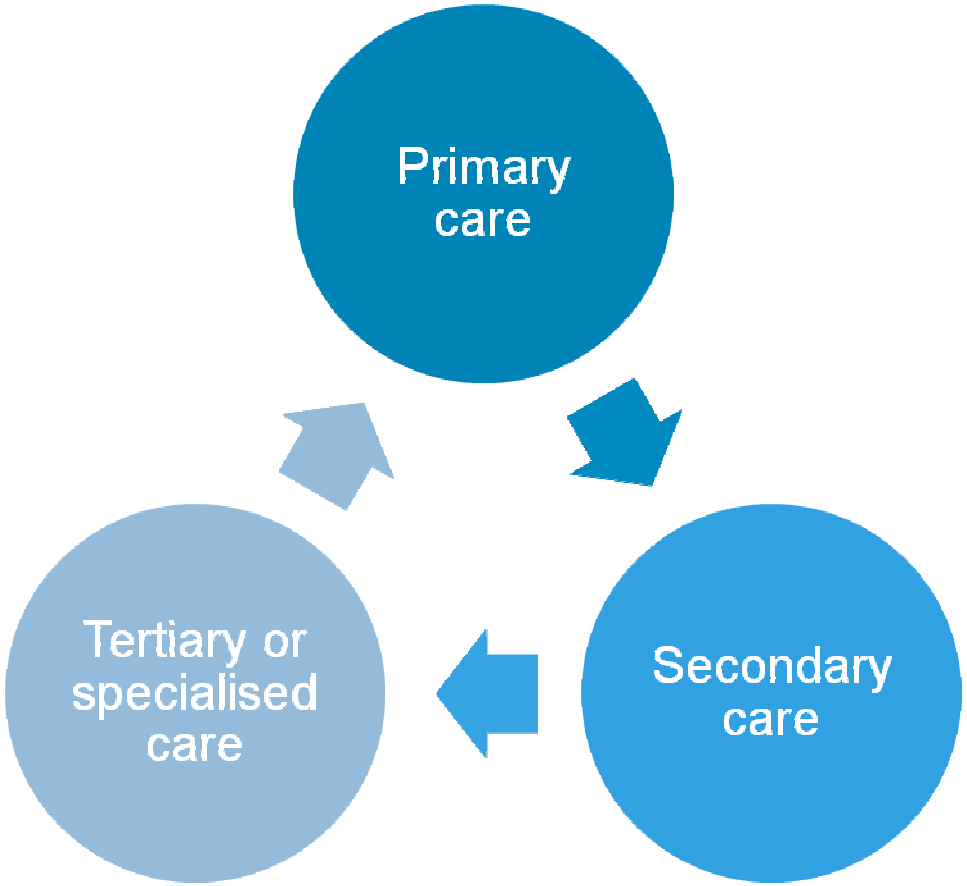
# Patient Centred Commissioning



# Commissioning across pathways of care

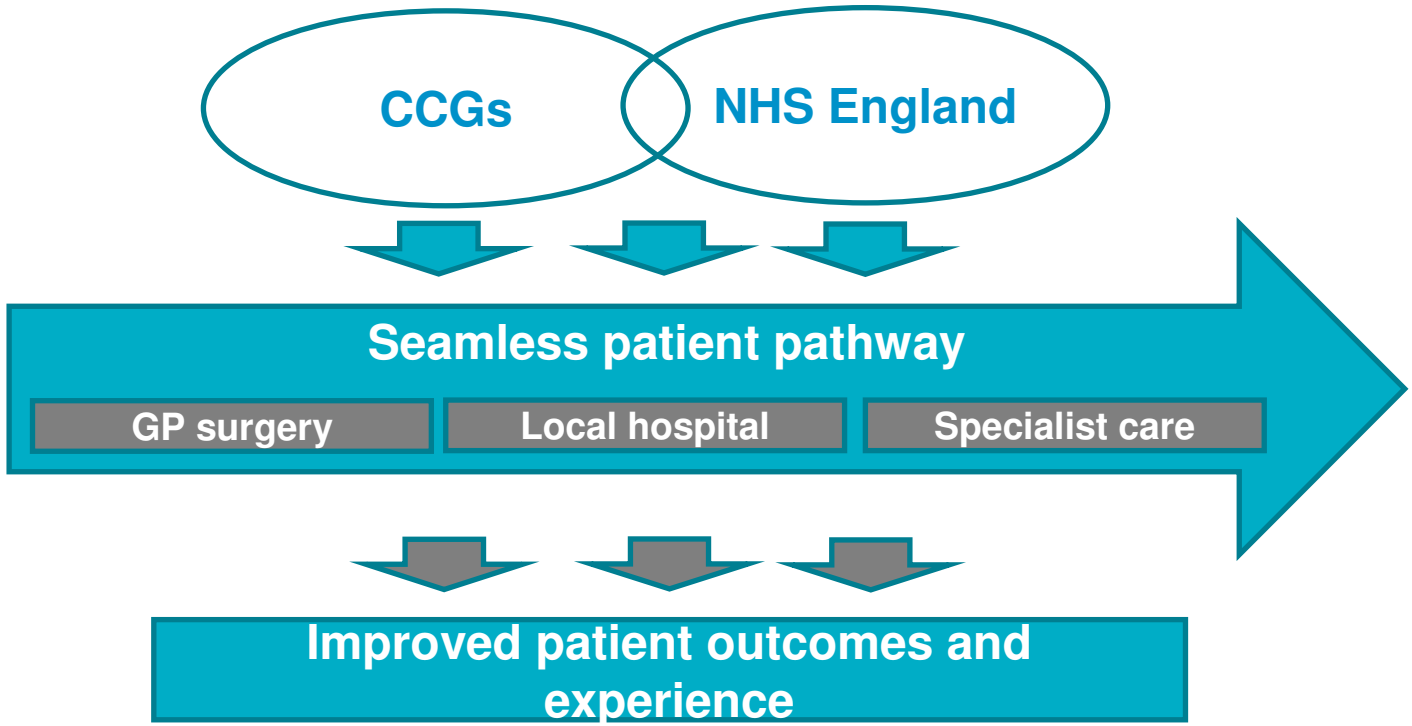
6 Rights of good care

RIGHT patient
RIGHT place
RIGHT time
RIGHT care
RIGHT clinician
RIGHT price



# Integration is vital

Clinical Commissioning Groups (CCGs) are **critical** to the ambition **to achieve world-class patient outcomes** and **experience** in specialised services. Strong working relationships and shared decision-making are important.

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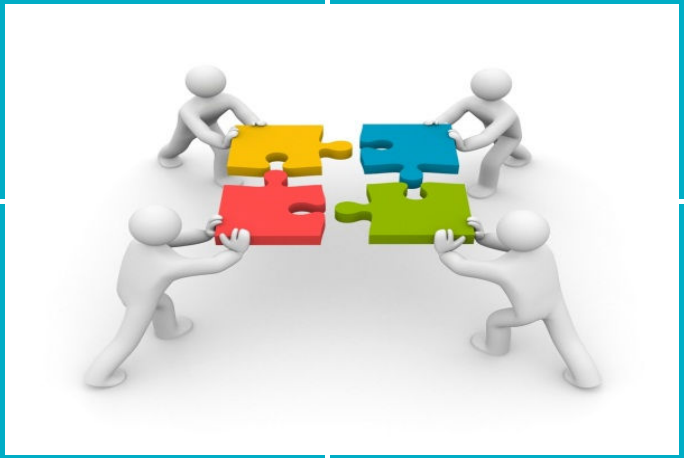
# Guiding principles for planning

Driver is improvement in clinical outcomes and patient experience

Plans must address variations in access and outcomes



Fundamental importance of system alignment

Open and transparent approach to planning approach

# What are Specialised Services?

NHS England

## Highly specialised

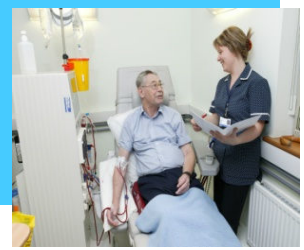
- Rare conditions
- Very low patient numbers
- Very few hospitals
- Examples:
- *Heart and lung transplantation*
- *Treatment of rare eye conditions*

## Specialised services (1)

- Episodic specialised services
- Examples:
- *Paediatric and Neonatal Intensive care*
- *Severe burn care*

## Specialised services (2)

- 'Pathway' specialised services
- Long term conditions
- Examples:
- *Kidney care*
- *Mental health*
- *Cardiac care*
- *Cancer services*



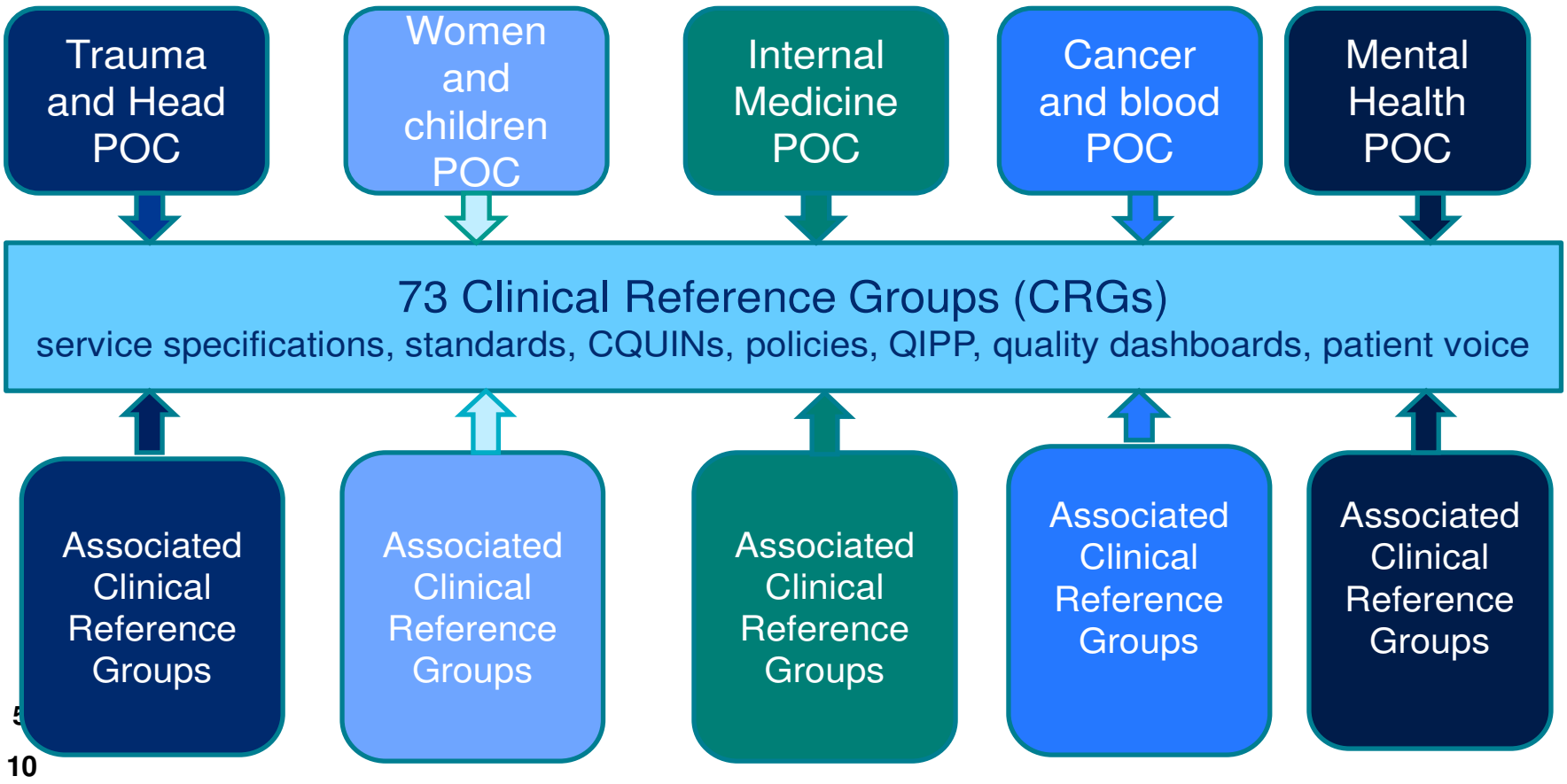
# Current commissioning arrangements

- NHS England – responsible for directly commissioning specialised services; screening; military health; offender health; and primary care
  - 27 Area Teams
    - 10 Area Teams responsible for specialised services (Cheshire, Warrington & Wirral for the NW)
- Clinical Commissioning Groups (>200)
  - Responsible for commissioning secondary care
- Public health services now commissioned by local authorities

# What this actually means

- Single commissioning approach
- One contract (NHS England)
- Single service specification per service (128+)
- Consistent commissioning policies (>40)
- One set of quality standards/dashboards (20)
- National QIPP Plan (Quality, Innovation, Prevention & Productivity)
- One set of CQUIN indicators (quality markers)
- 75+ Clinical Reference Groups
- Single decision making process (including Individual Funding Requests)

# National consistency in 'prescribed' specialised services



# Decision making

- 75+ CRGs
  - Consider relevant service developments
- Four IFR Panels (North; Midlands; South; and London)
- Clinical Priorities Advisory Group
  - Make recommendations to NHS England Board
- Rare Diseases Advisory Group
  - Make recommendations to NHS England Board
- Commissioning through Evaluation Programme e.g.
  - Selective Dorsal Rhizotomy
  - Mitraclip
  - Foramen ovale closure

# National context (2014/15 and beyond)

- Five-year strategy for specialised services being developed – aligned with CCG Strategic Plans e.g. *Healthy Liverpool*
- Planning guidance (Dec 2013)
  - Centres of Excellence (fewer than currently; not necessarily the 15-30 mentioned in the guidance)
  - Co-dependencies/responsiveness – which services need to be provided very close to or on the same site?
  - Planning bundles – consider related services together
  - **Financial sustainability (Taskforce)**

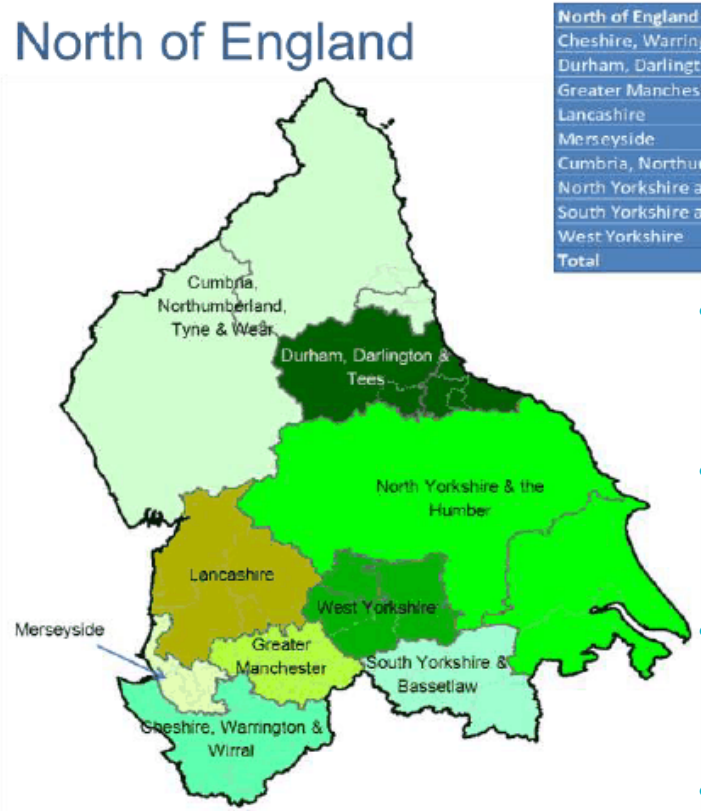
# Taskforce workstreams

- ***Strategic projects*** – ensuring continuation of complex programmes e.g. proton beam therapy
- ***Strategy*** – development of a financially sustainability strategy; **consideration being given to the range of specialised services and whether commissioning models should change**
- ***Clinically driven change*** – ensuring clinical benefit alongside efficiency improvements
- ***Analytics*** – ensuring good data and intelligence are available to support specialised commissioning

# Taskforce workstreams

- ***Operational leadership*** – responsible for QIPP programme and developing future shape of specialised commissioning infrastructure
- ***Commercial & technical delivery*** – ensuring market management through robust procurement and contracting
- ***Financial control*** – ensuring financial leadership and focus across all specialised commissioning programmes

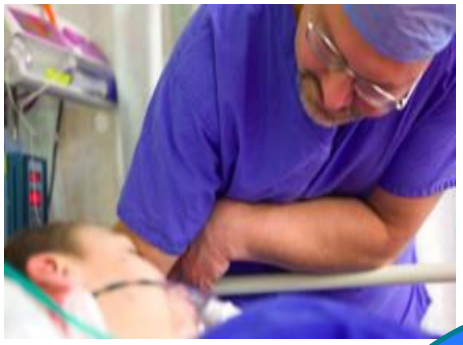
# How are specialised services currently commissioned?




| North of England | Popn (1,000s) | CCGs | HWBs |
|---|---|---|---|
| Cheshire, Warrington and Wirral | 1195 | 6 | 4 |
| Durham, Darlington and Tees | 1167 | 5 | 6 |
| Greater Manchester | 2636 | 12 | 10 |
| Lancashire | 1424 | 8 | 3 |
| Merseyside | 1170 | 6 | 5 |
| Cumbria, Northumberland, Tyne and Wear | 1910 | 8 | 7 |
| North Yorkshire and Humber | 1690 | 8 | 6 |
| South Yorkshire and Bassetlaw | 1427 | 5 | 4 |
| West Yorkshire | 2235 | 10 | 5 |
| **Total** | **14853** | **68** | **50** |

- NHS England commissions a range of services including specialised services.
- There are 10 Area Teams (ATs) across England responsible for commissioning specialised services
- Cheshire Warrington and Wirral AT commission specialised services across the North West.
- The budget is £1.8 billion; contracts with 42 providers
- There are 32 CCGs, 22 OSCs and Health & Well Being Boards in the North West

# Why is change needed in specialised services?



Too many providers

Move towards 7 day working

Some hospitals don't have enough specialist staff

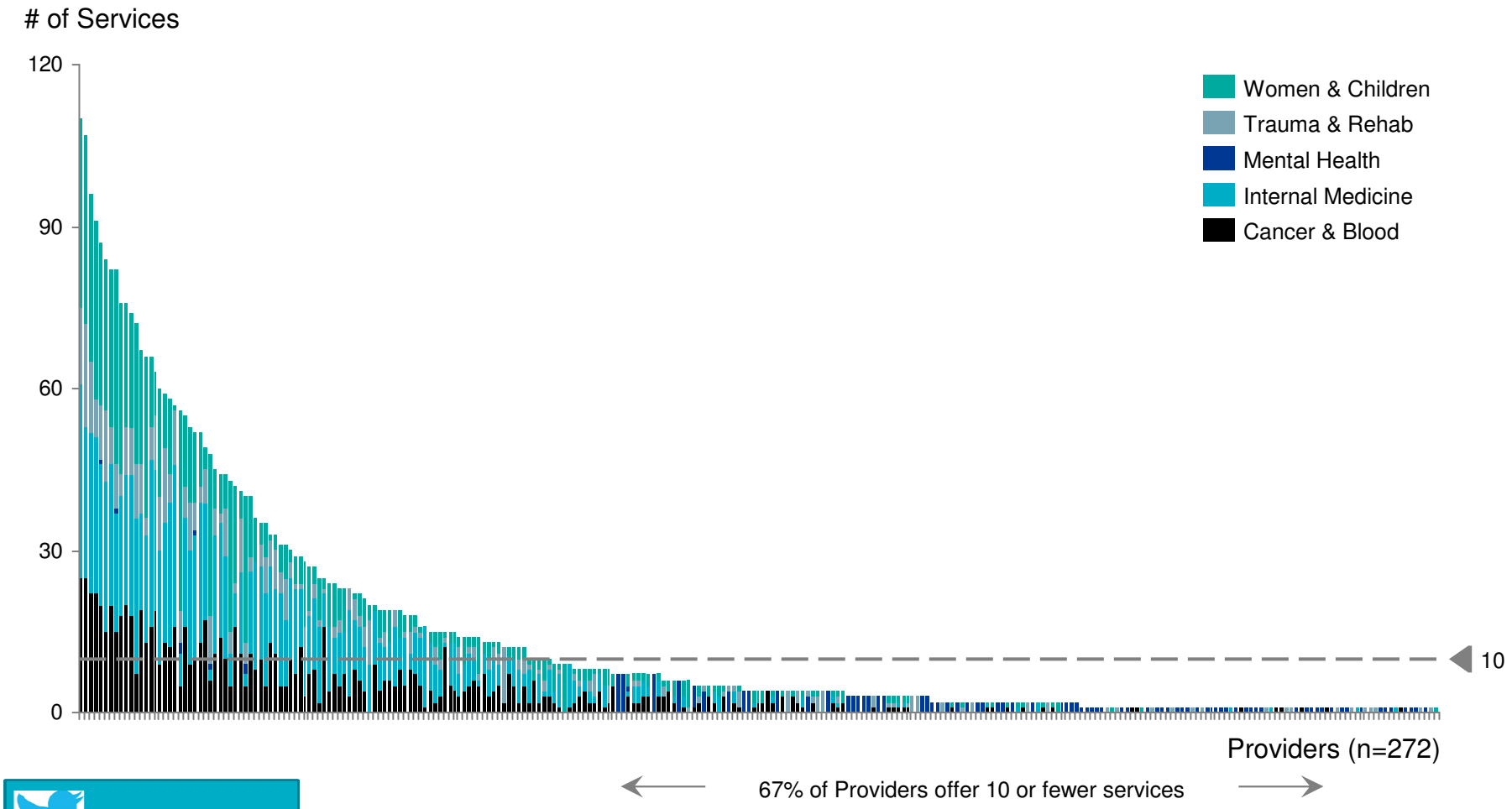
Too much variation in quality and outcomes

Some Providers are doing too little activity

Some providers are not meeting core quality standards

# 272 providers offer ~200 specialised services today

Services are grouped across 5 Programmes of Care

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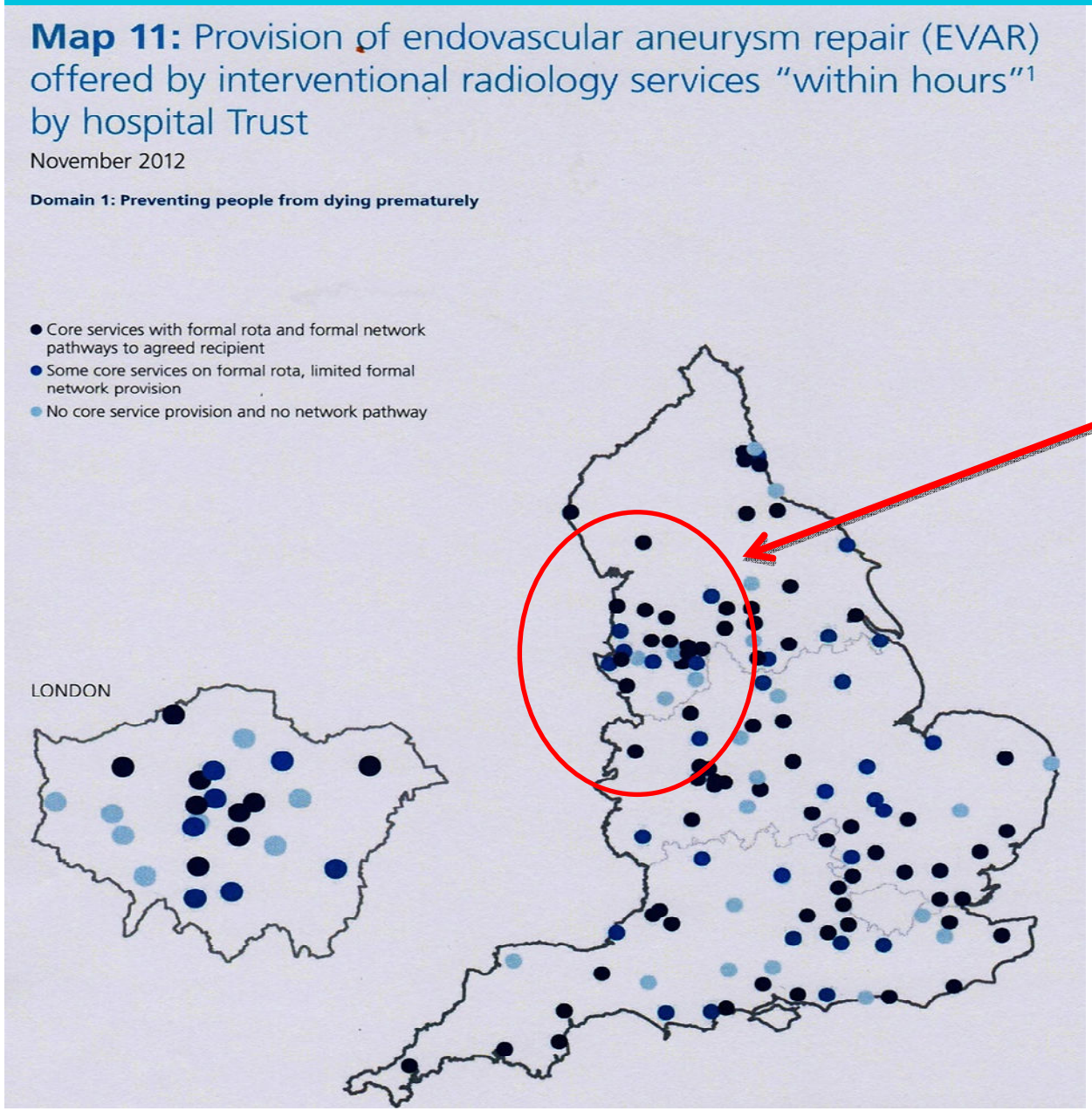
Source: NHS England Provider database

# How will these challenges be addressed?

National Planning Guidance '*Everyone Counts'* – foresees a concentration of expertise fewer Centres of Excellence

Concentration of expertise does not mean concentration of service delivery – access is a core factor

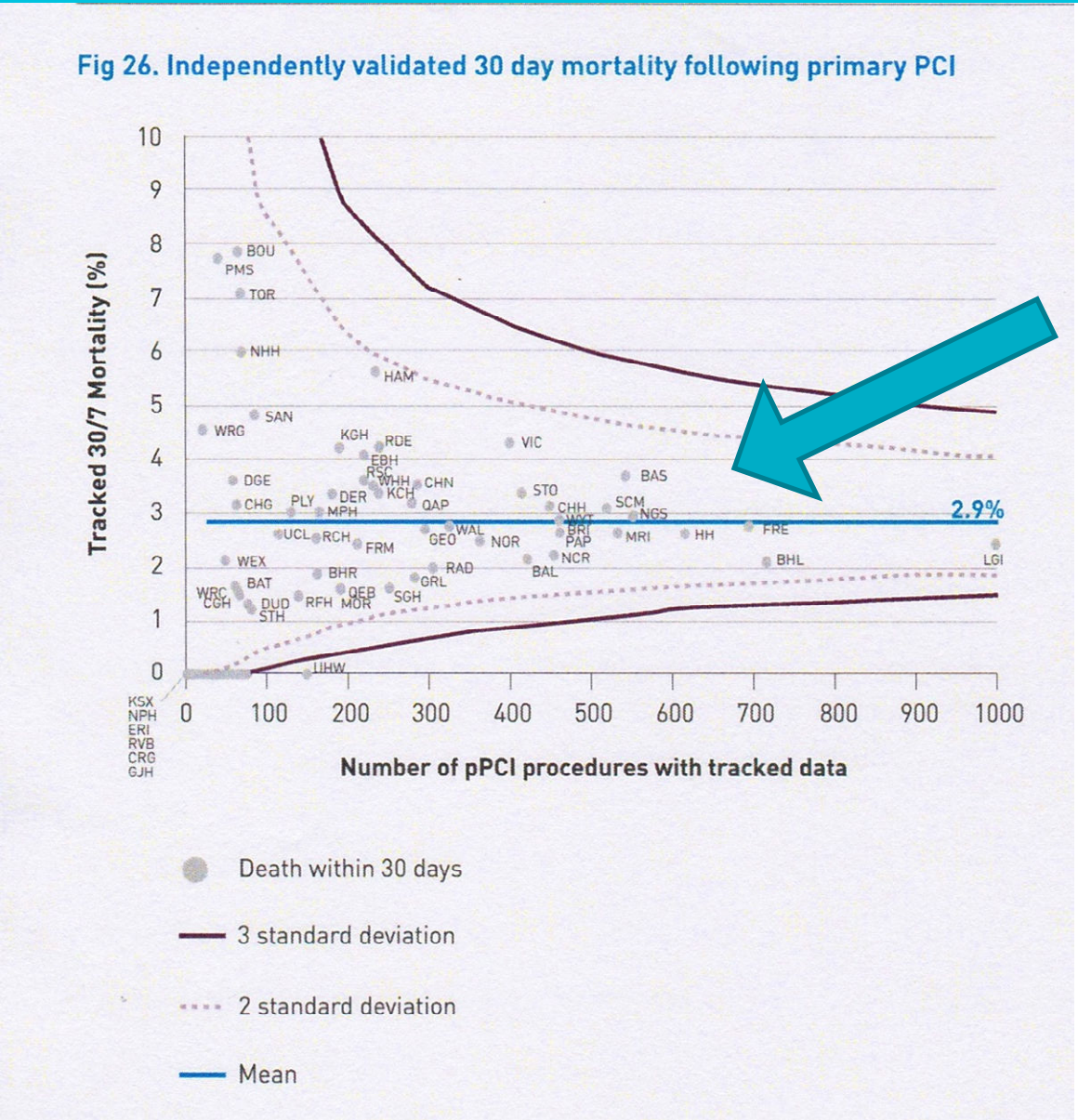
# Significant national variation in vascular procedures




Patients across the North West receive variable access to this treatment

*Consolidation of vascular services has already been achieved in Merseyside. National work is underway to identify other services where the evidence shows centralising expertise improves outcomes e.g. cancer surgery*

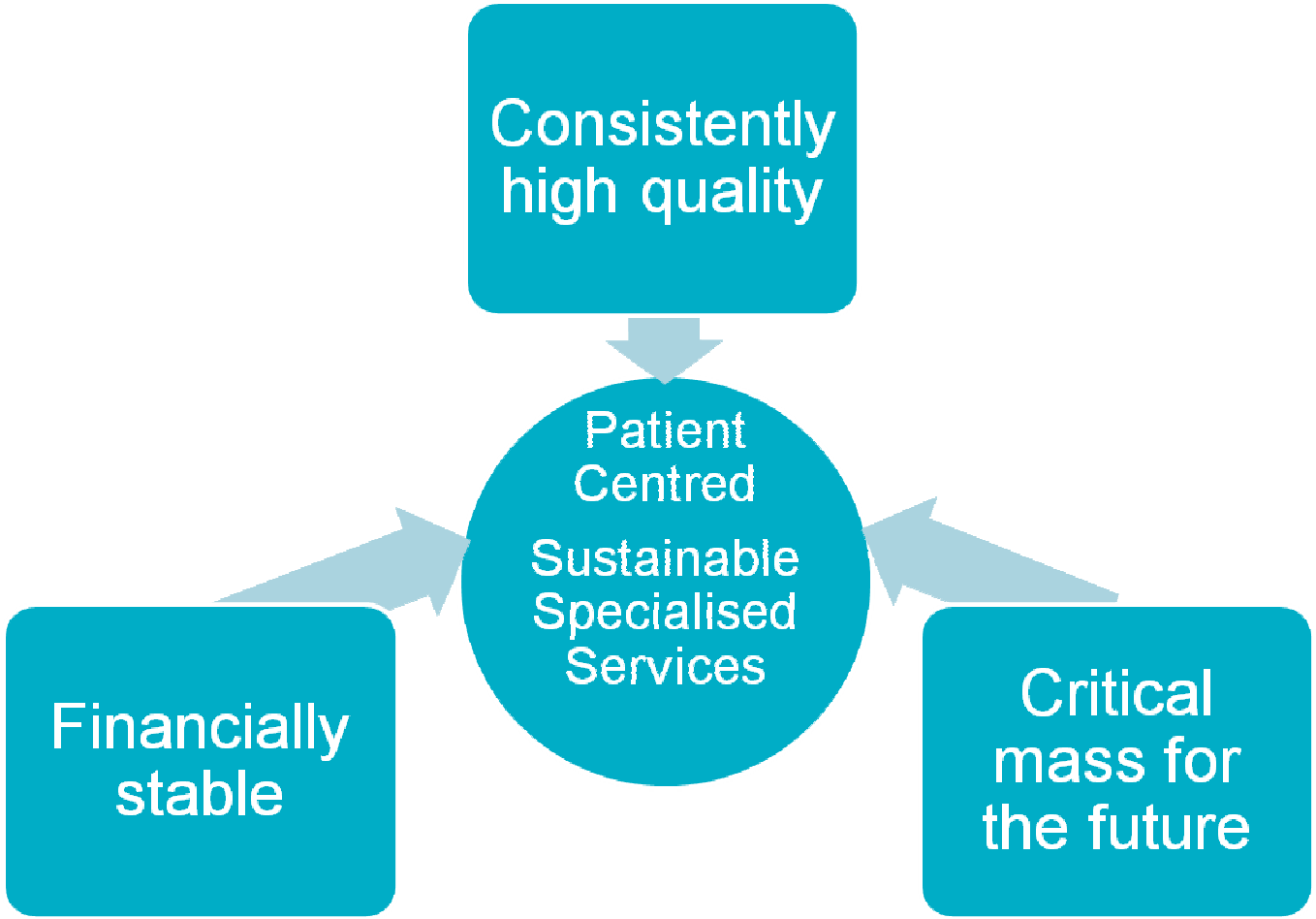
# Significant variation in mortality rates in cardiac care




The higher the number of procedures undertaken by a provider, the lower the mortality rate

CWW AT and the Cardiac Network will be undertaking a review of cardiac services across the NW to ensure they are meeting national standards and that providers are undertaking appropriate levels of activity. Models of care will also be considered.

# Developing the vision for specialised care

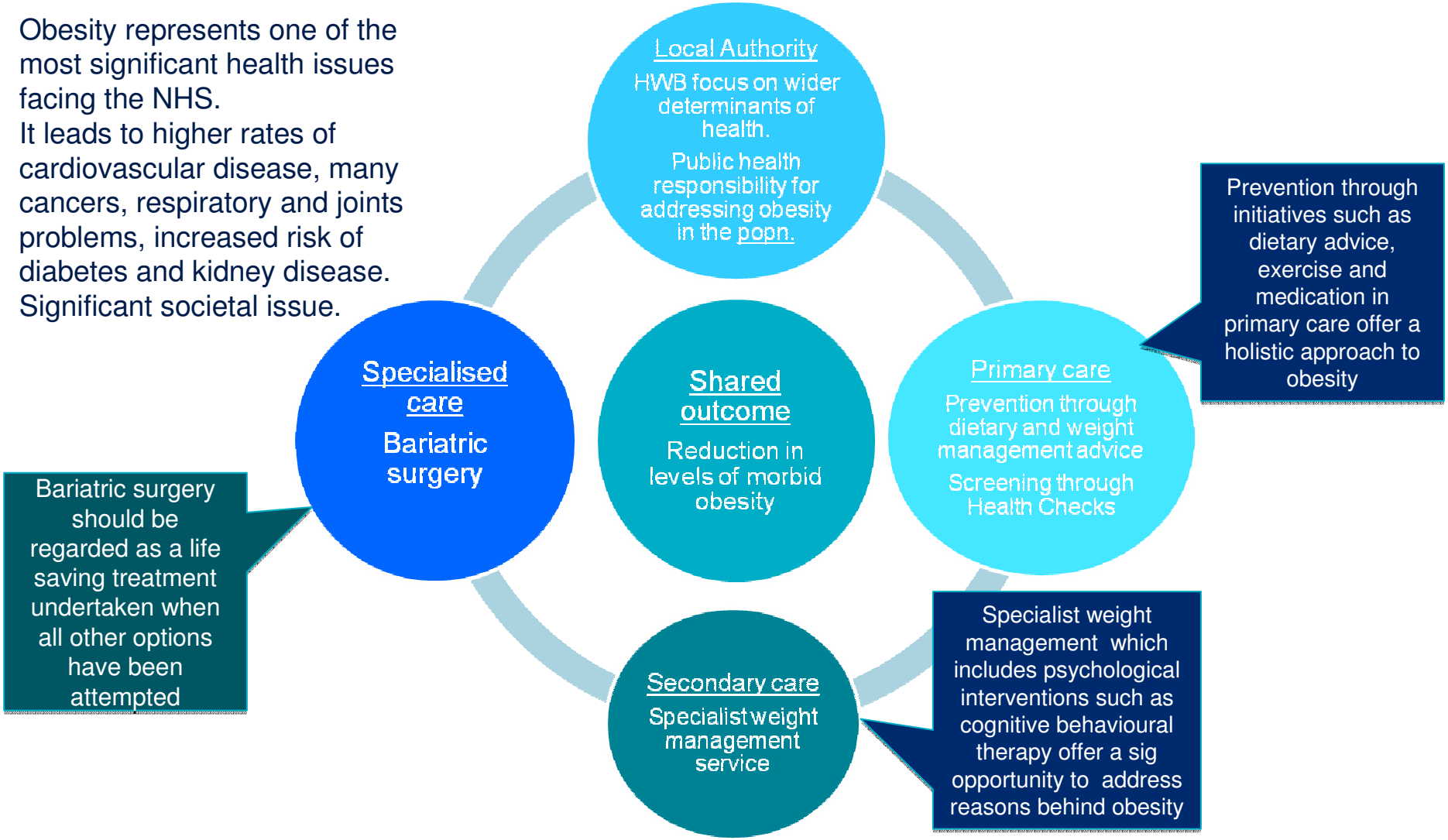


# Summary

- The majority of specialised services form part of a pathway of care
- Early management of chronic disease pathways will significantly impact upon demand for specialised services
- Co-commissioning partnerships along pathways of care are therefore fundamentally important to securing improved outcomes for patients and effective use of resources
- Consideration also being given to moving commissioning responsibility for some services completely to CCGs
- In the interim, work is underway to identify those services where co-commissioning is the best approach

# Commissioning integrated care across the obesity patient pathway

Obesity represents one of the most significant health issues facing the NHS.
It leads to higher rates of cardiovascular disease, many cancers, respiratory and joints problems, increased risk of diabetes and kidney disease.
Significant societal issue.



# Some questions for consideration

- How should we engage and communicate?
- How can national imperatives be progressed locally?
- Links between Health Watch and ‘OSCs’?
- How should we address cross boundary issues?
- How do we strengthen our ongoing partnership working?

**REPORT TO:** Health Policy & Performance Board

**DATE:** 9 September 2014

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Health & Wellbeing

**SUBJECT:** Halton Community Wellbeing Practices Update

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the PPB on progress and key developments for Community Wellbeing Practices initiative.

2.0 **RECOMMENDATION: That the Board note the findings of the report.**

3.0 **SUPPORTING INFORMATION**

3.1 The Community Wellbeing Practices (CWP) initiative provides a wraparound service for all 17 GP practices in the borough to ensure patients whose needs are predominantly psychosocial in origin are identified and provided with effective community based interventions. Wellbeing Enterprises CIC, an established, local social enterprise was commissioned to design and deliver the service in collaboration with patients, partner agencies and professionals working in health and social care.

The rationale for the CWP initiative is to ensure primary care provision is fully integrated with a broad and balanced range of psychosocial support on offer for patients in the community. Moreover the initiative aims to reduce pressures on primary care services by ensuring patients whose needs are predominately psychosocial receive a holistic wellbeing assessment and timely access to evidence based community interventions.

3.2 A team of 9 Community Wellbeing Officers serve as a link between the GP Practice setting and the wider community. The CWP initiative provides essentially three core services for patients and the public:

- **The provision of psychosocial support** - *such as life skills training, community events and a comprehensive, fully integrated social prescribing programme*

- **A community navigation service** - *a holistic wellbeing assessment in conjunction with a community brokerage service to link patients to support provided by the wider voluntary, community and social enterprise sector (VCSE)*

- ***Asset based community projects*** - *empowering patients and the public to play a lead role in designing and delivering community based activities that improve wellbeing. Working with our VCSE partners we have empowered young people to run their own wellbeing projects linked to GP practices, enabled patients to run their own hobby and interest groups and encouraged volunteers to play an active role in the CWP initiative as community champions.*

## 4.0 THE PATIENT JOURNEY

4.1 There are several referral points for the CWP initiative. Patients can be referred directly by their GP, and the CWP initiative is now fully integrated with the electronic booking systems of practices. Referral pathways have also been agreed with Primary Care MDT teams, VCSE organisations working across Runcorn and Widnes, the Police, the Discharge Teams at Warrington and Whiston Hospital, Halton Housing Tenancy Support and the Intermediary Care Team at Ashley House. We are currently in discussions with 5 Boroughs Partnership and the Primary Care Mental Health Teams to explore the option of integration with their service teams. Patients and public can also self-refer.

4.2 Patients may be referred directly for a 1 to 1 Wellbeing Review, in which patients work in partnership with a Community Wellbeing Officer (CWO) through a structured pathway of support, to identify any underlying social problems and any barriers to wellbeing. From here the patient and CWO co-develop a personalised wellbeing action plan to address any issues (Appendix 1). As well as identifying any problems and issues, patients are supported to identify capabilities and strengths and to bring these to the fore in developing their unique plan.

4.3 Typically, patients and the public who refer/or are referred into the CWP services have a range of psychosocial issues which in some instances may be exacerbating physical health problems and which could consequently result in attendance at an NHS or social care agency - potentially resulting in additional costs and pressures on stretched services. Examples of some of the typical issues that patients present with include, but are not limited to; loneliness, isolation, mental health issues, stress, stigma and discrimination, financial worries, relationship difficulties, lifestyle issues, housing concerns, victims of crime, lack of food, drug and alcohol worries, lack of confidence, unemployment, being new to the area.

4.4 Where patients disclose a specific issue for which another agency has specialist skills, we would support patients to navigate their way to this help, either through making a direct referral, or helping the patient to do this for themselves. Many patients tell us that they really value this aspect of the CWP service as they can sometimes find it difficult to know where to go for help. Moreover many patients tell us that they don't always feel confident to champion their issues - and so in this respect the Community Wellbeing Officers can support patients in practical ways so that they feel able to articulate their concerns and to describe the kind of support they feel will help.

4.5 In addition to the CWO's role as a community navigator - connecting patients to services available in the wider community, CWO's also provide patients and the public with a wide range of wellbeing activities such as :

- Life skills training - based on cognitive behavioural principles, participants learn practical skills in problem solving, goal setting, how to build confidence and self-esteem in a relaxed and friendly group setting.

- Community resilience events – such as *'Ignite Your Life!'* - Which teach the public top tips for staying strong during difficult times. *Music and Memories* – delivered in care homes and which engage elderly residents in interactive, sensory activities based on music and reminiscence. *The WOW event* – a half day event in which members of the public come together to rediscover their confidence skills, share their talents and develop a personalised WOW plan to improve their wellbeing levels.

- Social prescribing – which is about linking patients with non-medical sources of support (Appendix 2). Examples of some of the social prescriptions on offer include: Tango Dancing on Prescription, Astronomy on Prescription, Fruit on Prescription, Nordic Walking, Mindfulness, Stress Management, and Confidence Classes to name but a few. All of the programmes on offer incorporate a core learning framework based on evidence based top tips for improving wellbeing such as the 5 Ways to Wellbeing. Many of the programmes are delivered in collaboration with partner agencies and are co-developed by patients and the public.

- The CWP social prescribing programme serves as an intermediary step for patients and members of the public who don't yet feel confident enough to access mainstream social activities. Participants are supported to engage in group activities and build confidence in a friendly environment, with a view to supporting patients to access mainstream services as part of their exit strategy. All social prescribing

programmes are run in community venues such as community centres, and all make use of local community resources such as parks, nature spots, and libraries.

## 5.0 OUTCOMES AND KEY ACHIEVEMENTS

5.1 The CWP initiative has benefited from a wealth of support from a wide range of agencies across a broad array of sectors. We are indebted to the support and encouragement of our partners.

Support has included:

- Providing access to partner agency venues to run projects and events
- Working in partnership with a whole host of voluntary, community and social enterprise (VCSE) agencies to provide social prescribing activities
- Collaborating with VCSE agencies on local and national campaigns
- Co-designing projects such as the dementia passport, GP community gardens and green space activities.
- Building referral links with partners in VCSE sector, Police, Housing and Acute and Intermediary care.

5.2 To date the CWP initiative has provided more than 3000 full interventions to almost 2000 patients since the service went live in October 2012. In addition to this, it has also delivered 5300 brief interventions to patients in the practice waiting area. (Please see Appendix 3 CWP Impact report).

Other achievements include the provision of:

- 107 social prescribing groups to 1400 patients
- 29 community events to 1008 community members
- 24 Life Skills training programmes to 297 patients
- 36 Asset based community projects involving 564 members of the public.
- Almost 400 Wellbeing Reviews

5.3 <u>Outcomes for Patients and the Public</u>

Below is a list of some of the ways in which the CWP initiative is making a difference to people's lives in Halton:

- Helped an elderly man to obtain a boiler in order to remove damp that was exacerbating his respiratory condition.
- Secured support from a local cycling club so that a gentleman living with dementia could continue his passion for cycling by ensuring that he was picked up and returned home safely.

- Supported a woman living with depression to build her confidence levels so that she could start volunteering.
- Provided life skills training and money management information to a vulnerable elderly man referred to us by the police.
- Connected a single mum with three children who was in crisis to the food bank scheme so she was able to feed her family for the week. We worked with this individual to acquire a range of support services for her and her children over the longer term.
- Enabled a housebound woman to connect with friends and family by teaching her how to use Skype technology. We also linked her to a local befriending service.
- Identified funding to enable an elderly man with full-time caring responsibilities to look after and enjoy his garden again.
- Helped a Polish couple who are new to the area to settle in to the community. We connected them with a local support group, and they also attended our community events.

5.4 Using our data collection processes we have been to evidence the following outcomes for patients:

- A demonstrable improvement in subjective wellbeing scores. 64% of interventions have shown a significant improvement.

- A reduction in depression symptoms. 52% of interventions report a reduction in symptoms.

- An improvement in overall health status. 52% of interventions show a significant improvement.

- Patients have engaged in more than 2400 health promoting activities known to improve wellbeing levels such as connecting with friends, being active, learning a new skill or helping others.

- 64% of patients engaging in our community events have gone to help others using the knowledge and skills they have acquired.

5.5 <u>Supporting the Voluntary, Community and Social Enterprise sector</u>

In terms of supporting the wider VCSE sector the CWP initiative has:

- Worked in partnership with more than 120 local VCSE organisations as part of the CWP initiative.
- Welcomed VCSE agencies into the practice waiting areas to host stalls and promote an awareness of their services.

- Coordinated 8 young people's projects in collaboration with 10 CYP agencies which engaged more than 200 young people.
- Delivered 24 outreach sessions to 234 VCSE staff to raise the profile of the CWP initiative and to build effective partnerships.
- Delivered 6 free wellbeing training sessions, to approximately 150 staff working in the VCSE sector.
- We led on a successful application to the Department *of* Health and Social Enterprise UK to secure specialist support to implement the Social Value Act locally - one of the aims of which is to raise the profile of the VCSE sector.
- We have recruited 11 volunteers in the last 5 months who between them have donated 141 volunteer hours to the community.

## 6.0 FEEDBACK

### 6.1 Feedback from Patients

Patients and the public have told us:

- "I found it very helpful to talk to someone who understands."
- "My husband and I recently moved to the area and we felt quite isolated, but our Community Wellbeing Officer has helped us settle in by providing us with information about things happening in our local community – we've since made lots of friends".
- "The Wellbeing Review was fantastic because it really helped me a lot. I gained a lot of self-worth from it, and I learnt lots of things that were going on in the local area that I didn't know about".
- "The Community Wellbeing Officer helped me to put a plan together to help me back in to employment and to signpost me to organisations that could help me."
- 84% of patients who have engaged in a CWP intervention have rated their experience as 8/10 or more.

### 6.2 Feedback from Professionals

Professionals working across a broad array of sectors have told us:

- "The extra tools provided by the CWP approach have helped me to explore an alternate dimension of a patient's life that complements the traditional medical model."
- "Having conversations with patients about accessing activity groups has given me a greater depth to my understanding of patients - you can see how patients have grown."

- "Always very professional and knowledgeable - the clients are at the heart of everything that they do."

- "I have found your training days enlightening and it's helped me to provide a better service to the clients that I work with."

## 7.0 NEXT STEPS

7.1 Moving forward with the CWP initiative, the main priorities are to:

- Integrate the CWP initiative into new clinical and social care pathways to ensure patients whose needs are predominately psychosocial in origin are able to receive timely, effective community based support.

- To increase the referral rates for patients coming into the CWP service from newly established referral sources.

- Providing support to enable community members to develop their own wellbeing projects.

- To continue to collaborate with partners in the VCSE sector on community led projects and to raise the profile of VCSE partner agencies in health and social care.

- To expand the social prescribing service to provide additional out of hours provision.

## 8.0 POLICY IMPLICATIONS

8.1 The Social Care Bill introduces a focus on preventing and delaying the need for care and support, with a strong focus on integration.

## 9.0 FINANCIAL IMPLICATIONS

9.1 None identified.

## 10.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 10.1 Children & Young People in Halton

The CWP initiative has been working in collaboration with Children and Young People's services in the borough to ensure the views and aspirations of children are taken into account and acted upon.

This has included the delivery of young people's wellbeing projects led by young people in collaboration with CYP partner agencies, as well as securing external funding to provide additional capacity to ensure young people in the borough experiencing mild to moderate mental health problems have access to timely psychosocial support.

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

The CWP initiative has resulted in 17 new jobs in the borough. This initiative also works closely with agencies who support individuals who have employment and learning requirements to ensure such patients are connected to these opportunities through its community brokerage service.

The CWP initiative currently recruits two young people from the borough through the government apprenticeship scheme.

10.3 **A Healthy Halton**

The CWP initiative aligns with key health and social care needs identified for the borough. Integrating the CWP initiative with clinical and social care teams supports this.

10.4 **A Safer Halton**

The CWP initiative has built good links with the Police and the Safer in Town initiative and accepts referrals for patients who are a victim of, or at risk of crime.

