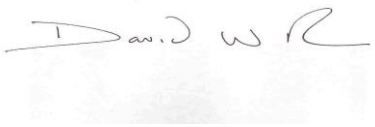
Public Document Pack

Health Policy and Performance Board

Tuesday, 8 March 2016 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Joan Lowe (Chairman)	Labour
Councillor Stan Hill (Vice-Chairman)	Labour
Councillor Sandra Baker	Labour
Councillor Charlotte Gerrard	Labour
Councillor Margaret Horabin	Labour
Councillor Mark Dennett	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Shaun Osborne	Labour
Councillor Carol Plumpton Walsh	Labour
Councillor Pauline Sinnott	Labour
Councillor Pamela Wallace	Labour

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.
The next meeting of the Board is to be confirmed.

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

Part I

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

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 8 March 2016

REPORTING OFFICER: Strategic Director, Community & 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: 8 March 2016

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 and Wellbeing Board 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, 13 January 2016 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors R, Polhill (Chairman), Philbin, Woolfall and Wright and G. Ferguson, T. Hill, J. Horsfall, M. Larking, A. McIntyre, D. Parr, H. Patel, M. Pickup, J. Rosser, C Samosa, R. Strachan, L. Thompson, S. Wallace-Bonner and S. Yeoman.

Apologies for Absence: S. Banks, A. Marr, Superintendent L. McDonnell, E. O'Meara, D. Sweeney, A. Waller.

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB28 MINUTES OF LAST MEETING

The Minutes of the meeting held on 4th November 2015 having been circulated were signed as a correct record.

HWB29 WELFARE REFORM - HALTON HOUSING TRUST

The Board considered a report from the Director of Halton of Housing Trust, which identified the impact of the Welfare Reforms since 2010. The report identified the changes already introduced and further reforms to reduce the welfare budget. The following welfare changes were highlighted with details on how each had impacted on Trust customers:

- Employment and Support Allowance;
- Personal Independence Payments;
- Universal Credit; and
- Spare Room Subsidy (Bedroom Tax).

Members were also advised that as part of a consortium, Halton Housing Trust tracked the impact of Welfare Reform on up to 100 households for 18 months up to February 2015. The research highlighted the impact that

these changes had, especially on health and wellbeing and detailed how the changes had impacted on claimants within Halton and specifically Halton Housing Trust customers.

Arising from the discussion the Board raised the following:

- Impact of the proposed welfare reforms which would bar 18-21 year olds from claiming housing benefit;
- Fees linked to the Employment Support Allowance; and
- Halton's Child Poverty Action Group would be tasked to adopt a multi-agency approach to identify priorities to address the impact of the welfare reforms on the health and wellbeing of Halton residents.

RESOLVED: That

1) the contents of the report be noted; and

2) further reports be submitted to track the on-going impact of the reforms as they are rolled out further.

HWB30 BETTER CARE FUND QUARTER 2 REPORT 2015/16

The Board considered a report of the Director of Adult Social Services which provided information on the Quarter 2 report for July to September 2015/16 for the Better Care Fund (BCF) that had been submitted to NHS England and progress with the implementation of the BCF, following approval at the Better Care Board on 26th November 2015. A summary of the Quarter 2 report was outlined in the report.

Members were advised that NHS England and the Local Government Association (LGA) were developing the year end reporting guidance and an Annual Report template which would build on the quarterly report. There were currently some outstanding queries around accounting and audit being worked through before these could be finalised and issued. Once finalised, they would be available on the Better Care Fund webpage.

RESOLVED: That the report be noted.

HWB31 BETTER CARE BOARD QUARTERLY UPDATE

The Board considered a report of the Director of Adult Social services which provided an update on the main issue that the Better Care Board had focused on progressing and

monitoring over the past few months. The Better Care Board met on a quarterly basis and its recent work included:-

- One to One Care: St. Luke's;
- Continuing Health Care;
- Falls;
- Minor Adaptations;
- Lillycross Care Home – Widnes; and
- Better Care Fund Review.

In addition, it was reported that the Better Care Board also monitored the activity of the Halton System Resilience Group (SRG). The Halton SRG provided multi-disciplinary strategic direction and guidance across health and social care in relation to non-elective and elective care. It was responsible for ensuring that, locally, there were quality processes in place which were safe and efficient for patients and cost effective. It was reported that over the past few months the SRG had considered issues around:-

- NHS 111 Mobilisation;
- Improving and Sustaining Cancer Performance;
- NHS England – SRG Assurance; and
- Winter Preparation 2015/16.

RESOLVED: That the report be noted.

HWB32 HALTON SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014-15

The Board considered a copy of the 2014/15 Halton Safeguarding Adults Board Annual Report. The report provided a summary of the key actions and priorities the Safeguarding Adults Board had been working towards in the last year. The report also set out the national and local developments on safeguarding adults at risk. During 2014/15, the Safeguarding Adults Board focused on four key priorities:-

1) Promoting the awareness of abuse and the right to a safe and dignified life – particularly among the vulnerable and at risk, but also among staff, volunteers and the wider community.

2) Increasing the contribution from service users and carers, ensuring their views and experienced inform the Board's work and service development. Provide individualised services that kept people safe but permitted informed decisions about risk.

3) Ensuring there was a strong multi-agency approach to the safety, wellbeing and dignity of all adults at risk;

4) Equip employees with the necessary tools and training to safeguard adults at risk and ensure their dignity was respected.

The future priorities for Halton's Safeguarding Adults Board were summarised as follows:-

- Empowerment;
- Protection;
- Proportionality;
- Prevention;
- Partnership; and
- Accountability.

It was anticipated that these priorities would be achieved by ensuring there was a full range of policies, strategies and an action plan in place, that provided a framework within which partner organisations could work together effectively to respond to abuse and neglect.

RESOLVED: That

1) the report be noted; and

2) the Halton Safeguarding Board Annual Report 2014- 15, be approved.

HWB33 HALTON INFANT FEEDING STRATEGY 2016-19

The Board considered a report of the Director of Public Health, which presented a new Infant Feeding Strategy, which outlined Halton's approach to infant feeding over the next four years. The strategy aimed to create a culture and services that supported families and carers within the Borough to make informed healthy choices when feeding their baby and young child, to ensure the best possible health and wellbeing outcomes were achieved.

Further, the strategy would contribute to Halton's Readiness for School indicator. Encouraging parents and service providers to enable infants and young children to breastfeed, be weaned and commence solids at the appropriate ages led to well-developed facial muscles and speech and language skills which in turn resulted in young children being ready for school.

In order to optimise the health of Halton residents the

infant feeding strategy also aimed to achieve the following three overarching outcomes:-

1) Create a culture of breastfeeding in Halton so that the number of infants who were breastfed and the duration of breastfeeding increased;

2) Increase the number of infants who were introduced to solid foods at or around six months of age; and

3) Increase the awareness of parents and the general public of healthy feeding practices for infants and change behaviour accordingly.

A detailed action plan which underpinned a strategy and measured the achievement of the aims and outcomes had been previously circulated to Members of the Board.

RESOLVED: That the Infant Feeding Strategy and recommendations be approved.

Meeting ended at 3.15 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 8 March 2016

REPORTING OFFICER: Strategic Director, People & Economy

PORTFOLIO: Health and Wellbeing

SUBJECT: Discharge from Hospital Scrutiny Review 2015/16

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present to PB the report and recommendations of the Discharge from Hospital Scrutiny Review 2015/16

2.0 **RECOMMENDATION: That:**

i) The Board note the contents of the report attached at appendix 1

3.0 **SUPPORTING INFORMATION**

3.1 The report outlines the key findings and makes a number of recommendations for consideration by the Health PPB

3.2 The group sought national and local evidence and undertook a range of site visits to understand best practice in and the systems and issues with ensuring timely, safe and effective discharge of people from hospital. Contributors included: Hospital Discharge Teams; the voluntary sector; Warrington and Halton Hospitals NHS FT; St Helens and Knowsley Teaching Hospitals NHST; Care Home support teams; NHS Halton CCG; 2 local GP's and their surgeries; North West Ambulance Service.

3.3 The recommendations from the group are:

3.4 **The Voluntary Sector need to develop a plan with the Acute Hospitals to map out how they will work collaboratively in respect of supporting people through hospital discharge.**

3.5 There are a range of voluntary sector services working in both acute hospitals and recently funding has been secured to assist with coordination of and recruitment of volunteers to support people in hospital. It was clear from the agencies that better coordination within hospitals is required and planning needs to be undertaken to

ensure this occurs

3.6 **A Community Care Matron with the capacity and skills to prescribe and undertake medication reviews would enhance the Care Home Support Team.**

3.7 The Care Home support teams provide a range of services for people in care homes and support the nursing and care staff to deliver quality care. This reduces the need for hospital admissions and supports a smoother discharge from hospital where the patient lives in a care home. Extending the scope of the team to include prescribing and medication review would enhance the clinical care delivered and reduce the need for GP visits.

3.8 **A review of patients repeatedly re-admitted for treatment of the same condition should consider coding such re-admissions in a different way such as open access. The use of the urgent care centres to deliver a broader range of treatments should be considered.**

3.9 Evidence from a visit to a GP surgery highlighted a small but significant number of people who have multiple admissions for urgent treatment of existing conditions. 1 person had over 100 admissions within one year and these were coded as 're-admissions'. Practices do routinely review people with frequent hospital attendances and where they do this, there is an opportunity to consider enhancing services delivered locally to support people in these circumstances.

3.10 **Acute Hospitals should continue to ensure the maximum use of their discharges lounges which support a more timely discharge process**

3.11 Both hospital trusts have developed 'discharge lounges' which provide accommodation, nutrition and hydration for people waiting for a range of things before discharge. It was evident that these units were well staffed and coordinated the elements required to achieve discharge (medication, transport). Hospital teams were working hard to ensure these lounges were used and had plans to continue this.

3.10 **Effective communication and timely access to clinical information is key to ensure safe and effective discharge and systems should continue to develop to improve this.**

All practitioners and the voluntary sector raised having timely access to information as key in the discharge process. When visiting the GP surgery's the group witnessed how care and treatment could be effectively continued when discharge information was received in a timely way and worked best when this was in electronic format.

4.0 **POLICY IMPLICATIONS**

4.1 Nil

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no final implications as result of this review.

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

6.1 **Children & Young People in Halton**

Effective discharge processes for children are essential in ensuring high quality treatment care and support. This review supports improvement in this area.

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

Nil

6.3 **A Healthy Halton**

Effective discharge processes for adults and children are essential in ensuring high quality treatment care and support. This review supports improvement in this area.

6.4 **A Safer Halton**

Nil

6.5 **Halton's Urban Renewal**

7.0 **RISK ANALYSIS**

7.1 No risks identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

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

None under the meaning of this Act.

HALTON BOROUGH COUNCIL

Health Policy & Performance Board

Scrutiny Review of Discharge from Hospital

Report
March 2016

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to present the findings of the scrutiny review, which:

Focused on the quality of the Discharge planning process and associated pathways to those Halton residents who have been admitted to the local Acute Trusts for both elective and emergency care. It examined the services that are already in place and evaluated their effectiveness in meeting the needs of the local population.

1.2 The full topic brief can be found at Appendix 1.

2.0 POLICY AND PERFORMANCE BOARD (PPB)

2.1 This review was commissioned by the Health PPB in June 2015. This report will be presented to Health PPB on 8th March 2016. The report will also be presented to Communities Directorate Senior Management Team, Executive Board and boards or committees of stakeholders, as appropriate.

3.0 MEMBERSHIP OF THE TOPIC GROUP

3.1

Councillor Joan Lowe (Chair)
Councillor Stan Hill (Vice Chair)
Councillor Pamela Wallace
Councillor Martha Lloyd-Jones
Councillor Charlotte Gerrard
Councillor Carol Plumpton-Walsh
Councillor Margaret Horabin
Tom Baker
Damian Nolan, Divisional Manager, Urgent Care
Debbie Downer, Policy Officer, Communities

Councillor Shaun Osborne declared an interest which prevented him from taking part in the Scrutiny Review.

3.0 METHODOLOGY

4.1 This scrutiny review was conducted through the following means:

- An information pack provided to Topic Group Members outlining national and local picture of discharge from hospital, summary of the key elements of services delivered in Halton, emerging issues facing hospital discharge and future delivery in Halton.
- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff involved in the Integrated Hospital Discharge teams based at Warrington and Whiston Hospitals;
- Site visits to Warrington and Whiston Hospitals;
- Site visits to Castlefields Health Centre and Beaconsfield Surgery;
- Presentations from local agencies/voluntary organisations;
- Presentation from Care Homes Team;

- Presentation from CCG/GP on commissioning hospital services;
- Presentation from North West Ambulance Service Patient Transport Service.

The final draft of this report was circulated to all participants/presenters to check for accuracy.

4.2 The above methods enabled Member's to:

- Gain an understanding of existing Discharge Planning processes and associated pathways in respect of Halton residents who are admitted to Warrington and Halton Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust.
- Understand the role that all agencies (both statutory and voluntary/community sector) play in the discharge planning process.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to Discharge Planning processes to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.

4.3 Areas considered as part of this review:

- How are people discharged from hospital?
- Understanding of self-care after discharge.
- What information is given to people and when? Do they know who to contact if something goes wrong?
- Transfer of care into primary care (e-discharge).
- Arrangements for people with supported discharge needs, planning, treatment, care and support for discharge.

4.4 Which enabled Members to consider, in making recommendations;

- National best practice, along with evidence based practice, and how it can be applied in Halton.
- Ways to continue to make improvements to services to ensure they continue to be effective in meeting the needs of the population of Halton.

The Chair and Members of the Topic Group would like to extend their thanks for the cooperation and contributions made by all those who have taken part in the review.

5.0 INTRODUCTION

5.1 Discharge planning is a routine feature of the Health and Social Care system and consists of the development of an individualised discharge plan for the patient prior to leaving hospital, with the main aim of improving a patient's outcome.

5.2 Discharge planning should ensure that patients are discharged from hospital at an appropriate time in their care and that, with adequate notice, the provision of other services are organised.

5.3 There are some common key elements when planning for discharge, regardless of whether a patient is receiving emergency or elective care. These are:

- Specifying a date and / or time of discharge as early as possible
- Identifying whether a patient has simple or complex discharge planning needs
- Identifying what these needs are and how they will be met
- Deciding the identifiable clinical criteria that the patient must meet for discharge

5.4 About 20 per cent of patients[1] have more complex needs and may need additional input from other professionals. The involvement of additional people makes effective co-ordination and planning even more critical.

5.5 As the older people age group (65+) within Halton are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025[2], it is anticipated that the percentage of those patients experiencing more complex needs and thus requiring more complex discharge planning processes will also increase.

5.6 Planning for discharge helps reduce hospital length of stay and unplanned/emergency readmissions to hospital, relieves pressure on hospital beds and improves the co-ordination of services following discharge from hospital.

5.7 Within Halton we experience a high number of emergency readmissions at both 30 and 90 days for people aged 65 and over and this has presented challenges to the Health and Social Care system. As outlined above, effective discharge planning can contribute to helping reduce the number of unplanned/emergency readmissions to hospital and as such there is a need to ensure that current discharge planning processes and associated pathways in place are having a positive impact on Halton's emergency readmission rates.

[1] NHS Institute for Innovation and Improvement

[2] ONS - Population Projections 2010

6.0 EVIDENCE CONSIDERED BY THE SCRUTINY TOPIC GROUP

6.1 The planning meeting, which took place on 10th June 2015, provided the members of the topic group with an opportunity to review the information pack and identify the key focus areas for the Scrutiny Review.

The areas are as follows:

- Discharge Lounges – in particular who is responsible for patients waiting for transport. What happens when patients are delayed because they are waiting for medication. What consideration is given to patient's needs regarding medical care, nutrition, hydration, privacy and dignity.
- Family Involvement in the discharge process – this was raised in relation to how conversations take place about a person's care after discharge and whether it would be beneficial to have the family present during these discussions.
- Discharges to Care Homes – what happens when a patient is unable to return to their 'home' due to changes in their condition.
- Mental Health Support with the discharge process and people living with dementia – what support is provided in hospital and on returning home.
- Financial information – the group wanted to know what information is provided about care charges within the discharge process.
- How many people in Halton are now going to elective centres further away (Centres of Excellence) and how this affects the information they are offered on discharge.
- The role which NHS Halton CCG/GP's have within hospital discharge.

6.2 Integrated Discharge Teams (Warrington and Whiston) – Presentations from Eddie Moss and Francesca Smith.

Staff from Halton Integrated Discharge team (based at Warrington and Halton Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust) provided the group with information about the Discharge processes at Warrington and Whiston Hospitals.

6.2.1 Halton Integrated Discharge Team (HIDT) at Warrington Hospital

The HIDT is a dedicated multi-disciplinary discharge team which incorporates assessment into Accident & Emergency, ensuring a focus on the proactive identification of people likely to require supported discharge.

The team delivers on all the discharge pathways out of Warrington and Halton Hospitals Foundation Trust (WHHFT) including Social Care, Continuing Health Care (CHC), Community Health Services and Intermediate Care. The team also manages discharges for Halton residents in out of area hospitals.

The staff group consists of Nurses, Social Workers, Community care Workers, District Nurses and Community Psychiatric Nurse.

The benefits of this approach to discharge include earlier engagement with patients and families to better manage need and expectations, therefore reducing delays in hospital beds and admissions to long term care.

HIDT undertake a proactive approach to identifying Halton residents within Warrington Hospital and do not necessarily wait for a formal referral to be made. On a daily basis a list of adults (50+) that have been admitted overnight is provided to the HIDT. Designated Care Managers then track and monitor the persons hospital journey during the duration of their stay.

Where referrals to the HIDT are made, these are done via a Section 2 referral notification generated by the Hospital ward; a Section 2 notification identifies the possible need for social work intervention on discharge from hospital.

6.2.2 Whiston Integrated Discharge Team at Whiston Hospital

In Whiston Hospital the Integrated Discharge Team ("IDT") is a single point of referral for all St Helens, Knowsley, and Halton resident patients identified by the ward staff as requiring support on discharge. The team comprises of discharge workers, social workers, band 6 nurses, a physiotherapist and support staff, working under a team manager and three assistant managers. This staff group was drawn from both health and social care to create a multi-disciplinary team.

Staff are allocated to specific wards to enable them to build relationships and become involved in decision making at the earliest opportunity. The workers will deal with all Halton, St Helens and Knowsley patients on their allocated wards, regardless of their employing organisation. The Intermediate Care (IC) assessors within the team will respond to referrals for those identified for IC, either via the ward direct or the ward allocated worker.

There are a number of pathways through which people requiring support for and on hospital discharge can be directed. Achieving timely discharge for people who need support is dependent on a number of related factors including:

- Commencement of discharge planning on admission;
- the availability of information about the individuals self-care ability and health status prior to admission;
- frailty of the individual pre and post admission;
- the responsive of diagnostic departments and analysis of results;
- the trajectory of the presenting condition and response to treatment;
- recovery processes;
- involvement of the individuals significant others;

- knowledge of all staff in the relevant agencies of the type and availability of community services (health and social care);
- discharge process management;
- the complexity of different services and pathways criteria's and responsiveness;
- tracking.

Performance

As part of ongoing internal scrutiny performance reports are produced and presented to the appropriate representative boards. These include;

- Length of Stay
- Number of referrals
- Delayed Transfers of Care
- Number of Assessments completed via each discipline
- Assessment outcomes

The range of performance information from last year illustrated the monitoring of hospital processes and outcomes at discharge;

- Last year HIDT received 831 referrals which converted into 818 assessments.
- The average length of stay for all patients referred to the HIDT from admission to discharge is 19.5.
- HIDT tracked 1393 in total.
- The number of referrals received by Whiston last year was 6540, which converted into 4358 assessments.
- On average there are 7 delayed transfers of care (Delayed Transfers of Care (DTOC) reportable delays) each day.

Conclusion

Following the presentation, the group discussed delays caused by transport and medication. Concerns were raised about who is responsible for the care of patients who are waiting to be discharged, in particular nutrition and hydration.

Discharge lounges were discussed and it was highlighted that adequate facilities were not always available for frail, older people.

The group expressed interest in the process for Discharges to Care Homes. For example, when a patient's condition resulted in them being unable to return to the care home they were admitted from.

That discharge lounges work well and the Trusts should ensure that the facility continues to be fully utilised. There are benefits to all patients, not just older people and evidence shows a reduction (20-40 minutes less) in NWAS transfer times.

There are also clear benefits to patients in how medication is provided on discharge.

6.3 Presentations from local agencies/voluntary organisations – Halton & St Helens Voluntary and Community Action (VCA), Age UK, Wellbeing Enterprises Red Cross.

The scrutiny topic group were keen to understand the role and contribution of local agencies in this area and the services they provide for people being discharged from hospital.

Halton & St Helens VCA/Wellbeing Enterprises

Sally Yeoman (Halton and St Helens VCA) and Mark Swift (Wellbeing Enterprises) briefed the group on a project to recruit and support Hospital Ward and Community Volunteers. Funding acquired for the project (9 months) will be used to evaluate whether the work will deliver cost savings and benefits.

Age UK

Age UK work in partnership with Warrington and Whiston Hospitals providing support to people being discharged. Volunteers provide help with supporting people during and after discharge home, this is particularly helpful where the person has been in hospital for some time. Signposting and advice is given relating attendance allowance and help with sourcing care and support. Age UK also provide signposting to the independent living team.

Karen Kenny explained that Age UK were keen to capture Halton residents who attend hospitals out of area. There can be patients from up to five different boroughs on the ward and at weekends there isn't anyone to signpost them.

Dawn Kenwright provided an overview of the survey being undertaken in partnership with Healthwatch to assess hospital discharge patient experience in Halton.

Wellbeing Enterprises

Mark Swift outlined the pilot project which aims to help people to leave hospital sooner and ensure they have support is in place if needed (shopping, heating etc.). The target group are patients who are at risk of re-admittance as identified via the Multidisciplinary Team (MDT) process. Volunteers will work with vulnerable people and act as navigators.

Conclusion

Whilst it was acknowledged that the various voluntary organisations have different skills/specialisms and referrals are becoming more complicated - a plan is needed to clearly map out how all the voluntary organisations will move forward to provide a one stop shop and work collectively with the hospitals.

Referrals are not just home help and shopping, but include issues such as mental illness, hoarding, and alcohol abuse. Whilst Age UK work alongside Red Cross and other voluntary organisations in Halton, it is recognised that there is a gap. The evaluation being undertaken via Healthwatch is working towards mapping what services are out there.

6.4 Presentation from Care Homes Team - Gaynor Cunliffe (Bridgewater Community NHS Trust) Clive Allman – 5 Boroughs Partnership (5BP).

One of the areas of interest identified by the Scrutiny Group is Hospital Discharge to Care Homes including people with dementia.

Care Homes Team

Gaynor Cunliffe is a Nursing Sister and her role encompasses 17 care homes within the Halton area. GC works to ensure services are in place and identifies training needs for nurses in care homes.

In answer to an enquiry regarding an area which could be improved, GC suggested that a Community Matron just for care homes who would be able to carry out medication reviews and could attend instead of the GP. A recent home closure led to a resident being moved and medication needed changing at the same time, but GC was not able to prescribe. If there was a Care Homes Community Matron this could be picked up sooner.

GC gave an example of the challenges of getting information on a patient who is being discharged, particularly if residents needs have changed. In some cases, Nurses don't know patients well enough and there are no case notes. The process works better if the nurse knows the patient well.

When a resident is admitted to hospital, a yellow transfer form is completed which provides the hospital staff and ambulance crews with important information about the resident. The forms are shared with GC, however not all care homes complete them. The same applies for Medication Records, which should go with a resident when they admitted to hospital.

There followed a discussion about the differences in the discharge process for mental health as they had access to hospital systems and were notified in advance of pending discharges. GC confirmed this wasn't always the case and the team are not routinely made aware of hospital discharge.

Care home managers go into hospitals to speak to the ward prior to a resident being discharged, however if they are unable to speak to a Nurse who knows the resident well, readmission becomes more likely.

Later Life & Memory Services (LLAMs)

Clive Allman's role focusses on dementia and mental health in addition to providing care homes with awareness and training. He carries out drug regime reviews, offers general advice and being in the homes means he can be proactive and address issues early.

There are 2.5 people in the LLAMs team (including an Occupational Therapist) focussing on Halton who work closely with community mental health teams. Cover is provided on a 9-5 basis but can flex to meet the needs of families. There is no weekend cover and concern was expressed on arrangements for holidays/sickness and DN and CA confirmed that GP's often pick this up if no-one else is available.

CA confirmed he is unable to prescribe and this function needs to go via a GP. In care homes they don't have the same access as someone at home does, putting pressure on GPs and leading to delays in treatment. Each care home can have 6/7 different practices with GP's coming out to patients (or a locum if out of hours).

Conclusion

There was an identified need for a Community Matron assigned to Care Homes who has the capacity and skills to prescribe and monitor medication.

6.5 Hospital Visits – Warrington & Halton Hospitals NHS Foundation Trust

A number of the Scrutiny Topic Group made a planned visit to Warrington Hospital with a view to gaining an insight into hospital discharge and what processes are in place to support vulnerable people with complex care needs.

The visit was facilitated by the Divisional Manager, Urgent Care. The group had a tour of the Discharge Lounge and spoke with Dawn Forrest, Associate Divisional Director Unscheduled Care and a number of staff from the Discharge team. A full report of the visit is included in appendix 2.

Background

DF gave an overview of improved outcomes as a result of an increase in therapy on the ward which focussed on moving patients towards independence as part of the discharge process. Weekly Multidisciplinary Team meetings include medical staff, Occupational Therapists and Social Workers.

Discharge Process

The Discharge process starts from admission and has separate pathways by condition (Stroke, Heart Attacks, Frail/elderly) and includes preventative work to prevent readmission. Visiting times have been extended to make it easier for families to be present when discussions/assessments are taking place so they are involved in the decision making process. Care is taken to ensure patients are at the centre of the process, and not just a focus on medical needs. Patients are also signposted to voluntary agencies (such as Red Cross) who provide services to people once they are home from hospital. Red Cross are based in A&E at Warrington Hospital and are currently working to identify vulnerable people who have a high risk of re-admission.

A recent new initiative (Quality Ward Round) is a Nurse-led Ward Round where a Nurse accompanies the Doctor after prioritising the patients who are due to be discharged. Ongoing work to improve 21 day delayed discharge will be helped by the move to Lorenzo (electronic records) which will help to reduce duplicate paperwork.

A member of the HPPB highlighted an example of delays in hospital discharge due to medication and problems where the person's GP was not notified that they had been discharged.

Staff explained that Warrington hospital has recently moved to electronic discharge and if medication is required, this is now flagged up and Pharmacists (who have specialities such as respiratory) work alongside ward staff to focus on the medication requirements of discharge to ensure this doesn't cause delays. Pharmacists are also able to provide training to patients on how to use inhalers. In the pharmacy, a tracker system highlights patients who are being discharged and these prescriptions are given priority to ensure beds are freed up to prevent A&E delays. Patients are also given the choice to go home without medication if not essential and they are able to reach a pharmacy independently once home.

In the event of a delay, Discharge Lounge staff continue to care for the patient until a transfer was arranged, via private ambulance if necessary. The improvements in loading times (down to 30 minutes) through better accessibility (drop off zone) meant more ambulances were available thus reducing delays.

The new Discharge Lounge can accommodate patients with complex needs/Dementia, whereas in the past they would have been kept on the ward. A single room is reserved for patients who need additional support and there is also a room in A&E for Mental Health patients which is safe/secure with a psychiatric liaison team on call. This team's brief has now been extended to the Intensive Therapy Unit and to support Dementia patients.

A member of the HPPB queried Discharge to Care homes and staff confirmed that a new post has recently been put in place to work with the Halton Integrated Discharge team to identify and focus on this group of patients.

There have been issues where Care Homes are reluctant to re-admit residents whose needs have changed whilst in hospital.

There have also been issues where residents have been admitted who are end of life, particularly where DNA CPR (Do Not Attempt Cardio-pulmonary Resuscitation) and Care Homes could do more to assess resident's health to avoid unnecessary distress in moving a resident at this stage. Patients who are end of life are sometimes discharged at night, with the family's support and agreement and the Discharge Team work closely with NWAS/private ambulance to facilitate a fast track discharge.

Conclusion

The group were impressed with the discharge lounge facilities at Warrington Hospital and it was clear that there have been beneficial changes made to the discharge process which have contributed to improved outcomes.

After speaking to Managers and Nursing Staff, the group could see that there was a clear commitment to providing a quality patient-centred service and a continued focus on improvement moving forward.

Feedback from a patient who was in the Discharge Lounge was very positive.

The layout of the unit was patient centred with an emphasis on privacy and dignity.

A copy of information provided to patients is included in appendix 4.

6.6 **Hospital Visits – Whiston**

A number of the Scrutiny Topic Group, focusing on Discharge from Hospital, made a planned visit to Whiston Hospital with a view to gaining an insight into hospital discharge and what processes are in place to support vulnerable people with complex care needs.

The visit was facilitated by the Divisional Manager, Urgent Care. The group had discussions with Jenny Farley, Interim Deputy Director of Operations and Rob Cooper, Assistant Director of Operations followed by a tour of the Discharge Lounge and the Frailty Unit. The visit was 2 hours in duration. A full report of the visit is included in appendix 3.

Background

Jenny Farley welcomed the group and Councillor Joan Lowe provided an overview of the Scrutiny Review Topic Group. Jenny Farley commented on how impressed she was regarding the Integrated Discharge team at Whiston and how beneficial they were for complex discharges. JF described the two different types of discharge – complex and standard.

Discharge Processes

JF gave an overview of the kind of information people are given depending on whether their discharge is complex or standard. JF described how the conversations about discharge begin on admission and it is very quickly established if help will be needed at home. Where the Integrated Discharge Team was involved in the process it worked very well, and JF was working with Francesca Smith to raise staff awareness of the team to broaden their reach. There are dedicated discharge co-ordinators outside of Nursing resources.

Family are involved in the conversations and signposting to voluntary groups is provided. Rob Cooper stated that this worked very well at Wirral and could be improved at Whiston. (Age UK are a relatively recent presence at Whiston).

Nursing and support staff are responsible for patients whilst they are in the discharge lounge to administer meds and provide fluids/food. RC confirmed that specialist Mental Health Social Workers support people with mental health problems and there was a Liaison Psychiatrist based in A&E. Dedicated dementia staff were alerted on admission and focussed on whether the patient was newly diagnosed or if they already had a package of care either in the community or at home.

Assessments are prioritised for people being discharged to care homes as this group of patients often experience delays when finding a suitable bed and liaising with family on home of choice. The choice of care homes offered depends on the person's needs and condition – the Integrated Discharge Team tailor choices to the needs of the patient.

A member of the HPPB queried how soon are family informed about costs as this could potentially cause extra worry and stress. RC confirmed that information is provided as part of the discharge process by the Integrated Discharge Team. The financial assessment is done at home, to minimise the length of time in hospital.

RC confirmed that recent improvements to processes between Discharge teams and Pharmacy has resulted in a reduction in the time (to under an hour) between when drugs are dispensed and handed to the patient. Delays do sometimes happen, usually if discharge is later on in the day. Pharmacy technicians are working with nurses on the ward (being piloted at the moment) to reduce delays.

JF confirmed that Respiratory Nurses were on hand to support and provide training.

A member of the HPPB outlined the case of a patient was discharged without anti-coagulant medication (Warfarin) who subsequently died and asked how Whiston informs GPs on discharge and medication. RC confirmed that Whiston has electronic discharge, however if the letter needs to be taken to the GP, it prints out in red.

Facilities

The group then moved onto the Discharge Lounge and the staff provided an overview of the processes used. Patients who still need a high level of nursing care stay on the ward as there are not suitable facilities to support them in the discharge lounge. Patients can also use the day rooms located near the wards. The lounge is also used by patients who are waiting for a bed, transport or medication. The unit is not open at weekends or Bank Holidays.

The visit continued into the Frailty Unit. Age UK (St Helens) are newly established in the unit and staff also refer to Sure Start to Later Life. The information board showed a range of areas where patients come from and those who had carers were identified to enable staff to provide extra support.

The ethos of the Frailty Unit was to ensure people were not on the ward for longer than 72 hours and to identify patients who can go home quickly. A medical assessment unit for the elderly includes medical/functional skills for those who have had a prolonged stay in hospital and have lost independence. The assessment aims to reduce levels of readmission. Visiting times are flexible to enable family to visit at times when the consultant is present and for them to be involved in assessments.

Patients are provided with a going home food parcel if needed.

Conclusion

JF explained how reductions in the number of beds had impacted the hospital and when there was a shortage of beds, people were sent out of the area.

RC outlined that the biggest challenge in delayed discharge was changing the perception of families who feel the safest place for their relative is in hospital. In reality they are more at risk of infection and a loss of independence.

There was an opportunity to further enhance the support provided by the voluntary agencies at Whiston, around signposting and information with charging. Information/signposting could be provided in the information leaflet given to patients on admission regarding discharge. This would help people move back to independence and improve patient experience. Age UK (St Helens) are newly established in Whiston (Tuesdays) and could assist Age UK (Halton) to also make connections.

The group were impressed with the Frailty Ward at Whiston Hospital and after speaking to Managers and Nursing Staff, the group could see that there was a

clear commitment to providing a quality patient-centred service and a continued focus on improvement moving forward. In particular, the group were very pleased to see that Carers were identified and supported. A home visit bag was also noted, which contained helpful items for staff when they were doing home visits.

A copy of information provided to patients is included in appendix 5.

6.8 Presentation from Halton NHS Clinical Commissioning Group (CCG) on commissioning hospital services – Dr Mick O'Connor (GP)

Dr O'Connor briefed the group regarding the scope of NHS Halton CCG and how the organisation commissions NHS services for Halton.

NHS Halton CCG monitors services such as discharges (weekends and emergency re-admissions), levels of delayed days and rate of re-admissions after 14/28 days. Dr O'Connor outlined the various reasons for delayed discharge, such as completion of assessment, Patient or Family choice, awaiting residential care/nursing home placement etc.