10.5 **Halton's Urban Renewal**

The CWP initiative has been leading on work to promote and improve the built up environment, including the establishment of GP community gardens, as well as working with partner agencies to raise awareness of local green spaces such as parks and nature reserves and to provide wellbeing activities in such locations.

11.0 **RISK ANALYSIS**

11.1 The CWP initiative has become a key conduit in linking community based provision with health and social care services. It plays a key role in integrating provision across a wide range of sectors. The loss of the CWP service may have a knock on effect on the demand for primary care services.

12.0 **EQUALITY AND DIVERSITY ISSUES**

12.1 The service is compliant with Equality and Diversity legislation.

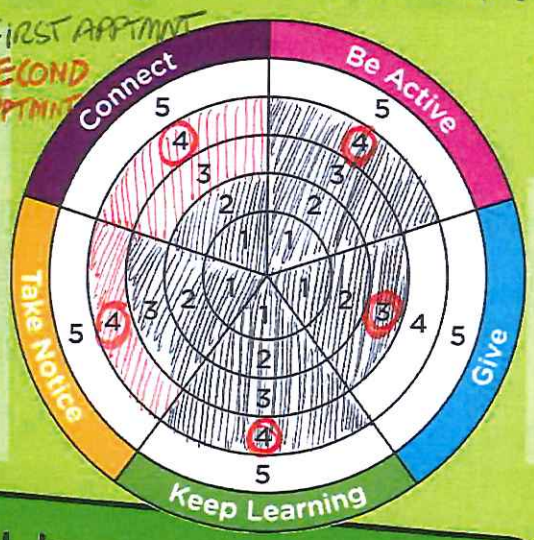
13.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None.

# Wellbeing Review Follow-Up

Please use this sheet to record the progress you have made since your first Wellbeing Review. You can also make a list of the things that help to keep you well.

**1.** Using the wheel on the right, mark your original wellbeing scores in one colour and your follow-up wellbeing score from today in another colour to show your progress.




## 2. What I have achieved

Since my first Wellbeing Review I have...

- ARRANGED A MANAGEABLE REPAYMENT FOR GAS BILL
- JOINED A [redacted] GROUP AND RELATIONSHIP WITH [redacted] IS MUCH BETTER
- MET NEW MUMS AT THE CHILDRENS CENTRES
- BAKED A CAKE FOR MY NEIGHBOURS

## 3. What keeps me well?

Make a list of people, places or organisations that may help you to improve your wellbeing:

Skills that I have...

- GOOD MUM
- COOKING
- CLEANING
- PEOPLE SKILLS

Places to go...

- [redacted] GROUP
- [redacted] CHILDRENS CENTRES
- NEIGHBOURS
-

People that I know...

- [redacted]
- SISTER IN LAW
- FRIEND IN [redacted]
- NEIGHBOURS

Organisations to help me...

- UMBRELLA ([redacted] GROUP)
- HALTON COUNCIL
- CAB
- WELLBEING ENTERPRISES

Wellbeing Enterprises CIC – delivering sustainable improvements in health and wellbeing
t: 01928 589799 | e: info@wellbeingenterprises.org.uk | w: www.wellbeingenterprises.org.uk

** The Five Ways to Wellbeing source: nef (New Economics Foundation)*

wellbeing enterprises

# Your Wellbeing Review

Your Community Wellbeing Officer will help you to complete this review. Please keep this sheet as a record of the activities you will carry out to improve your wellbeing.

## The Five Ways to Wellbeing*

| | Current rating (1-5) | My wellbeing pledge is to... | Completed? ✓/× |
|---|---|---|---|
| Connect | 2 | • MEET OTHER MUMS THROUGH THE CHILDRENS CENTRES<br>• FIND AN [redacted] SUPPORT GROUP | ✓ |
| Be Active | 4 | • TO DANCE WITH MY CHILDREN AT A DANCING CLASS | ✓ |
| Take Notice | 3 | • TO TAKE MORE NOTICE OF WHAT'S ON OFFER IN THE LOCAL AREA | ✓ |
| Keep Learning | 4 | • FIND AN ENGLISH COURSE (WITH CRECHE FACILITIES) TO DEVELOP READING AND WRITING SKILLS | |
| Give | 3 | • MEET MY NEIGHBOURS AND DO SOMETHING NICE FOR THEM (MAKE A CAKE) | ✓ |

## Overcoming challenges

Challenges identified:

- SORT OUT DEBT WITH [redacted] GAS
- RELATIONSHIP WITH [redacted]
- NEW TO THE AREA

Next steps and key contacts that can help:

- BOOK APPOINTMENT WITH CAB (0151 257 2449)
- CONTACT WELFARE RIGHTS (0151 511 8930) FOR BENEFITS SUPPORT
- CONTACT [redacted] CHILDRENS CENTRE FOR MUMS GROUP (0151 257 2450)

## What skills/resources do I have to help?

- I'M A GOOD MUM
- I'M A GOOD COOK AND I CAN LOOK AFTER MY HOUSE WELL
- GOOD PEOPLE SKILLS (WORKED IN A SHOP BEFORE).

Wellbeing Enterprises CIC – delivering sustainable improvements in health and wellbeing
t: 01928 589799 | e: info@wellbeingenterprises.org.uk | w: www.wellbeingenterprises.org.uk

** The Five Ways to Wellbeing source: nef (New Economics Foundation)*

wellbeing enterprises

# Wellbeing Enterprises CIC
# Runcorn 'Ways to Wellbeing' programme of activities: July to September 2014

Here's a list of all of our social prescribing activities running in the next three months. For further information or to book a place on any course or event please call the Wellbeing Enterprises team on 01928 589799, email info@wellbeingenterprises.org.uk or book online via www.wellbeingenterprises.org.uk

| Course / Event | Venue | Starts | Length & cost |
|---|---|---|---|
| **Strictly Come Wellbeing**<br>Learn a variety of dancing styles - find out how dancing can boost your wellbeing – no previous experience required. | Brookvale Community Centre, WA7 6PE | Tuesday 1st July<br>6.00pm – 8.00pm | 6 weeks - FREE |
| **Actiphons**<br>Bring your children to learn phonics through fun physical games to improve their speaking and listening skills (suitable for children aged 3-5 years) | Palacefields Community Centre, WA7 2UA | Tuesday 22nd July<br>11.30am – 12.30pm | 6 weeks – FREE |
| **My Forest School**<br>Spend time in the great outdoors with this FREE four week course! For parents and their children. | Phoenix Park, WA7 2NY | Monday 28th July<br>10.00am – 12.00pm | 4 weeks - FREE |
| **Jewellery making**<br>Learn simple jewellery and bead craft techniques and create your own unique piece of jewellery. No previous experience required and all materials provided. | Murdishaw Community Centre, WA7 6JW | Monday 4th August<br>10.30am - 12.00pm | 4 weeks - FREE |
| **Mindfulness**<br>Discover the power of Mindfulness to boost wellbeing and reconnect with your life through your senses | Churchill Hall, WA7 1DH | Tuesday 5th August<br>1.30pm - 3.00pm | 6 weeks - FREE |

| | | | |
|---|---|---|---|
| **Astronomy for Men**<br>Ever wondered what's up there in the sky or how a telescope works? Join our beginners course and learn basic astronomy knowledge! | Knowledge Observatory – Wigg Island, WA7 1PJ | Thursday 7th August<br>7.00pm – 9.00pm | 6 weeks - FREE |
| **'Stress Less' programme**<br>Take part in a fun and creative course to learn top-tips to combat stress in your life. | Grangeway Community Centre, WA7 5HA | Wednesday 20th August<br>1.00pm – 3.00pm | 6 weeks - FREE |
| **Living Life to the Full**<br>Find out how you can change your life in just 12 hours – tackle everyday problems and boost your wellbeing | Palacefields Community Centre, WA7 2UA<br><br>The Brindley Arts Centre, WA7 1BG | Wednesday 16th July<br>11.00am - 12.30pm<br><br>Monday 21st July<br>6.00pm - 7.30pm | 6 weeks - FREE |
| **Nordic walking**<br>Learn how to Nordic walk with a FREE four week course and turn every walk in to a workout! No equipment needed. Different levels available. | For course times and venues please contact the Nordic Walking tutor Elizabeth Kerley on 078 030 373 32. | | 4 weeks - FREE |
| **WOW Event**<br>Find out how wonderful and talented you really are and take away with you a route map to your future success! | St Andrew's Church, Grange, WA7 5JZ | Tuesday 29th July<br>6.00pm – 8.30pm | 6 weeks - FREE |

# Wellbeing Enterprises CIC
# Widnes 'Ways to Wellbeing' programme of activities: July to September 2014

Here's a list of all of our social prescribing activities running in the next three months. For further information or to book a place on any course or event please call the Wellbeing Enterprises team on 01928 589799, email info@wellbeingenterprises.org.uk or book online via www.wellbeingenterprises.org.uk

| Course / Event | Venue | Starts | Length & cost |
|---|---|---|---|
| **Actiphons**<br>Bring your children to learn phonics through fun physical games to improve their speaking and listening skills (suitable for children aged 3-5 years) | St Paul's Church (Victoria Square), WA8 7QU | Wednesday 23rd July<br>2.00pm – 3.00pm | 6 weeks – FREE |
| **My Forest School**<br>Spend time in the great outdoors with this FREE four week course! For parents and their children. | Meeting at Pickerings Pasture Visitors Centre, WA8 8LP | Monday 28th July<br>1.00pm – 3.00pm | 4 weeks - FREE |
| **Mindfulness**<br>Discover the power of Mindfulness to boost wellbeing and reconnect with your life through your senses | Beaconsfield Health Centre, WA8 6TR | Wednesday 30th July<br>3.30pm-5.00pm | 6 weeks - FREE |
| **Jewellery making**<br>Learn simple jewellery and bead craft techniques and create your own unique piece of jewellery. No previous experience required and all materials provided. | Upton Community Centre, WA8 4PF | Monday 4th August<br>1.30pm – 3.00pm | 4 weeks - FREE |
| **Astronomy for Men**<br>Ever wondered what's up there in the sky or how a telescope works? Join our beginners course and learn basic astronomy knowledge! | Pex Hill Observatory, WA8 5QW | Tuesday 12th August<br>7.00pm – 8.30pm | 6 weeks - FREE |

| | | | |
|---|---|---|---|
| **Living Life to the Full**<br>Find out how you can change your life in just 12 hours – tackle everyday problems and boost your wellbeing | Peelhouse Medical Plaza, WA8 6TN<br><br>Upton Community Centre, WA8 4PF | Friday 4th July<br>10.30am - 12.00pm<br><br>Thursday 7th Aug<br>6.00 pm-7.30pm | 8 weeks - FREE |
| **Strictly Come Wellbeing**<br>Learn a variety of dancing styles - find out how dancing can boost your wellbeing – no previous experience required. | Ditton Community Centre, WA8 8DF | Tuesday 26th August<br>11.00 – 12.30pm | 6 weeks - FREE |
| **Nordic walking**<br>Learn how to Nordic walk with a FREE four week course and turn every walk in to a workout! No equipment needed. Different levels available. | For course times and venues please contact the Nordic Walking tutor Elizabeth Kerley on 078 030 373 32. | | 4 weeks - FREE |
| **WOW Event**<br>Find out how wonderful and talented you really are and take away with you a route map to your future success! | CRMZ (next to Kingsway Leisure Centre), WA8 7QE | Monday 28th July<br>10.00 – 12.30pm | 6 weeks - FREE |

Halton community wellbeing practices

# CWP Impact Report

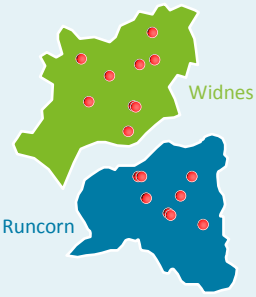
## October '12 - July '14

**A summary of some key outcomes and achievements from the Community Wellbeing Practices initiative over the last 21 months.**

wellbeing enterprises

Halton Clinical Commissioning Group

HALTON BOROUGH COUNCIL




Working with all

**17**

GP Practices in the Halton borough

**8,203**

patient interventions

Collaborated with over

**120**

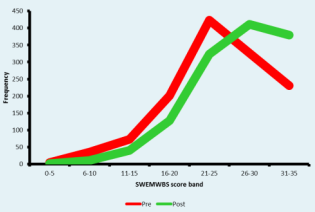
partner organisations and groups in the borough

- 85% of patients rated their experience as 8/10 or more
- 78% of patients feel confident to identify the signs and symptoms of common mental health problems
- 41% of patients feel more relaxed
- 97% of patients have implemented positive behaviour change

**2,239**

wellbeing pledges completed, including:

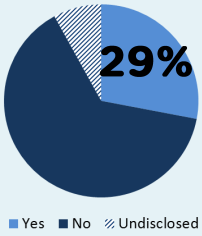
- 54 new dancers
- 180 reconnected with friends
- 40 people started volunteering
- 63 people stepped out in to a park




Shifting the population's wellbeing level

Post-intervention:

- **64%** of patients improved their wellbeing levels
- Patients reported a **52%** reduction in depression symptoms
- **76%** of Wellbeing Review attendees improved their wellbeing levels




Disability status of participants

Wellbeing volunteers trained, donating 141 hours of time to help others


Asset based community projects delivered with 564 people, including:


**Appleton practice makeover**
**Brookvale community garden**
**Fruit on Prescription**

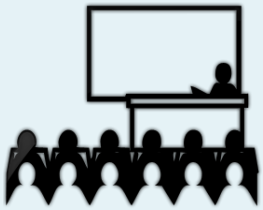
**8**

GP led wellbeing projects, including:

**Tai Chi**
**Nordic Walking**
**Dementia Passport**
**Tango on Prescription**

**155**

Clinicians and practice staff trained up in wellbeing brief interventions



**25**

community events delivered to 922 people, including:

**WOW event**
**'Ignite your Life!'**
**Music and Memories**

**89**

Social prescribing groups delivered to 1,258 people, including:

**Mindfulness**
**Spanish lessons**
**Ukulele on Prescription**

**245**

Number of people who undertook training based on cognitive behavioural approaches...and they all received a banana!

# Partnership project case studies

We worked with the Practice Manager and Clinicians from Grove House Practice to pull together a steering group to help design and launch the 'Purple Book' initiative, assisting people with memory problems to help maintain their independence. Partner organisations included the Alzheimer's Society, Halton Carers Centre, Age UK Mid Mersey, Later Life & Memory Service, Sure Start to Later Life, Halton Adult Placement Service, Home Instead Senior Care and Halton Speak Out. The initiative has been piloted to 30 Grove House patients, with the intention of rolling it out across the borough.

To assist Murdishaw Health Centre in creating a community garden, we coordinated a partnership group involving practice patients, Clinicians, PPG members, Liverpool Housing Trust, Jigsaw Housing, Groundwork Cheshire and Liberty Gas - all of whom shared their knowledge and resources to transform a barren courtyard in to a flourishing community garden for patients and local schools to enjoy. So far, children from Gorsewood Primary School, Murdishaw West Community Primary School and St Martin's Catholic Primary School have all used the community garden to learn about healthy eating and to plant their own fruit and vegetables.

# Patient case studies

Clive was referred to his Community Wellbeing Officer from a multi-disciplinary team meeting as he was living with a long-term respiratory condition and was also isolated from his local community. We helped Clive to contact relevant local agencies to repair damage within his home that was exacerbating his condition, "I feel a lot more optimistic about the future and that there is somebody to help me work through my problems. I'm now looking to volunteer to be able to give back to other people."

Dawn was referred to her Community Wellbeing Officer by her GP, after she reported that she was feeling low and her mood was preventing her from doing day to day activities. During a one-to-one Wellbeing Review, we helped Dawn to improve her wellbeing by sharing with her problem solving techniques and setting pledges around the Five Ways to Wellbeing, "I have learnt how to break my problems down in to small chunks and not to always dwell on the negatives. I have also tried some new activities and I have enjoyed meeting new people and making some new friends."

# What GPs say

"The Community Wellbeing Practices initiative has provided me with extra tools to be able to help my patients, by taking in to account the social factors that affect a patient's health. These tools have helped me to explore an alternative dimension of a patient's life that complements the traditional medical model."
Dr Lyon, Castlefields Health Centre

"The Community Wellbeing Practice initiative helps me to offer an alternative approach to helping patients. Having conversations with patients about accessing activity groups has given me a greater depth to my understanding of patients - my conversations now are completely different, and you can see how patients have grown."
Dr Burke, Appleton Village Surgery

"Our Community Wellbeing Officer helped to recruit volunteers and partners to completely transform an area of flagging to an amazing community space for the whole community to enjoy - every patient I see in my practice has commented positively on it!"
Dr O'Hare, Murdishaw Health Centre

**REPORT TO:** Health Policy and Performance Board

**DATE:** 9th September 2014

**REPORTING OFFICER:** Director of Public Health

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Halton Respiratory Health Profile 2014

**WARDS:** Borough wide

## 1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Policy and Performance Board with information relating to Halton's Respiratory Health Profile 2014 and provide analysis regarding the findings from a local perspective.

## 2.0 RECOMMENDATION: That the Board

1. **note the contents of the report and note programmes to address areas of concern; and**

2. **feedback comments to the Director of Public Health.**

## 3.0 SUPPORTING INFORMATION

3.1 The Joint Strategic Needs Assessment (JSNA) includes information about Chronic Obstructive Pulmonary Disease (COPD). The recently published Children's JSNA includes information on asthma. However, the development of the Halton Respiratory Group required a new piece of analysis which pulled together data on a range of respiratory conditions. It is designed to help local government and health service partners to understand their community's needs, so that they can work to improve people's respiratory health and reduce health inequalities associated with it. COPD is not curable so the group needed to look at measures to prevent people developing the condition as well as to identify and manage those who do develop COPD and other respiratory conditions early. Levels and patterns of hospital admissions as well as death rates also help to paint a picture of the population's experience of living with the respiratory disease.

3.2 The Halton Respiratory Health Profile 2014 shows that for both COPD and asthma the proportion of Halton's population who have these conditions is higher than the England average. Some of this may be accounted for by local efforts to increase case finding. However, as the borough has high levels of deprivation and many respiratory diseases are linked to this, it is likely Halton does have higher levels than the national average. Throughout the profile traffic-light analysis against both borough averages and, where available, North/North West and England averages has been undertaken.

This enables us to assess where outcomes (such as hospital admissions) may be better than the average as green, those similar to the average as amber and those performing worse than the average as red.

3.3 Halton's profile can be seen in the Appendix which shows that there is a mixed picture. Levels of disease are thought to be higher than the England average but once people have been diagnosed the majority are managed in line with the best clinical evidence. However, high levels of emergency (unplanned) hospital admissions continue to place a significant burden on the local population and healthcare system.

3.4 Key Headlines:

3.4.1 The data for Halton shows that:

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as many as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between our estimated number of people with COPD and those of GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- The management of patients with COPD and asthma are similar or slightly better than the North West and England averages
- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West. COPD is also a significant cause of excess winter deaths.

3.5 **Programmes to address areas of concern**

3.5.1 The progression of chronic respiratory diseases is influenced by the disease management the individual receives in primary care as well as their lifestyles and social factors such as warm homes/fuel poverty and deprivation.

3.5.2 There have been significant efforts over the last few years to case find those who have COPD. This has been successful and many GP practices now have similar levels of patients diagnosed as we think exist within their registered patient list. This means people can be managed, reducing flare ups of their condition and reduce the need for hospital care. It also helps people feel in control of their condition.

3.5.3 People who have COPD are offered the NHS influenza vaccination each year irrespective of age. The majority of people do take this offer up and the percentage of people who do has increased in recent years. At 89.8%,

uptake is slightly lower than comparators which are all just over 92%.

3.5.4 Smoking is the most significant factor in the likelihood of a person developing COPD. It can also influence how rapidly the disease worsens. Halton's Stop Smoking Service has helped thousands of people to quit smoking. The proportion of Halton adults who do smoke has been falling. Although the levels remain above the North West and England averages the trend is consistent and encouraging. However, certain groups within our community are more likely to smoke and this is heavily linked to levels of deprivation. Patients with COPD and other respiratory conditions who smoke are targeted and offered support to quit.

3.5.5 As well as ward and GP practice level variation, hospital admissions for COPD and pneumonia are also associated with temperature. As outside temperatures fall during the winter months admission rates rise. This can also result in deaths and COPD is a key cause on excess winter deaths. Although the level of excess winter deaths in Halton is slightly better than the England average, the country has higher levels than seen in much colder countries. Efforts to reduce fuel poverty and damp housing are key ways of addressing this.

## 4.0 POLICY IMPLICATIONS

The Halton Respiratory Health Profile 2014highlights a number of key health issues for Halton. A whole-systems Respiratory Strategy is in development, looking at actions from prevention through primary care management to specialist treatment and care, including end-of-life care.

## 5.0 FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications as a result of this report. Actions identified within the Respiratory Strategy and associated strategies however, may have implications that will be reported to the relevant boards as they arise.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

Improving the Health of Children and Young People, such as continued efforts to ensure less and less young people start to smoke, will be a key priority in Respiratory Strategy whilst 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 respiratory health of Halton residents.

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**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and should, therefore, be a key consideration when developing strategies that examine the wider determinants of health and wellbeing. For respiratory health, issues around housing conditions such as damp housing and fuel poverty are important interventions to reduce increased hospital admissions during the winter months and excess winter deaths.

7.0 **RISK ANALYSIS**

7.1 Developing strategies to address the issues outlined by Halton Respiratory Health Profile 2014 in itself does not present a risk. However, there may be risks associated with the recommended actions. These will be assessed as appropriate. There are no financial risks associated directly with this report. The recommendations are not so significant that they require a full risk assessment.

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** |
|---|---|---|
| Halton Respiratory Health Profile 2014 | Halton Council Website | Sharon McAteer Public Health |

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NHS Halton Clinical Commissioning Group

# Health Profile 2014

# Respiratory Health in Halton

The term respiratory disease covers a range of conditions, but the key areas for the JSNA are:

- Asthma
- Bronchitis, emphysema, and other COPD
- Pneumonia

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer.

There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole, and historically, COPD detection rates have been lower in these more deprived areas.

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking.

## Headline Facts

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between the modeled estimated number of people with COPD and those of GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- The management of patients with COPD and asthma are similar to the North West and England averages
- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

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## Future Estimates

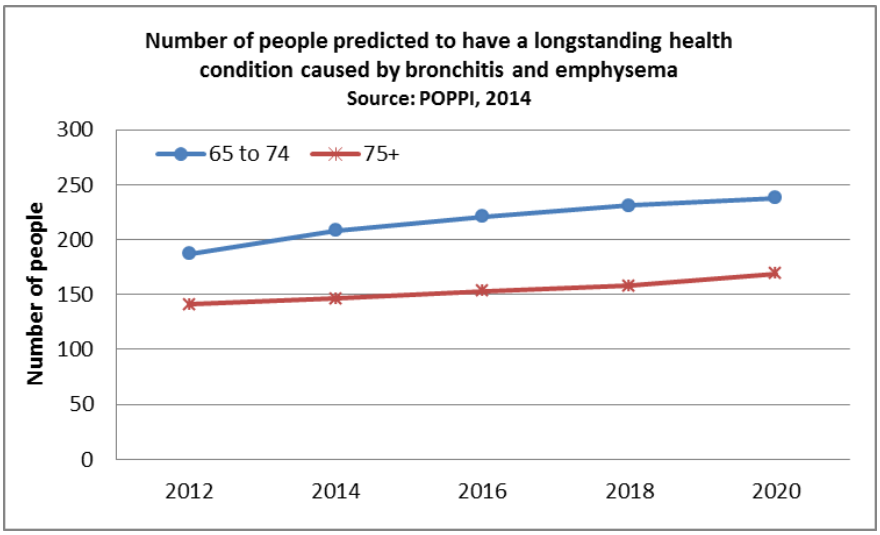
**Modelled estimates of prevalence of COPD, numbers and prevalence (person aged 16+)**

| Halton | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Persons 16+ | | 16-44 | | 45-64 | | 65-74 | | 75+ | |
| | Number | Prevalence | Number | Prevalence | Number | Prevalence | Number | Prevalence | Number | Prevalence |
| 2010 | 3916 | 4.0% | 678 | 1.5% | 1614 | 4.9% | 888 | 9.0% | 737 | 9.8% |
| 2015 | 4168 | 4.2% | 651 | 1.4% | 1592 | 4.8% | 1095 | 9.0% | 829 | 10.0% |
| 2020 | 4420 | 4.4% | 644 | 1.5% | 1611 | 4.9% | 1216 | 8.9% | 950 | 10.1% |

Source: Association of Public Health Observatories

In Halton it is estimated that 3,916 residents over the age of 16 had COPD as of 2010, rising to 4,420 by 2020. The biggest increase is predicted to be in the 65 plus age group.

Estimations have also been calculated for the number of people predicted to have a longstanding health condition caused by bronchitis and emphysema. It was estimated that 328 people over the age of 65 were affected by this in 2012, and that the number will rise to 406 by 2020.



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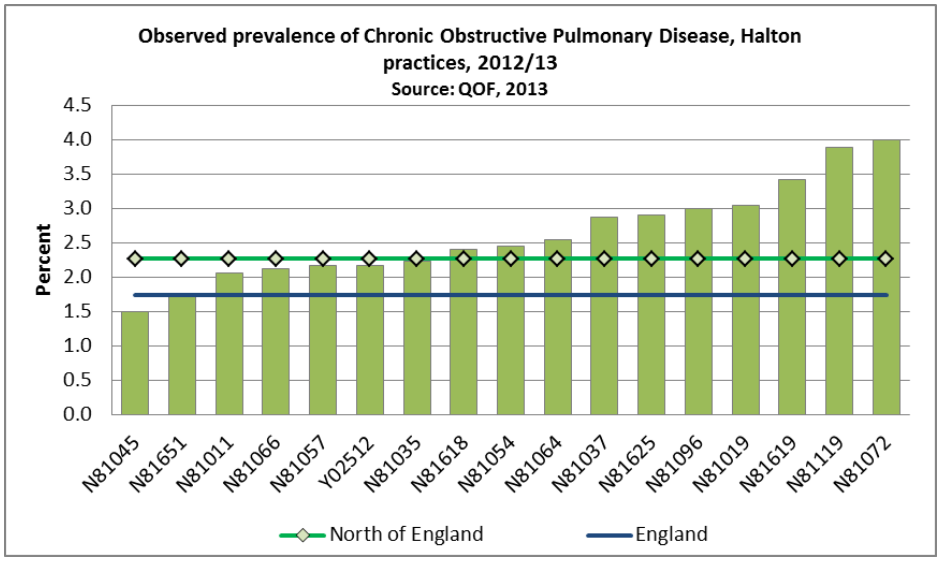
# Diagnosing Respiratory Disease in GP Practices

The GP contract includes the requirement for practices to establish a disease register for people with COPD and asthma.For the breakdown of all diseases included the GP contract (QOF data), as well as previous years data for Halton, please visit: http://www.gpcontract.co.uk/browse/01F/13.

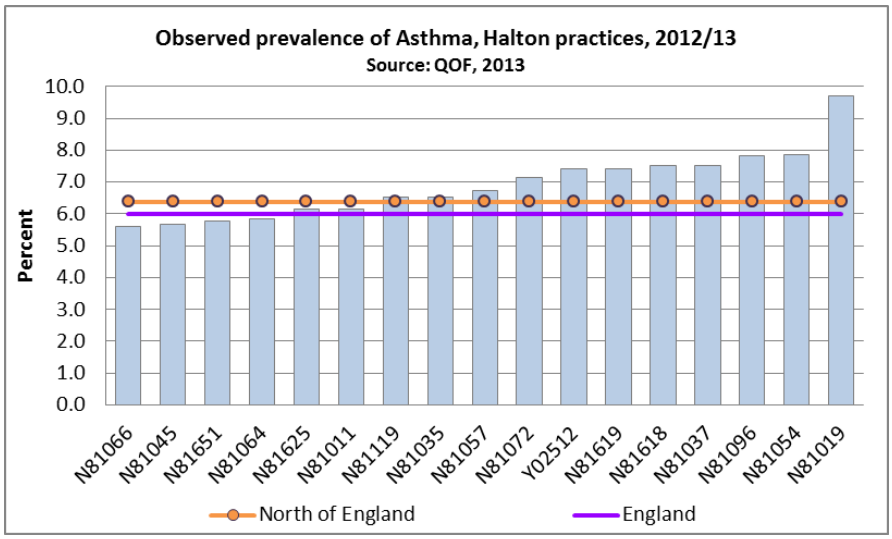
| | COPD Prevalence |
|---|---|
| Halton CCG | 2.5% |
| Merseyside Area Team | 2.8% |
| North of England | 2.3% |
| England | 1.7% |

QOF data for 2012/13 indicates that 3,210 patients who are registered at GP practices in Halton have COPD, which is 2.5% of the registered population. Seven out of the 17 practices in Halton have an observed prevalence above the CCG average and all but 2 are above the England average.




For 2012/13, the QOF data indicates that 8,886 people are registered as having asthma within the 17 GP practices in Halton. This means that 6.9% of the registered population have been diagnosed as having asthma. Eight of the 17 practices have an observed prevalence above the CCG average and 13 above the England average.

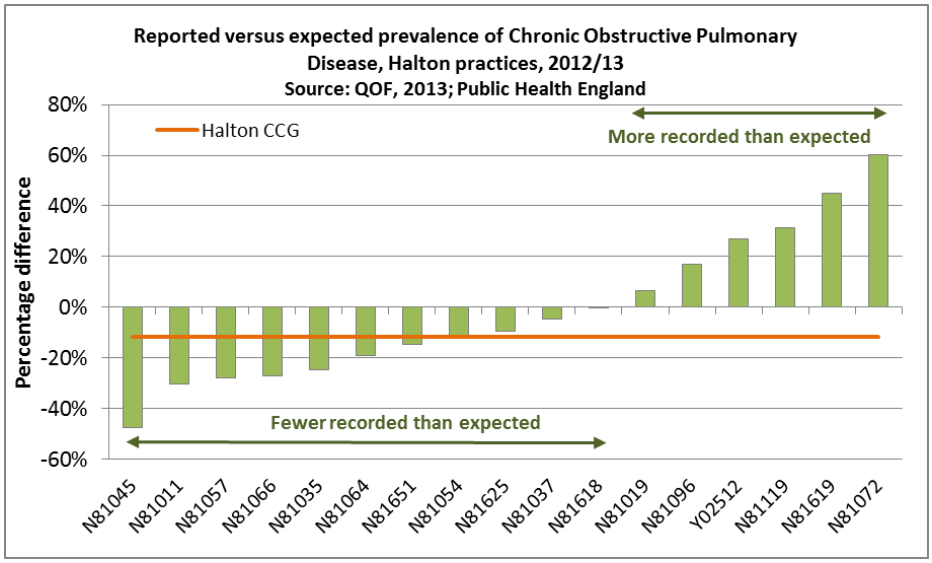
| | Asthma Prevalence |
|---|---|
| Halton CCG | 6.9% |
| Merseyside Area Team | 6.2% |
| North of England | 6.4% |
| England | 6.0% |




## Observed Against Expected Prevalence (COPD)

It has been estimated that there are many more patients with COPD who have not been diagnosed. To try to determine the total prevalence of disease a model has been developed by the Association of Public Health Observatories (APHO). It has used national prevalence findings from the Health Survey for England weighting prevalence rates in each area according to population structure and smoking status.

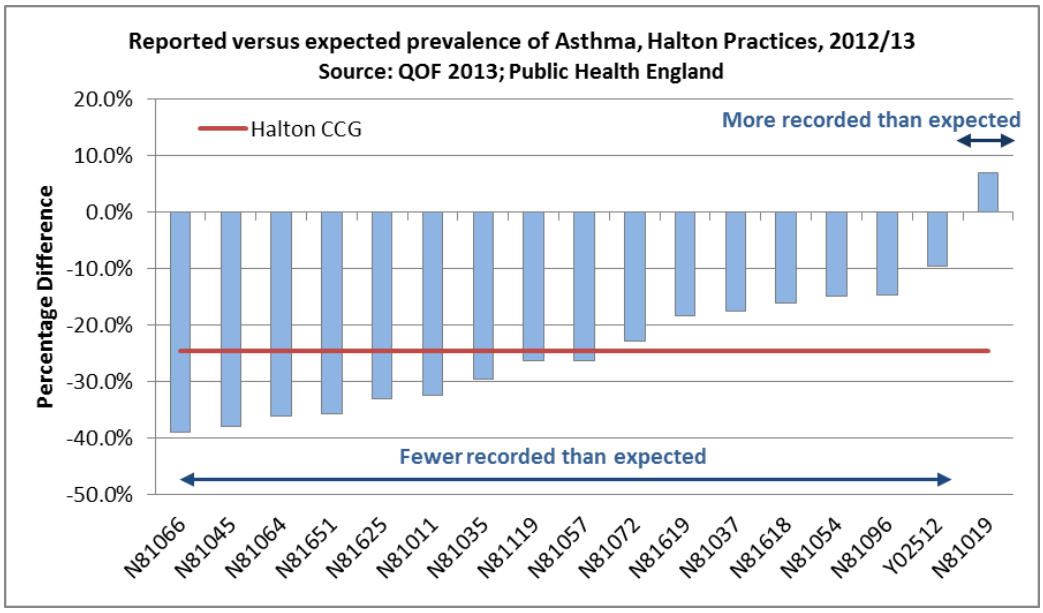
By applying the same age-specific prevalence rates as used in the APHO estimates to GP populations, they have estimated the estimated numbers of people with COPD per practice. Although most practices in both boroughs have less people registered as having COPD than the model estimates there has been considerable improvement since the analysis was run using 2009/10 QOF data.



Ten out of the 17 practices in Halton had fewer recorded patients with COPD than was expected. However, there were 6 practices that had more patients registered as having COPD than were expected and one practice which the expected number diagnosed.

## Observed Against Expected Prevalence (Asthma)

Expected Prevalence of asthma calculated using national age / sex specific rates from the Doncaster model applied to GP practice list size data by age and sex.




Only one practice, out of the 17 in Halton, had more than the expected number of patients registered as having asthma. The remaining 16 practices had a range of 9.6% to 39% fewer recorded patients that was expected.

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# GP Management of people with COPD and Asthma

The GP contract requires practices to manage patients in line with best practice. For COPD this relates to diagnosis, recording of FEV1 (maximal amount of air you can forcefully exhale in one second), influenza vaccination and an assessment of the level of breathlessness a patient is experiencing.

**Achievement against COPD clinical indicators, 2012/13**

| Practice Code | Practice Name | COPD08 | COPD10 | COPD13 | COPD15 |
|---|---|---|---|---|---|
| N81011 | Beaconsfield | 96.9% | 89.4% | 92.1% | 100.0% |
| N81019 | Castlefields | 96.6% | 87.6% | 96.4% | 97.2% |
| N81035 | Appleton Village | 88.9% | 80.5% | 97.0% | 97.2% |
| N81037 | Beeches | 97.1% | 85.0% | 90.8% | 90.0% |
| N81045 | Peelhouse | 93.0% | 90.0% | 91.3% | 86.2% |
| N81054 | Weaver Vale | 87.4% | 95.1% | 93.3% | 90.0% |
| N81057 | Tower House | 97.4% | 98.4% | 98.6% | 100.0% |
| N81064 | Newtown | 31.9% | 88.1% | 96.0% | 91.7% |
| N81066 | Grove House | 90.6% | 93.2% | 91.1% | 87.5% |
| N81072 | Murdishaw | 94.0% | 89.1% | 97.4% | 98.8% |
| N81096 | Brookvale | 96.3% | 80.9% | 90.1% | 90.9% |
| N81119 | Hough Green | 81.5% | 93.9% | 94.6% | 88.9% |
| N81618 | Heath Road | 92.7% | 95.1% | 95.0% | 88.9% |
| N81619 | Oaks Place | 94.9% | 94.0% | 92.0% | 85.7% |
| N81625 | West Bank | 94.5% | 95.6% | 97.1% | 85.7% |
| N81651 | Upton Rocks | 97.6% | 92.7% | 93.0% | 83.3% |
| Y02512 | Windmill Hill | 85.7% | 87.5% | 92.5% | 100.0% |
| **Halton CCG** | | **89.8%** | **89.4%** | **94.2%** | **93.6%** |
| **Merseyside Area Team** | | **92.4%** | **82.8%** | **91.0%** | **92.0%** |
| **North of England** | | **92.7%** | **87.9%** | **91.1%** | **91.3%** |
| **England** | | **92.7%** | **88.4%** | **91.1%** | **91.3%** |

| |
|---|
| **COPD08:** The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March |
| **COPD10:** The percentage of patients with COPD with a record of FEV1 in the preceding 15 months |
| **COPD13:** The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months |
| **COPD15:** The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry |

For asthma, the management required in the GP contract relates to diagnosis, assessment of control and smoking status in young people.

**Achievement against asthma clinical indicators, 2012/13**

| Practice Code | Practice Name | ASTHMA08 | ASTHMA09 | ASTHMA10 |
|---|---|---|---|---|
| N81011 | Beaconsfield | 82.6% | 79.3% | 85.1% |
| N81019 | Castlefields | 95.9% | 73.4% | 87.5% |
| N81035 | Appleton Village | 83.1% | 71.1% | 100.0% |
| N81037 | Beeches | 85.5% | 62.3% | 75.6% |
| N81045 | Peelhouse | 89.0% | 78.9% | 89.4% |
| N81054 | Weaver Vale | 94.9% | 81.9% | 86.8% |
| N81057 | Tower House | 97.5% | 90.7% | 95.7% |
| N81064 | Newtown | 82.2% | 78.0% | 88.5% |
| N81066 | Grove House | 95.6% | 74.5% | 85.5% |
| N81072 | Murdishaw | 94.4% | 77.2% | 87.5% |
| N81096 | Brookvale | 81.9% | 76.7% | 87.5% |
| N81119 | Hough Green | 98.1% | 74.2% | 100.0% |
| N81618 | Heath Road | 91.9% | 62.1% | 100.0% |
| N81619 | Oaks Place | 94.0% | 75.0% | 90.0% |
| N81625 | West Bank | 91.4% | 89.4% | 84.6% |
| N81651 | Upton Rocks | 82.8% | 78.3% | 100.0% |
| Y02512 | Windmill Hill | 87.5% | 77.9% | 83.3% |
| **Halton CCG** | | **90.5%** | **76.1%** | **88.9%** |
| **Merseyside Area Team** | | **87.4%** | **76.4%** | **90.6%** |
| **North of England** | | **87.8%** | **75.4%** | **89.6%** |
| **England** | | **87.6%** | **74.8%** | **89.3%** |

| |
|---|
| **ASTHMA08:** The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility |
| **ASTHMA09:** The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions |
| **ASTHMA10:** The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months |

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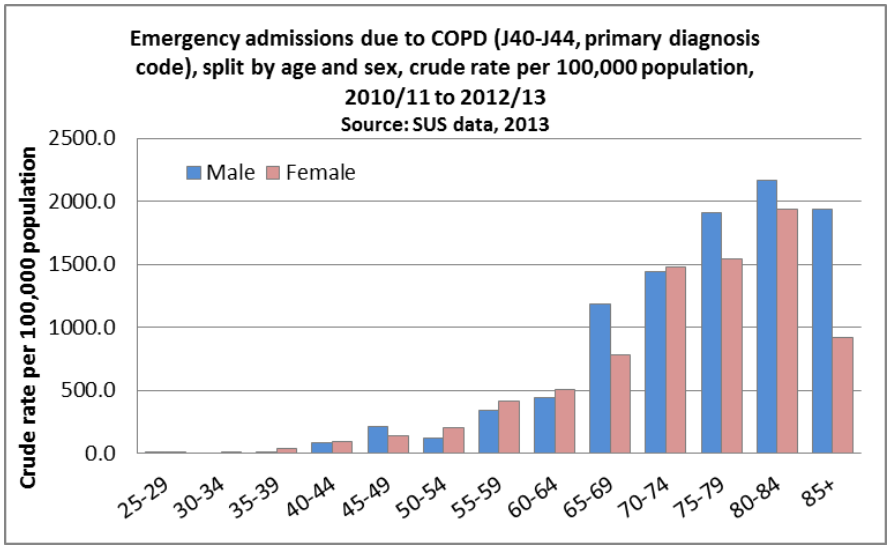
## Hospital Admissions due to COPD

COPD is a rare condition before the age of 40. Most people who develop the condition are managed within primary care. As previous data in this profile has shown the vast majority of patients are managed within evidence-based national standards of practice.

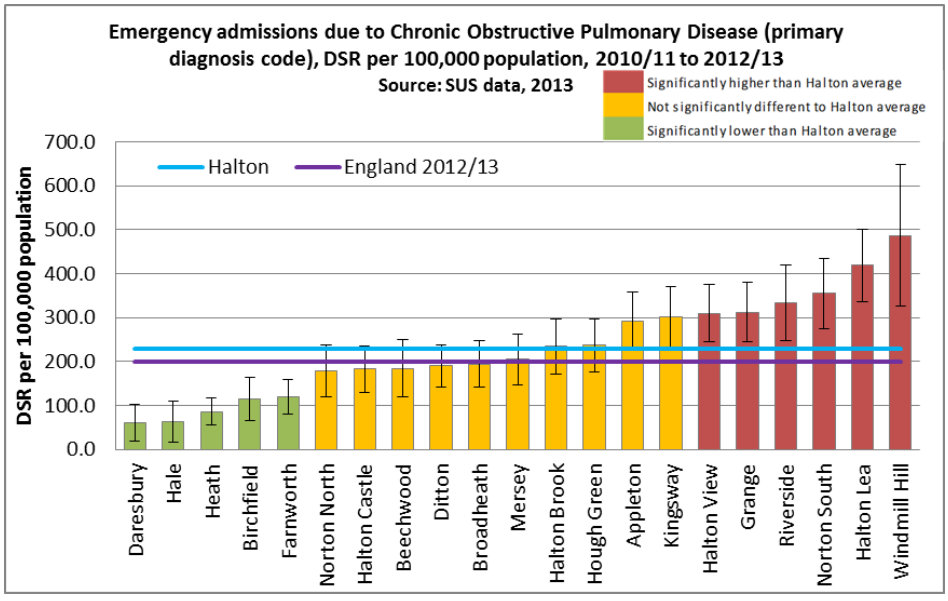
However, for some, they will develop exacerbations of the condition or they may be undiagnosed. This can result in an emergency (unplanned) admission to hospital.




As the data for 2010/11 to 2012/13 shows, admissions rise from age 45 onwards for both males and females with admissions generally being higher for males than females.

Small numbers at ward level means, for most of the analysis in this profile, having to combine multiple years' worth of data to achieve statistically robust analysis.

Six Halton wards had a statistically significantly higher admission rate compared to the borough average during 2010/11 to 2012/13.



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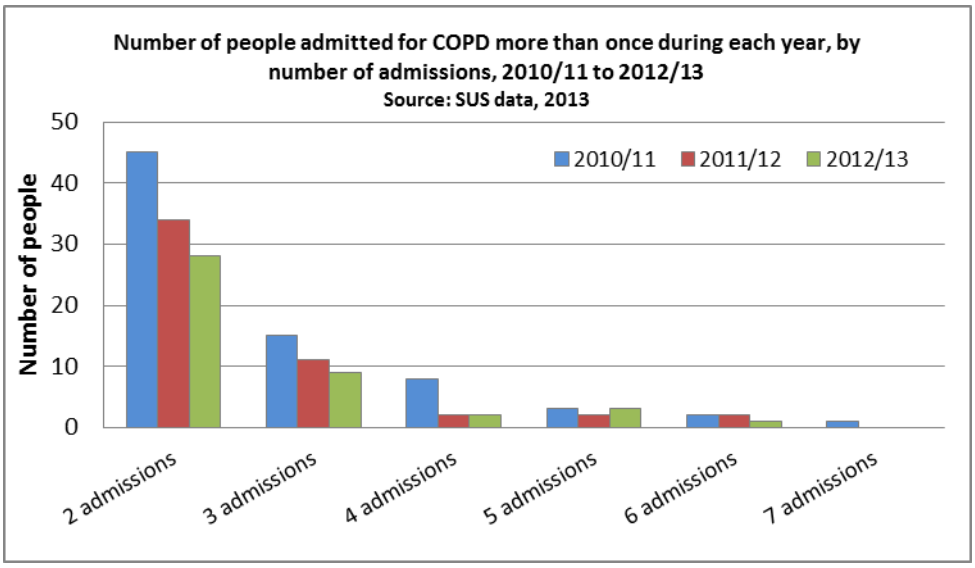
# 'Frequent Flyer' admissions for COPD

Research suggests that there are nearly half a million 'frequent flyers' in the United Kingdom and that they cost the health service approximately £2.3 billion a year (2003-4 figures). These tend to be ambulatory care sensitive (ACS) conditions – such as chronic obstructive pulmonary disease (COPD), asthma and heart failure. 'Frequent flyers' is the term used to describe patients who regularly admitted to hospital. The report does not suggest that the unplanned hospital admissions are unnecessary, but that further research could avoid patient stays in hospital and the costs.

***This analysis used the definition of a frequent user, as a patient who is admitted as an emergency into hospital more than once in a financial year.***



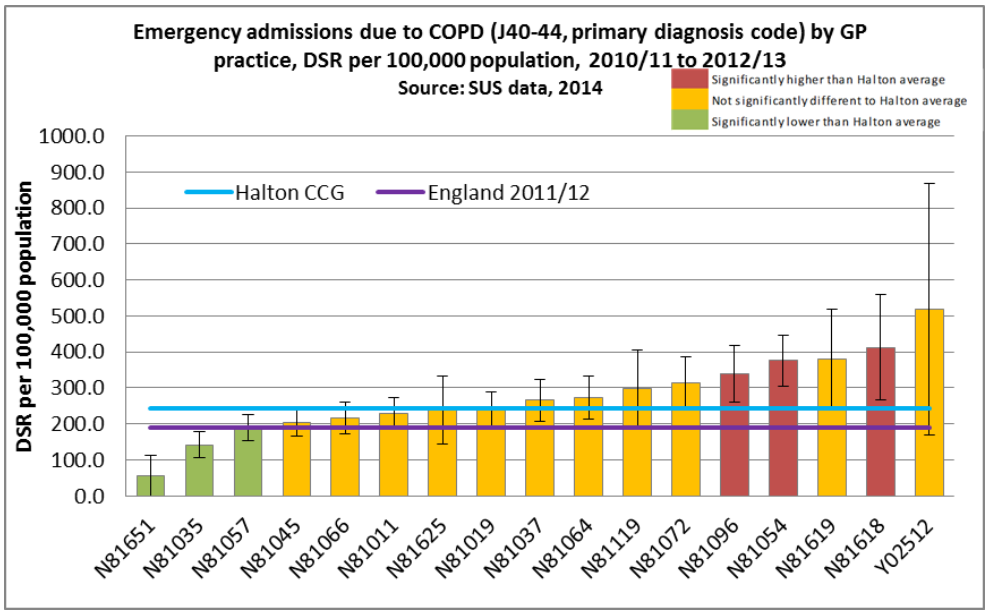

Local analysis shows that most people admitted on more than one occasion are admitted twice or three times during the financial year.

During 2012/13 there were over 100 readmissions due to COPD, however, the number,and percentage of total COPD admissions, has decreased from 2010/11

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| Total number of admissions | 452 | 331 | 358 |
| Number of readmissions | 201 | 131 | 112 |
| Percent | 44.5% | 39.6% | 31.3% |

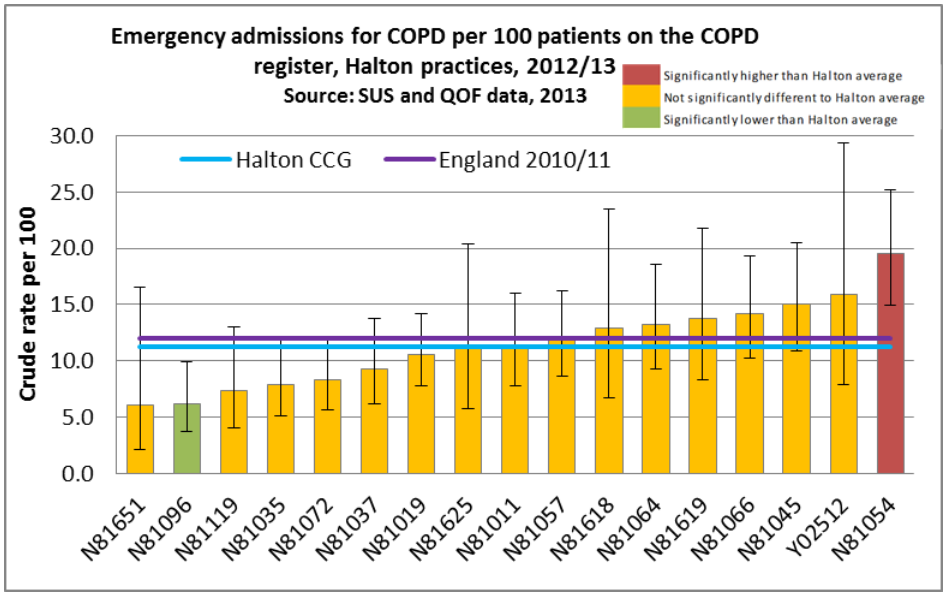
## GP Practice Level Hospital Admissions for COPD

Earlier in this profile emergency admission rates were calculated at ward level, however, it is also useful to calculate the rates at GP practice level. This data can be used to see how well each practice is managing their registered patients who have COPD.




The data for 2010/11 to 2012/13 shows that 3 practices had a rate which was statistically significantly higher than the borough rate. However, there were also 3 practices that had a significantly lower rate than the Halton average. The Halton rate was also higher than the England rate for 2011/12.

When comparing emergency hospital admissions to the number of people on the COPD register, for each practice during 2012/13, the data shows that only one practice had a significantly higher admission rate compared to the borough.



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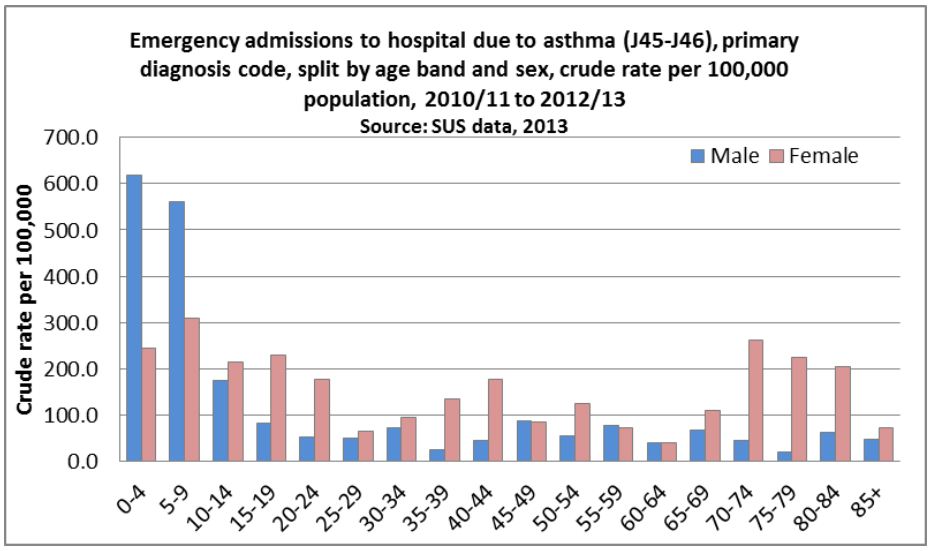
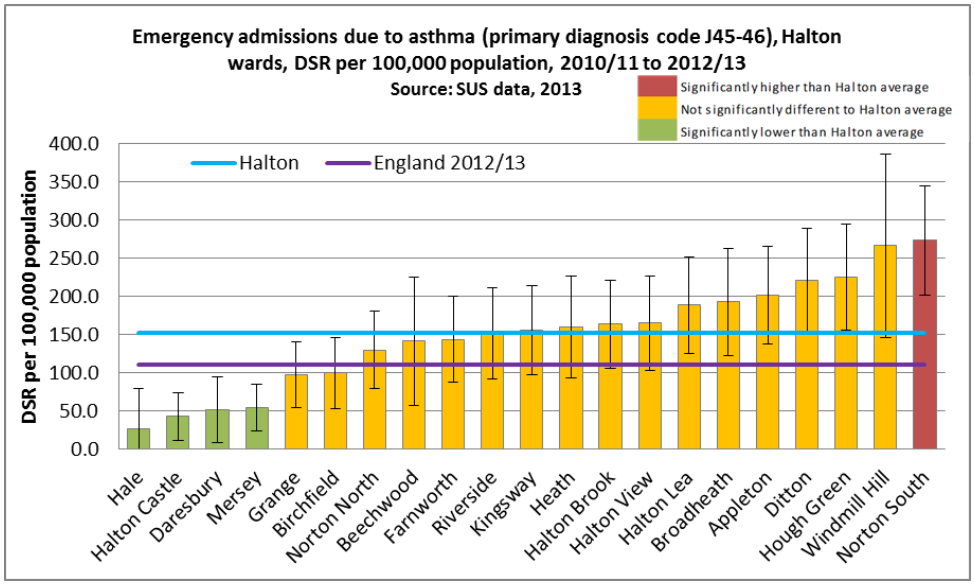
## Hospital admissions due to asthma

Unlike COPD, asthma is common in every age group. The majority of people who develop the condition are managed within primary care, as previous data in this profile has shown. However, for some, they will develop exacerbations of the condition or they may be undiagnosed. This can result in an emergency (unplanned) admission to hospital.




The data for 2010/11 to 2012/13 shows that the age band with the highest rate of admissions are males aged 0-9 years. However, females have a higher rate of admission than males for ages 65+.

Only one ward in Halton had a statistically significantly higher rate of emergency admissions compared to the borough, however, there were 4 wards that had a significantly lower rate.



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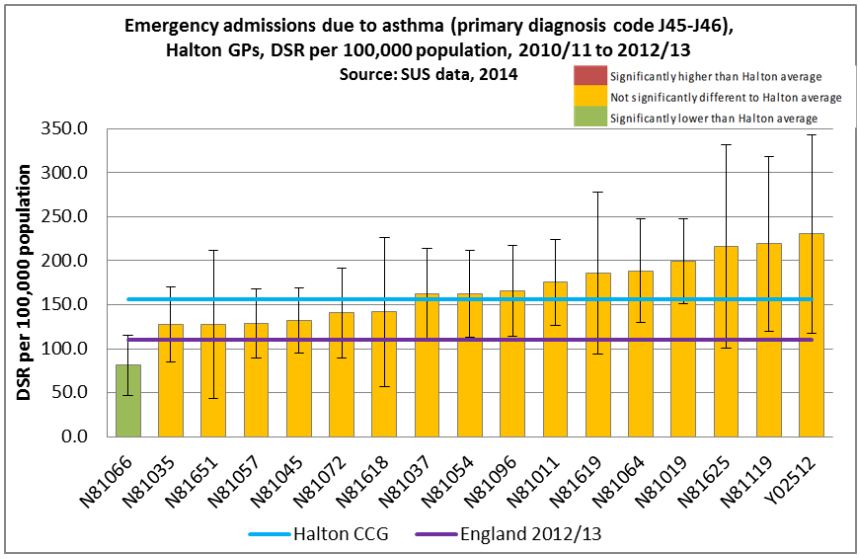
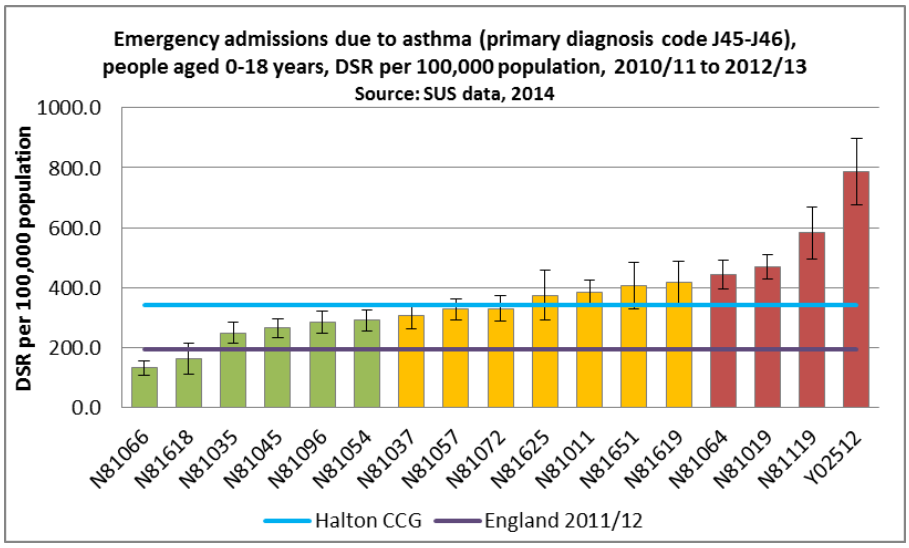
## GP Practice Level Hospital Admissions for asthma

It is also useful to calculate the rates at GP practice level. This data can be used to see how well each practice is managing their registered patients who have asthma.




The data for 2010/11 to 2012/13, for all ages, shows that only one practice had an admission rate which was significantly lower than the CCG average. This same practice was also the only one (out of the 17 in Halton) who had a rate which was lower than England.

The emergency admission rate for 0 to 18 years was also calculated at GP level. This was due to the Child and Maternal Health Intelligence Network (ChiMat) publishing the rate at a national level.




There were 4 wards during 2010/11 to 2012/13 that had a rate which was significantly higher than the Halton average. However, there were 6 wards that had a significantly lower rate.

Fifteen out of the 17 practices in Halton had a rate which was significantly higher than the England rate during 2011/12.

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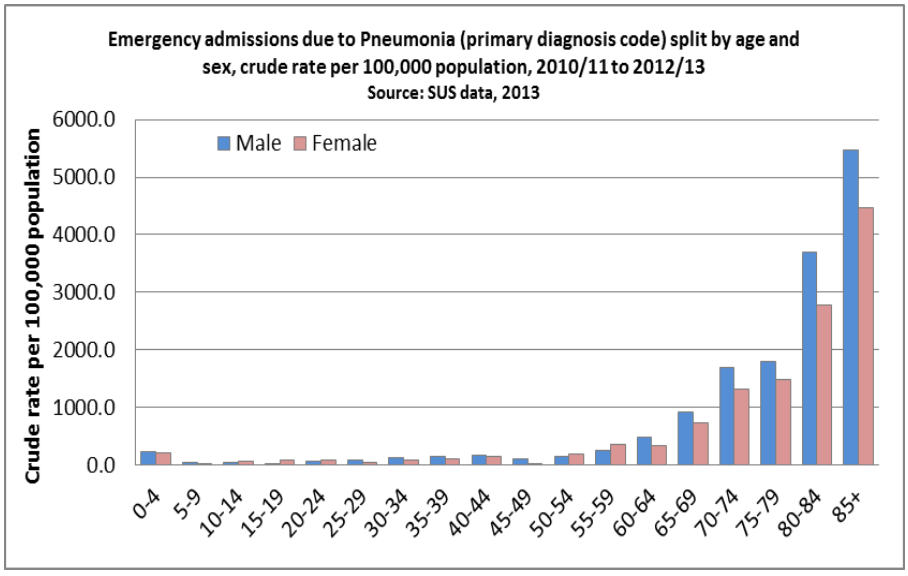
## Hospital admissions due to pneumonia

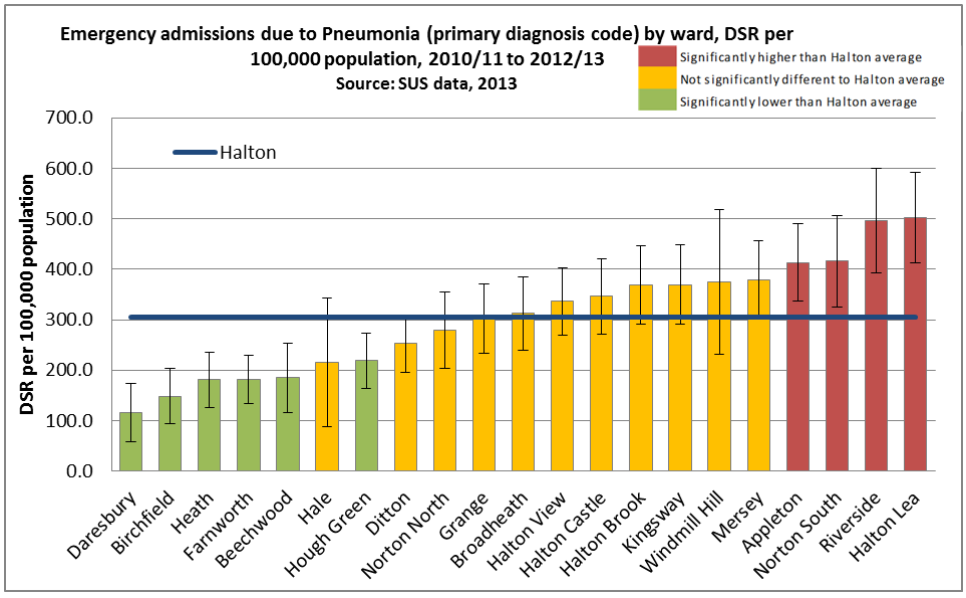
Pneumonia can affect people of any age; however, it is more common and can be more serious for:

- Babies, young children and the elderly
- People who smoke
- People will other health conditions, such as a lung condition or weakened immune system

Mild pneumonia can usually be treated at home with antibiotics, rest and fluids. For people with other health conditions, pneumonia can be severe and may need to be treated in hospital.




The data for 2010/11 to 2012/13 shows that the rate of emergency admissions increases from 55 year of age onwards for both males and females. However, the admission rate in the 0-4 age group is higher than the 5-9 to 50-54 age groups.




Four wards in Halton had a statistically significantly higher admission rate than the borough during 2010/11 to 2012/13.

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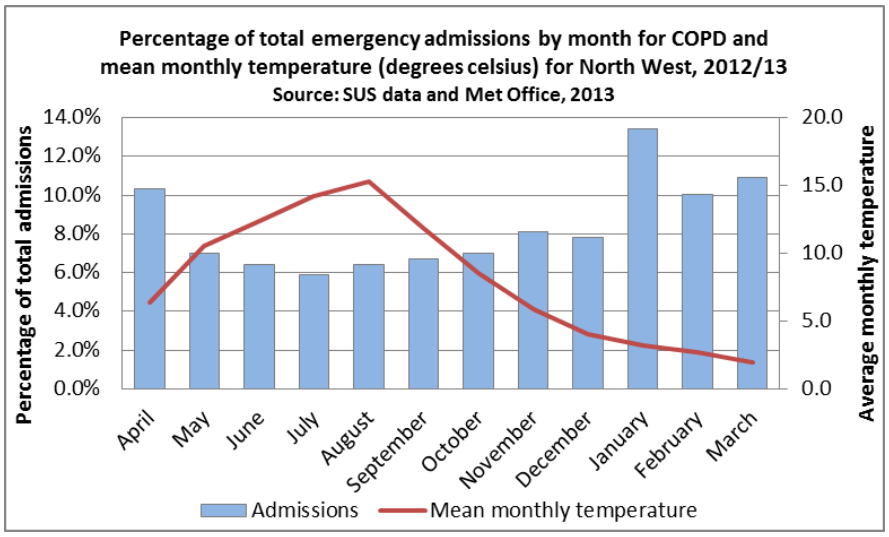
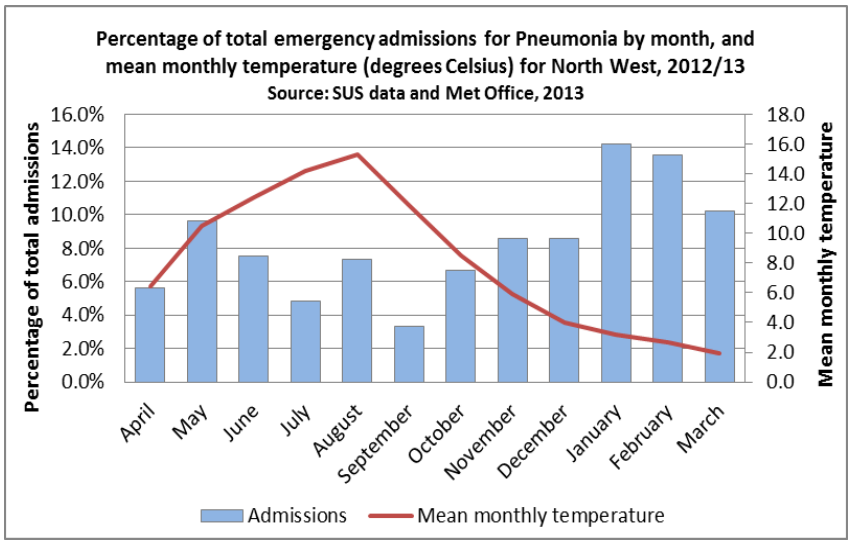
## Seasonal Hospital Admissions

There is a link with both the quality of air, especially in towns and cities, and changes in temperature. With air quality declining due to increased urban pollution and emissions more people are becoming affected by heart and lung illnesses. There is good evidence that cold houses increase mortality across all social classes. Indoor temperatures [i] as well as outdoor temperatures [ii], are related to increased risk of exacerbations and extra respiratory deaths. The charts below show that there is a relationship between colder outdoor temperatures i.e. during the winter months and higher levels of admissions for COPD and pneumonia in those corresponding months. This is similar to the national picture.




The data shows that, during 2012/13, as the average monthly temperature decreased the number of admissions for COPD increased.

For pneumonia, as the average monthly temperature decreases from October onwards, the number of admissions increases. However, the number of admissions did decrease in March even though the temperature continued to decrease.



## Smoking Cessation Services

The integrated household survey estimates that, during 2011/12, 23.1% of the population of Halton were current smokers. This is higher than the estimations for the North West (22.1%) and England (20.0%).

During 2012/13, a Lifestyle Survey was carried out in Merseyside. As part of this survey people were asked about their smoking status, and the results suggest that 30.5% of the Halton population currently smoke.

The result of the Merseyside Lifestyle Survey therefore suggests that the smoking prevalence within Halton may be higher than was previously thought; however, the actual percentage is likely to be between 23.1% and 30.5%.

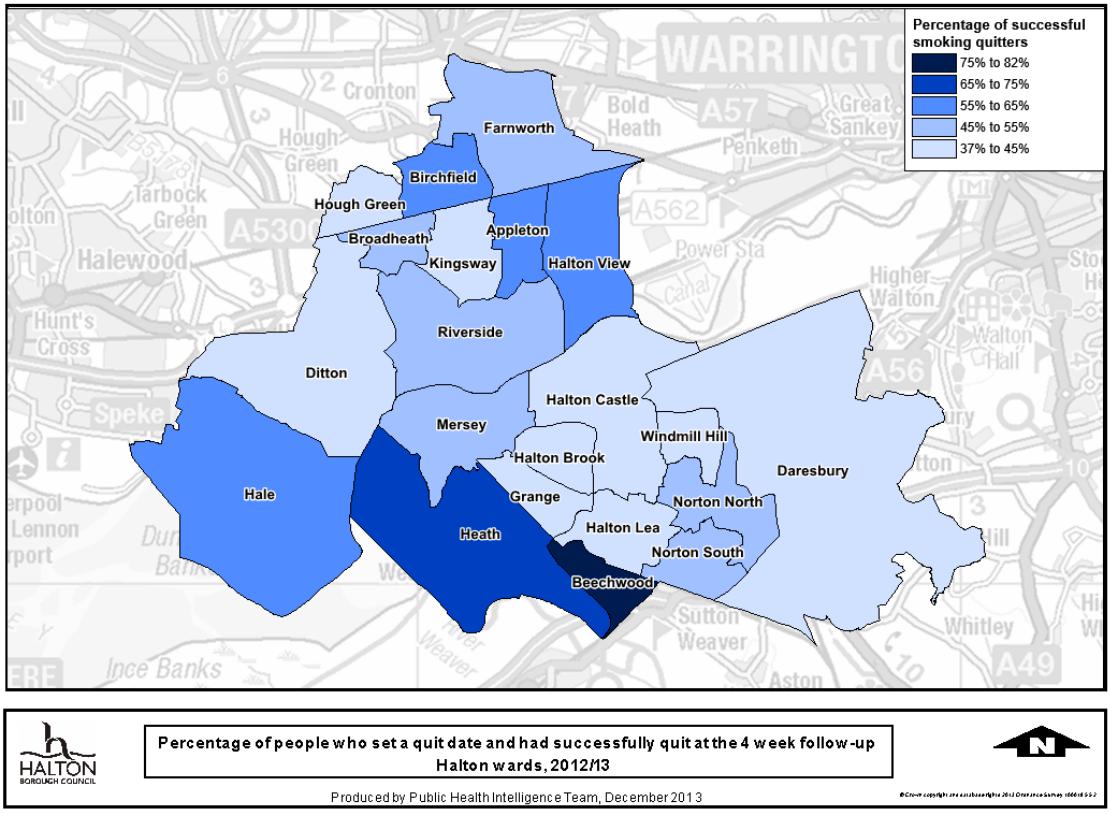
Smoking cessation comparator data is available annually from the Information Centre. It was available at PCT level only until the end of 2012/13; therefore local has been used to calculate the Halton rate. This data refers to successful quitters at the 4 week follow up.

| | 2012/13 |
|---|---|
| Halton | 930.4 |
| North West | 1024.3 |
| England | 867.9 |

The data shows that during 2012/13 there were more successful quitters per 100,000 population aged 16+ in Halton when compared to England. However, it also shows that the rate was lower in Haltonthan the North West.

Source: NHS Information Centre; Health Improvement Team (Bridgewater Trust)

In Halton during 2012/13 there were 1,962 quit dates set by people accessing the NHS Smoking Cessation Service (NHS SCS). Of these, 938 had quit at the 4-week follow-up.Thismeans that the average success ratein Halton for 2012/13 was 47.8%. At a ward level this varied from 37.5% in Daresbury to 81.8% in Beechwood.



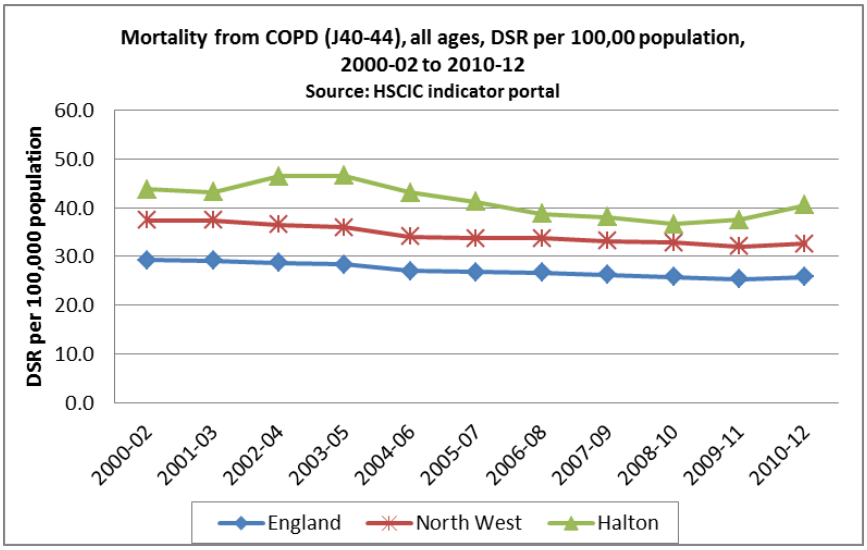

The percentage of successful quitters at the 4-week follow-up for Beechwood and Appleton were statistically significantly higher than the borough percentage.

HALTON BOROUGH COUNCIL

NHS Halton Clinical Commissioning Group

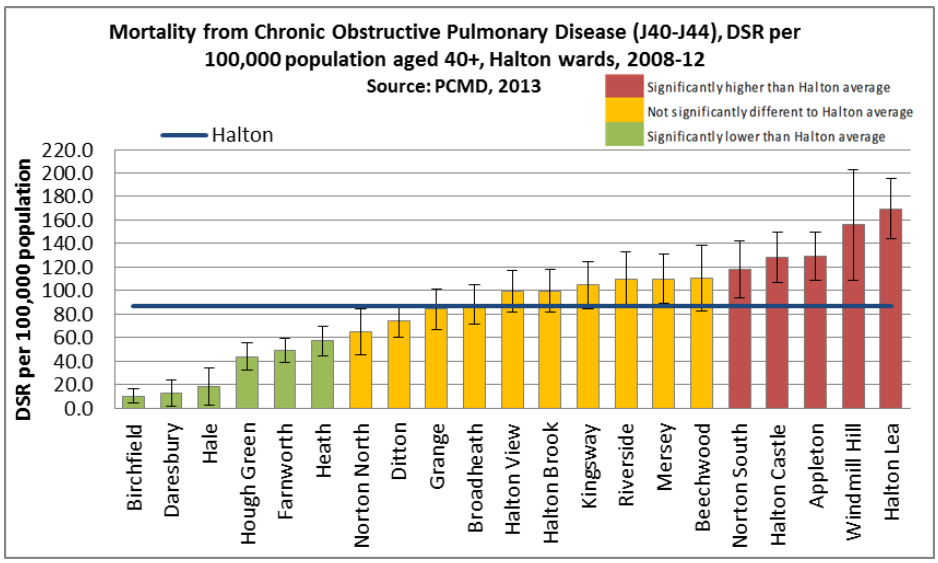
## Deaths due to COPD

Death rates due to COPD have, overall, decreased in Halton over the past few years; however, they still remain significantly higher than the rates for England and the North West. Halton rates fell between 2003-05 and 2008-10, but increased slightly in 2009-11 and again in 2010-12. An increase in rate also occurred for England and the North West during 2010-12.




As was the case for the hospital admissions, the small numbers at ward level also mean having to combine multiple years' worth of mortality data to achieve statistically robust analysis.

There were no deaths in Halton residents under 40 years of age due to COPD during 2008-12; therefore the rate was calculated for ages 40+.




The data shows that there were 5 wards which had a mortality rate that was statistically significantly higher than the borough rate. However, there were 6 wards that had a rate which was significantly lower.

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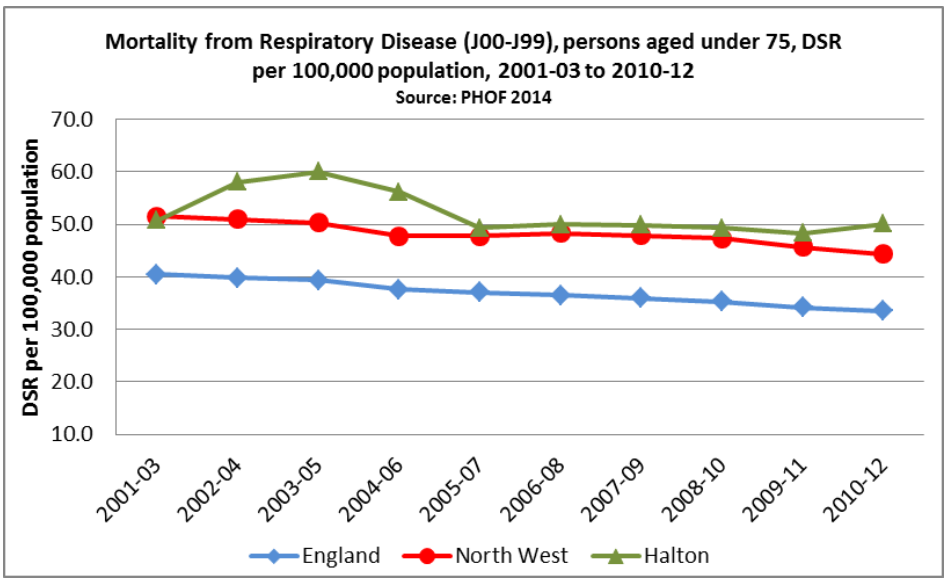
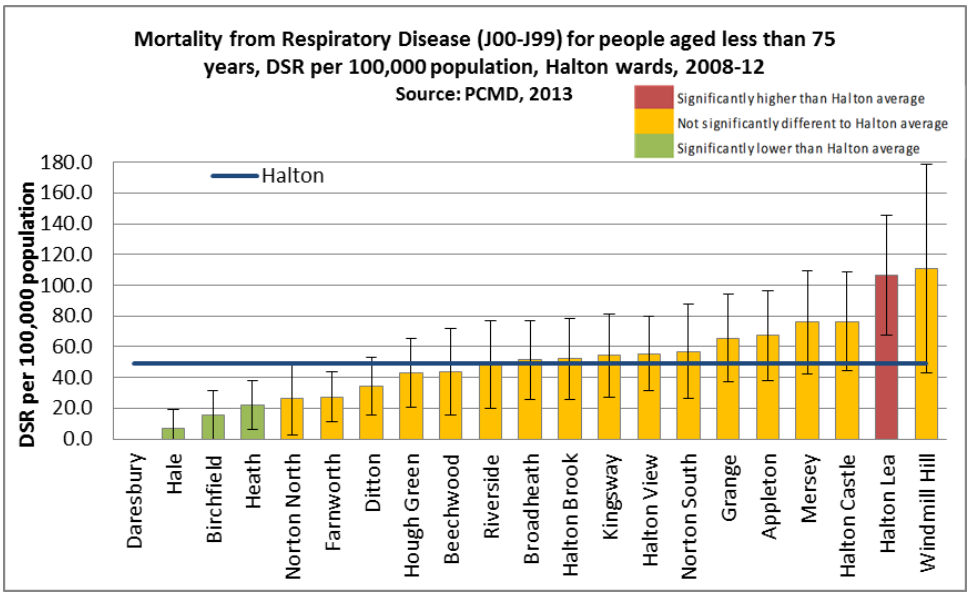
NHS Halton Clinical Commissioning Group

## Deaths due to Respiratory Disease in people aged less than 75 years

Deaths rates due to respiratory disease are only released nationally for people who are under 75 years of age. Between 2005-07 and 2010-12, the Halton rate has remained steady at around 49 per 100,000 population. The latest data shows that the Halton rate is still higher than the North West and continues to be significantly higher than England.




Local data shows that Halton Lea ward was the only ward having a statistically significantly higher death rate than the Halton averageduring 2008-12. However, there were 4 wards that had a death rate that was significantly lower than the borough rate.

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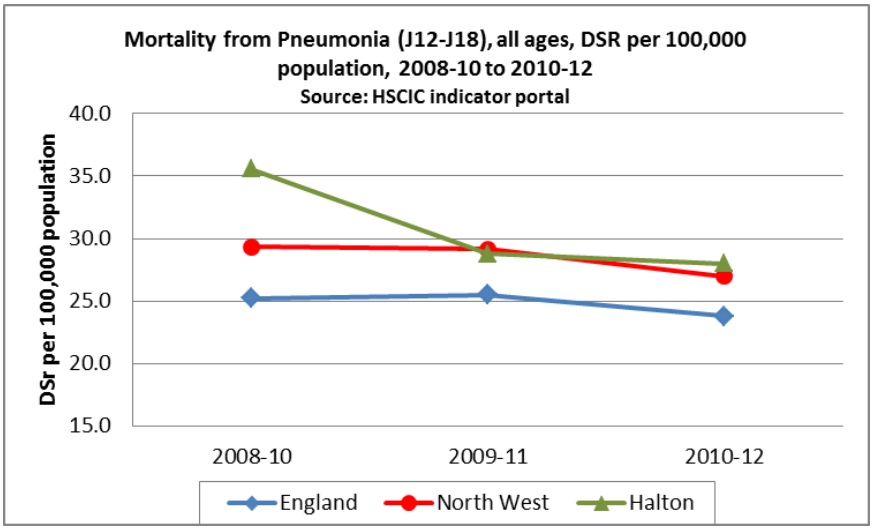
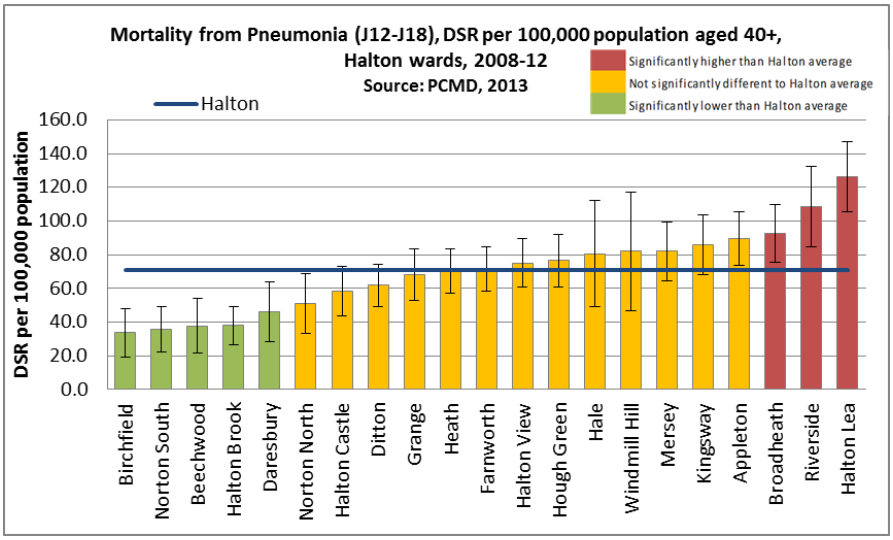
NHS Halton Clinical Commissioning Group

## Deaths due to Pneumonia

Deaths rates due to pneumonia have decreased in Halton since 2008-10; due to this the rate is now very similar to the North West. The England value remains lower than Halton, however, due to the decrease in the local rate, the gap has narrowed.




Mortality rates due to pneumonia were calculated at a ward level using local data. As there were no deaths to people aged under 40 years of age during 2008-12, the rate has been calculated for ages 40+.

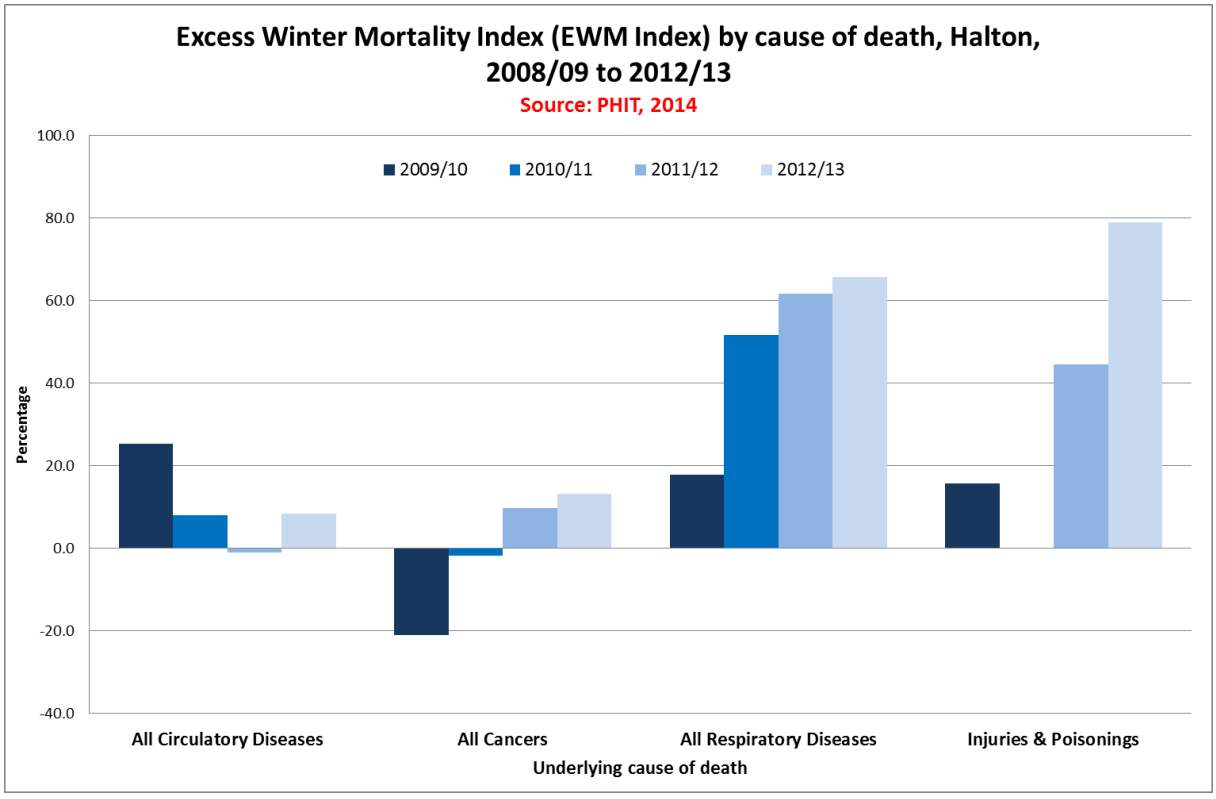



The local data shows that three wards had a statistically significantly higher death rate due to pneumonia than the borough during 2008-12. However, 5 wards had a rate which was significantly lower than Halton.

## Excess Winter Deaths

The Office for National Statistics (ONS) define excess winter deaths as deaths that occur between December and March minus the average number of deaths occurring in the preceding August to November and the following April to July. This methodology produces an Excess Winter Mortality (EWM) figure. For comparisons to be made the EWM Index is calculated by dividing the EWM by the average non-winter deaths multiplied by 100.

The main causes of excess winter mortality are circulatory disease, cancers, respiratory disease and injuries (predominantly in the form of falls). Overall respiratory diseases rise the most during the winter months, giving a greater percentage difference i.e. a greater excess winter death rate.



## Data Sources used in developing this profile

Association of Public Health Observatories: estimated prevalence figures

Primary Care Mortality Database (PCMD): detail on the cause of deaths of residents

SUS data: hospital admissions data via Cheshire & Merseyside Commissioning Support Unit

Office of National Statistics (ONS): resident population estimates

Health & Social Care Information Centre (HSCIC): QOF data

HSCIC indicator portal: death rates and GP populations

NICE: national guidance and quality standards http://www.nice.org.uk/

Met Office: mean monthly temperatures http://www.metoffice.gov.uk/climate/uk/datasets/

Smoking Cessation Service: QuitWithUs database

**Profile Author: Jennifer Oultram - Public Health Intelligence Officer**

**Public Health Evidence & Intelligence Team**

Health.Intelligence@halton.gcsx.gov.uk

**REPORT TO:** Health Policy & Performance Board

**DATE:** 9 September 2014

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Choice, Control, Inclusion - Commissioning Strategy for Adults of Working Age living with physical disability in Halton 2014-2019

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present to Health Policy and Performance Board the draft integrated Commissioning Strategy for Adults of Working Age living with physical disability in Halton 2014-2019 and supporting evidence paper.

2.0 **RECOMMENDATION: That the Board note and comment on the content of the draft integrated Commissioning Strategy for Adults of Working Age living with physical disability in Halton 2014-2019 and supporting evidence paper**.

3.0 **SUPPORTING INFORMATION**

3.1 Fulfilling Potential: Making it Happen (DWP 2013) sets out the Governments strategy for those living with disability. Emphasis is placed on delivery through partnership across the public and private sector with disabled people and their representative organisations to overcome barriers faced and promote new ways of working to deliver meaningful outcomes.

3.2 In Halton the number of working age adults reporting that their activity is limited by illness or health problems is significantly higher than nationally. Projections show that numbers of people living with more than one long term condition will increase and potentially this will limit the activity of more people.

3.3 'Choice, Control and Inclusion' takes an integrated approach to improving the health and wellbeing of disabled adults aged 18-64 in the Borough. The strategy brings together commissioning intentions of Public Health, the Clinical Commissioning Group, and Adult Social Care. This holistic approach will strengthen informal support and through effective prevention and early intervention minimise the need for more formal care.

3.4 This strategy does not include the needs of disabled children or those aged 65+. The former are overseen by Halton Children's Trust which sets integrated commissioning as one of its priorities. There are a number of strategies setting out needs and commissioning intentions for older people including Dementia Strategy, Stroke Strategy, Prevention and Early Intervention Strategy.

3.5 'Choice, Control and Inclusion' has been informed by feedback at public engagement events, open consultation with the public and key stakeholders through a recent survey. Discussions have also taken place with local disabled people and Halton Disability Partnership.

3.6 'Choice, Control and Inclusion' and the included action plan adopt the three national themes of :

i. Early Intervention
ii. Choice and Control
iii. Inclusive Communities

The priorities for 2014-19 have been developed with disabled people:

**Priority 1 - Promote the social model of disability to overcome the barriers faced by disabled people and build responsive, inclusive communities**

**Priority 2 - Support disabled people to have choice and control in their lives**

**Priority 3 - Improve outcomes for people living with disabilities and their carers through high quality, personalised services**

**Priority 4 - Recognise the expertise and assets of disabled people and use these to improve services**

**Priority 5 - Ensure efficient and effective use of resources**

3.7 Halton's Better Care Board will oversee progress in implementing 'Choice, Control and Inclusion' and is accountable to the Council's Executive Board and NHS Halton Clinical Commissioning Group's Governing Body.

## 4.0 POLICY IMPLICATIONS

4.1 This strategy will support progress in local delivery of Fulfilling Potential and the three national outcomes frameworks for the NHS, Adult Social Care and Public Health.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The action plan within the strategy contains a summary of resources required. These are primarily investment of staff time to effect the change or redirection of current investment to achieve service redesign. This is deliverable within existing staffing structures and funding levels; however the need to make efficiency savings across the system may impact on successful delivery of the strategy.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

The strategy considers the needs of young disabled people in transition to adulthood

### 6.2 Employment, Learning & Skills in Halton

Many disabled people wanting to work face barriers to employment. This is considered in the strategy and the action plan.

### 6.3 A Healthy Halton

Delivery of 'Choice, Control, Inclusion' will have a positive impact on the health of working age adults living with disability in Halton.

### 6.4 A Safer Halton

A number of priorities in the strategy promote safety of individuals and raise awareness of the impact of living with disability which will contribute to building stronger communities.

### 6.5 Halton's Urban Renewal

None identified

## 7.0 RISK ANALYSIS

7.1 'Choice, Control, Inclusion' supports progress in delivering the strategic priorities of the Council for a Healthy Halton. As described in 5.1 the Strategy is capable of delivering within existing resources, however a reduction in budget or staffing levels will impact on service delivery.

Similarly any reductions in service funding allocations in the financial years that the Strategy covers could have an impact in delivering on the five priorities.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The strategy specifically aims to meet the needs of disabled adults' age 18-64 living in Halton which are a protected group. It promotes a

personalised approach with the individual in control of decisions about their support needs and will therefore have a positive impact.

An equality impact assessment (EIA) has been completed.

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

| Document | Place of Inspection | Contact Officer |
|---|---|---|
| Fulfilling Potential: Making it Happen (Office for Disability Issues DWP July 2013) | Runcorn Town Hall (Second Floor) | Liz Gladwyn |
| | | |

HALTON BOROUGH COUNCIL

NHS

Halton Clinical Commissioning Group



# Choice, Control, Inclusion -

# Commissioning Strategy for Adults of Working age living with physical disability in Halton 2014-2019

myhalton living life well

# Contents

# Foreword

Choice, Control, Inclusion is Halton's five year commissioning strategy for adults of working age(18-64) living with disability. It does not consider the needs of disabled children as these are overseen by Halton Children's Trust. Nor does it cover those age 65+ as there are a number of strategies setting out needs and commissioning intentions for older people including Dementia Strategy, Stroke Strategy, Prevention and Early Intervention Strategy.

Choice, Control, Inclusion will drive progress towards achieving the vision of both:

Halton Borough Council:

> *"Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality, sustained by a thriving business community; and safer, stronger and more attractive neighbourhoods"*

and NHS Halton Clinical Commissioning Group:

> *"Involving everybody in improving the health and wellbeing of the people of Halton".*

There is no single agreed measure of disability. The Equality Act 2010 sets out the legal framework under which disabled people have rights: a person is considered disabled if they live with:

> *"a physical or mental impairment that has a 'substantial' and 'long-term' adverse effect on their ability to carry out normal day-to-day activities"*

In Halton we adopt the social model of disability which considers the barriers experienced by people living with impairment and encourages society to be more inclusive. This approach helps identify solutions to these barriers such as inaccessible buildings and services, people's attitudes and inflexible policies and practices.

People with physical disabilities have a range of needs from complete independence with little or no support to high level support including adaptations to remain in their home. For all, the aim is to ensure they are supported to maintain control over their lives and remain independent for as long as possible able to lead a full and active life if they choose.

Disabled people and Halton Disability Partnership have worked with us to identify the local priorities within the strategy which sets out the local response to the three themes of the national

strategy Fulfilling Potential – Making it Happen:

1. Early Intervention
2. Choice and Control
3. Inclusive Communities

Our approach to delivering the strategy is one of collaboration working across the statutory, independent and voluntary sectors as well as a continued drive to transform local health and social care provision moving to greater personalisation and community-based support.

# Why do we need a strategy for disabled adults?

Those living with long term physical conditions are the most frequent users of health and care services and commonly experience mental health problems such as depression and anxiety. Across all ages the number of people with one long term condition is projected to be relatively stable whilst numbers with multiple long term conditions are projected to increase by a third to 2.9 million in 2018.

The additional cost to the NHS and social care for the increase in co-morbidities is likely to be £5 billion in 2018 compared to 2011. Plans need to be put in place now to address the health and social care issues facing people with multiple long term conditions[1].

**In Halton:**

- **Adults of working age whose activity is limited by illness or health problems is significantly higher than nationally**
- **Halton residents can expect to live 25% of their lives with a limiting long term illness**
- **Life expectancy is lower than nationally and for women 4th lowest in the country**
- **Life expectancy is lower again for those living in Halton's most deprived Super Output Areas**
- **Just under 6% of the population is affected by a long term neurological disorder**
- **Long term neurological conditions are the third most common reason for seeing a GP and account for 20% of acute admissions.**

Halton has previously implemented the "Physical and Sensory Disability Joint Commissioning Strategy 2007-2011" which has been reviewed to build on its achievements and provide a baseline for this strategy and inform the direction for development of local services over the next five years.

Long Term Conditions (LTC) are not just a health issue they can have a significant disabling impact on a person's ability to work and live a full life. Those from lower socio economic groups have increased risk of developing a LTC whilst better management of the condition can help to reduce health inequalities.

[1] Long Term Conditions Compendium of Information Third Edition (DH 2012)

Those living with disability want to live independent lives, to play a full part in society and to be able to reach their full potential like anyone else[2]. Overcoming the barriers faced by disabled people and societal attitudes to disability together with increased life opportunities and choices, and the availability of appropriate information and support means that a good quality of life is possible for the individual whilst wider society and economic benefits are achieved.

Choice, Control, Inclusion relates to the needs of working age adults living with disability promoting independent living so that individuals are empowered to define the outcomes they desire based on their own aspirations to participate in society, feel valued and gain a meaningful life. This approach also supports the recovery of improved mental health and wellbeing for disabled people as they retain or develop new meaning and purpose in their life[3] .

This strategy has been developed within the context of a range of national, regional and local policies, strategies and plans as summarised below. Further details of how these influence the strategy can be found in the supporting evidence paper. Successful implementation of Choice, Control, Inclusion is dependent on sustaining the progress achieved in delivering Halton's Prevention and Early Intervention Strategy to maintain independence for as long as possible and delay the need for formal care. The needs of those living with sensory impairment are considered in the stand alone commissioning strategy SeeHear 2014-2019.


[2] Fulfilling potential nex… …nt for Work and …ensions 20…

[3] No Health Without Men… …)

# Local Issues

Halton is committed to a focus on individual people, their health and wellbeing and supporting the communities in which they live. The major local issues relating to living with physical disability which have influenced this Strategy are examined in detail in the Choice, Control, Inclusion 2014-2019 Evidence Paper and are summarised under three themes as illustrated below.

## Consultation

In developing this strategy the views of Halton residents, Halton Disability Partnership and other stakeholders were sought to help shape local services over the next five years.

The key themes from comments received are:

**Access in the community:** wheelchair users are obstructed by steps in shops and other buildings, lack of drop kerbs in some areas. Shop mobility needed in Old Town. Toilet facilities lacking

**Transport:** restrictions on dial a ride, buses not always accessible if ramps not working already full with buggies, evening services needed

**Health and Mental health:** greater understanding of disability and mental health and wellbeing, access to GP appointments.

**Transition:** Better balance between family and individual to ensure safe and fruitful transition

**Stigma**: Breakdown society's preconceptions and prejudices; make disabled people aware their disability does not mean they should be treated any differently.

**Information:** Better integration of information and advice services, better use of GP's, libraries, local press

These themes have been picked up within the action plan. They will be kept under review to ensure local views are listened to and where possible concerns addressed.

## People

- Number of people with a limiting long term illness is higher than national and regional rates.
- 6% of people live with a neurological condition
- Neurological conditions are the third most common reason for seeing a GP and account for 20% of hospital admissions
- Increased life expectancy for those disabled from birth
- Journey into adulthood can be diffcult for young disabled people

## Health & Well-being

- Disabled people experience poor health outcomes either as a direct or indirect result of their condition
- Life expectancy is lower than nationally and 4th lowest for women
- Halton people live 25% of their lives with a limiting long term condition
- Caring for someone with a long term condition may have an adverse impact on the carers health and wellbeing
- Rates of risky behaviours such as smoking, poor diet and physical inactivity ar higher amongst disabled people

## Communities

- Accessible Transport
- Access to adapted housing
- Impact of access in the community on ability of disabled people to be independent
- Impact of attitudes on ability of disabled people to contribute to their community
- Staying safe
- Employment opportunties

# Our vision, objectives and priorities

Our vision for those living with disability in Halton is:

***People living with a disability will have a high level of self-reported wellbeing, have happy and fulfilling lives and be motivated, valued participants in their local community.***

To help us achieve this vision the three themes of the national strategy Fulfilling Potential – Making it Happen (Office for Disability Issues, 2013) together with the best practice promoted by the Disability Action Alliance form the keystones of our strategy: early intervention, choice and control and inclusive communities. Through the work in this strategy Halton aims to ensure the **objectives** outlined in the national strategy and those identified in the Halton Health and Wellbeing Strategy 2013-2016 and the Halton Clinical commissioning Group Strategic Plan are realised for local people.

**(i) People living with disability will be supported to be independent for as long as possible**
This does not necessarily mean disabled people 'doing everything for themselves', but it does mean that any practical assistance people need should be based on their own choices and aspirations.

**(ii) People living with disability will have access to a range of informal support preventing, postponing and minimising the need for formal care**
We will improve the quality of life of disabled people in Halton through effective prevention and early intervention. We will make effective use of telecare and telehealth to support independence and early detection of health problems which will lead to improved wellbeing for disabled people and their families.

**(iii) People living with disability will have a positive experience of care and support**
Care and support, wherever it takes place, should offer access to personalised, timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

**(iv) People living with disability will have access to information and support to manage their health and wellbeing**
Local disabled people and their families will have access to information to help manage their physical health and also their mental health and wellbeing. Community based support

will be developed for those in residential settings to manage long term conditions avoiding the need for unnecessary and unplanned hospital admissions.

**(v) People living with disability will be supported to participate fully in the wider community**

More disabled people will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable place to live.

**(vi) People living with disability will shape future services**

Local disabled people and their organisations will have opportunities to feed in their views, informing delivery of services. Whenever possible a co-production approach will be adopted recognising the assets of the area and how partners across the statutory and voluntary sector will work together to address current and future health and social care needs.

Key to delivery is partnerships across the public and private sector with disabled people and their representative organisations to overcome barriers faced. This strategy identifies five priority areas of work to meet the needs of local people.