Halton is currently running at 15-17% re-admission within 30 days, which is quite high. CCG have commissioned a piece of work to scrutinise the reasons for re-admission, particularly at 7 days following discharge.

A discussion followed regarding the challenges in accurately pinpointing the reasons for re-admission. It can be challenging to identify a single reason for re-admission and the Contract Review Board and Quality Review Group regularly discuss and review data.

NHS Halton CCG manage contracts via CQUINs (Commissioning for Quality and Innovation) and set targets, one particular area being electronic discharge 4/5 years ago into both trusts. The introduction has improved the accuracy of information transmitted to primary care and 70/80% of patients (highest in the region) now receive an electronic discharge. The remaining 20/30% is due to reasons such as staffing issues and weekend discharges and is monitored on a monthly basis.

Patient records are still handwritten, and neither trust currently has electronic patient records. This would improve performance at weekends. With demand rising due to an increase in the elderly population and complicated drug regimens, manual records can run to 3 pages for a standard discharge with a junior doctor having to type out by hand.

There are some GPs not signed up to e-discharge and this raised concern for patients discharged at the weekend, particularly if the patient has been prescribed warfarin and needs either more medication or a blood test. Dr O'Connor pointed out that all practices in Halton are signed up for electronic discharge and the letter given to some patients on discharge is actually a copy of a letter, which is sent electronically to their GP.
GP's use a system called DocMan within each practice and it manages all appointments, blood results, patient messages, and letters for patients from

hospitals. A letter may indicate that medication/blood tests are required and the system records action taken. A&E admissions also generate letters, and patients are contacted according to risk.

The new CQUINs targets groups of people with chronic conditions (Chronic obstructive pulmonary disease (COPD), Diabetes, and Stroke) to ensure discharge includes additional information. GPs have more data, so they know what is 'normal' when they see a patient and can therefore detect any functional deterioration. Reviewing discharge procedures for people with these conditions will improve quality of care in hospital and the community as well as reducing the likelihood of readmission.

The level of intervention, which is appropriate for that person by condition, is also detailed. This information can potentially prevent re-admission with care provided in the community instead.

When asked what the frustrations were, Dr O'Connor gave the example of a patient treated for an apparent heart condition and whose discharge notes did not include adequate information. The eventual diagnosis was that it was probably a pulled muscle but the investigation led to a great deal of follow up correspondence with the consultant.

Another issue is patients discharged with outstanding tests, which should have been completed in hospital. This can cause problems, as it is not always clear why the test was ordered and patients may end up being referred back to the hospital for test results. This kind of work take patient contact away as doctors spend time doing paperwork. The problem was highlighted with the Clinical Quality Review Group and has resulted in an improvement.

There has been recent work on re-admissions in the frail and elderly and every GP practice runs Multidisciplinary Team meetings (including Community Matrons, District Nurses, GPs, and Occupational Therapists) and carries out risk stratification. This work proactively manages the risk of readmission via a register of patients who are more likely (according to condition/ circumstances) to have an unplanned hospital admission.

Both trusts are performing well on end of life discharges and patients are fast tracked with a phone call to notify District Nurses and Macmillan. Care at home is put in place with a GP visiting within a couple of hours of people arriving home/ or to a care home.

Dr O'Connor offered the Scrutiny Group a GP Practice tour during a protected learning time session (Thursday afternoon once a month). This enables people to understand what goes on behind the scenes and understand how a GP practice works.

Conclusion

The group subsequently visited Castlefields Health Centre and Beaconsfield Surgery – notes from the visits are included in Appendix 8.

6.9 Presentation from North West Ambulance Service Patient Transport Service (PTS) – Ian Stringer and Vicky Dodd.

Ian Stringer gave an overview of how the Patient Transport Service (PTS) is commissioned and how it links in with hospital discharge.

PTS are a commissioned service led by NHS Blackpool Clinical Commissioning Group (CCG) on behalf of all CCGs in the North West. PTS is a standard service across the area for patients registered within the commissioning area. Discharge activity forms part of the standard service. There is dedicated resource for Warrington and Whiston when required outside of contract arrangements.

The key performance indicators of the service include 80% of patients collected after treatment within 60 minutes of being notified as ready for collection. The services focus is on planned discharges but this sometimes means that targets for acute trusts are not met.

The same service provision applies regardless of where the patient is receiving treatment or where they live although who responds to the request for transport will differ according to area.

The main challenges facing PTS are that 10% of all activity is discharge activity with 80% planned which take place between 3-6pm. There can be issues with long stay patients with delays in medication or care package. Ward staff arrange for a take home parcel of food if needed and some patients are given a packed lunch.

Occasionally patients are transported individually particularly if the hospital needs to free up a bed. If a patient is not mobile (needs a stretcher) or has complex needs this can cause delays. However in cases like this, the patient needs are the priority, not the contract. PTS work with practitioners to make sure the discharge is safe rather than timely.

PTS receive a briefing beforehand to make them aware of patients' needs and to make sure any additional equipment is available. IS described the process PTS use in the event of safeguarding concerns/social care needs. NHS 111 will enhance this, so that NWAS know all the agencies involved.

Complaint numbers are low and nearly always related to timeliness – even if within contractual timescales. During periods of bad weather patients are prioritised (oncology and renal). PTS will contact families if needed and patients kept in overnight if required - safety is priority.

Discussion followed regarding vulnerable patients and IS stated that PTS work to reschedule activity until someone can take care of them. Adult Learning Disability (ALD) passports are utilised and there is a similar scheme for

dementia. This helps staff awareness especially if it is the first time they have transported the patient. PTS ask for additional information during the booking process and this is part of the staff induction to raise awareness of the needs of vulnerable people.

The discharge lounge in Warrington Hospital has improved the process and led to quicker turnaround, particularly for stretcher patients. Where there are discharge lounges and they are operating efficiently, this does help.

IS confirmed that staff are trained in basic first aid, safe moving and handling, infection control, dementia, and dignity. There are challenges around systems and meeting contract standards when patient's needs are paramount. Sometimes hospitals in their haste to meet targets and free up beds, don't always do what is best for patients.

Patient information leaflets are handed out to people being transported and their carers. They are also distributed in GP surgeries and hospitals. A copy is included in appendix 6.

Conclusion

It was clear that the PTS is delivering a high quality service with an ongoing investment in staff to meet the needs of patients (a training calendar is attached in appendix 7.

7.0 RECOMMENDATIONS TO HEALTH PPB

Issues identified and recommendations made:

- There is a lack of co-ordination/collaboration between the Voluntary Sector in Halton around hospital discharge. There is an opportunity to further enhance the support provided by the voluntary agencies regarding signposting and information about charging. A plan is needed to clearly map out how all the voluntary organisations will move forward to provide a one stop shop and work collectively with the hospitals. This work can be done within existing resources.

- A Community Care Matron with the capacity and skills to prescribe and undertake medicine reviews dedicated to care homes and attend instead of a GP. This is within the budget allocation for this services

- A review of the process for patients who are repeatedly readmitted via the use of an alternative pathway. A possible solution may be that admission is coded as open access (outpatient), rather than categorised as a readmission. There may be an opportunity to utilise the urgent care centre to enable the patient to self-manage their condition and for NHS Halton CCG and its partners to re-code readmissions for patients who require frequent hospital attendance for management of their condition.

- It is acknowledged by the Scrutiny Review Topic Group members that discharge lounges work well and Trusts should ensure that the facility continue to be fully utilised. There are benefits to all patients, not just older people and evidence shows a reduction (20-40 minutes less) in NWAS transfer times. There are also clear benefits to patients in how medication is provided on discharge.

- Across all of the presentations and visits undertaken by the topic group, communication - particularly relating to IT - and timely access to clinical information, was a common thread. The topic group recognises that effective communication is key to ensure safe and effective discharge and systems should continue to develop to improve this.

Appendix 1

TOPIC BRIEF

Topic Title: Discharge from Hospital

Officer Lead: Damian Nolan – Divisional Manager

Planned Start Date: April 2015

Target PPB Meeting: March 2016

Topic Description and Scope:

This topic will focus on the quality of the Discharge planning process and associated pathways to those Halton residents who have been admitted to the local Acute Trusts for both elective or emergency care. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population.

Why this topic was chosen:
Discharge planning is a routine feature of the Health and Social Care system and consists of the development of an individualised discharge plan for the patient prior to leaving hospital, with the main aim of improving a patient's outcome.

Discharge planning should ensure that patients are discharged from hospital at an appropriate time in their care and that, with adequate notice, the provision of other services are organised.

There are some common key elements when planning for discharge, regardless of whether a patient is receiving emergency or elective care. These are:

- Specifying a date and / or time of discharge as early as possible
- Identifying whether a patient has simple or complex discharge planning needs
- Identifying what these needs are and how they will be met
- Deciding the identifiable clinical criteria that the patient must meet for discharge

About 20 per cent of patients[3] have more complex needs and may need additional input from other professionals. The involvement of additional people makes effective co-ordination and planning even more critical.

As the older people age group (65+) within Halton are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025[4], it is anticipated that the percentage of those patients experiencing more complex needs and thus requiring more complex discharge planning processes will also increase.

[3] NHS Institute for Innovation and Improvement
[4] ONS - Population Projections 2010

Planning for discharge helps reduce hospital length of stay and unplanned/emergency readmissions to hospital, relieves pressure on hospital beds and improves the co-ordination of services following discharge from hospital.

Within Halton we experience a high number of emergency readmissions at both 30 and 90 days for people aged 65 and over and this has presented challenges to the Health and Social Care system. As outlined above, effective discharge planning can contribute to helping reduce the number of unplanned/emergency readmissions to hospital and as such there is a need to ensure that current discharge planning processes and associated pathways in place are having a positive impact on Halton's emergency readmission rates.

Key outputs and outcomes sought:

- An understanding of existing Discharge Planning processes and associated pathways in respect of Halton residents that are admitted to Warrington and Halton Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust.
- An understanding of the role that all agencies (both statutory and voluntary/community sector) play in the discharge planning process.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to Discharge Planning processes to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.

Which of Halton's 5 strategic this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member led scrutiny review of Discharge Planning and associated processes/pathways.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council/Health Services and partner agencies to examine current processes/provision.
- Desk top research in relation to national best and evidence based practice.

Agreed and signed by:

PPB chair ……. **Officer …….**

Date …… **Date ……**

Appendix 2

Health Policy and Performance Board Scrutiny Topic Group – Discharge from Hospital

Visit to Warrington Hospital

9th September 2015

Attendees	
Councillor Joan Lowe	
Councillor Stan Hill	
Councillor Charlotte Gerrard	
Councillor Martha Lloyd-Jones	
Damian Nolan	Divisional Manager, Urgent Care.
Debbie Downer	Policy Officer, People & Economy

A number of the Scrutiny Topic Group, focusing on Discharge from Hospital, made a planned visit to Warrington Hospital with a view to gaining an insight into hospital discharge and what processes are in place to support vulnerable people with complex care needs.

The visit was facilitated by the Divisional Manager, Urgent Care. The group had a tour of the Discharge Lounge and spoke with Dawn Forrest, Associate Divisional Director Unscheduled Care and a number of staff from the Discharge team.

The visit was 2 hours in duration.

The report below summarises the facilities, key findings of the group and feedback from a patient in the Discharge Lounge who spoke to one of the Councillors.

Background

Dawn Forrest welcomed the group and Councillor Joan Lowe provided an overview of the Scrutiny Review Topic Group. Dawn Forrest briefed the group on the background of the Discharge Lounge and STAR (Short Term Assessment & Rehabilitation) unit, which was commissioned as a result of challenges which Warrington Hospital was experiencing.

Discharge Processes

DF gave an overview of improved outcomes as a result of an increase in therapy on the ward which focussed on moving patients towards independence as part of the discharge process. Weekly MDT meetings include medical staff, OT's and Social Workers.

The Discharge process starts from admission and has separate pathways by condition (Stroke, Heart Attacks, Frail/elderly) and includes preventative work to prevent readmission. Visiting times have been extended to make it easier for families

to be present when discussions/assessments are taking place so they are involved in the decision making process. Care is taken to ensure patients are at the centre of the process, and not just a focus on medical needs. Patients are also signposted to voluntary agencies (such as Red Cross) who provide services to people once they are home from hospital. Red Cross are based in A&E at Warrington Hospital and are currently working to identify vulnerable people who have a high risk of re-admission.

A recent new initiative (Quality Ward Round) is a Nurse-led Ward Round where a Nurse accompanies the Doctor after prioritising the patients who are due to be discharged. Ongoing work to improve 21 day delayed discharge will be helped by the move to Lorenzo (electronic records) which will help to reduce duplicate paperwork.

Discharge Lounge Facilities & Services

The group were taken to the Discharge Lounge in the Daresbury Wing which is a dedicated facility with its own entrance and carpark. The unit was bright and modern with a spacious entrance and level access to a drop off zone immediately outside the main doors. There is a comfortable discharge lounge and a number of private ensuite rooms (single sex) to accommodate bedbound patients. Staff are on hand to provide refreshments, hot drinks and hot/cold meals. Staff also book taxis and ambulances, provide support and information on medication and a 'going home' food package if needed (free of charge).

Monday and Friday are busy times and this is monitored so additional staff can be put in place if needed. Each day at 2pm, there is a staff meeting to assess caseload.

Emerging Issues

A member of the Health PPB raised concerns about delays in hospital discharge due to medication and problems where the person's GP was not notified that they had been discharged.

Warrington hospital has recently moved to electronic discharge and if medication is required, this is now flagged up and Pharmacists (who have specialities such as respiratory) work alongside ward staff to focus on the medication requirements of discharge to ensure this doesn't cause delays. Pharmacists are also able to provide training to patients on how to use inhalers. In the pharmacy, a tracker system highlights patients who are being discharged and these prescriptions are given priority to ensure beds are freed up to prevent A&E delays. Patients are also given the choice to go home without medication if not essential and they are able to reach a pharmacy independently once home.

If there is a delay, Discharge Lounge staff continues to care for the patient until a transfer is arranged, via private ambulance if necessary. The improvements in loading times (down to 30 minutes) through better accessibility (drop off zone) meant more ambulances were available thus reducing delays.

The new Discharge Lounge can accommodate patients with complex care needs/Dementia, whereas in the past they would have been kept on the ward. A single room is reserved for patients who need additional support and there is also a room in A&E for Mental Health patients which is safe/secure with a psychiatric liaison team on call. This team's brief has now been extended to ITU and to support Dementia patients.

There is a new post to work with the Halton Integrated Discharge team to identify and focus discharge to care homes. There have been issues where Care Homes are reluctant to re-admit residents whose needs have changed whilst in hospital. There have also been issues where residents have been admitted who are end of life (particularly DNA CPR) and Care Homes could do more to assess resident's health to avoid unnecessary distress in moving a resident at this stage. Patients who are end of life are sometimes discharged at night, with the family's support and agreement and the Discharge Team work closely with NWAS/private ambulance to facilitate a fast track discharge.

Feedback

A member of the Health PPB spoke to a patient in the Discharge Lounge who is a Halton resident who commented that he had been looked after very well and that the food was really good.

Overall Findings

The group were impressed with the discharge lounge facilities at Warrington Hospital and it was clear that there have been beneficial changes made to the discharge process which have contributed to improved outcomes.

After speaking to Managers and Nursing Staff, the group could see that there was a clear commitment to providing a quality patient-centred service and a continued focus on improvement moving forward.

Feedback from a patient who was in the Discharge Lounge was very positive.

The layout of the unit was patient centred with an emphasis on privacy and dignity.

Appendix 3

Health Policy and Performance Board Scrutiny Topic Group – Discharge from Hospital

Visit to Whiston Hospital

23rd September 2015

Attendees	
Councillor Joan Lowe	
Councillor Stan Hill	
Councillor Pamela Wallace	
Damian Nolan	Divisional Manager, Urgent Care.
Debbie Downer	Policy Officer, People & Economy
Apologies	
Councillor Margaret Horabin	
Councillor Sandra Baker	

A number of the Scrutiny Topic Group, focusing on Discharge from Hospital, made a planned visit to Whiston Hospital with a view to gaining an insight into hospital discharge and what processes are in place to support vulnerable people with complex care needs.

The visit was facilitated by the Divisional Manager, Urgent Care. The group had discussions with Jenny Farley, Interim Deputy Director of Operations and Rob Cooper, Assistant Director of Operations followed by a tour of the Discharge Lounge and the Frailty Unit. The visit was 2 hours in duration.

The report below summarises the facilities, key findings of the group and feedback from a patient in the Discharge Lounge who spoke to one of the Councillors.

Background

Jenny Farley welcomed the group and Councillor Joan Lowe provided an overview of the Scrutiny Review Topic Group. Jenny Farley commented on how impressed she was regarding the Integrated Discharge team at Whiston and how beneficial they were for complex discharges. JF described the two different types of discharge – complex and standard.

Discharge Processes

JF described how the conversations about discharge begin on admission and it is very quickly established if help will be needed at home. Where the Integrated Discharge Team was involved in the process it worked very well, and JF was working with Francesca Smith to raise staff awareness of the team to broaden their reach. There are dedicated discharge co-ordinators outside of Nursing resources.

Family were involved in the conversations and signposting to voluntary groups was provided. Rob Cooper stated that this worked very well at Wirral and could be improved at Whiston. (Age UK are a relatively recent presence at Whiston).

Rob Cooper confirmed that nursing and support staff administer meds and provide fluids/food. Specialist MH Social Workers support people with MH problems and there was a Liaison Psychiatrist based in A&E. Dedicated dementia staff were alerted on admission and focussed on whether the patient was newly diagnosed or if they already had a package of care either in the community or at home.

Assessments are prioritised for people being discharged to care homes as this group of patients often experience delays when finding a suitable bed and liaising with family on home of choice. The choice of care homes offered depends on the person's needs and condition – the Integrated Discharge Team tailor choices to the needs of the patient.

A member of the HPPB queried how soon are family informed about costs as this could potentially cause extra worry and stress. RC confirmed that information is provided as part of the discharge process by the Integrated Discharge Team. The financial assessment is done at home, to minimise the length of time in hospital.

RC confirmed that recent improvements to processes between Discharge teams and Pharmacy has resulted in a reduction in the time (to under an hour) between when drugs are dispensed and handed to the patient. Delays do sometimes happen, usually if discharge is later on in the day. Pharmacy technicians are working with nurses on the ward (being piloted at the moment) to reduce delays.

JF confirmed that Respiratory Nurses were on hand to support and provide training.

A member of the HPPB outlined the case of a patient was discharged without anti-coagulant medication (Warfarin) who subsequently died and asked how Whiston informs GPs on discharge and medication. RC confirmed that Whiston has electronic discharge, however if the letter needs to be taken to the GP, it prints out in red.

Discharge Lounge Facilities & Frailty Unit

The group then moved onto the Discharge Lounge and the staff provided an overview of the processes used. Patients who still need a high level of nursing care stay on the ward as there are not suitable facilities to support them in the discharge lounge. Patients can also use the day rooms located near the wards. The lounge is also used by patients who are waiting for a bed, transport or medication. The unit is not open at weekends or Bank Holidays.

The visit continued into the Frailty Unit. Age UK (St Helens) are newly established in the unit and staff also refer to Sure Start to Later Life. The information board showed a range of areas where patients come from and those who had carers were identified to enable staff to provide extra support.

The ethos of the Frailty Unit was to ensure people were not on the ward for longer than 72 hours and to identify patients who can go home quickly. A medical assessment unit for the elderly includes medical/functional skills for those who have had a prolonged stay in hospital and have lost independence. The assessment aims to reduce levels of readmission. Visiting times are flexible to enable family to visit at times when the consultant is present and for them to be involved in assessments.

Patients are provided with a going home food parcel if needed.

Conclusion

JF explained how reductions in the number of beds had impacted the hospital and when there was a shortage of beds, people were sent out of the area.

RC outlined that the biggest challenge in delayed discharge was changing the perception of families who feel the safest place for their relative is in hospital. In reality they are more at risk of infection and a loss of independence.

There was an opportunity to further enhance the support provided by the voluntary agencies at Whiston, around signposting and information with charging. Information/signposting could be provided in the information leaflet given to patients on admission regarding discharge. This would help people move back to independence and improve patient experience. Age UK (St Helens) are newly established in Whiston (Tuesdays) and could assist Age UK (Halton) to also make connections.

The group were impressed with the Frailty Ward at Whiston Hospital and after speaking to Managers and Nursing Staff, the group could see that there was a clear commitment to providing a quality patient-centred service and a continued focus on improvement moving forward. In particular, the group were very pleased to see that Carers were identified and supported. A home visit bag was also noted, which contained helpful items for staff when they were doing home visits.

A copy of information provided to patients is included in appendix 5.

OTHER USEFUL HOSPITAL NUMBERS

MAIN NUMBERS:

The main hospital switchboard number is **01925 635 911** which can put you through to both hospital sites 24 hours a day.

Pharmacy Medicines hotline **01925 662238** (Mon-Fri 9am-5pm) can provide advice and information on taking medicines given to you.

Giving us feedback on our services

We are always grateful for your feedback on our services. If you have the time please complete the friends and family test card if you are given one during your stay. Alternatively you can leave feedback on the NHS Choices Website – **www.nhs.uk.** Just search for our hospitals and you can provide feedback that way.

Thank you

Leaving Hospital

Our patient information reference: pinfo 2014_08_02. Ratified: August 2014. Review date: August 2016
Authors: Hospital Discharge Service.

Warrington & Halton Hospitals NHS Foundation Trust
Lovely Lane, Warrington, WA5 1QG
Main switchboard: 01925 635 911
E-mail: enquiries@whh.nhs.uk

Find out more about Warrington and Halton Hospitals and the services we provide at:

www.whh.nhs.uk

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Leaving Hospital

Information for patients, relatives and carers.

Contents

INTRODUCTION

This booklet is designed to help us plan your discharge from hospital. It explains the different services you may need and arrangements that can be made to support you when you leave.

Keep it with you in hospital and following discharge. There are checklists and blank pages in order to note services that have been arranged and things that you want to discuss with your ward team.

There is also a list of telephone numbers which you may find useful.

Thank you.

WHEN WILL YOU LEAVE HOSPITAL?

If your stay in hospital was arranged in advance, your consultant or nurse may have already explained how long you may stay and given you an **expected discharge date**.

If you are admitted as an emergency, within 48 hours into your stay we will inform you of your **expected discharge date.** This date may alter during your hospital stay and if you are well enough before this date you may be discharged earlier - we will, of course, discuss this with you.

When planning your discharge, your ward team will ask you about the situation at the address to which you will be going, agree what transport arrangements need to be in place for you to go home and who will take you home and will also discuss the care available. If needed there are a variety of services available to support you on discharge.

Please let the ward team know of any problems you think you may have.

Leaving Hospital checklist

What is my estimated date and time for going home?		
How will I be getting home?		
Name of family member/friend/carer who is to be contacted?		
Please tick when family member/friend/carer has been contacted		
Will I be using the discharge lounge when leaving the ward?	Yes	No
Did I bring any of my own medications and do I need them to take home?	Yes	No
Has the medication I am taking home been explained to me?	Yes	No
Do I need a sick note?	Yes	No
Do I need assessment by a social worker?	Yes	No
Do I have the contact names and numbers for any services arranged and when I expect to be visited?	Yes	No
Have I got everything in place for me to be discharged e.g. keys, food, valuables, dressings, equipment?	Yes	No
Do I need a follow-up appointment with the hospital?	Yes	No
Do I need any information leaflets about my treatment?	Yes	No

WHAT YOU WILL BE GIVEN ON DISCHARGE

MEDICINES

If you brought medications in, these will be returned to you if it is safe to do so. You may be given more medication when you go home. The pharmacist or nurses on the ward will explain any instructions that you need to follow. Further prescriptions should be obtained from your GP.

DISCHARGE SUMMARY

This is a letter giving details of your hospital treatment and discharge medications; a copy will be sent to your GP and you will also be given a copy. Keep it to show to anybody involved in your care.

The Ward Team will complete a discharge checklist and a discharge card. You will receive a copy of these on your discharge. On the discharge card there are numbers which may be useful to you.

EQUIPMENT

You may be given hospital equipment to take home, e.g. a walking stick or a frame, a feeding pump or machine.

SUPPLIES

A short-term supply of items you will need at home may be provided, eg stoma or catheter bags, dressings or syringes and needles. Once at home further supplies must be obtained by you. The hospitals staff will give you contact details and instruction about what you need, when, and how to get them.

WHAT WILL HAPPEN ON THE DAY OF DISCHARGE?

The aim is for you to leave the ward by 10am.

It is expected that patients will make their own travel arrangements when they leave hospital. Please ensure that if you feel you are unable to travel alone you have someone to accompany you.

In exceptional circumstances hospital transport is available following discussion with the ward team.

Hospital transport can only take you, and one bag/suitcase. Please make alternative arrangements to take any extra personal property.

Please tell us about your stay by using the friends and family test card that is available on the ward. It will help us to continue to improve the quality of our patient care.

WHAT IF I AM PICKED UP AFTER 10AM?

At times when the discharge lounge is operational, the ward team may arrange your transfer to the Discharge Lounge. Refreshments are provided here. Any medicines that you are waiting for can also be delivered to you here.

DISCHARGE PLANS

Together with the ward team, plans will be made regarding your care requirements. This will include clinical management in relation to your EDD (expected date of discharge)

You will be transferred from hospital when your Consultant led ward team decide that you are clinically ready to leave hospital and you no longer require a hospital bed.

Below are examples of services you may require when you leave hospital:

1 Home with community support:
A range of community health and social care services can be provided to support you in your own home including district nursing, community matrons, case management and home-based rehabilitation programmes.

2 Community bed placements:
These beds will be in a local nursing or care home and will be for you if care in your own home is not feasible at the time you no longer require a hospital bed.

Please alert the ward team of any problems that you may have prior to discharge.

VISITORS AT HOME

District nurse: District nurses are qualified nurses with additional training to nurse you at home. They work closely with your GP to support your care at home.

Community matron: If you have a chronic condition, a community matron may visit you at home to co-ordinate the care you need. They will help you monitor and self-manage long-term conditions and help you to avoid a crisis.

British Red Cross – Support at Home Service:
This service provides free short-term support in the home for people after discharge from hospital. The British Red Cross can help with grocery shopping, collecting prescriptions, collecting pensions and paying bills, safe and well checks, confidence building, signposting onto other relevant organisations as well as support for carers who may need a few hours break. Please discuss further with your ward team or contact the British Red Cross direct on

- Warrington: **01925 662 688**
- Halton: **0151 424 7873**

USEFUL CONTACT NUMBERS

Age UK	**01925 639018**
Alzheimer's Society	**0151 420 8010**
Attendance Allowance & Benefits Helpline (Freephone number)	**0800 882200**
British Red Cross Mobility Aids. Loan of wheelchairs, commodes etc.	**01565 682 317**
Cheshire Fire & Rescue Service - Home fire safety checks	**01925 662 688**
Diabetes UK Helpline	**0845 120 2960**
Disabled Living Foundation	**0870 603 9177**
Halton Adult Social Care Team	**0854 0500 148**
Halton Carers Centre	**01928 580182**
Hospital Patient Transport Ambulance Service. Ring 48 hours before appointment time.	**0800 032 3240**
Pension Credit (Over 60-Freephone number)	**0800 991234**
Stroke Association	**0845 3033 100**
Warrington Adult Social Care Team	**01925 444239**
Warrington Sensory and Telecare Services Team	**01925 443979**
Wired Adult & Young Carers Services	**0800 731 6941**

Useful Websites and documents:

Warrington & Halton Hospitals NHS Foundation Trust
www.whh.nhs.uk
The trust's own website provides information on our hospital services and a range of patient and visitor guides that may be useful to you – as well as ways of providing your feedback after your stay with us.

ONCE HOME – WHAT IF?

What if the district nurse does not arrive?

A: Contact your GP surgery which will advise on a 24-hour number.

What if I need more dressings?

A: Ring the GP surgery or district nurse who can ensure you receive a supply.

What if my feed does not arrive at home?

A: Contact the home enteral feeding company.

What if my recovery is not going as expected?

A: Contact your own GP or call NHS 111 which is free of charge to call at any time of day & night – 7 days a week, 365 days a year.

What if my medication supply is running out?

A: The hospital pharmacy will usually give you at least a short supply of medications. Contact your GP surgery for further supplies of medications.

THIS PAGE IS FOR YOU TO WRITE DOWN NOTES, QUESTIONS OR OTHER CONTACT NUMBERS OF *SERVICES THAT YOU MAY NEED:*

If you have any worries or concerns about your care or treatment following your discharge from hospital; you may want to contact the ward team for advice

Your stay in hospital was on:_____

The direct dial number for this ward is:_____

The ward manager is: _____

The ward manager works shifts: please contact the ward and ask to speak to the nurse in charge.

The matron for this ward is:_____

If you are still concerned please contact your GP or telephone **NHS 111**

If you need this booklet in another format – for example, large print, Braille or a language other than English – **contact the PALS office on 01925 275512**

What will happen on the day I am discharged?

- We will aim to discharge you before midday.
- You may need to be prescribed medication to take with you when you are discharged. This will be requested by your doctor and prepared by the Pharmacy staff.
- You will need to arrange your own transport from the hospital, unless you meet the criteria for an ambulance. This will be arranged by the ward staff.
- You may be escorted to the Transfer Lounge to wait for your transport and for any medication.
- Alternatively, you, or a relative or friend, may wish to return to the ward you were on later in the day to collect your medication.

If you need this information in any other language or format, please ask the nurse who is looking after you to contact the Patient Experience Team on T: 0151 430 1376 www.sthk.nhs.uk

Created by: Medical Care Group
Date: January 2015
Review Date: December 2015

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Planning your discharge from hospital

Welcome to St Helens and Knowsley Teaching Hospitals NHS Trust.

We aim to provide '5 Star Care' every time you are in hospital. The staff will make every effort to make your stay as comfortable as possible, ensuring you leave hospital safely and as soon as you are well enough.

If you or your family/carers would like to ask any questions about your care or if you have any concerns, please raise them immediately with the nursing staff on the ward.

Getting you ready for home

- The length of time you spend in hospital will depend on the care and treatment you need.
- The staff in the hospital will talk to you and your family/carers throughout your stay about what you may need on discharge. These discussions will start on the day you are admitted to hospital.
- They will also let you know how long they think you will be in hospital and what date they think you will be ready to leave. This is called your **Expected Date of Discharge**. This date may change during your time in hospital depending on the treatment and tests you need.
- Other people such as social workers, therapists and district nurses may also be involved in your discharge planning.
- Some patients may need some extra help to recover from illness. This is called rehabilitation.

What do we need to know?

- Were you receiving any help at home before you came into hospital? This help may have been from social services, private carers, friends or family.
- Will you need any help when you go home or any equipment to assist you?
- Are the people who care for you available to help with your discharge planning?
- There may be a number of things that need to happen before you can be discharged from hospital to make sure that you are safe.
- **If there is going to be a delay in you leaving hospital of more than 48 hours, the Trust may transfer you to an out of hospital placement to wait for your discharge arrangements to be put in place.**

Care Home placements

- You might be leaving hospital to go into a care home.
- If you have selected a care home but there are no places available at the time of discharge, you may be looked after in another care home, until a place is available in your chosen home.
- If you or your family/carers have not selected a care home, you may be looked after in another care home temporarily to give you and your family more time to look.
- A member of the Trust Integrated Discharge Team will support you and your family/carers through this process and will keep you involved and fully informed at all times.

Your Comments / Concerns

If you have any compliments, comments or concerns about the Patient Transport Service then please telephone: **0345 112 6500** and speak to one of the Making Experiences Count team.

If you require any further information about the PTS, or would like to view our Patient Charter please visit: **www.patienttransport.nwas.nhs.uk**.

The Patient Transport Service can be contacted by telephoning freephone: **0800 0323 240*** or for mobile phone users telephone:

- Patients living in the Mersey area telephone: **0151 261 2580**
- Patients living in the Lancashire area telephone: **01772 904 919**
- Patients living in the Cheshire area telephone: **01244 651 311**
- Patients living in the Cumbria area telephone: **01228 403 064**

For haemodialysis and cancer patients, please telephone freephone: **0800 0289 224*** or mobile phone users telephone:

- Patients living in the Mersey area telephone: **0151 261 2581**
- Patients living in the Lancashire area telephone: **01772 904 919**
- Patients living in the Cheshire area telephone: **01244 651 311**
- Patients living in the Cumbria area telephone: **01228 403 064**

*some mobile phone providers may charge you to telephone a freephone number.

Please refer to individual mobile service providers for information on call charges.

The Patient Transport Service can also be contacted by emailing: **pts@nwas.nhs.uk**.

Contact Us

Your opinions are important to us. If you have any views about this document or if you would like to receive this document in large print, braille, on audio tape, or in an alternative language to those shown below, please contact us.

Arabic
اذا كنت تحتاج لهذه الوثيقة بلغة اخرى او بشكل آخر يرجى الاتصال بنا

Chinese
如果您需要本文件任何其它语言或格式的文本，请直接与我们联系。

Gujarati
જો તમને આ દસ્તાવેજ બીજી કોઈ ભાષા કે સ્વરૂપમાં જોઈતો હોય, તો કૃપા કરીને અમારો સંપર્ક કરો.

Polish
W celu otrzymania niniejszego dokumentu w innym języku lub formacie, należy się z nami skontaktować.

Somali
Haddii aad ku rabto xaashadan luqad ama qaab kasta oo kale fadlan nala soo xidhiidh.

Urdu
اگر آپ کو یہ دستاویز کسی اور زبان یا فارمیٹ میں درکار ہو تو ہم سے رابطہ کریں۔

Trust Headquarters

Ladybridge Hall, Chorley New Road, Bolton, BL1 5DD Minicom: 0151 260 8628
Email: nwasenquiries@nwas.nhs.uk Website: www.nwas.nhs.uk

Photography courtesy of Jason Locke

For further information visit the website, email or call

0845 112 0 999 (charged at local rate)

www.facebook.com/nwasofficial

www.twitter.com/nwambulance

North West Ambulance Service NHS
NHS Trust

Delivering the right care, at the right time, in the right place

Patient Transport Service
Information for Patients

You can ask to use the Patient Transport Service (PTS) if you have a medical or clinical condition which may stop you getting to your appointment by any other means. The service provides transportation for appointments between 08:00 hrs and 18:00 hrs, Monday to Friday (excluding Bank Holidays)*.