**Priority 1 - Promote the social model of disability to overcome the barriers faced by disabled people and build responsive, inclusive communities**

**Priority 2 - Support disabled people to have choice and control in their lives**

**Priority 3 - Improve outcomes for people living with disabilities and their carers through high quality, personalised services**

**Priority 4 - Recognise the expertise and assets of disabled people and use these to improve services**

**Priority 5 - Ensure efficient and effective use of resources**

This strategy aspires to meet the needs of working age disabled adults and those of all ages with a sensory impairment by using the best evidence of what works to increase the effectiveness and value for money of services. This will be achieved by:

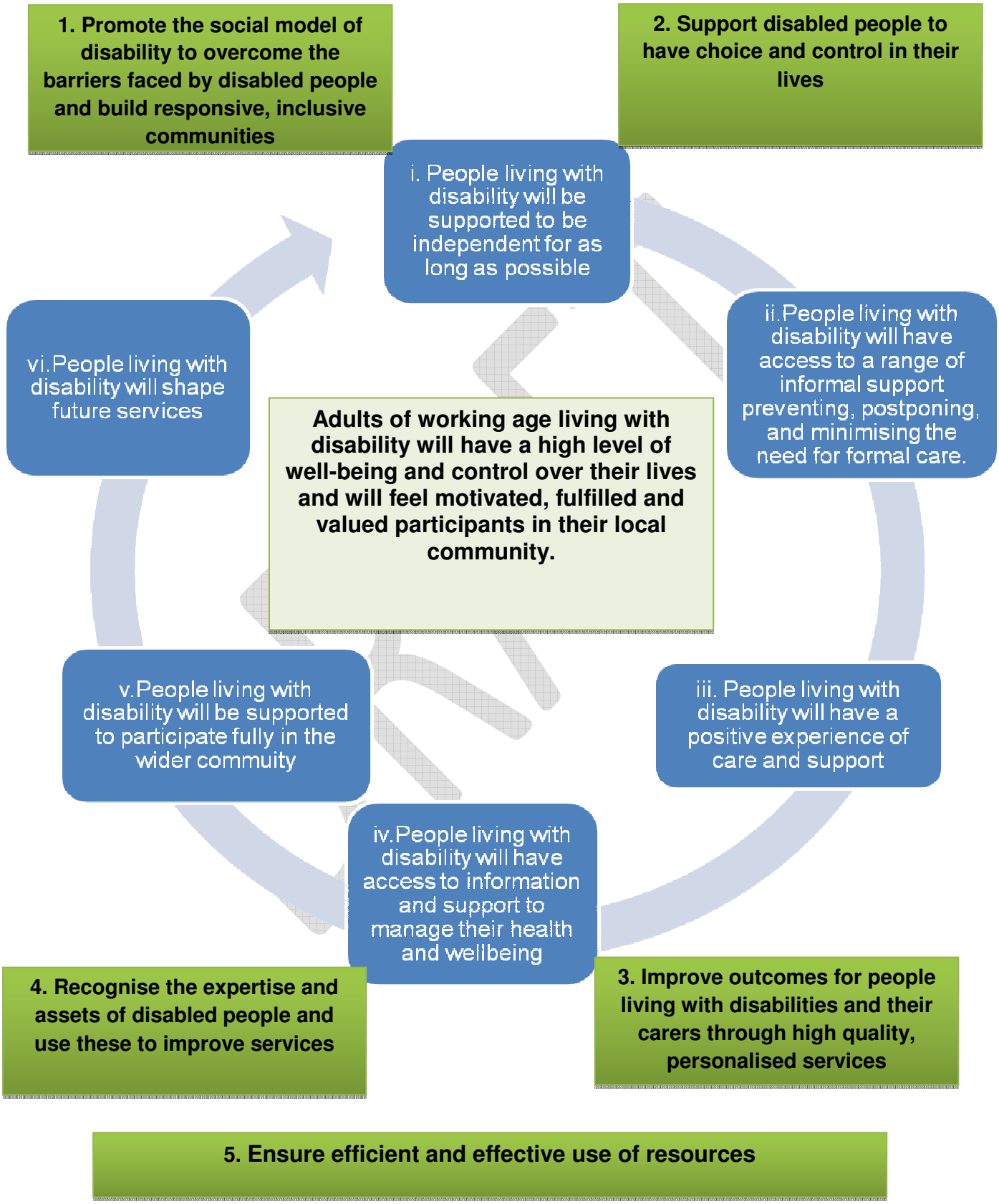
- **Improving the quality and efficiency of current services;**
- **Supporting and encouraging prevention and early intervention;**
- **Enabling disabled people to have increased and informed choice and control;**
- **Partnership working with disabled people; and**
- **Broadening the approach taken to promote the social model of disability and develop positive attitudes to disabled people.**

The accompanying evidence paper highlights significant increases in the numbers of people living with multiple long term conditions and that whilst individually these conditions are generally not

debilitating the combined impact can be disabling. This demographic change is set against a backdrop of significant funding reductions across the health and social care system. Clearly a different approach is required to the traditional models of service provision to manage future demand.

Services for those with physical disabilities along with preventative support, earlier interventions and a range of informal support are essential in meeting Halton's priorities. This strategy covers a five year period and progress will be kept under review. The strategy will evolve to respond to changes in national and local drivers and emerging issues.

## Our vision, objectives and priorities



# Implementing our priorities

National policy promotes the social model of disability as a way of thinking about how physical, social and environmental barriers can be removed so that disabled people can realise their aspirations and fulfil their potential. The approach to disability equality has a focus on **inclusion and mainstreaming**, with additional support provided where needed, and on the **involvement of disabled people in making decisions** that will affect their lives. **Fulfilling potential: Next Steps** prioritises action for disabled people around three themes:

i. **Early intervention and preventative approaches to impairment and disability –** enable people to build the lives they choose e.g. staying in education or employment and overcoming disability barriers, learning independent living skills and opportunities.

ii. **Independence, Choice and Control –** a focus on early intervention and prevention with access to independent information and advice to help people organise and plan care and support. Better support for people to remain in their own home through increased use of Assistive Technology and community based support which promotes dignity and choice and avoids isolation.

iii. **Inclusive, accessible communities –** enable disabled people to participate in their local area through safe inclusive access to key services, strong community links and affordable housing that can meet changing needs. Build community capability by developing User Led Organisations (ULO) and other community groups to play a key role in early intervention.

In line with national policy, Halton Borough Council and Halton Clinical Commissioning Group are working collaboratively to move towards greater integration of services to improve quality of care and ensure effective use of finite resources.

This strategy places an emphasis on prevention and early intervention and promotes reablement minimising the impact of disability and thus avoiding or delaying the need for more formal care. The success of the strategy will depend on broader partnership working across voluntary, community and commercial organisations to achieve the best possible outcomes for Halton's citizens.

We are currently exploring an asset or strengths based approach to commissioning and service delivery steering away from a deficit based model. Instead of looking only for an individual's problems, vulnerabilities and at what he or she cannot do an asset based approach will look first at what individuals and those close to them can do and at what they have the potential to do with a

little help. The emphasis will be on effective social care intervention leaving an individual better informed and connected and more confident, supporting the individual's unpaid relationships, informal networks and natural support networks.

This move from a deficit model that can undermine the resilience of people by only seeking to understand their eligibility and service entitlements, starts by understanding what's important to the person, what they want to do and the strength and nature of their social networks. The success of this strategy is dependent on the implementation of this asset based model. It will mean staff working in new ways and all partners need to ensure that the required culture shift is embedded into working practices and that staff have the right skills and knowledge and are enabled to take this forward.

Making it Real[4] is a set of "progress markers" - written by real people and families which sets out what people who use services and carers expect to see and experience if support services are truly personalised. The markers can help an organisation check how they are moving towards transforming adult social care. The aim of is for people to have more choice and control so they can live full and independent lives. To help us determine how this change in practice is impacting we will adopt the Making it Real progress markers. Further explanation of the progress markers can be found in the evidence paper.

The Halton Better Care Board aims to ensure that an integrated system is developed and appropriately managed to ensure that the resources available to both Health and Social Care, including the Better Care Fund, are effectively used in the delivery of personalised, responsive and holistic care to those who are most in need within our community. This includes a remit to determine the strategic direction and policy for the provision of services to those with identified care and support needs to improve quality, productivity and prevention. The Board will oversee implementation of this strategy and action plan and is accountable to both the NHS Halton Clinical Commissioning Group's Governing Board and Halton Borough Council's Executive Board.

[4] http://www.thinklocalactpersonal.org.uk/Browse/mir/aboutMIR/

# How is it paid for?

The following financial breakdown is based upon current direct expenditure on funding for initiatives specific to disabled people. It does not reflect all of the wider universal and targeted activity that is commissioned locally. Expenditure, on areas such as Primary Care (GPs, etc), general health promotion, weight management, or voluntary and community sector activity, all have a direct impact upon the quality of life of disabled people but does not fall within the direct influence of this strategy and action plan.

Further financial analysis across the range of activities and interventions can be found in the supporting evidence paper. I

### Gross Total spend 2013/14 Adults age 18-64 with physical disabilities

| | **£000** |
|---|---|
| Halton Borough Council – Adult Social Care | 5,014* |
| Halton Borough Council – Public Health | Part of universal services |
| Halton Clinical Commissioning Group | To be added |
| Halton Clinical Commissioning Group - Continuing Health Care | 2,040 |
| **TOTAL** | **7,054** |

# How will we know if we have been successful?

**When we have achieved our aims those living with disability will be able to overcome environmental and social barriers to realise their aspirations and play a full part in society.**

**There will be a high proportion of people feeling supported to manage their health and feeling safe and in control of their lives.**

**Time spent in hospital will be reduced and unplanned admissions avoided.**

**Those who live with disability will be able to contribute fully to the community, and be able to enjoy as much social contact as they would like.**

The Overarching Outcome for this Strategy is that people living with disability will have a high level of well-being and control over their lives and will feel motivated, fulfilled and valued participants in their local community. This will be achieved by focussing efforts on delivering against and achieving our five priorities. Disabled adults in Halton will be able to confirm that the Think Local Act Personal "Making It Real" six progress markers of personalisation have been met for them.

It is important to make sure that real health and wellbeing improvements are delivered through the implementation of this strategy. The best way to achieve this is to use recognised measures to monitor the benefits arising from agreed priority actions and five high level targets have been set as a measure of success:

| | Priority | Target to measure success | 2014/15 | 2016/17 |
|---|---|---|---|---|
| 1 | Promote the social model of disability to overcome the barriers faced by disabled people and build responsive, inclusive communities | The proportion of people who use services who feel safe<br>Outcomes frameworks:<br>Adult Social Care 4a<br>Public Health 1.19 | 64% | 65% |
| | | Number of physically disabled people helped into voluntary work in the year<br>Local indicator | 10 | 10 |
| 2 | Support disabled people to have choice and control in their lives | The proportion of disabled people who use services who have control over their daily life<br>Outcomes framework:<br>Adult Social Care 1b | 80% | 80% |
| | | Adults with physical disabilities helped to live at home per 1,000 population | 8.00 | 8.00 |

| | | | | |
|---|---|---|---|---|
| 3 | Improve outcomes for people living with disabilities and their carers through high quality, personalised services | Overall satisfaction of people who use services with their care and support<br>Outcomes framework:<br>Adult Social Care 3a<br><br>Overall satisfaction of carers with social services<br>Outcomes framework:<br>Adult Social Care 3b | 70%<br><br>47% | 70%<br><br>50% |
| 4 | Recognise the expertise and assets of disabled people and use these to improve services | Commissioned services demonstrating co-produced and personalised approaches to service development<br>Local indicator | 60% | 70% |
| 5 | Ensure efficient and effective use of resources | Maintain unit costs below England averages<br><br>Maintain quality of life for people with long term conditions higher than England average<br>Outcomes framework:<br>Adult Social Care 1a<br>NHS 2 | Benchmark against national published unit cost data<br><br>2013/14 baseline to be inserted | Benchmark against national published unit cost data |

An 'Outcomes Framework' provides a template of how measures can be used to monitor different priority areas. There are currently a number of recognised outcomes frameworks covering the NHS, Adult Social Care and Public Health. We will use these to inform our overall outcome measures and our performance indicators. As we achieve our desired outcomes we will review our priorities and change them if appropriate. More detail on these indicators can be found in the evidence paper.

It is also important that the quality of what we are delivering is monitored to make sure people have a positive experience. On-going customer feedback as well as activities such as local surveys and focus groups will be used to monitor current services and see where any improvements need to be made. The discussions that have taken place during the development of this framework should continue throughout the lifetime of the Strategy and to help in the development of the next JSNA and Strategy.

**PRIORITY 1: Promote the social model of disability to overcome the barriers faced by disabled people and build responsive, inclusive communities**

**The proportion of people who use services who feel safe**
(Outcomes Frameworks: Adult Social Care 4a, Public Health 1.19)
**Target 2014/15 64%  Target 2016/17 65%**

**Number of physically disabled people helped into voluntary work in the year**
**Target 2014/15 10  Target 2016/17 10**

## Why is this a priority?

The prevalence of disability will rise due to increased life expectancy at birth accompanied by increases in chronic health conditions such as diabetes, cancer and mental health.

Almost 1 in 5 of the population have rights under the disability provision of the Equality. Disability is a complex relationship between physical health and wellbeing and the features of society. People with more than 1 health condition are likely to be at significant risk of being disabled by the interaction of their impairments with social and environmental factors.

Disabled people are integral to the success of the economy and society but inequalities still exist and many face social exclusion. Overcoming the difficulties faced by disabled people requires interventions to remove the environmental and social barriers so those living with disability may realise their aspirations and play a full part in society.

## What do we want to achieve?

- Inclusive local communities where disabled people's voices are heard and they can realise their aspirations.
- Improved employment opportunities for disabled people
- Improved access for disabled people to accommodation and support options to maximise independence

| REF | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| 1a<br><br><br><br><br>1b | Local employment strategies will consider support needed for disabled adults to gain and maintain employment<br><br>Harness the opportunities created through local regeneration and enterprise developments to increase access to paid and voluntary employment for disabled people. | Increased numbers of disabled people in employment<br><br>Reduction in unemployment including youth unemployment and long-term unemployment | March 2015 | Staff time | Operational Director Enterprise and Property |
| 1c | Invite local transport | Disabled people | March 2015 | Staff time | Commissioning |

| | | | | | |
|---|---|---|---|---|---|
| | providers to listen to concerns of disabled passengers | influence quality of local transport provision | | | Manager<br>Logistics Lead Officer |
| 1d<br><br><br><br><br>1e | Work in partnership with social landlords to influence housing development to include the needs of disabled people<br><br>Promote the inclusion of lifetime homes and wheelchair standard dwellings in new developments | Increased number of new build lifetime homes and wheelchair accessible properties. | March 2015 | Staff time<br>Equipment and adaptations budget | Commissioning Manager |
| 1f | Work with local User Led Organisations (ULO's) and disability groups to ensure disabled people have their voices heard and needs recognised throughout the development and implementation of policies and services affecting them. | Monitor impact on disabled people and Recommendations made to relevant Board. | On-going across timelines of specific policy development. | Staff time<br>Halton Disability Forum | Commissioning Manager<br>Halton Disability Partnership |
| 1g | Evaluate the expansion of the Safe In Town initiative and future sustainability | Number of working age adults signed up | December 2014 | Staff Time | Commissioning Manager<br>Partnership Officer |

## PRIORITY 2: Support disabled people to have choice and control in their lives

**The proportion of disabled people who use services who have control over their daily life**
(Outcomes Framework: Adult Social Care 1b)
**Target 2014/15 80%  Target 2016/17 80%**

**Adults with physical disabilities helped to live at home per 1,000 population**

**Target 2014/15 8  Target 2016/17 8**

### Why is this priority?

Disabled people of all ages and backgrounds aspire to participate in every aspect of life – home and family, community life, education, training, employment and volunteering. They want the opportunity to participate fully in society and be valued for their contribution.

To achieve independent living disabled people need the same choice and control in their lives as everyone else. Having choice is key to improving health, maintaining independence and relationships within families and retaining lifestyles.

Disabled people are also more likely to experience poverty than non-disabled people.

### What do we want to achieve?

- Disabled people improve or maintain their mental wellbeing
- Disabled People are active members of their community
- Disabled people are financially stable and able to access benefit advice and support
- Improved access to information and advice for disabled people to self-manage their condition, keep healthy, active and well

| REF | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| 2a<br><br><br><br><br>2b | Review learning around use of public funding streams from Right to control Trailblazers<br><br>Evaluate the impact of personal health budgets and how the complex care pooled budget can support this. | Increased number of people in receipt of personal budgets and direct payments | March 2015 | Staff time<br>Community Care budget<br>Complex Care Pooled Budget | Divisional Manager Assessment and Care Management<br><br>Divisional Manager Urgent Care |
| 2c | Review impact of integrating Accessible Homes Register into Property Pool Plus to ensure system is not creating barriers to finding accessible property | Disabled people are able to choose suitable accommodation<br><br>Report and recommendations to SMT | December 2014 | Staff time | Commissioning Manager<br>OT Complex Needs |
| 2d | Identify opportunities to promote benefit/debt advice services | Increased number of Health and Wellbeing Practices<br><br>Voluntary Sector signposting | December 2014 | Staff time<br>Voluntary Sector Partners<br>HBC Internet site | Commissioning Manager |
| 2e | Ensure self- | | March 2015 | Staff time | Commissioning |

| | | | | | |
|---|---|---|---|---|---|
| | management of care needs information is readily available in a range of formats | | | Internet links to partner agencies | Manager Providers |
| 2f | Further develop Care and Support for You portal to offer online information on support options to maintain independence | Number of hits on portal | | | Divisional Manager Assessment and Care Management |
| 2g | Develop local Healthwatch information and signposting service | Numbers accessing the service | | Local Reform and Community Voices Grant | Commissioning Manager |
| 2h | Review Transition Strategy and Protocols to ensure remain in line with Support and Aspiration (DFE 2012) | Increased numbers of young people reporting a positive experience of transition | September 2014 | Staff time | Commissioning Managers Adults and Children's Services Transition Group |
| 2i | Work with the health and social care market to develop services that meet the raised expectations and aspirations of young adults. | | | | Commissioning Manager |
| 2j | Increase the use of Assistive Technology (telehealth and telecare) to enable people to be better supported at home | Maintain low level of admission rates for working age adults to residential care | December 2015 | Staff time | Divisional Manager Independent Living |
| 2k | Review access to and impact of support available at Halton Independent Living Centre to inform service development. | Report and recommendation to SMT | March 2015 | Staff time | Commissioning Manager |

**PRIORITY 3: Improve outcomes for people living with disabilities and their carers through high quality, personalised services.**

**Overall satisfaction of people who use services with their care and support**
(Outcomes Framework: Adult Social Care 3a)
**Target 2014/15 70%** **Target 2016/17 70%**

**Overall satisfaction of carers with social services**
(Outcomes Framework: Adult Social Care 3b)
**Target 2014/15 47%** **Target 2016/17 50%**

## Why is this priority?

Increases in life expectancy means people are living longer as disabled people both those disabled later in life and those disabled from birth. Evidence shows that disabled adults experience health inequalities and often experience difficulties in accessing health services including GP's and hospital services. Those with complex physical health and care needs are at high risk of unplanned admission to hospital. This is distressing and disrupting for them and their families. By improving community based support for those with complex physical health needs avoidable unplanned admissions can be reduced.

## What do we want to achieve?

- An enabling and preventative approach
- Maximise independence and good quality of life
- Young disabled people working towards achieving their aspirations
- Equal access to Health Improvement and Health Promotion initiatives
- Access to the right support to avoid unplanned hospital admissions
- Those with complex and on-going care needs retain control over how they are cared for and how they approach end of life
- Those with care and support needs feel safe, respected and maintain their dignity
- Carers are supported to maintain their caring role

| REF | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| 3a | Ensure person centred transition planning for young disabled people offers access to information to guide choices to maintain their education and to access employment | Information packs available and distributed through schools. | March 2015 | Staff time | Divisional Manager Assessment and Care Management |
| 3b | Review data relating to Acquired Brain Injury to determine trends | Enhanced focus on needs and better informed commissioning intentions | December 2015 | Staff time | Commissioning Manager Public Health |
| 3c | Ensure carers have access to information and advice on available support including carers breaks and respite | Increased numbers accessing carers breaks | December 2015 | Staff time | Commissioning Manager Carers Centre |
| 3d | Ensure short term Early Intervention | Increased numbers of adults aged | December 2015 | Staff time | Divisional Manager Urgent Care |

| | | | | | |
|---|---|---|---|---|---|
| | and Enablement services are being accessed by working age adults and develop an evidence base of the impact on supporting recovery and delaying dependency<br><br>3e Review access by younger adults to preventative services including telecare and telehealth support to ensure they are being used to full effect | under 65 accessing these services | December 2015 | Staff time | Divisional Manager Independent Living |
| 3f | Consider bariatric needs and use of equipment and assistive technology to maximise independence | Increased numbers of people with bariatric needs using assistive technology | July 2015 | Staff Time | Divisional Manager Independent Living |
| 3g | Promote the integrated Health and Wellbeing Service to health and social care professionals to increase referrals for disabled people including wheelchair users. | Source of referrals to Health and Wellbeing Service<br><br>Increased number of disabled people accessing health improvement and lifestyle services | April 2015 | Staff Time<br>Promotional materials | Health Improvement Team |
| 3h | Ensure current pathways to therapeutic and rehabilitation services including neuro-rehabilitation are clear, timely and flexible in their response | Reduce number of unplanned hospital admissions for adults under age 65 with long term conditions | December 2015 | Staff time | Commissioning Manager<br><br>Divisional Manager Urgent Care |
| 3i | Actively promote benefits of screening programs e.g. breast, cervical bowel cancer, to disabled people | Increased numbers accessing screening programs | December 2017 | Staff time<br>Promotion materials | Commissioning Manager Public Health |
| 3j | Embed Advanced Decision Making (ADM) tools into health and social care practice | Number of recorded ADM agreements in place. | September 2014 | Staff Time<br>Training | Divisional Manager Assessment and Care Management |
| 3k | Ensure safeguarding is balanced against independence and choice in all service specifications for | Minimise number of DOLS assessments<br><br>Increase in self-reported wellbeing | October 2015 | Staff Time | Commissioning Manager |

| | | | | | |
|---|---|---|---|---|---|
| | domiciliary, residential and supported living services | | | | |

**PRIORITY 4: Recognise the expertise and assets of disabled people and use these to improve services.**

**Commissioned services demonstrating co-produced approaches to service development**
**Target 2014/15 60%  Target 2015/16 70%**

## Why is this a priority?

Traditional models of support begin by exploring eligibility and entitlement to services which can undermine the resilience of people. By adopting an asset or strengths based approach people who use services, their families and the wider community contribute their in-depth knowledge of their requirements and how best to meet them to assist in the design, commissioning and provision of support and services rather than being passive recipients of services.

By placing the emphasis on more effective social care interventions, supporting the unpaid relationships and informal networks a person already has in place they are left better informed, connected and confident.

What do we want to achieve?

- co-design, including planning of services;
- co-decision making in the allocation of resources;
- co-delivery of services, including the role of volunteers in providing the service
- co-evaluation of the service.
- social care professionals and people who use services work in equal partnerships towards shared goals;
- people who use services and carers having an equal, more meaningful and more powerful role in services;
- people who use services and carers are involved in all aspects of a service – the planning, development and actual delivery of the service;
- power and resources are transferred from managers to people who use services and carers;
- the assets of people who use services, carers and staff are valued

| REF | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| 4a | Develop protocol for taking forward co-production in Halton | Co-production protocol in place | December 2014 | Staff time | Commissioning Manager |
| 4b | Implement Care Management Strategy to focus on the strengths and natural support already in place of those requesting an assessment | New working practices embedded | April 2015 | Staff time | Divisional manager Assessment and Care Management |
| 4c | Work in partnership with Halton Disability Partnership and other ULO's on policy and service development | Co-produced policies and service improvements | On-going through lifetime of the strategy | Staff time | Commissioning Manager<br>Halton Disability Partnership<br>Voluntary Sector organisations representing disabled people |

| PRIORITY 5: Ensure efficient and effective use of resources | |
|---|---|
| **Maintain unit costs below England averages**<br>**Target baseline Personal Social Services Expenditure 2013/14 published data**<br><br>**Maintain quality of life for people with long term conditions higher than England average**<br>(Outcomes Frameworks: Adult Social Care 1a, NHS 2)<br>**2013/14 baseline to be inserted** | |
| **Why is this priority?**<br><br>Halton is committed to empowering disabled people to take control of the decisions made regarding their needs and avoid or move away from dependency on formal care.<br><br>Both the Council and Clinical Commissioning Group face significant funding reductions accompanied by increased pressures on the system arising from increased life expectancy and increased numbers of people living with multiple long term conditions. Closer integration between health and social care to deliver better, more joined up services to disabled people are key to addressing these challenges and keep disabled people out of hospital or avoid long hospital stays. | **What do we want to achieve?**<br>• Good quality, locally provided care and support<br>• People with complex long term conditions enabled to remain independent in their local community<br>• Utilise Better Care Fund to commission more integrated and joined up pathways for those living with disability<br>• Achieve value for money |
| | |

| REF | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| 5a | Review scheduled JSNA disability prevalence data analysis and interpret strategic implications | Informed targeting of resources. | March 2015 | Staff Time<br>Refocus of existing resources | Public Health Commissioning Managers |
| 5a | Use integrated commissioning, contract monitoring and safeguarding arrangements to consolidate service specifications and quality standards of complex care | Percentage of providers rated good through local quality assurance reviews<br><br>Reduced numbers of safeguarding and VAA referrals | April 2015 | Staff time | Commissioning Manager<br>Quality Assurance Manager |
| 5b | Work with local providers to develop staff skills to better support those with the most complex needs | Number of delayed discharges for disabled adults under age 65 | March 2016 | | |
| 5c | Review existing contracting | Delivery targets met | March 2015 | Staff time | Commissioning Manager |

| | | | | | |
|---|---|---|---|---|---|
| | arrangements for equipment and minor adaptations to inform future procurement and value for money | | | | |
| 5d | Assess implications of the closure of the Independent Living Fund and transfer of responsibility for recipients to the Council in June 2015. | | March 2015 | Staff time<br>ILF transferred monies | Divisional Manager Independent Living<br>Senior Finance Officer |

Halton Clinical Commissioning Group

# Supporting Evidence Paper for

## Choice, Control, Inclusion - Commissioning Strategy for Adults of Working age in Halton 2014-2019

## &

## SeeHear - Commissioning Strategy for those living with sensory impairment in Halton 2014-2019

# Foreword

Halton Borough Council, NHS Halton Clinical Commissioning Group and Halton's Health and Wellbeing Board are driving improvement in the health and wellbeing of Halton people. A number of challenges to achieving this have been identified which highlight the significant

inequalities in life expectancy across the Borough and that 1 in 5 people in Halton live a greater proportion of their lives with an illness or health problem that limits their daily activities than in the county as a whole. Many disabled people commonly experience mental health problems such as anxiety or depression.

“Choice, Control, Inclusion” - Halton’s Commissioning Strategy for Physical Disability and “SeeHear” Halton’s Commissioning Strategy for those with sight and hearing loss 2014-2019 both incorporate national and local priorities described in Fulfilling Potential: Making it Happen and Halton’s Health and Wellbeing Strategy. This supporting evidence paper provides an overview of the national policy that has influenced the strategies and the local context is established through key statistical information. This evidence base encompasses adults of working age (18-64) who are disabled by their long term condition whilst Part 4 considers sensory impairments across all age groups.

The findings of the evidence paper will enable our partners, stakeholders and the wider community to understand the potentially disabling impact of living with a limiting long term condition. The strategy promotes independence, choice and control for disabled people through a collaborative approach that harnesses the assets and resources of local people and partner organisations across the Borough to deliver better outcomes. There is an emphasis on prevention and early detection/intervention to minimise the impact for individuals, their families and the local economy

The strategy and associated action plan complements other work programmes, including the local strategies and action plans for Prevention and Early Intervention, Stroke, Mental Health and Wellbeing and Carers.

# Part One : What do we mean by disability and Limiting Long Term Conditions?

- **In England, around 15 million (almost 1 in 3) people have a long term health condition and 10 million people say this limits their activity (DH/DWP estimates)**
- **In Halton, 1 in 10 16-64 year olds say their activity is limited by a long term condition – significantly higher than nationally**
- **By 2018 the number of people across all ages with multiple long term conditions (3 or more) will increase by a third (DH estimates)**
- **Nearly a third of people with long-term physical conditions have a concurrent mental health condition such as anxiety or depression (Centre for economic performance)**
- **Add Emergency admissions data 18-64**
- **Those with limiting long term conditions are half as likely to have a job than those with non-limiting or no long term condition**
- **At age 26 young disabled adults are 4 times more likely than their non-disabled peers to be unemployed**
- **Projections show significant increases in sight and hearing loss for those aged 65+ and particularly those aged 85+**

The World Health Organisation (WHO) describes disabilities as an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.

Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or

she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.[1]

The term disabled is also defined in The Equality Act 2010 which considers a person disabled if they have:

> *"a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities".*

Long-term conditions are defined by the Department of health as:

> "*those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal"*[2]

Among the most common of these conditions are hypertension, asthma, diabetes, coronary heart disease, chronic kidney disease, stroke and transient ischaemic attack, chronic obstructive pulmonary disease, heart failure, severe mental health conditions and epilepsy.

Within this evidence paper and accompanying strategy document, disabled people or disabled adults refers to those of working age who have one or more physical or sensory impairment or limiting long term condition which may be congenital or acquired at any age, temporary or long term, stable or fluctuating.

Sensory disability or impairment refers to people who are deaf, hearing impaired, blind or visually impaired. The term Deafblind, also called dual sensory loss, refers to combined sight and hearing loss, which leads to difficulties in communicating, mobility, and accessing information. Part Four of this evidence paper summarises the issues faced by those living with sensory loss and "See Hear" sets out the strategy and action plan for addressing these. The strategy explores needs arising from sensory impairment across all ages though prevalence is associated with ageing.

[1] http://www.who.int/topics/disabilities/en/

[2] https://www.gov.uk/government/policies/improving-quality-of-life-for-people-with-long-term-conditions

# Part Two: Fulfilling Potential: Making it Happen - The National Policy Context

*Fulfilling Potential: Making it Happen*[3] published in July 2013 sets out the Government's disability strategy. It places emphasis on the need for innovative cross-sector partnerships with disabled people and their organisations and promotes new ways of working to deliver meaningful outcomes. The strategy underscores the Government's commitments to the UN Convention on the Rights of Disabled People and to bring about the changes needed in communities that have a real and lasting effect on the day-to-day lives of disabled people. 'Fulfilling Potential-Making it Happen' also harnesses the inspirational power of the London 2012 Olympic and Paralympic Games to deliver further lasting change to attitudes and aspirations.

The strategy proposes six high level strategic outcomes (outlined below) with a supporting indicator. Key to delivery is partnerships across the public and private sector with disabled people and their representative organisations to overcome barriers faced.

| Strategic Outcome | Rationale | Headline Indicator |
|---|---|---|
| Education | Disabled people told us that education is fundamental, not just in school but in higher and further education, and in lifelong learning. | The gap in educational attainment between disabled and non-disabled young people at three key stages – GSCE, A-Level (or equivalent), and degree level. |
| Employment | Being in employment is a key life outcome, but also a driver for many of the other strategic outcomes. | The employment rate gap between disabled and non-disabled people |
| Income | Disabled people are more likely than non-disabled people to experience material deprivation. | The gap between the proportion of individuals in families where at least one person is disabled living in low income, and individuals in families where no-one is disabled living in low income.<br>The gap between the |

[3] Office for Disability Issues, Department for Work and Pensions, July 2013, Fulfilling Potential: Making it Happen

| | | |
|---|---|---|
| | | proportion of children living in families in low income with a disabled member, and children living in families in low income where no-one is disabled. |
| Health and well-being | Health outcomes are very important for everyone. Disabled people can experience poor health outcomes either as a direct or indirect result of their condition. Well-being presents an overarching indication of how satisfied disabled people feel with their life overall. | The gap between the proportion of disabled and non-disabled people reporting medium or high satisfaction with their life. |
| Inclusive communities | Communities that are inclusive to all people enable everyone to participate in and access all aspects of society. Particularly important to disabled people are transport; housing; social participation; friends and family; information and access; and attitudes. | Range of indicators across Housing, Transport, Social Participation, Friends and Family, Information and Attitudes. |
| Choice and control | To achieve independent living, disabled people should have the same choice and control in their lives as everyone else. | The gap between the proportion of disabled and non-disabled people who believe that they frequently had choice and control over their lives. |

Alongside *Fulfilling Potential: Making it Happen* the government also published supporting documents; Fulfilling Potential: Making it Happen - Action Plan[4] which captures current disability strategy activity and plans across the whole of Government and beyond. It sets out clearly in one place where innovative work through the Disability Action Alliance and disabled people's user-led organisations is being supported and encouraged.

Fulfilling Potential: Building a deeper understanding of disability in the UK today[5] is the evidence base that supports the national strategic direction set out in Making it Happen and aims to:

[4]Office for Disability Issues , Department for Works and Pensions, July 2013, Fulfilling Potential: Making it Happen - Action Plan

[5] Office for Disability Issues , Department for Works and Pensions, February 2013 Fulfilling Potential Building a deeper understanding of disability in the UK today

- provide an analysis of the current evidence on disability in the UK to inform the development of actions, outcomes and indicators;
- inform public understanding and prompt debate about disability and the issues faced by disabled people; and
- to raise awareness, drive a change in attitudes and support an increase in commitment to improving the lives of disabled people

## Care Act 2014

The Act delivers the commitments in the Government's white paper *Caring for our future: reforming care and support*[6], which set out the vision for a modern system that promotes people's well-being by enabling them to prevent and postpone the need for care and support and to pursue education, employment and other opportunities to realise their potential. The Act takes forward the recommendations of the Law Commission to consolidate existing care and support law into a single, unified, modern statute. It refocuses the law around the person not the service, strengthens rights for carers to access support, and introduces a new adult safeguarding framework.

The Act gives local authorities a new legal responsibility to provide a care and support plan (or a support plan in the case of a carer) and to review the plan to make sure that the adult's needs and outcomes continue to be met over time. For the first time, people will have a legal entitlement to a personal budget, which is an important part of the care and support plan. This adds to a person's right to ask for a direct payment to meet some or all of their needs. Even when an assessment says that someone does not have needs that should be paid for, the local authority can advise people about what needs they do have, and how to meet them or prevent further needs from developing. The Act requires local authorities to give information to people to help them support themselves better when this is the case.

This Act legislates for the changes recommended by the Commission on the Funding of Care and Support[7] to introduce a cap on the costs that people will have to pay for care in their lifetime.

Care standards are partially addressed by delivering a number of elements in the Government's response[8] to the findings of the Francis Inquiry, which identified significant failures across the health and care system that must never happen again. This response

6 Caring for our future: reforming care and support - White Paper 2012

7 www.dilnotcommission.dh.gov.uk/our-report/

8 www.gov.uk/government/news/putting-patients-first-government-publishes-response-tofrancis-report

aims to ensure that patients are 'the first and foremost consideration of the system and everyone who works in it' and restore the NHS to its core values.

## Health and Social Care Act 2012

The Government has created the first ever specific legal duties to tackle health inequalities including unequal outcomes for disabled people, such as those with learning disabilities.

The Secretary of State for Health has an overarching duty to have regard to the need to reduce inequalities relating to the health service, including both National Health Service (NHS) and public health, and relating to all the people of England

From April 2013, NHS commissioners must have regard to inequalities in access to, and outcomes of, health services when commissioning services.

NHS England and Clinical Commissioning Groups (CCGs) will have to explain in their plans how they propose to discharge their duties, and must include an assessment of how well they have discharged their duties in their annual reports. NHS England have included equality and health inequalities as part of its 2014-2017 Business Plan Putting Patients First[9].

## Fair Society, Healthy Lives

In 2010 the report of an independent review of health inequalities (the Marmot Review) commissioned by the Secretary of State for Health was published "Fair Society, Healthy Lives"[10]. The report outlined the most effective evidence based strategies for reducing health inequalities by action across all the social determinants of health including education, employment, housing transport and community. It stated that this could be achieved through two overarching policy goals:

1. **Create an enabling society maximising individual and community potential**
2. **Ensure social justice, health and sustainability is at the heart of all policies.**

Local Authorities have a key role in shaping the wider determinants of good health and supporting individuals, carers and communities. The public health white paper *Healthy lives, healthy people*[11] provided a comprehensive definition of public health, as aiming to improve public mental health and well-being alongside of physical health.

[9] http://www.england.nhs.uk/2014/03/31/ppf-business-plan/
[10] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[11] Department of Health (2010) Healthy Lives, healthy people. Available from: https://www.gov.uk/government/publications/healthy---lives---healthy---people---our---strategy---for---public---health---in---england

## National Service Framework for Long-term (Neurological) conditions

Launched in March 2005, this framework aimed to transform over a 10 year period, the way health and social care services support adults with long-term neurological conditions to live their lives. Key themes are independent living, care planned around the needs and choices of the individual, easier, timely access to services and joint working across all agencies and disciplines involved. The principles of the NSF are also relevant to service development for other long-term conditions.

Central to the NSF are 11 quality requirements, designed to put the individual at the heart of care and to provide a service that is efficient, supportive and appropriate at every stage from diagnosis to end of life. Progress in delivering these requirements will be achieved by working with local agencies involved in supporting people to live independently, such as providers of transport, housing, employment, education, benefits and pensions.

This NSF comes to an end in 2015 with no suggestion of a replacement. However the philosophy of the individual at the heart of care, partnership working and recognition of support for carers are now enshrined in the Care Act 2014 and embedded in working practices across the health and social care system.

## Vision 2020

The UK Vision Strategy was launched in 2008 in response to the World Health Assembly Resolution of 2003 which urged the development and implementation of plans to tackle vision impairment, now known as VISION 2020 plans.

The aims of the *UK Vision Strategy 2013-2018: Setting the direction for eye health and sight loss services12* are supported by UK governments, and implemented through a strong alliance of statutory health and social care bodies, voluntary organisations, eye health professionals and individuals.

[12] http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=291&sectionTitle=Strategy+publications

The strategy sets out a framework for change and the development of excellent services to build a society in which avoidable sight loss is eliminated and full inclusion becomes accepted practice. Underpinned by a set of core values it continues to respond to identified shortfalls in the UK's eye health, eye care and sight loss services and seeks to achieve the following strategic outcomes. An implementation plan for England is in development .

**Strategy Outcome 1: Everyone in the UK looks after their eyes and their sight**

**Strategy Outcome 2: Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support are available and accessible to all**

**Strategy Outcome 3: A society in which people with sight loss can fully participate**

The content of the refreshed UK Vision Strategy has drawn on the development of two key UK initiatives: *Seeing it my way* and the *Adult UK sight loss pathway.* Seeing it my way is a framework of outcomes identified as most important by blind and partially sighted people to drive how services are delivered to ensure that blind and partially sighted people benefit from these outcomes.

Public Health Outcomes Framework 2013-2016

Preventable sight loss has been recognised as a critical and modifiable public health issue of particular relevance when viewed in the context of an aging population. The Public Health Outcomes framework will monitor the proportion of Certificate of Visual Impairment (CVI) registrations related to the three major causes of sight loss; age-related macular degeneration, glaucoma and diabetic retinopathy.

## Strategy 2013-2018 Taking Action: Hearing loss a national and local response[13]

This strategy developed by Action for Hearing Loss (formerly Royal National Institute for the Deaf) outlines the organisations ambitions over the next five years including raising awareness by putting hearing loss on the national agenda. Informed by consultation the document has a focus on achieving three outcomes on how people want to be supported:

1. **Everyone has the right information, advice, care and support.**
2. **There is a range of equipment, treatments and cures available.**
3. **Equality and life choices are not limited**

[13] http://www.actiononhearingloss.org.uk/about-us/our-strategy-taking-action.aspx

## The Disabled People's Right to Control (Pilot Scheme) (England) Regulations 2010

The Right to Control was a legal right for disabled people giving them more choice and control over the support they needed to go about their daily lives. The pilot tested how disabled adults living in seven test areas would be able to combine the support they receive from up to six different sources and decide how best to spend the funding to meet their needs. During the pilot disabled people were able to choose to:

- continue receiving the same support
- ask a public body to arrange new support
- receive a direct payment and buy their own support
- have a mix of these arrangements.

The Funding streams that were available were:

- Access to Work (Department for Work and Pensions)
- Work Choice (Department for Work and Pensions)
- Independent Living Fund (Department for Work and Pensions)
- Disabled Facilities Grant (Department for Communities and Local Government)
- Supporting People -Non-statutory Housing related support (Department for Communities and Local Government)
- Adult Social Care (Department of Health)

The Right to Control requires a significant culture change for managers, staff, customers and providers. The Pilot ended in 12 December 2013 and the DWP Minister for Disabled People is now considering the findings.

## Making It Real - Personalisation (Self Directed Support)

Introduced by "Putting People First" personalisation of support and access to personal budgets are now integral to the Care Act 2014 which sees a model of social care designed to empower individuals and their carers by giving them control to choose the type of support or help they want and influence over the services on offer. This model is now being extended to people with NHS Continuing Healthcare needs through personal health budgets.

Think Local Act Personal (TLAP) is a national, cross sector leadership partnership focused on driving forward with personalisation and community based support – the process of enabling people to be in more control of the care and support services they receive. It encourages interaction between those using services, carers, Councils and other groups.

“Making it Real” is a set of "progress markers" - written by real people and families which sets out what people who use services and carers expect to see and experience if support services are truly personalised. The markers can help an organisation to check how they are going towards transforming adult social care. The aim of Making it Real[14] is for people to have more choice and control so they can live full and independent lives.

Personalisation fundamentally changes the relationship commissioners have with suppliers and their customers. This presents commissioners with a significant challenge. As people increasingly take the option of self-directed support, the role of strategic commissioners will change to become more concerned with market development and management and this is underpinned by new duties for local authorities set out in the Care Act. Securing value for money and financial sustainability will, however, remain key concerns for commissioners, who must continue to ensure cost-effective and appropriate use of public money whilst ensuring that local people and communities are involved in strategic commissioning decisions.

Commissioners need to understand the choices that people are making in terms of provision and how those choices are limited by gaps in the market. Within this new commissioning environment local service providers will need to be both flexible and agile. Providers will need to increase the range of support packages available to help people to remain at home longer and consider more innovative alternatives to meeting the care needs of vulnerable people.

Commissioners will need to enable providers outside the social care market to contribute to the independence of local people, by fostering innovation and improved choice.

### The Welfare Reform Act 2012 and resilience to the economic downturn

This Act has been described as the biggest shake up of the benefits system in 60 years. It aims to simplify the system and create the right incentives to get people into work by

[14] http://www.thinklocalactpersonal.org.uk/Browse/mir/aboutMIR/

ensuring that no individual is better off by not working. Key features of the Act that will have the most significant impact on Halton's residents are:

- Introduction of Universal Credit. The level of Universal Credit is to be capped at £26,000. While it is estimated that only a small number of Halton residents will see their income reduce as a result of the cap, some will be significantly affected. In addition, Housing Benefit is to be included in Universal Credit and will consequently be paid directly to tenants of social housing.
- Replacement of Disability Living Allowance with a Personal Independent Payment (PIP) for those of working age. Halton has a disproportionate amount of disabled residents and the change to PIP will involve a reduction in the numbers of those receiving financial assistance.
- Changes to Housing Benefit including the introduction of an under occupancy penalty for households whose homes are deemed to be too large for their needs. Described as the "Bedroom Tax", this change will have a very significant impact for Halton residents.

It is too early to assess the impact of other reforms such as the on-going reassessment of Incapacity Benefit claimants against the stricter criteria of the Employment Support Allowance, changes to Community Care Grants and Crisis Loans and recent reforms to Council Tax benefit which will include a 10% cut in scheme funding and "localised" benefit schemes.

Studies[15] show coping with the impact of the recession and rising costs of living have created a stressful burden for many by having to economise on food, heating and travel. Such effects occur disproportionately among people with disabilities, ethnic minorities, the poor, some women and single mothers (and their children), young unemployed and older people.

Cuts in public spending are affecting services that promote long-term health and wellbeing (such as: adult social care, libraries, community centres) and their reduction or closure could threaten the health of the vulnerable and the elderly.

[15] Assessing the impact of the economic downturn on health and wellbeing - Liverpool Public Health Observatoryhttp://www.liv.ac.uk/PublicHealth/obs/publications/report/88_Assessing_the_Impact_of_the_Economic_Downturn_on_Health_and_Wellbeing_final.pdf

It is estimated that 50-60% of disabled people live in poverty and are particularly vulnerable to cuts in public sector services and any changes in levels of entitlement or support can have life changing implications. There is also substantial evidence that poverty is both a determinant and a consequence of mental health problems.

These impacts are long term and will continue beyond entering financial recovery. The report suggests consideration should be given to:

- Health and social care professionals being trained to recognise debt triggers and sources of help for money problems
- Base debt/welfare benefit advisors in GP surgeries and hospital clinics
- Review access to welfare benefit/debt advice services and Credit Union.
- Continue programs of integration of care, health and potentially housing and leisure to minimise back office costs, maintain front line services and improve outcomes through seamless and jointly commissioned support.
- Develop a strategy of progression – 'Just Enough Support' so there is less reliance on formal services and more community based support (Prevention and Early Intervention Strategy)

# Part Three: Disability in Halton

## Halton's Vision

**"Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and a safer, stronger and more attractive neighbourhood." (Sustainable Community Strategy 2011-2026)[16]**

## Halton Core Strategy Local Plan

The Core Strategy[17] provides the overarching strategy for the future development of the Borough, setting out why change is needed; what the scale of change is; and where, when and how it will be delivered. It does this through identifying the current issues and opportunities in the Borough, how we want to achieve change and stating the future vision for Halton to 2028. To deliver this vision the Core Strategy sets out a spatial strategy stating the extent of change needed and the core policies for delivering this future change.

The Core Strategy will help to shape the future of Halton, including its natural and built environments, its communities and ultimately peoples' quality of life. The Core Strategy therefore joins up a range of different issues such as housing, employment, retail, transport and health. This is known as 'spatial planning'.

## Halton Priorities

Halton's Strategic Partnership has set out five strategic priorities for the Borough, in its Sustainable Community Strategy 2011-2026, which will help to build a better future for Halton:

- A Healthy Halton
- Employment learning and skills in Halton
- A Safer Halton
- Children and Young people in Halton

[16] (http://www3.halton.gov.uk/lgnl/pages/86821/86827/174277/Sustainable_Comunity_Strategy_2011__final_Nov_11_.pdf)

[17] http://www3.halton.gov.uk/lgnl/policyandresources/policyplanningtransportation/289056/289063/314552/1c)_Final_Core_Strategy_18.04.13.pdf

- Environment and Regeneration in Halton

## Corporate Plan

The Corporate Plan[18] presents the councils response to how it will implement the Community Strategy. This is achieved through a framework consisting of a hierarchy of Directorate, Division and Team Service Plans known as 'the Golden Thread' this ensure that all strategic priorities are cascaded down through the organisation through outcome focused targets. The Five strategic priorities discussed above are mirrored in the makeup of the Councils Policy and Performance Boards which together with the Executive Board provide political leadership of the Council.

## Health and Wellbeing Board and Strategy

Halton Health and Wellbeing Board has developed a vision that aims "To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives".

The Board has developed a strategy which has been informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, and has identified five key priorities for action.

- 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

The Joint Health and Wellbeing Strategy set the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. It does not replace existing strategies, commissioning plans and programmes, but influences them.

Within Halton there is an increasing shift to improving the prevention and early intervention services in the Borough, including public health improvement/promotion services. There is evidence from the evaluation of the Partnerships for Older People (POPP) programme that the funding of more prevention and early intervention services has a positive impact on

[18] http://councillors.halton.gov.uk/documents/s14868/ExecB%2022Sept11%20DftCorpPlanAppend.doc.pdf

acute services. The development of preventative services with higher emphasis on support to better self-manage conditions will continue to shift the focus from being reactive to proactive reducing the demand for more acute interventions.

The Complex Care Executive Commissioning Board has a remit to develop and oversee Strategies and action plans based on national best practice as outlined in Part Two including the National Disability Strategy "Fulfilling Potential: Making it Happen". The Board is responsible for developing actions that will feed into the Health and Wellbeing Board who will, in turn, co-ordinate commissioning activity to address identified needs

This strategy prioritises action to increase prevention, early detection and treatment of long term conditions as well as robust and comprehensive services for people with chronic and progressive degenerative health problems.

Underpinning this strategy is a philosophy of personalisation which maximises independence and control by empowering individuals to take responsibility for their own support and minimise the impact on their mental wellbeing. The strategy recognises that good mental wellbeing brings much wider social and economic benefit for the population.

## Integrated working

As national reforms continue to take shape, work has already taken place locally to look more strategically at improving models for integrated working and this vision has been captured within the **Framework for Integrated Commissioning in Halton (2012).** The Framework outlines the current strategic landscape of commissioning across Halton and explores national good practice translating this into an action plan.

In support of the implementation of the Framework, work is currently progressing in respect of the development of a Section 75 Partnership Agreement between Halton CCG and HBC which will provide robust arrangements within which Partners will be able to facilitate maximum levels of integration in respect of the commissioning of Health and Social Care services in order to address the causes of ill health as well as the consequences. Part of this Agreement has a focus on the commissioning of services for long term conditions.

Halton has identified further integration to support the strategic approach with all partners working together to deliver:

- joint commissioning

- culture change through community development
- training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work

## Better Care Fund (formerly Integration Transformation Fund)

Government believes that*:*

> *"to improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs."*[19]

Nationally a £3.8 billion pooled budget for health and social care services has been established to be shared between the NHS and local authorities to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. Access to this funding is based on a plan agreed between the NHS and local authorities that will deliver on national conditions:

- Protecting social care services;
- 7-day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional

National reforms and the introduction of the BCF will introduce a more comprehensive approach to joint working with increased influence of local people in shaping services, led by democratically-elected Councillors, the Health and Wellbeing Board and the local Health Watch, so that services can better address local need and be more joined up for the people using them.

Halton's Strategy is focussed on prevention of ill health and poor emotional wellbeing, early detection of disease, support people to remain independent at home, manage their long-term conditions, wherever possible avoid unnecessary hospital admissions and in situations where hospital stays are unavoidable ensure that there are no delays to their discharge.

HBC and NHS HCCG already have pooled budget arrangements in place to support people at home or within the community with various services to prevent more intensive intervention and to improve health gains. There are a range of integrated services which focus on promoting recovery from illness, preventing unnecessary hospital admissions or premature admissions to residential care, supporting timely discharge from hospital and maximising opportunities for independent living.

[19] Spending Review 2013, HMT

Payments of BCF in Halton will be made based on local performance related to:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service-user experience

## Halton Clinical Commissioning Group 5 year Strategic Plan and 2 year Operational plan

The 5-year strategic plan is totally aligned with the Better Care Fund (BCF). This integrated approach has identified 8 priority areas where the opportunities are greatest to transform our healthcare delivery, these are;

1. Maintain and improve quality standards
2. Fully Integrated commissioning and delivery of services across Health & Social care
3. Proactive prevention, health promotion and identifying people at risk early
4. Harnessing transformational technologies
5. Reducing health inequalities
6. Acute and specialist services will only be utilised by those with acute and specialist needs.
7. Enhancing practice based services around specialisms
8. Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population.

In overall strategic terms the health and adult social care system will focus on prevention, supporting people to remain independent at home, manage their long term conditions and wherever possible avoid unnecessary hospital admissions.

The strategic aims of the plan are:

1) Integrated Commissioning
2) Health and wellbeing of individuals in our community
3) Supporting Independence
4) Managing complex care and care closer to home

Over the next five years NHS Halton CCG, Halton Borough Council and our partners face significant financial challenges. These financial challenges are driving us to do things

differently and transform all aspects of health, social care and wellbeing in Halton beginning with a robust 2 years operational delivery plan. The 2 year operational plan summarises the key actions for each priority area that will provide real improvements in the health and wellbeing of the people of Halton.

## Urgent Care Partnership Board

Admissions data needed

The government's approach to delivering a new NHS is based on a set of core principles and their aim is to create an NHS which is much more responsive to patients and achieves better outcomes, with increased autonomy and clear accountability at every level.[20] A vital part of this will be having an effective and efficient Urgent Care pathway that is able to support the needs of the local population.

The Department of Health defines what urgent care is:

> "Urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly."

In Halton the Urgent Care Board is a multi-agency group that includes HBC, CCG, Warrington and Halton Hospital Trust, Whiston Hospital, North West Ambulance Service and Bridgewater Community NHS Trust. The work programme is driven locally by an agreed implementation plan derived from local baseline data and key national drivers.

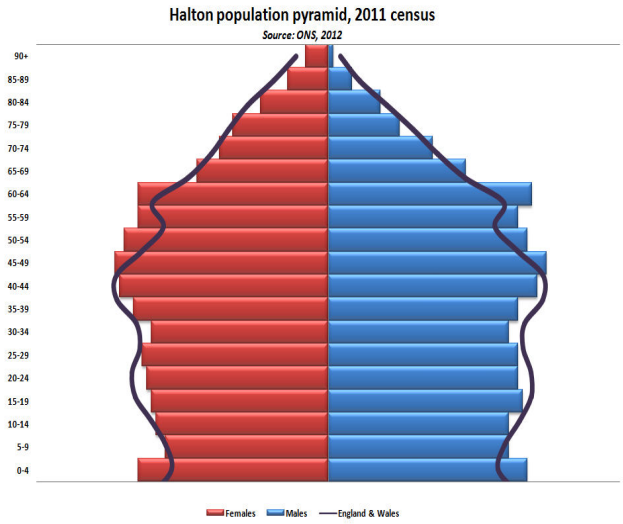
Current focus of work is the development of an Urgent Care Centre in both Widnes and Runcorn to offer community based diagnosis and treatment of conditions to prevent deterioration of health and avoid inappropriate attendances at Accident and Emergency Departments. The Centres should be operational in late 2014.

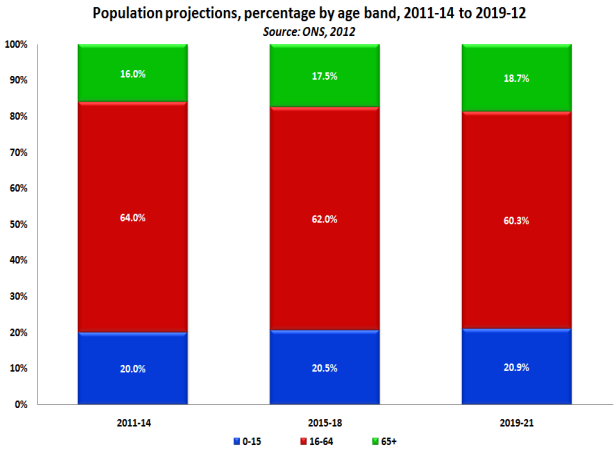
## Halton's Demographic Information

### Population

Halton is a largely urban area of 125,700 (2011 Census) people. Its two biggest settlements are Widnes and Runcorn. The population is predominantly white (98.6%) with relatively little variation between wards.

[20] The White Pape: Equity and Excellence: Liberating the NHS DH 2010 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf




Halton's population structure is slightly 'younger' than that seen across England as a whole. However, in line with the national trend, the proportion of the population in the working age bands i.e. 16-24 years and 25-64 years is projected to fall with the younger age band i.e. 0-15 years, projected to rise slightly. The most significant shift is the proportion of the population in the older age band.

## Deprivation

Deprivation is a major determinant of health. Lower income levels often lead to poor levels of nutrition, poor housing conditions, and inequitable access to healthcare and other services. Deprivation, measured using the English index of Multiple Deprivation (IMD) 2010, ranks Halton as 27th most deprived out of 326 local authorities (a ranking of 1 indicates the area is the most deprived). This is the 3rd worst out of the six local authorities which make up the Liverpool City Region, behind Liverpool and Knowsley.

The 2010 IMD shows that deprivation in Halton is widespread with 60,336 people (48% of the population) in Halton living in 'Lower Super Output Areas' (LSOA's) that are ranked within the most deprived 20% of areas in England.

In terms of Health and Disability, the IMD identifies 53 SOA's (Super Output Areas) that fall within the top 20% most health deprived nationally and that approximately 40,000 people in Halton (33% of the population) live in the top 4% most health deprived areas in England. At ward level, Windmill Hill is the most deprived area in terms of health. However, health deprivation is highest in a LSOA within Halton Castle, ranked 32nd most deprived nationally.

## Health

Health is a key determinant of achieving a good quality of life and the first priority of Halton's Sustainable Community Strategy. This states that 'statistics show that health standards in Halton are amongst the worst in the country and single it out as the aspect of life in the Borough in most urgent need of improvement'.

Those living with long term physical conditions are the most frequent users of health and care services and commonly experience mental health problems such as depression and anxiety. Care of people with long term conditions accounts for 70% of the money spent on health and social care in England[21].

## Numbers of disabled people in Halton

In Halton, more than 1 in 5 people (21.4%)[22] are living a greater proportion of their lives with an illness or health problem that limits their daily activities. Amongst the age 16-64 population more than 1 in 10 people say their activity is limited. This is slightly higher than the North West and significantly higher than in England (1 in 12).

It is difficult to estimate the numbers of working age disabled people in Halton. Benefit claims are a better guide than Limiting Long Term Illness (LLTI) figures and in November 2012 8.53% of the 16-64 age group were claiming Disability Living Allowance[23] which contributes towards the disability-related extra costs of severely disabled people under the age of 65. 7,780 (9.4%) were claiming Incapacity Benefit (now Employment Support Allowance) this is higher than the North West and England averages and most of these people have been receiving this benefit for more than three years.

Halton's Public Health service will undertake an in-depth analysis of local data relating to disability to refresh the Halton JSNA. This will be available by the end of 2014 and any implications will be incorporated into the strategy action plan

## Young disabled people

Early years in a child's life are a key time in the formation and development of aspirations. The levels of aspirations among disabled 16 year olds are similar to those of their non-disabled peers and they expect the same level of earnings from a full-time job. However, by

[21] Improving quality of life for people with long term conditions dh.gov.uk Norman Lamb
[22] Census 2011
[23] http://hbc/teams/RESINT/SharedDocuments/PeerReview/HealthBubbles.pdf

the age of 26 young disabled adults are nearly four times as likely to be unemployed compared to non-disabled people? By the age of 26 disabled people are less confident and more likely to agree that 'whatever I do has no real effect on what happens to me'. At age 16 there had been no significant differences between them and their non-disabled peers on these measures.[24]

The Transition between being a young person to being an adult is a time of great change and opportunity for all young people, but it can also present challenges, particularly for young people who have social and health care needs arising from sensory and physical disabilities, long-term conditions, learning disabilities or mental health problems.

The detail of Halton's approach to transition is described in the *Halton Multi-Agency Transition Strategy* and *Transition Protocol* and includes support in identifying realistic post 16 opportunities for living life, ensuring universal services consider the needs of young disabled people and support to reduce the numbers of disabled young people who are not in education, employment or training. By establishing a stable base for quality of life as an adult future issues and dependency relating to mental health and wellbeing can be minimised or avoided.

### *Young People with identified social care needs as adults*

Age at 31st August 2014

| Age | 15 | 16 | 17 | 18 |
|---|---|---|---|---|
| At 01/08/2014 | | | | |
| Visual impairment | | 1 | 2 | 1 |
| Hearing impairment | 1 | | 1 | 2 |
| Physical disability | | | 8 | 4 |
| **TOTAL** | **1** | **1** | **11** | **7** |

In Halton we recognise that planning for this transition needs to start early, and the planning processes will be geared to this from Year 9 at school (when the young person is about 14). Although young people officially reach adulthood at 18, we recognise that young adulthood

[24] Fulfilling Potential –Building a deeper understanding of disability in the UK today

continues to be a time of considerable change, and so the transition arrangements will continue until the age of 25.

## Life Expectancy and Disability Free Life Expectancy at birth (DFLE)

Life expectancy has risen steadily over time. In 2010-12 average life expectancy in the borough was 77.1 years for men and 79.2 years for women. However, the borough is consistently lower than its comparators (about 3 years lower than the England figures).

Disability-free life expectancy is the average number of years an individual is expected to live from birth, free of disability if current patterns of mortality and disability continue to apply.

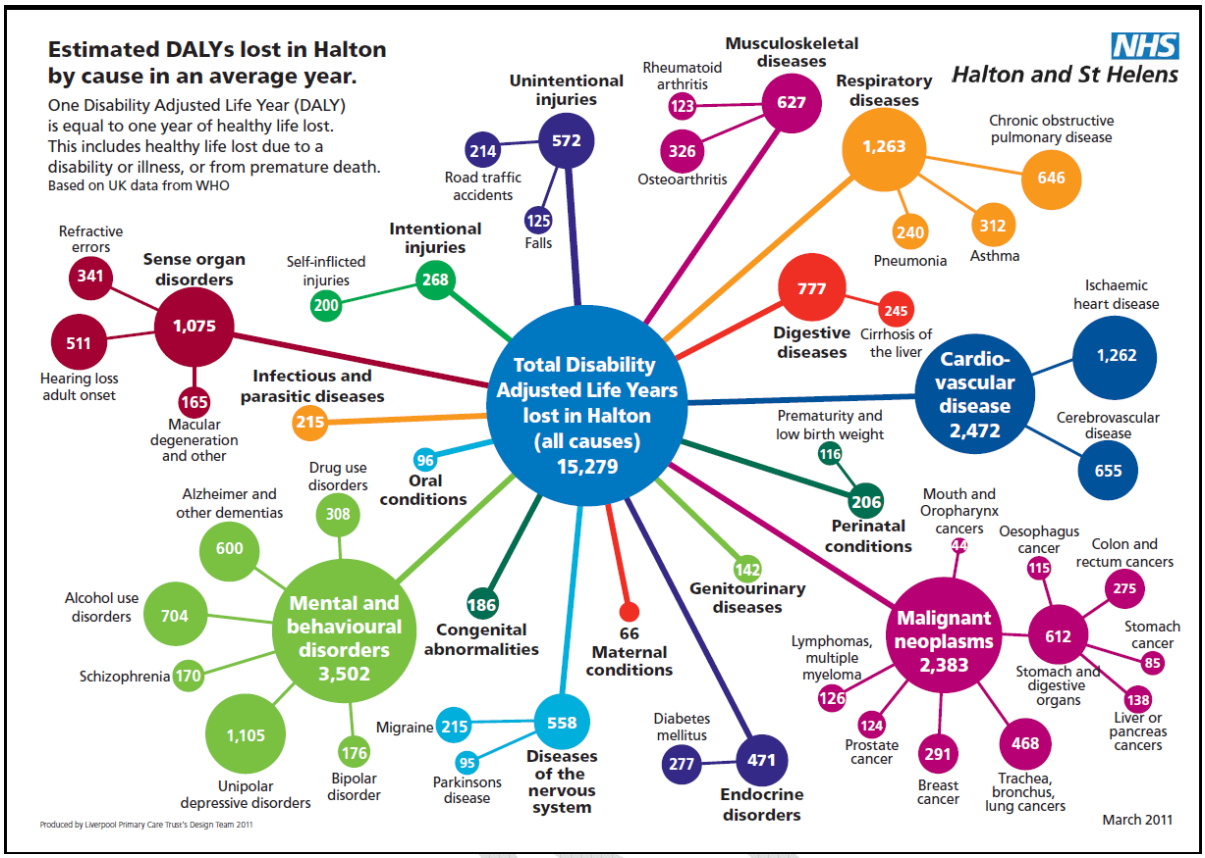
As life expectancy continues to increase in the UK, it is important to ask what proportion of these additional years of life are being spent in favourable states of health or in poor health and dependency. The figures represent a snapshot of the mortality and health status of the entire specified population in each time period not the number of years that a member of the specified population will actually live in a given health state.

Halton has a lower DFLE at birth than both the North West and England (2010-2012)[25]

| | Males | | Females | |
|---|---|---|---|---|
| | Life expectancy at birth | DFLE | Life expectancy at birth | DFLE |
| Halton | 77.1 | 59.8 | 79.2 | 64.1 |
| England | 79.2 | 64.1 | 83.0 | 65.0 |

An alternative representation of healthy life lost in Halton is the Disability Adjusted Life Year bubble chart combining years of life lost due to premature mortality and years of life lived in states of less than full health.

[25] http://www.ons.gov.uk/ons/datasets-and-tables/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=DFLE&content-type=Reference+table&content-type=Dataset




## Disability and Impairment

Most people are not born with an impairment but acquire an impairment in their adult life, mostly from the age of 50. The experiences of young people who are born with or acquire impairment in childhood are very different to those of someone who acquires an impairment later in life and who has lived through a large part of their life as a non-disabled person.

The Projecting Adult Needs and Service Information System (PANSI) uses national prevalence rates by age from the 2001 Health Survey for England applied to Halton's population projections to predict future numbers of working age disabled and sensory impaired residents in the Borough[26]:

The headline message conveyed in this analysis is that numbers of people with moderate/serious physical disability will reduce slightly but an aging population means an increase of 4% in the 55-64 age group.

- Similar trends are evidenced for sensory impairments amongst the working age population

[26] http://www.pansi.org.uk/

- There are significant increases in levels of sensory impairment amongst those aged over 65 and particularly over age 85
- The impact of dual sensory loss is a potential issue amongst the older population.

## Disability and health

People with disabilities have the same general health needs as non-disabled people and need access to mainstream health care and health improvement services – immunization, cancer screening etc. Disabled people may also experience a narrower margin of health, both because of poverty and social exclusion, and also because they are often vulnerable to secondary conditions and many have more than one health condition.

Evidence suggests that people with disabilities face barriers in accessing the health and rehabilitation services they need in many settings. Health promotion and prevention activities seldom target people with disabilities. For example women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Adolescents and adults with disabilities are more likely to be excluded from sex education programmes.[27]

Most people with a long-term health condition play an active role in managing their condition (83%). However, this varies by type of impairment. Those with mental health conditions or learning disabilities are less likely to feel confident about managing their condition themselves.[28]

## Disability and Secondary Health Conditions

Amongst adults of working age with on-going impairments 37% reported living with one impairment and 41% reported three or more impairments[29]. People with more than one health condition are likely to be at significant risk of being disabled by the interaction of their impairments with social and environmental factors.

The ageing process for some groups of people with disabilities begins earlier than usual. For example some people with developmental disabilities show signs of premature ageing in their 40s and 50s.

[27] http://www.who.int/mediacentre/factsheets/fs352/en/
[28] http://odi.dwp.gov.uk/docs/fulfilling-potential/building-understanding-main-report.pdf
[29] https://www.gov.uk/government/publications/life-opportunities-survey-wave-one-results-2009-to-2011

## Long Term Conditions (LTC) and Limiting long standing illness

LTCs are not just a health issue they can have a significant impact on a person's ability to work and live a full life. People from lower socio economic groups have increased risk of developing a LTC whilst better management can help to reduce health inequalities.

The two key factors for developing a LTC are lifestyle and ageing. Prevention, delaying onset and slowing progression of long term conditions can happen through improved public health messaging/targeting, personalised care planning, information and supported self-care. Effective management of a condition can slow progression having a positive impact not only on people's lives but on reducing health and social care costs.

Advances in medicine mean people of all ages not just those over age 75, are living with complex health needs. Data analysis[30] indicates 22% of men in the 16-64 age group self-reported living with a limiting illness whilst the figure for women is 23% (this includes mental ill health).

Nationally it is estimated that by 2018, the number of people across all ages with three or more health conditions whether physical or mental or both will rise by a third[31] Failure to respond effectively to these challenges is reflected in the numbers of people admitted to hospital in an emergency. At least one fifth are estimated to be directly avoidable in some way. [32] Potentially the impact of multi-morbidity will be disabling for many people.

Some studies have indicated that people with disabilities have higher rates of risky behaviours such as smoking, poor diet and physical inactivity. People with at least one LTC are more likely to have high blood pressure and be obese, though it is unclear the direction of causation[33].

NHS England have responsibility for coming up with plans to help make life better for people with long term conditions by:

- helping them to get the skills to manage their own health
- agreeing with them a care plan that is based on their personal needs
- making sure their care is better coordinated

[30] Health survey for England 2009( HSCIC)
[31] Fulfilling potential – Building understanding (ODI 2013)
32 Transforming Primary Care (DH 2014)
[33] Long Term Conditions Compendium of Information: Third Edition (DH 2012)

## Long Term Conditions and Mental Health

Every long term condition will affect different people in different ways. However there are some common issues that can affect a lot of people living with long term conditions. These issues are not symptoms of mental health problems but can be difficult to cope with and can sometimes trigger anxiety, depression and other psychological problems meaning people with long term conditions are at far higher risk of developing mental health problems than the rest of the population. 30% of people with long term conditions will have potential mental ill health such as anxiety or depression[34] compared with only 9% of other adults. This is believed to be a conservative estimate and can lead to significantly poorer health outcomes and reduced quality of life.

The government's mental health outcomes strategy *No Health Without Mental Health* places considerable emphasis on the connections between mental and physical health, and gives new responsibilities to Improving Access to Psychological Therapy (IAPT) services for supporting the psychological needs of people with long-term conditions or medically unexplained physical symptoms. Locally *A Mental Health and Wellbeing Strategy 2013-2018 for Halton* overseen by the Mental Health Strategic Commissioning Board promotes local action to improve the mental health and wellbeing of those with physical illness.

## Long-term neurological conditions (LTNCs)

Long-term neurological conditions (LTNCs) comprise a diverse set of conditions resulting from injury or disease of the nervous system that will affect an individual for life. Some 2 million people in the UK are living with a neurological condition, excluding, migraine[35], which has a significant impact on their lives; they account for 20% of acute hospital admissions and are the third most common reason for seeing a GP.

LTNCs can be broadly categorised as follows:

- **Sudden onset**, for example acquired brain injury or spinal cord injury, followed by a partial recovery.

[34] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf
[35] http://www.nao.org.uk/wp-content/uploads/2011/12/10121586.pdf

- **Intermittent and unpredictable**, for example epilepsy, certain types of headache or early multiple sclerosis, where relapses and remissions lead to marked variation in the care needed;
- **Progressive**, for example motor neurone disease, Parkinson's disease or later stages of multiple sclerosis, where progressive deterioration in neurological function leads to increasing dependence on help and care from others. For some conditions (eg motor neurone disease) deterioration can be rapid;
- **Stable**, but with changing needs due to development or ageing, for example post-polio syndrome or cerebral palsy in adults.

The time course of conditions varies widely as does the effect on an individual. Problems commonly experienced are:

- Physical or motor – inability to walk, paralysis, loss of functions
- Sensory – vision, hearing, pain and altered sensation
- Cognitive/behavioural
- Communication difficulties

The NSF drives the philosophy of supporting people with LTnC to live as independently as possible. It is recognised that people with LTnC have improved health outcomes and a better quality of life if they can access prompt advice and support from relevant practitioners with dedicated neurological expertise.

Rehabilitation over a sustained period of time to regain former skills where possible and compensate for skills lost can be a key factor in determining quality of life. The services a person needs can change particularly where conditions rapidly deteriorate or fluctuate. Access to appropriate equipment and to appropriate health and social care professionals, as necessary is essential. Such professionals may include speech and language therapists, occupational therapists, physiotherapists, neuropsychologists, clinical psychologists, rehabilitation physicians, orthotists and care managers.

## Promoting Equality and Reducing Inequality

Fulfilling Potential[36] places an emphasis on tackling health inequalities and promoting equality. It identifies that those already disadvantaged are at greater risk of becoming disabled and that there are strong associations between being poor, being out of work,

[36] Fulfilling Potential: Building a Deeper Understanding of Disability in the UK today DH 2013

having low educational qualifications and the risk of developing a long term health condition or impairment. Those in the bottom fifth of the income distribution face a risk of becoming disabled two and a half times as high as those in the top fifth of the distribution.

Pre-existing disadvantage such as low or no qualifications; low income; being out of work; smoking; drinking and poor diet are associated with increased likelihood of onset of a health condition or impairment and onset is associated with increased likelihood of disadvantage such as unemployment or poverty. Having qualifications can provide protection against the adverse effects of onset.

Disability can affect many parts of a person's life, from their ability to work and have relationships to housing and education opportunities. The Office for Disability Issues (ODI) provides an overview of UK disability statistics.[37] Some key messages from this are:

- Employment – although disabled people are now more likely to be employed than they were in 2002, they remain significantly less likely to be in employment than non-disabled people. If the disabled people employment rate matched that of the rest of the population, nationally an extra two million disabled people would be working.

- Disabled people remain significantly less likely to participate in cultural, leisure and sporting activities than non-disabled people. Disabled people are more likely to have attended a historic environment site, museum or gallery than in 2005/06 but are less likely to have attended a library over the same period.

- Disabled people are significantly less likely to engage in formal volunteering.

- 88 percent of buses now have low-floor wheelchair access. Around a fifth of disabled people report having difficulties related to their impairment or disability in accessing transport.

- Although the gap in non-decent accommodation has closed over recent years, one in three households with a disabled person still live in non-decent accommodation

Fulfilling Potential identifies the following aspects to reducing inequality for disabled people:

- Access to housing
- Environmental barriers

[37] www.odi.dwp.gov.uk/disability-statistics-and-research/disability-facts-and-figures

- Transport
- Social participation
- Choices
- Information
- Public Attitudes

There have been significant improvements in educational attainment, in the employment rate and a reduction in the employment rate gap between disabled and non-disabled people. There have also been improvements in other factors contributing to quality of life, for example in access to transport and access to goods and services. Even so, disabled people can still face significant barriers to fulfilling their potential and playing a full part in society[38].

Through its enabling role the Council works with local communities on service developments, facilities and resources to ensure they promote equality through inclusion and equitable treatment whilst eliminating discrimination and advancing equality of opportunity for disabled people.

## Employment

Disabled people are more likely to be long term unemployed and economically inactive. Fulfilling Potential highlights that 60% of disabled working-age adults are not in paid work compared to only 15% of their non-disabled counterparts. A third of these people - 1 million people - say that they want to work but that they have not been able to find a job.

The Labour Force survey provides an insight into numbers of disabled people who would like to work. It categorises the unemployed working age population into two groups:

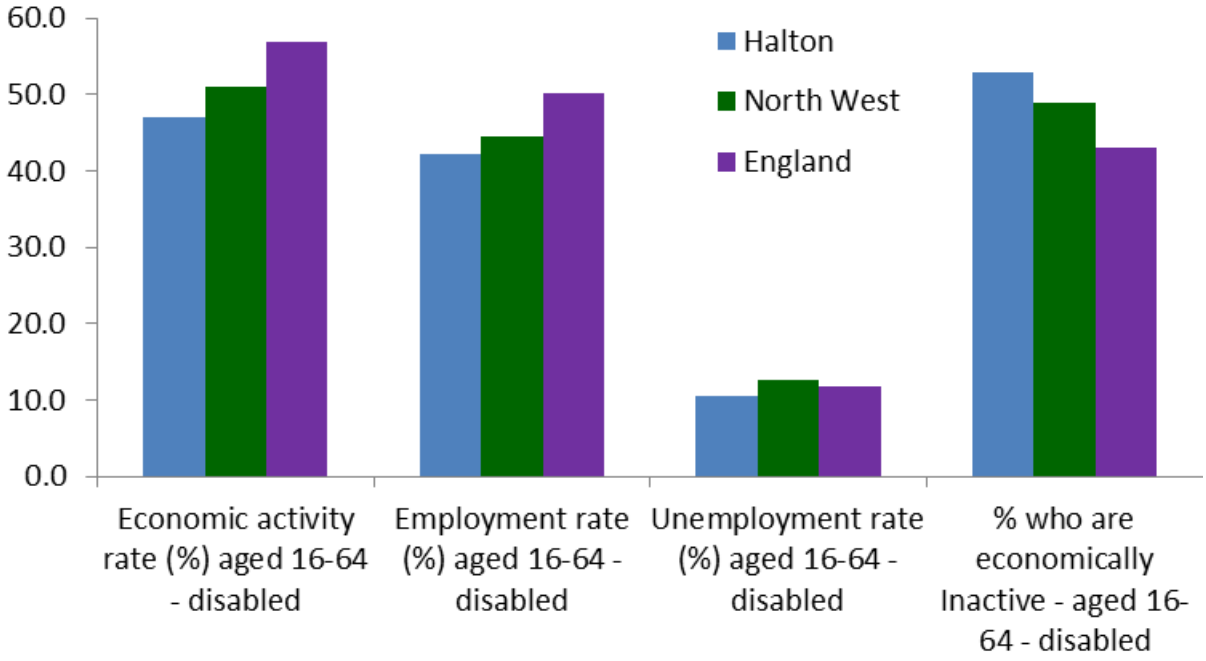
- **Unemployed** includes only people who are: without a job, but want a job, are seeking a job, and available to work.
- **Economically Inactive** includes all other people who are out of work (the highest reason for these… around a third of this group are out of work due to 'long term sick').

In Halton we have a larger proportion of people who are economically inactive (disabled or not-disabled), than NW and England. This is mainly explained by those who are 'long-term sick' as Halton has a higher proportion of people reporting this.

[38] Fulfilling Potential –Building a deeper understanding of disability in the UK today

The proportion of disabled people in Halton who are 'without a job, but want a job, are seeking a job, and available to work' is lower than the North West and England. It is however 800 local people who would like to work.

**Economic activity and unemployment, disabled group, Halton, NW and England (Apr-12 to Mar-13)**




## Accessible Homes

The need for accessible properties for adults of working age and older people is considered in the Halton Housing Strategy 2013-18. The Council has responded to this identified need and Naughton Fields now open and Barkla Fields currently in development offer 97 Extra Care housing units.

Property Pool Plus hosted by Halton Housing Trust is an approach to allocating property, which gives home seekers greater control over the property they are offered as it requires them to express an interest in homes which are advertised locally. Analysis of registrations indicates numbers of families, adults and older people currently waiting for accessible accommodation:

**Accessible accommodation needs logged on Property Pool Plus May 2014**

| | 1BED | 2 BED | 3 BED | 4+ BED |
|---|---|---|---|---|
| Families with disabled children requiring specialist wheelchair housing | | | 3 | 1 |
| Families with disabled parent/adult requiring specialist wheelchair housing | | 2 | | |
| Older people requiring specialist wheelchair housing | 3 | 2 | | |
| Older people requiring Sheltered or Extra Care specialist wheelchair housing | 1 | 2 | | |
| Adults requiring specialist wheelchair housing | 3 | 1 | | |
| Older people requiring Sheltered or Extra Care | 10 | 1 | | |

## Learning Disabilities and secondary long term conditions

There are estimated to be 1.14m people with learning disability in England[39] and evidence shows that people with learning disabilities on average die 5 to 10 years younger than other citizens, often from preventable illnesses. People with learning disability face inequalities in health status and some evidence suggests the prevalence of asthma is twice as high amongst those with learning disabilities and epilepsy is 25 times more likely to occur, being present in around 1 in 4 (24.9%) of all adults with a learning disability, compared to only 1% of the general population.[40]

This poorer physical health, means people who are already exceptionally socially excluded – on every measure from education and employment to housing and social networks – often face the additional challenge of diabetes, heart disease or other long term condition. This makes it harder to participate socially and economically and harder to play an active, valued role in family and community.

The Halton Adults with Learning Disabilities Strategy currently in development considers the health and support needs of this vulnerable group arising from both their learning disability and physical health needs.

[39] People with learning disabilities in England 2012 IHAL

[40] Full Summary and Recommendations: Learning disabilities and autism: A health needs assessment for children and adults in Merseyside and North Cheshire. Liverpool Public Health Observatory

## Loneliness, Social Isolation, Depression

Whilst 'social isolation' and 'loneliness' are often used interchangeably, people attach distinct meanings to each concept[41]. 'Loneliness' is reported as being a subjective, negative feeling associated with loss (e.g. loss of a partner or children relocating), while 'social isolation' is described as imposed isolation from normal social networks caused by loss of mobility or deteriorating health. Although the terms might have slightly different meanings, the experience of both is generally negative and impacts upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services.

The different issues faced by disabled people are inter-linked. In the working age population for example, low educational attainment can lead to poor employment outcomes. Not having a job can be associated with poverty and social isolation. Experiencing barriers to transport can result in not being able to get to work or education.

Estimates of prevalence of loneliness tend to concentrate on the older population and they vary widely, with reputable research coming up with figures varying between 6 and 13 per cent of the UK population being described as often or always lonely[42]. There is growing recognition that loneliness is a formidable problem which impacts on an individual's health and quality of life and even on community resilience. There is increasing evidence that people who are lonely are more likely to use health and social care services and a developing confirmation, through personal stories, of the emotional costs and misery that loneliness can cause.

People with poor physical health are at higher risk of experiencing common mental health problems, and people with mental health problems are more likely to have poor physical health.

Physical illness is associated with increased risk of depression:

[41] http://www.scie.org.uk/publications/briefings/files/briefing39.pdf

[42] http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

- Depression is three times as common in people with end-stage renal failure, chronic obstructive pulmonary disease and cardiovascular disease as in people who are in good physical health.
- Depression affects 27% of people with diabetes, 29% of people with hypertension, 31% of people who have had a stroke, 33% of cancer patients and 44% of people with HIV/AIDS.[43]
- People who experience persistent pain are four times as likely to have an anxiety or depressive disorder as the general population.
- Depression is more than seven times more common in those with two or more chronic physical conditions.

These issues are explored further and actions proposed in *A Mental Health and Wellbeing Commissioning Strategy for Halton.*

## Carers

There are 5.8 million unpaid carers in England and Wales (Census 2011) and adults with impairments are likely to be carers themselves (15 percent of adults with impairments provide informal care compared with 8 percent adults without impairment)[44] Adults with impairments are more likely to spend longer hours caring for others than adults without impairment and the majority of carers in Halton spend more than 19 hours in their caring role with a significant number providing more than 50 hours of care per week.

### *Table 7: Unpaid care hours per week*

| | 1-19 hours | 20-49 hours | 50+ hours |
|---|---|---|---|
| **Number of carers** | 8,009 | 2,440 | 4,569 |
| **Halton %** | 6.4 | 1.9 | 3.6 |
| **England %** | 6.5 | 1.4 | 2.4 |
| **North West %** | 6.4 | 1,6 | 2.0 |
| **Ranking** | 247th | 10th | 12th |

Source: ONS Census data 2011

[43] Mental Health Foundation The fundamental Facts 2007
[44] Life Opportunities Survey Wave 1 2009/11

From 2008 to 2022 the number of disabled older people with informal care (in households) will rise by 39%. Many of these informal carers will be of working age now and it is imperative they receive support to maintain their own health and wellbeing to carry on this role.

Caring can impact on the health of the carer and when this is compounded with an existing impairment can seriously diminish quality of life and mental wellbeing. The latter is addressed within *A Mental Health and Wellbeing Commissioning Strategy for Halton* whilst the *Carers Action Plan* considers support for the caring role.

## Prevention

The primary aim of the prevention agenda is to offer support and early interventions to avoid the high cost hospital admissions and crisis management. There are a range of generic low-level services provided across the Borough ranging from information and advice services and exercise groups to intermediate care and rapid response services delivered through strong partnership working across the CCG, Council and the voluntary sector. Many of these services are accessed by younger adults but could offer people with long term conditions effective ongoing support to live their everyday lives and should form part of the care pathway for re-enablement and self–management of the condition.

## Personalisation and Co-production

Co-production emphasizes that people are not passive recipients of services and have assets and expertise which can help improve services. At an individual level this is generally referred to as personalised support developed in conjunction with health and social care professionals. In Halton this means:

…*everyone having choice and control over the shape of their support, along with a greater emphasis on prevention and early intervention*.

Co-production goes further than this by offering a broader model of active citizenship, equality and mutual support. Collaboration between the Council and Halton CCG, the voluntary sector and other community partners to identify and work through local challenges and opportunities will enable transformative, innovative local solutions to be developed based on the in-depth knowledge of local citizens who know what is required.

## Advanced decision making and end of life care

All decisions about care and treatment interventions should be made jointly between the individual and professionals. For those who do not have legal capacity or may lose that capacity in the future it is important that the right choices are made. Decisions must be centred on the individual and minimise the likelihood of unnecessary or unwanted interventions.

Professionals should encourage individuals with degenerative illness to think about their prognosis and options for how this is managed. The person is then in a position to decide what is best for them and to communicate their wishes to professional staff and family members.

These conversations are not easy and families may disagree with the individual's decision. Staff should receive appropriate training in how to approach these discussions.
All decision

# Part Four: Sensory Impairment

Commissioning of support for sensory impairments is across all age groups and includes varying degrees of sight loss, hearing loss and loss of both senses:

Visual impairment (severely sight impaired to partial sight loss)

Hearing impairment (profound deafness to partial hearing loss)

Deafblind (dual sensory impairment)

Evidence shows significantly higher prevalence of sensory loss in areas with higher levesl of socio-economic deprivation and this effect is more prominent in younger people.

In Halton, there is a small decline (1.4%) in the numbers of working age adults with sensory loss. However, there is a significant rise in numbers aged 65+ due to age related conditions in an aging population. Around 30% of those reporting either a hearing or visual impairment and 60% of those reporting dual sensory loss in those over age 65 have at least four long term conditions and feel less confident in managing their own health[45].

The Chief Medical Officers report also shows that the proportion of 55-84 year olds with deafness or blindness who report dementia or Alzheimer's disease is substantially greater than those reporting neither deafness nor blindness. This association is not understood but may have implications for the prevention and management of dementia.

## Visual Impairment

The term "sight loss" has been used as an inclusive term to cover all people who are blind or partially sighted, including people who have no sight from birth, people with sight loss at certifiable levels and people with sight loss below these levels. This does not imply that the needs and requirements of people within these different groups are the same.

[45] Annual /report of the Chief Medical officer (DH 2014)

Sight loss is a major health issue affecting about 2 million people in the UK the majority of which are older people. This figure includes around 360,000 people registered as blind or partially sighted in the UK, who have severe and irreversible sight loss.The number of people in the UK with sight loss is set to increase dramatically and it is predicted that by 2050 the number of people with sight loss in the UK will double to nearly four million[46].

Sight loss and eye health costs the UK economy at least £8 billion each year.[47] Thousands of people lose their sight each year and it is estimated that 50% of sight loss is from avoidable causes.[48]

Sight loss affects people of all ages but especially older people: 1 in 5 people aged 75 and 1 in 2 aged 90 and over are living with sight loss. At all ages there is a significant trend for higher prevalence in areas of socio economic deprivation. This may be related to differences in exposure to risk factors for sight loss. There is an association between age-related macular degeneration and smoking and smoking levels are higher in more deprived areas.[49] There are more women (59%) than men reporting blindness though the reason for this is unclear. It may be partly explained by demographics as sight loss is age related and there are more women than men in the older age groups.

Causes of visual impairment in the UK are changing with disability adjusted life years (DALYs) attributable to glaucoma and macular degeneration increasing by 50% over the last 20 years and those attributable to cataract decreasing.

In Halton the prevalence of sight loss is reducing slightly amongst the working age population but by 2020 there is a projected 21% increase (an extra 460 people) in those aged over 65 with severe hearing impairment. These figures are significantly higher than the predictions for the North West (16.8%) and England (19.1%)[50].

Consultant ophthalmologists in an eye clinic complete a Certificate of Visual Impairment and forward a copy to social services who then offer registration and other relevant advice and support. Halton's maintains register shows 250 people are registered blind and 345 people

[46] Access Economics, 2009
[47] RNIB, 2013
[48] Access Economics, 2009
[49] Annual Report of the Chief Medical Officer (DH 2014)
[50] www.pansi.org.uk

are registered partially sighted. 79% of registered blind and partially sighted people are also recorded as having an additional disability

Sight loss has a significant impact on quality of life and independence by increasing vulnerability to social isolation, depression and falls. However some important causes of vision impairment, such as glaucoma, are treatable if detected early. Investment in public awareness of eye health, early detection and treatment of eye conditions can have a significant impact on people's quality of life. Prevention of sight loss reduces or avoids the need for health, social care, education and training to support people in the later stages of eye disease.

Eye health has been recognised as a national priority and is included in the Public Health Outcomes measures. Effective health promotion and improvement initiatives are key to promoting the importance of eye care and to reduce levels of preventable sight loss.

The provision of emotional and practical support at the right time can help people who are experiencing sight loss to retain their independence and access the support they need. Visual impairment rehabilitation is an early intervention delivered by specialist professionals to help people to maximise their functional vision and skills for confident daily living.

## Children and Young People

There are almost 25,000 blind and partially sighted children in Britain. That is equal to 2 in 1,000 children and as many as half of these children may have other disabilities.

Halton's JSNA estimates how many children and young people are blind or partially sighted in the Borough. This figure is 53 0-16 year olds and 29 17-25 year olds. [51]

Sight loss in children is attributable to numerous causes and often is part of a wider picture of childhood disability. The report, 'Sight Impaired at Age Seven'[52], reveals worrying differences between children with sight loss and their sighted peers around happiness, success at school, financial hardship and social inclusion. The findings show that sight loss can have a major impact on every aspect of a child's development and that without the right support many are at risk of being less confident, having fewer friends and under performing at school. However, the results also indicate that with the right kinds of early intervention, blind and partially sighted children can flourish.

[51] Halton Children's Joint Strategic Needs Assessment 2014
[52] https://www.rnib.org.uk/aboutus/Research/reports/education/Pages/sight_impaired_age_seven.aspx

## Working Age Adults

Historically the leading cause of blindness in the UK working population was diabetic retinopathy but is no longer the leading cause of certifiable blindness among adults aged 16-64 having been overtaken by inherited retinal disorders. This change may be explained by the introduction of nationwide diabetic retinopathy screening programmes and improved glycaemic control [53].

Employment rates for people with sight loss are consistently lower than the general population and two-thirds of people living with sight loss say that they experience restrictions in being able to access and fully participate in employment.[54] The Chief Medical Officers annual report suggests less than 30% of those with blindness are in employment. Many registered blind and partially sighted people reported the main reason for leaving their last job was onset of sight loss or deterioration in their sight.

## Older People

Evidence suggests 50-70% of sight loss in the older population is due to preventable or treatable causes including: age-related macular degeneration, glaucoma and diabetic retinopathy. 1 in 5 people aged 75 years and 1 in 2 aged 90 years or over is visually impaired

In Halton between 2012 and 2020 there is a predicted 22% increase (an extra 360 people) with serious visual impairment amongst those aged over 65. This is significantly higher than both the North West (16.8%) and England (19.1%) figures. Those aged over 85 are most at risk of eye disorders causing vision impairment.

Evidence suggests that there is a strong link between sight loss and reduced psychological wellbeing, particularly amongst older people who develop sight loss later in life.[55] People living with sight loss report lower feelings of wellbeing, reduced self-confidence and lower satisfaction with their overall health.

[53] http://bmjopen.bmj.com/content/4/2/e004015.full
[54] UK Vision Strategy – A case for change 2013-2018
[55] UK Vision Strategy A Case fro Change 2013-2018

Impaired vision is a recognised risk factor contributing to falls in older people. This can be for a number of reasons including[56]:

- Change in gait of those with sight loss
- Sight loss reduces mobility which impacts on balance increasing risk of falling
- Wearing multi-focal glasses
- Changes in the home environment – e.g. moving furniture

It is suggested that generic falls prevention programmes and strategies may not work for those with visual impairment and that a different approach should be adopted with a focus on the home environment, lighting and colour schemes.

## Social Inclusion and Mobility

Over one-third of people with sight loss say that they have little or no choice about how they spend their free time. This includes activities such as going on holiday, playing sport, visiting friends or family or undertaking voluntary work. Half of people with sight loss experienced difficulties getting into and moving around buildings.[57]

Travel is a crucial element of independence and inclusion, but for many blind and partially sighted people travelling is a challenge. This can result in blind and partially sighted people being trapped at home and can lead to isolation, reduced wellbeing and low confidence. Nearly two-thirds of blind and partially sighted people say that because of their sight loss they need help to get out of the house

More broadly, the needs of blind and partially sighted people are often not taken into account by designers or planners. For example, the design of transport systems, signage, labelling, public buildings and shared space environments often fail to take into account the needs of people with sight loss.[58] Half of people with sight loss say they experience difficulty getting into and moving around buildings.

## Support for those with sight loss

People with sight loss should be able to make informed choices about their lives. Access to support and services should enhance independence and wellbeing and provide opportunities to learn and work. But evidence tells us that people with sight loss continue to

[56] http://www.pocklington-trust.org.uk/Resources/Thomas%20Pocklington/Documents/PDF/Research%20Publications/RDP%2012_final.pdf

[57] Sight Loss UK 2013 RNIB

[58] RNIB 2011

face restrictions and barriers in accessing services. Tasks that most of us take for granted, such as catching a bus or shopping for everyday necessities, can provide major challenges for blind and partially sighted people.[59]

"Seeing it my way"[60] is an initiative to ensure that every blind and partially sighted person, regardless of age, ethnicity, extent of sight loss, other disabilities, or location across the UK, has access to the same range of information and support.

Living with little or no sight requires access to a range of information and support from a number of services, such as social services and voluntary sector organisations in order to live independently. This includes information in a format that people can read, rehabilitation for people who lose their sight so they can gain the skills and confidence to carry out day-to-day tasks and get around easily.

Seeing it my way sets out a range of outcomes, that is specific changes that blind and partially sighted people have told us are most important to them and want to make a reality.

**'Seeing it my way' has 10 outcomes:**

1. That I have someone to talk to.
2. That I understand my eye condition and the registration process.
3. That I can access information.
4. That I have help to move around the house and to travel outside.
5. That I can look after myself, my health, my home and my family.
6. That I can make the best use of the sight I have.
7. That I am able to communicate and to develop skills for reading and writing.
8. That I have equal access to education and lifelong learning.
9. That I can work and volunteer.
10. That I can access and receive support when I need it.

# Hearing Impairment

The term "hearing loss" has been used as an inclusive term to cover all people who are deaf or hard of hearing, including people who are deaf from birth and people with mild hearing

[59] McManus and Lord, 2012
[60] http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=301&sectionTitle=Seeing+it+my+way

loss and profoundly deaf. This does not imply that the needs and requirements of people within these different groups are the same.

For around 15,000 people in the UK their first language is British Sign Language (BSL). BSL is a visual form of communication using hands, facial expression and body language mainly used by people who are Deaf. BSL is a fully recognised language and is independent of spoken English.

Normal ear function is important not only for hearing but also balance and any impairment compromises a person's ability to interact socially and with the environment. Loss of balance impacts on abilities to walk and drive making them difficult to impossible. The primary cause of hearing loss is age related damage occurring naturally as part of the ageing process. Other causes and triggers include:

- Regular and prolonged exposure to loud sounds
- Ototoxic drugs that harm the hearing nerve
- Infectious diseases such as rubella
- Complications at birth
- Injury to the head
- Benign tumours of the auditory nerve
- Genetic predisposition – half of childhood deafness is inherited

One in 6 of the UK population, more than 10 million people have some form of hearing loss. Of this figure 3.7m are working age (16-64) and 6.3 aged over 65. More than 800,000 people are severely or profoundly deaf. The prevalence of hearing loss is growing and the Medical Research Council estimates it will increase by 14% every 10 years. By 2031 there will be 14.5 million people with hearing loss in the UK.

The WHO predicts that by 2030 adult onset hearing loss will be in the top 10 disease burdens in the UK above diabetes and cataracts (See DALY chart in Part 3)

In Halton the prevalence of hearing loss is reducing slightly amongst the working age population but by 2020 there is a projected 22% increase (an extra 1700 people) in those aged over 65 with moderate, severe or profound hearing impairment. These figures are again significantly higher than the North West (17.5%) and England (19.8%) predictions. There is a north/south imbalance in prevalence of deafness with rates being higher in the

north. This is believed that this reflects the concentration of noisy industry in the north when those now in their 70's and 80's were at the start of their working lives[61].

There is no cure for hearing loss and those who experience it are also likely to have other problems such as tinnitus and balance disorders which contribute as risk factors to falls and other accidental injuries.

## Dual sensory impairment (Deafblindness)

The term dual sensory impairment can be used interchangeably with deaf blindness; denoting the fact that combined impairment of sight and hearing are significant for the individual, even though they may not be profoundly deaf or totally blind and each of the impairments may appear to be mild. The loss of both senses affects communication difficulties, getting around safely and access to information.

The Coppersmith Matrix provides a visual representation of the intersections of sight and hearing impairment:

<table>
<tr><td></td><td>HEARING</td><td>HARD OF HEARING</td><td>DEAF</td></tr>
<tr><td>SIGHTED</td><td>Hearing and Sighted</td><td>Hard of hearing<br>"Normal" Vision</td><td>Deaf<br>"Normal" Vision</td></tr>
<tr><td>PARTIALLY SIGHTED</td><td>Partially sighted<br>"Normal" Vision</td><td colspan="2" rowspan="2">DUAL SENSORY IMPAIRED OR DEAFBLIND</td></tr>
<tr><td>BLIND</td><td>Blind<br>"Normal" Hearing</td></tr>
</table>

Those with dual sensory loss use many different communication methods dependent on the age of onset. Those deaf blind from birth or early childhood are more likely to use British sign language. The needs of those with dual sensory impairment cannot be met by services for single impairment

Deaf blindness can be due to several causes, such as Ushers Syndrome, Rubella (German measles) and problems caused by premature births.

[61] Annual Report of the Chief medical Officer, Surveillance Volume, 2012:On the State of the Public's Health (DH 2014)

The estimated prevalence of deafblind people is 40 per 100,000 population suggesting there are approximately 48 deafblind people (all age groups) in Halton with 30 aged over 18. This is thought to be a significant under estimate as the level of dual sensory impairment in the population is often masked by other physical and mental health conditions which can take precedence in statistical recording.

## Children and Young People

There are 45,000 deaf children in the UK and around half are born deaf, and around the same amount acquire deafness during childhood. Estimates suggest that 1-2 children are born every year in Halton with permanent deafness[62]. 90% of deaf children are born to hearing parents with little or no experience of deafness or knowledge of how to communicate with a deaf person[63].

The incidence almost doubles by ten years of age because of acquired hearing loss from meningitis mumps, measles, trauma and other causes.

Halton's JSNA for Children estimates 76 children with permanent hearing loss and 26 experiencing severe or profound loss. 40% of deaf children have additional or complex needs: at least one other clinical or developmental problem and half of these children had at least two additional problems. The JSNA has further detail on prevalence of additional disabilities and identifies the following:

- Visual impairment
- Neurodevelopmental disorder
- Speech Language Disorder: range of prevalence
- Autistic Spectrum Disorder (ASD)
- Cerebral Palsy: range of prevalence
- Pervasive Developmental Disorder (PDD)

A major difficulty for deaf children and young people is language. Communication lies at the heart of a child's social, emotional and intellectual development. For example research suggests that:

a) deaf children and young people are 1.5 times more likely to experience mental health difficulties at a clinically identifiable level than hearing children

[62] Children with Disabilities and Complex Health Needs - Halton Joint Strategic Needs Assessment 2014
[63] http://www.ndcs.org.uk/about_us/ndcs/

b) they are more likely to be abused than hearing children (studies show they are at least twice as likely to experience abuse as hearing children, with one study identifying an incidence of abuse being 3.4 times that of hearing children[64])
c) their educational attainment is below that of hearing children[65]
d) they are more likely to be unemployed as young adults[66]

Thus there are good reasons for being concerned that deaf children may not achieve key outcomes, such as being healthy, keeping safe, educational success and economic well-being[67]

## Adults of Working Age (18-65)

Around 3.7 million people aged 16-64 have a hearing loss and for 20% of those aged over 50 their hearing loss is moderate to profound. In Halton the projected number of people aged 18-64 with hearing loss by 2020 increases by only 1% in contrast to higher rises in the North West (6%) and England (8%). This is most likely explained by Halton's shrinking population rate which is faster than the regional prediction whilst for England there is a predicted increase in population.

Employment is often important to individuals' quality of life and those with hearing impairment are significantly less likely to be in employment. In the 18-64 age group those in full time employment without any sensory impairment is 53%; amongst the deaf community this figure is 38%. It is likely that other factors are involved such as the higher prevalence of comorbidities amongst those with sensory impairment.

## Older People

An emerging issue is the numbers of people developing combined sight and hearing impairment after the age of 60. Dual sensory loss in this age group is often not labelled as 'deafblindness' or recognised as an identifiable disability. For some with a pre-existing sight or hearing impairment the development of impairment in the second sense places them within the deafblind continuum. The prevalence is difficult to quantify but estimated to be substantially higher than recorded numbers indicate.[68] Sensory impairment is generally assumed to be an inevitable and inescapable element of aging and for older people may be

[64] www.gscc.org.uk, Care Council for Wales - ccwales.org.uk, Northern Ireland Social Care Council - nisocialcarecouncil.org.uk, Scottish Social Services Council - sssc.uk.com
[65] www.ndcs.org.uk/closethegap
[66] Office for Disability Issues Annual Report 2008:
[67] http://www.teachingtimes.com/zone/every-child-matters.htm
[68] Identification of deafblind dual sensory impairment in older people SCIE Research Briefing 21 2007

overlooked as dual sensory impairment and a disability requiring investigation and possible intervention.

Dual sensory impairment can make a person more physically vulnerable in the environment in which they live, both domestic and social spaces, and is recognised as a clear underlying cause of falls in older people. Greater awareness of the challenges faced would lead to more preventative actions.