*If you are a haemodialysis patient or a patient receiving treatment for cancer, please speak to the hospital you are receiving treatment at to find out their specific operating times as these do vary.

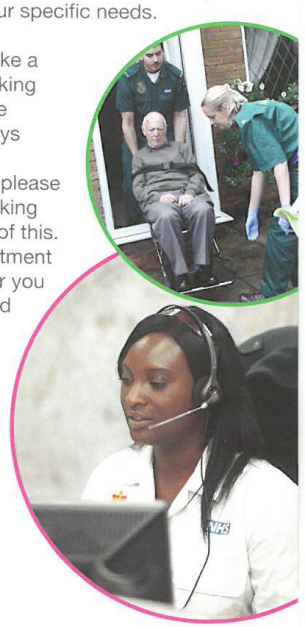
Booking Transport

The clinic you are attending may book transport on your behalf. If not, you may need to ask your GP or clinic to provide you with the telephone number of where you can book your PTS.

Staff will ask you some simple questions to make sure you are eligible to use the service. You will need your NHS number to hand to make a booking and it is available from your GP.

Please make the call taker aware of your mobility and any additional needs you may have, so the right type of transport is provided for you. We can also provide special aids such as our Pictorial Handbook for patients who are hard of hearing or who experience language barriers. In order to help you, we need to be fully advised of your specific needs.

If you would like a transport booking reminder to be provided 3 days before your appointment, please make the booking centre aware of this. If your appointment is cancelled or you need to amend your booking e.g. you only require transport home, please let the booking centre know as soon as possible.



If you require haemodialysis treatment, then you will be assessed by your relevant unit/clinic before commencing your treatment and then re-assessed every six months to ensure you still qualify for hospital transport. If you are a cancer patient, you will be assessed every three months by your clinic. Once you have been assessed, you do not have to book any transport yourself; this will be done by the staff at the unit or clinic you attend.

Your Mobility

We provide a range of vehicle types and levels of care appropriate to your medical needs to ensure that you travel as safely and comfortably as possible. **It is important to make the call taker aware of your mobility and any additional needs you may have** (including walking frames, wheelchairs, steps at your home address), so that the right type of transport can be provided for you.

Escorts

If you have a physical or mental incapacity you may be entitled to take an escort and you should mention this to the booking centre. The escort may be either a professional, a relative/carer or a guide/hearing dog and their attendance is subject to meeting the assessment process mentioned above. Only one escort can travel with you on your journey.

Patients under the age of 16 must be accompanied by an adult.

Before You Travel:

- If you have been given an appointment card or letter please show it to the ambulance crew and bring details of any medications that you need with you.
- Please be aware that you may be away from home for a number of hours. It is a good idea to bring with you a packed lunch, a drink, a newspaper or book to occupy yourself with and any medications that you may need during the day.

The Journey to Hospital/Clinic

- **Please be ready to travel at least 90 minutes prior to your appointment time. When possible, we will give you a more specific estimated collection time at the point of booking.**
- Please note that you may not necessarily have a direct journey to your destination. The vehicle you travel to your appointment in may have to collect other patients who are attending the same hospital as you or other hospitals in the surrounding areas.
- We are committed to respecting and maintaining the dignity of all our patients.
- Please remember there may be both male and female patients on the vehicle and ensure you are appropriately dressed to travel, particularly in cold weather.
- When you arrive at the hospital, we will escort and book you into the clinic you are attending.

The Journey Home

- Once you have finished your appointment please tell the clinic that you have travelled with the Patient Transport Service and that you are ready to go home. The nursing staff will notify the PTS that you are ready and where you will be waiting for collection.
- You may have to wait for other patients who are scheduled to travel on the same vehicle that has been planned for your return journey.
- When you reach your homeward destination the transport staff will escort you to your front door and make sure you are safely inside before leaving. Transport staff members are not allowed to drop you anywhere else other than the address supplied at the time your ambulance was booked.

Quality Standards

- **Appointments** - We are contracted to ensure that 90% of all patients will arrive no more than 45 minutes early or 15 minutes after their actual appointment time. If you do arrive prior to your actual appointment time, you may still have to wait until your scheduled time to be seen by a doctor. However, if you arrive up to 15 minutes after your actual appointment time, please do not worry - you will still be seen by the doctor.

  If you are attending for haemodialysis or cancer treatment, we are contracted to ensure that 90% of all haemodialysis and cancer patients will arrive within 30 minutes of their appointment time.

- **Returning Home** – Once your appointment is finished and we are notified that you are ready, we aim to collect 80% of patients within 60 minutes and 90% within 90 minutes.

  If you have attended for haemodialysis or cancer treatment, we aim to collect 85% of patients within 60 minutes and 90% within 90 minutes of being notified that you are ready to travel home.

Appendix 7

NWAS PTS Training Syllabus

	Classroom Sessions	Workbook Topics
Subjects	• Oxygen Therapy • Basic Life Support • Resilience • Conflict Resolution Training – Practical • Prevent • Proportional Response • Non-emergency Driving • British Sign Language • Information Governance • Moving and Handling Equipment - familiarisation and demonstration • Moving and Handling – practical • Safeguarding/Moving and Handling/Risk Assessment Scenarios • AED Familiarisation • Patient Experience	• Security • Fire Safety • Infection Prevention & Control • Hazards, Risk Assessment and Decisions • Manual Handling • Slips, Trips and Falls • Patient Report Forms • Information Governance • Resilience (Major Incidents) • Equality and Diversity • Dignity at Work • Communication and Conflict Resolution • NHS Protect (Fraud) • Corporate Governance • Psychosocial Resilience • Alzheimer's and Dementia • Patient Experience • Duty of Candour • Safeguarding

All staff undertakes mandatory training annually through a combination of workbook exercises and classroom sessions.

Appendix 8

Health Policy & Performance Board (PPB) Scrutiny Group – Discharge from Hospital

Visit to Castlefields Health Centre, Village Square, Castlefields, Runcorn

Monday 23rd November 2015, 1:00pm – 2:00pm

Present:
Councillor Joan Lowe, Chair, Health PPB, Halton Borough Council (HBC)
Councillor Stan Hill, Vice-Chair, Health PPB, HBC
Councillor Pauline Sinnott, Health PPB Member, HBC
Damian Nolan, Divisional Manager, Urgent Care, HBC
Natalie Johnson, Policy Officer, HBC
Dr David Lyon, GP, Castlefields Health Centre
Maria Stacy, Practice Manager, Castlefields Health Centre
Angela Furnival, IT Manager, Castlefields Health Centre
Sarah Stenson, Health & Safety Officer/Admin Support, Castlefields Health Centre

Notes of the discussion:

There were introductions around the room and Cllr. Lowe explained the purpose of the visit in connection with the Health PPB's Discharge from Hospital Scrutiny Topic, which commenced around June of this year and has involved visits to hospitals and presentations from various services. At the last meeting, Dr Mick O'Connor invited the group to visit a GP surgery to find out more about the information that is transferred between hospitals and GP surgeries. Members of the group are also visiting Beaconsfield Surgery in Widnes on 3rd December.

Cllr. Lowe also explained that a report on the findings will be prepared (including the information shared at today's visit); it will also include recommendations for improving practice. Those present today will have the opportunity to view the report before it goes to Health PPB, Executive Board and Full Council for approval.

Question: What works well and what issues/opportunities for improvement are there in terms of exchanging information between general practice and hospital?

Maria explained that there are problems communicating with hospitals at times. Maria provided an example of on occasion where a clinician was working late and needed to provide some information to a hospital re a patient that would be admitted. Initially, there were difficulties even getting through to the ward and once the call was answered, there was no way of transferring the information about the patient as the ward's fax was broken and they could offer no alternative communication method (e.g. email).

Simple measures to improve this process could include having contact numbers for wards (due to issues with going via the main switchboard), with someone taking responsibility (e.g. ward clerks) for answering calls in a timely manner. It was acknowledged that wards probably receive calls constantly from various people, including worried relatives; perhaps there should be a separate number for professionals to use to ensure clinical information can be shared.

Question: What does general practice look like on a day-to-day basis/how does it run?

Copy of organisational structure provided – see Appendix A.

There are around 12,000 patients.

Currently in the process of splitting the reception team into two – one for dealing with appointments and the other for prescriptions.

As well as GPs running appointment based clinics, there is also a GP based behind reception each day to provide a triage service. The receptionist will take brief information from the patient and the GP will call back.

Mondays are characterised by responding to the backlog generated over the weekend.

Question: How does information come into the practice from hospitals?

Information comes in via EDT – Electronic Document Transfer – or in a paper-based form.

Warrington, Halton, Whiston and St Helens Hospitals all use EDT.

EDT displays information such as 'There are X documents waiting to be seen' along with a description of the type of document (e.g. outpatient letters).

Practice staff will then attach the document to the relevant patient record and send to their GP and this also automatically links in with EMIS (electronic patient record system/software used by GPs) using date of birth / NHS number.

There is no-one dedicated for dealing with medication following discharge from hospital but there are plans to establish Prescription Clerks within the practice and they will be trained by GPs to assist with medication changes etc. following discharge from hospital. This will help to reduce the amount of work for GPs.

Commonly finding that information is coming from hospitals with an instruction for a patient to start medication in, for example, two weeks but this information is not received until the two week period has passed.

Also, hospitals/out-of-hours may ask a patient to contact their GP following a visit over the weekend – the patient will think that the practice receives the information immediately but that is often not the case.

Question: What is the process for dealing with any follow-up care required after discharge from hospital, e.g. if the patient requires district nurses?

There is a process separate to GP practices for district nurses – the ward will contact the district nurses directly.

Question: What would improve the communication process from hospitals?

Dr Lyon explained that there is some current discussion between Doctors, the Royal Colleges and the BMA (British Medical Association) that the clinician who orders a test should be the one to follow it up. Therefore, it is bad practice for hospitals to be asking GPs to follow up with patients.

With the above in mind, an agreed set of principles would be of assistance, which should include the requirement for consultants to follow up on any tests they have requested, in line with agreed good practice.

Speed of communication would also be another basic principle and this could be addressed by enabling the different systems used by hospitals/GPs to link in with one another. There is some software that would achieve this – the Multi-Interface Gateway (MIG). There is money set aside for this and the Scrutiny Group received a presentation on this software during one of the earlier meetings.

Another issue that creates delay in the communication process is the fact that consultants dictate their letters onto voice recorders and then this is typed into a letter by the secretarial teams. However, there have been devices available for some time that can be talked into and will automatically generate an electronic document, which is simultaneously displayed on screen.

The ICE system for requesting tests and recording results (e.g. CT scans, pathology) was discussed – GPs can link into this and often access the information before the consultant – why can't letters be transferred this way also?

It was noted that Warrington Hospital will be implementing the 'Lorenzo' system which will speed up the transfer of information but realistically it will be 12 months before this is fully functional.

Currently, there is information coming into the practice from Warrington that is not very detailed – it has date of admission, date of discharge and the text says that a summary cannot be produced at this time. Therefore, practice staff cannot identify what the patient has been in for etc. and cannot send this information onto the GP; it is simply filed. IT Manager will check if there is any information included such as ward/consultant etc. *Update following the visit – ward/consultant information is included but there are no medication details, therefore, the practice cannot make use of this information and question the purpose of it being sent. See anonymised example included at Appendix B.*

There was some discussion around the volume of paper generated – a patient can present with one issue, first to a walk-in centre, then they may be transferred to A&E, then to EAU (Emergency Assessment Unit) and finally they may be admitted to a ward – this would generate at least four pieces of paper. It was questioned if all would be classed as admissions, are we getting a true picture?

Ultimately, the solution is IT and relevant information being fed in to the systems put in place.

Question: What is communication like from the walk-in centres?

The practice receives information the following day – may be later in the day and the patient will often get in touch first thing (they may, however, be misinterpreting the instruction from the walk-in centre in terms of when they should contact their GP).

It was noted that walk-in centres are successfully dealing with most issues without the need for onward referral to A&E.

Question: When does communication work well and why?

It works well when information is received quickly and in a typed format so it is readable.

Practice in Poland was discussed as an example where the patient is given a copy of everything that their GP will need following a visit to hospital. **Question – would such practice work here as an interim measure whilst IT systems were being implemented?**

It is possible that this would be a good way of reducing delay, especially in terms of medication following hospital discharge.

The Government wants the public to have access to their records so involving them is a positive thing and anything that empowers them to take responsibility is good because the level of trust people have in the NHS can sometimes mean they don't question inevitable glitches in the system.

It was noted that hospitals still have a lot of paper records, whilst in the practice everything has now been scanned so is in electronic form, even historical records.

Question: What is the process for people in nursing homes?

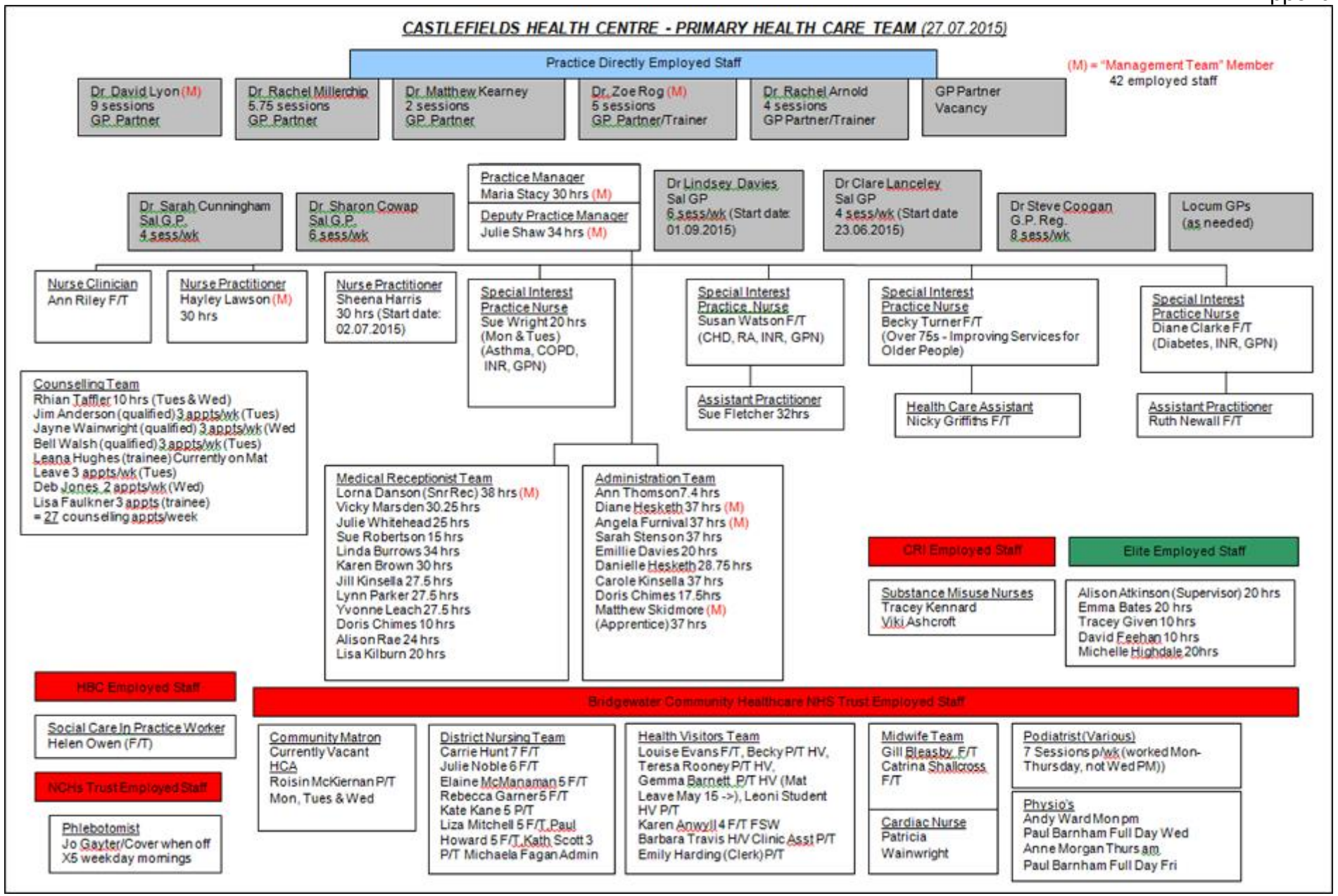
From a practice perspective, it is the same as people in nursing homes are patients in the same way as those not in nursing homes. Regarding medication, nursing home staff should get information as they have strict rules to abide by in this respect.

There are glitches in the practice receiving information following someone staying in a rehab unit – e.g. information may be received re admission but not discharge.

End of discussion.

On behalf of the board, Joan thanked the practice staff for their valuable time.

CASTLEFIELDS HEALTH CENTRE - PRIMARY HEALTH CARE TEAM (27.07.2015)



Appendix B

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Discharge Summary - GP COPY

10 November 2015

GP Name: [redacted] GP Address: Castlefields Health Centre The Village Square Castlefields Runcorn WA7 2ST GP Nat Code: [redacted] Practice Code: N81019	Patient Name: [redacted] Patient Address: [redacted] Dob: [redacted] Hospital No: [redacted] New NHS No: [redacted]

Ward: [redacted] **Consultant:** [redacted]

Admission: 03/10/2015 **Date of Discharge:** 04/11/2015

Dear [redacted]

Your patient has recently been discharged from our hospital.

It has not been possible to provide you with medication details for this admission.

If applicable, medication details will follow in a letter provided by the consultant.

Kind regards

Warrington and Halton Hospitals NHS Foundation Trust

Appendix 9

Hospital Discharge Scrutiny Review 2015/16

Beaconsfield Surgery Visit, Thursday 3rd December 2015. 3pm-4.30pm

In attendance:

Councillors:
Joan Lowe
Stan Hill
Charlotte Gerrard
Sandra Baker

Halton Borough Council Officers:
Damian Nolan – Divisional Manager
Emma Bragger Policy Officer (note taker)

Beaconsfield GP Surgery Staff:
Dr Mick O'Connor - GP
Diane Henshaw – Practice Manager

The group attended a visit to Beaconsfield Surgery, Widnes, to gain insight into the hospital discharge process from the view point of general practice, looking at how patients are discharged to general practice and the role of the GP.

The visit was facilitated by Dr O'Connor and Diane Henshaw, to which Cllr Lowe extended thanks on behalf of the group for the opportunity to visit the practice and for their time.

Hospital Contract Key Performance Indicators (KPIs)
Dr O'Connor explained to the group that the hospitals have KPIs around discharge from A&E, Ward and Clinic – these KPIs are facilitated by the use of electronic discharge (E-discharge) in some cases.

Whiston & Warrington Hospitals have a target of 90% of discharge communication within 24 hours. Currently Whiston is achieving 77% and Warrington a bit lower. Both hospitals are aware that this is an issue, but it is acknowledged by both Hospital and general practice that staff resource is needed to be patient focused, and discharge communication is sometimes a lower priority. Some discharge notices come outside of the 24 hour target, some do not arrive at all.

Dr O'Connor reported that the Hospital CQUIN (incentive payment based on performance) is not sufficient to make it a viable incentive to hospital trusts.

Discharge notices received into the GP Practice
Although e-discharge notices are received every 2 hours throughout the day, the system at Beaconsfield downloads them into the GP's email in box once in every 24 hour period. This enables a more structured workflow for the GPs. There are some mandatory fields on the e-discharge forms, which provides a fuller picture. However, not all Trusts are on the e-discharge system. Many discharge notices still come in the form of a paper letter that must be scanned in to the system. Both Warrington and Whiston send discharge summaries as e-discharge. Warrington are in the process of moving to electronic patient case notes and discharge summaries will be automatically populated from this system. Whiston are looking to implement an electronic pharmacy system which will populate the medication discharge information.

Quality of Discharge Notices
Dr O'Connor reported that the quality of the discharge notice, where received, can affect the chances of readmission for a patient. Where the quality of the information is poor, the GP may not have the full picture of the patient's condition or reason for admission, in order to treat effectively in general practice, resulting in a readmission to hospital. Building the full picture of what has happened to the patient whilst in hospital is aided by the fact that all GP practices have electronic access to radiology and laboratory data, so they are able to see what tests/results have been undertaken.

Prescribing in Hospital
Whiston is moving towards e-prescribing, which will speed up the discharge process. Completion of prescribing data will be done through a selection of pre populated lists, saving time against manually inputting drug, quantity and frequency. As well as saving time, especially where people have a large number of drugs prescribed, it will also lessen the chances of human error or misreading of handwritten notes. Warrington are planning something similar after the electronic patient case note system is implemented.

Follow up of hospital tests and result, post discharge
Currently national guidelines state that test results should be followed up and acted upon by whoever has requested the tests. However, in practice, GPs are getting requests from hospital to follow up tests results, and action, on their behalf. Dr O'Connor reported that this issue is an ongoing conversation with the local Trust's Quality Groups, regarding the role of GPs in test follow up.

The future role of IT in discharge
There is work taking place to look at how the various health and mental health systems interface with each other, rather than getting everyone on the same system. That way information from all health stakeholders can be accessed to provide a full picture. There is work underway for practices to be able to access other GP practice information. There is a pilot taking place at the Health Resource Centre, Widnes, known as 'GP Access'. The patient gives the clinician consent to see their medical record, which gives potential for people to visit other places to access services, not just their own GP.

There is a need to link pharmacy into the electronic system – in the future there may be no need for prescription pads!

Demonstration of EMIS Web by Dr O'Connor
Dr O'Connor demonstrated the appointment system, prescriptions, full patient record, and discharge letters.

Dr O'Connor showed examples of a variety of discharge letters showing the type of information contained, level of detail etc. He showed e-discharge and letters that had been scanned on to the system. It was clear to the group that there was little consistency between the various Trusts about what information was provided. Some provided too much, others provided too little. Some was good quality, others less so. It demonstrated the amount of work that the GPs have to do on receipt of the discharge notice, and their required follow up.

Patients will have access to their records on line in future. They are able to see only 'coded' elements of their record ie diagnosis, tests they have had. These coded elements are one word descriptors of conditions, results etc, selected form a pre populated drop down list. The patient is not able to see 'free text', which are the manually typed notes inputted into the patient's record by the GP.

Dr O'Connor showed a patient who has a rare syndrome requiring frequent hospital attendances to manage the condition. Community alternatives are being explored with a a range of services and the further development of the Urgent Care Centre's could assist the management of this type of condition. It was noted that this type of admission is currently coded as a readmission (for one patient upto 100 in a year).

There is work underway around risk stratification of patients using the electronic patients records by doing reports based on 'read codes'– identifying those who would benefit from review. This work is valuable in preventing readmission to hospital by those most likely to be admitted to hospital.

End of Visit

Cllr Lowe thanked Dr O'Connor and Diane Henshaw for their time and contribution. Cllrs Lowe and Hill took a short tour around the Practice facilities with Diane.

Appendix 10

NICE National Institute for Health and Care Excellence

NICE guideline

Transition between inpatient hospital settings and community or care home settings for adults with social care needs

NICE guideline
Published: 1 December 2015
nice.org.uk/guidance/ng27

REPORT TO: Health Policy & Performance Board

DATE: 8th March 2016

REPORTING OFFICER: Strategic Director, Community & Resources

PORTFOLIO: Health & Wellbeing

SUBJECT: Halton Safeguarding Adults Board Annual Report 2014-15

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 **To update the Board on key issues and progression of the agenda for safeguarding adults at risk of abuse in Halton.**

2.0 **RECOMMENDATION: That:**

i) Health Policy and Performance Board note the contents of the report.

3.0 **SUPPORTING INFORMATION**

3.1 The Care Act requires that all Safeguarding Adults Boards are required to produce an Annual Report, (Appendix 1) which summarises all of the key achievements and priorities the Safeguarding Adults Board has been working towards over the last twelve months. The report sets out the national and local developments on safeguarding adults at risk.

3.2 Membership of the Halton's Safeguarding Adults Board includes senior representatives from all partner agencies, including Directors; Lead Clinicians and Lead Officers responsible for safeguarding adults in Halton. It is everyone's responsibility to ensure that we work together as a community to support and safeguard all adults who are most at risk in society. To achieve this, the Board continues to develop and establish strong partnership to ensure that the most vulnerable in society are safeguarded and are free from fear; harm; neglect and abuse

3.3 Halton's Safeguarding Adults Board contributes to the objectives of the Health and Wellbeing Board's Joint Health and Wellbeing Strategy and Halton's Strategic Partnership's Sustainable Community Strategy. During 2014/15, the Safeguarding Adults Board focused on four key priorities:

1. Promote awareness of abuse and the right to a safe and

dignified life – particularly among the “vulnerable” and “at risk”, but also among staff, volunteers and the wider community

2. Increase the contribution from service users and carers, ensuring their views and experience inform the Board’s work and service developments. Provide individualised services that keep people safe, but permit informed decisions about risk

3. Ensure there is a strong multi-agency approach to the safety, wellbeing and dignity of all adults at risk

4. Equip employees with the necessary tools and training to safeguard adults at risk and ensure their dignity is respected.

3.4 Halton has joined the Anti- Slavery Network, a multi-agency group that is committed to working together to prevent modern slavery and human trafficking. Nationally, it is a very disturbing and complex problem. Breaking the lives of the vulnerable and voiceless, it represents a grave abuse of human rights and basic dignity. Many have come from broken families, leaving them less protected from attachments to those who wish them harm. Some have been unable to find work, leaving them more vulnerable to exploitation. Others are serious addicts, some struggle with unmanageable debt and many have never experienced decent education.

3.5 Modern slavery exists in the UK and destroys lives. It manifests in an appallingly wide range of forms. Adults and children – UK nationals and those from abroad – are exploited in the sex industry, through forced labour**,** domestic servitude in the home, and forced criminal activity. Nationally there have been numerous cases of exploitation in factories, fields, construction sites, brothels and houses.

3.6 The Local Government Association and ADASS (Directors of Adult Social Services) published an evaluation of Making Safeguarding Personal (MSP). This is the approach embedded within the Care Act and has moved safeguarding investigations from a process driven approach to one which focusses on outcomes for the person involved.

3.7 Halton worked with MSP at bronze level and presented the work undertaken at the ADASS Spring Conference in 2014, prior to the implementation of the Care Act, and are advanced in our progress We have undertaken a whole service redesign to incorporate person centred involvement and the capturing of outcomes. A full programme of workshops has been held to support both practitioners and managers and a MSP group established. The new IT system went live in July 2015 and the first report on outcomes was presented to HSAB.

3.8 A task and finish group was established to look at developing a Financial Abuse Toolkit which is intended to be used by practitioners and members of the public to provide information to anyone concerned that someone they know maybe a potential victim of financial abuse. This has been agreed by Halton Safeguarding Adult Board and an e learning programme is now being developed which will enhance this further.

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**
The Annual Report highlights the key actions undertaken and the priorities that the Safeguarding Adults Board have worked towards during the last twelve months

6.4 **A Safer Halton**
The Annual Report highlights the key actions undertaken and the priorities that the Safeguarding Adults Board have worked towards during the last twelve months

6.5 **Halton's Urban Renewal**
None identified

7.0 **RISK ANALYSIS**

7.1 None identified

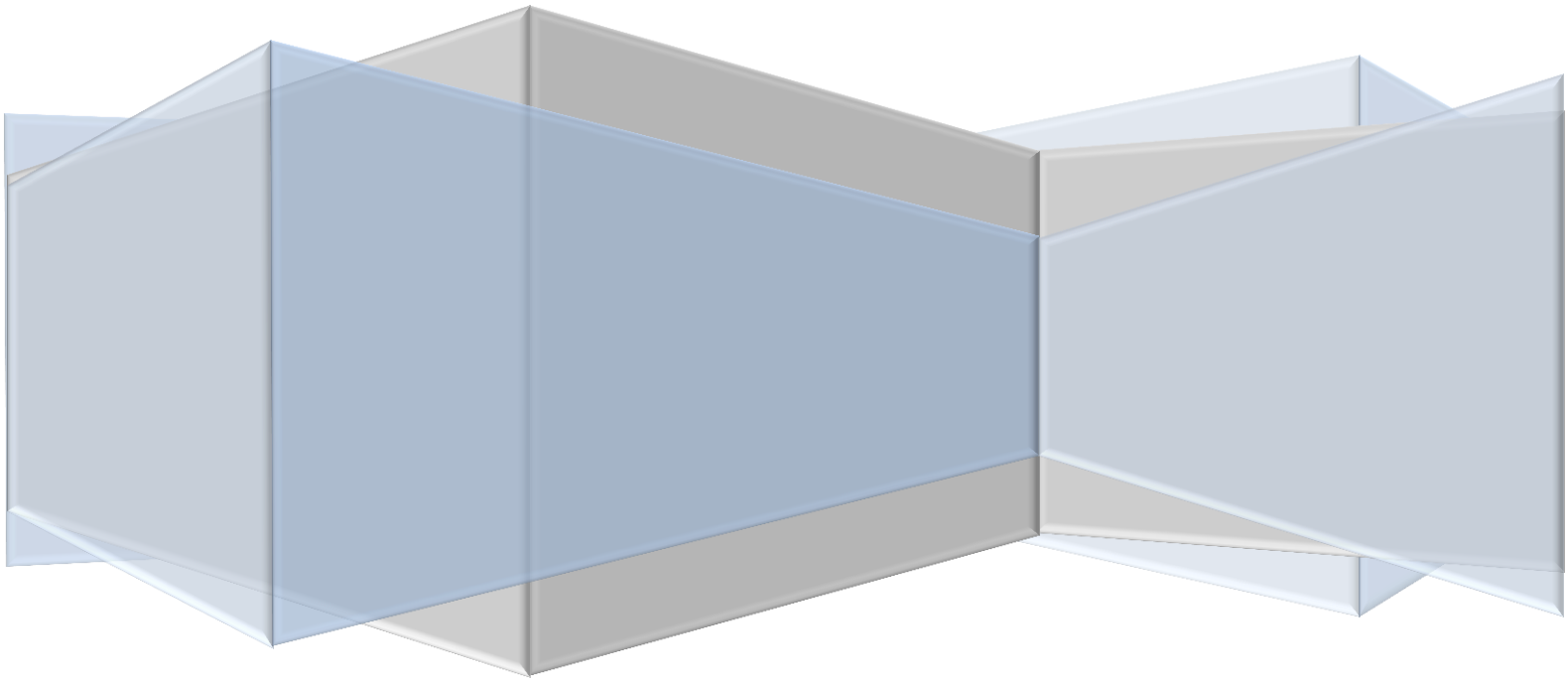
8.0 **EQUALITY AND DIVERSITY ISSUES**

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

9.1 None under the meaning of the Act.

Halton Safeguarding Adults Board

Annual Report 2014-15



FOREWORD

Halton's Safeguarding Adults Board believes that the safeguarding of vulnerable people is everybody's business, with all communities playing a part in preventing, detecting and reporting neglect and abuse. Although safeguarding adults is a complex and challenging area of work, effective measures are in place locally to protect those least able to protect themselves. As Chair of the multi-agency Safeguarding Adults Board, I am pleased to present this Annual Report which describes how organisations and individuals across all sectors, are working together to safeguard vulnerable people.

As well as reporting on its work over the past year, the Annual Report explains the national context in which we all operate and lists our priorities for the coming year. Some of the key highlights from the past year include working towards implementation of the Care Act from April 2014; continuation of the Safe in Town scheme in Halton; addressing key areas of safeguarding such as the increase in financial abuse and working with our partners in order to raise awareness of safeguarding across our various organisations and ensuring staff members have received appropriate training

I want to assure local people and partner agencies of our continuing commitment to this work, which is essential to the quality of life and experience of people whose circumstances make them vulnerable and take the opportunity to thank all those involved for their vital contribution to this essential area of activity. I am grateful to all those managers and practitioners who seek to ensure that adults at risk are safeguarded and who uphold the highest standards of care and support. I hope that you find the Annual Report both informative and reassuring.

From September 2015, the role of Chair of Halton Safeguarding Adults Board will be undertaken by an Independent Chair – Audrey Williamson and I wish the new Chair all the very best in their future work with the Board.

Dwayne Johnson

Chair of Halton Safeguarding Adults Board
Strategic Director – Communities
Halton Borough Council

1. OVERVIEW OF HALTON SAFEGUARDING ADULTS BOARD

The purpose of Halton's Safeguarding Adults Board is to:

- **Act as a multi-agency partnership board of lead officers and key representatives, which takes strategic decisions aimed at safeguarding vulnerable adults in Halton**
- **Determine and implement policy, co-ordinate activity between agencies, facilitate training and monitor, review and evaluate the safeguarding of adults**
- **Promote inter-agency cooperation activity between agencies**
- **Develop and sustain a high level of commitment to the protection of vulnerable adults**
- **Ensure the development of services to support people from hard to reach groups**

The HSAB has four main priorities, which underpin the work of the Board and its annual plan ensures all members are actively engaged/involved in supporting these priorities:

Priority 1: To promote awareness of abuse and of all individuals' right to be safe and be afforded dignity, particularly amongst people who are "vulnerable" or at risk and others, including the wider community, staff and volunteers

Priority 2: To increase the contribution from service users and carers and wider communities, by seeking to ensure that the views and experience inform the Board's work and service developments and by ensuring that personalised services are available in a way that keeps people safe but enables them to make informed decisions about risk

Priority 3: To ensure there is a strong multi-agency approach to assuring the safety, wellbeing and dignity of vulnerable adults

Priority 4: To equip employees with the necessary tools to both safeguard vulnerable adults and ensure their dignity is respected.