"A World of Silence"[69] summarises research undertaken with care home residents. Around 2/3rds of the care home residents experienced hearing loss. The report highlighted concerns that hearing loss was seen merely as a sign of aging and there was a significant level of unidentified hearing loss. In addition, care home staff could be more proactive in checking hearing aids and creating an environment which reduces background noise to improve their effectiveness. The report made three recommendations:

1. Intervene earlier in hearing loss
2. Meet communication needs in care homes
3. Improve hearing aid use and management in care homes

## Tinnitus

Tinnitus is usually caused by a problem in the auditory pathway arising from ageing, hearing loss or noise exposure but can also be caused by head injury ear infection or emotional trauma, illness or stress.

Around 10% of the adult population has some form of tinnitus and for 1% the impact of their tinnitus affects their quality of life. It is associated with higher occurrences of depression and many sufferers will avoid visiting public places such as shops and restaurants as they know the background noise will trigger or worsen their tinnitus.

## Noise induced hearing loss

Exposure to excessive noise can damage different types of cells in the ear. Exposure is cumulative and over time will lead to tinnitus and temporary or permanent hearing loss. The WHO classifies noise exposure as the major avoidable cause of permanent hearing impairment.

There are two groups at a higher risk of noise-induced hearing loss:

[69] A World of Silence – Action on hearing loss 2012

i. Armed forces personnel and the Police – this is now being mitigated as far as possible with the use of ear protection.

ii. Young People – due to exposure to loud music at venues and through personal music players.

Campaigning by Action on Hearing Loss is on ongoing to prevent noise-induced hearing damage among young people.

## Social Impact of hearing loss

Hearing loss has a significant personal and social impact due to the communication barrier that it creates. This can lead to social isolation and exclusion as research shows that those with hearing loss withdraw from social activities involving large groups of people.[70]

Often a family member will intervene in communication with third parties which erodes the independence of the person with the hearing loss as they become dependent on others for information.

## Stigma

Stigma relating to hearing loss is both real and perceived. It is a key factor in the delay in taking up hearing aids, and makes many people unwilling to tell others about their hearing loss. One element of stigma is the fear that people with hearing loss are seen as less capable [71]

## Support for those with hearing loss

Following diagnosis people with hearing loss need a range of services and support from health and social care. Evidence demonstrates that appropriate support can have a substantial impact on the quality of life for those with sensory impairment[72].

Communication is the principal challenge and there are a range of services and assistive technology that can bridge this gap. Lack of awareness of what is available can hamper uptake and development.

## Sensory impairment and people with a learning disability

[70] Hidden Crisis RNIS 2009
[71] RNID, Hidden Crisis, 2009
[72] Annual Report of the Chief Medical Officer (DH 2014)

People with a learning disability are more likely to have a hearing loss, and are 10 times more likely to have a sight loss than people in the wider community. This can have a profound impact on how they are understood and are able to interact with others, and people with challenging behaviour will be more likely to challenge if there is a limited understanding of any sensory loss that they may have.

## Hidden and untreated sensory loss

Hidden and/or untreated sensory loss leads to a withdrawal from social interaction. To a person with dementia, for example, failure to recognise and respond to a sensory loss will result in greater isolation, will generate behaviours that can be misinterpreted as symptoms of advancing dementia, and will lead to a consequent failure to respond appropriately to basic physical needs.

Specifically, neurological sight loss, caused by injury or trauma to the brain, is often undiagnosed and can, therefore, remain untreated. Between 20% and 60% of people who have a brain injury from stroke or traumatic injury have associated neurological visual impairment.[6] This type of sight loss has a significant, detrimental impact on survivors of brain injury and their carers.

## Sensory loss and other Long Term Conditions (LTC)

Based on the GP Patient Survey73 only 3% of those reporting no sight or hearing loss report 4 or more LTC's compared to 29% of those reporting hearing loss, 32% of those reporting sight loss and 69% of those reporting both sight and hearing loss. In the context of multi-morbidity, confidence in managing one's own health conditions is likely to be an important contributor to quality of life and influence long-term outcomes. Among those aged over 55 91% of those with neither sight or hearing loss feel confident in managing their own health compared to 84% among those with hearing loss and 72% of those with sight loss and 60% of those with both sight and hearing loss.

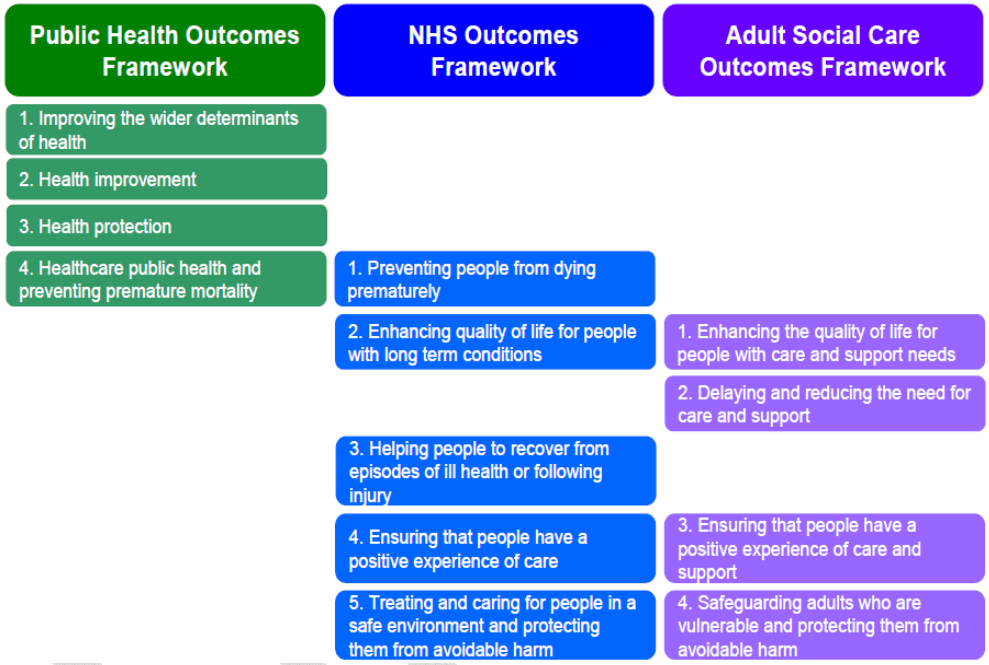
[73] Annual report of the Chief Medical Officer DH 2014

# Part Five: Outcomes Frameworks

## Outcomes Frameworks

Outcome measures provide a description of what a good social care and health system should aspire to achieve, as well as a method of checking progress in achieving these aims. All three of the National Outcome Frameworks – Public Health[74], NHS[75], and Adult Social Care[76] have been aligned so local partners across the health and care systems can identify the challenges for their population to determine local priorities for joint action.

### The 3 outcomes frameworks 2013/14




[74] Available from: http://www.phoutcomes.info/
[75] Available from: https://www.gov.uk/government/publications/nhs---outcomes---framework---2013---to---2014
[76] Available from: https://www.gov.uk/government/publications/the---adult---social---care---outcomes---framework---2013---to---2014

The detailed indicators relating long term conditions are summarised below along with the outcome they contribute to.

## Long term conditions indicators and outcomes framework domains

| National Indicators | Adult Social Care | NHS | Public Health |
|---|---|---|---|
| Quality of life for people with long-term conditions | 1.A | 2.0 | |
| Proportion of people who use services who have control over their daily life | 1B | | |
| **To be revised from 2014/15:** Proportion of people using social care who receive self-directed support, and those receiving direct payments | 1C | | |
| Carer reported quality of life | 1D | 2.4 | |
| Proportion of people feeling supported to manage their condition | | 2.1 | |
| Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services | 1E | 2.2 | 1.8 |
| Proportion of people who use services and their carers, who reported that they had as much social contact as they would like. | 1I | | 1.18 |
| Permanent admissions to residential and nursing care homes, | 2A | | |
| Delayed transfers of care from hospital, and those which are attributable to adult social care | 2C | | |
| Reducing time spent in hospital by people with long-term conditions | | 2.3i/ii | |
| Overall satisfaction of people who use services with their care and support | 3A | | |
| Overall satisfaction of carers with social services | 3B | | |
| The proportion of carers who report that they have been included or consulted in discussions about the person they care for | 3C | | |
| The proportion of people who use services and carers who find it easy to find information about support | 3D | | |
| *New placeholder 3E: Improving people's experience of integrated care* | 3E | 4.9 | |
| The proportion of people who use services who feel safe | 4A | | 1.19 |
| The proportion of people who use services that say those services have made them feel safe and secure | 4B | | |
| Mortality rate from causes considered preventable ** | | 1A | 4.3 |
| Emergency readmissions within 30 days of discharge from hospital* | | 3B | 4.11 |
| *Preventable sight loss* | | | 4.12 |

# Part Six: Evidence based interventions

## National Standards

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are central to supporting the Government's vision for a health and social care system focussed on delivering the best possible outcomes for people who use services, as detailed in the Health and Social Care Act (2012). NICE quality standards enable:

- **Health professionals and public health and social care practitioners** to make decisions about care based on the latest evidence and best practice.
- **People receiving health and social care services, their families and carers and the public** to find information about the quality of services and care they should expect from their health and social care provider.
- **Service providers** to quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide.
- **Commissioners** to be confident that the services they are purchasing are high quality and cost effective and focussed on driving up quality.

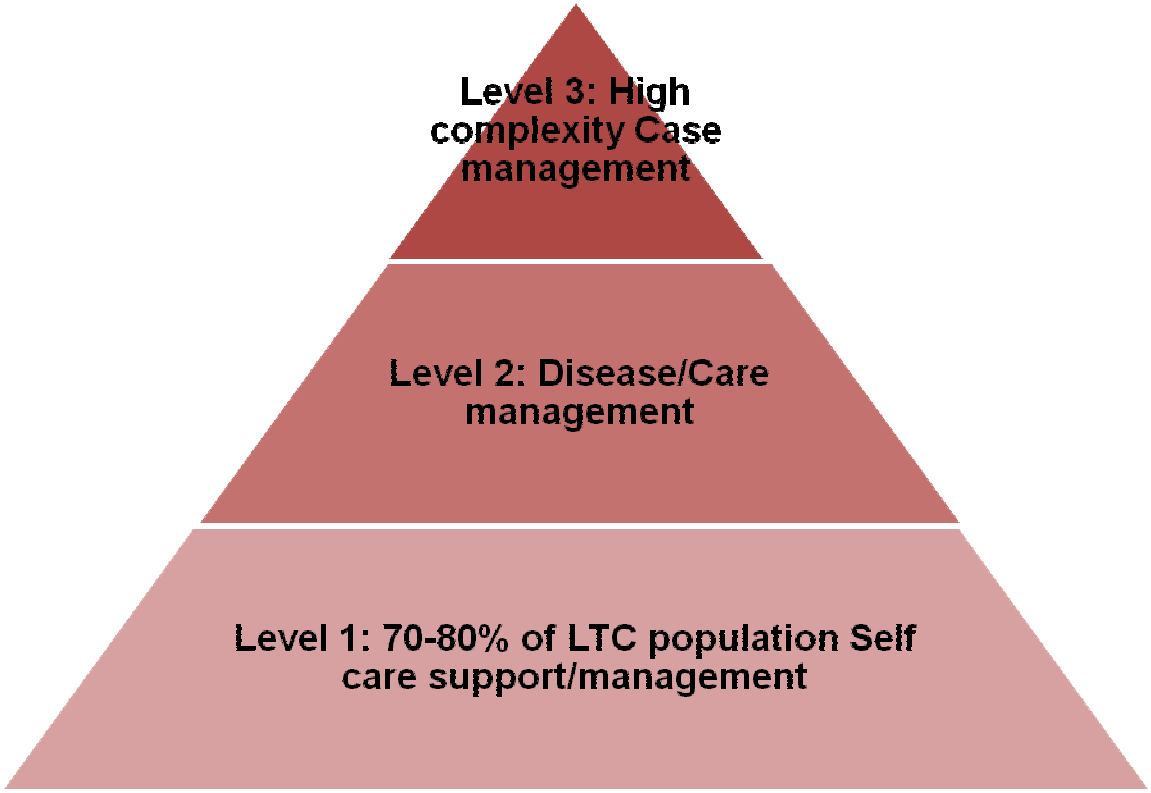
*Supporting People with Long term Conditions*[77] was published in 2005 to promote a model of health and care which aimed to:

- embed an effective, systematic approach to the care and management of patients with a long term condition.
- reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment.
- Ensure availability of high-quality, personalised care
- Promote a healthier future by ensuring that self care support is in place – particularly for those in disadvantaged groups and areas – to make healthier choices about diet, physical activity and lifestyle.

The recommended route and one which has been adopted in Halton is a systematic approach utilising multi-professional teams and integrated patient pathways to ensure closer integration between health and social care.

Different interventions should then be used for patients with different degrees of need. The NHS and Social Care Long Term Conditions Model sets out a delivery system that matches care with need.

[77] Supporting people with long term conditions: An NHS and social care model to support local innovation and integration (DH 2005)




(Based on the Kaiser Permanente triangle)

**Level 3: Case management** – requires the identification of the very high intensity users of unplanned secondary care. Care for these patients is to be managed using a community matron or other professional using a case management approach, to anticipate, co-ordinate and join up health and social care.

**Level 2: Disease-specific care** management – This involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework.

**Level 1: Supported self-care** – collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively. Underpinned by promoting better health – building on the public's growing desire for a healthier future by ensuring that the self-care support is in place for people – particularly those in disadvantaged groups and areas – to make healthier choices about diet, physical activity and lifestyle, for example stopping smoking and reducing alcohol intake.

This is now being followed up with the development of a guideline on social care of older people with complex care needs and multiple long-term conditions. The link between ageing and long-term conditions and the discrimination that older people can experience

provides the rationale for focusing the guideline on this age group. The National Institute of Clinical Governance (NICE) is leading this work for the Department of Health and publication is anticipated in 2015.

NICE clinical guidelines are already in place for the diagnosis, treatment and management of MS, epilepsy and Parkinson's. These evidence based guidelines outline the range of care that should be available. These include providing specialist services, a system for rapid diagnosis, a seamless and responsive service, thorough problem assessment and self-referral after discharge. Full details of these recommendations are available at www.nice.org.uk.

In January 2014, following consultation, a further 5 topics relating to Adult Social Care have been identified for formal referral to NICE for development of guidance and standards in social care

- falls - regaining independence for older people who experience a fall
- care and support of older people - with learning disabilities
- medicines management - managing the use of medicines in community settings for people receiving social care
- regaining independence - short term interventions to help people to regain independence
- adult social care - service users and carers experience of adult social care

## Using technology to manage long term conditions

Within the model illustrated above helping people to manage their own health condition as much as possible forms the foundation of the health and social care delivery system. Telehealth and Telecare services support this approach but what are they:

**Telehealth (remote care)** - Electronic sensors or equipment that monitor vital health signs remotely, e.g. in your own home or while on the move. These readings are automatically transmitted to an appropriately trained person who can monitor the health vital signs and make decisions about potential interventions in real time, without the patient needing to attend a clinic

**Telecare** - Personal and environmental sensors in the home that enable people to remain safe and independent in their own home for longer. 24 hour monitoring ensures that should an event occur the information is acted upon immediately and the most appropriate response put in train.

Research into the benefits of telehealth and telecare[78] in the management of long term conditions found that correct use of technology reduced:

- death rates by 45%
- visits to accident and emergency departments by 15%
- emergency admissions to hospital by 20%

National estimates suggest that at least 3 million people with long term conditions could benefit from using telehealth and telecare which has led to the NHS England Vision Statement on telehealth and telecare:

> *"3millionlives* is underpinned by the idea of service integration to improve patient care and outcomes. When different services and sectors work together, towards shared goals, patients get far more flexible, better, and more appropriate care. To achieve true service integration, we recognise that *3millionlives* needs to be delivered through a genuine partnership across NHS England – facilitating collaboration between clinicians, and empowering patients to better self-manage their conditions, with the use of technology. We also recognise that this cannot be achieved through technology alone – the key will be to deliver service transformation through realising the potential of that technology to support clinicians, patients and carers."
>
> http://3millionlives.co.uk/about-3ml

[78] Whole System Demonstrator Programme Headline Findings – DH December 2011

# Part Seven: Paying for local services

## Expenditure

The following financial breakdown is based upon direct expenditure in 2013/14 on funding for initiatives specific to disabled people. It does not reflect all of the wider universal and targeted activity that is commissioned locally. Expenditure, on areas such as Primary Care (GPs, etc.), general health promotion, weight management, equipment or voluntary and community sector activity, all have a direct impact upon the quality of life of disabled people but does not fall within the direct influence of this strategy and action plan.

In 2013/14 Resources were spent as follows:

Insert pie

In Halton 11% of the total spend on Adult Social Care supports those whose primary need arises from their physical or sensory disability. The table below summarises how this is spent[79]:



[79] Expenditure Report 2012-13 Halton (321) (Health and Social Care Information Centre 2013)

## Gross Total spend 2013/14 Adults age 18-64 with physical disabilities

| | **£000** |
|---|---|
| Halton Borough Council – Adult Social Care | 5,014* |
| Halton Borough Council – Public Health | Part of universal services |
| Halton Clinical Commissioning Group | To be added |
| Halton Clinical Commissioning Group - Continuing Health Care | 2,040 |
| **TOTAL** | **7,054** |

## Percentage Local Authority Total Gross Spend Adults age 18-64 with physical disabilities by activity 2010-11 to 2012-13

2013/14 data not yet published

| **Figures are %** | **2010/11** | **2011/12** | **2012/13** |
|---|---|---|---|
| Residential and Nursing | 15 | 7 | 9 |
| Day and Domiciliary# | 48 | 51 | 54 |
| Assessment and Care Management | 37 | 42 | 36 |
| # % of Day and Domiciliary Care spent on Direct Payments | 40 | 31 | 37 |

Source: Expenditure Report 2012-13 Halton (321) NASCIS

These figures show the continuing shift from placements in residential and nursing care to supporting people to remain at home in line with local policy.

## Halton Unit Costs and England Average Per person per week 2012-13 Adults of Working Age (18-64)

2013/14 data not yet published

| SERVICE<br>£ per person per week | NUMBER OF PEOPLE OR HOURS | HALTON<br>£ | ENGLAND<br>£ |
|---|---|---|---|
| Residential and Nursing placements | 8 | 878 | 877 |
| Home Care | 75 | 279 | 199 |
| Day Care – average hours per week | 31 hours | 205 | 188 |
| Direct Payment | 94 | 196 | 244 |
| Meals | not available | 4.10 | 5.40 |

Source: PSS-EX1

The cost of residential services to the Council is in line with the England average. However costs of home care and day care are somewhat higher. Most disabled adults accessing services receive more than 5 hours home care support per week

## Range of weekly Home Care support for disabled people living at home

| | Arranged by Directorate | Purchased via Direct Payment |
|---|---|---|
| Less Than 2 hours | 6 | 3 |
| More than 2 hours less than or equal to 5 hours | 12 | 13 |
| More than 5 hours less than or equal to 10 hours | 15 | 23 |
| More than 10 hours less than or equal to 20 hours | 25 | 28 |
| More than 20 hours | 17 | 27 |

Source: RAP H1 2012-13 and Direct Payments database

The Council supports

## Capital Investment Proposals 2014/15

| | 2014/15 Capital Programme Proposals<br><br>£ |
|---|---|
| Disabled Facilities Grants (incl. capitalised salaries) | 500,000 |
| Energy Promotion | 6,000 |
| Stair lifts | 250,000 |
| RSL Adaptations (Joint Funding) | 175,000 |
| Contribution to new build Bungalows for complex needs | 400,000 |
| **TOTAL** | **1,331,000** |

## Appendix A

# Current Services

### Access to information, advice and advocacy

*Information and Advice*

Halton Council's Direct Link offices and Contact Centre have trained advisors who can offer advice on a range of issues relating to council services or are able to sign post to more appropriate agencies. Referrals for Adult Social Care are received by the Initial Assessment Team (IAT).

The Council also has a web portal "Care and Support for You" which acts as a hub for people to find out what support is available whether they are eligible for social care or self-funding. This portal will be further developed to include a resource directory of service providers

Halton Disability Partnership (HDP) is a Disabled People User Led Organisation (DPULO) which works to improve the lives of disabled people by providing information and advice on a range of issues of concern to disabled people. HDP also provide an advice and support service for people in receipt of Direct Payments.

For those with sensory impairments Deafness Resource Centre and Vision Support are commissioned by the Council to offer information and support as well as advising on resources to assist with daily living and offering befriending services. There are other voluntary organisations in the Borough offering information to disabled people and through Halton Disability Forum have the opportunity to exchange information on their services which supports better signposting.

### Maintaining Independence and Control

*Initial Assessment Team*

Within Adult Social Care the first point of contact for everyone is the Initial Assessment Team (IAT) consisting of Social Workers, Community Care Workers and Occupational Therapist Community Care Workers. This acts as a single point of access to all adults with adult social care needs providing universal advice, guidance and signposting to other services. For more complex support planning and care management the team refers on to the appropriate Complex Care Team.

*Independent Living Services*

It is important that people feel safer, more protected and independent in their own home and the Community Alarm Service facilitates this by offering a rapid response alarm service for vulnerable people aged 18+, available 24 hours a day, and seven days a week.

### *Specialist Equipment and Adaptations*

Some people may be struggling at home due to their physical or sensory condition. This may be short term following hospital discharge or longer term. Adult Social Care offer assessments and may be able to assist through specialist equipment such as grab rails or can advise on adaptations to the property. For those living in the private rented sector or owning their own home assistance with the cost of any adaptations may be available through Disabled Facilities Grant.

### *Registered Provider protocol*

Funding constraints have historically led to tenants of social housing having to wait longer for major adaptations. In 2008 the Council and Registered Providers put an agreement in place whereby the Council provides additional financial help to increase the number of tenants benefitting. This action significantly reduced waiting times and the agreement remains on-going subject to available resources.

### *Accessible Housing Service*

The Accessible Housing Service works in partnership with all Registered Providers with stock in Halton to enable a better match for disabled applicants to accessible and adapted homes when they become available in the borough. Disabled applicants of any age from all property tenures are assessed when they have applied for housing to any of the providers, and available void adapted properties are also assessed to try and match applicants to the accommodation best suited to their needs. This service will be integrated with the IT system for the sub regional Property Pool Plus choice based lettings sytem.

### *Complex Care Teams*

Complex Care Teams are based in Runcorn and Widnes and aligned with GP practices. The teams work with all adults age 18+ with complex needs (except mental health) regardless of age. For those young people identified as having complex needs, to facilitate the transition from children's' to adult services, care management assistance with planning is available from age 16+. The focus throughout all care management processes is on enablement, to promote independence and includes:

- Longer-term complex assessments and support planning
- Facilitating people to undertake assessments and support plans with limited social services input;
- Scheduled annual reviews
- Re-assessments and safeguarding vulnerable adult assessments (VAA)

### *Hospital DischargeTeam*

Both Whiston and Warrington Integrated Hospital Discharge Teams provide care management support to inpatients in the hospitals to enable hospital discharge and avoid

delays. The teams work alongside staff of neighbouring authorities as well as health commissioners.

### *Therapy Services*

Therapy services include physiotherapy, occupational therapy, speech and language, and psychology. Therapists are based within hospitals as well as community settings. Halton residents are also able to access a specialist neuro-rehabilitation team.

### *Independent Living Centre (ILC)*

Located at Collier Street in Runcorn the ILC is a resource centre offering permanent displays of basic and specialist equipment for independent living. Agencies located here include Vision Support offering low level support for the visually impaired and Bridgewater Community Healthcare Trust Wheelchair and Mobility service.

### *Deafness Resource Centre*

The Deafness Resource Centre provides services that aim to empower, support and enhance the quality of life of D/deaf people. Deafness Resource Centre is commissioned to complete technical assessments for equipment on behalf of the Council. Halton residents of all ages are able to access centre based activities in St Helens including a chapel. There are also regular signing social groups and drop in sessions located around Halton.

## Social Integration and Community Contribution

The Council's Sure Start to Later Life services work with those aged 55+ and offer low level information provision and support for people to explore their interests and engage in community activities including volunteering. The Community Bridge Builders Service (CBB) works across all adult age groups and also supports disabled young people during their transition to Adult Services. As well as addressing social isolation CBB also strive to move people into volunteer placements with a view to long term employment.

### *Community Day Services*

Day services offer disabled people a range of activities based at community and leisure centres, libraries and parks across the Borough, the aim is to develop skills, promote independence and ensure a community presence that is both meaningful and valued. There is a focus on enterprise which offers work experience and vocational qualifications to move people closer to the job market as well as giving something back to the community.

### *Shop Mobility*

One of the enterprises run by Halton Day Services is Shop Mobility which offers members of the public mobility scooters and wheelchairs for hire. The service is available in both Widnes Town Centre and Halton Lea Shopping Centre from Monday to Saturday.

### *Safe In Town*

Safe In Town is a scheme designed to ensure vulnerable residents feel safe when out and about in the community. Launched by Halton Borough Council working alongside Cheshire

Police and charity Halton Speak Out, Safe In Town is aimed at residents aged 60-plus and adults and young people who suffer from a learning or physical disability or have mental health issues.

A special Safe In Town logo is displayed in participating shops and businesses across the borough to show residents that the staff inside are fully equipped to help them should they feel vulnerable or in trouble at any time. In 2014 Halton CCG and the Cheshire Police and Crime Commissioner have taken over funding of the scheme and greater participation is being encouraged through venues such as libraries and community centres.

### Maintaining Health and Wellbeing

Community Wellbeing Practice (see Appendix 3) model is delivers a range of health and wellbeing initiatives within general practice. A wider view is taken of the key determinants of health and wellbeing than purely medical aspects. Robust, integrated networks across voluntary and community settings are being established and staff empowered to promote and coordinate interventions within general practice settings. As this model evolves any gaps will be highlighted and a solution developed.

The Health Improvement Team is part of Bridgewater Community Healthcare NHS Trust and works in close partnership with Halton Borough Council to offer a wide range of local, tailored services and initiatives including weight loss and smoking cessation designed to improve the health and wellbeing of local people.

The team works with individuals and the community as a whole to understand what services are needed and how best to deliver them – be it in a community venue or through one-to-one visits. Support is also available for local businesses and organisations to provide education and training services to help local people make healthy choices.

### Intermediate Care

RARS is a multi-disciplinary team of health and social care professionals providing initial and on-going assessment, admission to other Intermediate Care services and rehabilitation, treatment and care to people in their own homes, in a residential intermediate care unit (Oak Meadow) or in a sub-acute unit. Less than 9% of referrals for intermediate care are under age 65.

### Residential/Nursing Care

Whilst all efforts are made to support people to remain in their homes and avoid admittance to long term care there comes a point for some people where residential or nursing care is appropriate. There are a number of residential and nursing homes across the Borough offering both short and long term care to adults under age 65.

The numbers of people with more specialist residential or nursing support needs is relatively low and these are met by specialist placements outside Halton. Currently there are three

people in such placements. For those with cerebral palsy SCOPE offers small residential units' located in both Widnes and Runcorn.

*Bredon*

Bredon Respite Unit though primarily for adults with learning disabilities is also registered for physically disabled adults and offers short stay residential respite care.

*Adult Placement*

Adult Placement offers flexible care in an Adult Placement Carer's own home from a few hours a day to overnight stays or longer. This can be an opportunity the care to have some respite or can help a person recovering following a hospital stay or illness. There are some restrictions in accessing this support as the carers homes may not be suitable for those with poor mobility or wheelchair users.

## Ensuring safety and quality in local services

The Council also has a duty to monitor all residential and nursing homes in the Borough and there is an annual monitoring programme in place through the Quality Assurance Team (QAT). The team also monitors domiciliary care providers and supported living services purchased by the Council.

Agreements have been put in place with providers contracted to the Council which enable Direct Payment holders to purchase care from them at the same competitive hourly rates. This offers the person confidence they are purchasing quality support from a provider that is monitored by the Council and at a realistic rate.

Personal Assistants employed directly by a direct payment holder are not monitored but the Council has produced an information leaflet on employing PA's.

*Compliments and Complaints*

Analysis of compliments and complaints offers useful feedback to services on their performance and can help identify any underlying adverse trends to be addressed. There is also valued learning in how to replicate good practice as well as informing system changes to offer clients a more positive experience of their contact with the Directorate. Commissioners maintain an overview to identify any gaps in service provision or services that need development

All complaints received by the Communities Directorate are analysed by type and client group. Themes within recent complaints related to communication and information provision.

**Appendix B**

## PSD Joint Commissioning Strategy 2007-2011 Action Plan Achievements

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| **Improved Health** | Rehabilitation | Develop a consistent approach to physical and psychological rehabilitation services and establish community based services and support groups.<br><br>Identify how short-term neuro-rehab can be accessed.<br><br>Ensure continuity of rehabilitation and follow up reviews. | Individuals learn strategies to help manage their condition and remain independent. | Halton residents have access to the Bridgewater NHS Trust Neuro-Rehabilitation team based at the Independent Living Centre. The team includes a Consultant Clinical Neuropsychologist and whilst not formally integrated with social care, strong links have been forged. |
| | | Extend intermediate care to those aged under 65. | | Both Intermediate Care and reablement services are available to all adults aged 18+.<br><br>Falls Specialist Service is also available to anyone over age 18 |
| **Improved Quality of Life** | Voluntary Sector contracts | Review contracts to identify gaps / improvements and develop action plans with agencies.<br><br>Implement ongoing provider | Individuals will be able to access appropriate effective services | Health and social care funding of Vision Support is now an integrated contract.<br><br>Monitoring is built into the quality Assurance Team annual work |

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| | | monitoring arrangements | | programme |
| | Deaf/Blind Strategy | Checklist/mapping exercise leading to action plan | Individuals have access to specific support. | Scrutiny review completed and recommendations implemented.<br><br>Service Specifications revised with emphasis on developing greater community presence. This is being delivered by Deafness Resource Centre |
| **Improved Quality of Life** | Transport | Replacement programme for HBC fleet and HCT vehicles will support modernisation of day activities.<br><br>Offer travel training and improve information to enable individuals to access public transport.<br><br>Improve frequency of public transport services.<br><br>Encourage bus companies to replace remaining non-accessible vehicles. | Accessible transport available and passenger journey times reduced.<br><br>Individuals are enabled to travel independently.<br><br>Improve accessibility in areas of the Borough across the week and Bank Holidays.<br><br>Accessible vehicles will be available on all public transport routes at all times. | HCT has accessed lottery funding to acquire a new bus in its fleet.<br><br>This is available through the Community Bridge Builder Service<br><br>Frequency is dependent on demand and monitored by the bus companies. Routes must be commercially viable. **This remains an issue for disabled adults**<br><br>Most routes now have accessible vehicles.<br><br>Halton Community Transport and |

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| | | | | Taxis offer alternatives to those with impaired mobility or who are vulnerable. |
| | Care management | Care plans will be person centred and specify measurable outcomes for individuals. | Services will focus on enablement and be able to demonstrate achievement | Individuals now complete their own supported assessment, reviews and care plans are all person centred. |
| **Making a positive contribution** | Service user/carer involvement | Formalise opportunities for involvement | Service provision will be informed by service users and their carers at both micro and macro levels of commissioning. Individuals can express their views and be heard. | Halton Disability Partnership represents disabled people and are working with the Council and CCG to influence service quality and development. |
| | | Review access to Advocacy services | Implications of IMCA are addressed | Access to both generic advocacy and IMCA available through Advocacy Matters. |
| **Exercise choice and Control** | Individualised Budgets<br><br>Independent Living Team | Pilot IB's for Adults with physical disabilities as part of the In Control project work.<br><br>Care managers to encourage self-assessment and support planning<br><br>Self-Assessment for equipment | IB's will be made available to all who want them.<br><br>Individual sets the outcome they wish to achieve.<br><br>Reduced waiting times and individuals are in control. | Systems in place to offer self-directed support across adult social care and offer all service users personal budgets.<br><br>Individuals are supported to complete their own assessment of need.<br><br>Smartassist available through HBC web portal to self-assess |

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| | Carers Support | Ensure services are available to meet carers needs identified through assessment. | Carers will be supported to maintain their health and social networks. | equipment needs.<br><br>Addressed through the Carers Action Plan and Halton Carers Centre |
| | Information | Explore opportunities to promote services/support and signpost individuals appropriately.<br><br>Ensure people have full information about their condition and what this may mean for them. | Individuals will make informed choices. | Halton Direct Link and Contact Centre trained advisors offer this. A range of information leaflets are available to download through the website. Web portal "Care and Support for You" is a hub for people to find out what support is available |
| | Independent Living Centre | Re-establish vision/purpose | Effective use of building. | Considered in previous review of day services. This is now being revisited |
| | Equipment services | Scope of HICES<br><br>Build capacity to expand HICES in response to aging population.<br><br>Direct payments for equipment | Clarity around support for C&YP<br><br>Equipment is available within time target.<br><br>Greater choice for individuals | Service is meeting demand and n 7 day delivery target is being maintained |
| **Freedom from discrimination and harassment** | Diversity monitoring | Record diversity data in assessment, planning and review.<br><br>Training to ensure diversity is addressed in care planning / | Individuals' cultural and religious needs are met. | Carefirst data shows ethnicity is recorded for 99% of clients. Supported assessment addresses diversity in planning to meet assessed need. |

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| | | service provision. | | |
| **Economic well-being** | Life chances | Consider best use of Bridgewater<br><br>Ensure Management Responsibility protocol is in place for all in-house services. | Available services will be designed to move people on.<br><br>Council managers working alongside agency staff will ensure care plans are followed. | Bridgewater Centre closed and service users linked into community based activities as appropriate.<br><br>In place. |
| | Employment | Develop support for maintenance of existing employment skills.<br><br>Offer training to access employment | Individuals can continue or return to employment. | Picked up through Supported Employment in Children and Enterprise Directorate. |
| | Housing | Set up adapted housing register.<br><br>Colleagues responsible for Housing elements of local development framework to sit on PSD LIT | Housing need will be quickly matched with suitable accommodation<br>Need for an accessible environment compliant with both Lifetime Homes and Decent homes standards is promoted. | Completed. Now exploring management of this through the adapted housing register |
| | Community bridge building | All aspects of PSD services to link to the Bridge Building Service and ensure appropriate referrals are made | Opportunities for social integration and employment are identified and realised. | Now part of pathway. |

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| | Cultural and Leisure services | Implement findings of accessibility review and actively promote mainstream services to people with disabilities. | Barriers that disable people will be removed. | Competed and has supported transfer of day activities to community venues. |
| **Personal dignity and respect** | Adult Protection | Safe Guard Vulnerable Adults in Line with Halton's *no secrets* Inter-Agency, Policy Procedures and Guidance | Vulnerable Adults are protected from abuse and their personal dignity and respect remain intact. | Now embedded into all service specifications. Integrated health and social care safe guarding unit established. |
| **Leadership** | Transition | Develop strategy for transition from Children's to Adult services. | Joint planning so young people experience a positive move into adulthood | Strategy and Protocol in place. Being reviewed following SEN reforms in September 2014 |
| | PSD/OP Care Management | Review process for Adults approaching age 65 | Continuity of care management will be maintained. | Revised care management structure 2012 and establishment of Complex Care teams based in Runcorn and Widnes has addressed this. |
| | | Develop and implement clear and robust interface agreements across AOWA, OP and Children's services | Impact of service changes will be fully assessed and consulted on. | See above |
| | Primary Care Services | Build relationships with local clinicians to influence PBC and promote whole system working | Promote preventative services and early intervention. | Early Intervention and Prevention strategy implemented.<br>Health and Wellbeing Strategy in place.<br><br>Integrated working with Clinical Commissioning Group supported by Section 75 and pooled budget. |

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| **Commissioning and use of resources** | HBC Independent Living Team/North Cheshire Hospital Trust /PCT | Whole system review of Therapy services | Effective utilisation of staff. Single assessment pre-hospital discharge | Integrated hospital discharge teams based in Whiston and Warrington Hospital Trusts linked to RARS and reablement support |
| | Independent Living Services | Whole system redesign of Equipment and Adaptations processes including safer handling.<br><br>Modernisation of Halton major adaptations service. | Streamlined working practices creating capacity to respond to demand of aging population and maximising staff skills and resources | Completed - delays for adaptations minimised and equipment delivered in reasonable timescales |
| | Visual Impairment Service | Determine where this service is best situated. | Integrated, effective support available. | Scrutiny review of Sensory Services completed.<br><br>HBC/CCG reviews of low vision services scheduled for 2014 |
| | Providers | Ensure staff are appropriately trained. | Only skilled staff will provide care/support. | Service Specifications are kept under review and monitoring of services by Quality Assurance team ensures provider staff are appropriately skilled to meet changing demands. |
| | | Incorporate person centred working practices into staff induction and ensure implemented. | Individuals will be in control of how and when they receive care and support. | Providers are adapting to market themselves at personal budget holders. |
| | | Review specifications within contracts and SLA's to promote continuous | Commissioners will be able to monitor performance and know | All specifications are reviewed as contracts end to ensure they reflect current policy and offer |

| Adult Social Care Outcome | Service area/activity | Actions | Outcome | Progress |
|---|---|---|---|---|
| | | improvement. | when intervention is required. | quality value for money services |
| | Joint Council/PCT Financial Strategy | Identify funding available over next three years and link service redesign to dis-investment / retraction | Re-focussed services within available resources | From April 2013 integrated commissioning across Public Health, Social Care and CCG supported by Section 75 and pooled budget has enabled health and social care transformation |

| | |
|---|---|
| **REPORT TO:** | Health Policy & Performance Board |
| **DATE:** | 9 September 2014 |
| **REPORTING OFFICER:** | Strategic Director, Communities |
| **PORTFOLIO:** | Health and Wellbeing |
| **SUBJECT:** | SeeHear - Commissioning Strategy for those living with sensory impairment in Halton 2014-2019 |
| **WARD(S)** | Borough-wide |

1.0 **PURPOSE OF THE REPORT**

1.1 To present to Health Policy and Performance Board the draft integrated Commissioning Strategy for those living with sensory impairment in Halton 2014-2019 and supporting evidence paper.

2.0 **RECOMMENDATION: That the Board note and comment on the content of the draft integrated Commissioning Strategy for those living with sensory impairment in Halton 2014-2019 and supporting evidence paper.**

3.0 **SUPPORTING INFORMATION**

3.1 At all ages sight and hearing loss have a large impact on quality of life. Significantly fewer deaf or blind adults of working age are in full time employment than those without sight or hearing loss.

3.2 Halton's ageing population means by 2020 there will be more than a 20% increase in numbers over age 65 living with hearing impairment and a similar increase for those living with visual impairment. Both are contributing factors to falls in older people and many over 65's will experience loss in both senses. 50-70% of sight loss in the older population is avoidable or treatable.

3.3 'SeeHear' is Halton's first stand-alone commissioning strategy focusing only on sight and hearing impairment for adults and older people. It takes an integrated approach to improve the quality of life for Halton residents living with sensory impairment and brings together commissioning intentions of Public Health, the Clinical Commissioning Group, and Adult Social Care.

3.4 This holistic approach will strengthen prevention of avoidable sight and hearing loss. Earlier detection when it does occur means rehabilitation support can be offered to minimise the impact on daily

living.

3.5 National policy for disabled people including those with sensory impairment is set out in' Fulfilling Potential: Making it Happen' (DWP 2013) whilst the 'UK Vision Strategy 2013-2018: Setting the direction for eye health and sight loss services'[1] sets out a framework to build a society in which avoidable sight loss is eliminated and full inclusion becomes accepted practice.

As yet there is no government strategy relating to hearing loss though Action on Hearing Loss promotes best practice at national level.

There is a commonality in the themes of these policies and these have formed the keystones of 'SeeHear':

i. prevention and early intervention,

ii. appropriate support including rehabilitation

iii. inclusive communities.

3.6 'SeeHear' incorporates the three strategic outcomes of the UK Vision Strategy:

1. Everyone looks after their eyes and their sight

2. Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support are available and accessible to all

3. A society in which people with sight loss can fully participate

3.7 'The strategic priorities set out in 'SeeHear' for 2014-19 have been informed by feedback at public engagement events, open consultation with the public and key stakeholders through a recent survey. Discussions have also taken place with Vision Support and Deafness Resource Centre to gather their experience of local needs:

**Priority 1 – Raise awareness of avoidable sight and hearing loss and encourage early action when it does occur**

**Priority 2 - Maximise independence and wellbeing of those living with sensory impairment through rehabilitation and technology**

[1] [1] http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=291&sectionTitle=Strategy+publications

**Priority 3 - Recognise the expertise and assets of people living with sensory impairment and use these to improve services**

**Priority 4 - Raise awareness of the barriers to social inclusion faced by people living with sensory impairment to build responsive, inclusive communities**

**Priority 5 – Ensure efficient and effective use of resources**

3.8 Halton's Better Care Board will oversee progress in implementing 'SeeHear' and is accountable to the Council's Executive Board and NHS Halton Clinical Commissioning Group's Governing Body.

## 4.0 POLICY IMPLICATIONS

4.1 'SeeHear' will support progress in local delivery of Fulfilling Potential, the UK Vision Strategy and the three national outcomes frameworks for the NHS, Adult Social Care and Public Health.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The action plan within the strategy contains a summary of resources required. These are primarily investment of staff time to effect the change or redirection of current investment to achieve service redesign. This is deliverable within existing staffing structures and funding levels; however the need to make efficiency savings across the system may impact on successful delivery of the strategy.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

This strategy considers the needs of young disabled people in transition to adulthood and some social needs of children and their families. Halton Children's Trust oversees integrated commissioning and development of support for children with sensory impairment .

### 6.2 Employment, Learning & Skills in Halton

Employment is a key determinant of health and wellbeing.

### 6.3 A Healthy Halton

Delivery of 'SeeHear' will have a positive impact on the health of Halton citizens.

### 6.4 A Safer Halton

The strategy promotes inclusion and raising awareness of the impact of living with sight or hearing loss to reduce isolation and contribute to building stronger communities.

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 'SeeHear' supports progress in delivering the strategic priorities of the Council for a Healthy Halton. As described in 5.1 the Strategy is capable of delivering within existing resources, however a reduction in budget or staffing levels will impact on service delivery.

Any reductions in funding allocations for sensory services in the financial years that the Strategy covers could have an impact in delivering on key aims.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An equality impact assessment (EIA) has been completed.

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

| **Document** | **Place of Inspection** | **Contact Officer** |
|---|---|---|
| Fulfilling Potential: Making it Happen (Office for Disability Issues DWP July 2013) | Runcorn Town Hall (Second Floor) | Liz Gladwyn |
| UK Vision Strategy 2013-2018: Setting the direction for eye health and sight loss services | Runcorn Town Hall (Second Floor) | Liz Gladwyn |

Halton Clinical Commissioning Group

# SeeHear

## A Commissioning Strategy for those living with sensory impairment in Halton

## 2014-2019

# Contents

# Foreword

Sight and hearing loss at any age have a significant impact on the quality of a person's life and their vulnerability to social isolation. Tasks that many of us take for granted such as catching a bus, shopping, paying a bill can be challenging to those with sensory loss.

We all know that both sight and hearing loss deteriorate as we get older and both are contributing factors to falls in older people. Halton's population is ageing and by 2020 the numbers of people aged 65 and over living with sight or hearing loss will increase by more than 20%. Many will be living with both hearing and sight loss. Significant levels of sight loss in the older population are preventable or treatable and by intervening early we can help to prevent or delay the consequences.

The aging process is not an excuse to ignore the consequences of sensory loss as a range of information and support is available including technology to help overcome these and assist older people with their daily lives and to maintain their independence for longer.

For younger people in the Borough greater awareness of volume levels on personal music players and at some entertainment venues could prevent long term noise induced hearing loss.

Commissioners need to consider the impact of an ageing population on local health and social care service provision. SeeHear is Halton's first standalone commissioning strategy focusing only on sight and hearing impairment for children, adults and older people. The strategy embraces a preventative pathway beginning with early detection through awareness raising of screening programs and sets out the strategic direction and priorities for health and social care services for people living with sensory impairment in Halton.

Developed by Halton Borough Council in partnership with Halton Clinical Commissioning group SeeHear sets out key objectives and priorities to improve quality of life for Halton residents living with sight loss, hearing loss or dual sensory loss

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# Why do we need a sensory disability strategy?

This is Halton's first commissioning strategy focusing only on sight and hearing impairment. The document sets out the strategic direction and priorities for social care and health services for people living with sensory impairment in Halton. This includes people who are blind or sight impaired people who are Deaf and use British Sign Language (BSL), people who are deafened or hard of hearing and people who have dual sensory loss often referred to as Deafblind.

At all ages deafness and blindness have a large impact on quality of life with combined deafness and blindness having a larger impact still. The focus of this strategy is to achieve outcomes which make a real difference to the quality of life and wellbeing of people living with sensory impairment.

- **In Halton there is a projected 22% increase by 2020 in numbers of people aged over 65 with hearing impairment**
- **In Halton there is a projected 21% increase by 2020 in numbers of people aged over 65 with visual impairment**
- **50-70% of sight loss in the older population is due to preventable or treatable causes**
- **Rising numbers of older people means a growing number of individuals are affected by dual sensory loss**
- **Impairment of both hearing and sight loss contribute as risk factors to falls**
- **40% of deaf children have additional or complex needs**
- **High levels of social isolation and mental ill health are experienced by those living with sensory impairment**
- **Significantly fewer deaf or blind adults of working age are in full time employment than those without sight or hearing loss**

Halton has previously implemented the "Physical and Sensory Disability Joint Commissioning Strategy 2007-2011". This has been reviewed and refreshed to build on its achievements and inform and influence the development of this first standalone strategy to set the direction for development of local services for those living with sensory impairment over the next five years.

The Halton Better Care Board aims to ensure that an integrated system is developed and appropriately managed to ensure that the resources available to both Health and Social Care, including the Better Care Fund, are effectively used in the delivery of personalised, responsive

and holistic care to those who are most in need within our community. This includes a remit to determine the strategic direction and policy for the provision of services to those with identified care and support needs to improve quality, productivity and prevention. The Board will oversee implementation of this Sensory Strategy and action plan and is accountable to both the NHS Halton Clinical Commissioning Group's Governing Board and Halton Borough Council's Executive Board.

Those living with sensory loss want to retain their independence and remain active participants in society and to be able to reach their full potential like anyone else[1]. Overcoming the barriers experienced by people with sight and hearing loss and societal attitudes together with increased life opportunities and choices, and the availability of appropriate information and support means that a good quality of life is possible for the individual whilst wider society and economic benefits are achieved.

This strategy promotes independent living so that individuals are empowered to define the outcomes they desire based on their own aspirations to participate in society, feel valued and lead a meaningful life. This approach also supports the recovery of improved mental health and wellbeing for disabled people as they retain or develop new meaning and purpose in their life[2]

This strategy has been developed within the context of a range of national and local policies,


[1] Fulfilling potential next steps - ... and Pensions 2012

[2] No Health Without Mental

strategies and plans summarised below. Further details of how these influence the strategy can be found in the supporting evidence paper.

# Local Issues

Halton is committed to a focus on individual people, their health and wellbeing and supporting the communities in which they live. The major local issues relating to sensory impairment which have influenced this Strategy are examined in detail in Part 4 of the supporting Evidence Paper and are summarised under three themes as illustrated below.

## Consultation

The views of Halton residents and other stakeholders have helped in developing this strategy to shape local support for those living with sensory impairment over the next five years.

The key themes from comments received are:

**Early detection:** uptake of some screening programs for preventable or treatable sight loss is low

To be expanded following conclusion of voluntary sector input

## People

- Number of people with sight or hearing impairment is higher than national and regional rates
- Significant increase in those aged 65+ with serious visual or hearing impairment
- Impact of dual sensory loss is problematic and disabling particularly in the older population
- 40% of deaf children have additional or complex needs
- The Journey into adulthood can be diffcult for young people with sensory impairment

## Health & Well-being

- 50-70% of sight loss in older people is preventable or treatable
- Sight and hearing loss are both risk factors in falls
- Sensory loss has an adverse impact on mental health and wellbeing

## Communities

- Accessible transport
- Impact of isolation in the community on ability of those with sight loss to be independent
- Impact of societal attitudes on ability of sensory impaired people to contribute to their community
- Staying safe
- Access to and retention of employment

# Our ambition, objectives and priorities

Our ambition for those living with sight and hearing loss in Halton is:

**People of all ages living with sensory loss experience a high level of well-being and control over their lives and will feel motivated, fulfilled and valued participants in their local community**

To help us achieve this ambition the three themes of the national strategy Fulfilling Potential – Making it Happen (Office for Disability Issues, 2013) together with the UK Vision Strategy and best practice promoted by Action on Hearing Loss form the keystones of our strategy:

i. prevention and early intervention,
ii. appropriate support including rehabilitation
iii. inclusive communities.

Through the work in this strategy we aim to ensure the **objectives** and priorities outlined in Fulfilling Potential and the UK Vision Strategy and those identified in the Halton Clinical Commissioning Group Strategic Plan and Halton Borough Council Strategic Priorities are realised for local people.

**(i) Halton residents understand the importance of looking after their sight and hearing**
We will raise awareness and understanding of avoidable sight and hearing loss particularly focusing on people most at risk.

**(ii) People living with sensory loss will be supported to regain and maintain their independence for as long as possible**
We will ensure that when permanent sight or hearing loss occurs, emotional support and rehabilitation will be provided in a timely fashion, enabling people to retain or regain their independence

**(iii) People living with sensory impairment will have a positive experience of care and support**
Care and support, wherever it takes place, should offer access to personalised, timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's dignity is protected.

**(iv) People living with sensory impairment will have access to information and support to manage their health and wellbeing**

Those living with sensory loss and their families will have access to information in appropriate formats to help manage their physical health and also their mental health and wellbeing.

**(v) People living with sensory impairment will shape future services**

Local people living with sensory loss and their organisations will have opportunities to feed in their views, informing delivery of services. Whenever possible a co-production approach will be adopted recognising the assets of the area and how partners will work together to address current and future health and social care needs.

**(vi) People living with sensory impairment will be supported to participate fully in the wider community**

More people living with sensory loss will have a good quality of life with greater ability to manage their own lives, stronger social relationships and skills for living and working. There will be greater community awareness of the impact of sight and hearing loss and the need to make reasonable adjustments.

Key to delivery is person centred local partnership working across the statutory and voluntary sector, to overcome barriers faced. This strategy identifies five priority areas of work to meet the needs of local people.

**Priority 1 – Raise awareness of avoidable sight and hearing loss and encourage early action when it does occur**

**Priority 2- Maximise independence and wellbeing of those living with sensory impairment through rehabilitation and technology**

**Priority 3 - Recognise the expertise and assets of people living with sensory impairment and use these to improve services**

**Priority 4 - Raise awareness of the barriers to social inclusion faced by people living with sensory impairment to build responsive, inclusive communities**

**Priority 5 – Ensure efficient and effective use of resources**

This strategy aspires to meet the needs of people with sensory loss by using the best evidence of what works to increase the effectiveness and value for money of local services. This will be achieved by:

- **Greater awareness of avoidable sight and hearing loss and earlier identification and intervention when they do arise.;**
- **Enabling people living with sight or hearing loss to remain independent and in control of their lives**
- **Improving the quality and efficiency of current services;**
- **Partnership working with people with sensory loss to develop services**
- **Broadening the approach taken to promote the social model of disability and develop positive attitudes towards those with sight and hearing loss.**

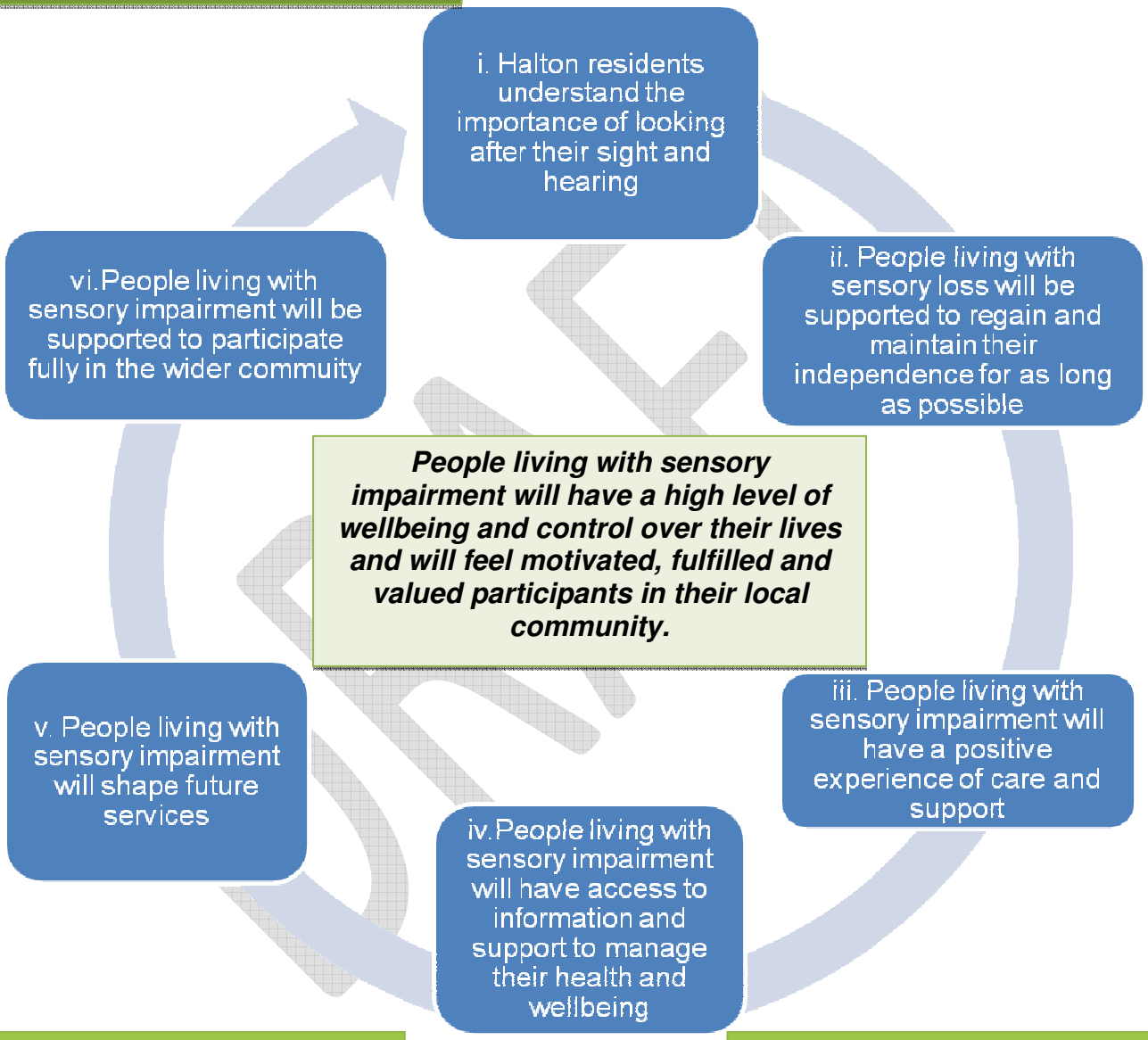
The accompanying evidence paper highlights significant numbers of people living with multiple long term conditions and sensory impairment and that whilst individually these conditions are generally not debilitating the combined impact can be disabling. This demographic change is set against a backdrop of on-going financial pressures across health and social care. Clearly a different approach is required to the traditional models of service provision to manage future demand.

Services for those with sensory impairment along with preventative support, earlier interventions and a range of informal support are essential in meeting Halton's priorities. Whilst this strategy covers a five year period it will be kept under review and will evolve in response to changes in national and local drivers and emerging issues.

**Our ambition, objectives and priorities**

**1. Raise awareness of the barriers to social inclusion faced by people living with sensory impairment to build responsive, inclusive communities**

**2. Maximise independence and wellbeing of those living with sensory impairment through rehabilitation and technology**




**4. Raise awareness of avoidable sight and hearing loss and encourage early action when it does occur**

**3. Recognise the expertise and assets of people living with sensory impairment and use these to improve services**

**5. Ensure efficient and effective use of resources**

# Implementing our priorities

National policy promotes the social model of disability as a way of thinking about how physical, social and environmental barriers can be removed so that disabled people including those with sensory loss can realise their aspirations and fulfil their potential. The approach to disability equality has a focus on **inclusion and mainstreaming**, with additional support provided where needed, and on the **involvement of people in making decisions** that will affect their lives. **Fulfilling potential: Next Steps** prioritises action for people around three themes:

i. **Early intervention and preventative approaches to impairment and disability –** enable people to build the lives they choose e.g. staying in education or employment and overcoming disability barriers, learning independent living skills and opportunities.

ii. **Independence, Choice and Control –** a focus on early intervention and prevention with access to independent information and advice to help people organise and plan care and support. Better support for people to remain in their own home through increased use of Assistive Technology and community based support which promotes dignity and choice and avoids isolation.

iii. **Inclusive, accessible communities –** enable disabled people to participate in their local area through safe inclusive access to key services, strong community links and affordable housing that can meet changing needs. Build community capability by developing User Led Organisations (ULO) and other community groups to play a key role in early intervention.

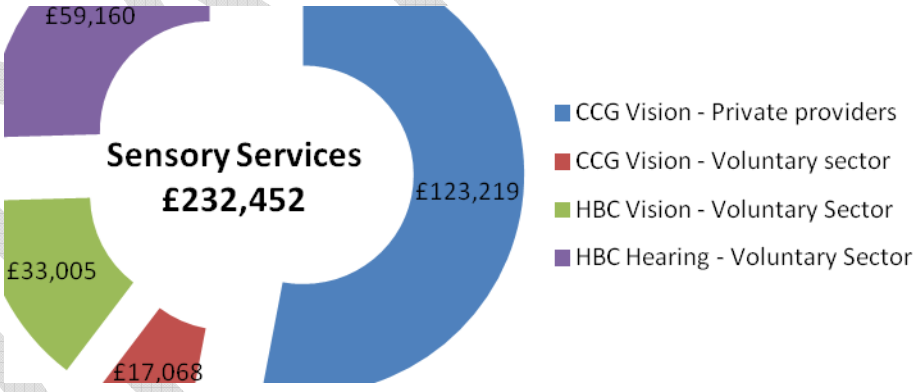
In line with national policy, Halton Borough Council and Halton Clinical Commissioning Group are working collaboratively to move towards greater integration of services to improve quality of care and ensure effective use of finite resources.

This strategy places an emphasis on prevention and early intervention and promotes rehabilitation and reablement minimising the impact of sensory loss and thus avoiding or delaying the need for more formal care. The success of the strategy will depend on broader partnership working across voluntary, community and commercial organisations to achieve the best possible outcomes for Halton's citizens.

# How is it paid for?

The following financial breakdown is based upon current direct expenditure on funding for initiatives specific to those with sensory impairment. It does not reflect all of the wider universal and targeted activity that is commissioned locally. Expenditure, on areas such as Primary Care (GPs, etc), general health promotion, or voluntary and community sector activity, all have a direct impact upon the quality of life of people living with sight or hearing loss but does not fall within the direct influence of this strategy and action plan.

**Planned Council and CCG Expenditure on Hearing and Vision Services 2014/15**



# How will we know if we have been successful?

**When we have achieved our aims those living with sight and hearing loss will be able to overcome environmental and social barriers to realise their aspirations and play a full part in society if they choose to.**

**There will be a high proportion of people feeling supported to manage their health and feeling safe and in control of their lives.**

**Those who live with sight and hearing loss will be able to contribute fully to the community, have good levels of employment and be able to enjoy as much social contact as they would like.**

**Eye healthcare will be important to everybody and levels of avoidable sight loss will reduce**

The Overarching Outcome for this Strategy is that people living with sight or hearing loss will have a high level of wellbeing and control over their lives and will feel motivated, fulfilled and valued participants in their local community. This will be achieved by focussing efforts on delivering against and achieving the five priorities.

It is important to make sure that real health and wellbeing improvements are delivered through the implementation of this strategy. The best way to achieve this is to use recognised measures to monitor the benefits arising from agreed priority actions and five high level targets have been set as a measure of success:

| | Priority | Target to measure success | 2014/15 | 2016/17 |
|---|---|---|---|---|
| 1 | Raise awareness of avoidable sight and hearing loss and encourage early action when it does occur | Preventable sight loss – number of Certificates of Visual Impairment issued<br>Outcomes framework:<br>Public Health 4.12<br><br>Note increased registrations may be positive if higher numbers of people access screening programs – low access levels are associated with areas of high deprivation | Trends to be monitored against 2010/11 baseline | Trends to be monitored against 2010/11 baseline |
| 2 | Maximise independence and wellbeing of those living with sight and hearing loss through rehabilitation and technology | Overall satisfaction of people who use services with their care and support<br>Outcomes framework:<br>Adult Social Care Outcomes Framework 3a<br><br>Overall satisfaction of carers | 70% | 70% |

| | | | | |
|---|---|---|---|---|
| | | with social services<br>Outcomes framework Adult Social Care 3b<br><br>The proportion of disabled people who use services who have control over their daily life<br>Outcomes framework Adult Social Care 1b<br><br>Percentage of items of sensory equipment delivered within 7 working days | 47%<br><br>80%<br><br>97% | 50%<br><br>80%<br><br>97% |
| 3 | Recognise the expertise and assets of people living with sight and hearing loss and use these to improve services | Commissioned services demonstrating co-produced and personalised approaches to service development | 70% | 80% |
| 4 | Raise awareness of the barriers to social inclusion faced by people living with sight and hearing loss to build responsive, inclusive communities | Proportion of people who use services and their carers, who reported that they had as much social contact as they would like<br>Outcomes framework Adult Social Care 1I<br>Public Health 1.18 | 2013/14 baseline to be inserted | |
| 5 | Ensure efficient and effective use of resources | Maintain quality of life for people with long term conditions higher than England average<br>Outcomes framework Adult Social Care 1a<br>NHS 2 | 2013/14 baseline to be inserted | 2013/14 baseline to be inserted |

An 'Outcomes Framework' provides a template of how measures can be used to monitor different priority areas. We will use the current recognised outcomes frameworks covering the NHS, Adult Social Care and Public Health to inform our overall outcome measures and our performance indicators. As we achieve our desired outcomes we will review our priorities and change them if appropriate. More detail on these indicators can be found in the evidence paper.

It is also important that the quality of what we are delivering is monitored to make sure people have a positive experience. On-going customer feedback as well as activities such as local surveys and focus groups will be used to monitor current services and see where any improvements need to be made. The discussions that have taken place during the development of this framework should continue throughout the lifetime of the Strategy and to help in the

development of the next JSNA and Strategy.

| PRIORITY 1: Raise awareness of avoidable sight and hearing loss and encourage early action when it does occur | |
|---|---|
| **Preventable sight loss - number of Certificates of Visual Impairment issued**<br>(Outcomes Framework: Public Health 4.12)<br><br>**Trends to be monitored against 2010/11 baseline** | |
| **Why is this a priority?**<br>Though related to aging some conditions leading to sight loss can be avoided through greater awareness of the potential problems and good eye care.<br><br>In younger adults and children noise induced hearing loss can become permanent but is avoidable if the risks are known.<br><br>Sensory loss can often have a slow onset and individuals may not be aware that their loss is increasing, or may feel reluctant to ask for assistance. There is also the important group of people who have, or may have, 'hidden' sensory loss.<br><br>Early identification of sensory loss can have a positive impact in reducing negative outcomes (e.g. it could reduce the risk of falls, avoids social isolation ). | **What do we want to achieve?**<br>• Early detection in childhood<br>• Reduce avoidable sight loss<br>• Those with sensory loss remain active members of their community<br>• Improved access to information and advice for those with sensory loss to self-manage their condition, keep healthy, active and well |

| Ref No | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| 1a | Seek NHS England response to the Merseyside Eye Health Needs Assessment | Informed commissioning and targeting of local eye care services | March 2015 | Staff training | Public Health |
| 1b | Explore use of ICT for broadening access to audiology and eye screening in schools | Early detection | December 2015 | Investment in ICT<br>Staff training | Halton Clinical Commissioning Group<br>Public Health |
| 1c | Increase uptake of screening programs through an "every contact counts" approach | Early detection and access to rehabilitation<br><br>Reduction in health inequalities | March 2016 | Staff time | Public health with NHS England |
| 1d | Analyse factors affecting registration of blindness locally | Increased recognition of sight loss and access to support | March 2015 | Staff time | Commissioning Manager and Performance team |
| 1e | Understand the needs of hard to reach groups e.g. homeless and positive promotion of health checks and keeping well | Reduction in health inequalities | March 2016 | Staff time | Halton Clinical Commissioning Group<br>Health Improvement Team |

| | | | | | |
|---|---|---|---|---|---|
| | programs | | | | |
| 1f | Actively promote smoking cessation to those at higher risk of losing their sight | Preventable sight loss will reduce | December 2017 | Staff time<br>Publicity materials | Public Health and Health Improvement Team |
| **1g** | Accessible information on:<br>• Preventative measures<br>• Managing sight and hearing loss<br>• How to access support | Promote action on avoidable sight and hearing loss | March 2016 | Staff time<br>Publicity materials | Public Health Divisional Manager Assessment and Care Management |

**PRIORITY 2: Maximise independence and wellbeing of those living with sensory impairment through rehabilitation and technology**

**Overall satisfaction of people who use services with their care and support ASCOF 3a**

**Target 2014/15 %** **Target 2016/17 %**
**70%** **70%**

**Overall satisfaction of carers with social services ASCOF 3b**

**Target 2014/15 %** **Target 2016/17 %**
**47%** **50%**

**The proportion of disabled people who use services who have control over their daily life**
(Outcomes framework: Adult Social Care 1b)

**Target 2014/15 %** **Target 2016/17 %**
**80%** **80%**

**Percentage of items of sensory equipment delivered within 7 working days**
(Local indicator)

**Target 2014/15 %** **Target 2016/17 %**
**97%** **97%**

**What do we want to achieve?**

- An enabling and preventative approach
- Maximise independence and good quality of life
- Equal access to Health Improvement and Health Promotion initiatives
- Access to the right support to avoid unplanned hospital admissions
- Those with care and support needs feel safe, respected and maintain their dignity

| REF NO. | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| **2a**<br><br><br><br><br>**2b** | Ensure self-management of care needs information is readily available in a range of formats<br><br>Further develop Care and Support for You portal to offer online information on support to maintain independence | Number of hits on portal | March 2015<br><br><br><br>December 2015 | Staff time<br><br>Internet links to partner agencies<br><br>Staff time<br>IT support | Commissioning Manager<br><br>Providers<br><br>Divisional Manager Independent Living |
| **2c** | Review Transition Strategy and Protocols to ensure remain in line with Support and Aspiration (DFE 2012) | Increased numbers of young people reporting a positive experience of transition | September 2014 | Staff time | Commissioning Managers Adults and Children<br><br>Transition Group |
| **2d** | Increase the use of Assistive Technology (telehealth and telecare) and ICT to enable people to be better supported at home | Increased numbers of people using AT/ICT | Ongoing across lifetime of strategy | Investment in technology | Divisional Manager Independent Living |
| **2e** | Review access to and impact of support available at Halton Independent Living Centre to inform service development. | Report and recommendation to SMT | March 2015 | Staff time | Commissioning Manager |
| **2f** | Jointly review pathways to and co-ordination of CCG and HBC low vision services. | Integrated, seamless pathway for those with visual impairment | September 2015 | Staff Time | Commissioning Manager<br>Halton Clinical Commissioning Group |
| **2g** | Implement the proposed cross-Government strategy on hearing loss | Local strategy/actions will be in place | December 2015 | Staff Time | Commissioning Managers<br>Halton Clinical Commissioning Group<br>Public Health<br>Adult Social Care |

**PRIORITY 3: Recognise the expertise and assets of disabled people and use these to improve services.**

**Commissioned services demonstrating co-produced approaches to service development**
(Local indicator)

**Target 2014/15 70%** **Target 2015/16 80%**

## Why is this a priority?

Traditional models of support begin by exploring eligibility and entitlement to services which can undermine the resilience of people. By adopting an asset or strengths based approach people who use services, their families and the wider community contribute their in-depth knowledge of their requirements and how best to meet them to assist in the design, commissioning and provision of support and services rather than being passive recipients of services.

By placing the emphasis on more effective social care interventions, supporting the unpaid relationships and informal networks a person already has in place they are left better informed, connected and confident.

What do we want to achieve?

- co-design, including planning of services;
- co-decision making in the allocation of resources;
- co-delivery of services, including the role of volunteers in providing the service
- co-evaluation of the service.
- social care professionals and people who use services work in equal partnerships towards shared goals;
- people who use services and carers having an equal, more meaningful and more powerful role in services;
- people who use services and carers are involved in all aspects of a service – the planning, development and actual delivery of the service;
- power and resources are transferred from managers to people who use services and carers;
- the assets of people who use services, carers and staff are valued;

| REF NO. | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| **3a** | Develop protocol for taking forward co-production in Halton | Co-production protocol in place | September 2014 | Staff time | Commissioning Manager |
| **3b** | Implement Care Management Strategy to focus on the strengths and natural support already in place of those requesting an assessment | New working practices embedded | April 2015 | Staff time | Divisional manager Assessment and Care Management |
| **3c** | Work in partnership with local User Led Organisations on policy and service development | Co-produced policies and service improvements | On-going through lifetime of the strategy | Staff time | Commissioning Manager<br><br>Voluntary Sector |

| PRIORITY 4: Raise awareness of the barriers to social inclusion faced by people living with sight and hearing loss to build responsive, inclusive communities | |
|---|---|
| **Proportion of people who use services and their carers, who reported that they had as much social contact as they would like**<br>(Outcomes framework: Adult Social Care 1I, Public Health 1.18))<br><br>**Target 2014/15 %  Target 2016/17 %**<br>**2013/14 baseline to be inserted** | |
| **Why is this priority?**<br><br>The prevalence of sight and hearing loss will rise due to an aging population and many people also have additional health conditions and are likely to be at risk of isolation through the interaction of their conditions with social and environmental factors. Interventions are required to remove thee barriers to improve quality of life for those living with sight and hearing loss. | **What do we want to achieve?**<br><br>• Inclusive local communities where everyone's voice is heard and they can realise their aspirations.<br>• Improved access for disabled people to accommodation and support options to maximise independence |

| Ref No. | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| **4a.** | Work with voluntary sector and User Led Organisations to ensure impact of sensory loss is addressed by statutory services throughout the development and implementation of policies and services. | Equality impact assessments | On-going across timelines of specific policy development. | Staff time<br><br>Voluntary Sector capacity | Commissioning Manager |
| **4b** | Facilitate dialogue between local transport providers and local residents living with sight and hearing loss. | Local concerns regarding transport are listened to. | December 2014 | Staff Time | Logistics Manager |
| **4c** | Ensure working age adults living with sight or hearing loss have access to support to retain or gain employment. | | Ongoing across lifetime of strategy | Staff time | Division Manager Employment Learning and Skills |
| **4d** | Service specifications prompt providers to review compliance with the Equality Act in regard to sensory loss and in particular communication needs and consider if further adjustments are required. | Commissioned services will make all reasonable adjustments in supporting those with sensory loss | Ongoing across life time of strategy | Staff time | Commissioning Managers |

## PRIORITY 5: Ensure efficient and effective use of resources

**Maintain quality of life for people with long term conditions higher than England average**
(Outcomes framework: Adult Social Care 1a, NHS 2)

**2013/14 baseline to be inserted**

### Why is this priority?

Halton is committed to empowering to take control of the decisions made regarding their sensory impairment and avoid or move away from dependency on formal care.

Both the Council and Clinical Commissioning Group face significant funding reductions accompanied by pressures on the system arising from increased life expectancy and increased numbers of people living with multiple long term conditions. Closer integration between health and social care to deliver better, more joined up services adopting a preventative approach with early intervention are key to addressing these challenges.

### What do we want to achieve?

- Good quality, locally provided care and support which strives to reduce the impact of sensory loss
- People with complex long term conditions enabled to remain independent in their local community
- Utilise Better Care Fund to commission more integrated and joined up pathways for those living with sensory loss
- Achieve value for money

| REF NO. | ACTION | SUCCESS MEASURES AND OUTCOMES | TIMESCALE | RESOURCES | RESPONSIBILITY |
|---|---|---|---|---|---|
| **5a** | Use integrated commissioning, contract monitoring and safeguarding arrangements to consolidate service specifications and quality standards of complex care | Percentage of providers rated good through local quality assurance reviews<br><br>Reduced numbers of safeguarding and Vulnerable Adult Abuse referrals | April 2015 | Staff time | Commissioning Manager<br>Quality Assurance Manager |
| **5b** | Work with care homes to develop staff awareness of the impact of sight and hearing loss and ensure residents are accessing sight and hearing checks and aids are working | Trained staff<br><br>Improved communication and participation for care home residents. | March 2016 | Staff time<br>Training | Commissioning Manager |
| **5c** | Review care pathways for sight and hearing loss and effectiveness of mainstream interventions and links to other services. | Integrated person centred pathway | December 2015 | Staff time<br>Possible service reconfiguration within existing resources | Divisional Manager Assessment and Care Management<br>Commissioning Manager<br>Halton Children's Trust |
| **5d** | Review contracting arrangements for equipment and minor adaptations | Targets for delivery of equipment and completion of adaptations met | March 2015 | Staff time | Commissioning Manager |

| | | | | | |
|---|---|---|---|---|---|
| | to inform future procurement and value for money | | | | |

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| **REPORT TO:** | Health Policy and Performance Board |
| **DATE:** | 9 September 2014 |
| **REPORTING OFFICER:** | Chief Officer, NHS Halton Clinical Commissioning Group |
| **PORTFOLIO:** | Health & Wellbeing |
| **SUBJECT:** | Developing a strategy for general practice services in Halton |
| **WARDS:** | Borough Wide |

## 1.0 PURPOSE OF THE REPORT

To inform the Health Policy and Performance Board of the programme to develop a strategy for general practice services in Halton.

## 2.0 RECOMMENDATION: That the Health Policy and Performance Board note the report and accompanying presentation.

## 3.0 SUPPORTING INFORMATION

General practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day. NHS England is responsible for commissioning the core primary medical services that general practice provides. Clinical Commissioning Groups (CCGs) have a duty to support NHS England in promoting quality in general practice services.

The basic delivery model of general practice has evolved over time but not radically changed. There have been seismic shifts and environmental pressures in health and social care in recent years that have challenged the sustainability of general practice. General practice faces challenges from:

- An ageing population, growing co-morbidities and increasing patient expectations.
- Increasing pressure on NHS financial resources and increased regulation.
- Persistent inequalities in access and quality of general practice.
- Growing reports of workforce pressures, including recruitment and retention problems.
- Political pressure to change.

NHS Halton CCG and NHS England are discussing the development of formalised co-commissioning arrangements for general practice services in the borough, following an expression of interest process. This means

that NHS England may, over the next few months, be delegating more responsibility for the commissioning of general practice services in the borough to NHS Halton CCG. NHS Halton CCG and NHS England agree that strong sustainable general practice is needed in Halton to support commissioning *and* service provision. This needs a co-ordinated and engaged approach to deliver this, which is why NHS Halton CCG is supporting the development of a co-commissioning strategy for general practice services in Halton.

## 4.0 POLICY IMPLICATIONS

NHS England has stated their ambition for general practice services to operate at greater scale and be at the heart of a wider system of integrated out-of-hospital care. This will require a shift of resources from acute to out-of-hospital care. These ambitions are congruent with NHS Halton CCG's 2 Year Operational Plan and 5 Year Strategy and also with the Better Care Fund delivery plan developed with Halton Borough Council. NHS Halton CCG, engaging with NHS England, local practices and other partners is developing a co-commissioning strategy to meet these ambitions by focusing transformational activity in six areas:

- Improved access and resilience.
- Integrated care.
- New services in the community.
- Community development.
- Quality improvement.
- Enabling work streams (i.e. governance, finance, estate, contracting, information technology and workforce).

The presentation that accompanies this paper provides more information on the approach and rationale behind the programme to develop this strategy.

## 5.0 OTHER IMPLICATIONS

The strategy will impact on how general practice services in the borough are commissioned and delivered.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children and Young People in Halton

Children and young people will benefit from transformed general practice services.

### 6.2 Employment, Learning and Skills in Halton

None as a result of this report.

### 6.3 A Healthy Halton

A coherent strategy for general practice services in Halton, with an associated implementation and evaluation plan, will contribute to improving the health of the borough and reducing inequalities.

### 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

The programme is collating a risk register as it progresses. A lack of engagement in the programme by practices and other partners is a potential risk, which is being mitigated by dedicated management resource.

## 8.0 EQUALITY AND DIVERSITY ISSUES

There are no equality and diversity issues arising as a direct result of this work.

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

Addicott, R. and Ham, C. (2014) *Commissioning and funding general practice: Making the case for family care networks*, London: The King's Fund.

British Medical Association (BMA), (2013) *Developing General Practice today: Providing healthcare solutions for the future*, [Online], Available: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision.

Department of Health (2014), *Transforming Primary Care: Safe, proactive, personalised care for those who need it most*, London: Department of Health.

Dyson, B. (2014), *Improving General Practice: A Call To Action Phase 1 Report*, London: NHS England.

Health and Social Care Information Centre (HSCIC) (2013) *NHS Staff 2002-12:General Practice*, [Online], Available: http://www.hscic.gov.uk/article/2021/Website-Search?productid=10382&q=NHS+Staff+2002-12+General+Practice&sort=Relevance&size=10&page=1&area=both#top.

NHS England (2013), *Improving General Practice: A Call to Action*, [Online], Available: http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/.

NHS Improving Quality (2013), *An introduction to the NHS Change Model*, [Online], Available: http://www.changemodel.nhs.uk/pg/dashboard [28 May 2014].

Rosen, R. and Parker, H. (2013), *New models of primary care: practical lessons from early implementers,* London: Nuffield Trust.

Roughton, R. and Hakin, B. (2014), *Co-commissioning of primary care services: Publications Gateway ref. Number 01599*, NHS England, Leeds.

NHS
Halton Clinical Commissioning Group

# Developing a strategy for general practice services in Halton

Simon Banks
Chief Officer, NHS Halton CCG

Halton Borough Council
Health Policy and Performance Board
9th September 2014

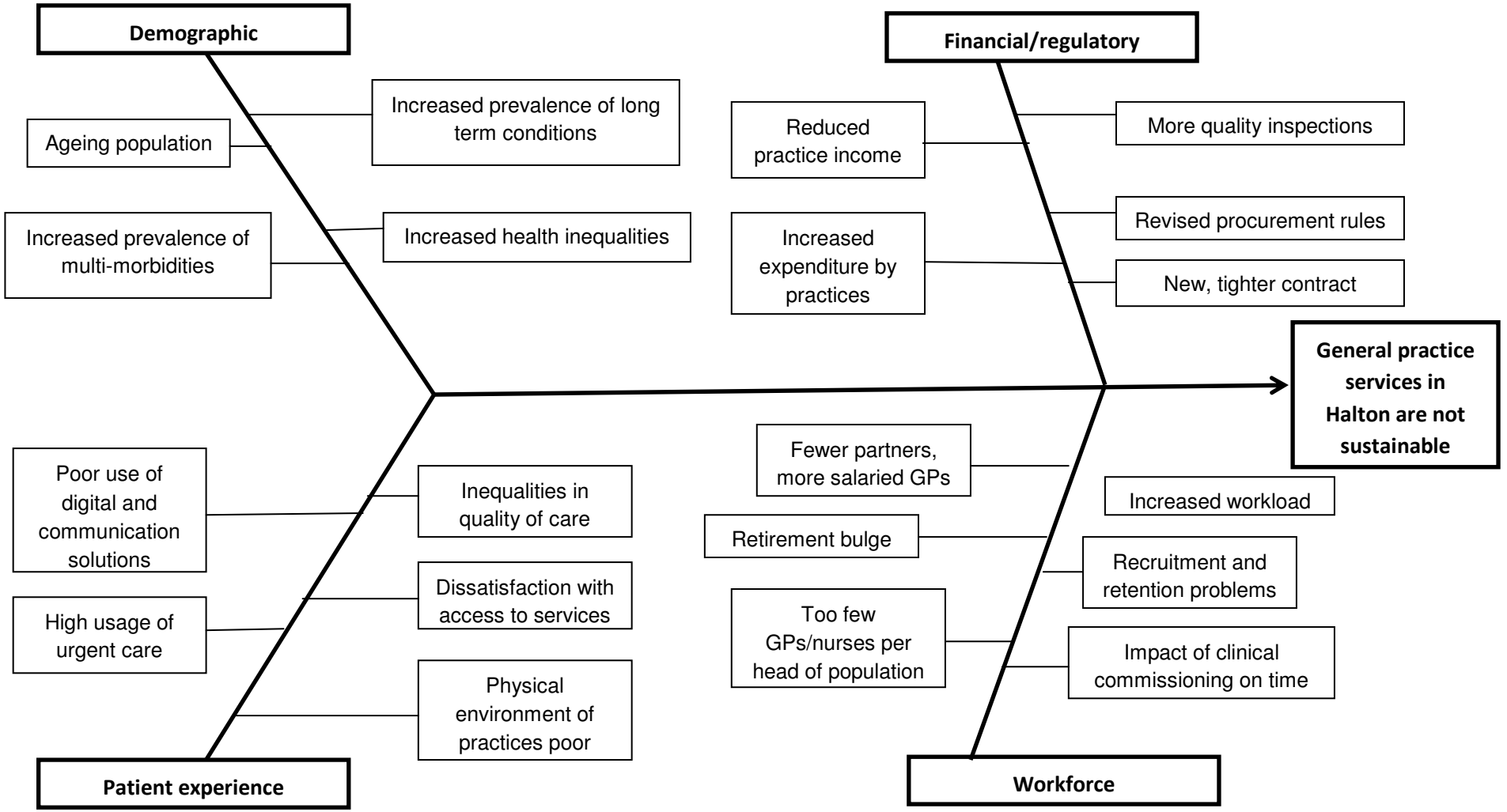
# Overview of the current state (1)

- NHS Halton CCG is a membership organisation formed from the 17 general practices in the borough.
- NHS Halton CCG is responsible for the commissioning of the majority of healthcare services for the borough.
- NHS England is responsible for commissioning general practice services in the borough.
- Practices are simultaneously commissioners and providers.

# Overview of the current state (2)

- General practice has been the cornerstone of primary care in the NHS in England since 1948.
- Basic delivery model has evolved over time but not radically changed.
- Seismic shifts and environmental pressures in health and social care.
- General practice under pressure to change.
- NHS Halton CCG and NHS England are discussing the development of formalised co-commissioning arrangements for general practice.
- Strong sustainable general practice is needed in Halton to support commissioning ***and*** service provision.
- Needs a co-ordinated and engaged approach to deliver this, hence the development of strategy.

# Root Cause Analysis



# What is the problem?

*The problem is that general practice services in Halton are not sustainable.*

# What is the objective?

*By January 2015 to have developed and agreed a strategy to deliver sustainable general practice services in Halton.*

# What does good general practice deliver?

- Proactive, co-ordinated care.
- Holistic, person-centred care.
- Fast, responsive access to care.
- Health-promoting care.
- Consistently high-quality care.

# What does NHS England Commissioning want to see?

- General practice operating at ***greater scale***.
- Preserve ***relationship continuity***.
- Heart of a wider system of ***integrated out-of-hospital care***.
- ***Shift of resources*** from acute to out-of-hospital care.

# Themes for transformation in Halton

- ***Improved access and resilience*** – extended hours and responsive care.
- ***Integrated care*** – care coordinators, multi-professional integrated community team, community hospital/virtual ward/intermediate care.
- ***New services in the community*** – advanced skills, community diagnostic services, enhanced access to care professionals and therapists, access to specialist advice, patient (and family) support and education.
- ***Community development*** – collaboration on asset based approaches to improving health and wellbeing.
- ***Quality improvement*** – improving patient experience, reducing variation, peer to peer challenge and increased service improvement capacity.
- ***Enabling work streams*** – establishing robust governance arrangements with NHS England (including contracting and performance), reviewing the use of estate (with NHS England and NHS Property Services), embracing technology and workforce planning (with Health Education North West).

# Benefits of transformation

- Better outcomes for patients.
- Better partnerships.
- Better value.
- Better for the workforce.

# Approach and rationale

- Systemic and systematic, leading *and* delivering a change programme.
- Create a climate for change.
- Agreeing a collective vision of what “good looks like” before exploring solutions.
- Involving and engaging as many people as possible, wide public engagement.
- NHS England/NHS Halton CCG setting the commissioning challenge.
- General practice shaping the response.
- Using NHS Improving Quality as ‘honest broker’ and NHS Change Model to build solutions.
- Burning ambition over burning platform.

# Questions?

| | |
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| **REPORT TO:** | Health Policy and Performance Board |
| **DATE:** | 9 September 2014 |
| **REPORTING OFFICER:** | Chief Officer, NHS Halton Clinical Commissioning Group |
| **PORTFOLIO:** | Health & Wellbeing |
| **SUBJECT:** | End to End Assessment |
| **WARDS:** | Borough Wide |

## 1.0 PURPOSE OF THE REPORT

To inform the Health Policy and Performance Board of the outcomes of the End to End Assessment Project, commissioned by NHS Halton CCG with NHS Knowsley, St Helens and Warrington CCGs and NHS England.

## 2.0 RECOMMENDATION: That the Health Policy and Performance Board note the report.

## 3.0 SUPPORTING INFORMATION

NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England commissioned work to deliver:

- A high level retrospective review of health care activity, spend and patient flows by commissioner and by location per quarter in the past three years.
- A review of all current health care activity, spend and patient flows by commissioner and by location.
- Projected activity, spend and patient flows by commissioner and by setting for the next 3, 5 and 10 years assuming current cost and payment arrangements.

The Chief Officer of NHS Halton CCG acted as co-sponsor of this project with David Cooper, Acting Chief Finance Officer - NHS Warrington CCG. They co-chaired a steering group working with Capita, who were selected following a procurement process to deliver this project.

## 4.0 POLICY IMPLICATIONS

The outcomes of the End to End Assessment work have been factored into the 5 Year Strategy for NHS Halton CCG.

## 5.0 OTHER IMPLICATIONS

There will be an impact on the provider landscape for Halton as the 5 Year Strategy is progressed. The End to End Assessment work highlights some of the areas in which this will happen.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children and Young People in Halton

NHS Halton CCG's 5 Year Strategy will have areas that will impact on children and young people. The End to End Assessment explored paediatric activity but the outcomes focus mainly on frail and older people.

### 6.2 Employment, Learning and Skills in Halton

None identified.

### 6.3 A Healthy Halton

The End to End Assessment work will help shape the future direction of health and social care commissioning in the borough.

### 6.4 A Safer Halton

None identified.

### 6.5 Halton's Urban Renewal

None identified.

## 7.0 RISK ANALYSIS

The End to End Assessment work influences the risk assessment that has been undertaken as part of the development of the 5 Year Strategy by NHS Halton CCG.

## 8.0 EQUALITY AND DIVERSITY ISSUES

There are no equality and diversity issues arising as a direct result of this work.

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

None.

# END TO END ASSESSMENT

## Background

NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England commissioned work to deliver:

- A high level retrospective review of health care activity, spend and patient flows by commissioner and by location per quarter in the past three years.
- A review of all current health care activity, spend and patient flows by commissioner and by location.
- Projected activity, spend and patient flows by commissioner and by setting for the next 3, 5 and 10 years assuming current cost and payment arrangements.

The Chief Officer acted as co-sponsor of this project with David Cooper, Acting Chief Finance Officer - NHS Warrington CCG, and co-chaired a steering group working with Capita, who were selected following a procurement process to deliver this project.

## Summary

This project has provided a retrospective, current, and future view of health and social care activity, spend and patient flows across the Mid Mersey area. Looking back over the past three years the four CCGs have been relatively consistent in their activity trends. Activity has generally grown in line with underlying population growth, with recent signs of this being offset by schemes put in place to manage demand. The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more complex case mix or coding changes. Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that continued focus on the frail / elderly will be of particular benefit to the health and social care economy moving forwards.

At present there is a large degree of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for population characteristics and weighting for healthcare need. The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes. Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

Looking forward, a large proportion of commissioning intentions are interventions for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus. There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.

Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate headroom to put the necessary investment into non-acute services to enable long-term change.

**Retrospective Analysis**

The key purpose of the initial high-level analysis was to differentiate between underlying growth and acuity, shifts between providers, re-provision of activity in alternative settings, changes to tariffs, local prices, payment mechanisms, technical coding and counting, contract penalties and incentives, recurrent and non-recurrent changes. Data was assembled and validated for financial years 2010/11, 2011/12, 2012/13 and 2013/14 to January 2014. Capita created a 'standardised' view of the historic data to allow a like-for-like comparison over the three-year period. This work found that:

- The four CCGs have been relatively consistent in their activity trends seen over the past three years.
- With exception of a peak in winter 2012/13, non-elective activity has grown in line with underlying population growth, and has been relatively flat or decelerating in recent months, it appears that population pressure has been offset by schemes put in place to manage demand.
- Elective demand is growing overall but more of this is being carried out in the day case setting.
- The majority outpatient growth over the last year has been in non-GP referred activity
- All CCGs have seen a reduction or slowing of the upward trend in A&E attendances over the past year.
- The largest overall non-elective cost increases in individual specialties has been seen in Respiratory Medicine and General Medicine.
- The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more

complex case mix, coding changes over time may have impacted on this.
- Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that this is a particular area of opportunity, and that continued focus on frail/elderly patients will be of particular benefit to the health economy.

**Current baseline**

Capita applied similar principles as to the historic analysis to 2013/14 activity to date to profile current activity, spend and patient flows in order to present a picture of current activity using 2013/14 organisational structure and coding. They provided a statement of the baseline position as well as comparisons of current activity levels between practices and between CCGs to understand variation in the baseline. The main findings were that:

- There is a large scale of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for populations an weighting for healthcare need.
- The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes.
- There is a similar level of overall acute spend per head between the CCGs, combined with larger variation in non-acute spend per head, this may indicate that the level of acute activity is either true patient demand (i.e. there is a level of acute activity that goes into hospital regardless of what is commissioned elsewhere) or that this is led by the providers capacity to accommodate demand (supply led demand).
- With some exceptions the patient flow from practice to provider follows a natural pattern, with limited opportunity for repatriation from Liverpool or Manchester.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

**Forecasting the future**

Capita worked up a projection of future activity, spend and patient flows. It is made up of the following elements:

• The collation and understanding of commissioning intentions and strategic plans.
• The mapping of intentions to specific patient cohorts impacted by the change.
• The modelling of the impacts on future activity, spend and patient flows.

The main findings are:

- Grouping of commissioning intentions has shown that by far the biggest area of focus for interventions is for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus.
- There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.
- Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Public health initiatives and preventative schemes may have an impact over the longer term but would need investment now for longer term benefits to be realised.

**Implications for commissioners**

The purpose of the assignment was to undertake modelling of historic, current and forecast activity, flows and spend. The ultimate aim of this exercise was to support commissioners in their decision making for the longer term. Capita offer a commentary on some of the key points arising from the review, which help address some of the questions CCGs are seeking to answer, and signpost the CCGs to what they might consider next to address remaining gaps in their knowledge. The key issues are summarised below.

| | |
|---|---|
| **Scope of plans** | The analysis shows that the current plans will help stem the tide of demand growth from population change but that in the long term, demand will continue to grow. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate breathing space to put the necessary investment into non-acute services to enable long term change. |
| **Community data** | The data provided for community services is not adequate to derive reliable calculations of the impact of commissioning intentions and the information provided in this report should be seen as illustrative. We would recommend that the basis |

| | |
|---|---|
| | for our modelling should be validated in collaboration with providers and further work be undertaken locally to understand the extent to which capacity in community services could be released to support the activity shifts associated with the commissioning intentions, and then the true quantum of additional capacity that will be required to support the long term shift indicated in the first point above. |
| **Impact of social care resource constraints** | The modelling suggests that austerity across the system is having an impact on the provision of social care, with a reduction in spend on assessments and shift in provision from institutional to home based care . The impact of this on health status and demand for health services cannot be inferred from the modelling at this point, but it seems logical to assume that there will be an increase in demand, particularly for home-based health care. By investing in more integrated approaches to risk stratification, population segmentation, prevention and proactive care, and by considering further opportunities for pooling resources to achieve this, health and social care commissioners will be better able to avoid this demand emerging in acute services and to deliver the most beneficial outcomes for the population in terms of overall health status. Further work should be undertaken now to understand the nature of social care provision, the client groups impacted and the care pathways / packages needed to address their needs. |
| **Specialised Services / impact of new technologies** | Despite the direction of travel to consolidate further the provision of specialist services into larger centres, from the information available, this is unlikely to have a major impact on patient flows within the Mid Mersey geography, as neither of the two local providers delivers significant specialist services (the key exception being burns). The delegation of commissioning of some services to CCGs will impact on local commissioning intentions but is unlikely to impact on patient flows. It is likely that, with technological and pharmaceutical advances, more services and procedures become more amenable to local delivery (as in the case of renal dialysis and chemotherapy) but the need for these to be linked back to specialist expertise suggests the development of outreach from specialist centres of chains of providers, rather than involving a shift of provider. |
| **Aligning wider system changes** | The modelling has been built on commissioning intentions and it is suggested that these be compared with the impact of provider supply strategy and business plans, where known. For example, it would be helpful to understand the strategies of local trusts in respect of attracting activity from competitors. The pressure at St Helens and Knowsley Trust to optimise the use of Whiston Hospital may drive it towards a more aggressively competitive approach to practices in Halton, where flows are more varied, which would impact on the viability of the Halton Hospital site.<br>While it is unlikely that the Greater Manchester Healthier Together strategy will impact on flows from mid Mersey, any plans for reconfiguration of services across Liverpool (and in the longer term, the re-build of the Royal Liverpool Hospital) |

| | |
|---|---|
| | may impact on flows from practices on the western edge of the patch.<br>A more likely scenario for CCGs to consider is the impact of their plans for a sustained shift from acute to community services on provider sustainability and consequently, behaviour. To mitigate the impact on income, Trust responses may focus on developing partnerships and alliances with community services, or they may become more overtly competitive, seeking to develop vertically integrated alternatives to current provision. The latter, coupled with potential for establishment of GP Federations, provides a potential threat to Bridgewater Community Trust, which in turn may threaten the implementation of CCGs' plans in the medium term. Further work to understand community services flows would help CCGs develop a clear approach to this area of the market. |

**Halton specific issues**

Capita worked with NHS Halton CCG and Halton Borough Council to produce some findings specific to the borough:

- Including the Better Care Fund there is a governed pooled arrangement worth £42m between NHS Halton CCG and Halton Borough Council for adult services.
- The pooled arrangements delivered savings of £158k in complex care in 2013/14.
- Joint commissioning and funding of intermediate care ensures the reduced need for nursing placements.
- NHS Halton CCG and Halton Borough Council have integrated safeguarding teams, leading to improvements in working arrangements and responsiveness.
- The Integrated Care Home Teams are contributing to a continued reduction in A&E attendances and subsequent admissions.
- Integrated Discharge Teams working with the two main acute providers are ensuring that there are little to no delays for Halton residents. They are contributing to length of stay (LOS) maintenance and improvement.
- Pooled budgets for Continuing Health Care (CHC) result in one assessment and one package of care; this potentially explains the data in the report which shows low assessment levels for Halton.
- The pooled arrangements and Better Care Fund place Halton in a good position to meet the challenges of Social Care Act.
- The Better Care Fund and NHS Halton CCG investment to provide 2 Urgent Care Centres will further reduce A&E activity and non-elective admissions (NELs).

**i5 Work**

In addition to the work with Capita, NHS Halton CCG commissioned i5, who are health economists, to review the potential benefits of the Better Care

Fund, 2 Year Operational Plan and 5 Year Strategy with a specific focus on acute activity.

I5 reviewed actual patient data over a seven month period from April to October 2013 using:

- the actual numbers of patients attending A&E
- what time they attended
- how long they were admitted for (if they were admitted)
- what treatment / diagnostics they received (if any)
- the types and acuity of the conditions they presented
- the costs associated with the attendance and/or admittance

i5 also calculated the actual cost of activity which could have been treated elsewhere. In common with Capita, i5 assumed some growth in elective activity and did not factored in the cost of the schemes needed in the community or elsewhere to achieve the savings required from the acute sector.

NHS Halton CCG has compared the i5 and Capita work against our plans (Appendix One). Overall both the i5 and Capita assessments give assurance that the commissioning intentions of NHS Halton CCG with Halton Borough Council are focussed in the right areas (acute care and older people). They also provide assurance the level of savings identified in the financial and operational plan are broadly achievable, although at the top end of what is possible.

**Conclusion**

The Capita End to End Assessment work has shown that the 'Mid Mersey' CCGs all have similar strategic commissioning intentions. The Capita and i5 work suggest that the plans of NHS Halton CCG, in partnership with Halton Borough Council and local providers, are achievable but that there are some significant challenges ahead.

**Appendix One Potential savings in acute sector**

| Savings Identified, (figures in £,000's) | | | | | | |
|---|---|---|---|---|---|---|
| Financial Plan (2 year)* | Financial Plan (5 year)* | Operational plan (2 year)** | i5 Health*** | BCF**** | Capita likely savings (5 year)***** | Capita Max savings (5 Year)****** |
| 3,708 | 7,951 | 3,930 | 3,638 | 377 | 1,665 | 3,393 |

* The Financial plan figures reported here are the cumulative recurrent QIPP savings and do not include running cost, tariff and price efficiency savings)

** The Operational plan 2 year savings should match the financial plan 2 year savings, this variation will be amended in the operational plan before submission to NHS-E on the 20th June

*** The sum total of i5 Health's savings is actually £5,978,000 (adjusted for a more realistic A&E attendance cost), however this include schemes in which the savings overlap, when an adjustment is made for this the total amount of savings available in acute care is £4,522,000, This includes some schemes which have not been identified in the operational plan such as 'Roving GP support with Ambulance crews' When these schemes are excluded the total amount of savings for schemes which match in i5 and the operational plan is £3,638,000

**** The savings identified in the BCF are the top level reported in the template, this does not show the breakdown of all savings, as some schemes whilst saving money in the acute sector will cost money elsewhere.

*****The Capita likely savings are based on reductions on acute activity to the best performing 25% of Practices in regards to A&E attendance, Outpatient appointments (first and follow up), Avoidable emergency admissions and early supported discharge.

******The Capita Max savings scenario includes savings identified in the BCF and operational plan, since these plans over cover a two year period the bulk of the £3,393,000 savings identified as 5 year, will in fact be achieved in the first two years, assuming that the Urgent care centre and reduction in variations in general practice activity can be achieved.

**REPORT TO:** Health Policy & Performance Board

**DATE:** 9 September 2014

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Health & Wellbeing

**SUBJECT:** Priority Based Report 2014-15 (Quarter 1)

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to health in Quarter 1 of 2014-15. This includes a description of factors which are affecting the service.

2.0 **RECOMMENDATION: That the Policy and Performance Board:**

1) **Receive the Quarter 1 Priority Based report;**

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

3) **Highlight any areas of interest or concern for reporting at future meetings of the Board.**

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 1, 2014-15.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this Report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this Report.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

There are no implications for Children and Young People arising from this Report.

### 6.2 Employment, Learning & Skills in Halton

There are no implications for Employment, Learning and Skills arising from this Report.

### 6.3 A Healthy Halton

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

### 6.4 A Safer Halton

There are no implications for a Safer Halton arising from this Report.

### 6.5 Halton's Urban Renewal

There are no implications for Urban Renewal arising from this Report.

## 7.0 RISK ANALYSIS

7.1 Not applicable.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no Equality and Diversity issues relating to this Report.

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

None under the meaning of the Act.

**Health Policy & Performance Board Priority Based Report**

**Reporting Period:** Quarter 1: 1st April 2014 – 30th June 2014

## 1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the first quarter of 2014/15; for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Prevention & Assessment
- Commissioning & Complex Care (including housing operational areas)
- Public Health

## 2.0 Key Developments

There have been a number of developments within the first Quarter which include:-

**COMMISSIONING & COMPLEX CARE SERVICES**

**Housing**

**The Housing & Community Agency (HCA) Affordable Homes Programme 2015/18** - The deadline for funding bids to the Homes and Communities Agency passed on the 30th April 2014. Bids have been submitted by Liverpool Housing Trust (LHT), Plus Dane Group, Halton Housing Trust (HHT) and Galliford Try Plc for developments in Halton. The proposals comprise 365 dwellings for affordable rent across 19 sites. The outcome of the bids is due to be announced mid-July.

25% of the Programme funds have been reserved for subsequent in year bids, and we will seek to take advantage of this and maximise housing delivery through continued joint working with local Housing Associations.

**Belvedere** - Belvedere supported housing scheme has been successfully decommissioned and was returned into Council possession on the 20th June. Options for disposal are currently being considered.