2. CURRENT PICTURE IN HALTON

From taking a closer look at the data collated for the statutory statistical Safeguarding Adults Return in 2014/15, we can start to build a profile of who are the most vulnerable to potential abuse in Halton and start to focus the work of the Board around addressing the needs of the community, in order to help keep people safe in Halton.

The 2014/15 data indicated that the most potentially vulnerable in our community were females, aged 65 and over, have an ethnicity of white british and who primarily require support for their physical needs from adult social care. The most prominent type of alleged abuse in Halton is physical abuse, followed by neglect / acts of omission. This year also saw an increased in referrals regarding alleged financial / material abuse, which was also identified as a trend nationally. The alleged abuse is most likely to occur in the person's own home and by someone who is known to the individual, for example a relative or a care worker.

By using this data, the following information highlights the work that has been undertaken by the Halton Safeguarding Adults Board in order to keep the people of Halton safe from potential abuse or neglect.

3. HOW HAS HALTON SAFEGUARDING ADULTS BOARD HELPED TO KEEP PEOPLE SAFE?

The Safeguarding Adults Inter-Agency Policy, Procedure and Good Practice Guidance has been updated for Halton, in terms of our safeguarding referral process and the new statutory requirements for safeguarding adults in light of the implementation of the Care Act 2014. The policy was agreed by members of the Halton Safeguarding Adults Board and the policy has now been circulated to all agencies for implementation. The policy is also available to view on the Halton Borough Council website at www.halton.gov.uk/safeguardingadults

A Multi-Agency Domestic Abuse and Sexual Violence Strategy 2014-17 has been developed. The purpose of the strategy is to set out what Halton intends to do over the next 3 years, to tackle the issue of domestic abuse and sexual violence within our communities. Halton Domestic Abuse Forum as a partnership will aim to create equality for all our residents through reducing fear and harm experienced from this form of violence and abuse. The strategy will seek to improve the risk identification, assessment and management processes and to target educational and support services effectively. No single agency can adequately deal with domestic abuse and sexual violence. The issue needs to be addressed by joint working and multi-agency strategies.

This year has also seen the implementation of Domestic Violence Prevention Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs). The implementation is legislated through the provisions of the Crime and Security Act 2010. DVPOs were designed to provide immediate protection for victim-survivors following a domestic violence incident in circumstances where, in the view of the Police, there are no other enforceable restrictions that can be placed upon the perpetrator. DVPOs aim to give victim-survivors time, space and support to consider their options by placing conditions on perpetrators, including restricting/removing perpetrators from households and preventing contact with, or molestation of, victim-survivors. Cheshire Police have committed to appoint dedicated resources to support this work. A newly developed role of DVPO Coordinator/Court Presentation Officer has been established. From Monday 2nd June 2014 – Friday 19th December 2014, there has been a total of 48 Domestic Violence Protection Notices issued. All notices were taken to court within the time limit of 48 hours. Of the 48 applications, 8 were contested by the offender at court and 3 orders were not granted by magistrates. The impementation of DVPNs and DVPOs has provided an opportunity to build upon established multi-agency working and strategies to intervene in

domestic abuse by providing additional measures to safeguard victims and their children. Effective multi-agency working is critical to ensuring the success of these orders.

A summary of the Independent Inquiry into child sexual exploitation (CSE) in Rotherham was presented to Halton Safeguarding Adults Board in October 2014. An Independent Inquiry into Rotherham Borough Council's internal processes and procedures, as well as its work alongside partners, in responding to historical cases of child sexual exploitation during the period 1997-2013 was undertaken. The inquiry was commissioned by the Council's Cabinet in September 2013 and was carried out by Alexis Jay OBE. No one knows the true scale of child sexual exploitation in Rotherham over the years. A conservative estimate is that 14,000 children were sexually exploited during 1997-2013. The abuse is not confined to the past, but still continues to this day. In May 2014, the caseload of the Specialist Child Exploitation Team was 51, with more CSE cases being held by other Children's Social Care Teams. In 2013, the Police received 157 reports concerning child sexual exploitation in Rotherham.

Following the publication of the Alexis Jay report, David Parr – Chief Executive of Halton Borough Council, wrote to all 23 North West Local Authorities requesting they all consider a review in light of the report's findings. Gerald Meehan, Strategic Director People & Economy - Halton Borough Council, is chairing a multi-agency group to agree a Terms of Reference to be used by partners across Cheshire and to report to Local Safeguarding Children Boards. A Pan-Cheshire Missing From Home and Child Sexual Exploitation Group has been established by the Police. This group has produced a Pan-Cheshire Strategy and Protocol which each Local Safeguarding Children Board has approved and an action plan developed.

A presentation was delivered to Halton Safeguarding Adults Board in March 2015, in regards to the establishment of a Child Sexual Exploitation Team within Halton. It was agreed that regular updates would be presented to both the Children and Adult Safeguarding Boards.

In January 2015, a report was presented to the Board regarding reporting financial abuse incidents during July-December 2014, due to an identified increase in the number of safeguarding referrals relating to alleged financial / material abuse. In the Care Act 2014, it states that financial abuse includes:

- Having money or property stolen
- Being defrauded
- Being put under pressure in relation to money or other property
- Having money or other property misused

Many types of financial crime can go unnoticed and factors, such as the economy, technology and social change are diversifying the threat. In 2008, Help the Aged reported that 60 - 80% of financial abuse against older people takes place in their own home and 15 - 20% in residential care. Research suggests that financial abuse is most frequently perpetrated by a person acting in a trusted capacity, for example, a family member or friends, neighbours or care workers/other professionals.

In order to address the local and national increase in financial abuse incidents, it was agreed by Halton Safeguarding Adults Board to establish a Task and Finish Group to develop a Financial Abuse Toolkit. The purpose of the toolkit is to raise awareness of both professionals and members of the public, in recognising the potential indicators of financial abuse and what support and services are available to help prevent such abuse occurring in the future. The toolkit has now been drafted and is in its final stages of development.

A launch event is being considered in order to help raise awareness of this type of abuse and to provide training to professionals to help support potential victims of financial abuse.

The Safe in Town Scheme has been running in Halton since 2012, to provide a safe haven for people who may feel vulnerable when out in the community. Once individuals enter a shop which has the Safe in Town logo sticker displayed and declare themselves as part of the scheme by showing their laminated card, one of the staff members would phone a dedicated number for the individual and a family member or carer would come to collect them. The Halton scheme has widened the range of beneficiaries and now includes adults and young people (aged 14 years plus) who have a learning or physical disability and anyone over 60 years of age. The logo for the scheme was designed and agreed by the Halton People's Cabinet and is now being used by Cheshire Police to roll out the scheme across the whole geographical footprint. Easy read comic books, which were produced for both individuals and organisations, to ensure the scheme's guidelines and safeguarding messages were consistent when shared with participants, have also been used by the Police, with thanks given to Halton Speak Out who produced the comic books.

As at November 2014:

- 504 people have signed up to the scheme
- 31 venues in Runcorn Shopping Centre are now Safe in Town havens
- 22 venues in Runcorn Old Town are now in Safe in Town havens
- 18 venues in Widnes Town Centre are now Safe in Town havens
- 10 local shops on housing estates throughout Halton are Safe in Town havens

- 3 Community Centres are Safe in Town havens
- 2 Health Centres are Safe in Town havens

It was anticipated that by the end of March 2015, the numbers would have further increased, with targeted activity to sign up more local shops, non-commercial premises and in particular, health centres and GP surgeries. Widnes Vikings Rugby Team are in discussions to put the Safe in Town logo on the t-shirts of their younger players and the scheme has been included as part of the Bright Sparks Kitemark and the purple handbook for people experiencing Alzheimer's and other forms of dementia.

A report was presented in March 2015 to the Board regarding reported medication errors, as it was identified that an increased number of safeguarding referrals were relating to medication errors in both domiciliary and residential care. The National Patient Safety Agency (NPSA) defines a medication error as an error which occurs in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred. Care providers who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people using the service, will have their medicines at the times they need them and in a safe way. The statutory requirements of care providers around medication errors requires that the registered person must protect service users against risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the obtaining; recording; handling; using; safe keeping; dispensing; safe administration and disposal of medicines used for the purposes of regulated activity. All medication errors should be reported in line with care provider's Management of Incidents policy, as soon as possible after the incident. Medication incidents have a number of causes, such as lack of knowledge; failure to adhere to systems and protocol; interruptions, staff competency; poor handwriting and instruction and poor communication. The National Patient Safety Agency has divided definitions of medication errors into the following areas:

- Prescribing errors
- Dispensing errors
- Preparation and Administration errors
- Monitoring errors
- Other errors (including poor or inadequate communication and recording etc.)

In Halton, in line with the NPSA definitions, local data suggests the majority of reported medication errors involve poor administration by care providers; this includes administration of the wrong medication or dose, administering medication too early or late and that the administration or medication has been recorded incorrectly or not recorded at all. Where medication errors are reported action is required by the provider service to protect the adult at risk from harm and to ensure that no other adults are put at risk. In many cases, the safeguarding investigation identifies that the worker needs more training and where this occurs, the worker is supported to deliver safe care. The Care Home Support Team is now well established in Halton with a dedicated Pharmacist, who provides support and advice to the care homes. All data regarding medication errors are shared with the NHS Halton Clinical Commissioning Group Medicines Management Team, so that trends, themes and ongoing support can be identified.

Halton Borough Council's Human Resources & Development Manager has chaired the Safeguarding Learning and Development Sub Group and has implemented Learning and Development Strategies that give a framework that contributes to helping to keep people safe. Core programmes for Adults and Children's

Safeguarding Training has been delivered, covering a wide range of subjects, such as:

- Alerter Workshops (0.5 days)
- Safeguarding Adults Basic Awareness (e-learning)
- Safeguarding Adults Safer Recruitment (e-learning)
- Safeguarding Children Basic Awareness (0.5 days)
- Safeguarding Adults Referrers Training (1 day)
- Safeguarding Adults Investigators Training (2 days)
- Safeguarding Adults Chairing Skills (1 day)

The chair of the Safeguarding Learning & Development Sub Group has worked closely with Halton's Safeguarding Children Business Manager, to ensure that:

- Quality assurance arrangements are in place in respect of safeguarding training delivered or commissioned by partners, agencies or the Boards
- Recording, monitoring, analysing and reporting on the volume, profile and impact of the training delivered under the direction of the Board
- A range of Learning & Development opportunities and to implement them as appropriate
- Promotion of key safeguarding messages through the organisation at workshops/events and engaging in local and national campaigns
- Engage a range of stakeholders in safeguarding development activity
- Links are esablished with other groups in order to ensure that safeguarding knowledge and practice is embedded in strategies and priorities

During the year, training packages from Halton Borough Council, Schools, Youth Federation and Early Years and Day Care providers have gone through a training validation process to ensure the quality of training is meeting the expectations of the Board. Each year the Safeguarding Learning & Development Sub Group undertake a Training Needs Analysis to establish emerging training requirements and to ensure appropriate levels of training are available.

Disclosure and Barring Service requirements are well established within Halton Borough Council and work is ongoing into the implementation of an online registration process that will ensure efficient processing of applications.

In September 2014, the Halton Borough Council Trading Standards Team began a Scams Project to raise awareness of mass marketing fraud, after they became aware that at least 190 people in Halton had been targeted. The team have been trained in clean questioning and coaching skills for behaviour change. Trading Standards work with individuals to understand what scams they respond to, why they respond and work with them to find alternatives to fill the gap. The individual often feels a sense of belonging/friendship or purpose from responding to these scams. The team will also try to assist with the resolution of other problems that the individual may be experiencing, by referring to other agencies if necessary. As part of this work, the team have been raising awareness of this form of financial abuse with other Council services and agencies, as well as giving talks to community groups. For the purposes of the Scams Project, Trading Standards shared information with Adult Social Care, developing links with various teams. The team have also liaised with the Police and gathered information about services provided by local agencies and organisations that may be useful to the people they work wih.

Some members of the Trading Standards Team have also received Dementia Awareness training and all have been trained in clean questioning techniques to improve their ability to communicate with vulnerable people.

Case Example

Mr E is a 97 year old victim who has lost approximately £6,000 to scam mail but is reluctant to stop spending money. He is now receiving approximately 20 letters per day and numerous phone calls. Adult Social Care is involved and reported to Trading Standards that in a week Mr E's bank balance had gone from £60 credit to £220 overdrawn. The victim had no money for food and he had stopped paying his care bills.

Adult Social Care have worked with Mr E and his bank and arranged for him to have a new card as his current account is being drained by a series of direct debits that he has set up to the scam companies. The victim has agreed to have his mail redirected to Trading Standards so that the team can filter out any scam mail.

Mr E walks with the aid of sticks and the team was concerned that he was receiving a lot of scam and nuisance phone calls and his eagerness to reach the phone was likely to result in a fall. Trading Standards have provided him with a call blocker device, which should stop all of the scam and nuisance calls that he is receiving.

Working with Adult Social Care, Trading Standards have been able to remove the risk of continued financial abuse for this vulnerable person.

NORTH WEST AMBULANCE SERVICE

The North West Ambulance Service NHS Trust has a legal duty to protect patients, staff and the public from harm. This includes harm from others as well as avoidable harm to patients. The Clinical Safety and Safeguarding Team have worked hard during the year to identify patients at risk and have focused the following work streams to ensure patients and the public receive appropriate care and protection when required. The following summarises some of the achievements for the Trust over the last financial year: The Trust took part in the Care Quality Commission pilot assessments of Ambulance Service NHS Trusts. The result is that a number of standards have been developed for Ambulance Services and good assurance was received in relation to safeguarding arrangements. The Trust has a named contact for each of the 46 Safeguarding Adults Boards across the North West. This strengthens working together and information sharing relationships and is reflected in the increased number of Serious Case Reviews/Safeguarding Adult Revews and Domestic Homicide Reviews. Staff also access multi-agency training and share learning and expertise with their peers. The Safeguarding and Frequent Caller Teams are regularly identifying and sharing information, to enable a joined up approach to ensure vulnerable people are afforded the assessment and care they require, in accordance with their wishes. When appropriate they are protected from harm of abuse and a significant amount of patient data is now shared to ensure the best outcomes for these patients. This also includes sharing concerns in relation to nursing and care homes. A significant amount of work has been done to update the policy and associated procedures. These now include the principles of adult safeguarding and pathways are included for victims of Child Sexual Exploitation, Female Genital Mutilation and the radicalisation of vulnerable people. Over 75% of all North West Ambulance Staff have received WRAP 3 training, which is the “Workshop to Raise Awareness of Prevent” – part of the Government’s Anti-Terrorism Strategy. WRAP is included within mandatory training for all staff and compliance with this national requirement continues to increase monthly.

The following summarises some of the proposed developments for the Trust in 2015-16: The Electonic Information Sharing System (ERISS) is a bespoke web-based system used by the Trust for sharing safeguarding referral information with Children's and Adult Social Care. This system has the functionality to place warning flags, to alert the attending crew about child or adult protection issues. The application will be piloted over the forthcoming year. The current position of staff raising alerts with the Trust Safeguarding Team remains in place. The Trust is continuing to develop processes in relation to Domestic Abuse. Following the success of the pilot last year, a referral form for domestic abuse will be developed with provision for enhanced information sharing which links to the national guidance (NICE). The Trust Safeguarding Team is in the process of developing links with all the Child Sexual Exploitation Teams in the North West, to enable efficient and timely information sharing in relation to child sexual exploitation. This is over and above the current safeguarding procedures already in place. There is also a process to capture data relating to female genital mutilation, which has been communicated to all staff and this will be monitored during the year. The Trust is working with partners to help tackle issues relating to Slavery and Trafficking of children and adults. This work is in the initial scoping phase and any identified actions will be added to the safeguarding work plan for the year and progress monitored.

NHS ENGLAND NORTH (CHESHIRE & MERSEYSIDE)

NHS
North West

The following provides a summary of the activities and initiatives which have been undertaken by NHS England North in order to help keep people safe in 2014/15:

- Baseline Safeguarding Audit undertaken across all GP surgeries
- Safeguarding Training Assurance discussed at annual GP appraisal

- All NHS England Merseyside staff have undertaken Level 1, 2 or 3 training dependent on position held
- Second National Safeguarding Conference held in October 2014 hosted in Merseyside
- Safeguarding Report is presented to the Merseyside Quality Surveillance Group bi-annually
- All Clinical Commissioning Groups in Merseyside are assured for Safeguarding Service accountability
- A robust Serious Untoward Incident System and process is in place to monitor child deaths, Serious Case Reviews/Safeguarding Adult Reviews and Domestic Homicide Reviews
- NHS England North are members of all Local Safeguarding Children and Adults Boards
- A Merseyside Safeguarding Forum has been established for Designated Professionals
- Additional funding for Mental Capacity Act/Deprivation of Liberty Safeguards has been secured for training independent contractors (GPs, Dentists, Optometrists and Pharmacists)

NHS England North have identified the following as priorities for 2015/16:

- NHS England Assurance and Accountability implementation
- Review of Health Key Performance Indicator framework for all NHS contracted services
- Implementation of the Care Act 2014 in relation to adult safeguarding
- Develop in partnership with Clinical Commissioning Groups and Local Authorities – Mental Capacity Act/Deprivation of Liberty Safeguards awareness training
- Focus on PREVENT
- Implementation of Female Genital Mutilation mandatory recording for GPs

- Implementation of key recommendations from the Lampard Report 2015

WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust have participated in promoting public awareness by holding 'Safeguarding Events' in the main foyer of the hospital, providing the general public with up to date information on 'what is safeguarding?' and 'what to do if you have a concern or need to report abuse?'. Further engagement has taken place with partner agencies on National World Elder Abuse Day, Learning Disability Week and Domestic Violence Week, which has included promotional posters for Polish speaking families in the various departments across the hospital. Additional information resources have been added to the Patient Information HUB at the main entrance, which includes contact names and numbers for internal and external safeguarding teams. The Trust has also established a network of Safeguarding Champions in clinical areas to promote safeguarding and dignity standards. The Safeguarding Team within the Trust are triangulated with the Trust DATIX reporting system and Complaints Department. This allows for any incident that is reported and has a safeguarding element to it, to be reviewed by the Safeguarding Team to ensure correct investigation, referrals and processes have been undertaken. For example, investigation of any internal allegations made by patients or families against members of staff. The outcome of any internal investigations are shared with the Clinical Commissioning Group lead and Local Authorities. The Safeguarding Team are also participating members of the Trust Patient Experience Committee, Equality and Diversity Group and Learning Disability Group which all have third sector representation and patient representatives to allow for feedback. The Safeguarding Team have worked closely with other professional groups to allow for risks to be identified and plans put in place to, wherever possible, allow patients to continue to maintain their right to a family life.

Case Example

Mrs S lived alone and had a history of falls and of being alcohol dependent. She had a private carer who she paid to do her shopping and washing. She was admitted to hospital following a fall whist intoxicated. Her paid carer would supply the alcohol if requested to. Her daughter raised concerns with the staff that she felt her mother needed to go into a Care Home as she could no longer take care of herself.

A referral was made to the hospital Safeguarding Team to ask for help and support. The team along with the clinical staff, completed a mental capacity assessment on Mrs S regarding her wishes and choice of home. It was apparent that when not under the influence of alcohol, Mrs S had capacity to determine her own choices and wished to remain at home for as long as possible.

Along with the Discharge Planning Team, Mrs S was supported to understand the risks she was putting herself at by asking the paid carer to buy her alcohol and not providing her with appropriate nutritional needs. Mrs S agreed that her paid carer was not supporting her correctly and agreed to a package of care and to not have a private carer. Her daughter was also supportive of the new arrangements and Mrs S remained in her own home.

The Trust is represented at both the Halton Safeguarding Adults Board and the Safeguarding Childrens Board and subsequent sub groups. The Trust also has a representative at the Domestic Abuse Partnership and Multi Agency Risk Assessment Conference (MARAC). The Safeguarding Team cooperate with partner agencies to develop and agree protocols and policies that all staff can adhere to. The Trust have in place an agreed Information Sharing Protocol with partner agencies, which allow for the passing of information that is in the best interests of the patient. All requests for safeguarding information is channelled through the Safeguarding Team, where a record of the request for information and the information provided in response, is logged. This year the Safeguarding Team have

agreed a change of process with the Local Authority regarding the reporting of patients who have undergone a DoLS assessment. The Local Authority now informs the Safeguarding Team if a DoLS request has been made to them from the clinical areas. This allows for the team to provide additional support to the ward and the Local Authority, to ensure the correct process is being followed and patients' reviews are monitored. This has allowed for less duplication and errors in the process. This year has also seen the introduction of an Independent Domestic Violence Advocate (IDVA) service 2 days per week. This allows staff to refer any patient who discloses domestic violence to this service for guidance and support and provides a confidential service for low and medium risk clients, therefore, supporting prevention to the high risk category. There are a number of robust policy and procedures in place, that are accessible to all staff. These policies reflect local and national guidance. These include the process, procedure and guidance for Safeguarding Children and Adults; Domestic Violence; Mental Capacity Act and Deprivation of Liberty Safeguards; Prevent Agent; Clinical Holding and Restraint of Patients and are all widely promoted through the governance structure and available to all staff by the internal electronic intranet, known as the HUB.

The Trust views Safeguarding Adult training as a priority and is a mandatory requirement for all staff. Safeguarding Training Level 1 includes all clinical and non-clinical staff and is delivered in all Trust induction programmes. This programme is also delivered to all volunteers who join the Trust. Level 2 training is delivered by e-learning and twice monthly a 2.5hr session is delivered face to face to clinical staff. Bespoke one to one training is provided on request and to support action plans from internal investigations. Training has expanded to include Child Sexual Exploitation, Honour Based Violence including Female Genital Mutilation, Human Trafficking and the PREVENT agenda. There is a 3 yearly update session that all consultants have to undertake. The latest has been running since October 2014 and this will continue to run through to September 2015. Safeguarding Champion Days have taken place twice in the last twelve months, which is a multi-agency event to share learning and embed good practice. Each year we participate in the Halton audit of training evaluation and review the programme of training that staff require in accordance with national and local policy. The Safeguarding Team participated in the Crucial Crew Education Forum held at Select Security Stadium, which was in partnership with the Halton Safeguarding Adult Board's Learning & Development Sub Group. It is an

annual event that aims to offer Year 5 students across Halton advice regarding how to keep safe across a range of areas. The event received excellent feedback from all those who attended the event.

ST HELENS & KNOWSLEY HOSPITALS NHS TRUST

The following summarises the work undertaken by St Helens & Knowsley Hospitals Trust over the last year, in regards to helping keep people safe in Halton. The Trust has reviewed and ratified its Safeguarding Adults Policy to take account of the Care Act and statutory guidance. Safeguarding Adult activity issues are reported on a monthly basis to the Patient Safety Council supported by a Trust Safeguarding Adult Steering Group. The Trust has a Safeguarding Adult Work Plan which details all outstanding actions and progress is monitored through a Steering Group. The Trust has an Integrated Performance Report which includes a range of safeguarding metrics which is reported on a monthly basis to Trust Board level. The Trust reports on a quarterly basis to its commissioners on a range of Safeguarding Key Performance Indicators and is currently judged as providing reasonable assurance in respect of its safeguarding adult processes. On 26th June 2014, the Trust hosted a Care and Compassion Conference which was held at Whiston Hospital and attended by over 120 delegates, with internationally renowned speakers focusing upon creating a high quality care environment. The Trust Governance Process includes Patient Safety and Patient Experience Councils, both of which include representation from two local HealthWatch and parent carers. The Trust has a Learning Disability Pathway Group which includes representation from the local community disability services, advocacy groups and parent carers. The Trust has a number of Carer Focus Groups involving the on site Carer Support Team.

In January 2015, the Trust successfully bid for funding to develop and implement a single standardised pathway to enable adults who lack capacity and who may be resistant, phobic and challenging and who require acute care, to obtain that care through consistent best interest decision making and pathway planning. The aim is to deliver this in September 2015. The Trust ensures that it is well represented at all multi-agency meetings from Board to individual case level and achieved a 90% attendance in the period. The Trust has implemented the Halton Multi-Agency Procedures and has a good record of making appropriate safeguarding referrals, which are progressed through to an outcome. The Trust has signed up to the Crisis Care Concordat and is working with its partners in implementing its Local Action Plan.

The trust has a well established Dignity Champions Network which was reviewed and relaunched in 2015, leading to a much wider representation which includes both HealthWatch members and care providers. The Trust has a Safeguarding Adult Training Needs Analysis which supports four levels of training. Level 1 compliance is 97%, Level 3 is 80% and Level 2 compliance has been achieved in line with the trajectories agreed with the Trust's commissioners. The Trust has a range of policies and procedures which support safer workforce initiatives, identifies allegations made against professionals, makes safeguarding referrals to the local authority and collaborates with the investigative process. The Trust has a central reporting system known as DATIX, which generates reports and which feeds into the process of learning from such incidents. The Trust Safeguarding Team provides guidance to all areas of the Trust and provides quarterly reports on all activity, demonstrating that all areas of the Trust now raise safeguarding adult concerns at an increasing rate for advice and guidance, but the proportion referred on formally to the local authority continues to be consistent. The Trust has maintained a regular level of review of its processes relating to identifying and managing Deprivation of Liberty Safeguards over the period and is reviewing its Mental Capacity Act/DoLS policies. The Trust has adopted NICE Guidance in respect of managing incidents of Domestic Abuse and has achieved good progress against full compliance.

HALTON CLINICAL COMMISSIONING GROUP

NHS Halton Clinical Commissioning Group

NHS Halton Clinical Commissioning Group (CCG) requires that all its commissoned services, Governing Body Members, Member Practice staff and Clinical Commissioning Group staff are appropriately trained to ensure that they are aware of

abuse and the right to a safe and dignified life. The NHS Halton CCG through its contracts require that all providers evidence appropriate policies and procedures. Providers are required to evidence that their policies and procedures are in line with those approved at the Halton Safeguarding Adults Board. The NHS Halton CCG has developed and approved appropriate policies and procedures for staff to have completed appropriate training and this is monitored internally. All commissioned providers are required to assure the NHS Halton CCG of their compliance with staff training trajectories and to evidence how they are ensuring that staff are aware of risks of abuse and mitigate against these. The Designated Nurse for Safeguarding Adults has worked to support the development and review of a number of policies and procedures in relation to prevention on behalf of the NHS Halton CCG. One of the key functions for NHS Halton CCG is engagement and involvement of local people, on all areas of work undertaken. During 2014/15, NHS Halton CCG was involved in a large number of patient and service user engagement events obtaining views on commissioning plans and service delivery. NHS Halton CCG requires all providers to evidence how they enable and encourage service users and carers to share their views to influence service delivery and change. This information is shared with the Board to inform them of its work. Individualised care is a requirement in all health provision and currently providers are providing evidence of 'I Statements' from patients to evidence the level of involvement in care planning, the level of understanding of care planning and delivery and how confident patients feel of their ability to influence what happens to them. The NHS Halton CCG received regular reports from all providers in relation to comments, compliments and complaints which includes evidence of how this has led to service changes. Whilst this does not relate specifically to safeguarding, it will impact on the care of adults at risk. The NHS Halton CCG has supported and facilitated a string of multi-agency approaches to safety, wellbeing and dignity across all care areas. It provides a wellbeing service to all practices, which all local people can access. The development of a Multi Disciplinary Team around practices and patients has improved our ability to support vulnerable people to facilitate and encourage safety, dignity and independence. NHS Halton CCG in collaboration with all local stakeholders have enabled the development of person-centred planning to enable self care and independence whilst ensuring vulnerable people are protecting themselves from harm.

CHESHIRE CONSTABULARY

The following summarises some of the key work undertaken by Cheshire Constabulary during 2014/15 to help keep people safe in Halton:

- Active use of social media to promote all aspects of safeguarding, including Force Twitter, Neighbourhood Twitter accounts and Public Protection Unit Twitter accounts

- Reviewed and implemented the Force Adult at Risk procedure in line with the Care Act 2014

- Worked with all four Local Authorities and Safeguarding Adult Boards to develop a new Adult at Risk procedure

- Delivered training to all front line officers as part of regular monthly training days. Training focused on Adults at Risk in April to coincide with the launch of the new Force procedure

- The Force have committed to the delivery of regular safeguarding training across the whole workforce, as safeguarding is identified as a priority for the Force

- Training also includes other specific vulnerable groups - Domestic Violence and Stalking and Harassment

- Developed revised system to record concerns around vulnerable people through the new reporting system – Vulnerable Persons Assessment (VPA). This replaces the older IT system CAVA.

- Introduction of new reporting system was supported by training provided to all officers and staff about identification of vulnerability, local problem solving and escalation through submission of a Vulnerable Persons Asssessment

- A dedicated Adult at Risk Officer has been appointed by the Force

- The Force has supported a number of Domestic Homicide Reviews across the county. Learning from these reviews is coordinated through the Strategic Public Protection Unit

NATIONAL PROBATION SERVICE - CHESHIRE

The National Probation Service which was established as a separate entity by the Government in June 2014, has a dual responsibility to offenders (some of whom are at risk and vulnerable) and to their victims who can at times be exploited/abused by offenders and who indeed may target such victims. Victims of serious crimes have been advised over the last year of their right to have some protection written into offender's prison licenses on release, via no contact clauses and exclusion zones where the offender may not pass through or visit. They are also given support and advice and guidance linked into Independent Domestic Violence Advocates/Adult Social Care/Police as relevant and with their permission and active participation wherever possible.

The main multi-agency partnerships that the National Probation Service link into, in order to ensure safety and dignity of both victims and offenders are Multi- Agency Public Protection Arrangements (MAPPA) for our dangerous offenders and Multi-Agency Risk Assessment Conference (MARAC) and Domestic Violence Forums for domestic violence victims, where our offenders are the perpetrators and similarly in child safeguarding and in particular the developing strategy over 2014/15 of Child Sexual Exploitation. MAPPA meetings are primarily concerned with the past and potential victims of dangerous offenders and links are made with agencies that can assist in the protection of those who are vulnerable and they are invited to the meetings to contribute to the risk of management plans of the offender. All potential victims are tracked and constraints as well as therapeutic interventions are placed on offenders including, where necessary, proportionate disclosure to new partners/families etc.

The National Probation Service undertake victim feedback audits each year, which the Victim Contact Service have been in contact. An Offender Survey is also analysed and working practices altered where indicated. The offenders responding to the last survey indicated that they felt treated with respect in the way they were responded to; waiting times; interventions and transparency of the service they received. Feedback both positive and negative, as well as learning from reviews and

investigations and complaints from service users, are responded to by the management of the service.

Service User Forums are held in most of the offender management units. These are active and lively forums, which also contribute to the development of policy and practice. One of the biggest strengths/skills a Probation Officer requires, is their ability to be transparent with service users about the danger they are seen to represent to others more vulnerable than themselves, whilst at the same time supporting and respecting the needs of the offender who may also be vulnerable to others. They understand that often the best way of reducing the risks that an offender represents, is to meet their needs that have often been neglected in the past. It is well recognised that many offenders have mental health needs that can, if untreated, influence their negative behaviour to others.

CARE QUALITY COMMISSION

As a regulator, the main responsibility of the Care Quality Commission (CQC) is to ensure that all health and adult social care providers have clear and robust systems in place to keep people who use their services safe and employ staff that are suitable skills and supported. The role and overarching objective of the CQC in safeguarding is to protect people's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. As a regulator, CQC are keen to work with local safeguarding teams and to establish effective working relationships. These relationships help to keep people safe.

CQC commit to representation to a Halton Safeguarding Adults Board meeting as least once per year. Local agreements should be in place to ensure that local CQC Inspection Managers receive minutes from all Board meetings. As a partner, as opposed to a member of the Board and a national regulator, the focus of our local inspection teams is on inspecting regulated services against their five key questions of safe, effective,caring, responsive and well-led. In doing this, CQC work in partnership with Local Authorities and local Clinical Commissioning Groups, to highlight areas of concern within regulated services. CQC will take regulatory action as appropriate.

CQC has implemented a specialist approach to the inspection of health and social care services, informed by intelligent monitoring. This informs when and how they inspect health and social care services and with the use of real time data, results in appropriate and timely action to safeguarding concerns. The CQC's position with

regard to working with Local Authorities does not change under the implementation of the Care Act 2014 and therefore CQC will not be implementing a Designated Adult Safeguarding Manager for each Local Authority across England. CQC have two National Advisors for safeguarding, who work across all Directorates and offer advice and support to staff and who work with national bodies, such as the Department of Health. All CQC staff are offered role appropriate safeguarding training. CQC has, and continues to, raise awareness amongst the general public about their role. Safeguarding concerns raised with CQC come from members of the public or from community organisations. People who use services and their carers are involved as partners in inspections. CQC is continually working to forge closer links with local organisations.

5 BOROUGHS PARTNERSHIP

Over the reporting year the Trust has introduced the Duty of Candour into our delivery of services as a key recommendation of the Mid Staffs enquiry. This places a duty on us, as a health provider, to be open with patients when things go wrong. The safeguarding service are working with partners to ensure that our Duty of Candour is embedded into the culture of the organisation and works alongside ither agendas such as Making Safeguarding Personal.

The Safeguarding Team in the Trust continue to provide advice and support to all our services. Practitioners reporting concerns to the team are guided to asking the individual concerned what they want to happen in the first instance, are they aware of safeguarding and what this means t them and more importantly what they don't want to happen.

Safeguarding Adults training is mandatory for all clinical staff who have patient facing contact. This training highlights what abuse is, the effects abuse has on an individual and how to report it. Safeguarding Adults training has undergone an extensive review over the reporting year and the Trust will now commence embedding the National Competency Model (Bournemouth) into training provision. This will seek to further embed the key knowledge and training expected of all staff in the Trust in relation to Adults at Risk.

The Trust continues to support the work of the Board and to implement the changes in safeguarding practice in line with the requirements of the Care Act which came

into force in April 2014. One of the key challenges for our staff is the process of "making an enquiry" on behalf of the Board. This will continue to be driven by the safeguarding process and advice sought from our Local Authority partner in the first instance as to how much involvement is needed by our staff.