**Domestic Abuse**

Following the recent tender exercise, the new Halton Domestic Abuse service commenced on 1st July 2014 with the service being delivered by a new support provider, Changing Lives.

The remodelling work on the Refuge accommodation has now been completed and the service now provides 12 fully self-contained accommodation units which can also accommodate male victims of domestic abuse.

**Alcohol Strategy**

The Alcohol Strategy Steering Group has met regularly since the Alcohol Strategy workshop which took place in early January. A series of sub-groups reporting to the Alcohol Strategy Steering Group have also been meeting, with a focus on specific actions in accordance with a life-course approach. An initial outline draft of the Strategy has been developed and each chapter is structured in accordance with a life-course approach. Work on the development of the strategy and pathway will continue until the launch of the Strategy during Alcohol Awareness Week (mid November 2014).

**Mental Health**

The Cheshire wide policy on the operation of Section 136 Mental Health Act – the legal provision which allows police to detain anyone they find in a public place who appears to be mentally disordered and a risk to themselves or others – has now been fully agreed and signed off by all partners. This is now in operation across social services, the police and health services across Cheshire. Its implementation is monitored locally by the Halton Mental Health Delivery Group, and across the county footprint by the newly-developed Cheshire, Halton and Warrington Mental Health Strategic Board (see below).

In 2013, Cheshire Police identified that the rate of Section 136 detentions in Halton was higher than would be expected, and the rate across Cheshire as a whole was greater than the national average. In addition, there was concern that individuals who were detained under this provision were not receiving the best outcomes from all services. In response to this, a project was developed – initially in Warrington, and quickly extended to Halton – to address this issue. In partnership with the 5Boroughs, and supported by local Halton Clinical Commissioning Group (CCG) and the Council, a community psychiatric nurse was assigned to work closely with front line officers, providing an assessment and triage function, with the aim of ensuring that any Section 136 detentions were appropriate, and that people received appropriate and timely support. This project has been extremely successful, both in terms of reducing the numbers of people who are detained under this provision, and in ensuring that the right interventions are provided to people in mental distress. The project - now known as Operation Emblem – has been extended to the whole of the Cheshire footprint. Its continuing viability and effectiveness are monitored by the Cheshire, Halton and Warrington Strategic Partnership.

The Cheshire, Halton and Warrington Mental Health Strategic Partnership arose in 2014 from a series of meetings that had been taking place at senior level between the police, the Cheshire local authorities, the health service commissioners and the mental health Trusts in the area. These meetings have now developed into a formal strategic structure designed to encourage consistent service responses across the footprint to issues relating to mental health and criminal justice. This group is responsible for monitoring the progress of Operation Emblem, and is taking a county-wide approach to the delivery of the Mental Health Crisis Care Concordat.

For over six months, a pilot programme has been in place in Halton, offering interventions from the Mental Health Outreach Team (MHOT) to people in mental distress who are managed through Primary Care Services alone. Working with a targeted number of GP practices, the MHOT has taken referrals from surgeries relating to people who:

- Have an underlying mental health condition, but who are not currently being worked with by secondary mental health services, and who may have social needs which impact on their physical or mental health
- Present repeatedly to surgeries but with no clear reason for this, suggesting that they may have underlying social care issues which present as a medical complaint
- May have issues with drugs or alcohol misuse, but where the GP feels there is also an underlying mental health need.

To date, the team has had 50 referrals under this pilot programme. Early indications provide promising results; of the people who have successfully engaged with the pilot, all have reported improvements in their mental wellbeing, and there have been some notable outcomes in individuals, including reductions in suicide attempts, reductions in use of prescribed mediation (by agreement with their GP), reductions in inappropriate surgery attendances, improvements in finance and the addressing of underlying physical health issues. The pilot will continue, with plans to extend further into the Borough.

In November 2013, the Care Quality Commission visited the 5Boroughs, to assess the quality of the interventions provided by all partners in the operation of procedures relating to compulsory admission to hospital under the Mental Health Act. An action plan was developed; implementation of this plan is being monitored in Halton by the Mental health Delivery Board, and a new Board has been set up within the 5Boroughs – a Mental Health Strategic Partnership – to take this and other issues forward.

**Other developments within the Commissioning and Complex Care Division:**

The new national performance framework for adult social care, SALT (Short and Long Term packages of care) has now been successfully implemented within the Directorate. This has involved considerable work to adapt existing data collection systems, and to train and support front line staff to use the new system.

Emergency Duty Team (EDT): the EDT partnership board has agreed in principle to extend the partnership to a neighbouring local authority. A work plan is being identified to take this forward.

Interface with children's services: the linkages between the Communities Directorate and Children's Services are now well established but also continue to develop. Both services are represented on their respective Safeguarding Boards, and adults services also contribute to the Children's Trust. A formal piece of work, looking at the way drugs and alcohol services, mental health services and children's services work together, is being taken forward under the auspices of the Children's Safeguarding Board. The Directorate is also engaging with new developments in the children's services early intervention and prevention services for children and families.

**Physical and Sensory Disability Services**

The Halton Commissioning Strategy is being refreshed and following a consultation period will be presented to Health Policy and Performance Board in the Autumn of 2014.

**Other Developments**

**Better Care Fund** – The Better Care Fund (BCF) is a tool to enable greater integration between the Council, NHS Halton CCG and other stakeholders within the Borough to provide services in a more coherent way, make efficiencies and improve services for the people of Halton. Part of this includes developing joint commissioning plans, joint performance frameworks, data sharing protocols and delivery of integrated health and social care mental health services. The BCF spans across the next two years where these developments, and more, will be progressed.

**Social Care Act** - The Care Act outlines the most significant change in Adult Social Care in decades with changes to underpinning legislation, eligibility criteria, funding, changes to the status of Adult Safeguarding and a host of other associated areas which are likely to impact across all Council Portfolios. New requirements, duties and responsibilities will be implemented from April 2015 with full implementation planned for April 2016. A Strategic Group has been established to look at all strands of the Care Act, and under this area project plans have been developed for Carers, Charging for Services and Transition. Other pieces of work are also being undertaken linking in with national initiatives that assist Local Authorities with various aspects of implementation of the Care Act. This includes the Skills for Care Workforce Capacity Plan pilot.

## PREVENTION & ASSESSMENT

### Making Safeguarding Personal (MSP)

Halton joined the Making Safeguarding Personal (MSP) project in November 2013. The intention of MSP is to facilitate person-centred, outcomes-focused responses to adult safeguarding. Since the project commenced 24 cases have now been analysed and of these cases 96% of people involved felt that the investigation was conducted in such a way that they felt in control, informed and involved.

On-going work from this project to embed this approach into day to day practice will change the nature of the performance data and will provide Halton Safeguarding Adults Board with a better understanding of people's experiences and thus serve to influence and improve the delivery of safeguarding services in Halton.

As the project progresses, it is generally accepted alongside the 53 participating local authorities that outcome focused, person centred approaches must be integrated into safeguarding procedures if people are to be supported to live their lives with as much autonomy as possible. It is clear that seeking the person's own definition of a good outcome at the start of a safeguarding process, keeps professionals focused on a person centred approach and leads to better outcomes for the person and their family. As people achieve better outcomes, they are less likely to re-enter the system at a later date, being supported to stay independent for longer and encouraged to utilise their own skills, strengths and natural supports to build a safer future for themselves.

Halton has now achieved the Bronze level and is now working towards silver level in MSP. This involves taking learning from the pilot and embedding it into practice. Plans are to ensure that current safeguarding documentation is update /replaced to reflect learning from the project and social worker and managers implement the MSP approach in their day to day practice.

### Making It Real

In Care Management Services as part of 'Personalisation' we have developed a steering group to take forward the 'Making it real' marking progress towards personalised, community based support agenda. This helps check our progress an decide what we need to do to keep moving forward to deliver real change and positive outcomes with people. We met with members of the TLAP programme (Think Local Act Personal) and they helped us facilitate a 'Making It Real Live" event that took place on the 4th of June. The event was well attended and involved people using services, a wide cross sector of partners and other agencies, including the independent sector and voluntary agencies. From the event we developed an action plan which the steering group will oversee to take forward. A follow up event will be held in the Autumn.

**Winterbourne View**

Winterbourne View Review Concordat: Programme of Action was published by the Department of Health in December 2013. Halton CCG and Council have developed a localised action plan – this will be monitored through the Learning Disability quality and performance then reported to the Learning Disability Partnership Board and CCG Quality and Integrated Governance Committee. Assurance is provided to NHS England as per the Concordant Action Plan.

- By April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice as a consequence; there will be a dramatic reduction in hospital placements for this group of people.
- The Council has continued to work with health colleagues to review all out of area placements regardless of funding arrangements.
- Halton have a strategic task group set up to ensure those placed out of area are managed and monitored appropriately with professionals tasked with reassessing those individuals to enable them return to Halton this meeting meets quarterly. This work has been on-going with successful placements now achieved locally with the co work of the care management teams, health colleagues and the Positive Behaviour team.
- Joint Health and Social Care Learning Disability Self-Assessment Framework (LD SAF) to be submitted 6th December 2013 – Validation and Assurance Panel (25th April 2014) – chaired by NHS England - Halton Borough Council and Halton CCG to attend to complete the Joint Health and Social Care SAF process 2013 – Validation completed June 2014, joint action plan to be developed following the panel and to be presented to the LD Partnership Board.
- Bryon Unit 5 Borough Partnership Inpatient bed usage currently being monitored usage for 2013/14 was 10 inpatient admissions.

**Learning Disability Nurses**

The team continue to work proactively with individuals, their family, carers and professionals such as GPs, allied Health professionals etc.
Progress:

- 2 team members have completed a course on applied behaviour analysis to support the team with refocussing behaviour interventions.
- The team are continuing to seek feedback from customers on their experiences with team members. These are in easy read format and show consistently positive results

- A recent audit has been completed of Health Action Plans generated by the team, has shown a high standard of health support is being offered to Halton residents.
- A nursing team member has worked with advocacy and the heart hospital to support an individual to explore their heart condition and examination of this.
- Joint working with social care has enabled hard to reach family to have numerous health interventions, including dental care, which has been absent for many years.
- The team are working within the pro-active draft dementia pathway for people with Downs Syndrome, customers who are in their 30's are currently being screened.
- The team have been completing peer observations and management observations to ensure the service provided is of a high quality.
- A customer was experiencing heart related symptoms, and had previously had heart surgery. Liaison was had with the heart hospital for her to be seen.
- The latest Fresh start programme in Runcorn is half way through. Widnes showed good weight loss. This has continued through the next steps.
- The plans are being put in place for the Big Health Day. This will explore health issues raised via the LD SAF.
- One of the individuals has been discharged from Hollins Park successfully and is settled back at home.

**Urgent Care**

Halton Borough Council and NHS Halton Clinical Commissioning Group are continuing to actively work together in conjunction with our partners to lead on the development and management of the Urgent Care system used by the Borough's population. The Urgent Care agenda is a complex and challenging one; we need to ensure that there is a system wide approach to Urgent Care which requires high quality and accessible primary, community and social care services to be in place to provide alternatives to A&E attendance and admittance to hospital for the local population.

There are a number of current local developments which are having a positive impact on the urgent care system/agenda within Halton, the main ones being:-

- Development of a Halton Operational Resilience and Capacity Plan (see Emerging Issues, Section 3) which not only outlines how Halton is to address issues relating to urgent care but also elective care as well;
- Development of a Community multi-disciplinary team (MDT) approach to the management of people with Complex Needs which aims to reduce the number of non-elective admissions and A&E attendances through the use of individualised programmes of care and support;
- The care home project in Halton which is working to investigate unmet need in Halton's care homes from the perspective of health and social services; and
- Development of 2 new Urgent Care Centres in Halton, one in Runcorn and one in Widnes which aim to be open by the end of the year . In addition to being able to assess/treat minor illnesses and injuries, the Centres will be able to provide care to those presenting at the Centres will a range of other conditions, through the development of the necessary competencies of staff teams; the Centres will be staffed by a multidisciplinary, multiagency team of professionals.

**PUBLIC HEALTH**

Halton has successfully implemented the following programmes.

**Alcohol harm reduction**: Local Alcohol Action Area status gained. Development of an education campaign around alcohol and pregnancy. 100% of midwives, health visitors & early years staff trained in Information and Brief Advice (IBA). 100% of staff working with Children and Young People (CYP) trained in IBA. 100% of CYP in schools & the community provided with alcohol awareness education. Test sales related enforcement in place. Operation Staysafe in place. GP practices including nurses & Health Care Assistants trained in IBA.
Reduction in the level of social disruption and harm due to alcohol consumption through Arc Angel, Pub Watch, street pastors and process of bench marking against Purple flag standards. Training for appropriate front-line Home Care professionals.

**Mental Health**: New Mental Health & Wellbeing Strategy for Halton. Like Minds Campaign launched against stigma. Development of prenatal, antenatal and postnatal support pathway. Bullying and cyber-bullying programme in place with the Vikings. Health Needs Assessment and new CAMHS Tier 2 specification in place. Development of the new School Health Service specification. Live Life Well Website has new section for CYP in place. Procurement of new Improving Access to Psychological Therapies Service. Review of Dementia Strategy completed.

**Reducing falls**: Developed a falls strategy. Agreed an integrated pathway for clinical and community services. Redesigned the falls specialist service. Shifted the training provision to the Health Improvement Team. Focussed all of the falls specialist role onto clinical assessments. Developed a multi-agency steering group. Developed a falls awareness week with partner organisations (events attended by over 370 older people). Developed a performance framework that offers the Board up to date information to act upon

**Healthy vitamins programme:** A programme for the universal provision of healthy start vitamins to all pregnant and breastfeeding women is due to start in August 2014. The programme will also provide one bottle of free vitamins to the child at 6months to a year, and increase accessibility of the vitamins through making them available through children's centres and health centres. This aims to improve health outcomes for mother and child, and prevent infections, and conditions such as Spina Bifida.

**Family Nurse Partnership:** The Family Nurse Partnership (FNP) is due to start recruiting Halton parents in October 2014. The Family Nurse Supervisor has been recruited, and the FNP board has met. FNP is an intensive, client centred programme to improve outcomes for first time teenage parents. 1-2-1 support is given by the same family nurse from early pregnancy to the child being 2 ½ years old. It is a licenced structured programme that is grounded in research.

**Sexual Health Services:** Building on the sub regional review of sexual health services work has either begun or is soon to begin on a number of discrete Cheshire and Merseyside reviews relating to sexual health. These are (in priority order):

1. Cross charging arrangements for sexual health services delivered out of area (this work has already begun);
2. Provision of long acting contraceptives in GP practices;

3. Interrelationship and pathways between Public Health commissioned sexual health services and HIV treatment services commissioned by NHS England;
4. Pathways for erectile dysfunction and psychosexual health services.

**Children, Young People and Families**

**Halton Children & Young People's Plan 2014-17 and Children's Trust Priorities:** The Halton Children & Young People's Plan (CYPP) is the agreed joint strategy of the partners within Halton Children's Trust, detailing how they will co-operate to improve children's wellbeing. It represents Halton's local vision and aspirations for children and young people in the borough, and provides strategic direction and determines how the Children's Trust Board will work together to commission services to address locally identified needs and better integrate provision.

The new CYPP which has been developed by a multi-agency task group is developed around the following three strategic priorities that have been agreed by Halton Children's Trust:

***Working together to*** deliver services in a joined up way to make sure children and their families get the right help at the right time *(Early Help & Support)*
***Working together to*** plan and fund outcome focused services for children and families that deliver high quality services that are value for money *(Integrated Commissioning).*

***Working together to*** focus services towards the needs of our most vulnerable children, young people and families to *'close the gap'* by improving health and education outcomes. The development of the new Plan is being taken forward with the involvement of young people in several ways, including a young people's version and direct involvement in the main document. For copies please contact mark.grady@halton.gov.uk.

**Teenage Pregnancy**: ONS data for quarter 4 2012, shows Halton's teenage conception rate is at its lowest ever. In quarter 4 2012, there were 22 conceptions compared to 28 in quarter 4 2011. The total number of conceptions for 2012 is 92.

Halton had 27 less conception's, then its statistical neighbour's average and has now seen a 36.1% reduction from the baseline in 1999 and a 48.6% reduction from 2007, when the rate was at its highest. Some of the schemes in operation in the Halton area include:

- Targeted outreach sessions delivered through the VRMZ outreach bus and street based teams in identified hotspot areas.
- Holistic health drop-ins lead by Halton Youth Provision providing information and advice on reducing risk taking behaviour, such as sexual health and substance misuse.
- Free access to condoms, through the C-Card scheme.
- Free sexual health awareness training is available across the Children Trust, to enable frontline staff to feel competent in talking to young people about positive relationships.
- The development of dedicated young people's sexual health clinics, provided in community venues.
- A whole-school approach to relationships and sex education with the development of the Healthitude and Teens and Toddlers programmes.

Free emergency hormonal contraception (EHC) available from pharmacists across the Borough

## 3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the fourth Quarter that will impact upon the work of the Directorate including:-

**COMMISSIONING & COMPLEX CARE**

**Residential & Nursing Care**

Work is underway to monitor residential and nursing bed usage and voids within Halton, also considering the use by other Local Authorities of residential and nursing beds within Halton. The project group is also considering the suitability of other buildings within the Halton area.

**Mental Health**

Work is underway to redesign elements of the Council's Mental Health Services in order to make contact with people at the very early stage of their illness. This involves one of the team's working closely with GP surgeries and additional work to develop a comprehensive preventative strategy is also underway.

The Mental Health Crisis Care Concordat was issued by central government in early 2014. This important piece of work aims to improve the quality and type of supports available for people in mental health crisis. A self-assessment for Halton has been completed and work on this will be monitored by the Mental Health Delivery Group.

**PREVENTION & ASSESSMENT**

**Deprivation of Liberty Safeguards (DoLS)**

The recent Supreme Court ruling P v Cheshire West and Chester and P and Q v Surrey Council is significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty. A deprivation of liberty for such a person must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under DoLS in the MCA 2005, or (if applicable) under the Mental Health Act 1983. The ruling has clarified that there is now a revised test for a deprivation of liberty and two key questions that should be asked are:

• Is the person subject to continuous supervision and control?
• Is the person free to leave?

The judgment is important as it holds that a DoLS can occur in a domestic setting where the State is responsible for imposing those arrangements. This will include a placement in a supported living arrangement in the community. Hence, where there is, or is likely to be, a deprivation of liberty in such placements that must be
authorised by the Court of Protection. An action plan is currently being developed to fully scope and address the implications. It is anticipated that this will place an extra burden on the Council in terms of an increase in the number of applications to the Court of

Protection and the number of DoLS cases will be significantly greater than previously assumed.

**Independent Living Fund (ILF)**

The ILF helps severely disabled people live independently by providing additional funding to top-up their social care support. In November 2013, the Court of Appeal ruled the Department for Work and Pensions had failed to fulfil its duty to promote equality when making the decision. However, following a new equality impact assessment of the plan, the government is going to press ahead with closing the fund. The ILF will now close in June 2015 and the responsibility for supporting ILF users will fall to the local authority. Work has started in preparation for the transfer.

**Transition Planning - Special Education Needs (Disability) (SEN) 2014**

The SEN reforms 2014 will be implemented from September 2014 – the reforms will have implications for service delivery across the age range of 0 to 25 yrs. Multi-agency task and finish groups are currently working to adapt systems, processes and to implement the new guidance that will be introduced in September 2014.

The introduction of Education, Health and Care Plans will be a key change for professionals and families, alongside the publication of the 'Local Offer' where local services are published for individuals and families to choose from when deciding how to meet their needs. The Transition Strategy will be redrafted in line with the new legislation and codes of practice.

**The Personal Budgets Outcomes and Evaluation Tool (POET)**

This has been developed over a number of years by In Control and the Centre for Disability Research at Lancaster University. Its aim is to provide a national benchmark on the impact that personal budgets are having on people's lives. The
Care Services Minister Norman Lamb has just recommended that all councils should be checking people's experiences of using personal budgets, through tools such as POET. This is an area of work identified to be taken forward and will be used to feed in to the 'Making it real' follow up event in the Autumn.

**Operational Resilience and Capacity Planning**

After the success that Urgent Care Working Groups have achieved in the past year, national guidance has recently been issued by NHS England, Monitor, Trust Development Agency and Association of Directors of Adult Social Services which outline the need for these groups to build upon their existing roles, and expand their remit to include elective as well as urgent care. They will now become the forum where capacity planning and operational delivery across the health and social care system is coordinated.

Bringing together both elements within one planning process underlines the importance of whole system resilience and that both parts need to be addressed simultaneously in order for local health and care systems to operate as effectively as possible in delivering year-round services for patients.

Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires capacity planning to be ongoing and robust. This will put the NHS, working with its partners in local authorities, in a position to move away from a reactive approach to managing operational problems, and towards a proactive system of year round operational resilience.

Work is underway to ensure that Halton can fully comply with the guidance recently issued; this includes the change of role of the Urgent Care Working Group to that of a System Resilience Group and the development of a Halton Operational Resilience and Capacity Plan.

**PUBLIC HEALTH**

Halton needs to continue to focus on bowel screening, accidents for all ages and reducing the level of alcohol abuse amongst adults. A number of strategies and action plans are either already in place or are currently being developed to address these issues. They include: Halton Cancer Strategy, Alcohol Harm Reduction strategy and Falls Strategy.

## 4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. During the development of the 2014/15 Business Plan, the service was required to undertake a risk assessment of all key service objectives with high risks included in the Directorate Risk Register.

As a result, monitoring of all relevant 'high' risks is undertaken during Quarter 2 and Quarter 4.

## 5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

## 6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Communities Directorate. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

### *Commissioning and Complex Care Services*

**Key Objectives / milestones**

| Ref | Milestones | Q1 Progress |
|---|---|---|
| CCC1 | Continue to monitor effectiveness of changes arising from review of services and support to children and adults with | ✓ |

| | | |
|---|---|---|
| | Autistic Spectrum Disorder. **Mar 2015.** (AOF 4) | |
| CCC1 | Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2015.** (AOF 4) | ✓ |
| CCC1 | Continue to implement 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2015** (AOF 4) | ✓ |
| CCC1 | The Homelessness Strategy be kept under annual review to determine if any changes or updates are required. **Mar 2015. (AOF 4, AOF 18)** | ✓ |
| CCC1 | Conduct a review of Domestic Violence Services to ensure services continue to meet the needs of Halton residents. **Mar 2015** (AOF11) | ✓ |
| CCC2 | Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2015 (AOF 21)** | ✓ |
| CCC3 | Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Groups, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **Mar 2015. (AOF 21 & 25)** | ✓ |

***Key Performance Indicators***

**Supporting Commentary**

**CCC 1 Services / Support to children and adults with Autism**
The Autism Strategy group continues to monitor the progress of the Autism Strategy 2012 – 2016 action plan.

Autism Self-Assessment Framework 2013 was submitted to iHals and presented to the Health and Well-being Board (January 2014). Next Self-Assessment due September 2014 (pending confirmation).

Refresh of the Autism Strategy Action Plan 2014 to reprioritise key areas to reflect local needs and national guidance, linking into the Department of Health recent publication Think Autism (2014).

**CCC 1 Dementia Strategy**
The Dementia Board continue to meet monthly to review delivery of the strategy. Work is underway to review the community pathway and findings form a recent Community Pathway Provider's meeting has informed a commissioning options appraisal that is being presented at the July Board.

**CCC1 Mental Health**
Work continues with the 5BP NHS Foundation Trust to review inpatient and

community services for older people with mental health problems. An options appraisal should be available to elected Members over the coming months.

**CCC1 Homelessness Strategy**
The 2013/18 Homelessness Strategy was approved by Executive Board on 27th March 2014. The designated sub groups will continue to meet on a bi monthly basis to discuss and implement strategic action plan. The focus is presently around improving the monitoring & performance of the service, with further emphasis to develop prevention initiatives around Health.

This has now been completed with the commencement of the new Halton Domestic Abuse service on 1st July 2014.

**CCC 2 HealthWatch**
Healthwatch Halton relocated to new premises during Quarter 1, moving from their existing location in Sefton House, Runcorn, to St Marie's Church, Lugsdale Road, Widnes. Due to the re-location, Healthwatch Halton have worked together with the Cheshire and Merseyside Independent NHS Complaints Advocacy Service to develop an Engagement plan, aimed to reach out to local communities to promote and raise the profile of the services that both Healthwatch Halton and the Cheshire and Merseyside Independent NHS Complaints Advocacy Service provide within the borough of Halton. A series of community-based events and activities are planned to take place right across the borough in the coming months, including coffee mornings which will take place in community centres across the borough.

**CCC 3 Review and development of commissioning strategies to align with Public Health and Clinical Commissioning Groups**
The CCG five year plan, two year plan is now aligned with the Better Care Fund, the JSNA and the priority set by the Health and Wellbeing Board. The Integration Agenda continues to make progress with the move to push for greater alignment around governance and the integrated approach to performance management.

***Key Performance Indicators***

| Ref | Measure | 13 / 14 Actual | 14 / 15 Target | Q1 Actual | Q1 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| CCC 4 | Adults with mental health problems helped to live at home per 1,000 population | 2.64 | 3.5 | **2.57** | ? |  |
| CCC 5 | The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6). | 0 | 1.2 | **0** | ✓ |  |

| Ref | Measure | 13 / 14 Actual | 14 / 15 Target | Q1 Actual | Q1 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| CCC 6 | Number of households living in Temporary Accommodation (Previously NI 156, CCC 7). | 11 | 12 | **10** | ✓ | ↑ |

**Supporting Commentary**

**CCC 4 Adults with mental health problems helped to live at home per 1,000 population**
This figure has declined steadily in the past 12 months, due in part to technical reasons (a change in the baseline population figures for Halton), but also because of the successful implementation within the 5Boroughs of the Acute Care pathway, which has focused work on people with the most complex needs. Work is being taken forward however to engage with people known only to primary care services, to support people at an earlier stage and prevent their condition from escalating, and this is expected to improve performance figures through 2014/15.

**CCC 5 The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years**
Halton forms part of the Merseyside Sub Regional, No Second Night Out scheme which is proven to be a successful resource and fully utilised across the Merseyside Authorities. . The service provides an outreach service for rough sleepers and has successfully worked in partnership with Halton to identify and assist this vulnerable client group.
The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

**CCC 6 Number of households living in Temporary Accommodation**
The Housing Solutions Team has taken a proactive approach to preventing homelessness.
There are established prevention measures in place and the Housing Solutions team will continue to promote the services and options available to clients.
The changes in the TA process and amended accommodation provider contracts has had a big impact upon allocation placements. The emphasis is focused on early intervention and further promotes independent living.
The improved service process has developed stronger partnership working and contributed towards an effective move on process for clients. The Authority will strive to sustain the reduced TA provision.

***Prevention and Assessment Services***

**Key Objectives / milestones**

| Ref | Milestones | Q1 Progress |
|---|---|---|
| PA 1 | Fully implement and monitor the effectiveness of the complex care pooled budget **March 2015.** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Continue the integrated provision of frontline services including multidisciplinary teams, care homes, safeguarding services and urgent care **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Develop a Care Management Strategy to reflect the provision of integrated frontline services for adults **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Work within adult social care to focus on preventative service to meet the needs of the population **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Develop an integrated approach to the delivery of Health and Wellbeing across Halton **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 2 | Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets **March 2015 (AOF 2, 3,4,10,21)** | ✓ |
| PA 2 | Continue to review the quality of commissioned services and continue to develop the role of the integrated safeguarding unit **March 2015 (AOF 2, 3,4,10,21)** | ✓ |

**Supporting Commentary**

**PA 1 Complex care pooled budget**
Pooled Budget fully implemented. Governance structures in place to monitor effectiveness.

**PA 1 Integrated provision of frontline services**
Work continues on the integrated provision of front line services, for example the Community Multi-disciplinary Team's in General Practice project is continuing during 2014/15 and an initial evaluation of the benefits for individuals will be available shortly. In respect of the Care Homes project work is underway with NHS Halton Clinical Commissioning Group, Bridgewater Community NHS Trust and 5 Boroughs Partnerships to provide a long term service. Developments within Urgent Care continue with the planned opening of the Urgent Care Centres, staffed by a team of

multidisciplinary, multiagency professionals, by the end of 2014.

**PA 1 Develop a Care Management Strategy**
Draft Strategy being developed. On target for completion March 2015

**PA 1 Work within Adult Social Care focussing on Preventative Services**
The Initial Assessment Team is working closely with Sure Start/Bridge Building, Telecare and offering better sign posting. There is a dedicated project team re-assessing 24 hour supported living accommodation.

**PA 1 Develop an integrated approach to the delivery of Health and Wellbeing across Halton**
Integrated model currently being developed. On target for completion by March 2015.

**PA 2 Personalisation/Self-directed Support**
In Care Management to ensure effective arrangements for 'Personalisation' across adult social care, we have developed a steering group to take forward the 'Making it real' marking progress towards personalised, community based support agenda. TLAP programme (Think Local Act Personal) supported us to facilitate a 'Making It Real Live" event that took place on the 4th of June. An action plan is being developed and overseen by the group.

**PA 2 Integrated Safeguarding**
The safeguarding unit and quality assurance team have continued to work closely with a focus on improving outcomes for vulnerable people in Halton.

***Key Performance Indicators***

| Ref | Measure | 13 / 14 Actual | 14/15 Target | Q1 Actual | Q1 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| PA 2 | Numbers of people receiving Intermediate Care per 1,000 population (65+) | 81.31 | 82 | **19.79** | ✓ | ↓ |
| PA 3 | Percentage of VAA Assessments completed within 28 days | 87.69% | 85% | **82.7%** | ✓ | ↓ |
| PA 7 | Percentage of items of equipment and adaptations delivered within 7 working days | 96.3% | 97% | **96.44%** | ✓ | ↑ |

**Supporting Commentary**

**PA 2 Numbers of people receiving Intermediate Care per 1,000 population (65+)**
Although referral numbers are slightly down when comparing Q1 14/15 with Q1 13/14, we are on course to meet this target.

**PA 3 Percentage of VAA Assessments completed within 28 days**
Within the safeguarding unit we have been engaging well with the PPU and consequently the police are leading on a number of investigations and the system does not allow us to close down this work which is likely to be impacting on this target. In addition, the CPS are also taking forward more cases for prosecution which will also create an impact. There are a small number also with the Coroners Court. We are actively monitoring this situation and we are also re-looking at paperwork and procedures to increase the performance.

**PA 7 Percentage of items of equipment and adaptations delivered within 7 working days**
Performance in this area remains very strong and consistent.

***Public Health***

**Key Objectives / milestones**

| Ref | Milestones | Q1 Progress |
|---|---|---|
| PH 01 | Work with the public and service providers to raise awareness of the early signs and symptoms of bowel, breast and lung cancer so we can identify it an early stage in the population. **March 2015** | ✓ |
| PH 01 | Reduce obesity rates in the local population, thereby reducing the incidence of bowel cancer through promoting healthy eating and screening programmes for adults and children via a range of services. **March 2015** | ? |
| PH 01 | Meet the target for the take up of HPV vaccination in girls 11-13, to reduce cervical cancer rates by working proactively with the School Nursing Service and GPs. **March 2015** | ✓ |
| PH 01 | Work proactively with GPs, all service providers, Alcohol Liaison Nurses, teachers in schools to reduce the number of people drinking to harmful levels and alcohol related hospital admissions given the rise in pancreatic and liver cancer rates. **March 2015** | ✓ |

| | | |
|---|---|---|
| PH 02 | Facilitate the Early Life Stages development which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2015** | ✓ |
| PH 03 | Working with all service providers, implement the action plan to reduce falls at home in line with the Royal Society for the Prevention of Accidents (ROSPA) guidance as outlined in the new Falls Strategy **March 2015** | ✓ |
| PH 05 | Implement the Mental Health and Wellbeing Programme in all schools and provide training for GP Practices and parenting behaviour training in the Children's Centres. **March 2015** | ✓ |

**Supporting Commentary**

**Raise awareness of Bowel, Breast and Lung Cancer**
This is a priority for Halton Health & Wellbeing Board and sits within its underlying action plans. We are making good progress through the roll out of the national Be Clear on Cancer campaign and the team of volunteers that work with local people to deliver the message. We do not yet have easy access to staging data from the local hospitals.

GP practices have been supported to conduct the cancer audit.

**Reduce Obesity Rates**
Work is underway to refresh the Halton Healthy Weight management care pathways for children and adults.
A range of services are delivered for children and adults on an individual or group level, such as the fresh start programmes, active play and introduction to solid food parties.

**Reduce Cervical Cancer Rates**
Data is only available for HPV at a Halton and St Helens level. However in 2012/13 the rates were higher than the England average for all three doses of HPV. New evidence has meant that in the future only 2 doses of HPV will be given.

**Reduce the number of people drinking to harmful levels**
Work is underway to develop an alcohol harm reduction strategy for Halton. The strategy is being developed in partnership with colleagues from health, social care, education, voluntary sector, police and the community safety team. The strategy will set out actions across the life course to reduce alcohol related harm and reduce hospital admissions. Good progress has been made related to reducing Under 18 admission rates locally. Alcohol health education sessions are being delivered in all local schools.

**Facilitate Early Life Stages development**
The Number of Health Visitors in Halton has increased through the Department of Health Call to action work, and is on target. The health visitors are key to delivering a universal preventative service to young families, and are conducting developmental reviews at 21/2 years.

Childhood Immunisation rates in Halton are all above the 95% target, which affords the population protection from a potential outbreak. Halton has made good improvements in the numbers of children receiving the MMR vaccine, and is above the England average.

A range of evidence based parenting programmes are being delivered across the borough, such as Triple p, and Terrific twos.

**Falls Reduction Action Plan**
Quarter 1 has seen the implementation of a redesigned falls triage service that enhances the existing referral process between RARS and the falls specialist nurse. This has led to improved speed of referral and increased access to therapy services within the community.

Falls awareness week took place in June and throughout the week we engaged in close conversations with 253 individuals, on top of this many more took recipe leaflets and exercise timetables resulting in a total of 4000 marketing materials being disseminated across the borough and at the roadshow locations. More robust outcomes at this early stage from the week include:-

- 7 people have been contacted and signed up to the Falls Prevention service starting Sept/ Oct.
- 3 people referred to Fresh Start
- 25 new people joined the Tea Dance weekly group - 11 were from local care homes.
- 8 people attended Tai Chi at Runcorn library Monday
- 5 people attended Tai Chi taster at Brunswick house TLC club Tuesday
- 10 people attended Tai Chi taster Widnes library Friday
- 5 referrals to the Falls Team at Bridgewater
- 8 consultations resulted in referrals to the Falls Prevention exercise class
- 16 people received advice on hearing, 3 booked in for hearing checks with Age UK
- 2 people received advice on loss of sight by Vision Support

There will be a further evaluation in October which will include follow up to the sheltered accommodation management to see if as a result falls have reduced and if any of the residents have engaged in further exercise groups. Plus contact will be made with the referrals to establish if they engaged post the road show.

**Mental Health and Wellbeing Programme**
A review of all local mental health and wellbeing provision is underway to ensure that there are consistent, high quality services available.

A new Mental Health and Wellbeing strategy has been developed and this will inform the development of a new action plan to meet local need across all ages and levels of need.

***Key Performance Indicators***

| Ref | Measure | 13/14 Actual | 14/15 Target | Q1 | Current Progress | Direction of travel |
|---|---|---|---|---|---|---|
| PH LI 01 (SCS HH 5a) | All age all-cause mortality rate per 100,000 males (previously NI 120a) 2011 | 737.3 (Jan 13 – Dec 13) | 752 | 733.0 (Apr 13 – Mar 14) | ? | ↑ |
| PH LI 02 (SCS HH 5b) | All age all-cause mortality rate per 100,000 females (previously NI 120b) 2011 | 589.5 (Jan 13 – Dec 13) | 615 | 543.0 (Apr 13 – Mar 14) | ? | ↑ |
| PH LI 03 (SCS HH 6) | Mortality rate from all circulatory diseases at ages under 75 (previously NI 121) 2001 | 70.9 (Oct 12 – Sep 13) | 72 | 68.7 (Apr 13 – Mar 14) | ? | ↑ |
| PH LI 04 (SCS HH 7) | Mortality rate from all cancers at ages under 75 (previously NI 122) 2011 | 138.6 (Oct 12 – Sep 13) | 140 | 142.9 (Apr 13 – Mar 14) | ? | ↑ |
| PH LI 06 New SCS Measure Health 2013-16) | Falls and injuries in the over 65s (Public Health Outcomes Framework) | 2,850.4 (Jan 13 – Dec 13) | 2,847 | 2,898.9 (2013/14) | ? | ↑ |
| PH LI 08 **(New)** | Mental Health: Self-reported wellbeing | N / A | 69% | N /A | N / A | N / A |

**Supporting Commentary**

**PH LI 01** Comparison vs. 2012/13 rate in quarter 1. All age, all-cause mortality for men is reducing in Halton. This is the result of a whole systems approach to prevent people from becoming ill and treating them more quickly and effectively if they do develop a disease. Key areas we have identified are alcohol harm reduction, mental health, falls and cancer. Robust plans are in place for each of these and they are being successfully implemented.

**PH LI 02** Comparison vs. 2012/13 rate in quarter 1. All age, all cause mortality for women is reducing in Halton for this quarter. This is particularly good news as the female mortality rate has been stubbornly high for a number of years. As with men this is the result of a whole systems approach to prevent people from becoming ill and treating them more quickly and effectively if they do develop a disease. Key areas we have identified are alcohol harm reduction, mental health, falls and cancer. Robust plans are in place for each of these and they are being successfully implemented.

**PH LI 03** Comparison vs. 2012/13 rate in quarter 1. Halton has seen significant reduction in heart disease in the past 10 years and this continues. This is particularly due to a reduction in smoking, early detection of people at risk via health checks and good health care treatment.

**PH LI 04** Comparison vs. 2012/13 rate in quarter 1. Although the rate for the same quarter last year was higher than for this quarter cancer remains a challenge. We need to continue to reduce smoking prevalence and work on increasing our screening rates, particularly for bowel screening.

**PH LI 06:** Comparison vs. 2012/13 rate. Hospital admissions for injuries due to falls (65+). A range of prevention training has taken place to support a contribution to improving performance in falls and injuries in older people. 73 professionals and 207 members of the public attended the training during quarter 1 and there have already been some positive outcomes from the people who have attended.

The falls awareness week was a huge success and mixed general awareness raising with supporting individuals to make direct referrals into relevant services.

**PH LI 08 (new)** No data available yet.

## APPENDIX 1 – Financial Statements

**COMMISSIONING & COMPLEX CARE DEPARTMENT**

**Revenue Budget as at 30th June 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (overspend) £'000 |
|---|---|---|---|---|
| Expenditure | | | | |
| Employees | 7,463 | 1,770 | 1,729 | 41 |
| Premises | 241 | 87 | 88 | (1) |
| Supplies & Services | 1,905 | 460 | 451 | 9 |
| Carers Breaks | 422 | 145 | 145 | 0 |
| Transport | 170 | 40 | 36 | 4 |
| Contracts & SLAs | 149 | 36 | 27 | 9 |
| Payments To Providers | 3,816 | 888 | 884 | 4 |
| Emergency Duty Team | 103 | 0 | 0 | 0 |
| Other Agency Costs | 521 | 128 | 132 | (4) |
| **Total Expenditure** | **14,790** | **3,554** | **3,492** | **62** |
| Income | | | | |
| Sales & Rents Income | -221 | -150 | -138 | (12) |
| Fees & Charges | -173 | -25 | -32 | 7 |
| CCG Contribution To Service | -613 | -186 | -184 | (2) |
| Reimbursements & Grant Income | -663 | -55 | -56 | 1 |
| Transfer From Reserves | -870 | 0 | 0 | 0 |
| **Total Income** | **-2,540** | **-416** | **-410** | **(6)** |
| **Net Operational Expenditure** | **12,250** | **3,138** | **3,082** | **56** |
| **Recharges** | | | | |
| Premises Support | 192 | 40 | 40 | 0 |
| Transport | 436 | 109 | 109 | 0 |
| Central Support Services | 1,685 | 421 | 421 | 0 |
| Asset Charges | 76 | 16 | 16 | 0 |
| Internal Recharge Income | -1,685 | 0 | 0 | 0 |
| **Net Total Recharges** | **704** | **586** | **586** | **0** |
| **Net Departmental Total** | **12,954** | **3,724** | **3,668** | **56** |

**Comments on the above figures:**

Net operational expenditure is £56,000 below budget profile at the end of the first quarter of the financial year.

Employee costs are currently £41,000 below budget profile. This results from vacant posts, specifically in relation to mental health and day services. These vacant posts are in the process of being filled, and it is not anticipated the spend below budget profile will continue at this level for the remainder of the financial year.

Expenditure on Contracts and Service Level Agreements is projected to be £28,000 below budget at the year-end. This relates to savings made in payments to providers for the Bredon respite care contract.

Income is currently marginally below the target to date. There is an anticipated shortfall on rental income due to the intended refurbishment of a homeless facility. At this stage in the financial year it is anticipated that this shortfall can be met from over-achievements of income in other service areas, and savings from expenditure.

**Capital Projects as at 30th June 2014**

| | 2014/15 Capital Allocation £'000 | Allocation To Date £'000 | Actual Spend To Date £'000 | Allocation Remaining £'000 |
|---|---|---|---|---|
| ALD Bungalows | 400 | 0 | 0 | 400 |
| Grangeway Court | 347 | 0 | 0 | 347 |
| Section 256 Grant | 56 | 0 | 0 | 56 |
| Community Capacity Grant | 351 | 0 | 0 | 351 |
| **Total Spending** | **1,154** | **0** | **0** | **1,154** |

**PREVENTION & ASSESSMENT DEPARTMENT**

**Revenue Budget as at 30th June 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (underspend) £'000 |
|---|---|---|---|---|
| **Expenditure** | | | | |
| Employees | 6,558 | 1,567 | 1,535 | 32 |
| Other Premises | 63 | 11 | 12 | (1) |
| Supplies & Services | 400 | 21 | 24 | (3) |
| Aids & Adaptations | 113 | 6 | 13 | (7) |
| Transport | 5 | 1 | 1 | 0 |
| Food Provision | 28 | 6 | 6 | 0 |
| Other Agency | 23 | 3 | 2 | 1 |
| | 800 | 0 | 0 | 0 |
| **Transfer to Reserves** | 17,614 | 2,869 | 2,857 | 12 |
| Contribution to Complex Care Pool | | | | |
| **Total Expenditure** | **25,604** | **4,484** | **4,450** | **32** |
| **Income** | | | | |
| Other Fees & Charges | -226 | -56 | -62 | 6 |
| Reimbursements & Grant Income | -349 | -10 | -12 | 2 |
| Transfer from Reserves | -2,185 | 0 | 0 | 0 |
| Capital Salaries | -39 | 0 | 0 | 0 |
| Government Grant Income | -155 | 0 | 0 | 0 |
| CCG Contribution to Service | -442 | -235 | -235 | 0 |
| **Total Income** | **-3,396** | **-301** | **-309** | **8** |
| | | | | |
| **Net Operational Expenditure** | **22,208** | **4,183** | **4,141** | **42** |
| **Recharges** | | | | |
| Premises Support | 221 | 55 | 55 | 0 |
| Asset Charges | 210 | 0 | 0 | 0 |
| Central Support Services | 1,980 | 472 | 472 | 0 |
| Internal Recharge Income | -419 | 0 | 0 | 0 |
| Transport Recharges | 50 | 9 | 10 | (1) |
| **Net Total Recharges** | **2,042** | **536** | **537** | **(1)** |
| **Net Departmental Total** | **24,250** | **4,719** | **4,678** | **41** |

**Comments on the above figures:**

In overall terms, the Net Operational Expenditure for the first Quarter of the financial year is £41,000 under budget to date and £29,000 under the budgeted profile when excluding the Complex Care Pool.

Employee costs are currently showing £32,000 under budget profile. This is due to vacancies within the Department, in particular Care Management. Some of these vacancies are yet to be filled. If these vacancies remain unfilled, the current underspend will continue to increase beyond this level.
Supplies and Services expenditure to date is £3,000 over budget profile. This is mainly due to the increase in Deprivation of Liberty Safeguards (DOLs) assessment costs. (DOLs) assessments aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Expenditure on Aids and Adaptations is £7,000 above budget profile in the first quarter and continues to be a pressure area as more people are supported within their own homes.

Overall, income has achieved the first quarter's target and this trend is expected to continue for rest of the financial year.

A detailed analysis of the Complex Care Pool is shown below:

**Revenue Budget as at 30th June 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (overspend) £'000 |
|---|---|---|---|---|
| **Expenditure** | | | | |
| Intermediate Care Services | 3,757 | 633 | 632 | 1 |
| End of Life | 192 | 61 | 61 | 0 |
| CHC Assessment Team | 255 | 0 | 0 | 0 |
| Sub Acute | 1,788 | 198 | 193 | 5 |
| Joint Equipment Store | 532 | 7 | 7 | 0 |
| Intermediate Care Beds | 596 | 149 | 149 | 0 |
| Adult Care: | | | | |
| Residential & Nursing Care | 19,428 | 3,764 | 3,711 | 53 |
| Domiciliary & Supported Living | 10,590 | 1,698 | 1,674 | 24 |
| Direct Payments | 3,293 | 1,073 | 1,186 | (113) |
| Day Care | 457 | 80 | 72 | 8 |
| **Total Expenditure** | 40,888 | 7,663 | 7,685 | (22) |
| **Income** | | | | |
| Residential & Nursing Income | -4,920 | -838 | -860 | 22 |
| Community Care Income | -1,552 | -239 | -252 | 13 |
| Direct Payments Income | -189 | -47 | -46 | (1) |
| Other Income | -285 | -285 | -285 | 0 |
| CCG Contribution to Pool | -12,784 | -3,196 | -3,196 | 0 |
| Reablement & Section 256 Income | -3,544 | -189 | -189 | 0 |
| **Total Income** | -23,274 | -4,794 | -4,828 | 34 |
| **Net Divisional Expenditure** | **17,614** | **2,869** | **2,857** | **12** |

The overall net expenditure budget is £12,000 under budget at the end of the quarter.

Intermediate Care Services includes spend for the Therapy & Nursing Teams, Rapid Access Rehabilitation and Reablement. Spend is expected to remain within budget throughout the financial year

The number of clients in receipt of residential & nursing social care increased last year by 17% but from April this year it has decreased by 1%. The number of clients in receipt of domiciliary social care (including supported living) last year decreased by 8.8% and then from April this year it has increased by 1%.
The number of clients in receipt of a Direct Payment has substantially increased in the first quarter of the year and this is due to the renegotiation of the Domiciliary Care contracts, clients who were receiving domiciliary care have now opted to take a Direct Payment and new clients who have never received a package of care taking the option of a Direct Payment. The increase is expected to continue into the next quarter and this should result in a reduction in the numbers for domiciliary care.

Trends of expenditure and income will be scrutinised in detail throughout the year to ensure a balanced budget is achieved. Spend can be volatile and will fluctuate throughout the year, this is due to the number and value of new packages being approved and existing packages ceasing.

The budgets across health and social care have been realigned to reflect the expenditure and income in the previous year.

**Capital Projects as at 30th June 2014**

| | 2014/15 Capital Allocation £000 | Allocation To Date £000 | Actual Spend To Date £000 | Allocation Remaining £000 |
|---|---|---|---|---|
| Disabled Facilities Grant | 500 | 50 | 26 | 474 |
| Energy Promotion | 12 | 0 | 0 | 12 |
| Stair lifts (Adaptations Initiative) | 200 | 50 | 31 | 169 |
| RSL Adaptations (Joint Funding) | 250 | 60 | 42 | 208 |
| **Total Spending** | **962** | **160** | **99** | **863** |

**PUBLIC HEALTH DEPARTMENT**

**Revenue Budget as at 30th June 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (underspend) £'000 |
|---|---|---|---|---|
| **Expenditure** | | | | |
| Employees | 1,718 | 415 | 388 | 27 |
| Supplies & Services | 55 | 10 | 7 | 3 |
| Other Agency | 20 | 20 | 17 | 3 |
| **Contracts & SLA's** | 5,779 | 849 | 843 | 6 |
| Transfer to Reserves | 707 | 0 | 0 | 0 |
| **Total Expenditure** | **8,279** | **1,294** | **1,255** | **39** |
| **Income** | | | | |
| Other Fees & Charges | -49 | -12 | -8 | (4) |
| Sales Income | -26 | -20 | -19 | (1) |
| Reimbursements & Grant Income | -3 | 0 | 0 | 0 |
| Government Grant | -8,749 | 0 | 0 | 0 |
| Transfer from Reserves | -200 | 0 | 0 | 0 |
| **Total Income** | **-9,027** | **-32** | **-27** | **(5)** |
| **Net Operational Expenditure** | **-748** | **1,262** | **1,228** | **34** |
| **Recharges** | | | | |
| Premises Support | 50 | 13 | 13 | 0 |
| Central Support Services | 2,135 | 115 | 115 | 0 |
| Transport Recharges | 25 | 2 | 2 | 0 |
| **Net Total Recharges** | **2,210** | **130** | **130** | **0** |
| **Net Departmental Total** | **1,462** | **1,392** | **1,358** | **34** |

**Comments on the above figures:**

In overall terms, the Net Operational Expenditure for the first quarter of the financial year is £34,000 under budget profile.

Employee costs are currently £27,000 under budget profile. This is due to savings being made on vacancies within the Department. Some of the vacant posts, specifically in relation to Trading

Standards are in the process of being filled. Therefore, it is not anticipated that this variance will continue at this level for the remainder of the financial year.

## APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

| Progress | | Objective | Performance Indicator |
|---|---|---|---|
| **Green** |  | Indicates that the objective is on course to be achieved within the appropriate timeframe. | *Indicates that the annual target is on course to be achieved.* |
| **Amber** |  | Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe. | *Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.* |
| **Red** |  | Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe. | *Indicates that the target will not be achieved unless there is an intervention or remedial action taken.* |

**Direction of Travel Indicator**

*Where possible performance measures will also identify a direction of travel using the following convention*

| | | |
|---|---|---|
| **Green** |  | *Indicates that* **performance is better** *as compared to the same period last year.* |
| **Amber** |  | *Indicates that* **performance is the same** *as compared to the same period last year.* |
| **Red** |  | *Indicates that* **performance is worse** *as compared to the same period last year.* |

| | |
|---|---|
| **N/A** | *Indicates that the measure cannot be compared to the same period last year.* |