The Trust has reviewed its Consent Policy and the Safeguarding Team are heavily involved with the review of how this works in practice Trust wide across all of our busines streams. This seeks to ensyre that service users are fully informed of the care and treatment being provided to them and when concerns are raised what happens next. This has been run in conjunction with a series of Mental Capacity Act workshops looking at how to complete assessments and maximise an individual's ability to make decisions for themselves.

The Safeguarding Team in the Trust continue to provide advice and support to all our staff. Safeguarding concerns are communicated to the team on an electronic form as well as telephone advice being available in working hours. The team will quality assure all safeguarding activity across the Trust to continually improve practice and maintain a safe, effective service. This involves support being given to practitioners who are working with complex cases and managing high levels of risk.

The Trust has "what to do" flowcharts in all clinical areas that guide staff through the reporting process of reporting abuse. The presence of the flowcharts are checked within our Internal Quality Review process to ensure staff have easy and quick access to the appropriate contact numbers and advice. Both the Trusts internal safeguarding team and the Local Authority Contact Centre details are on the flowchart.

The Trust has a robust Information Governance procedure that guides staff through the handling of sensitive information. We are also signed up to Information Sharing agreements across our partner agencies for processes such as MARAC. Training is mandatory for staff and advice available from our Information Governance Lead.

Trust staff are aware that information must only be shared on a need to know basis and that consent should always be sought to disclose information unless inappropriate to do so. This is covered in existing safeguarding training with case examples being used to highlight the scenarios staff may face when out in practice.

Under the Care Programme Approach, service users who are classed as "CPA" will have a care plan which clearly documents the roles and responsibilities of all those involved. Care plans are subject to rigorous audits to ensure they are of high quality and meaningful to the individual in receipt of the service. For those service users who are not meeting the threshold of CPA, in that their needs/presentation is not as complex, there is a statement of care provided. Again, this will outline what service is being provided and by whom.

The Trust runs regular inspection of services which we call Internal Quality Reviews. These involve a team of "experts" who visit a service/team over the course of a day looking at standards of care and the patient experience. Within the reviewing team will be service user/carer representatives who will lead on speaking to other service users/carers on their experience of services and how we can improve as an organisation. This will include asking about the care plan/statement of care and if they are happy with this.

4. KEY ISSUES WHICH HAVE HAD AN IMPACT ON THE BOARD

Deprivation of Liberty Safeguards: The Deprivation of Liberty Safeguards (DoLS) is one aspect of the Mental Capacity Act 2005. The safeguards are to ensure that people in care homes and hospitals are cared for in a way that does not inappropriately restrict their freedom and, if necessary, restrictions are only applied in a safe and correct way and is only done when it is in the best interests of the person and there is no other way to provide appropriate care.

On 19th March 2014, the Supreme Court made a judgement, which is significant in determining whether arrangements made for the care and/or treatment of an individual, lacking capacity to consent to those arrangements, amount to a deprivation of their liberty.

There are a number of implications for Local Authorities as a result of this judgement:

- There is likely to be an increased number of applications for DoLS authorisations, which will inevitable place pressue on the Best Interest Assessors across the Council and other agencies

- There is likely to be a need to revisit previous decision making and address it in some cases. There is a need to scope settings outside of residential care homes and hospitals and proceed with those that need authorising

- Communication and guidance will be required for all stakeholders

An initial scoping exercise has been completed to estimate the number of assessments that may be required and a risk assessment undertaken. In addition to the Best Interest Assessors, there is a requirement for a Mental Capacity Assessment to be completed by an appropriately qualified Doctor. NHS England are to address the increased need for Doctors qualified in this area.

Period	DoLS Applications 2014-15	DoLS Applications 2013-14
Quarter 1	38	10
Quarter 2	51	12
Quarter 3	53	5
Quarter 4	48	6

Care Act 2014

Care Act 2014: The Care Act come into effect from 1st April 2015. Regular updates regarding the implementation of the Care Act and the statutory requirements for Safeguarding Adults Boards, have been presented to Halton Safeguarding Adults Board. A Care Act Compliance Checklist has been developed in order to monitor if the Board is meeting all of its statutory requirements. Updates in relation to this checklist will be presented to the Board at regular intervals.

In relation to the North West Ambulance Service, the implementation of the new Care Act 2014 provides a legal framework for the assessment and protection of adults including those at risk with an emphasis on the wellbeing of the patient. This may account in part, for the noticeable rise in safeguarding adult activity over the year, which includes concern for the welfare of vulnerable adults requiring assessment. Likewise, safeguarding children activity steadily increased across the trust, particularly within the Paramedic Emergency Service, but at a slower rate than for adults. A number of high profile national investigations have resulted in an update to safeguarding procedures and training, to ensure that adults and children who are at risk or victims of exploitation and radicalisation are also safeguarded.

The National Probation Service – Cheshire: The service has managed vulnerable offenders over the last 12 months. Elderly sexual offenders or those serving life for other serious crimes have to be assessed for release when their risk to others is deemed to have been reduced to a safe enough level or where they have reached a determinate release date whatever their risk levels. Such offenders can be quite frail and in need of care and support to live in the community. At times they have become dependent on the prison regime and their ability to look after themselves is severely diminished. Advocating for their needs to be met can be very challenging for their Probation Officers. Such needs are taken account of in the Service's Vulnerable Adults Practice Guidelines, where needs of the service users need to be balanced with the risks that they may still pose to others.

Case Example

A Probation Officer had to find appropriate care for an elderly male who had been convicted of serious child and adult sexual offences. He needed residential care and was released from prison at the end of a determinate prison sentence. As he still presented some risk and this may have increased with the onset of early dementia, the Probation Officer had to ensure that sufficient safeguards were present in any residential setting for both visitors/fellow residents and staff, that was being investigated, but that his needs could still be met and that only those who needed to know about his background were informed and that he was still treated with dignity and respect.

This was very challenging for the Probation Officer simply to have him accepted anywhere and the safeguards and needs met, but this was achieved and the officer worked very closely with the management of the residential setting that was accepting and respecting of him.

The Care Act now includes those in the National Probatin Service, who reside temporarily in their Approved Premises. These house, in the main, those offenders who are deemed to still present a significant risk to others. As above, the responsibility for those offenders who may be vulnerable to the exploitation of others because of their physical and mental health needs, has to be combined with ensuring that meeting their needs and wishes does not present a risk to others. The main challenge in relation to communities that abound our Approved Premises, is getting across that if such offenders were not housed in this facility, they would be subject to much less oversight and monitoring if they were out in the community and that they too have rights and needs and can be vulnerable and need assistance themselves, to live a worthwhile life post prison. The Probation Service work through multi-agency partnerships such as Multi Agency Public Protection (MAPPA), to try and achieve the balance of protecting the public, whilst meeting the needs of the individual offender to allow them to live as independent a life as possible in the community.

2014/15 has been a very turbulent year for the Probation Service as the Government legislated that the high risk offenders would be dealt with by a National Probation Service and the others managed by a private company, generically known as a Community Rehabilitation Company. This split took place in June 2014 and created much disruption to both staff and clients for a considerable period and hampered innovation in all areas of work. Currently policies and practice guidelines are all being reworked, as the National Probation Service has developed the necessary management and infrastructure to allow the basics to be in place. In the interim, the Probation Service has continued to use the Probation Trusts' previous policies, with amendments as required. Workshops and events around both child and adult safeguarding are planned for the summer months covering all the offender management units.

Despite the disruption, the adult safeguarding concernsfor both victims and offenders have been uphelad via forums, such as MAPPA, and in individual supervisions sessions of Probation Officers managing offenders and those staff whose primary role is victim contact and support. The service has also developed reflective practice sessions in particular for those offenders with Personality Disorders, often presenting a high risk of harm to others whose own needs have not been met by established systems. There is a well established complement of psychology staff, advising Probation Officers as to how best to combine both risk and need management. This has been an invaluable resource and has aided Probation Officers to work more effectively with that complex dynamic.

5. PERFORMANCE

The Safeguarding Adults Return is based on a data collection from 1st April 2014 - 31st March 2015. This is a mandatory collection which records information about individuals for whom safeguarding referrals were made during the reporting period.

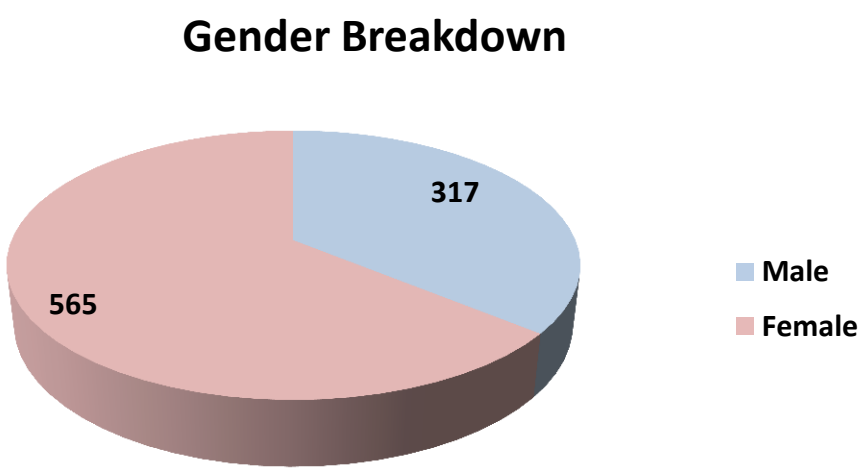
A safeguarding referral is where a concern is raised about a risk of abuse and this instigates an investigation under the safeguarding process. A referral can involve more than one location of abuse, type of abuse or more than one person alleged to have caused harm.

An adult at risk is the person who is alleged to have suffered the abuse. The adults at risk included in the Safeguarding Adults Return are aged 18 and over and have some level of care and support needs.

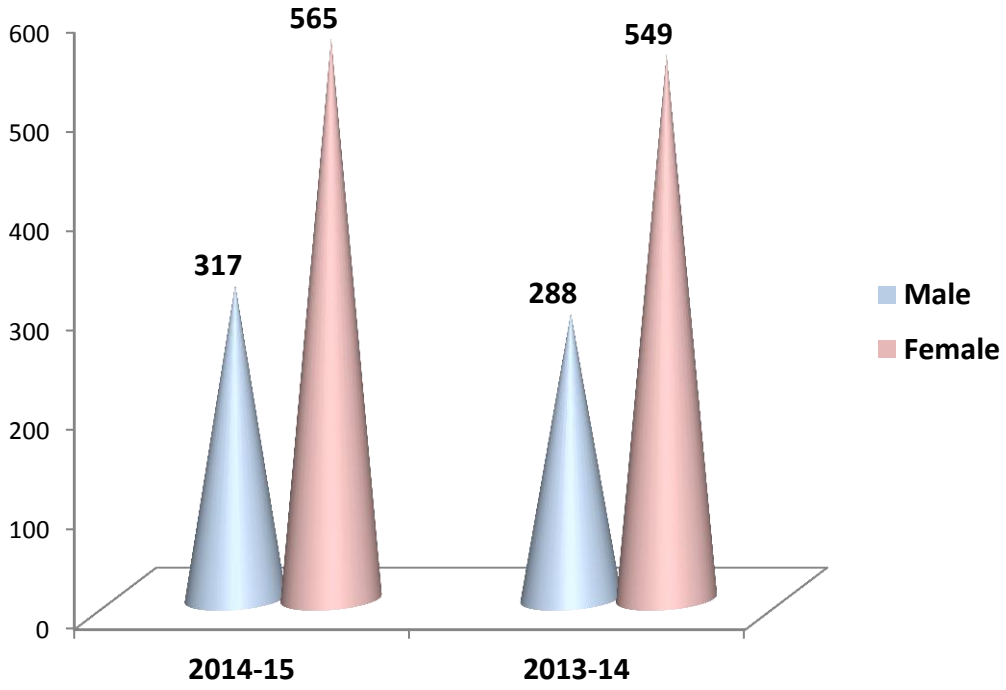
Please find below a summary of the findings from the Safeguarding Adults Return and a comparison of figures between 2013/14 and 2014/15, where applicable.

The total number of safeguarding referrals received during 2014/15 was **882**. This compares to **837** safeguarding referrals received in 2013/14.

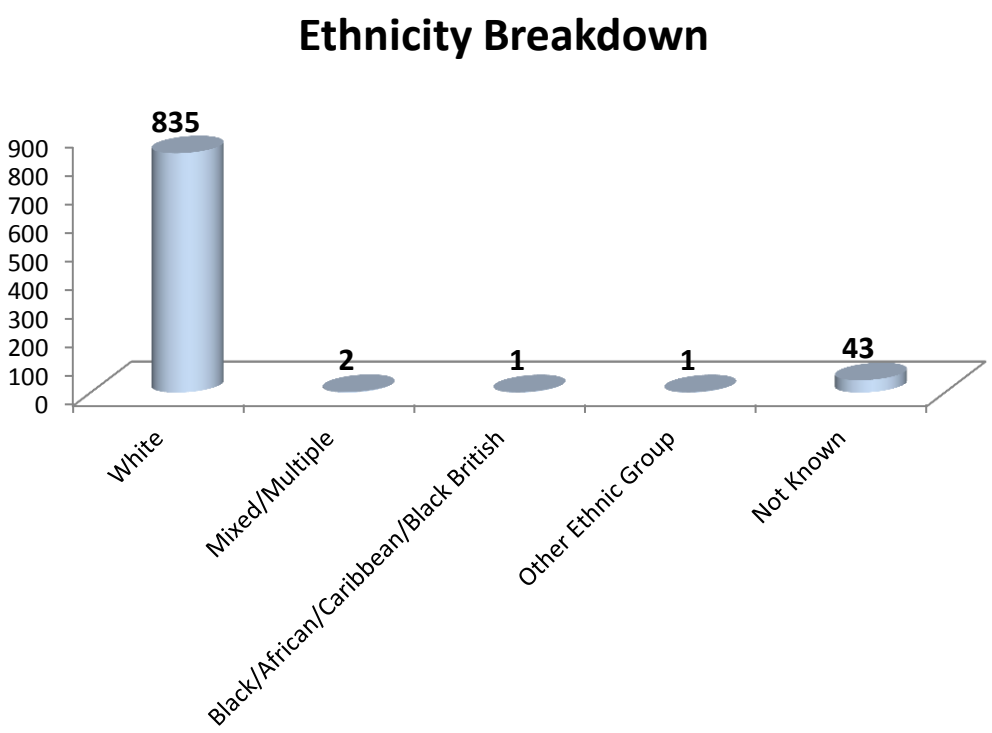
Gender	2014/15 Total
Male	317
Female	565



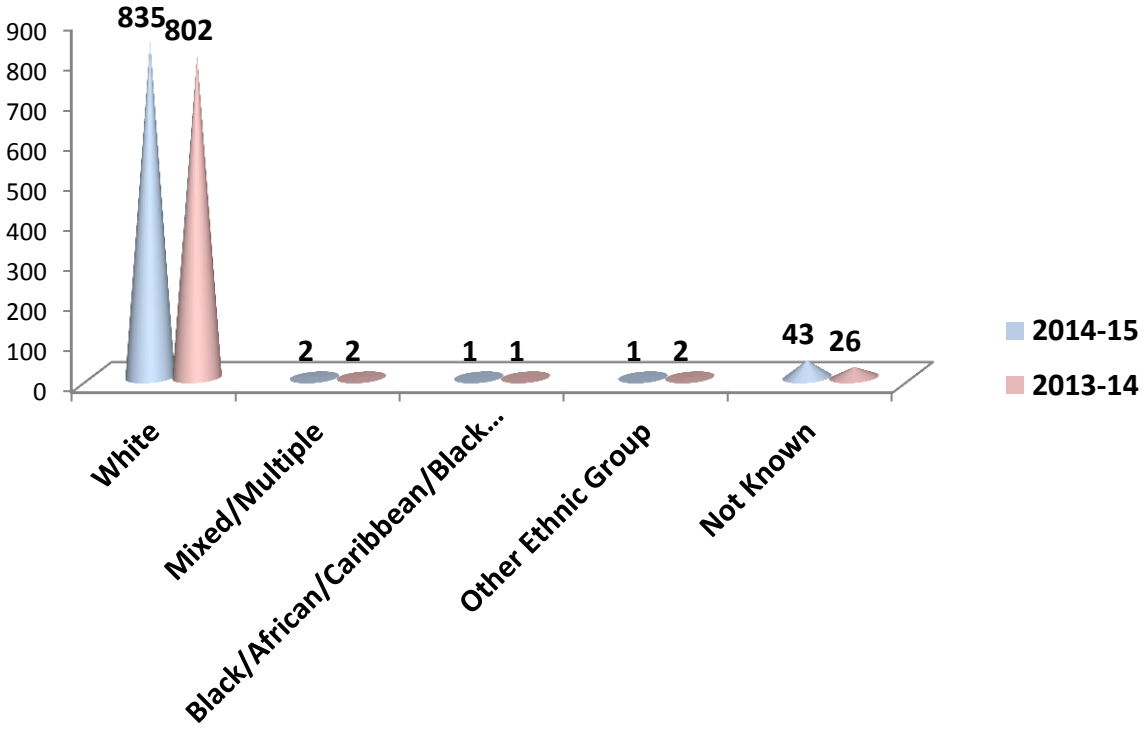
Gender	2014-15	2013-14
Male	317	288
Female	565	549



Ethnicity	2014/15 Total
White	835
Mixed/Multiple	2
Black/African/Caribbean/Black British	1
Other Ethnic Group	1
Not Known	43

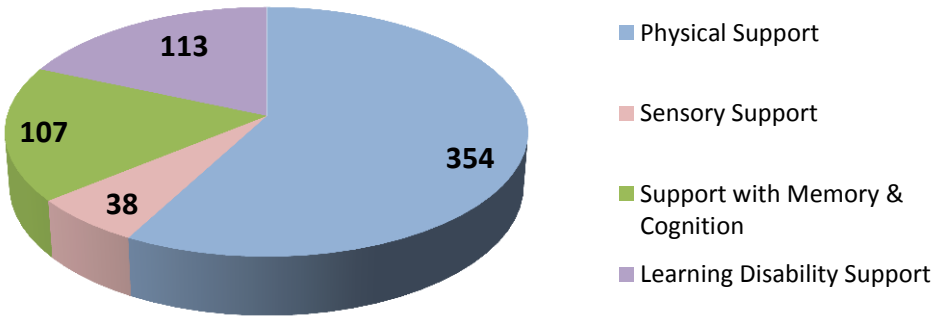


Ethnicity	2014-15	2013-14
White	835	802
Mixed/Multiple	2	2
Black/African/Caribbean/Black British	1	1
Other Ethnic Group	1	2
Not Known	43	26



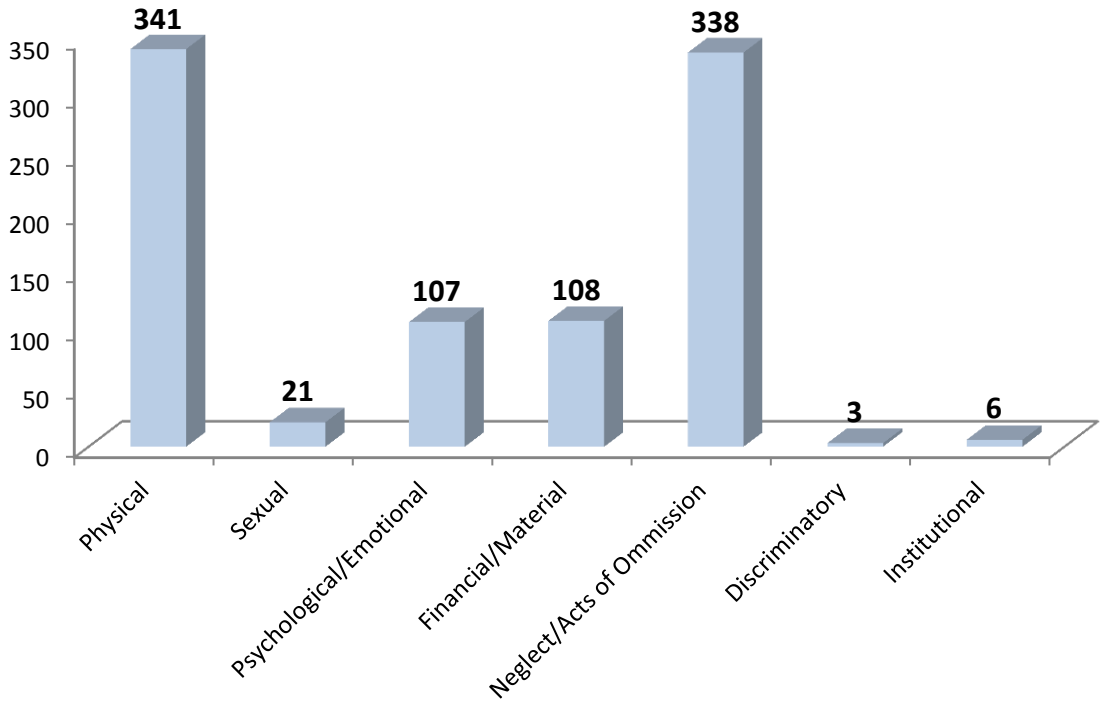
Primary Support Reason	2014/15 Total
Physical Support	354
Sensory Support	38
Support with Memory & Cognition	107
Learning Disability Support	113

Primary Support Reason Breakdown



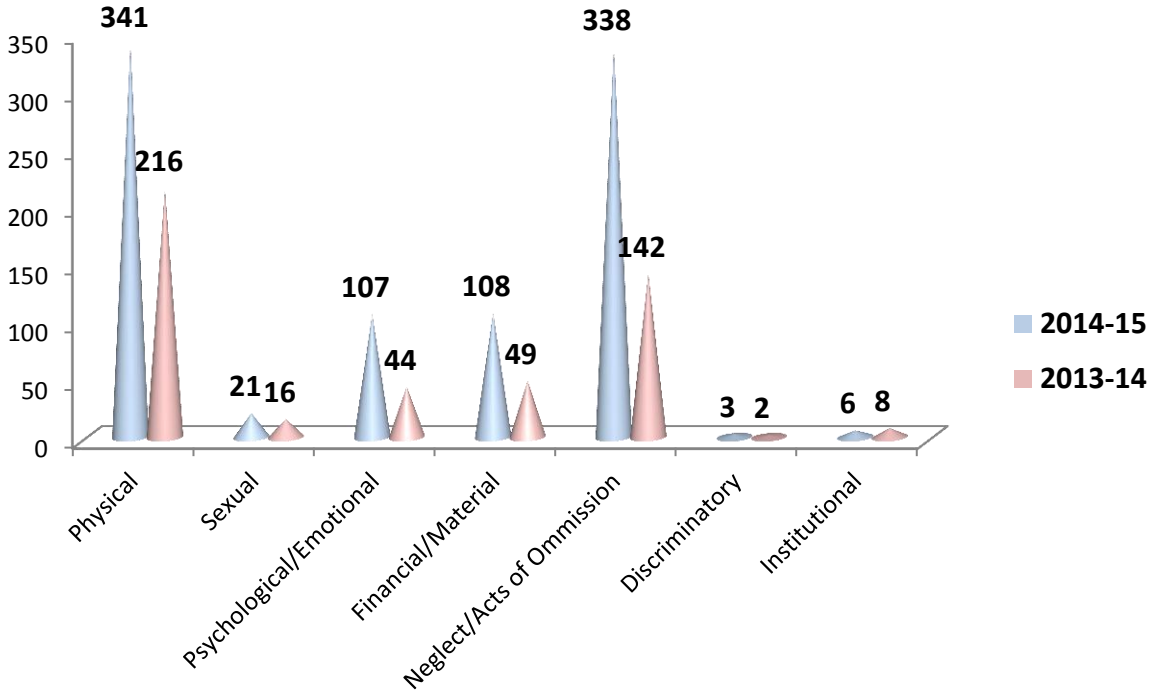
Type of Abuse	2014/15 Total
Physical	341
Sexual	21
Psychological/Emotional	107
Financial/Material	108
Neglect/Acts of Omission	338
Discriminatory	3
Institutional	6

Type of Abuse Breakdown



please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one type of abuse

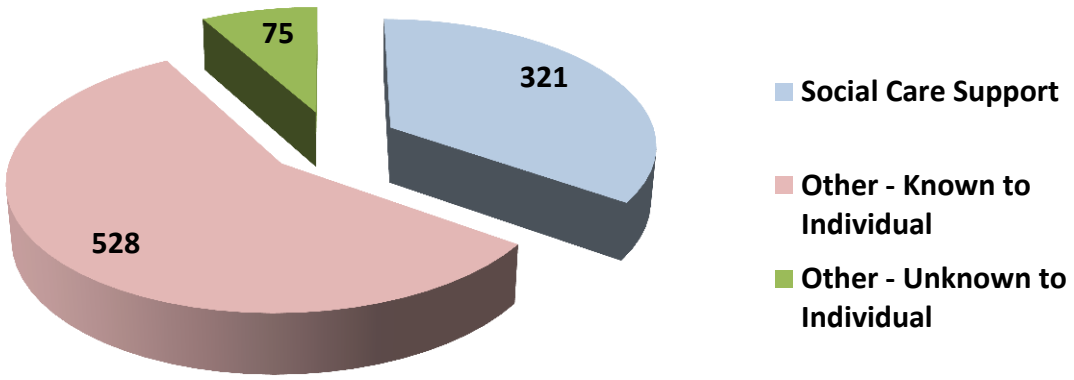
Type of Abuse	2014-15	2013-14
Physical	341	216
Sexual	21	16
Psychological/Emotional	107	44
Financial/Material	108	49
Neglect/Acts of Omission	338	142
Discriminatory	3	2
Institutional	6	8



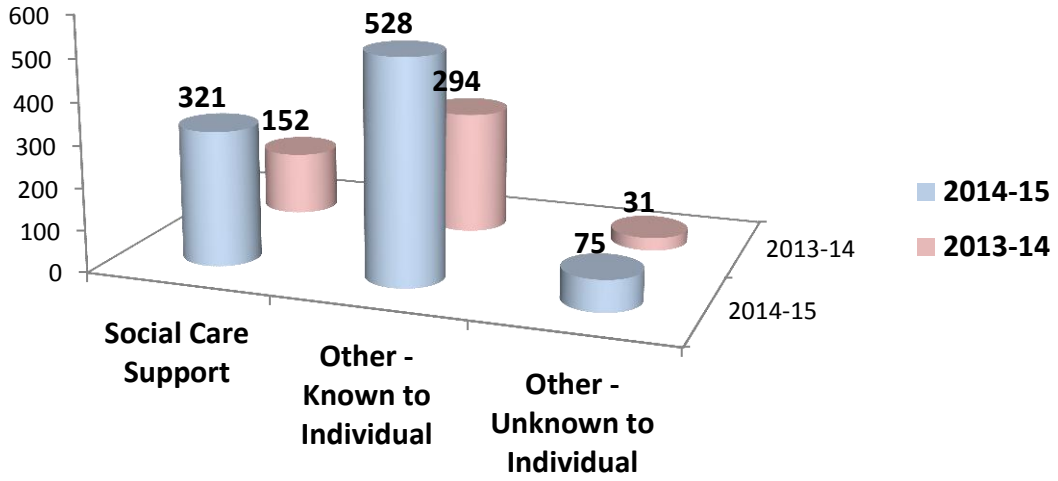
Source of Risk	2014/15 Total
Social Care Support	321
Other - Known to Individual	528
Other - Unknown to Individual	75

*please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one person alleged to have caused harm

Source of Risk Breakdown

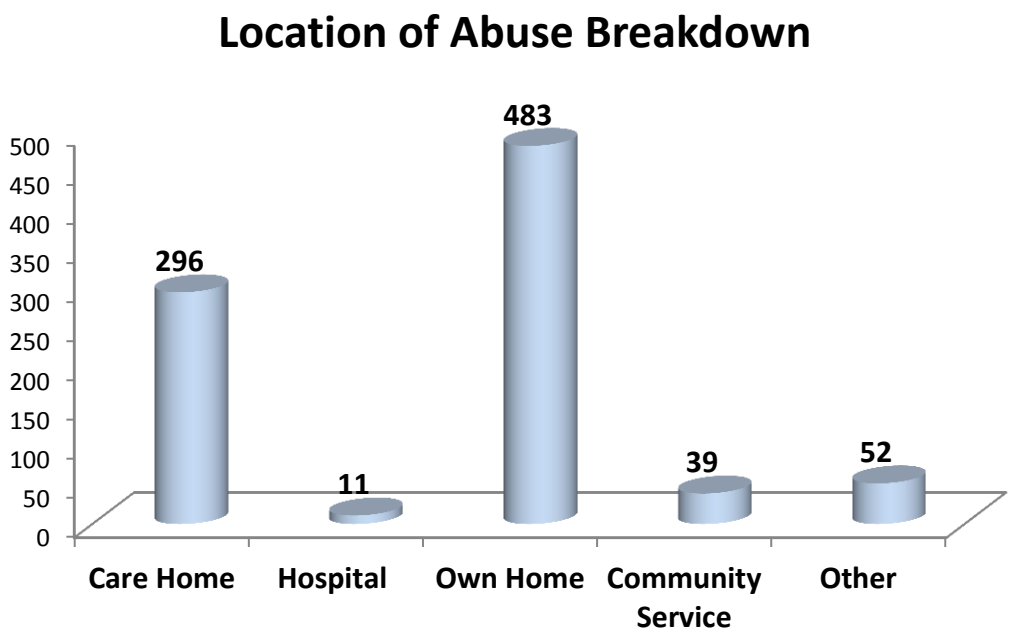


Source of Risk	2014-15	2013-14
Social Care Support	321	152
Other - Known to Individual	528	294
Other - Unknown to Individual	75	31

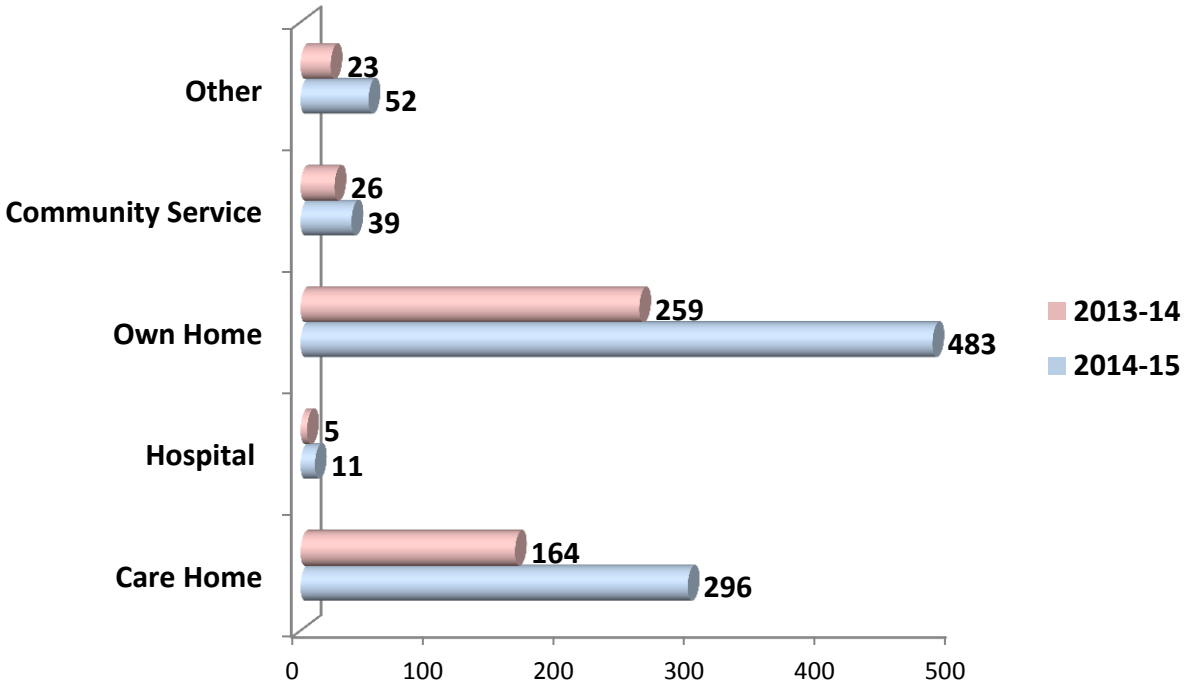


Location of Abuse	2014/15 Total
Care Home	296
Hospital	11
Own Home	483
Community Service	39
Other	52

**please note the figures above exceed the total number of safeguarding referrals received, as some allegations involve more than one location of abuse*

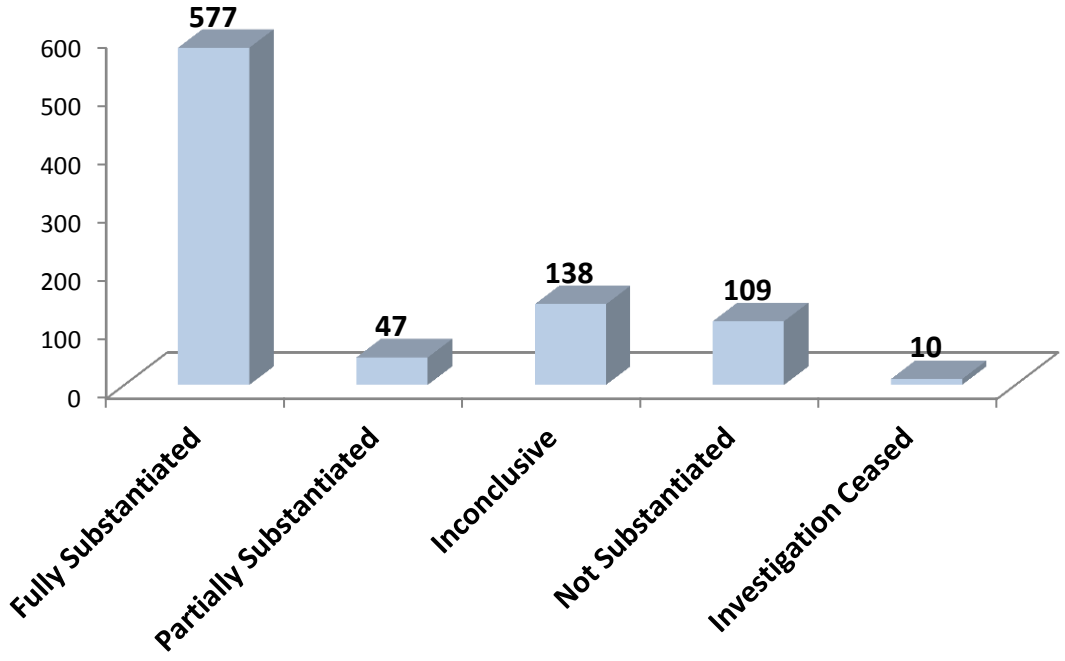


Location of Abuse	2014-15	2013-14
Care Home	296	164
Hospital	11	5
Own Home	483	259
Community Service	39	26
Other	52	23

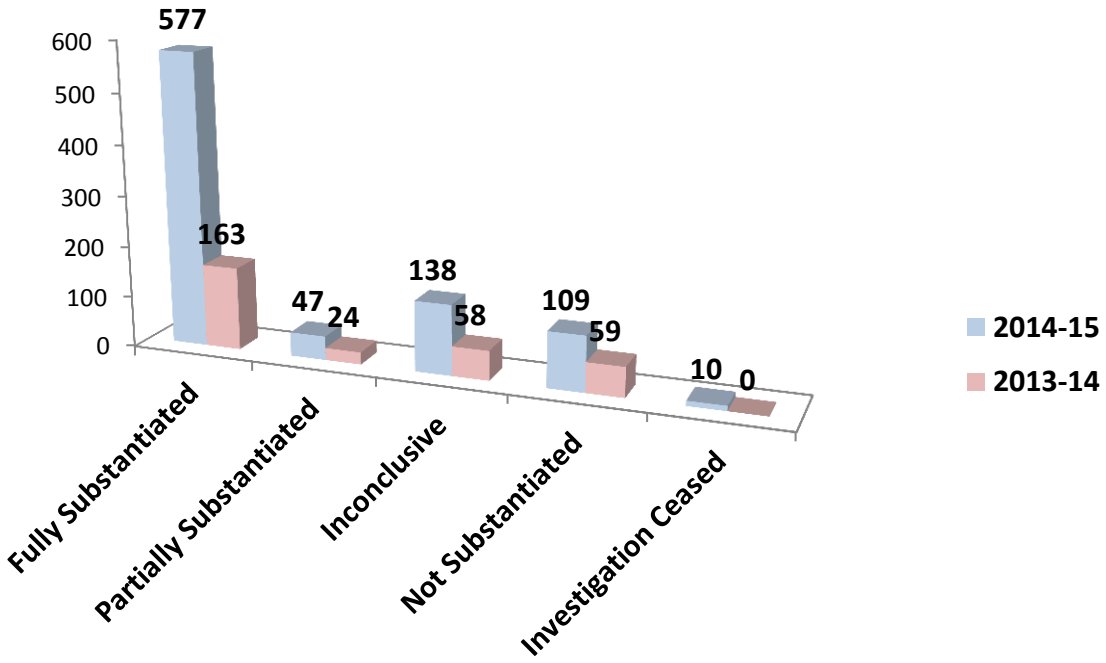


Conclusion of Referral	2014/15 Total
Fully Substantiated	577
Partially Substantiated	47
Inconclusive	138
Not Substantiated	109
Investigation Ceased	10

Conclusion of Referral Breakdown



Conclusion of Referral	2014-15	2013-14
Fully Substantiated	577	163
Partially Substantiated	47	24
Inconclusive	138	58
Not Substantiated	109	59
Investigation Ceased	10	0



6. FUTURE PRIORITIES

The priorities for 2015-16 which Halton Safeguarding Adults Board will be working towards are as follows:

EMPOWERMENT – *I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens*

PREVENTION – *I receive clear and simple information about what abuse is, how to recognise signs and what I can do to seek help*

PROPORTIONALITY – *I am sure that the professionals will work in my interests, as I see them and they will only get involved as much as needed*

PROTECTION – *I get help and support to report abuse and neglect. I get help so that I am am able to take part in the safeguarding process to the extent to which I want*

PARTNERSHIP – *I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me*

ACCOUNTABILITY – *I understand the role of everyone involved in my life and so do they*

REPORT TO: Health Policy and Performance Board

DATE: 8th March 2016

REPORTING OFFICER: Strategic Director, People & Economy

PORTFOLIO: Health and Wellbeing

SUBJECT: Mental Health Champion Quarterly report

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an update to PPB on mental health related activity undertaken by Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (CCG).

2.0 **RECOMMENDATION: That**

1) The contents of the report be noted.

3.0 **SUPPORTING INFORMATION**

3.1 It should be noted that Mental Health services in Halton are under huge pressure. Nationally the wait times and need for Mental Health services have risen to an all-time high. Halton is no different and we have a significant challenge to ensure our services (both preventative and treatment) meet National standards. Work has been undertaken to fully review all the adult services and older peoples in patient beds in line with parity of esteem. The report was completed December 2015 and the recommendations will set the scene for the creation of a more effective, responsive service. Our ongoing consultation and co-production of services will continue to help us shape service provision in partnership with users of services. However, huge strides have been taken, and below is an update of changes, updates and innovation underway.

3.2 **Award winning innovation**

Halton's Wellbeing Practice approach has gained National interest, recently winning a National Association of Primary Care (NAPC) award. The initiative has also won a national Health Service Journal award in 2015.This and other services offer a preventative approach to mental health, developing strategies for the public to improve their own resilience. The drive is to know incorporate parity of esteem, meaning we meet the psychological requirements of patients as well as their physical. Work is underway with partners to improve the input of low level mental wellbeing interventions in all primary care settings. Joint work is ongoing with providers of lower level mental health support commissioned by both CCG and HBC to help support achievement of the IAPT waiting times target by March 2016 (See 3.16)

3.3 **Service Provision**

Appendix 1 has summary of just some of the service provision across the age ranges, commissioned by Halton CCG and HBC.

3.4 **New Governance Structure**

In order to support delivery of the All age Mental Health Strategy for Halton and the supporting All Age Action Plan, a revised governance structure has been established to ensure robust oversight of delivery. The Mental Health Oversight Group chaired by the Local Authority Mental Health Champion has been established and continues to meet quarterly. This group holds to account the variety of other groups such as the Dementia Partnership Board, the Suicide Prevention group etc. for delivery of their respective elements of the Strategy and Action Plan.

3.5 **Dementia Friendly Communities**

Within Halton we have established a Halton Dementia Action Alliance (Halton DAA) in October 2014. This is in line with national dementia strategy recommendations and is an action of the Halton Dementia Strategy. The Halton DAA will work with services, organisations and individuals across all sectors to promote 'dementia friendly practice', to improve outcomes for people living with dementia and their carers. Current membership includes organisations in primary and secondary care, leisure services, trading standards, commissioned care provision, 3rd sector, CCG and HBC. The next meeting of the DAA is in March 16 and will be utilized to launch the Admiral Nurse Service

For more information about the Halton Dementia Action Alliance and Dementia Friendly Communities please click on the link below
http://www.dementiaaction.org.uk/

3.6 **Admiral Nurses for Dementia**

Admiral Nurses provide families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member.

An Admiral Nurse service has been commissioned and staff recruited to enable the service to mobilise in February 2016. Following an options appraisal process a hybrid model of the service being hosted by 5Boroughs Partnership mental health Foundation trust, but very much based within a primary and community setting, was selected as bringing the most benefits.

3.7 **5 Boroughs Footprint Review**

The review was completed in December 2015 and the report is currently being shared via a number of different groups and boards. There were 5 main 'big ticket' recommendations common

to all 5 CCG's

- Primary care/secondary care interface
- Establish the role and function of services/teams within the borough
- Services for personality disorder
- Out of area treatmetns and complex care
- Bed base proposal.

Each CCG has established task and finish groups to take forward the work streams within each borough with oversight of progress via the 5BP Footprint Review Steering Group and locally via the Halton Mental Health Delivery Group and the Mental Health Oversight Group.

3.8 **Emotional Wellbeing services for children**

The Tier 2 CAMHS Service has now successfully mobilized and is co located with the Tier 3 service to provide a single point of referral for CAMHS and an opportunity to direct support as most appropriate. The on line counseling element of support provided by KOOTH, has been well received and there is considerable uptake already.

3.9 **The National Schools Pilot**

Halton are one of approximately 20 national pilot sites for the Schools Link Project. Matched funding had to be provided by the CCG, to secure one of the national pilot sites for the schools link model. Ten local schools have signed up and are taking part in bespoke training from the Anna Freud Centre, London, and a named CAMHS Link worker will be funded to support the pilot. The first training session was held in December and the second will be in March. The national pilot will be evaluated and results shared**.**

3.10 **'Future in Mind' (FIM) report and Transformational plans for CAMHS, including Eating Disorders**

NHS Halton CCG submitted a transformational Plan as required in October and has secure pro rata funding for 2015/16 to support service transformation –and also funding for a specialist Eating Disorder Service which will be commissioned on a Mid Mersey footprint to ensure achievement of the critical mass of population that is required within the guidance (500k). A steering Group has been established and Merseyside Internal Audit have been commissioned to support the work and scope out the service requirements, specification, procurement support etc. The service will be commissioned during 2016/17.

There are a number of plans around increasing capacity in CAMHS to support Youth Offending Services, support for perinatal initiatives, a psychiatric liaison service at Warrington and Halton Hospitals Foundation Trust for under 18 years to name but a few,

There is slippage funding on the allocation and this has been utilised to support 17 projects on a non recurrent basis from a mixture of third sector, community groups and statutory organisations which will support the aims of the Future in Mind Report.

3.11 **System Resilience Funding**

Halton was awarded £81k of additional funding to ensure 24/7 provision of psychiatric liaison services in acute settings through the winter period. Plans are underway to ensure a full 24/7 service is available at Warrington and Halton Hospital Foundation Trust (WHHFT) and additional social work input provided to the service available at St Helens & Knowlsey Acute Trust.

3.12 **The Mental Health Crisis Care Concordat**

The Mental Health Crisis Care Concordat was published by Central Government in late 2013. The concordat aims to encourage all services which provide support to people with mental health needs across a wide area to work closely together to reduce the likelihood of people reaching a mental health crisis. This includes health services, the police, housing authorities, social services and the private and voluntary sectors, all of whom are required to sign a pledge to achieve the aims of the concordat, and then develop and implement and action plan. Locally, Halton has been working closely for some time with partners across the Cheshire footprint. A declaration has been developed and agreed across the partners, and an action plan is in development. Regular meetings are taking place to monitor progress. The overall process is being supported regionally by the Advancing Quality Alliance; a membership body consisting of Mental Health Trusts, CCGs and Local Authorities, and the Association of Directors of Adults Social Services is also actively promoting this work.

The local action from the Halton Crisis Care Concordat Action Plan have now been subsumed within the Adult section of the all age mental health action plan for ease of monitoring of progress.

3.13 **Operation Emblem/ Street Triage**

The Operation Emblem Service was being externally evaluated to demonstrate the benefits this scheme has brought to the wider system and patients. The report was shared in September 2015 and was very positive and as a result the service will be commissioned recurrently from 20116. Discussions are underway to lower the age range of cases handled by the service.

3.14 **Liaison Psychiatry Service – Ward element**

The extended Liaison Psychiatry Service was launched within Warrington and Halton Hospitals NHS Foundation Trust in August 2014. This service has been introduced to reduce waiting times in A&E, reduce length of stay and to reduce discharge to institutional care placements. The service has met with some challenges in becoming embedded within the hospital trust and so a workshop was held for senior stakeholders on 9th July. A way forward was agreed and steady progress has now been made. The commissioners are due to receive a final presentation on the pilot finding in March to understand if any additional investment or change of model is needed.

3.15 **IAPT – Halton Psychological Therapies Service**

The Halton Psychological Therapies service is now provided by 5 Boroughs Partnership NHS Foundation Trust and went live on 1st August 2014. The service was launched with a considerable waiting list, however, action plans and recovery plans are in place to reduce the list and early performance data indicates that the service has begun to increase the access and recovery rates for Halton patients. All initial appointments are now offered within a 2-3 week time fame of referral or 'opt in' by patients.

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Considerable additional non recurrent funding has been provided into the service to clear any internal waits for treatments and recurrent funding has also been invested to increase capacity to meet referral numbers. The CCG is required ot meet a 6 week access into treatment target, plus meeting 15% of prevalence and recovery rates of 50%. The service is on plan to achieve the access targets however the recovery rate remains a challenge – as it does nationally.

3.16 **Suicide Prevention Strategy**

The final draft of the suicide prevention strategy will shortly be presented for Board level approval. The public health team have engaged with a wide range of stakeholders in this process and a task and finish group has been formed. The suicide prevention initiatives outlined within the strategy focus on increasing protective factors and reducing risk factors for suicide within Halton.

Key areas for action to prevent suicides include:

- Improving the mental health and wellbeing of Halton residents
- Promoting the early identification and support of people feeling suicidal
- Reducing the risk of suicide in known high risk groups
- Reducing access to the means of suicide
- Providing better information and support to those bereaved or affected by suicide
- Evaluating interventions, data collection and monitoring progress

Key activities linked to the strategy to reduce suicides locally include:

- Developing a local multi-agency suicide awareness campaign plan
- Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals who interact with known groups at high risk of suicide
- Ensuring those identified as being at risk of suicide can access immediate support
- Reducing access to the means of suicide locally
- Continued support of Operation Emblem
- Commissioning a post intervention service to ensure we have effective local responses to the aftermath of a suicide

This was in last time no update do we want it in or not??

3.17 **Support 4 Change**

The Warrington Criminal Justice Liaison Service (CJLS) is an integrated, multi-professional and practitioner led mental health service. The service acts as a link between Health, Social Services and all Criminal Justice Agencies in their work with adults who have mental health needs or a learning disability, who find themselves at any stage of the criminal justice system.

In September 2014, additional funding from NHS England was successfully sought/awarded to expand the Support 4 Change service to cover Halton and Warrington. In November 2014 Warrington Borough Council and HBC commenced working together to provide the Support 4 Change service across Halton and Warrington. The magistrates' court covers Halton and Warrington, as does the Probation court staff. Therefore it has previously been confusing for the magistrates and Probation staff to consider recommending a Community Order for one area and not the other.

The aim is to offer intensive, innovative and assertive CJLS support, coupled, where appropriate, with an element of compulsion provided by a formal court order, to engage these offenders and to help them turn their lives around.

Funding for Warrington was originally until March 15 but because of delays in receiving the funding in the first place the pilot only started running in October 2012 so Warrington will tie their work into the pilot in Halton and this will run up until to September 2015. Unfortunately due to a decision by NHS E the funding for the Support for Change service will cease end March 2016.

3.18 **Access targets for Early Intervention in Psychosis for First episode of psychosis**

In addition to the access target around IAPT services there is also a requiring for access to treatment within 2 weeks of referral to an EI service. The service will also have to accept clients who are 'at risk of mental state' and also extend the age range up to age 65yrs. A task and finish group has been established to work on the implications of achieving this target and the associated additional resource required given there is no 'new funding' being made available nationally. Self Assessment of state of readiness have been submitted and the process is closely monitored by NHS E. Additional staff have been recruited and NHS E are 'partially assured' at this time that 5BP will achieve the target in April 2016.

3.19 **Public Health, Mental Health posts**

Public health have invested in increasing capacity within the Health Improvement Team with dedicated staff to support the prevention and promotion agenda for young people, adults and older people.

3.20 **Social Work for Better Mental Health:** following the publication of national guidance in 2013 about the roles and functions of social workers in mental health services, the Department of Health is rolling out an implementation programme for localities around the country. Halton, in partnership with Sefton Council, has taken up the offer to be an early implementer of this programme, which will be starting early in 2016. The outcomes of this programme, which will involve partners in the NHS, will be a proper focusing of the work that social workers do within mental health services, and the development of effective service user feedback about the services that are delivered.

4.0 POLICY IMPLICATIONS

4.1 The activity outlined has been directed by the overarching Mental Health Delivery Plan and national mandates.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any financial implications associated with the activity outlined has been/ will be highlighted through the appropriate reporting channels.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Emotional and mental health and wellbeing is a critical factor in supporting children and young people's social development, behaviour and resilience, educational attainment and achievement and life chances.

Emo E

6.2 Employment, Learning & Skills in Halton

Good emotional and mental health and wellbeing is a vital factor for children, young people and adults accessing learning and future employment opportunities.

6.3 A Healthy Halton

Emotional and mental health services impact directly upon the health and wellbeing of adults, children and young people.

6.4 A Safer Halton

Those who do not experience good emotional and mental health and wellbeing are more likely to be subject to a range of risk factors that can impact negatively on community safety issues.

6.5 Halton's Urban Renewal

None identified at this time.

7.0 RISK ANALYSIS

7.1 Failure to ensure that appropriate services to support emotional and mental health and wellbeing is likely to impact negatively on outcomes and life chances for local residents.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this time.

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

None.

Appendix 1 – Examples of Service Provision

Young People

- Universal and Targeted Emotional Health and Well-being, educational sessions in youth clubs and community venues, across Halton.
- Tier 2 Emotional Health and Well-being service to all children and young people aged 5yrs to 19yrs.
- Emotional Health and Well-being service for Children in Care, through Barnardos.
- Young Addaction offer support to children and young people age 10yrs to 19yrs affected by parental mental illness.
- Multi-agency training on mental health, dual diagnosis and self-harm.
- Robust specialist services Tier 3 support for young people with complex issues.

Alternatives for Adults and Children

- Wellbeing Enterprises deliver the NAPC award winning Community Wellbeing Practices initiative to all 17 GP practices in borough. Patients experiencing mild to moderate mental health problems are referred by the GP or health care worker for a personalised wellbeing review, which includes one to one tailored support to identify any social problems at the root cause of mental health distress. The reviews also aim to unlock patient's skills and talents in order to develop a personalised wellbeing plan - in which staff provide ongoing support to help patients to address underlying problems, achieve their goals and to connect with other sources of support available locally.

- The outcomes evidence that 56% of patients report a reduction in their depression symptoms and 64% of patients improve their subjective mental and physical wellbeing levels as a result of their intervention.

- Halton commission wellbeing enterprises to work in partnership with local Mental Health providers (e.g. 5 Boroughs Partnership NHS Foundation Trust) to ensure patients who have been admitted to hospital because of mental health problems also receive wellbeing and social support to ensure they are fully repatriated into their community and receive appropriate community support from their team and other partners.

- Wellbeing Enterprises provides the highly acclaimed 'Ways to Wellbeing' social prescribing programme. Social prescribing is about providing non-medical sources of support to patients with mild to moderate mental health conditions. The team delivers educational and social support groups based on life skills training, cognitive behavioral principles, relaxation classes, sleep hygiene courses, confidence classes and community events that teach people how to stay resilient during difficult times.

- Wellbeing Enterprises CIC have received three years of funding to develop the first, comprehensive wraparound service for children and younger people on waiting lists for CAMHs services because of mild to moderate mental health problems. Children and young people in the borough who are waiting for specialist services will have access to life skills training based on cognitive behavioral principles as well as mindfulness and confidence training as an adjunct to main stay treatment, which it is believed will better prepare younger people for clinical care and will improve outcomes. In addition to this there will be a series of community led projects run by and for children that enable them to share their stories of recovery and to train young people up as peer supporters with a view to creating an informal ecosystem of mental wellbeing support.

Marketing/Prevention and Anti-Stigma

- 'Like Minds for better mental health in Halton' was developed in partnership with the CCG, HBC and PPB to help tackle stigma associated with Mental Health.

- Drawing on the national Time for Change campaign, Like Minds took local people's stories and discussed their experiences with mental health and what they did to help them overcome or work towards overcoming their issues.

- The campaign was launched via a mixed media approach in October 2013, with a second phase focusing on loneliness in the over 55s being launched in October 2014 to coincide with World Mental Health Day.

- To date we have disseminated 10,000 materials across GP surgeries, pharmacies and other community venues. We received mass press coverage in the local media and have delivered approx. 50 training sessions to health professionals, schools and colleges that encompass the Like Minds campaign. We are currently in the process of training all school teachers in self-harm using Sophie's story as a training aide- this to be completed by March 2015.

- The website dedicated to Like Minds www.haltonlikeminds.co.uk has received positive feedback via the online feedback form in terms of changing opinion of mental health and feeling more inclined to talk about mental health than they did before seeing the campaign.

A quote from a member of public on the Like Minds campaign:

"I actually cried reading this, not because I was sad or upset. Seeing stories like this written down made me see where I was back then to where I am now. It was a happy cry, and the last time I cried like that was when my son was born, which made me cry more because I've gotten access to seeing him again. What I mean to say is thank you. I think it's great, I really do".


Like Minds
For better mental health in Halton
My name is David, I'm 30, from Halton View and I've felt suicidal
It's Time to Talk.
If you feel like David talk to somebody you trust or see your GP
For David's full story visit www.haltonlikeminds.co.uk
Like Minds
For better mental health in Halton
My name is Sophie, I'm 16, from Halton Brook and I used to self harm
It's Time to Talk.
If you feel like Sophie talk to somebody you trust or see your GP
For Sophie's full story visit www.haltonlikeminds.co.uk
Like Minds
For better mental health in Halton
My name is Rob, I'm 45, from Halton and I suffer from post traumatic stress
It's Time to Talk.
If you feel like Rob talk to somebody you trust or see your GP
For Rob's full story visit


Like Minds
For better mental health in Halton
My name is Helen, I'm 31, from Sandymoor and I've suffered from postnatal depression
It's Time to Talk.
If you feel like Helen talk to somebody you trust or see your GP
For Helen's full story visit
www.haltonlikeminds.co.uk

Loneliness and older people

- The Halton loneliness strategy aims to make Halton a place without loneliness. We aim to achieve this by working with communities and professionals to identify people who are lonely and then tackling that loneliness with a range of interventions.

- These include visits from professionals and volunteers to try and engage the lonely person in activities in the community, simple Skype like devices to enable people to keep in touch with friends and loved ones, linking with existing tele-friending services such as Silverline and Call in Time, and encouraging schools to twin up with local care homes.

- Dementia Navigator Service, for people living with dementia and their carers. Service provides a listening ear, someone who understands, getting to root cause of social issues and providing tailored support to help them improve wellbeing. We also signpost patients to various sources of clinical and non-clinical support.

- NHS Halton CCG and HBC are signed up as a Dementia friendly organisation and action alliance.

REPORT TO: Health Policy & Performance Board

DATE: 8th March 2016

REPORTING OFFICER: Strategic Director, People & Economy

PORTFOLIO: Health and Wellbeing

SUBJECT: Care Act Implementation – Evaluation

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the first of a two-part evaluation, attached at Appendix 1. The first summarises how the Care Act has resulted in a number of changes in the way Care Management carries out its various processes.

The second and more difficult part will be presented to Board at a later date. This will look at how these changes in health and social care are making a difference to the lives of adults with needs in Halton. Together these two reports will provide evidence of how effective the Act has been in helping adults with a long-term illness to live more fulfilling and meaningful lives while retaining their independence and active role in their community for as long as possible.

2.0 RECOMMENDATION

That the Board:

i) Note the contents of the report and associated appendix.

3.0 SUPPORTING INFORMATION

3.1 On April 1st 2015 phase 1 of the Care Act came into force and its principal objectives are to:

1. reduce reliance on formal care
2. promote independence and wellbeing
3. give people more control over their own care and support
4. Improve the quality, accessibility and importance of information such that it is no longer an add-on but a service

Achieving these goals has not been easy and required major procedural changes in the way social care was presented. This was compounded by both the short timescale that local authorities in England were given to embed the Act and the climate of austerity and local government cuts prevalent in the background. Hence, the local approach was to use as far as possible current social care staff, but to make changes in the way they carried out their role. In this sense, implementing the Care Act has become

an exercise in 'doing things differently.' Evaluating its effectiveness requires taking a closer look at what we are doing that is so different and then assessing how effective this has been in realising the four objectives above.

To help the Local Government Association, Department of Health and the Association of Directors of Adult Social Care Services conducted a series of regional analyses. These monitored how effectively LAs were adapting to the changes and the most recent (Stocktake 5) looked at the Act's impact 6 months after implementation. The rationale for the present evaluation follows on from this.

3.2 The report looks at both the national and local picture. It illustrates the cultural change that Halton has experienced since the days of FACS (Fair Access to Care Services) and stresses the four key shifts that have occurred in Adult Social Care and Support since the advent of the Act. Finally, it selects nine different areas (Safeguarding, Financial Assessment…etc) and looks at the changes that have occurred within each and in some cases provides some early analysis of how such changes have made a difference.

The Information section (pages 10–12), as an example, shows how some of the new changes in procedure can be measured. This will be taken up in much more detail in the next report.

4.0 POLICY IMPLICATIONS

4.1 There are no implications.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no implications.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

There are no implications for this priority.

6.2 Employment, Learning & Skills in Halton

There are no implications for this priority.

6.3 A Healthy Halton

There are no implications for this priority.

6.4 A Safer Halton

There are no implications for this priority.

6.5 Halton's Urban Renewal

There are no implications for this priority.

7.0 **RISK ANALYSIS**

7.1 There are no risks identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no issues that have been identified.

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

9.1 None under the meaning of the Act.

Care Act 2014 Evaluation

1. 0 Introduction

Rationale

It is 10 months since phase 1 of the Care Act was implemented (April 1st 2015). Its principal objectives are to reduce reliance on formal care, to promote people's independence and wellbeing and give people more control over their own care and support. As a consequence many local authorities have had to make major procedural changes in the way they provide social care. In addition, they have had to look at different ways of working with partner organisations and better methods of communicating information about what the Act means for individuals.

Through a series of 5 separate analyses (Stocktakes), the Local Government Association (LGA), Dept. of Health (DH) and the Association of Directors of Adult Social Services (Adass), investigated how effectively LAs were adapting to the changes required by the Care Act. Stocktake 5 (November 2015) looked at the highest priority issues including specific measures to monitor in-year activity and assess the Act's impact 6 months after implementation.

The present evaluation here follows on from Stocktake 5 and will be presented in two parts. The first part, the bulk of this document, concentrates on the changes in approach Halton has had to adopt in order to implement all aspects of the first phase of the Act. These procedural changes have been considerable across a number of different aspects of care management and reflect what is now regarded as 'best practice.' They derive from the culture change and outcomes of introduced by the Act (**Figure 1**) and the key shifts that have occurred to underpin such change (**Figure 2**).

Part two, which will be presented at a later date (June 2016) will attempt to answer the question - how have these changes made a difference? Or to put it another way is the Act delivering all the advantages to people that it was designed to do? The delay between parts 1 and 2 is to enable us to collect appropriate data from each of the nine areas featured and to carry out (where possible) an appropriate 'before and after' the Act analysis of this data Some of this data has never been collected before or has been collected in a different way so that making a comparison may prove problematic. Nonetheless it should be possible to show either way, especially using case histories, just how effective the Act has been, in such areas as assessment, safeguarding and the provision of information. A start has been made to collate this kind of information and the nature of additional data required is discussed for each care management area and featured in Figure 3 (page 12).

The National Picture

The Care Act puts new legal responsibilities on local authorities in England and requires them to cooperate with local partners to meet them. Only a small proportion of care is publically funded. Unpaid family, friends and neighbours provide most care and support. Many adults pay for some or all of their care, but for many local authorities adult social care is one of their biggest areas of spending. Local authorities provide universal and preventative services and usually only pay for individual packages of care for adults assessed as having eligible needs and limited

means. The National Audit Office estimated that the local authority net spend on adult social care in 2014-15 was £14.4 billion.

Through the Care Act the DH aims to achieve the government's vision (**Figure 1**.). This approach empowers people who use care and support, their families, carers and friends to be able to find help and maintain their independence. By this means local authority information, advice and assessments become services in their own right, rather than routes to publically funded intensive care and support.

Nationally the overall picture is positive according to a Department of Health Stocktake analysis entitled "The Care Act Six Months On" (October 2015). The following three major findings emerged:

- Overall council' confidence in their ability to deliver the Act's reforms in 2015/16 remains high with 99% stating they were very or fairly confident. 57% said they were very confident compared with 35% in a similar analysis carried out in February 2015.
- 89% of councils say they are 'on track' with their implementation of the Act in 2015/16.
- Nonetheless, despite high overall levels of confidence more local authorities admitted to having potential support needs. For example 33 councils recorded 5 or more key measures (out of a possible 11) with potential support needs relevant to 2015/16. This compares with 6 councils during the previous stocktake, though admittedly data then was based on estimates.

In addition, a number of lessons have been learnt. *Co-production* is critical to the quality of the end product and the engaging those who have experience of social care takes time to do well. *Joint programme management* has enabled a common vision and a shared view of progress as well as risks, both of which are important aspects of local accountability. *Best practice* already exists among LAs, but it can be difficult to share more widely. It is important to strike the right balance between supporting existing networks or developing new ones for sharing practice on a regional/ local level and producing national guidance. Both can be effective. Changing a previously embedded culture, is difficult and requires significant ongoing effort. Local authorities have observed that "***delivering the rules is not the same as achieving outcomes***."

Care Act Objectives – A culture Change for Halton

Figure 1.

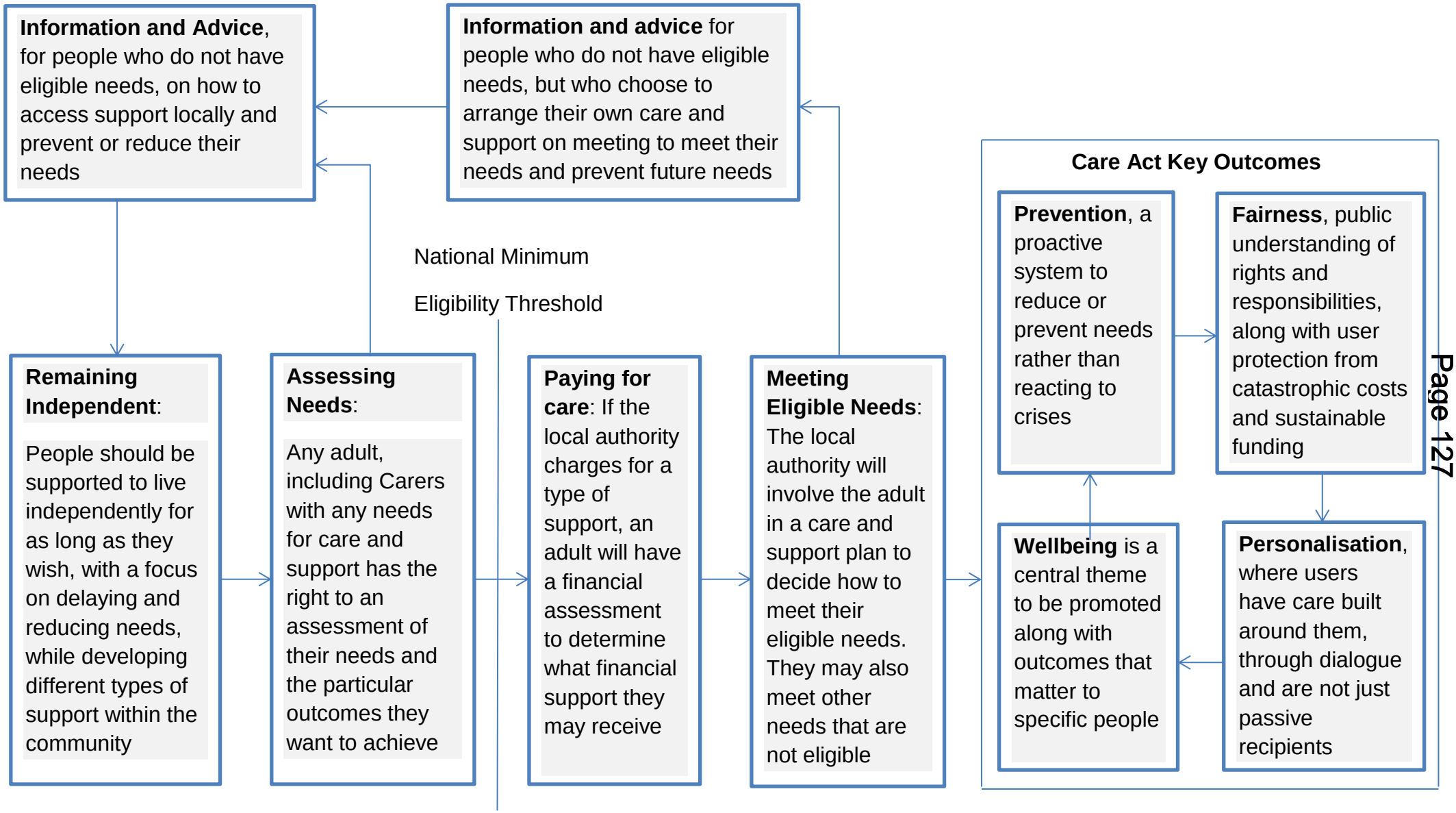

Figure 2

How the Care Act Has Changed Adult Care and Support In Halton – Four Key Shifts

Pre-Act National Approach **FROM** →	**Post-Act Halton Approach** **TO**
1. Paternal The state is responsible for making decisions about a person's care and the services that individuals are entitled to receive. The mechanism for deciding who is entitled to what is called Fair Access to Care Services (FACS).	**Personal** Support is built around the needs and desired outcomes of the individual, to fit in with their quality of life as they see it. This involves a focus on workforce leadership and culture change.
2. Repair The focus is on the appropriate response to make after a crisis has already occurred when needs are greater and available options are fewer.	**Prevention** Acting at a much earlier stage in order to prevent or reduce individual needs. The approach is to help people to stay well for longer in the home environment where they are most comfortable.
3. Fragmentation Isolated services focused internally, with little consistency or continuity. This often results in people being lost between the gaps of organisations or repetition as different services carry out their own separate assessment.	**Integration** Joined up services working as partners across local communities and resulting in measurable benefits for the local community. Regionally led learning networks enable LAs to share practice and challenges based around issues that have been identified locally.
4. Exclusive The overall focus is on services and institutions and as a result people are reduced to being passive recipients of care. A one approach suits all where the individual is consulted infrequently at best.	**Inclusive** Working with people and communities through dialogue and frequent consultation. The aim is to develop shared solutions which will bring measurable benefits to the individual.

The Local Picture

Although health within Halton is improving it still remains a significant challenge, with life expectancy in the borough relatively low compared to many other local authorities in England. Many other key health indicators also remain an issue in Halton, such as high rates of early deaths from cancer and alcohol-specific hospital stays (0-18 year olds).

Halton shares many of the social and economic problems more associated with its urban neighbours on Merseyside. The Index of Multiple Deprivation (IMD) for 2015 is one of the most comprehensive sources of deprivation indicators and 38 different indicators are used. It shows that overall, Halton is ranked 27th nationally (a ranking of 1 indicates that an area is the most deprived), which is third highest on Merseyside, behind Knowsley and Liverpool, and 10th highest in the North West.

The IMD score suggests that deprivation has stayed relatively level in the Borough from 2010 to 2015. The proportion of Halton's population in the most deprived areas (i.e. the top 10% of super output areas) has also remained relatively constant at about 25% in 2010 and 2015. The most deprived neighbourhood in Halton is ranked 355th and is in Runcorn. However, there are now no neighbourhoods in Halton which fall in the top 1% most deprived super output areas nationally, whereas in 2010 2 local neighbourhoods fell into this category. Much has been done, but clearly there is still much to do.

The cost of adult social care annually in Halton is in excess of £40m and the reforms from the Act have resulted in 4 key shifts in the way that local people will experience the act. These shifts involve significant changes to how local authorities must operate. The underlying principle is co-production between local government and those individuals who use care and support. These are outlined in **Figure 2**.

In addition to these key shifts, the following are the main duties stemming from Phase 1 of the Care Act that LAs have had to accommodate in the brief preparation phase available in the run-up to April 1st 2015:

- Provide services that prevent care needs from becoming more serious or delay the impact of their needs;
- Meet a national minimum level of eligibility for a person's care and support needs;
- Assess Carers, regardless of how much care they provide and meet Carer's needs on a similar basis to those they care for;
- Offer deferred payment or loan agreements to more people, avoiding property sales to pay for care and support while the person is still living;
- Provide information and advice (including financial advice) on care and support services to all, regardless of care needs;
- Provide an independent advocate where such support is needed;
- Work with care providers to get a diverse and high quality range of local services;
- Comply with a new legal framework for protection of adults who are at risk of abuse and neglect;
- Provide continuity of care to those whose needs are funded by the local authority and who choose to move to another area;
- Assess the care and support needs of children and their Carers, who are in transition from child to adult social care and so may need support after they turn 18;

A further four changes that have been postponed until April 2020 (phase 2 of the Care Act) will not be dealt with at this stage. These are:

- A cap on the amount a person will pay towards their eligible care;
- The introduction of a personal account so people can monitor how much they have paid in eligible social care costs towards the cap;
- An increase in the threshold above which people will start to contribute fully to their residential care costs;
- The introduction of a right for people to appeal against specific local authority decisions about their care and support.

To implement all of these changes Halton's Care Act Strategy Group met monthly to report the activity and findings of each separate sub-group. To evaluate the impact that the Act has had during the 10 months (April 2015 to January 2016) since its implementation, each sub-group was asked to respond to the following 5 questions:

1. What difference has the Care Act made in your area of work?
2. In what way are you able to demonstrate this?
3. Please outline any **positive** effects the Care Act has made in your area compared with before.
4. Please outline any **negative** effects the Care Act has made in your area compared with before.
5. Briefly outline any areas of the Act that you feel need further development to improve your service.

Results are briefly presented below for each sub-group. All involved agreed that although it was fairly simple to outline the new processes that had to be adopted as a consequence of meeting the Act's guidance, it was more challenging and probably still too soon to assess how effectively these changes were making a difference to users and professionals. To make such a judgement requires further detailed analysis, if it is to be more than just a subjective opinion. Consequently, this report will concentrate on the procedural changes that have had to be adopted and leave the more difficult 'before and after' comparison to a later date when more data has become available.

1. Safeguarding

Changes in Process:

Adult Safeguarding has been strengthened as a result of Safeguarding Adult Boards becoming statutory. Halton's Board has undertaken a full review of its roles and core duties, policies and procedures and have appointed an independent chair. The Board's first Business Plan is being drafted and its Annual Report has been signed off and shared as required by the Care Act.

A whole service redesign was undertaken introducing a Care Concern model and Making Safeguarding Personal approaches. These are being developed and embedded into practice with 'champions' identified within each care management team and extended to include domiciliary care, residential and nursing care, and supported living providers.

The IT systems have been redesigned to capture outcomes, and indicators of self-neglect, human trafficking and modern slavery and domestic abuse.

How have these changes made a difference?

The first report on outcomes of people's experiences of safeguarding has been presented to the Safeguarding Board. This information has supported a more personalised approach to safeguarding allowing practitioners to take different approaches to resolving situations more satisfactorily so that people can feel empowered with their outcomes improved. There is considerable scope for further development of this work.

2. Financial Assessment

Changes in Process:

1. Within the Income & Assessment Team we have seen more interest in Deferred Payment Agreements. The Deferred Payment process has been tightened up and requires a higher level of administration both in terms of the initial application and on -going 'maintenance' of the Deferred Payment agreement;
2. Increased level of queries from both service users and social care staff. This has resulted in a significant increase in the time taken to process DPA applications;
3. National Guidance around financial assessments has been reviewed and updated. Whilst still sparse the revised Guidance did clear up some long standing ambiguities/queries which have been a positive benefit;
4. Significantly more staff time is required dealing with DPA applications;
5. Further updates to the 'Guidance' in respect to financial assessments

How have these changes made a difference?

Ideally the financial assessment should occur as soon after the social care assessment as possible. Prior to the implementation of the Act there was often a delay between the two (sometimes a number of weeks). This no longer happens due to the fact that data is captured more efficiently on CF6.

For those individuals taking up a Deferred Payment, they are now taking advantage of the option to retain more of their weekly income to maintain their properties (which isn't something we have been able to offer them before). However, they are now being charged administration fees and interest on the DPA which is not something we have applied before.

3. Carers and Carer's Assessment

Changes in Process:

We have negotiated with the carers Centre a service re-design to support our implementation of the Care Act, Better Care Fund and GP Enhanced Services. This re-design emphasises the following processes:

1. Identifying carers' at the earliest opportunity, specifically targeting groups that are viewed as 'seldom seen' or 'hidden' for example:
   - Older carers in poor health
   - Male carers aged over 65
   - Individuals providing over 50 hours of care per week
   - Those caring for individuals with mental health issues
   - Those caring for individuals with dementia
   - Those caring for individuals with a substance misuse and/or alcohol issue
   - Those caring for individuals with Learning Disabilities and/or Autism
2. The provision of specific information, advice and guidance, compliments similar services provided by Halton Borough Council and NHS Halton CCG

3. Signposting and referring carer's to the correct information, advice and support to ensure that they are not financially disadvantaged as a result of their caring role
4. Supporting carers' to have their voice heard in decisions that affect them, and where appropriate, advocate on their behalf
5. Providing short term, intensive support to those carers identified by adult social care and health care services where there is a significant risk of 'carer breakdown'
6. Expanding and diversifying the provision of activities and peer support for carers'
7. Supporting carers' to take part in educational, training or work opportunities that they may feel excluded from because of their caring responsibilities
8. Providing a range of learning and development opportunities for carers', front line staff and the community
9. Through a variety of methodologies, gathering and reporting on carer experiences of using mainstream health and social care services; and supporting carers to participate in the planning, commissioning and quality assurance of health and social care services
10. Developing an integrated 'one stop shop' approach to service delivery with specialist services such as Halton Borough Council's welfare rights, home equipment and telecare services, and NHS Halton Clinical Commissioning Group's mental health and well-being services

How have these changes made a difference?

As the number of Carer assessments increase there is likely to be a related increase in access to learning, employment and skills in Halton. This is data that we intend to capture and discuss in the next report.

4. Adult Assessment

Changes in Process:

- The entire ethos behind what the assessment is aiming to achieve, the person's involvement and any assistance they may require to help them express their needs and desired outcomes has had to change. Much of this has involved viewing the purpose of the assessment in a different way to before. The individual is now an active participant and no longer a passive observer. We now record a person's strengths, assets and capabilities, so that the focus of the assessment is around what a person can do, not what they can't. In addition, it is now important to look for ways in which the need for support can be prevented, reduced or delayed and each of these can be measured in different ways.
- The Social Care IT team have been working closely together to develop an online assessment which will include a financial assessment calculator

How have these changes made a difference?

- There is now a new approach to signposting which involves a 4 week follow-up to see whether the person was happy with the service recommended and if not to offer further assistance. This allows us to develop a measure of satisfaction based upon signposting success.

5. CareFirst 6 (data capture and case recording)

- Changes in Process:
- **Carer Assessment** – revised carer assessments to be Care Act compliant - **Changes have been implemented in live 1st April 2015**

- **Safe guarding –** Seven new Safe guarding forms have been developed in accordance with the CareAct implications for safeguarding adults. **Changes have been implemented in live 1st April 2015**
- **Initial Assessment & Screening Referral –** this assessment now includes signposting to all universal services. Follow up reviews are carried out by Halton Direct Link – **Changes have been implemented in live 1st April 2015**
- **Supported Assessment Questionnaire** – The assessment now includes eligibility banding **Changes was implemented 1st April 2015**
- **Information and Advice Portal –** An in house portal has been approved by senior managers. The portal would be developed by the Customer Intelligence Unit and will be free of charge. Using a micro site the concept is to radically improve people's experience, fundamental enabling people, carer's and families to take control and make well informed choices about their care and support. – **go live to take place April 2016**
- **Self-Assessments** - Client / Carer self-assessments and referral will be devised and published on Halton's new in house portal – **Changes are to be launched to all adult workers April 2016**
- **Support Plan Summary Assessment** – The assessment has been reviewed to include a client's Personal Budget Statement. Letters will also be produced from CareFirst to include clients/ carer eligibility and non-eligibility assessed needs. **Changes are to be launched to all Adults' workers April 2016**

How have these changes made a difference?

- This will be assessed in the next report.

6. Integration

Changes in Process:

The Care Act is very clear on why cooperating with relevant partners including the NHS and other health-related services, in performing their care and support responsibilities involving adults and Carers. In terms of processes this has meant:

- Improving the provision of pathways of care particularly for people with multiple long term conditions and frail older people
- Improving coordination across the locality in the commissioning, market management, contracting and delivery of care
- Focusing on person-centred rather than service-centred delivery
- Reducing the number of 'hand offs'
- Maximising quality, safe, effective and efficient care by using skills across the sector
- Improving planning and coordination through understanding the system wide effects of changes in different parts of the local health and social care economy

To achieve these improvements in process, resulting from the Act, Halton has made use of the JSNA and strategic planning across health, social care, housing, safety etc. The aim has been to gain a better understanding of the local profile and to model service provision around this intelligence. At the level of Commissioning this has involved gaining a better understanding of a person's needs 'in the round'. This included for example housing, and commissioning across pathways and care agencies as a means of promoting self-care. At the level of Assessment, information and advice, it includes a wider approach involving areas not considered before and giving a wider array of info and signposting. Actual delivery and provision involves linking agencies into a single care and support plan for each person.

This has involved integrating the following:

- Assessment and case management functions across CCG and Adult Social Care
- Understanding and delivering services at Borough, Town, Hub and GP practice levels

- Developing pathways of care where multiple agencies will work cooperatively to deliver for individuals
- Quality assurance and safeguarding and
- The contract for residential and nursing provision – followed by domiciliary care

This has led to additional process changes involving:

- Expanding the use of expertise in Acute Sector to provide care closer to home – e.g. Urgent Care Centres
- Sharing data (soft and hard) all the time to understand local need and evidence based solutions
- Developing a joint culture and language
- Moving forward together under a 'One Halton' banner

How have these changes made a difference?

This question will be dealt with in a future report as it requires analysis that is not currently taking place. This will involve a means of measuring change in the provision of pathways for frail old people and individuals with long-term conditions, so that improvement and a reduction in hand-offs can be demonstrated. It will also show how we measure the use of skills across the sector, how effectively we are sharing data, how we are making use of local profile intelligence and a measure of how multiple agencies are working cooperatively under 'One Halton.'

7. Information

Changes in Process:

The development of an information model is well underway and will deliver the following:

1. Ensure people are aware there is information, advice or advocacy that could help in their situation;
2. Make access to appropriate and comprehensive information and advice; and
3. Receiving practical assistance to act on the information and achieve a solution.

The model uses information already available to people, but focused around their individual need. This will improve the person's access to information. A number of layers are in the process of development and although there will be some elements that can be completed quickly, others will take longer. Changes in process that are planned will concentrate on the following key areas:

- **Simplify information pathways**- there are many examples of how difficult it is for people to navigate through their own particular pathway that they find themselves on. This is due to a number of reasons that have already been considered within this document. It is therefore vital that we simplify the pathway for people to ensure that they get the correct information as quickly as possible.
- **Remove blocks to preventative information and interventions** – this is linked to improving the information pathways, the information model will need to ensure that they have thoroughly researched all of the relevant preventative interventions before a health or social care service is offered. This can include methods of self-help, managing your own condition or linking through to low-level community activity.
- **More specific intelligence available to people using or about to use services** – a system will be developed that allows greater information and transparency on the information that is collected. This will be the most significant change as it will require Halton Borough Council to publish information that is gained on providers in the course of monitoring visits. The detail of what is published will need to be agreed through each of the individual services, however how it will be done will be consistent through the council.
    a) Agreed intelligence will be available on the council website or on request.
    b) Information will relate to performance, risks, quality and other relevant information

c) It will be presented in a clear manner that will help people make an informed choice of which service they should choose.
d) This will cover areas including residential care, domiciliary care, voluntary sector, housing etc.

- **Information quality and access** – rather than recreate from scratch, trusted sources of information that have been developed nationally will be used as the core of information provision for people in a specific service area. This will be completed by taking the following steps:
  a) Identify the service area for example carers, older people, mental health, learning disability, sensory disability
  b) Bring together a network of services already working in these areas, this would be your service cluster.
  c) Share all information methods that are currently available in this area
  d) Assign a lead organisation who will be the first point of contact
  e) Agree joint marketing, newsletters, referral processes etc.
  Review after 6 months
- **Online referral system** – this would be an opportunity to develop an online referral system that could easily operate between the services within each service area. This would mean that if someone was supported in the first instance by Citizens Advice Bureau, but also needed help to access a local social group an online referral to Sure Start to Later Life could be made and then tracked. This would make the process of referring much easier and again if there was a lead organisation it would make it much easier for commissioners to track trends, performance, gaps etc.

- **Appointment booking** – The next logical stage (although there will be considerations around IT systems and sharing protocols) would be for organisations to be able to book appointments for people directly with organisations that work in their area. For example if someone was supported through the Fire Service Home Safety Assessment, but was identified as having a need to access benefits, it would make a significant difference to the service user if an appointment could be arranged there and then by the Fire Service. There are barriers to overcome before this can happen, however the technology already exists to do this, it is just about how we apply it and use it in the future.

- **Co-ordinated information distribution** – as well as shared marketing (newsletters etc.) the leads from each area would develop a system to effectively distribute information across the borough. This is important to avoid duplication or information overload in different community assets. For example GP surgeries, libraries, community centres, it would also allow targeted campaigns to hit a number of venues and by keeping a record of what is produced and where it should ensure that no information is out of date.

- **Develop the service clusters** – as mentioned in point 1 above we would be developing a group of services that sit around a main service area. This does not mean that a service can only work in their own cluster or that if you not included in an area that you not going to be involved. The clusters are only a guide to help improve the navigation for people, services can cross over and also some organisations like Citizens Advice Bureau would not fit easily into one theme and would actually cut across most if not all themes.

How have these changes made a difference?

This will be the challenging part and will require a number of very specific measures along the following lines in **Figure 3**:

Figure 3

New changes	Measures
Simplify pathway and remove blocks to preventative information	Speed of access and user satisfaction
More specific intelligence	Performance data available on council website
Quality and access	Making available specific data on all services within a cluster
Online referral system	Ability to track all referrals for later analysis
Information distribution	Recording what is produced and where so information in GP surgeries, libraries, community centres is not out of date
Personal Perspectives	Case histories to illustrate outcomes and their relevance

8. Training

Changes in Process:

Training cuts across all areas of the Act and has been made available for all staff involved in Adult Social Care, for Members and partner organisations. A series of 'Bite-size' and 'Joining the Dots' learning sessions were delivered to look at key elements of the Act with a view to raising awareness in preparation for the skills and knowledge to deliver appropriate and meaningful care under the Act. The following topics have been presented:

A. A customer journey through the Care Act: First contact and identifying need
B. Fairer for the Carer: equal access to services - changes under the Care Act
C. What can you do? Asset-based support planning - the key to personalisation
D. Wellbeing: preventing and delaying the need for care
E. Transition to adulthood
F. Assessment - A legal perspective
G. Ordinary Residence - The legal definition
H. Safeguarding Adults - the new legal framework and the practical processes
I. The role of the independent advocate

A number of further events focussed on themes of the Care Act 2014 to provide a one-stop shop for those in occupations who support people, together with those who require support and their Carers. The 'drop-in' market place gave people the opportunity to gather information, ask questions, and to gain a wider understanding of the implications of new legislation. In addition to the market place of services each event hosted a 'Cyber Learning Zone' with free access to a range of health and social care e-learning modules as a means of complementing practitioner knowledge and skills. The aim was also to assist people in making connections, gaining knowledge of services, and ensuring a joined up approach.

As well as Halton Borough Council, the following partner organisations were involved: Halton Speak Out; CRI; Citizens' Advice Bureau; Positive Behaviour Support Service; HBC Libraries; Halton Healthwatch; Halton's Health Improvement Team; Sure Start to Later Life.

Feedback after each well-attended event indicated there were other areas of knowledge involving specific areas of the Act that people were interested in learning more about. As a consequence, a series of half-day sessions are being planned for late February and early March. These will revisit fundamental components of the Act from a more in-depth legal perspective. This will enable those attending to consider its application to working practices in such areas as Assessment, Wellbeing, Care and Support Planning and Financial Assessment.

How have these changes made a difference?

SW assessors are now more informed and aware that the assessment has to be a dialogue with the individual and or their advocate and this involves detailed explanations of how and why the assessment process has changed and the importance of these changes for the individual in terms of explaining how needs outcomes and wellbeing are closely interrelated. However, in order to assess the effectiveness of these changes in the assessment process a number of new measures will have to be developed. These will be discussed in the next evaluation report.

9. Legal

Changes in Process:

Legal awareness is central to the Act and cuts across all aspects of it. Consequently, an additional P/T legal post was created to cope with any additional legal activity stemming from the Government's publicity campaign and increased public awareness stemming from it. This meant that Halton's legal department could have a dedicated individual who would be the single contact for all legal queries involving the Care Act. This has proved extremely useful in providing continuity in such areas as: policy, assessment, training and information.

How have these changes made a difference?

Social Workers who are at the forefront implementing the Care Act, particularly those aspects involving social care assessment have expressed a need for additional legislative knowledge and case studies involving the application of the Act and its implications for individuals. As a consequence of this, a series of half-day events are planned for late February to March 2016 in order to inform best practice. These will look at fundamental components of the Act and will consider such areas as: Wellbeing, Assessment, Care and support planning and financial assessment.

Being in close contact with legal has made areas of the Act involving the drawing up of second and 3rd party contracts (e.g. for the Top-Up fees Policy) much more efficient.

REPORT TO: Health Policy & Performance Board

DATE: 8th March 2016

REPORTING OFFICER: Strategic Director – People & Economy

PORTFOLIO: Health and Wellbeing

SUBJECT: Scrutiny Topic 2016/17 : Carers

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To present the Board with details of the Carers Scrutiny topic as outlined in the attached topic brief.

2.0 **RECOMMENDATION**

RECOMMENDED: That the Board

i) Note contents of the report;
ii) Approve the Topic Brief outlined at Appendix 1; and
iii) Nominate Members of the Board to form part of the Scrutiny Topic Working Group.

3.0 **SUPPORTING INFORMATION**

3.1 The 2011 census found that there were over 15,000 carers in the Borough who were providing unpaid help and support to their partners and relatives etc.

3.2 With the introduction of the Care Act 2014, Carers are now recognised in law in the same way as those they care for; this means they have the right to an assessment of their needs. As a consequence, the Act has resulted in an unprecedented focus on Carers and their own health and for the first time sets out a set of national criteria to establish whether the Carer is eligible for support.

3.3 This topic will focus on the type and quality of Carers Services provided in Halton and the associated pathways in place to support Carers' ability to access those Services. It will examine these services and associated pathways, with a view to evaluating their effectiveness in meeting the needs of the local population.

3.4 Subject to agreement by Board to accept the topic brief; this report seeks nominations from members of the Board to form a member led scrutiny working group.

4.0 **POLICY IMPLICATIONS**

4.1 The recommendations from the resulting scrutiny review may result in a need to

review associated policies and procedures and will contribute to the development of a new Carer's Strategy for Halton.

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**
The remit of the Health Policy and Performance Board is directly linked to 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 under the meaning of the Act.

TOPIC BRIEF

Topic Title:	Carer Services
Officer Lead:	Paul McWade – Operational Director, Commissioning & Complex Care: People & Economy Directorate
Planned Start Date:	April 2016
Target PPB Meeting:	March 2017

Topic Description and Scope:

This topic will focus on the type and quality of Carers Services provided in Halton and the associated pathways in place to support Carers' ability to access those Services. It will examine these services and associated pathways, with a view to evaluating their effectiveness in meeting the needs of the local population.

Why this topic was chosen:
The Health Policy and Performance Board recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community.

The 2011 census found that there were over 15,000 carers in the Borough who were providing unpaid help and support to their partners and relatives etc.

- Approximately 8,000 individuals provided unpaid care for 1 – 19 hours per week;
- Nearly 2,500 individuals in Halton provided unpaid care from 20 – 49 hours per week; and
- Over 4,500 individuals provided unpaid care for 50 or more hours per week

It should be noted that approximately 3,000 carers were aged 65 and over.

With the introduction of the Care Act 2014, Carers are now recognised in law in the same way as those they care for; this means they have the right to an assessment of their needs. As a consequence, the Act has resulted in an unprecedented focus on Carers and their own health and for the first time sets out a set of national criteria to establish whether the Carer is eligible for support. If this is the case they are entitled to a Carer Support Plan and a further review of their status after 6 to 9 weeks. The purpose of this review is to see whether the impact of their caring role is still significant.

It is felt that this Scrutiny topic will provide the Board with the opportunity to actively contribute to the review and development of a new service specification for the Halton Carers Centre and development of a Carer's Strategy, which have been identified as key developments in respect of Adult Social Care during 2016/17, as part of the Business Planning process, in addition to ensuring that the Local Authority is discharging its duty in respect of Carers as outlined in the Care Act 2014.

Key outputs and outcomes sought:

- An understanding of existing Carers Services available in Halton and associated pathways for Carers to be able to access them.
- An understanding of the role that all agencies, including their associated responsibilities, (both statutory and voluntary/community sector) play in the provision of Carers Services.

- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to Carers Services in Halton to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.
- Identification of the best methods for measuring the outcomes for Carers.
- Outcome of Scrutiny review to contribute to the development of the new service specification for Halton Carers Centre and the development of Halton's Carers Strategy.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton – To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member led scrutiny review of Carer Services and how these Services can be accessed.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council and partner agencies to examine current services.
- Visit to Halton Carers Centre/Other Carers Centre.
- Carer Interviews.
- Desk top research in relation to national best and evidence based practice.

Agreed and signed by:

PPB chair ……. **Officer …….**

Date …… **Date …….**

REPORT TO: Health Policy & Performance Board

DATE: 8th March 2016

REPORTING OFFICER: Operational Director, Prevention & Assessment

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 3 2015-16

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 3 of 2015-16. This includes a description of factors which are affecting the service.

2.0 RECOMMENDATION: That the Policy and Performance Board:

i) Receive the Quarter 3 Priority Based report

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

iii) 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 3, 2015-16.

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 3: 1st October to 31st December 2015

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the third quarter of 2015/16 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 third quarter which include:

PREVENTION & ASSESSMENT

Minor Adaptations Service
The contract for delivering this service ended on 30th September 2015. A tender process was completed during quarter 2 and a contract from 1st October 2015 to 30th September 2016 awarded to a new provider. Provision has been made to extend the contract period for up to a further 3 years subject to satisfactory performance. The service will be closely monitored to ensure quality of work is maintained and delivery targets set as part of the Better Care Plan are achieved.

Care Act
The relevant elements of the Care Act implementation phase have been completed in line with the Government deadline of April 2015. All of the required policies have either been amended or written to ensure that the Act is operational. Training of frontline staff has been completed and this training has also been rolled out to partners and other stakeholders. The second phase of the Act that relates to the financial requirements for people has been postponed by the Government until 2020.

Learning Disability Nursing Team
The team continue to work proactively with individuals, their family, carers and professionals such as GPs, allied Health professionals. Key developments include:

- A team member attended the RCN Conference with 2 experts by experience to discuss reasonable adjustments within acute hospital settings and their experiences.
- A team member has continued supported a lady through treatment for breast cancer.
- The team have been working with other agencies and providers to promote positive outcomes for people.
- Relationship work has been carried out with couples as part of their support.
- Out of Borough reviews have been supported by team members.
- A team member has supported the acute trust with best interest decisions.

- A team member has been integral to the support for Muslim man to explore his faith in the area of marriage.
- The Monday walking group have met for a meal to celebrate their attendance at the group. This was very positive for all!
- A team member has provided advice and support to enable a man to move from home to his own place.
- A Friendship and relationships course was facilitated by some team members and self-advocates to a staff and self-advocate group.
- A team member has been supporting the Health Improvement Team to run the Freshstart group
- Ongoing monitoring of a customer following their discharge from an inpatient ward.
- A team member provided a learning disability awareness training session to CHC nurses and day service and HSHN support staff
- The team have received PBSS training and medication training

The "Making a Difference" a strategy for transforming care management in Halton that is aimed at staff and partner agencies, continues to be developed. The overall purpose has been to provide a shared vision of the future of care management services and provide us with a plan to shape our future, over the next five years. This Care Management strategy has stemmed from the growing need to identify a future vision of assessment and care management services that are fit for purpose to meet the many challenges at national and local level whilst maintaining high quality, effective and safe practice. A Steering group is established to take forward the Action plan, and key areas of work. One of these areas has been the successful development of , a "Progression Routes Policy and Procedure" It demonstrates Halton is committed to developing the careers of Social Workers through vocational and academic routes. Adopting a stepped advancement pathway that allows for the successful recruitment, retention and succession planning of social work staff within the Borough. Another important area to highlight is a regular "Social Work Matters Forum" where the Principal Social Worker meets with social workers to ensure the professionalism and voice of social work is supported within the integrated working environment. It is anticipated the forum will receive a visit from the chief social worker later in the year. Social Workers are meeting in "Action Learning Sets" to enable opportunity for reflective learning, research, and support evidence based practice.

Making Safeguarding Personal
The Local Government Association and ADASS (Directors of Adult Social Services) published an evaluation of Making Safeguarding Personal (MSP). This is the approach embedded within the Care Act and has moved safeguarding investigations from a process driven approach to one which focusses on outcomes for the person involved. The new IT system went live in July 2015 and the report on outcomes has been presented the Safeguarding Adult Board.

COMMISSIONING & COMPLEX CARE SERVICES

Mental Health Services:
Review of the Acute Care Pathway (ACP) and Later Life and Memory Services (LLAMS) within the 5Boroughs: both of these services have now been in place for well over two years, so in 2015 the combined CCGs across the 5Boroughs footprint commissioned a detailed review of the effectiveness of these services, and the scope for future developments. The review has now been completed, with recommendations which cover the 5Boorughs as a whole, as well as each individual borough area.

For Halton, five key areas have been identified, ranging from the development of stronger links between primary and secondary care mental health services, and the development of more effective early intervention and prevention services, to improvements in services for people with personality disorders and complex mental health problems. Each of these is to be developed into a local workstream which will be supervised and driven by the Halton Mental Health Delivery Group.

Operation Emblem: this is the joint initiative between the police, the CCG and the 5Boroughs, and supported by the Borough Council, to reduce the numbers of people believed to have a mental health problem detained in a place of safety by the police, using their powers under Section 136 Mental Health Act 1983. This initiative has now been reviewed in detail, and revealed some extremely positive results:

- In 2014, there was a reduction of 54% in the numbers of people in Halton detained under Section 136
- This reduction reached 100% in the last six months of the evaluation period, for the times of day that Operation Emblem was in place
- This has created significant reductions in the use of staff time across all involved agencies
- Professionals report the development of really positive relationships and levels of understanding across the services
- People who use services felt respected and treated with dignity, which allowed them in turn to be open and honest; they felt that the services and supports they were offered were appropriate and there was a positive impact on families

The service continues to be commissioned and is well regarded. Consideration will be given to extending the service within Halton as part of the action plan arising from the review of the Acute Care Pathway and LLAMS.

Mental Health Crisis Care Concordat: this concordat, designed to ensure that key local agencies work together effectively to either prevent mental health crisis, or minimise its effects if it happens, was published by central government in 2013. A detailed action plan has been developed across the Cheshire region, complemented by a local Halton-based plan. This is monitored on a regular basis by the Halton Mental Health Delivery Group, and many of its actions will be incorporated into the implementation of the review of the ACP and LLAMS.

Review of Halton Borough Council Mental Health services: through the Spring and Summer of 2015, a review involving key partners took place of the delivery of the social care services within Halton for people with mental health needs. This took into account the social work service, the Mental Health Outreach Team and a number of services commissioned by the Council. A number of recommendations were made, which support the overall objectives of intervening with people at an earlier stage of their conditions, and preventing mental health conditions from arising if possible. The actions to deliver these recommendations are incorporated into the Halton Mental Health Delivery Group's work plan and will be supported by delivery of the outcomes of the review of the ACP and LLAMS.

CQC inspection of 5Boroughs Partnership NHS Trust: this detailed inspection took place across the whole footprint of the 5Boroughs in summer 2015. The published outcome was expected in autumn 2015 but has not yet been delivered; the council will be involved in and will support any action planning which takes place as a result.

Other developments in the Commissioning and Complex Care Department:

Halton and St Helens Emergency Duty Team: this service is run as a joint partnership between the two councils, and covers both children's and adults services. This service has been in place for over ten years, during which time there have been a considerable number of developments: the legal context has been through significant changes in both children's and adults services, the demand for the services has increased, the ways in which partners work has been through substantial change and there is an increasing need for efficient and cost-effective service delivery.

As a result of all of this, and from approaches made by other Local Authorities in an attempt to join the partnership, a detailed review has taken place. Recommendations have been made and will be implemented through the service's joint partnership board.

Homelessness

The Merseyside Sub Regional Homeless Group successfully qualified for single homeless funding. Each of the six authorities agreed that vulnerable client with complex needs was a priority, subsequently, it was agreed that the funding would be used to develop a small team of four who would provide intense support for high complex needs clients. The recruitment process has now been completed and the contract was awarded to Whitechapel and the service commenced November 2015 and will run for a two year period. Discussions are underway with the organisation to develop an efficient referral process and identify the key agencies within Halton

Halton commissioned a new supported hostel Brennan Lodge, which officially opened July 2015. The scheme offers 39 bed self-contained units for single vulnerable homelessness clients. The building is owned by Halton Housing Trust and the Salvation Army are responsible for the operational management. Unfortunately, in November 2015 a number of management/safeguarding issues were identified, consequently, this led to the service was suspended. A number of quality inspections have been completed and it has been agreed that the suspension will be lifted with restrictions, whereby, client admittance will be restricted to no more than 8 per month the service will be monitored.

The homelessness reporting I.T system is due to be removed and consultation and training is underway. The service will now collect homelessness/prevention data using the Capita system, which will improve the data collection and reporting process. The system is due to go Live week beginning 25/1/2016 and all client records will be recorded electronically.

As part of the Gold Standard the Merseyside Sub Regional Homeless group have registered for the peer review. Each of the six authorities will review a number of services within the group. Halton recently completed a service review within Sefton and has presented the Authority with the overall findings and scores.

Halton was due to be reviewed by St Helens early September 2015, however, due to work commitments; the reviewing Authority was forced to cancel. The review process will be rearranged; however, Halton has agreed that due to other priority issues, the preference would be for the review to be arranged for February/March 2016. Upon completion of the Peer Review, the Authority will then pursue registering for the Gold Standard and undertake the necessary assessment.

Housing
Riverside has been selected as one of a handful of Housing Associations to run a 6 month pilot of the new Right to Buy scheme for Housing Association tenants. Before the scheme is rolled out nationally the pilot aims to test a number of key issues, in particular the nature and level of demand in different parts of the country, the values at which homes will be sold and the processes required to implement the full scheme.

For Riverside sales will be restricted to around 200 properties across the 6 local authority areas making up the Liverpool City Region, and for the duration of the pilot scheme applications will be restricted to those who have been tenants for 10 years or more.

The Government's November Spending Review included the following announcements –

- From 1/4/2018 Housing Benefit for new tenants in social rented housing will be capped to Local Housing Allowance rates (the limits for tenancies in the private rented sector), including a shared room rate for under 35s who are single with no dependants.
- Government investment for new build will be focussed on shared ownership and 'affordable' housing for owner occupation.

Government will look to sharpen incentives for the New Homes Bonus and reduce the level of funding provided.

PUBLIC HEALTH

Prevention and Early Detection of Cancer
Cancer remains a particular challenge in Halton and is therefore a key priority for the local Health and Wellbeing Strategy. Contributory factors include poor diet, smoking and screening rates. However, in spite of the challenges that exist, Human Papilloma Virus (HPV) vaccination rates, to protect girls from developing cervical cancer later in life, are currently on target.

Whilst 62 day breaches for referral to cancer treatment are currently on target, Public Health and the CCG are working with Hospital Trusts to improve reporting and system wide assurance. A new Health and Wellbeing Action Plan is also being developed to address system wide issues which should help to develop a whole systems approach to reducing breaches.

Improved Child Development
Work is underway with the Health Visiting Service to ensure that the additional components of the Healthy Child Programme will be delivered to all eligible families.

Public Health is also working with the Clinical Commissioning Group (CCG) and local hospitals to place a paediatrician in the community for families and importantly with health professionals. It is hoped that this development will build knowledge and expertise, which has been proven elsewhere, to improve patient care and reduce A&E attendance by families. A paediatrician has been recruited to this programme.

Reduction in the number of falls in Adults
The new falls pathway is on course and now includes low-level services including falls exercise, environmental checks and telecare installations. This has helped to further support the overall redesign of the falls service that has seen a significant reduction in areas such as hospital readmissions and a reduction in the number of people suffering a fracture neck of femur injury.

Reduction in the harm from alcohol
Good progress continues to be made in implementing the Halton Strategy Action Plan. Following the "Halton Alcohol Inquiry", which instigated a community conversation around alcohol, an Alcohol Inquiry group was established. The group has developed a range of recommendations for local action and the group is now being supported by local stakeholders to make these recommendations a reality.

Prevention and Early Detection of Mental Health conditions
Good progress continues to be made on implementing the Suicide strategy action plan.

This includes:

- Working towards Halton being a suicide safer community
- Developing a local multi-agency suicide campaign awareness plan

Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals

3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the first quarter that will impact upon the work of the Directorate including:

PREVENTION & ASSESSMENT

Domiciliary Care
Work has commenced on transforming and redesigning the current domiciliary care service in Halton. This will take the form of developing in conjunction with local providers, professionals and members of the public a new model of service delivery that is designed around an individual's needs. This will require more collaborative working, but in the first stages will need a full analysis of the existing service provision in the borough.

Community MDTs
There is early development of a Community Multi-Disciplinary Team (MDT) approach in Halton. This is being introduced to help the management of people with Complex Needs and intends to Improve the health and well-being of people with complex needs, building on the current Social Care In Practice Model.

Financial Abuse
A task and finish group was established to look at developing a Financial Abuse Toolkit which is intended to be used by practitioners and members of the public to provide information to anyone concerned that someone they know maybe a potential victim of financial abuse. This has been agreed by Halton Safeguarding Adult Board and an e learning programme is now being developed which will enhance this further.

COMMISSIONING & COMPLEX CARE

Mental Health Services:
Social Work for Better Mental Health: following the publication of national guidance in 2013 about the roles and functions of social workers in mental health services, the Department of Health is rolling out an implementation programme for localities around the country. Halton, in partnership with Sefton Council, has taken up the offer to be an early implementer of this programme, which will be starting early in 2016. The outcomes of this programme, which will involve partners in the NHS, will be a proper focusing of the work

that social workers do within mental health services, and the development of effective service user feedback about the services that are delivered.

Direct Payments in Mental Health: these are a key way of supporting people to manage their own care and support, by channelling the funding for their services directly to the person concerned, so that they can determine for themselves and purchase the right support to meet their needs. In mental health services in Halton, reflecting the pattern across the country, take-up of this approach has been low.

In 2015, a detailed review and analysis of the reasons for this low take-up in Halton was undertaken by the Directorate's policy team, and a number of recommendations were made. As a result of awareness-raising across health and social care staff, the numbers of people with mental health problems receiving direct payments has shown a slow but steady increase, and is now higher than it has ever been. A new service has also been commissioned from Halton Disability Partnership, which will be in place from early 2016. This will work directly with people who use mental health services to practically support and encourage them to take up direct payments. It is expected that this will lead to a further increase in the numbers of people with mental health problems who receive direct payments.

PUBLIC HEALTH

Cancer Screening

To date Halton is not achieving its cancer screening targets for cervical and bowel cancer. Cervical screening stands at 75.8% with a target of 80% and bowel cancer at 50.7% with a target of 60%, however, the overall trend shows an improvement. Public Health England is responsible for delivering on bowel screening and Halton CCG is responsible for cervical screening. Halton have signed up to a 2 year Memorandum of Understanding with Local Public Health England Screening and Immunisation team to address cancer screening across the zone.

Whilst breast screening uptake in Halton is currently above the national target, there is still wide practice variation of uptake across the Borough. The service was offered from a mobile screening unit based at the Highfield Hospital site. However, due to essential demolition work the unit has now moved to Warrington which may affect uptake. Work is currently underway to relocate the service locally as soon as possible.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2015-16 Directorate Business Plans.

Progress concerning the implementation of all Directorate high-risk mitigation measures was reported in Quarter 2 and Risk Registers are currently being reviewed for 2015/16 in tandem with the development of next year's Directorate Business Plans.

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.

"Rate per population" vs "Percentage" to express data

Four BCF KPIs are expressed as rates per population. "Rates per population" and "percentages" are both used to compare data but each expresses the same amount in a different way. A common guide used is that if a percent is less than 0.1 then a rate (e.g. per 100,000) is used. For example, permanent admissions to residential care expressed as a rate (50 admissions per or for every 100,000 people) makes more sense when comparing performance with other authorities rather than as a percentage (0.05%) which is quite a small number and could be somewhat confusing. More examples below:

Location	Rate per 100,000 population	Percent
Region A	338.0	0.34%
Region B	170.5	0.17%
Region C	225.6	0.23%

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q3 Progress
PA 1	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21, 25) March 2016.**	✓
PA 1	Implement the Care Act **(AOF 2,4,10, 21) March 2016.**	✓

Supporting Commentary

PA 1 Monitor effectiveness of Better Care Fund pooled budget:
Pooled Budget is on target to deliver a small underspend at the end of the year.

PA 1 Implement the Care Act:
All key stages of the first phase of the implementation of the Care Act have been completed.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q3 Actual	Q3 Progress	Direction of travel
PA 1	Numbers of people receiving Intermediate Care per 1,000 population (65+)	80	77	414 (Cumulative to end of Q3 1216)	✓	↑
PA 2	Percentage of VAA Assessments completed within 28 days	86.8%	85%	61.59%	?	↓
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	95.5%	97%	98%	✓	↑
PA 6b	Percentage of items of equipment and adaptations delivered within 5 working days – new indicator	89.5%	95%	91%	✓	↑
PA 11	Permanent Admissions to residential and nursing care homes per 100,000 population,65+ (ASCOF 2A1) *Better Care Fund performance metric*	600.8	635.1	398.9	✓	↓
PA 12	Delayed transfers of care (delayed days) from hospital per 100,000 population *Better Care Fund performance metric*	tbc	2831	501 v target 472 (To November 2015)	N/A	N/A
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	tbc	12771.8 Admissions: 16,141 Pop: 126,380	11162 V plan 12060	N/A	N/A
PA 15	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric*	823.89	884.2	**685.1**	✓	↑

Ref	Measure	14/15 Actual	15/16 Target	Q3 Actual	Q3 Progress	Direction of travel
PA 16	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B1) *Better Care Fund performance metric*	65.6	70%	**Annual collection**	N/A	N/A
PA 20	Do care and support services help to have a better quality of life? (ASC survey Q 2b) *Better Care Fund performance metric*	93.3%	91%	**Annual collection**	N/A	N/A

Supporting Commentary

PA 1 Numbers of people receiving Intermediate Care per 1,000 population (65+):
IC referrals are up by approximately 6% at the same point last year.

PA 2 Percentage of VAA Assessments completed within 28 days:
VAA's completed within 28 days continues to be monitored, exception reports are circulated on a monthly basis, along with in team support for social workers. There is potentially some data loading issues which are currently being looked into.

PA 6a Percentage of items of equipment and adaptations delivered within 7 working days:
This remains on target to achieve the indicator.

PA 6b Percentage of items of equipment and adaptations delivered within 5 working days:
This indicator will continue to be monitored but are confident that it will be achieved**.**

PA 11 Permanent Admissions to residential and nursing care homes per 100,000 population, aged65+:
We are likely to be within this target. Total of 81clients aged 65 plus have been placed in permanent care.

PA 12 Delayed transfers of care (delayed days) from hospital per 100,000 population:
Both October and November had a very large number of delayed discharges this put us over target, however the reason for this is currently unknown.

PA 14 Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population:
Data to end November 2016, reported as whole numbers. We are 898 admissions below plan (7% below plan) and 1.4% below last year non-elective activity

PA 15 Hospital re-admissions (within 28 days) where original admission was due to a fall, aged 65+:
Please note that the data included is for quarter 2 as the quarter 3 information will not be available until February 2016.

PA 16 Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services:
No data available, annual collection only.

PA 20 Do care and support services help to have a better quality of life?:
No data available, annual collection only.

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q3 Progress
CCC 1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2016.** (AOF 4)	✓
CCC 1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2016.** (AOF 4)	✓
CCC 1	Continue to work with the 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 2016.** (AOF 4)	✓
CCC 1	The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **Mar 2016.** (AOF 4, AOF 18)	✓

Key Performance Indicators

Supporting Commentary

CCC1 - Services / Support to children and adults with Autism:
The Autistic Spectrum Condition Group continues to monitor progress and is currently reviewing same against the recently published and updated National strategy for adults in England.

CCC 1 Dementia Strategy:
During Q3 the Post Diagnosis Community Pathway specification what developed, which will go through a procurement process during Q4. This will see the reconfiguration of existing services under a Prime Provider Model.

The Living Well community screening pilot (an action of the Dementia Delivery Board)is being taken forward by HBC Health Improvement Team, who are developing a quarterly training programme to support front line stakeholders (not just HBC) in memory, falls and loneliness awareness and screening.

During Q3 the posts within the new Admiral Nurse Service were appointed to, with the service

being fully operational from Q4

CCC 1 Mental Health:
The outcome of the independent review of the Acute Care Pathway and Later Life and Memory Service has now been published. An action plan has been developed across partner agencies and the council is taking proactive steps to support the recommendations of the review. Social care staff are directly involved in all relevant aspects of the action plan and the process is being fully monitored by the Halton Mental Health Delivery Group.

CCC 1 Homelessness Strategy:
The homelessness strategy 2014 – 2018 is a working document that captures future change, trends, and demands. A consultation event was held in June 2015 to review the strategy and action plan, which involved both statutory and voluntary agencies to determine the key priorities for next 12 months. The main priorities identified for 2015/16 are Health and Homelessness, and Complex needs and a number of initiatives have been developed to improve this service area provision. The focus will be around the key priorities, with additional emphasis placed upon achieving the objectives outlined within the St Mungo's report, which will be incorporated within the reviewed strategy action plan. The purpose of the review is to ensure that the working document is current and reflects legislative and economical change.
As part of the homelessness strategy a further youth strategy will be developed to identity key area services for young people. A consultation event was held mid-2015 and the CLG consultant is working directly with Halton to identify key objectives and good practice.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q3 Actual	Q3 Progress	Direction of travel
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	2.64	3.0	**2.45**	?	↓
CCC 4	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	✓	↑
CCC 5	Number of households living in Temporary Accommodation (Previously NI 156, CCC 7).	19	11	15	✓	↑

Supporting Commentary

CCC 3 Adults with mental health problems helped to live at home per 1,000 population:
Although the numbers of people with mental health needs supported to live at home has slowly reduced over time, this is mainly due to the implementation of the Acute Care Pathway in the 5Boroughs, which has resulted in a reduction in the overall caseloads of

the social workers. The review of the ACP has now been published, and this, along with the work being done in the Social Work for Better Mental Health programme, will mean a refocusing of the social care input into mental health services and should result in an increase in numbers of people supported.

CCC 4 The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years:
The Authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients.
The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC 5 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 fully utilise and continue to promote all service options available to clients.

The changes in the TA process and amended accommodation provider contracts had a big impact upon allocation placements. However, the opening of Brennan Lodge hostel, which offers 39 single units and the new priority legislation, will have a gradual increase on the total number of clients placed into temporary accommodation.
The emphasis is focused on early intervention and empowerment to promote independent living.

The improved service process has developed stronger partnership working and contributed towards an effective move on process for clients.

Public Health

Key Objectives / milestones

Ref	Milestones	Q3 Progress
PH 01	Work with PHE to ensure targets for HPV vaccination are maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2016**	✓
PH 01	Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2016**	?
PH 01	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2016**	?
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 2016**	✓
PH 02	Fully establish the Family Nurse Partnership programme **March**	✓

	2016	
PH 02	Facilitate the Halton Breastfeeding programme so that all mothers have access to breastfeeding-friendly premises and breastfeeding support from midwives and care support workers. Achieve UNICEF baby friendly stage 3 award **March 2016**	✓
PH 03	Development of new triage service between Rapid Access Rehabilitation Team and Falls Specialist Service. **March 2016**	✓
PH 03	New Voluntary sector pathway developed to support low-level intervention within falls in the borough. **March 2016**	✓
PH 04	Implement the Halton alcohol strategy action plan working with a range of partners in order to minimise the harm from alcohol and deliver on three interlinked outcomes: reducing alcohol-related health harms; reducing alcohol-related crime, antisocial behaviour and domestic abuse and establishing a diverse, vibrant and safe night-time economy. **March 2016**	✓
PH 04	Deliver a local education campaign to increase the awareness of the harm of drinking alcohol when pregnant or trying to conceive. **March 2016**	✓
PH 04	Hold a community conversation around alcohol – using an Inquiry approach based on the citizen's jury model of community engagement and ensure recommendations for action are acted upon by all local partners. **March 2016**	✓
PH 05	Successfully implement a new tier 2 Children and Young Peoples Emotional Health and Wellbeing Service. **March 2016**	✓
PH 05	Monitor and review the Mental Health Action plan under new Mental Health Governance structures. **March 2016**	✓
PH 05	Implementation of the Suicide Action Plan. **March 2016**	✓

Supporting Commentary

PH 01 HPV vaccinations:
Initial preliminary results show that first dose HPV vaccination are above 90% target for year, and dose 2 is already almost at target despite not being formerly reported until 2017. We will continue to engage with current school nurse providers to support high level delivery.

PH 01 Cancer Screening Programmes:
Halton is currently working across the wider Merseyside authorities area alongside Public Health England (PHE) on a Bowel Cancer Screening Campaign to encourage individuals to 'Use your Kit'. The campaign features TV, Radio as well as visible promotional materials on Street signs, bus shelters, buses, taxis etc. The evaluation is ongoing and previous evaluation of the marketing campaign has proven effective elsewhere.

Breast screening uptake at 71.4% is above the national target of 70%. There is still wide practice variation for uptake across the Borough. The service is offered from a mobile

screening unit. Until recently the unit was located at the Highfield Hospital site, but due to essential demolition work, was forced to move location at short notice. The unit will be based in Warrington for a period of time which may adversely affect uptake in the short term. We are working with the unit to identify a longer term solution to relocate more locally as soon as possible.

PH 01 Referral to treatment:
62 day breaches for referral to a cancer treatment are now being reported through the Halton System Resilience Group which includes the CCG and adult social care. Individual breaches by hospitals continue to be investigated and analysed so that the root causes for the delays can be assessed and mitigated. 62 Day referral is currently above target indicators. Public Health and CCG are currently working with Trusts to improve reporting and system wide assurance.

A new Health and Wellbeing Cancer Action plan is being developed to address system wide issues which should help develop a system approach to reducing breaches.

PH 02 Early Life Stages:
Work is underway with the Health Visiting Service to ensure that the additional components of the national Healthy Child Programme will be delivered to all eligible families. For example, each child aged 2-21/2 will have a health developmental check, the results of which will be shared with the early years setting to inform their assessment of the child and services will collaboratively put in place a support package as required.

The 'BabyClear' smoking cessation programme is being delivered in Halton to enhance smoking cessation support to all pregnant women.

Public Health and the CCG are working with the local hospitals to place a paediatrician in the community. The aims of the pilot are to increase access to paediatric expertise within the community for families and importantly for health professionals. This will build knowledge and expertise, which has been shown elsewhere to improve patient care, and reduce attendance by families at A&E. A paediatrician has been recruited to the programme.

In collaboration with children's commissioners researchers have been recruited to better understand child development in Halton, and make recommendations for how it can be improved.

PH 02 Family Nurse Partnership programme:
Halton's Family Nurse Partnership programme is fully operational, all staff have been trained, and mothers are being recruited to the programme. At present the service has the capacity to work with all eligible families. This programme supports young teenage parents to improve outcomes for their children. The programme has now been recruiting patients for a year, and an event in January 2016 is taking place to reflect on progress made.

PH 02 Breastfeeding programme:
Bridgewater Community Health Trust, Halton and St Helens division achieved Stage 3 UNICEF Baby Friendly Inspection (BFI) status in July 2015. Achieving stage 3, the final BFI stage, shows that the services are fully able to support women to breastfeed through their policies, training and staff knowledge. Breastfeeding support continues to be available across the borough in community and health settings. The infant feeding

coordinator and children's centres are working towards achieving BFI in the children's centres.

PH 03 New triage service - Rapid Access Rehabilitation Team and Falls Specialist Service:
The new pathway that incorporates the initial falls triage is now in place and complete. The impact has been positive in relation to patients time to assessment.

PH 03 Voluntary sector pathway to support low-level intervention within falls:
The pathway is on course and now includes low-level services including falls exercise, environmental checks and telecare installations. This has helped to further support the overall redesign of the falls service that has seen a significant reduction in areas such as hospital readmissions and a reduction in the number of people suffering a fracture neck of femur. The next stage is to further increase the voluntary sector support which will take place over the next quarter.

PH 04 Alcohol Strategy Action Plan:
Good progress is being made towards implementing the Halton alcohol strategy action plan.
Key activity includes:

- Developing a coordinated alcohol awareness campaign plan.
- Delivery of alcohol education within local school settings (Healthitude, R U Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Ensuring the early identification and support of those drinking above recommended levels through training key staff members in alcohol identification and brief advice (alcohol IBA).
- Reviewing alcohol treatment pathways
- Working closely with colleagues from licensing, the community safety team, trading standards and Cheshire Police to ensure that the local licensing policy supports the alcohol harm reduction agenda, promoting more responsible approaches to the sale of alcohol (e.g. promotion of Arc Angel and the local pub watch schemes within Halton), promoting a diverse night-time economy.
- Working to influence government policy and initiatives around alcohol: 50p minimum unit price for alcohol, restrictions of all alcohol marketing, public health as a fifth licensing objective.

PH 04 Education campaign around alcohol:
The 'please stop drinking mummy' campaign ran from February to July 2015, and is still ongoing through social media and websites. The campaign has been well received with good traffic to sites, and positive feedback from midwives that it has helped them to discuss drinking habits with pregnant women.

PH 04 Community conversation around alcohol:
The Inquiry group have developed recommendations for local action related to: alcohol education in schools and educating parents, alcohol licensing and promoting responsible retailing, alcohol advertising and education around alcohol especially awareness of alcohol units and recommended safe drinking levels. These were shared with local stakeholders at a well-attended launch event held in June. Local stakeholders will now support the group going forward in making these recommendations a reality. Members of the Inquiry group attended the local alcohol strategy group to ensure their recommendations are taken forward locally.

PH 05 Children and Young People Health and Wellbeing Service:
Five Boroughs NHS trust have been jointly commissioned by the CCG and Public Health to deliver the tier 2 children and young people's mental health service. This service has now been in place since July 2015 and as well as providing the targeted mental health service, work will include mental health and wellbeing training for staff working with children and young people, such as schools, school based face-to-face work and an online counselling service.

PH 05 Mental Health Action plan:
The action plan and activity reports from sub groups are reviewed at the Mental Health Oversight Board.
All new Mental Health roles have individuals in post and are beginning to move forward the mental health promotion and delivery agendas.

PH 05 Suicide Action Plan:
Good progress is being made towards implementing the Suicide strategy action plan. This work is being overseen by the Halton suicide prevention partnership.
Key developments include:

- Working towards Halton being a suicide safer community
- Developing a local multi-agency suicide awareness campaign plan
- Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals who interact with known groups at high risk of suicide

Halton being part of a pilot programme across Cheshire and Merseyside to provide a support service for individuals bereaved by suicide. The service became operational on the 1st April 2015 and is called Amparo. Amparo provides support to anyone who has been affected by suicide within Halton.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q3	Current Progress	Direction of travel
PH LI 01	Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population *Published data based on calendar year, please note year for targets.*	179.8 *(2014)*	185.6 *(2015)*	180.3 (Oct 14 – Sep 15)	✓	↓
PH LI 02	A good level of child development	46% *(2013/14)*	TBC (Awaiting confirmation of new target definition)	54.7% (2014/15)	?	↑
PH LI 03	Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000	3237.6	3263.9	2904.1 (Oct 14 – Sep 15)	✓	↑

	population (PHOF definition).					
PH LI 04	Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population	814.0 (2013/14)	808.4	753.2 (Q2 15/16)	✓	↑
PH LI 05	Under 18 alcohol-specific admissions Crude Rate, per 100,000 population	60.5 (11/12 to 13/14)	55.0	Annual data only	✓	↑
PH LI 06	Self-reported wellbeing: % of people with a low happiness score	12.1% *(2013/14)*	11.1%	11.8% (2014/15)	?	↑

Supporting Commentary

PH LI 01 Mortality from all cancers at ages under 75:
The Data methodology for this indicator has changed from previous years making comparison with previous year's data difficult. Despite some annual fluctuations data does show an overall continual improvement with decrease in premature death from cancer over recent years.

PH LI 02 Child development:
There has been an improvement in the number of children reaching a good level of development, but this remains low.

PH LI 03 Falls and injuries in the over 65s:
Falls and injuries in the over 65s have reduced significantly below both last year's performance and the 2015/16 target. It is anticipated that this improvement will continue over the next quarter.

PH LI 04 Alcohol related admissions:
Alcohol related admissions during Q2 have reduced from the 2014/15 rate and are below the 2015/16 threshold (target).

PH LI 05 Under 18 alcohol-specific admissions:
Good progress is being made related to this indicator with the number of under 18 alcohol-specific admissions continuing to reduce and being below the 2015/16 threshold (target).

PH LI 06 Self-reported wellbeing:
Recent data identifies that we have not achieved target for 2014/15 with a higher self-reported low happiness score, though this still shows improvement on previous years scores.

APPENDIX 1 – Financial Statements

ADULT SOCIAL SERVICES AND PREVENTION & ASSESSMENT DEPARTMENT

Revenue Budget as at 31st December 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date underspend £'000
Expenditure				
Employees	6,816	4,960	4,881	79
Other Premises	113	55	62	(7)
Supplies & Services	399	263	265	(2)
Aids & Adaptations	113	61	88	(27)
Transport	17	8	8	0
Food Provision	28	12	15	(3)
Other Agency	22	18	18	0
Transfer to Reserves	1,874	0	0	0
Contribution to Complex Care Pool	17,330	6,011	5,993	18
Total Expenditure	**26,712**	**11,388**	**11,330**	**58**
Income				
Fees & Charges	-302	-210	-206	(4)
Reimbursements & Grant Income	-196	-132	-120	(12)
Transfer from Reserves	-940	-46	-46	0
Capital Salaries	-121	-91	-91	0
Government Grant Income	-300	-300	-300	0
Other Income	-5	-5	-5	0
Total Income	**-1,864**	**-784**	**-768**	**(16)**
Net Operational Expenditure	**24,848**	**10,604**	**10,562**	**42**
Recharges				
Premises Support	331	248	248	0
Asset Charges	175	0	0	0
Central Support Services	2,193	1,572	1,572	0
Internal Recharge Income	-1,560	-1,162	-1,162	(1)
Transport Recharges	49	32	31	1
Net Total Recharges	**1,188**	**689**	**689**	**0**
Net Departmental Total	**26,036**	**11,292**	**11,250**	**42**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the second quarter of the financial year is £24,000 under budget profile excluding the Complex Care Pool.

Employee costs are currently showing £79,000 under budget profile. This is due to savings being made from vacancies within the department. Some of these vacancies have been advertised and have been or are expected to be filled in the coming months. A saving proposal has been agreed for the staffing budget for the 2016/17 financial year onwards relating to the deletion of a vacant post with Care Management. The current year underspend is therefore not set continue for the 2016/17 budget year onwards.

Other Premises expenditure is £7,000 over budget profile. This is a result of expenditure on maintenance and repairs for Independent Living equipment. There are approximately 324 stair lifts, 19 thru floor/wheelchair lifts and 77 ceiling track hoists requiring an annual service and potentially repairs. For quarter three, the cost included 125 visits to 106 properties.

Expenditure on Aids and Adaptations is £27,000 over budget at this stage of the financial year and this trend is expected to continue for the remainder of the year. As more service users are supported within their own homes, as opposed to moving into residential homes, this places pressure on this budget as more modifications to homes are required.

COMPLEX CARE POOL

Revenue Budget as at 31ST December 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	3,561	2,053	2,046	7
End of Life	192	184	213	(29)
Sub Acute	1,743	1248	1,226	22
Urgent Care Centres	615	615	615	0
Joint Equipment Store	810	270	270	0
Contracts & SLA's	1,197	520	542	(22)
Intermediate Care Beds	596	447	466	(19)
BCF Schemes	2,546	1405	1,405	0
Adult Care:				
Residential & Nursing Care	20,960	12,967	12,823	144
Domiciliary & Supported Living	9,569	8,381	8,378	3
Direct Payments	3,706	4,427	4,472	(45)
Day Care	463	292	303	(11)
Contingency	518	0	0	0
Total Expenditure	46,476	32,807	32,758	49
Income				
Residential & Nursing Income	-5,018	-3,709	-3,700	(9)
Community Care Income	-1,583	-990	-956	(34)
Direct Payments Income	-193	-185	-204	19
Income from other CCGs	-114	-86	-79	(7)
BCF Income	-9,451	-9,009	-9,009	0

Contribution to Pool	-12,166	-12,166	-12,166	0
ILF Income	-571	-428	-428	0
Other Income	-225	-223	-223	(0)
Total Income	-29,146	-26,796	-26,765	(31)
Net Divisional Expenditure	**17,330**	**6,011**	**5,993**	**18**

Comments on the above figures:

The overall net expenditure budget is £18,000 under budget profile at the end of quarter 3 of the financial year.

Intermediate Care Services includes spend for the Therapy & Nursing Teams, Rapid Access Rehabilitation and Reablement. Invoices relating to Intermediate Care Services continue to be slightly behind schedule. However, close monitoring will be undertaken between now and the end of the financial year to ensure these costs are accrued for correctly.

The End of Life service is delivering more hours that the contract value resulting in an overspend.

The total number of clients receiving a residential care package has decreased by 2.81% for the period April to December from 604 to 587 clients. However the average cost of a residential package of care for the same period has slightly increased from £547 to £550 for the same period.

The total number of clients receiving a domiciliary package of care has increased by 5.19% for the period April to December from 867 to 912 clients. The average cost of a domiciliary care package increased from £198 to £221 in the same period.

The total number of clients receiving a Direct Payment has increased by 9% for the period April to December from 379 clients to 414 clients. The reason for the increase is previously Independent Living Funded service users now coming under the management of local authorities. The average cost of a DP package increased from £252 to £258 for the same period.

The Adult Health and Social Care budget will continue to be monitored closely due to its volatile nature, to ensure a balanced budget is achieved.

Capital Projects as at 31st December 2015

	2015-16 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	500	375	310	190
Stair lifts (Adaptations Initiative)	250	188	181	69
RSL Adaptations (Joint Funding)	200	150	86	114
Community Meals Oven	10	0	0	10
Total	**960**	**713**	**577**	**383**

Comments on the above figures:

Spend on Disabled Facilities Grants funded projects and Joint Funded RSL Adaptations are currently running below budget profile. Spend to date on these two initiatives amounts to £396k, compared with £447k for the equivalent period in the previous financial year. The bulk of the capital allocations for 2014/15 were substantially spent by year-end and it is currently assumed

that this trend will continue in 2015/16, although the capital allocations will be monitored closely for the remainder of the year in light of the current reduced spend levels.

Spend on stair lift adaptations is currently running to budget profile, and is consistent with 2014/15 spend patterns.

The Community Meals Oven is a new project for 2015/16, and it is anticipated that the capital allocation will be fully spent during the final quarter of the year.

COMMISSIONING & COMPLEX CARE DEPARTMENT

Revenue Budget as at 31st December 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,533	5,322	5,202	120
Premises	243	185	165	20
Supplies & Services	2,102	1,630	1,627	3
Carers Breaks	427	347	351	(4)
Transport	187	140	140	0
Contracts & SLAs	90	68	77	(9)
Payments To Providers	3,531	2,273	2,273	0
Emergency Duty Team	93	14	14	0
Other Agency Costs	640	592	613	(21)
Total Expenditure	**14,846**	**10,571**	**10,462**	**109**
Income				
Sales & Rents Income	-218	-186	-175	(11)
Fees & Charges	-176	-132	-110	(22)
CCG Contribution To Service	-360	-237	-207	(30)
Reimbursements & Grant Income	-536	-391	-393	2
Transfer From Reserves	-620	0	0	0
Total Income	**-1,910**	**-946**	**-885**	**(61)**
Net Operational Expenditure	**12,936**	**9,625**	**9,577**	**48**
Recharges				
Premises Support	174	108	108	0
Transport	450	337	337	0
Central Support Services	1,516	1,136	1,136	0
Asset Charges	62	47	47	0
Internal Recharge Income	-2,479	-567	-567	0
Net Total Recharges	**-277**	**1,061**	**1,061**	**0**
Net Departmental Total	**12,659**	**10,686**	**10,638**	**48**

Comments on the above figures:

Net operational expenditure is £48,000 below budget profile at the end of the third quarter of the financial year.

Employee costs are currently £120,000 below budget profile. This results from savings made on vacant posts, specifically in relation to Day and Mental Health Services.
In the case of Day Services, the majority of these posts have now been recruited to, and the spend below budget is not anticipated to continue at this level for the remainder of the year. A saving proposal has been agreed in relation to the Mental Health Services staffing budget from 2016/17

onwards, relating to the deletion of vacant posts. The current year underspend is therefore, not set to continue after this year.

Income is below target to date. There is an anticipated shortfall on Fees & Charges income as a result of revised contract arrangements for the homeless hostel. Additionally, income received from the Clinical Commissioning Group is projected to be below target. This income relates to Continuing Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user's care packages. The shortfall is currently estimated to be in the region of £40,000 for the full year.

Trading income from Day Services ventures is forecast to over-achieve this year, principally as a result of contract for student work placements with Riverside College.
A temporary savings target reflecting this increased income has been approved as part of the 2016/17 budget setting process.

At this stage in the financial year, it is anticipated that a balanced budget overall will be achieved for the year. Whilst income is projected below target, this will be offset by in-year savings in other areas, principally on savings on staff turnover above the set target.

Capital Projects as at 31st December 2015

	2015-16 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
ALD Bungalows	200	1	1	199
Lifeline Telecare Upgrade	100	0	0	100
Grangeway Court Refurbishment	75	9	9	66
Halton Carer's Centre Refurbishment	34	34	34	0
The Halton Brew	16	16	16	0
Total	**425**	**60**	**60**	**365**

Completion of the first phase of the Bungalows for ALD clients has been delayed due to the original contractor going into liquidation. The building works are now estimated to be completed in February 2016. Spend is now anticipated to be £200,000 in-year, with the remaining £200,000 of the original capital allocation being spent in 2016/17 on a further phase of build.

The Lifeline Telecare upgrade is due to be completed in March 2016, with payment to match the original capital allocation.

The refurbishment of Grangeway Court is expected to commence late in January 2016. £75,000 is expected to be spent of the original £400,000 capital allocation in the current financial year, with the balance to be spent in the 2016-17 financial year upon completion of the works.

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 31st December 2015

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	2,989	2,220	2,213	7
Supplies & Services	341	157	172	(15)
Other Agency	21	21	17	4
Contracts & SLA's	5,269	2,924	2,924	0
Total Expenditure	**8,620**	**5,322**	**5,326**	**(4)**
Income				
Other Fees & Charges	-109	-46	-34	(12)
Sales Income	-52	-52	-45	(7)
Reimbursements & Grant Income	-59	-51	-78	27
Government Grant	-9,565	-7,196	-7,196	0
Transfer from Reserves	-167	-137	-137	0
Total Income	**-9,952**	**-7,482**	**-7,490**	**8**
Net Operational Expenditure	**-1,332**	**-2,160**	**-2,164**	**4**
Recharges				
Premises Support	166	125	125	0
Central Support Services	2,163	2,037	2,037	0
Transport Recharges	21	11	11	0
Net Total Recharges	**2,350**	**2,173**	**2,173**	**0**
Net Departmental Total	**1,018**	**13**	**9**	**4**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the third quarter of the financial year is £4,000 under budget profile.

From 01 October, the commissioning of the Children's Public Health Services moved to the Council. The Council's responsibilities now include Health Visiting Services and Family Nurse Partnership (FNP) services (targeted service for teenage mothers). This transfer of 0-5 Children's Services increased the public health grant for 2015/16 by £1.41million.

However, as reported in the previous quarter, in June the Chancellor of the Exchequer announced a package of savings to be made across Government Departments in 2015/16, including a reduction of £200 million from the current year's public health grant. This in year reduction represents a 6.2% cut to the national public health grant. As a result of the consultation process, it has been confirmed that Halton's grant allocation for 2015/16 has been reduced by £630,000, to £9,565,000. Therefore the department will need to use reserves to achieve a balanced budget position.

Other fees & charges income is currently showing £12,000 below budget profile. This is due in the main to domestic pest control fees income underachieving. The income target has already been

reduced, as it was highlighted as unachievable. Sales income is £7,000 below budget profile. Air Pollution Prevention Control income is received in the first quarter of the financial year and is not expected to change during the fourth quarter. However, a higher than anticipated reimbursement & grant income from the Health Improvement Team of £27,000 has offset the underachievement within the Environmental, Public Health & Public Protection Division.

It is expected the net spend outturn position will be in line with budget following the transfer of funding from reserves to ensure Public Health spend for the year is fully funded from grant.

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.*